February 10, 2022

NOTICE

The Board of Directors of the Kaweah Delta Health Care District will meet in a Quality Council Committee meeting at 7:30AM on Thursday, February 17, 2022, in the Kaweah Health Lifestyle Fitness Center Conference Room, 5105 W. Cypress Avenue, Visalia, CA 93277.

The Board of Directors of the Kaweah Delta Health Care District will meet in a Closed Quality Council Committee at 7:31AM on Thursday, February 17, 2022, in the Kaweah Health Lifestyle Fitness Center Conference Room, 5105 W. Cypress Avenue, Visalia, CA 93277, pursuant to Health and Safety Code 32155 & 1461.

The Board of Directors of the Kaweah Delta Health Care District will meet in an open Quality Council Committee meeting at 8:00AM on Thursday, February 17, 2022, in the Kaweah Health Lifestyle Fitness center Conference Room, 5105 W. Cypress Avenue, Visalia, CA 93277.

All Kaweah Delta Health Care District regular board meeting and committee meeting notices and agendas are posted 72 hours prior to meetings in the Kaweah Health Medical Center, Mineral King Wing entry corridor between the Mineral King lobby and the Emergency Department waiting room.

The disclosable public records related to agendas are available for public inspection at Kaweah Health Medical Center – Acequia Wing, Executive Offices (Administration Department) {1st floor}, 400 West Mineral King Avenue, Visalia, CA and on the Kaweah Delta Health Care District web page https://www.kaweahhealth.org.

KAWEAH DELTA HEALTH CARE DISTRICT
Michael Olmos, Secretary/Treasurer

Cindy Moccio

Cindy Moccio
Board Clerk, Executive Assistant to CEO

DISTRIBUTION:
Governing Board, Legal Counsel, Executive Team, Chief of Staff
http://www.kaweahhealth.org

KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS
QUALITY COUNCIL

Thursday, February 17, 2022
5105 W. Cypress Avenue
Kaweah Health Lifestyle Fitness Center Conference Room

ATTENDING: Board Members; David Francis – Committee Chair, Michael Olmos; Gary Herbst, CEO; Keri Noeske, RN, BSW, DNP, Vice President & CNO; Monica Manga, MD, Chief of Staff; Daniel Hightower, MD, Professional Staff Quality Committee Chair; Tom Gray, MD, Quality and Patient Safety Medical Director; Sandy Volchko DNP, RN CLSSBB, Director of Quality and Patient Safety; Ben Cripps, Vice President, Chief Compliance and Risk Management Officer; Evelyn McEntire, Director of Risk Management; and Rita Pena, Recording.

OPEN MEETING – 7:30AM

1. **Call to order** – *David Francis, Committee Chair*
2. **Public / Medical Staff participation –** Members of the public may comment on agenda items before action is taken and after it is discussed by the Board. Each speaker will be allowed five minutes. Members of the public wishing to address the Board concerning items not on the agenda and within the jurisdiction of the Board are requested to identify themselves at this time. For those who are unable to attend the beginning of the Board meeting during the public participation segment but would like to address the Board, please contact the Board Clerk (Cindy Moccio 559-624-2330) or cmoccio@kaweahhealth.org to make arrangements to address the Board.
3. **Approval of Quality Council Closed Meeting Agenda** – 7:31AM
   - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Daniel Hightower, MD, and Professional Staff Quality Committee Chair; James McNulty*
   - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Evelyn McEntire, RN, BSN, Director of Risk Management and Ben Cripps, Vice President & Chief Compliance and Risk Officer.*
4. **Adjourn Open Meeting** – *David Francis, Committee Chair*

CLOSED MEETING – 7:31AM

1. **Call to order** – *David Francis, Committee Chair & Board Member*
2. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Daniel Hightower, MD, and Professional Staff Quality Committee Chair*

3. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Evelyn McEntire, RN, BSN, Director of Risk Management, and Ben Cripps, Vice President & Chief Compliance and Risk Officer.*

4. **Adjourn Closed Meeting** – *David Francis, Committee Chair*

OPEN MEETING – 8:00AM

1. **Call to order** – *David Francis, Committee Chair*

2. **Public / Medical Staff participation –** Members of the public wishing to address the Committee concerning items not on the agenda and within the subject matter jurisdiction of the Committee may step forward and are requested to identify themselves at this time. Members of the public or the medical staff may comment on agenda items after the item has been discussed by the Committee but before a Committee recommendation is decided. In either case, each speaker will be allowed five minutes.

3. **Written Quality Reports –** A review of key quality metrics and actions associated with the following improvement initiatives:
   - 3.1. Interventional Cardiology Quality Report
   - 3.2. Central Line-Associated Bloodstream Infections (CLABSI) Quality Focus Team

4. **Orthopedic Surgery Quality Report** – A review of key quality outcomes and actions associated with the orthopedic surgical population. *Dan Allain, FNP, MSN, Vice President of Surgical Services.*

5. **Pain Management Committee Quality Report** - An overview of measures and actions related to pain management safety, effectiveness, intervention types and assessment. *Sandy Volchko, RN, DNP, Director of Quality and Patient Safety*, Tom Gray, MD, Medical Director of Quality & Patient Safety

6. **Update: Clinical Quality Goals** - A review of current performance and actions focused on the fiscal year 2022 clinical quality goals. *Sandy Volchko, RN, DNP, Director of Quality and Patient Safety*.

7. **Adjourn Open Meeting** – *David Francis, Committee Chair*

In compliance with the Americans with Disabilities Act, if you need special assistance to participate at this meeting, please contact the Board Clerk (559) 624-2330. Notification 48 hours prior to the meeting will enable the District to make reasonable arrangements to ensure accessibility to the Kaweah Delta Health Care District Board of Directors committee meeting.

Quality Improvement for Institutions

AMERICAN COLLEGE of CARDIOLOGY

Kaweah Health Medical Center PCI Data Quality Analysis

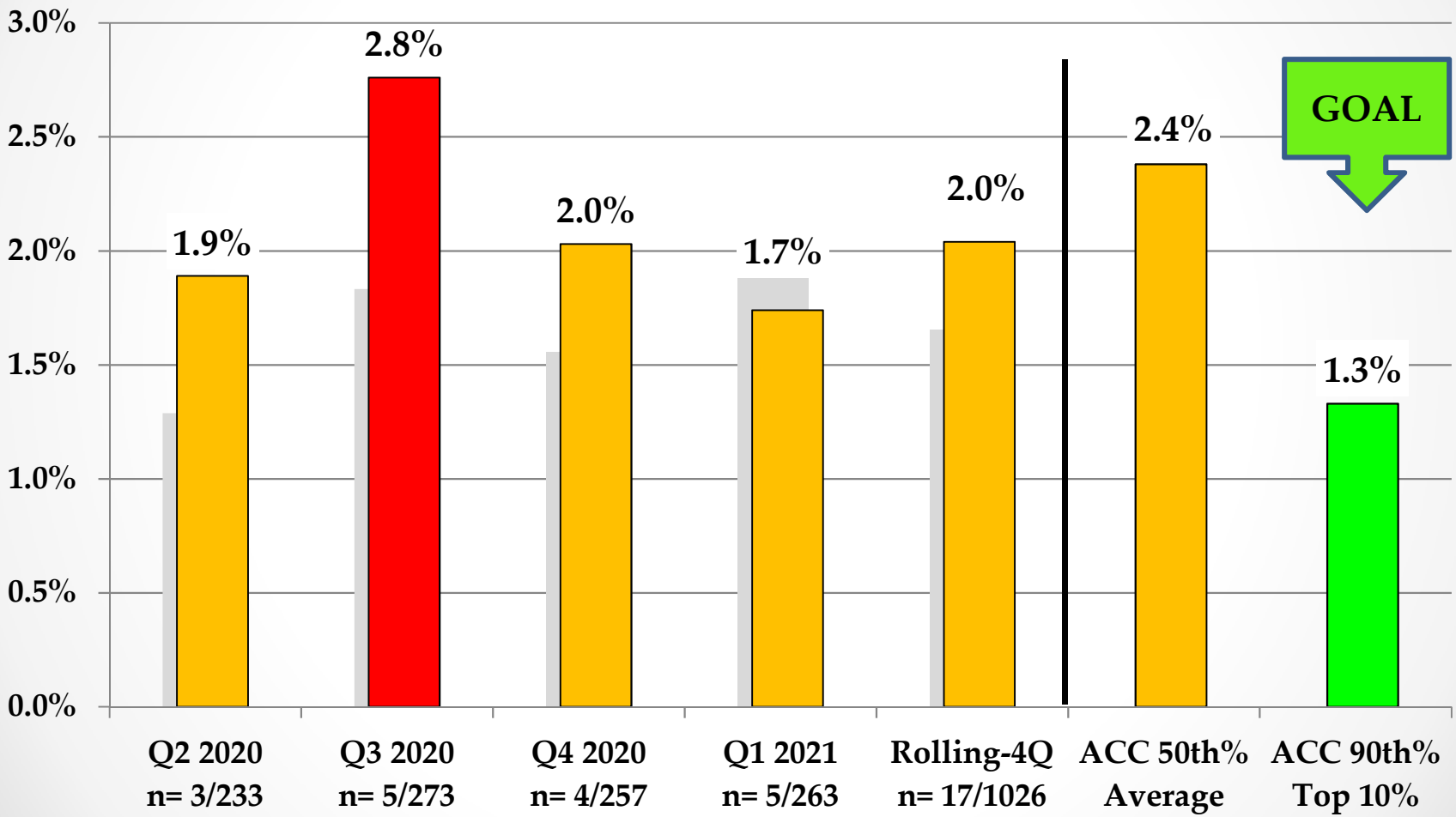
Q2 2020 – Q1 2021

Green = In the Top 10% of the Nation
Yellow = Better or Equal to the National Average
Red = Worse than National Average
Gray = Non-Risk Adjusted Value (for Reference only)

***Comparison reporting period Varies per Metric**

PCI In-Hospital Mortality Rate[1]

Risk Adjusted[InColor] (All patients)



R4Q Risk Adjusted O/E = 0.9

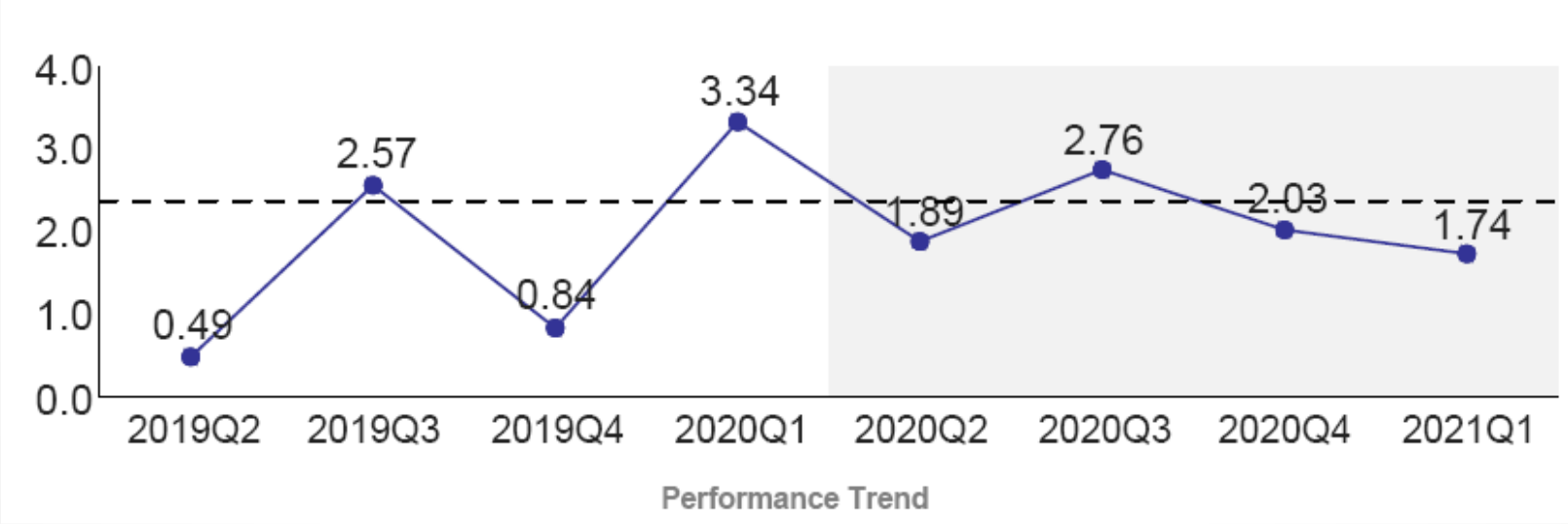
[1] PCI in-hospital mortality rate for all patients, risk adjusted. Exclusions include patients with a discharge location of "other acute care hospital." (ref: 4739, 4736)

***Comparison reporting period is 04/01/20 through 03/31/21**

PCI In-Hospital Mortality Rate[1]

Risk Adjusted (All patients)

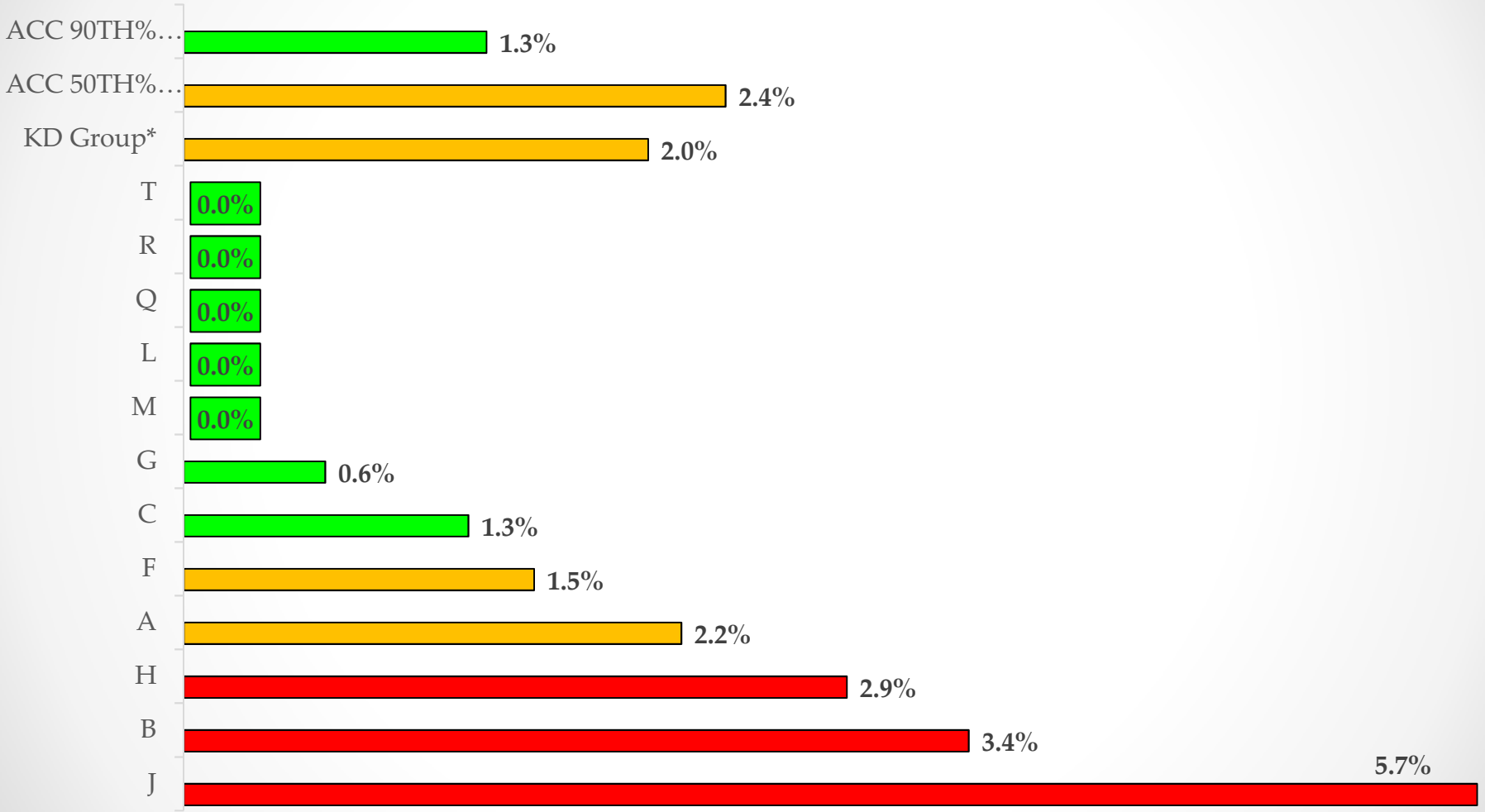
- TWO-YEAR TRENDING



[1] PCI in-hospital mortality rate for all patients, risk adjusted. Exclusions include patients with a discharge location of “other acute care hospital.” (ref: 4739, 4736)

PCI Mortality[1] Rate by Physician

All Patients - Rolling 4 Quarters (Q2 2020 – Q1 2021*)

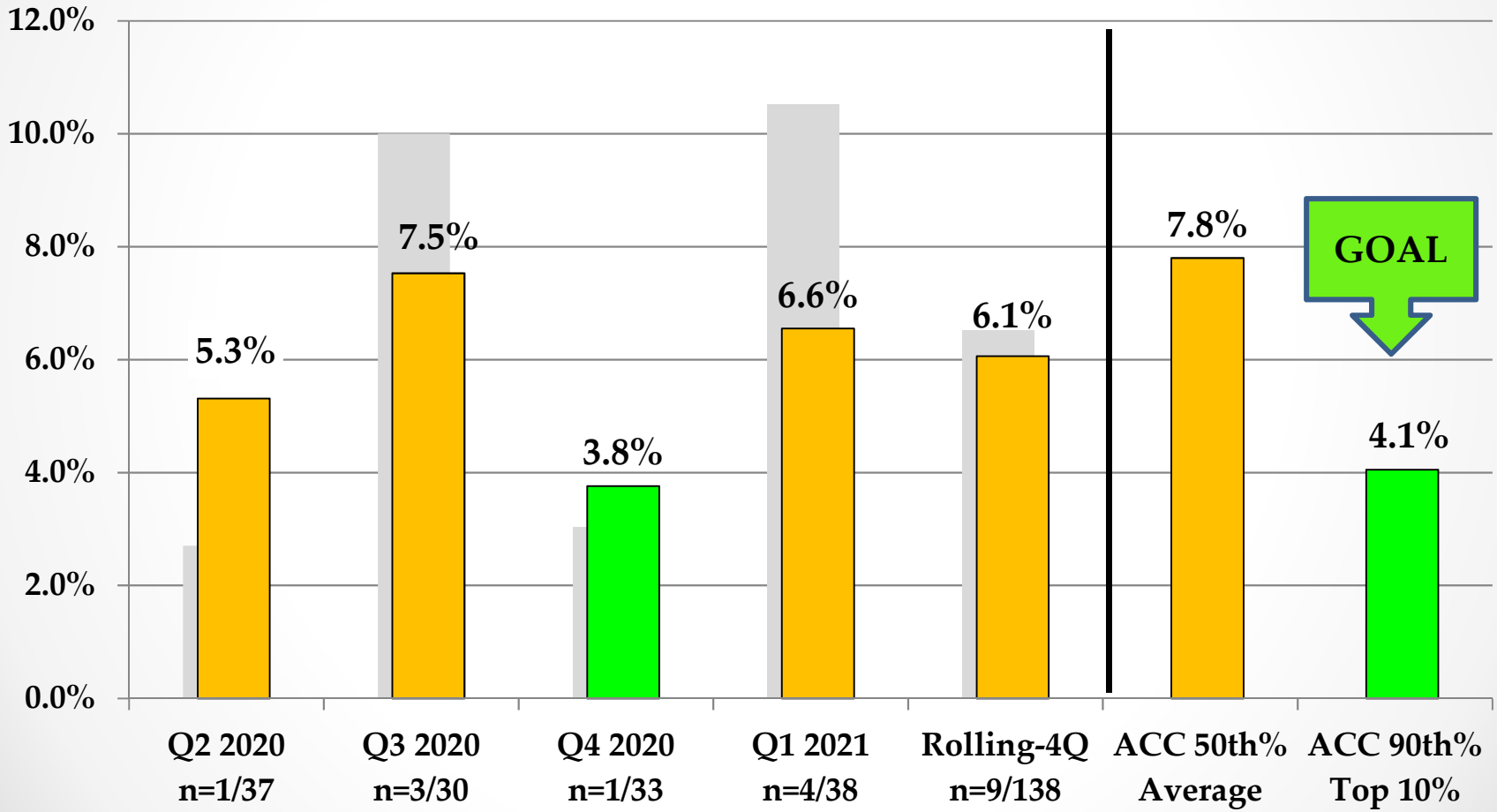


[1] PCI in-hospital mortality rate for all patients for that MD. Exclusions include patients with a discharge location of "other acute care hospital." (ref: NCDR/ACC Physician Dashboard)

*** Comparison reporting period is 04/01/20 through 03/31/21 – Raw DATA all Quarters**

PCI In-Hospital Mortality Rate[1]

Risk Adjusted[InColor] (STEMI patients)



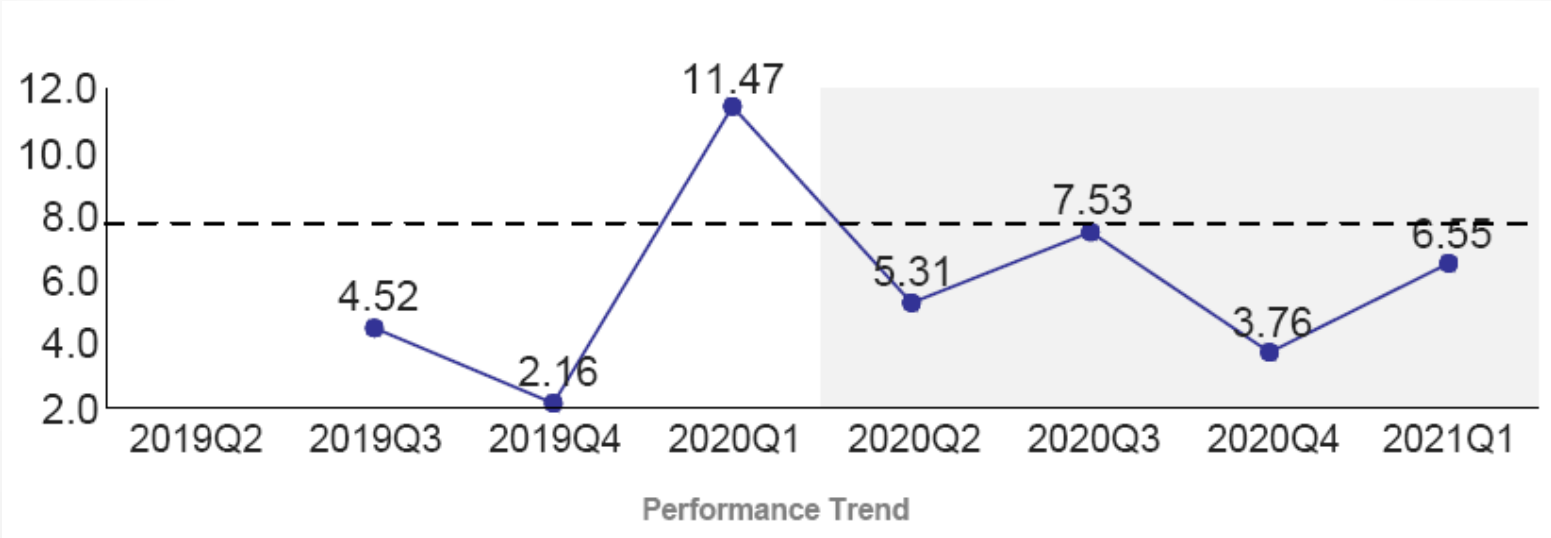
R4Q Risk Adjusted O/E = 0.85

[1] PCI in-hospital mortality rate for STEMI Pt.'s. (ref: 4740, 4734)

*** Comparison reporting period is 04/01/20 through 03/31/21**

PCI In-Hospital Mortality Rate[1]
Risk Adjusted (STEMI patients)

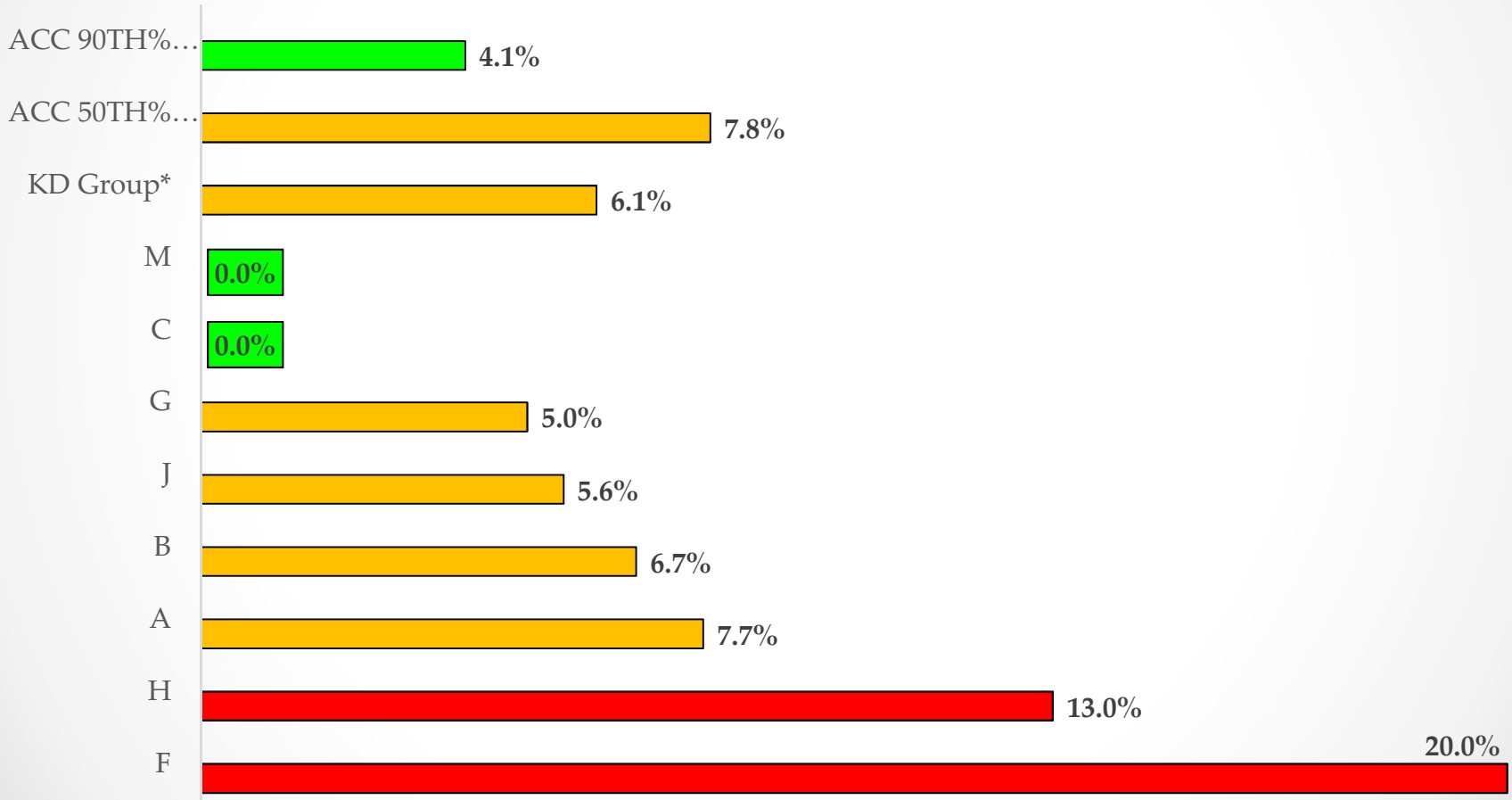
- TWO-YEAR TRENDING



[1] PCI in-hospital mortality rate for STEMI Pt.'s. (ref: 4740, 4734)

PCI Mortality[1] Rate by Physician

STEMI Patients - Rolling 4 Quarters (Q2 2020 – Q1 2021*)

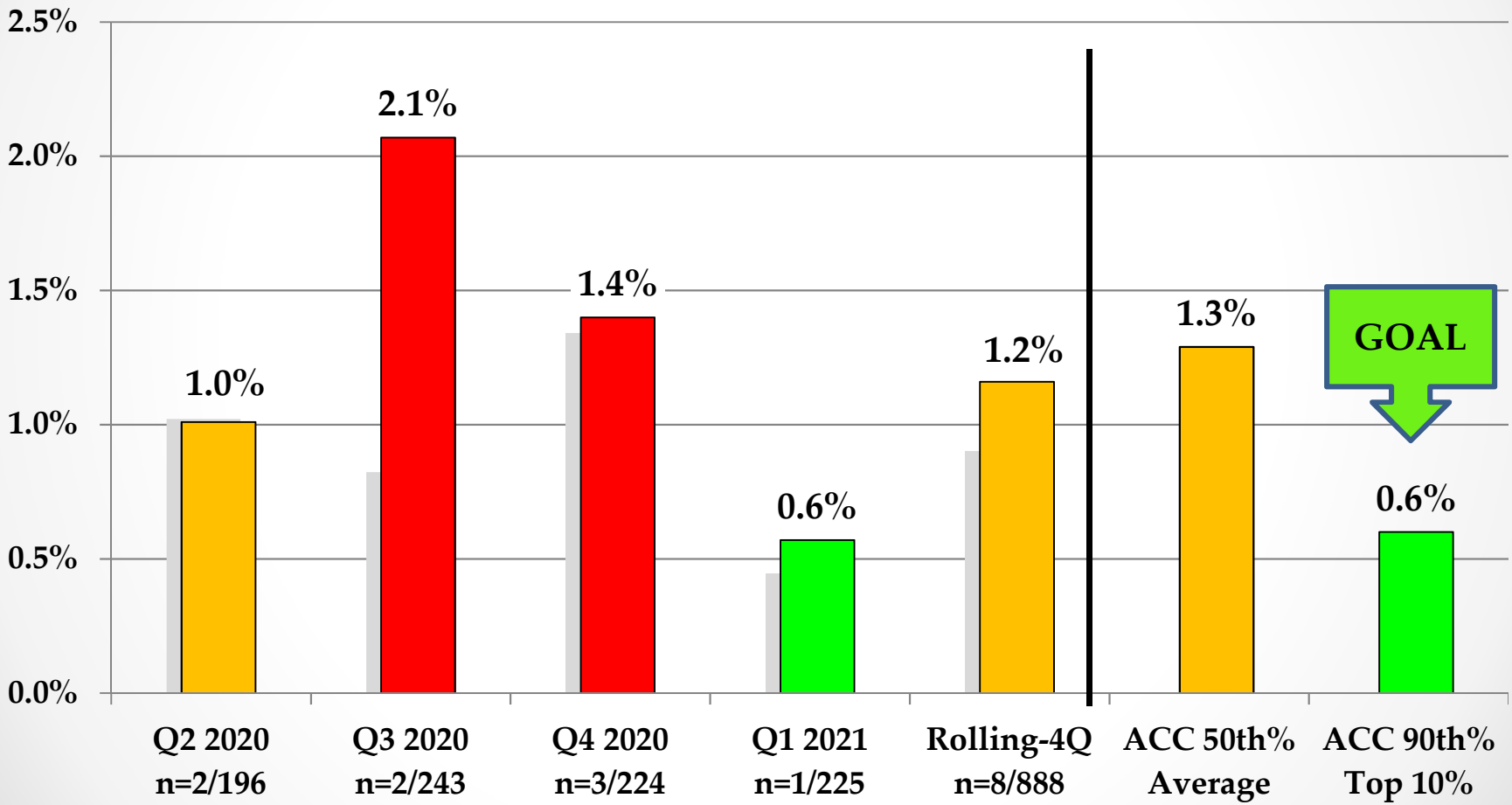


[1] PCI in-hospital mortality rate for STEMI patients for that MD. Exclusions include patients with a discharge location of "other acute care hospital." (ref: NCDR/ACC Physician Dashboard)

*** Comparison reporting period is 04/01/20 through 03/31/21 – Raw DATA all Quarters**

PCI In-Hospital Mortality Rate[1]

Risk Adjusted[InColor] (NSTEMI, unstable angina, electives)



R4Q Risk Adjusted O/E = 1.02

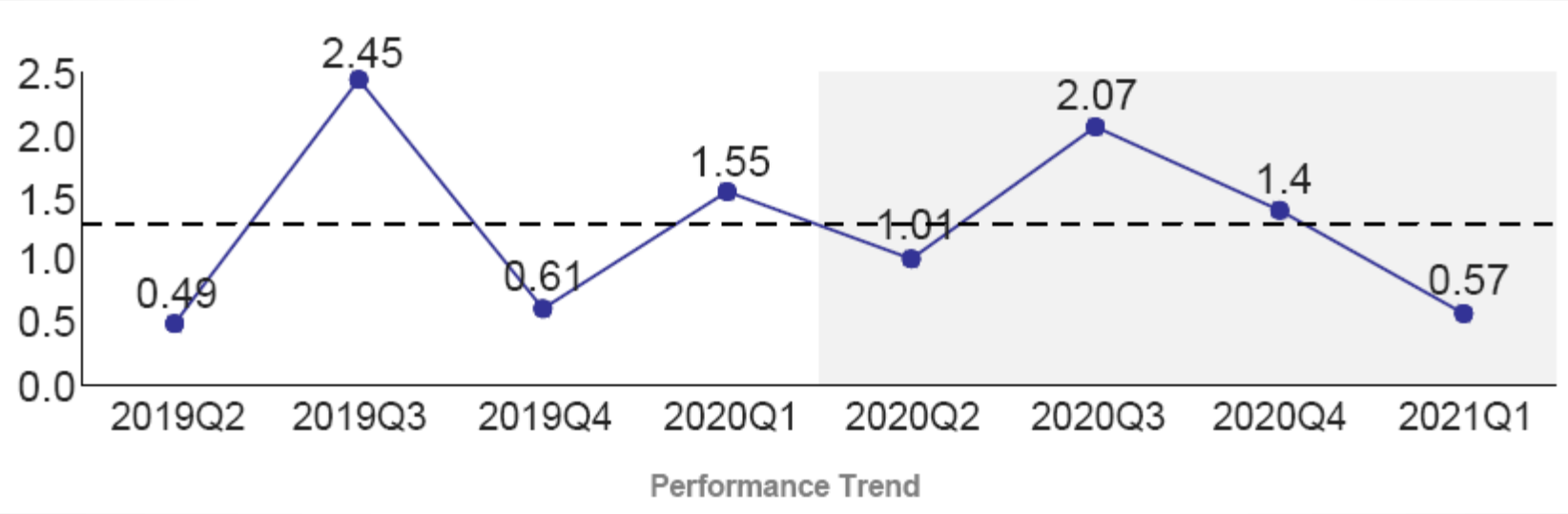
[1] PCI in-hospital mortality rate for all patients Excluding STEMI. Exclusions include patients with a discharge location of "other acute care hospital." (ref: 4741, 4735)

*** Comparison reporting period is 04/01/20 through 03/31/21**

PCI In-Hospital Mortality Rate[1]

Risk Adjusted (NSTEMI, unstable angina, electives)

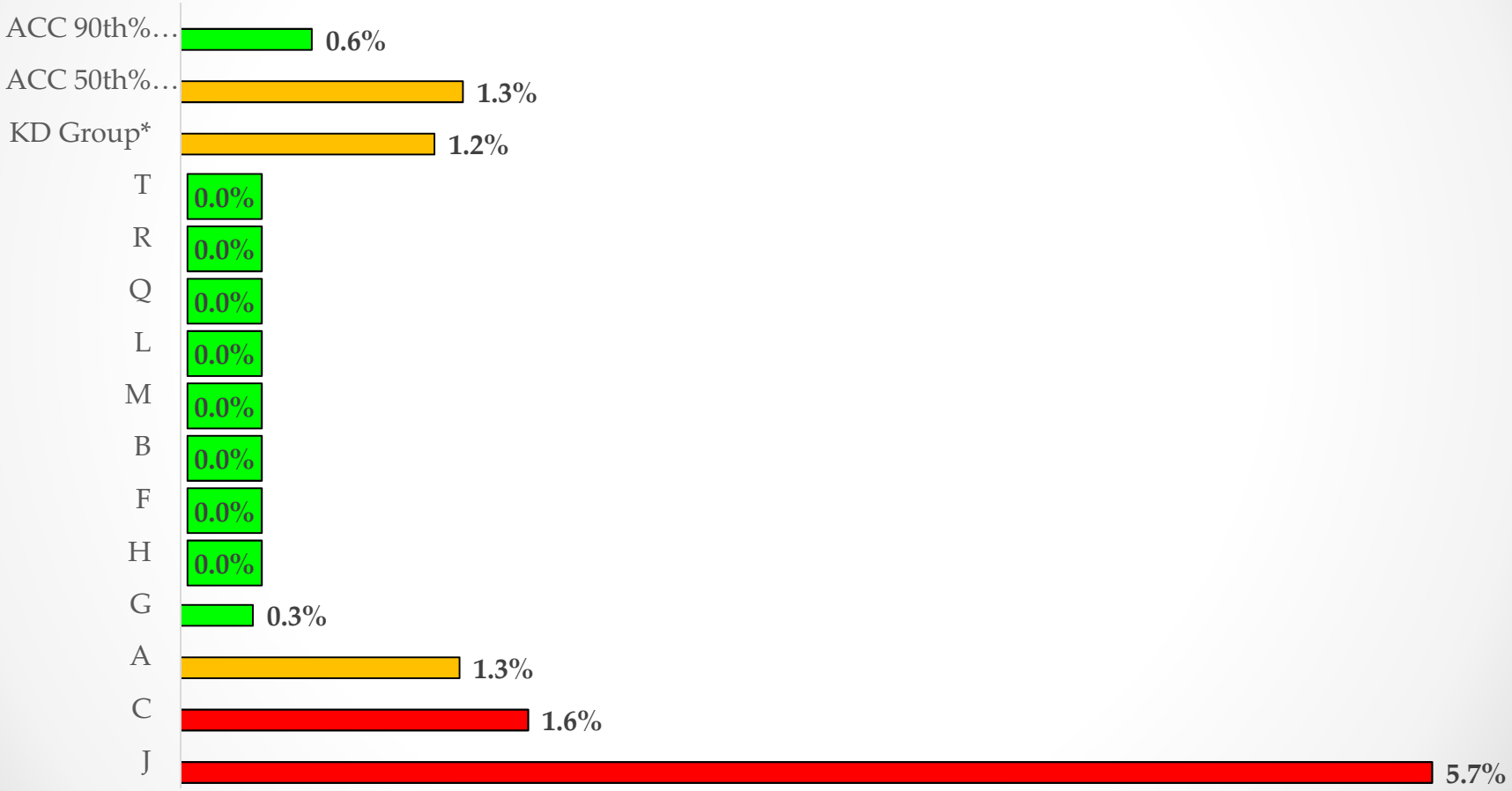
- TWO-YEAR TRENDING



[1] PCI in-hospital mortality rate for all patients Excluding STEMI. Exclusions include patients with a discharge location of "other acute care hospital." (ref: 4741, 4735)

PCI Mortality[1] Rate by Physician

N-STEMI, USA, Elective Patients - Rolling 4 Quarters (Q2 2020– Q1 2021*)



[1] PCI in-hospital mortality rate for N-STEMI, USA, Elective patients for that MD. Exclusions include patients with a discharge location of "other acute care hospital." (ref: NCDR/ACC Physician Dashboard)

*** Comparison reporting period is 04/01/20 through 03/31/21 – Raw DATA all Quarters**

STEMI Triage Guidelines
Thoughtful Pause

- Should go to CVICU First, not the Cath Lab
  - Cardiac Arrest with CPR ≥ 20 minutes and un/minimally responsive
  - Cardiogenic Shock, age ≥ 80
  - STEMI ≥ 24 hours without Chest Pain
  - Excess risk of bleeding (e.g. active internal bleed, ICH<3 mos, Hct<22, PLT<30K)
  - Altered Mental Status
  - Apparent sepsis or other conditions (other than pure cardiogenic shock) that would markedly increase the risk of dying within 30 days
  - Pre-existing DNR / No Code Status

  - ❖ Consider lytic agents for symptoms < 3 hours, anticipated DTB time > 120 minutes and low risk of bleeding

  - ❖ These are intended as guidelines, not to supersede clinical judgement

Adopted from The Cleveland Clinic Heart Institute: Triage Guidelines for STEMI patients.

Predicted Mortality Risk Factors

- STEMI
- Age >70
- BMI
- Cerebral Vasc. Disease
- Peripheral Vasc. Disease
- Chronic Lung Disease
- Previous PCI
- NIDDM
- IDDM
- GFR
- Renal Failure / Dialysis
- Ejection Fraction
- Cardiogenic Shock
- NYHA Class I/II/III
- NYHA Class IV
- Cardiac Arrest
- Thrombosis w/in 1 month
- PCI of Prox LAD
- PCI of LM
- >=2VD
- Total Chronic Occlusion

*Risk Factors taken from the American College of Cardiology inclusion list for their Risk Model for Predicted Mortality: version 4.4

Quality Initiative:

Treatment Algorithm for Invasive Cardiac Procedures

- Targeted Temperature Management
  - Immediate hypothermia measures to be implemented on cardiac arrest patients
- 12-Lead ECG must be done within 10 minutes of arrival to hospital
- ACT initiated – (Do not delay cooling measures)
  - Assessment for unfavorable resuscitation features
  - Consultation between ED, Critical Care and Cardiology physicians
  - Transport to CathLab urgently when consensus reached

Rab, Tanveer, and Karl B. Kern. "Cardiac Arrest A Treatment Algorithm for Emergent Invasive Cardiac Procedures in the Resuscitated Comatose Patient." *Journal of the American College of Cardiology* 66.1 (2015): 62-73.

Quality Initiative:
Vitally Important Steps

- Physician collaboration & coordination between departments is required
- Cardiologist must participate in all thoughtful pause discussions
- ED physician and Cardiologist will consult with an Intensivist as needed for difficult cases
- Intensivist will respond to the ED for thoughtful pauses as requested
- Thoughtful pause must be documented in patient's EMR by a physician
- Families must be given aggressive treatment options with their corresponding prognosis or futility
- Honest communication between all parties required to maintain transparency and trust

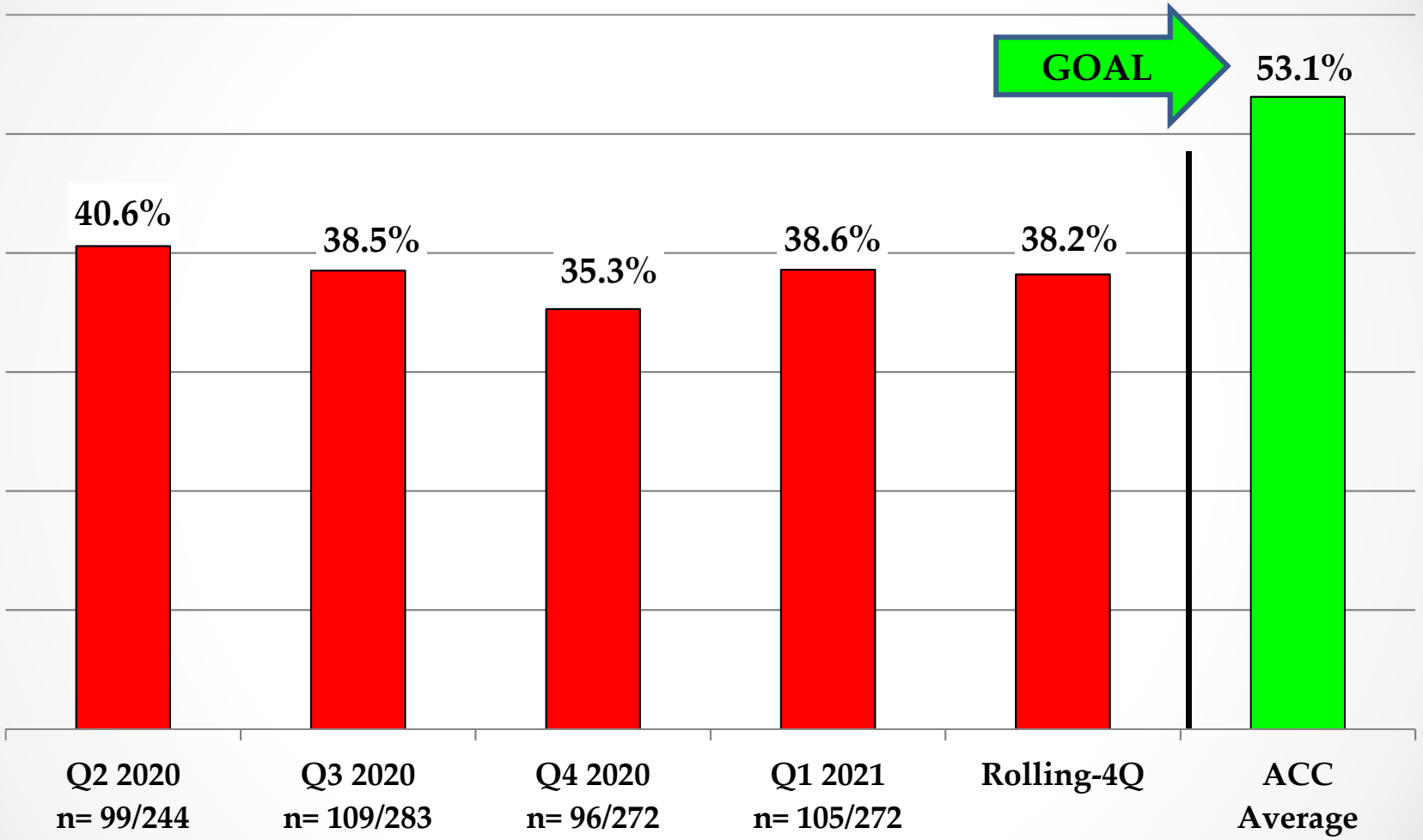
Rab, Tanveer, and Karl B. Kern. "Cardiac Arrest A Treatment Algorithm for Emergent Invasive Cardiac Procedures in the Resuscitated Comatose Patient." *Journal of the American College of Cardiology* 66.1 (2015): 62-73.

Ethical Issues pertinent to care

- Ethical issues are unavoidable in the care of critically ill patients but we must maximize the ethical decision-making regarding angiography and PCI in these patient populations
  - Clinical judgments of the multidisciplinary physicians must be observed whenever possible
  - Diagnostic tools and data must be readily available for discussion in real time so that decisions can be made
  - Additional research into emerging data on this topic and diagnostic tools to keep our patients receiving state of the art care
  - Transparent discussions at the practice and policy making levels about what characterizes appropriate or futile care
  - Assessing patient wishes, respecting DNR and advanced directives even in times of family crisis and proxy decision makers
  - ***Lastly and importantly, a frank and honest discussion with families as to what is futile care***

Rab, Tanveer, and Karl B. Kern. "Cardiac Arrest A Treatment Algorithm for Emergent Invasive Cardiac Procedures in the Resuscitated Comatose Patient." *Journal of the American College of Cardiology* 66.1 (2015): 62-73.

PCI Radial Artery Access



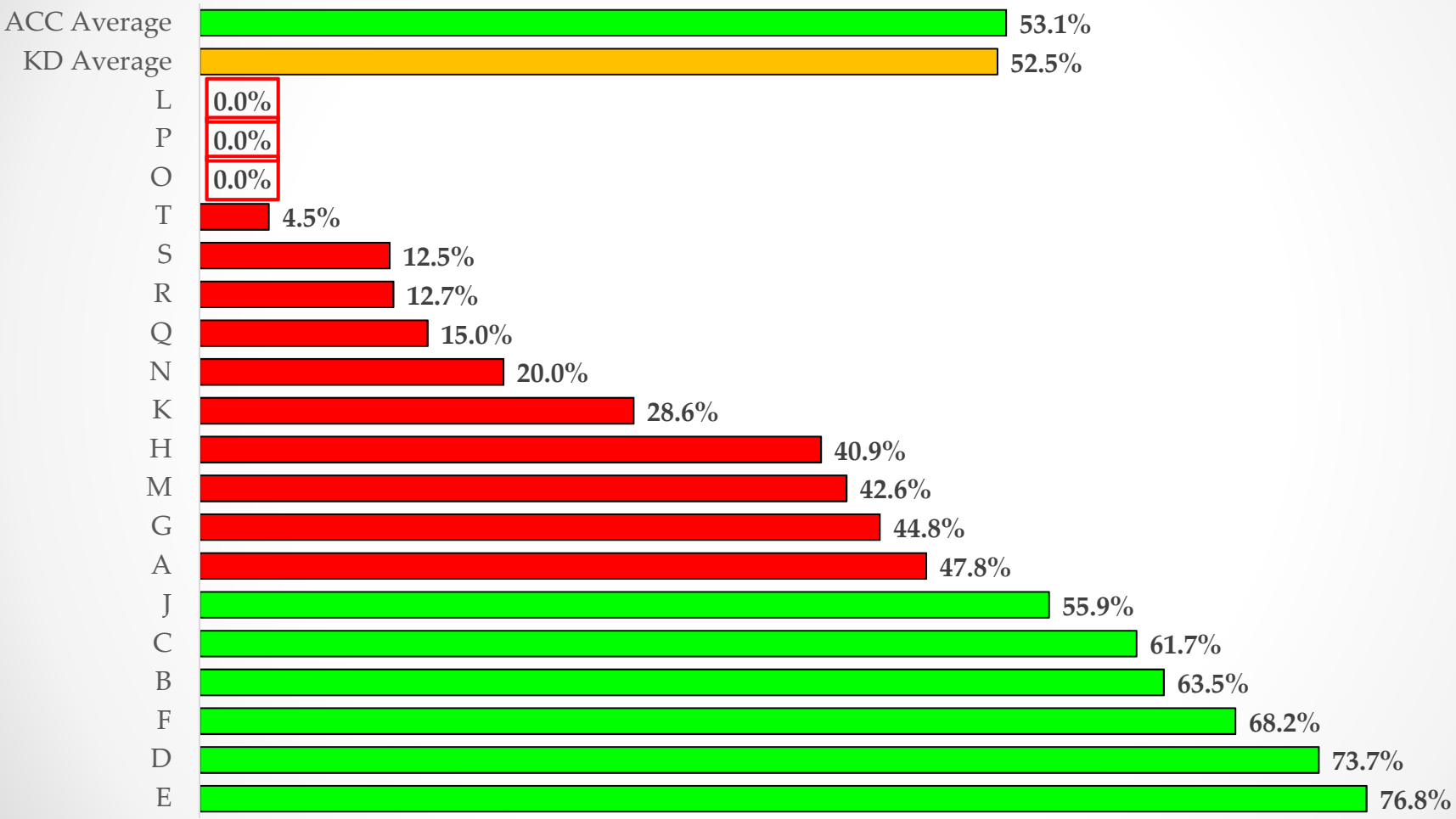
R4Q O/E = 0.7

(ref: NCDR Detail Line 4163)

*** Comparison reporting period is 04/01/20 through 03/31/21**

All Caths Radial Artery Use[1] by Physician

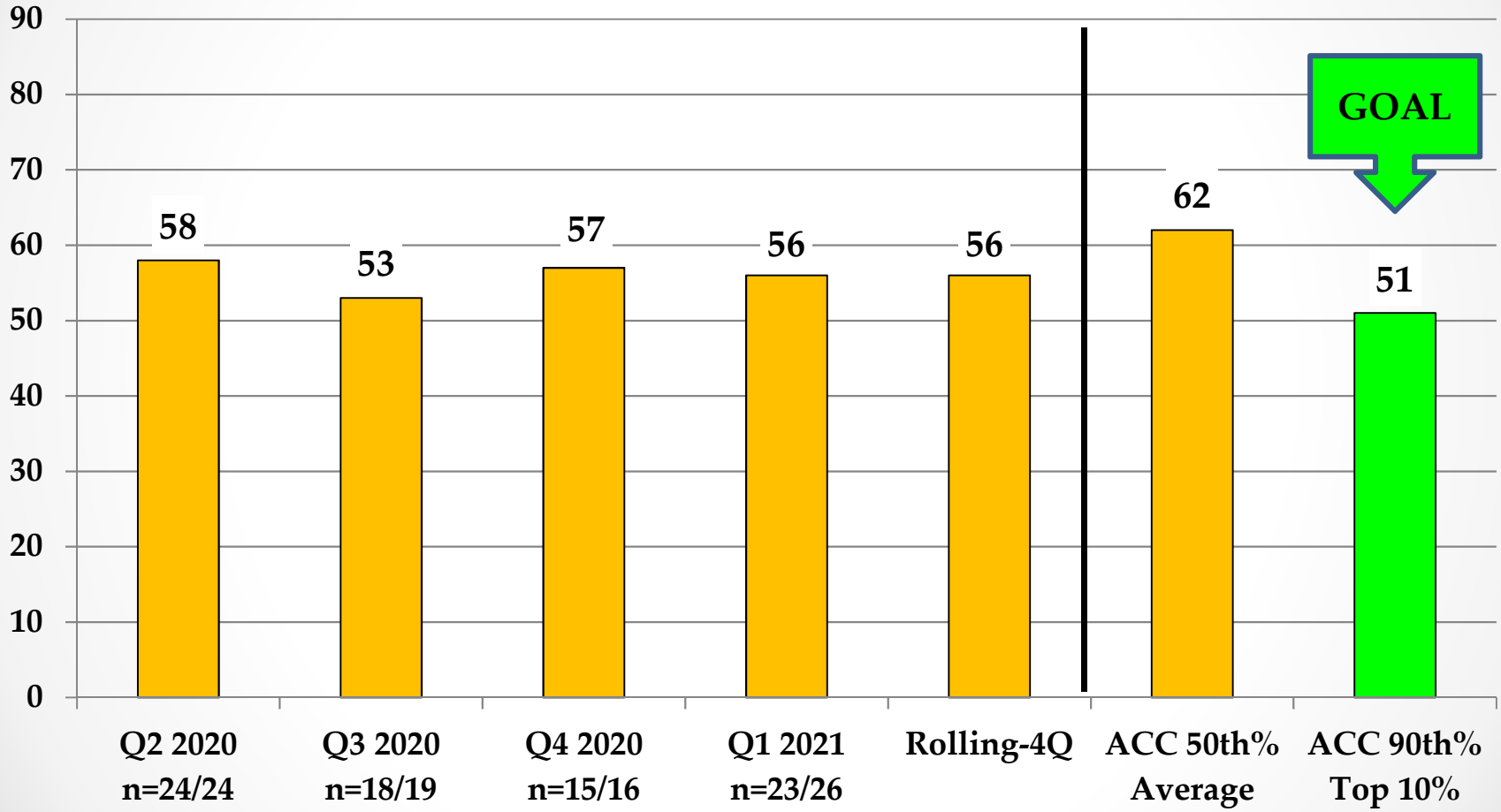
ROLLING 4 QUARTERS (Q2 2020– Q1 2021*)



[1] PCI & Diagnostic Cardiac Catheterization Procedures - Arterial Access Site equaling "Radial" for all patients for that MD. No Exclusions; Pt.'s with an aborted Radial attempt included in denominator (ref: SENSIS Statistical Manager)

*** Comparison reporting period is 04/01/20 through 03/31/21 – RAW DATA all quarters**

Immediate PCI for STEMI
(in minutes)[1]

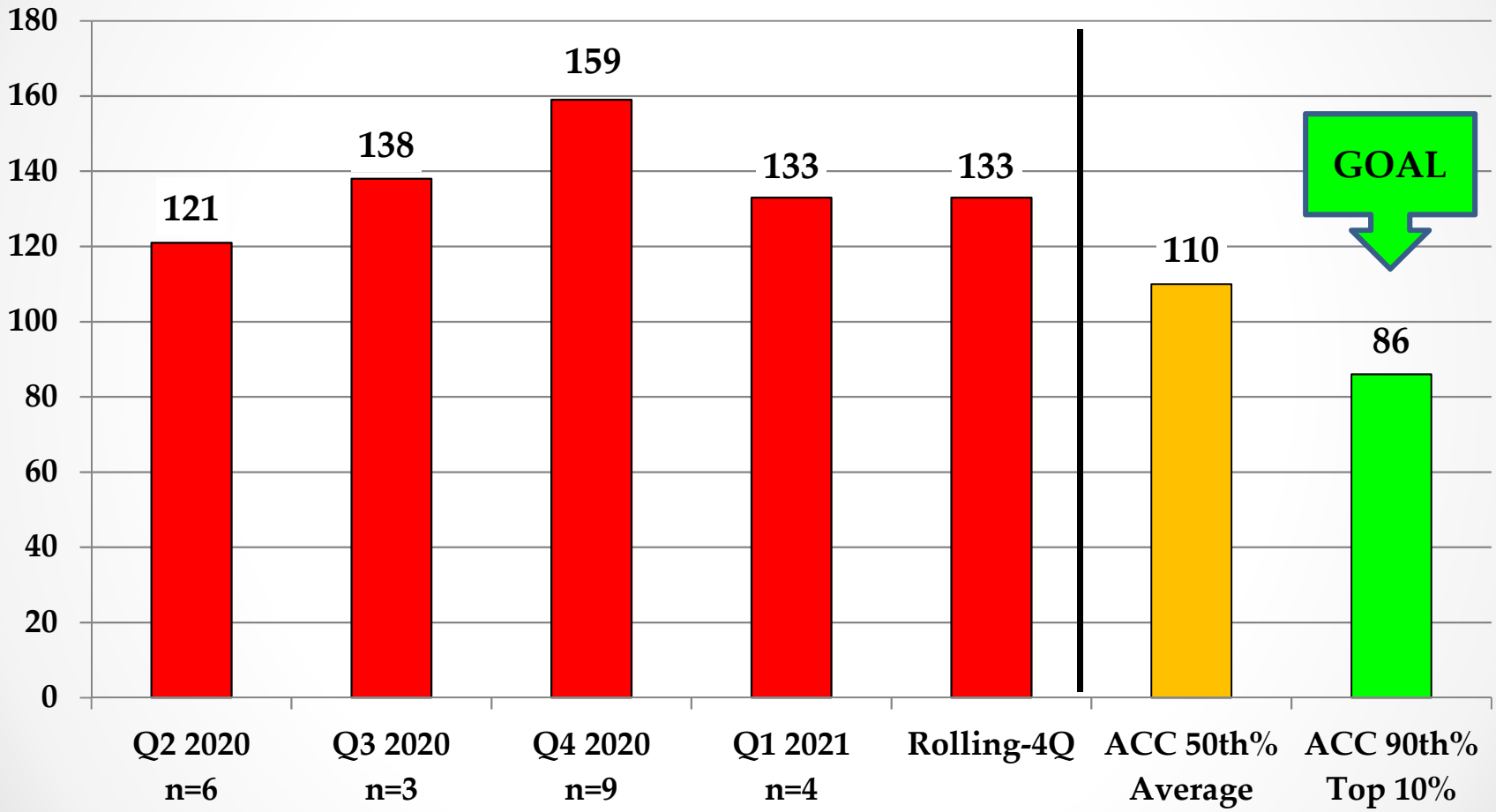


R4Q O/E = 0.9

[1] Median time frame from hospital arrival to immediate PCI for STEMI pts in minutes. Exclusions: Patients transferred in from another acute care facility; Reasons for delay does not equal none. N= pt.'s receiving PCI within 90 minutes. (ref:4448)

*** Comparison reporting period is 04/01/20 through 03/31/21**

Immediate PCI for STEMI Transfers
(in minutes)[1]



R4Q O/E = 1.2

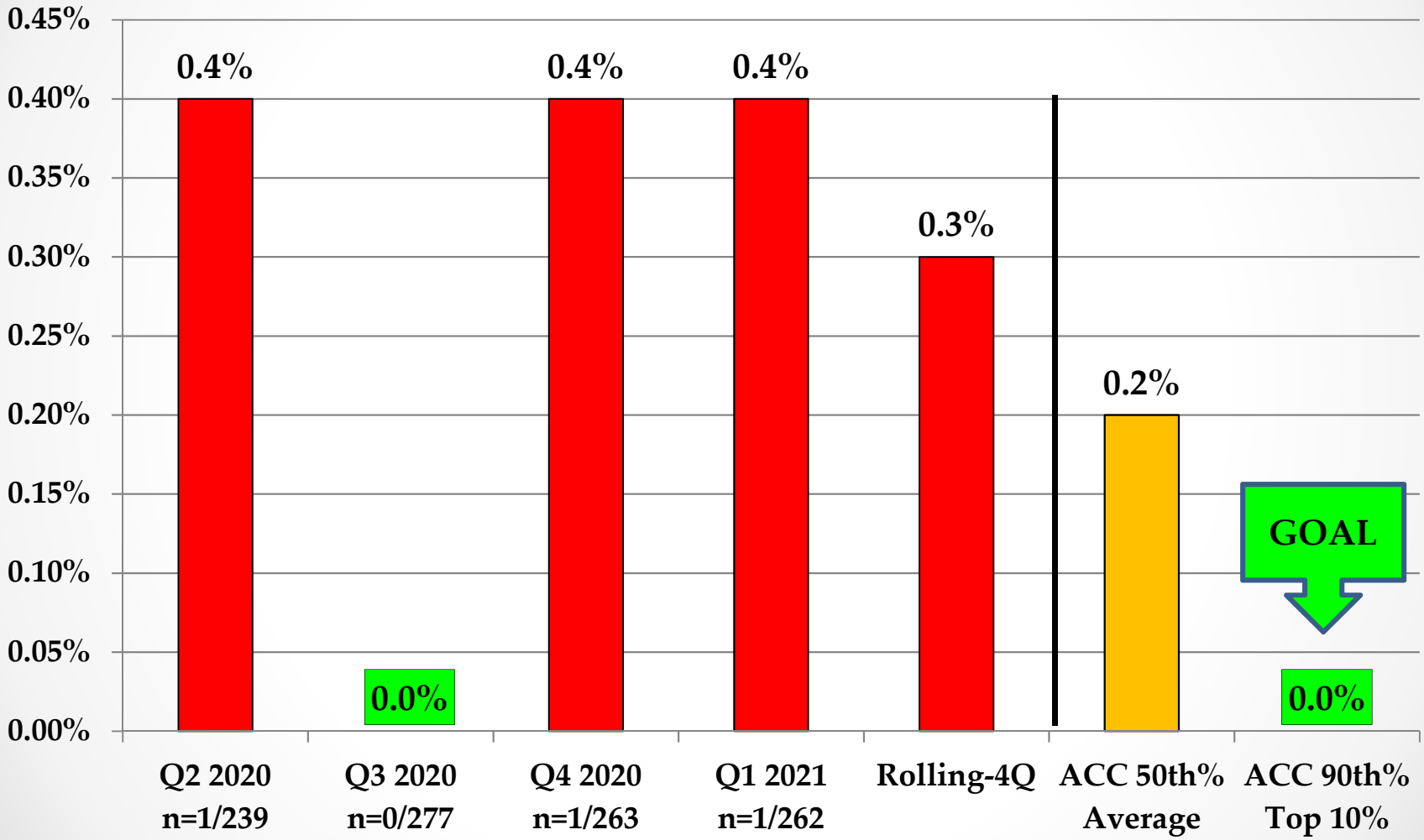
[1] Median time from ED arrival at STEMI transferring facility to immediate PCI at STEMI receiving facility among transferred patients (excluding reason for delays); Reasons for delay does not equal none. (ref:4452, 10888)

*** Comparison reporting period is 04/01/20 through 03/31/21**

Quality Initiative:
Best Practice in Door to Balloon

- 4 Staff on call at all times (started Fall 2020) w/ crew response time of 20 minutes
- Recognition of staff with a monthly fastest Door to Balloon award to incentivize staff
- Cardiac Alerts to be called at the time of leaving transferring hospitals
- ED EKG to be placed in EMR or Tracemaster
- STEMI taskforce with ED, Quality, Cath Lab to review ED STEMI hand off including STEMIs called in the field and from other facilities
- Cardiac Alerts called within 10 minutes of ED arrival unless Thoughtful Pause is documented in the EMR

Stroke Post PCI[1]



R4Q O/E = 1.4

[1] Exclusions: Patients with an Intervention this admission (Surgery, EP, Other); Pt's discharged to *Other Acute Care Facility* (ref: 4235) *** Comparison reporting period is 04/01/20 through 03/31/21**

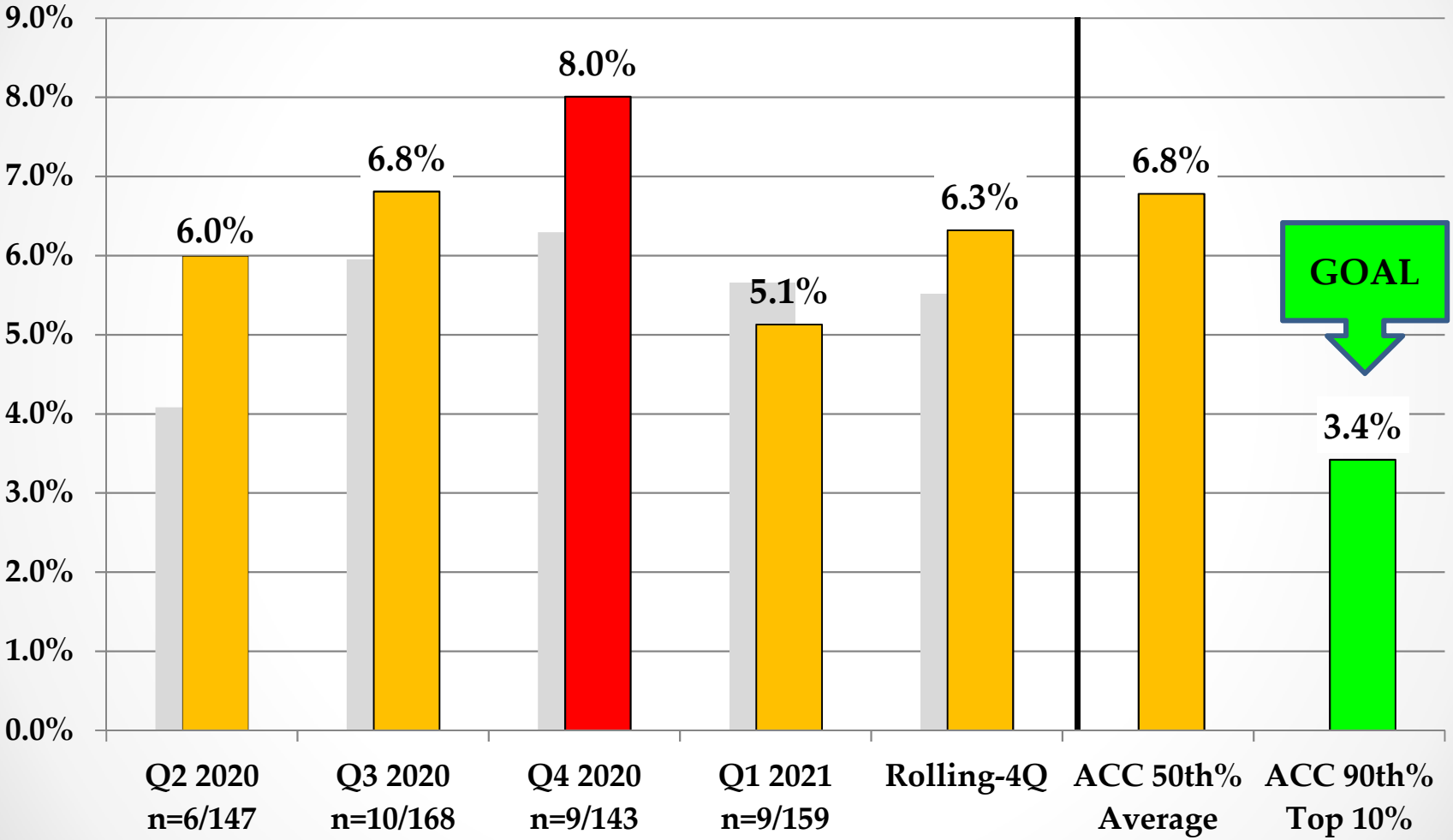
Quality Initiative:

Stroke Recognition and Treatment

- Assess Stroke Risk factors in PCI for each patient
  - Age, gender, history of CVA, End Stage Renal Disease, Diabetes, Hypertension, Peripheral Vascular Disease, Smoking, Congestive Heart Failure, Atrial Fibrillation, CABG surgery or emergent PCI
- Rapid recognition of stroke symptoms in Cath Lab
- Use of the clear protocol for recognition and interventions will facilitate efficient care in the unlikely event of a stroke in Cath Lab

Acute Kidney Injury[1] Post PCI

Risk Adjusted[InColor]



R4Q Risk Adjusted O/E = 0.86

[1] Proportion of pt's with a rise of serum creatinine of > 50% or ≥0.3 mg/dL over the pre-procedure baseline; all pt's w/ New Requirement for Dialysis. Exclusions: pt's on dialysis pre-procedure; pt's second PCI within this episode of care; same day discharges. (ref: 4882) *** Comparison reporting period is 04/01/20 through 03/31/21**

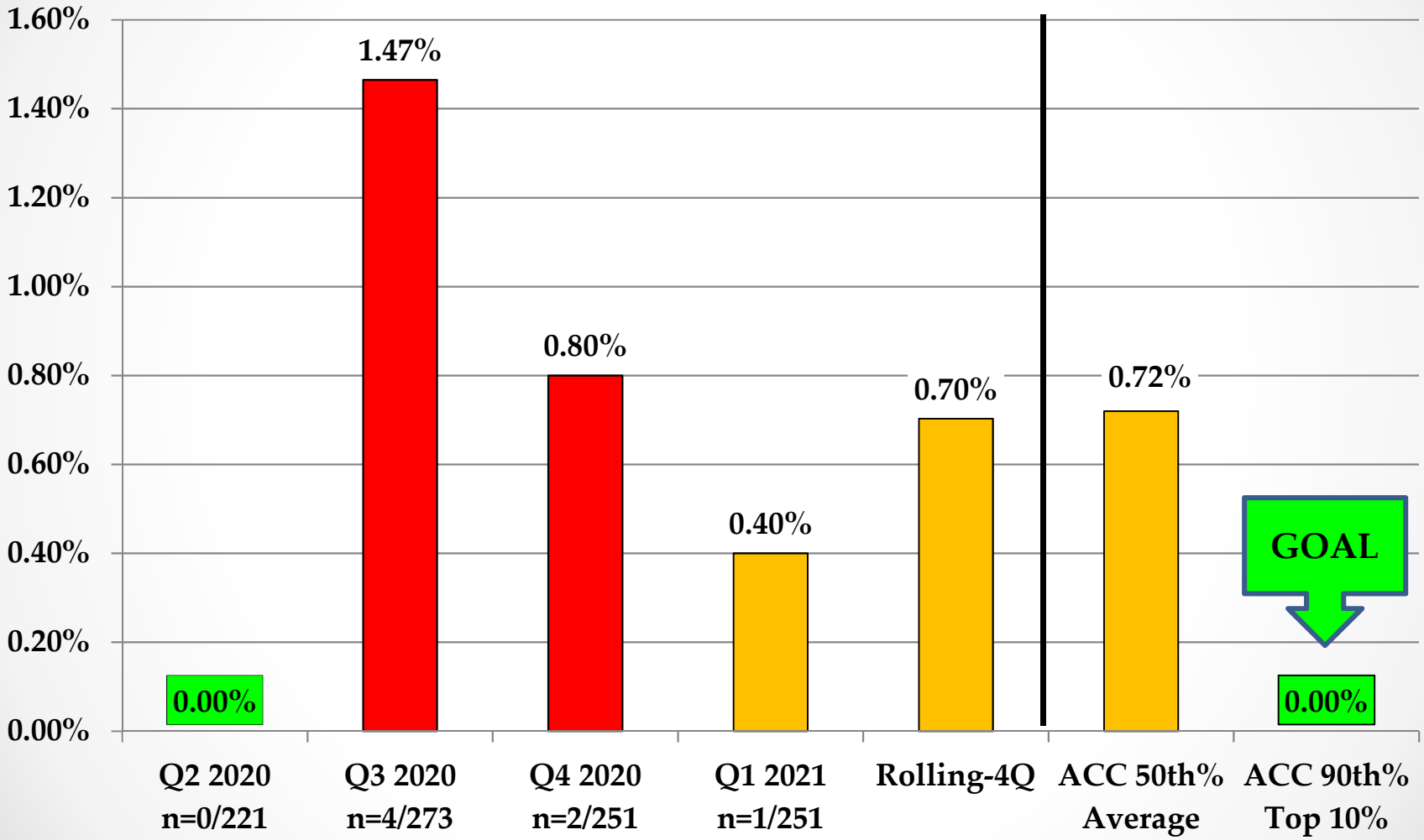
Quality Initiative:

Contrast Induced Nephropathy

- Renal impairment = estimated glomerular filtration rate ≤ 60mL/min
- Hydration Needs
  - Pre procedure: Normal Saline at 250 ml/hour to be started upon arrival
  - Intra procedure:
    - LVEDP <18 → NS 500 mL/hr for 4 hours
    - LVEDP >19 → NS 250 mL/hr for 4 hours
  - Post procedure: Normal Saline at 250 ml/hour for 6-24 hours
- For outpatients, an increase in oral hydration is encouraged the day before arrival. The patients are encouraged to drink clear liquid up to 2 hours before procedure
- Post procedure labs must be ordered
- Metabolic panel ordered one day post procedure
- Track and Report contrast utilization for Diagnostic and Interventional procedures

*Merschen, Richard. "An Overview of Chronic Kidney Disease and Useful Strategies for Clinical Management." *Cath Lab Digest* Mar. 2012 http://www.cathlabdigest.com/articles/Overview-Chronic-Kidney-Disease-Useful-Strategies-Clinical-Management

Transfusion Post-PCI of RBCs[1]



R4Q O/E = 1.0

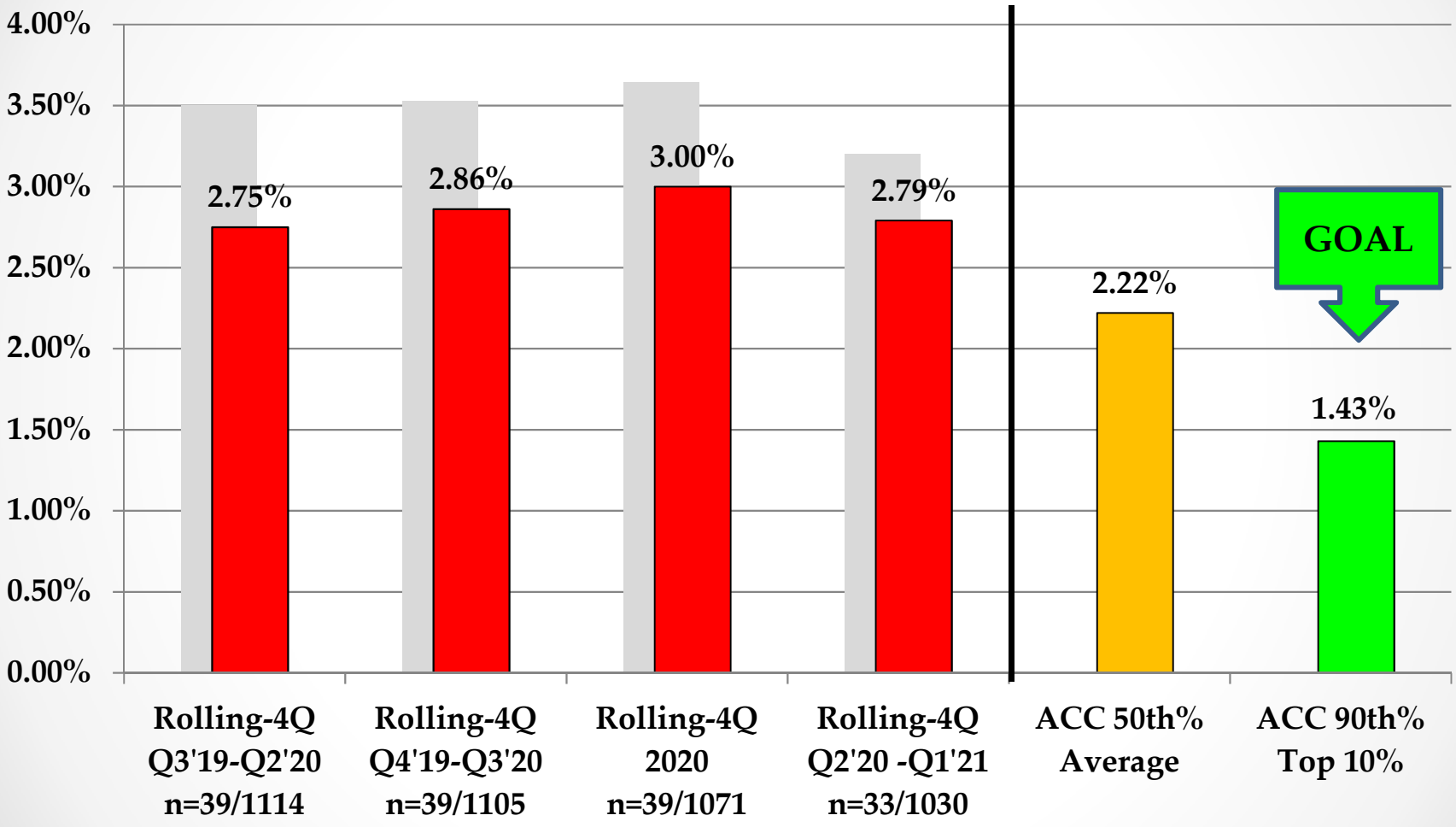
[1] Proportion of pt's who receive a transfusion of whole blood or RBCs during or after, but within 72 hours of PCI procedure. Exclusions: Patients on dialysis; EP study or CABG or other major surgery during the same admission; Pt.'s with a pre-procedure hemoglobin <8g/dL or no value. (ref: 4288) *** Comparison reporting period is 04/01/20 through 03/31/21**

APPROPRIATE USE OF RED BLOOD CELLS

A. Pre-transfusion hematocrit of less than 24% or hemoglobin less than 8 grams/dl.

B. Transfusion may be administered when hemoglobin levels are 8-10 grams/dl in the following circumstances:
    1. Acute Blood Loss/Active Bleed
    2. Presence of Symptomatic Anemia
    3. HGB <9 w/ Chemotherapy
    4. HGB <10 w/ Radiation Treatment

Risk Standardized Bleeding Rate[1]



R4Q O/E = 1.4 [1] Pt's with a Bleeding event defined as 1) occurring within 72 hours of procedure (Bleeding at access site, hematoma at access site, retroperitoneal bleed, GI, GU or any transfusion) 2) occurring during hospitalization (hemorrhagic stroke, tamponade, Hgb drop ≥4 g/dL requiring transfusion, or a procedural intervention/surgery to reverse/stop or correct the bleeding) Exclusions: subsequent PCI procedures, death w/in 24 hours, CABG this hospitalization, transfusion in presence of mechanical support. (ref: 4934) *** Comparison reporting period is 04/01/20 through 03/31/21**

Quality Initiative:

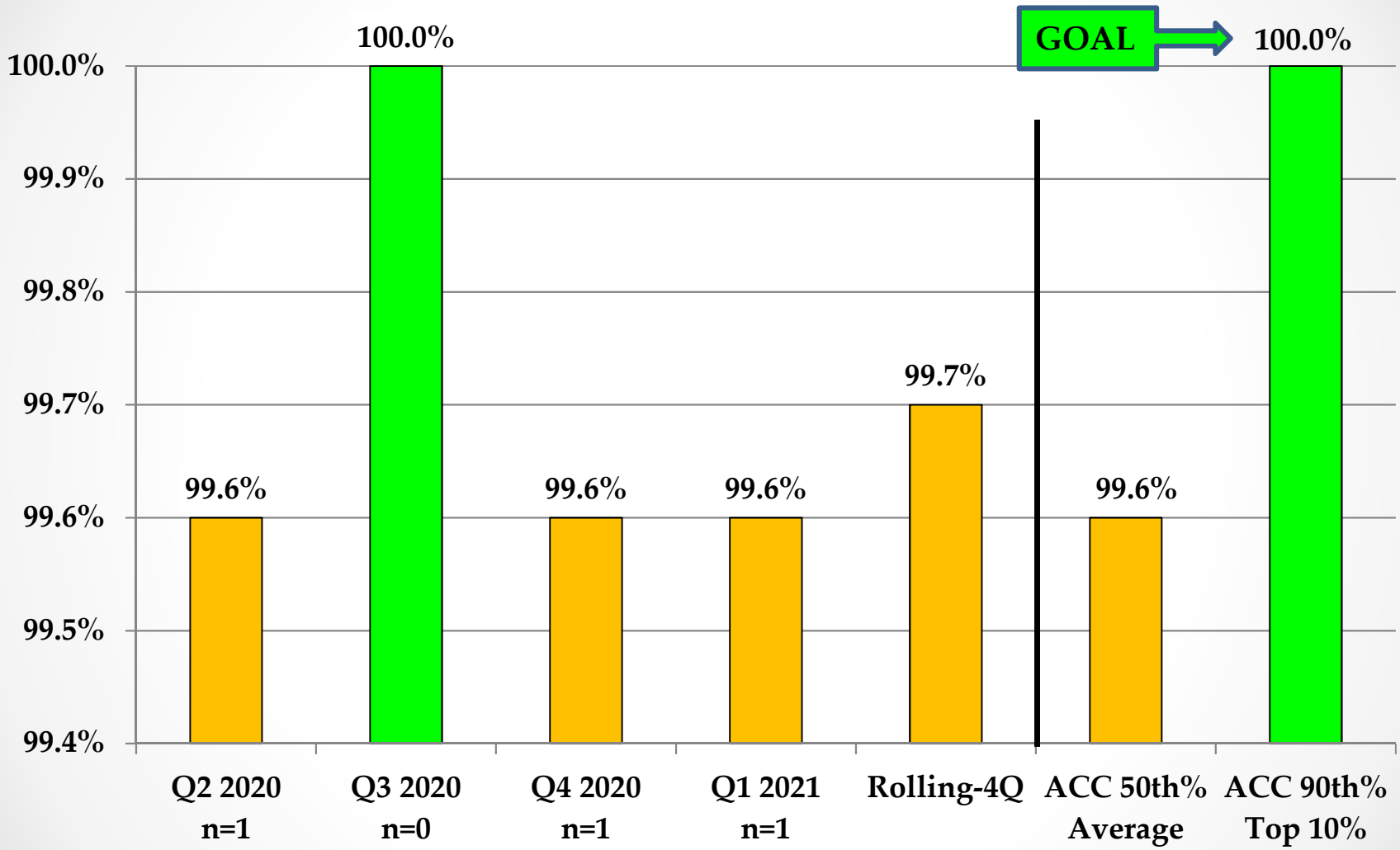
Bleeding Protocol

- Establish a vascular site protocol in accordance with SCAI safe femoral access guidelines
    1. Radial first
    2. Use of ultrasound guidance
    3. Use of fluoroscopy to mark the femoral head
    4. Use of micro puncture needle

- Implemented best practice hemostasis management strategies standardized for Post Procedure Bleeding and Sheath Removal
  - Hemostasis management education program for early recognition of post procedure bleeds
    - Includes recognition of signs and symptoms of bleeding
    - Standardized communication
      - Communication between the procedure team and physician with emphasis on the quality of the groin stick and whether the use of sealant is used.
      - Bedside reporting between procedure team through the admitting nurse with emphasis on the vascular access site assessment
  - Manual sheath removal
      - Hold manual pressure minimum of 20 minutes
      - Frequent vital signs and distal pulse monitoring
      - Diligent vascular access site assessment
      - Assess Patient for pain
  - Vascular sealant device
      - Hold manual pressure minimum of 5 minutes
      - Frequent vital signs and distal pulse monitoring
      - Diligent vascular access site assessment
      - Assess patient for pain

- Implementation of mandatory hemostasis management education
  - Mandatory self study educational presentation using pre and post test evaluation testing. (Must be completed and passed)
    - Added to Nursing Unit Annual Competency
    - Added to core curriculum nursing education (Cardiac and CV ICU units)
      - 4 Tower, 2 North, 3 West, CVICU and ICU, CV ICCU.
  - Mock simulation of a post procedure bleeding patient is being done twice a year. Once in the skills lab and the other on the nurses home unit

ASA Prescribed at DC[1]

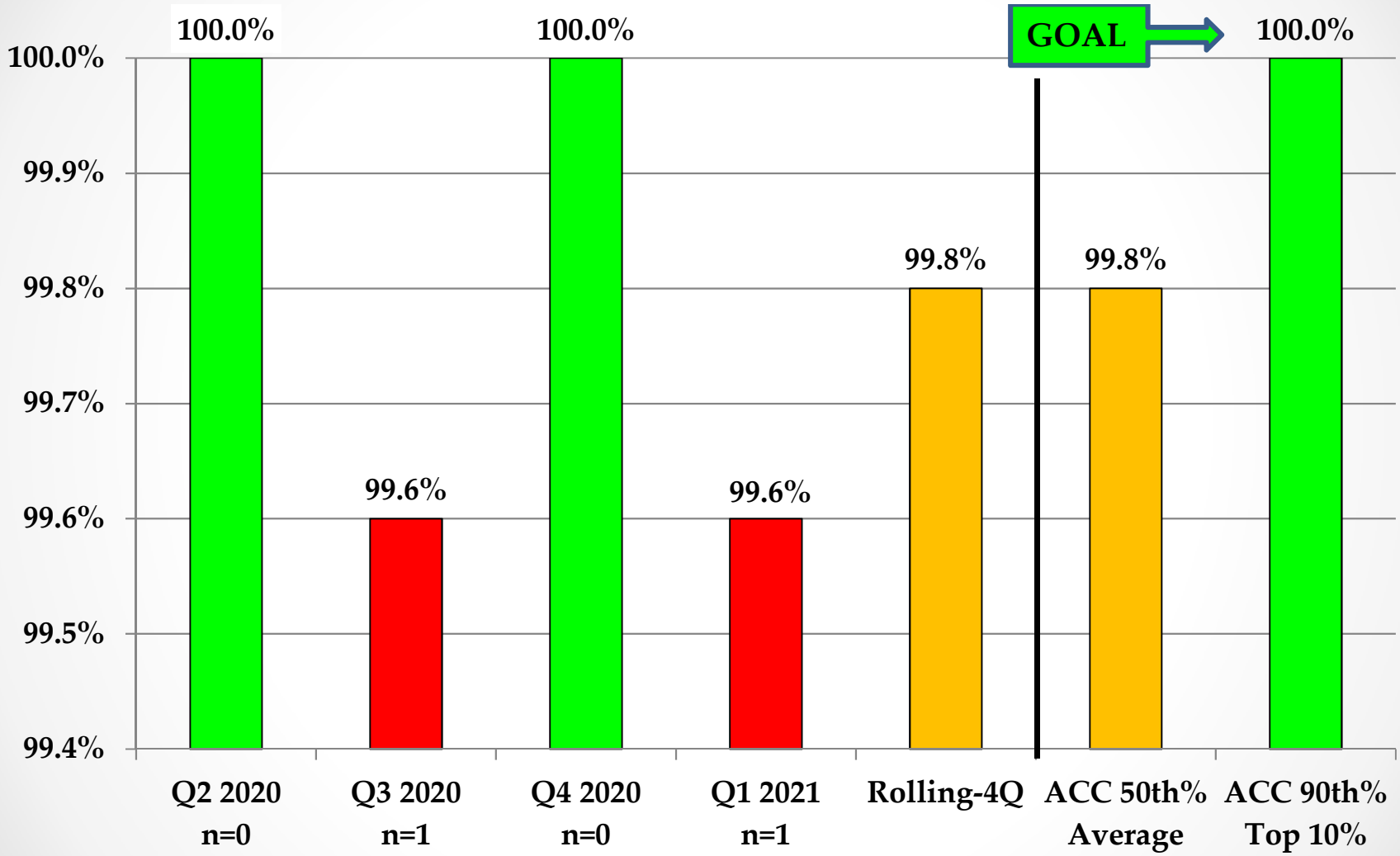


R4Q O/E = 1.0

[1] Proportion of pt.'s (without a documented contraindication) with a PCI attempted or performed that were prescribed aspirin at discharge. Exclusions: pt.'s that were discharged on Comfort Measures only; discharged to "Other acute care hospital", "Hospice", "Left against medical advice (AMA)" or deaths. (ref: 4702)

*** Comparison reporting period is 04/01/20 through 03/31/21**

P2Y12 Inhibitor Prescribed at DC[1]

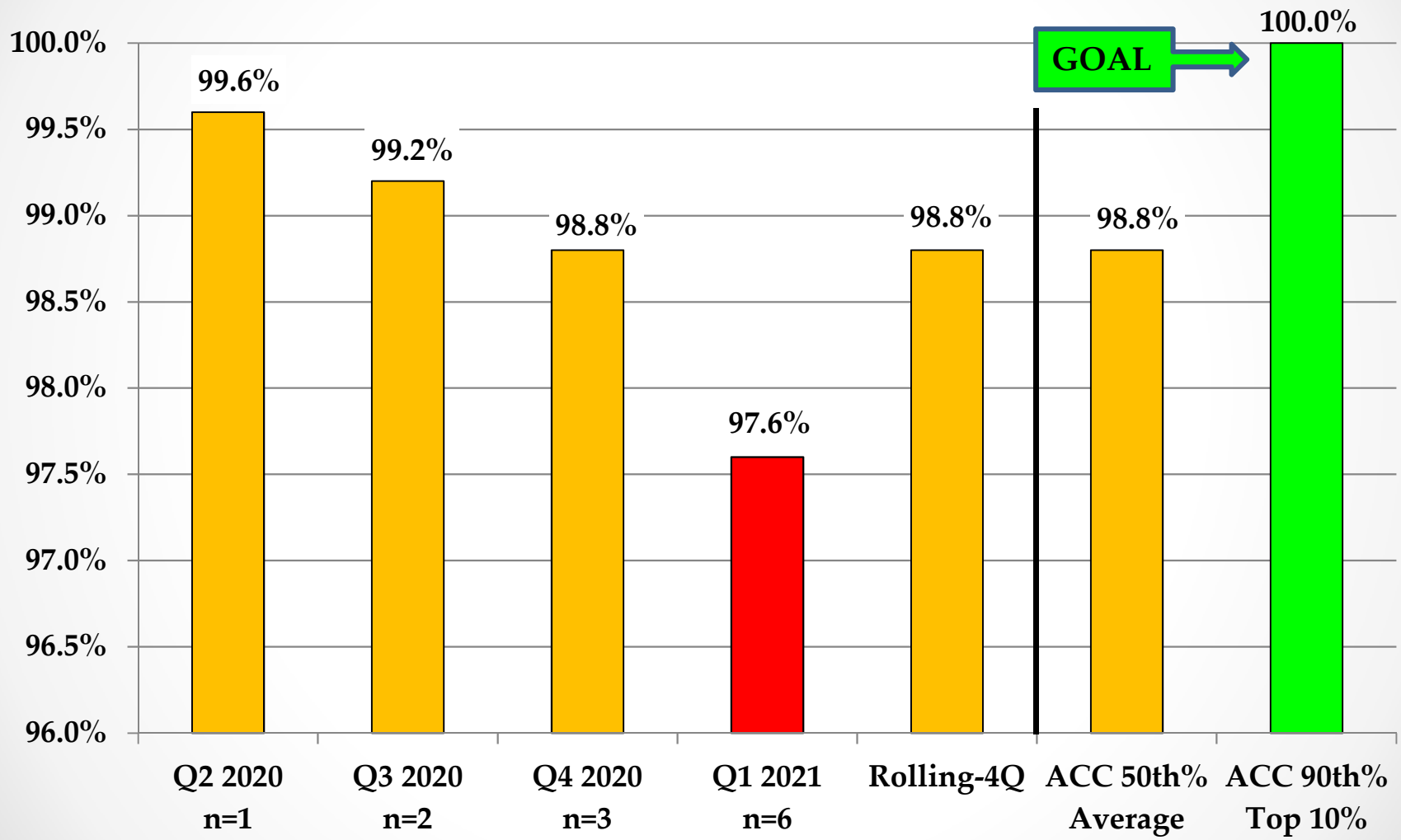


R4Q O/E = 1.0

[1] Proportion of pt.'s (without a documented contraindication) with a cardiac stent placed that were prescribed a thienopyridine/P2Y12 inhibitor at discharge. Exclusions: pt.'s that were discharged on Comfort Measures only; discharged to "Other acute care hospital", "Hospice", "Left against medical advice (AMA)" or deaths (ref: 4711)

*** Comparison reporting period is 04/01/20 through 03/31/21**

Statins Prescribed at DC[1]



R4Q O/E = 1.0

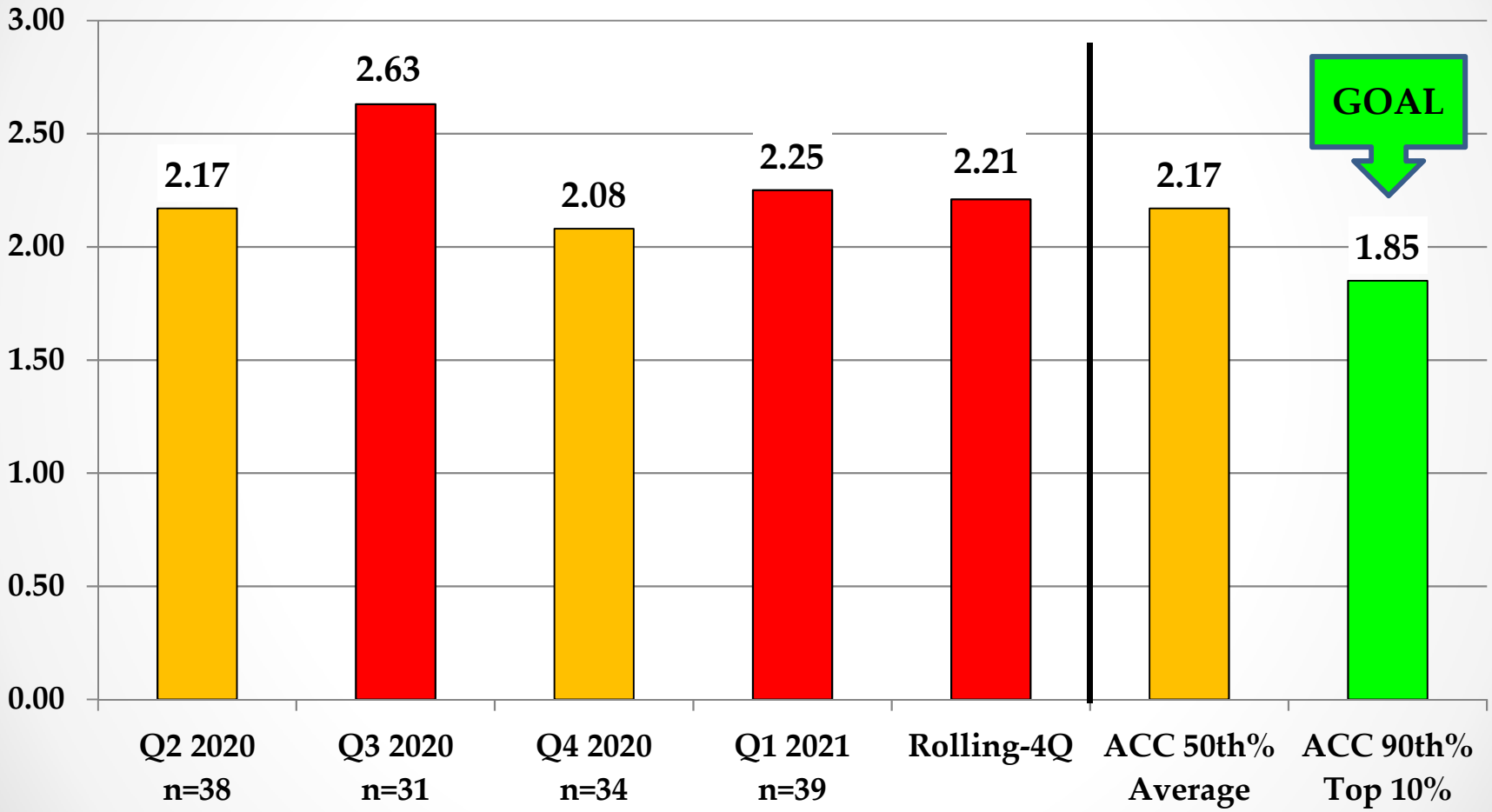
[1] Proportion of pt.'s (without a documented contraindication) with a PCI attempted or performed that were prescribed a statin at discharge. Exclusions: pt.'s that were discharged on Comfort Measures only; discharged to "Other acute care hospital", "Hospice", "Left against medical advice (AMA)" or deaths. (ref: 4707) *** Comparison reporting period is 04/01/20 through 03/31/21**

Quality Initiative:

Discharge Medications

- Develop and implement PCI specific discharge order set
- Re-educate Hospitalists and Nurse Practitioners on importance of specific discharge medications in this patient population and utilization of new Order Set.
- Track utilization of order set
- Contact Lead Hospitalist or Nurse Practitioner with all fallouts and track
- Improving Clinical documentation in the Discharge Summary of any contraindications
- Improving Clinical documentation in the Discharge Summary clarifying any pending diagnosis (i.e. possible NSTEMI, possible MI)

Post-PCI Length of Stay[1] – STEMI

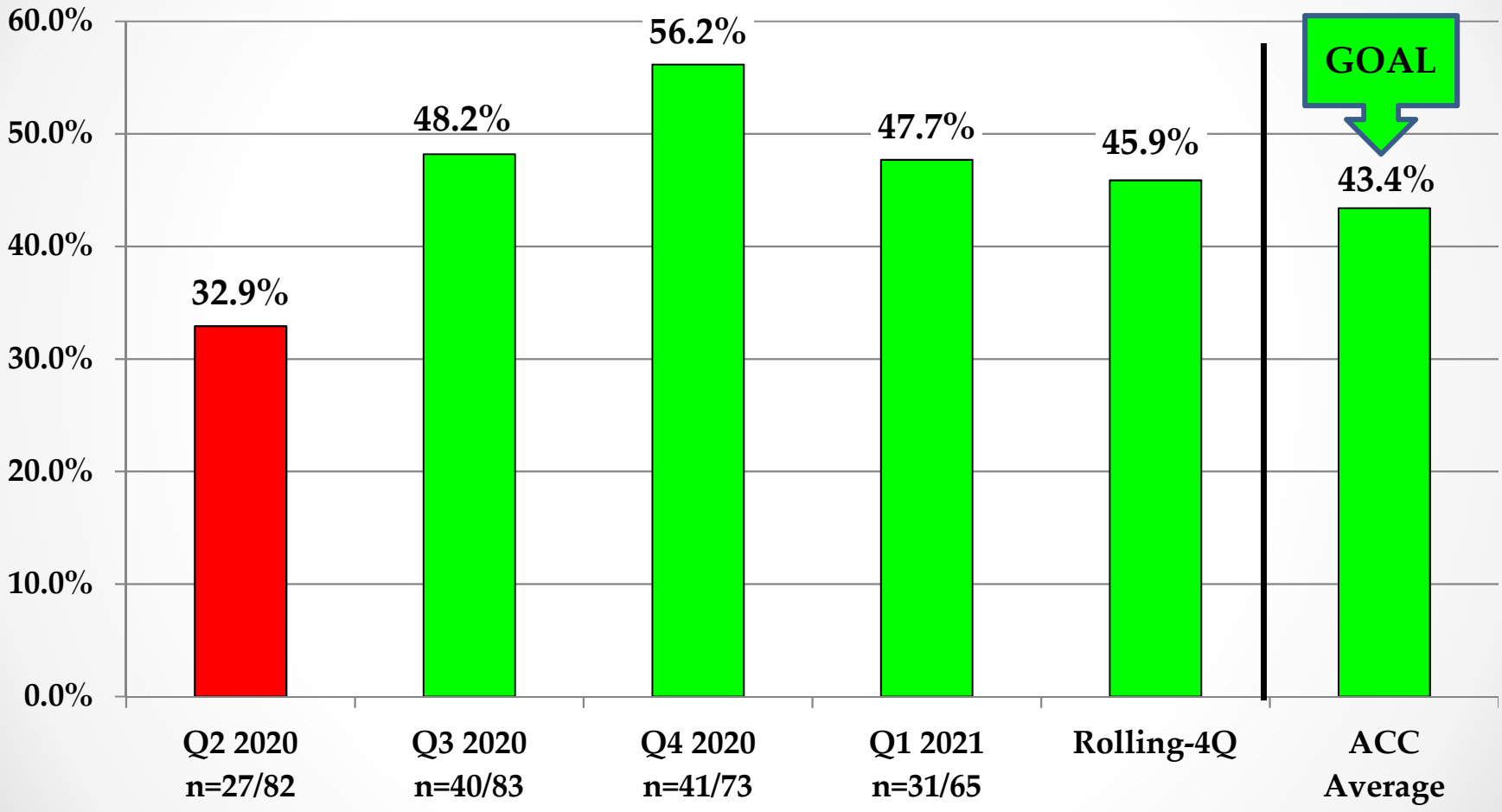


R4Q O/E = 1.0

[1] Median Post-procedure length of stay in STEMI patients. Exclusions: pt.'s discharged to Another Acute Care Facility; death during procedure (ref:4340, 10894)

*** Comparison reporting period is 04/01/20 through 03/31/21**

Post-PCI Same Day Discharge - Electives



R4Q O/E = 1.1

[1] Elective patients discharged on the same day as procedure. Exclusions: mortalities and pt.'s discharged to Another Acute Care Facility or AMA (ref:4971)

*** Comparison reporting period is 04/01/20 through 03/31/21**

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee

Unit/Department: Cardiovascular Services **Prostaff Report Date:** September 2021

Measure Objective/Goal: Contrast Induced Nephropathy (CIN) post PCI to be in the top 90th percentile nationwide

Date range of data evaluated: Q2 2020 – Q1 2021

Analysis of all measures/data: (Include key findings, improvements, and opportunities):
Based on the ACC CathPCI Registry definition of CIN (stated as "acute kidney injury") [detail line: 4882 of the ACCF Institutional Outcomes Report] is the proportion of patients who received post-PCI dialysis or had a rise of serum Creatinine of > 50% over their pre-procedure baseline or absolute rise of >=0.3 mg/dL (excluding patients who had dialysis pre-procedure, same day discharges and 2nd PCI procedure within one episode of care). Inclusions: ≥ 90% of patients with a pre and post Creatinine drawn. Kaweah Health had a risk adjusted rate of 6.3% in rolling four quarter data (n=34/617). This represents an improvement from Q4 2020 of 8.0% to 5.1% in Q1 2021. Refer to attached slide for trending over the past four quarters. Note that KH's percentage is better than national average/US 50th percentile of 6.8% and worse than the top 10% nationally/ US 90th percentile of participants at 3.4%.

If improvement opportunities identified, provide action plan and expected resolution date:

- Physician documentation of patient risk factors is lacking specifically CHF class (if the class is not documented, class I is entered which can lead to a lower risk factor). Our cases risk adjust higher due to lack of documentation. For example, the rolling four quarters AKI post PCI is calculated as 34/617=5.5% but once risk adjusted it rises to 6.3% of patients showing as AKI
- Intra procedure and post procedure fluid bolus based on contrast given are non-existent
- Physicians are not putting in post procedure orders in a timely manner resulting in a decrease in post procedure hydration

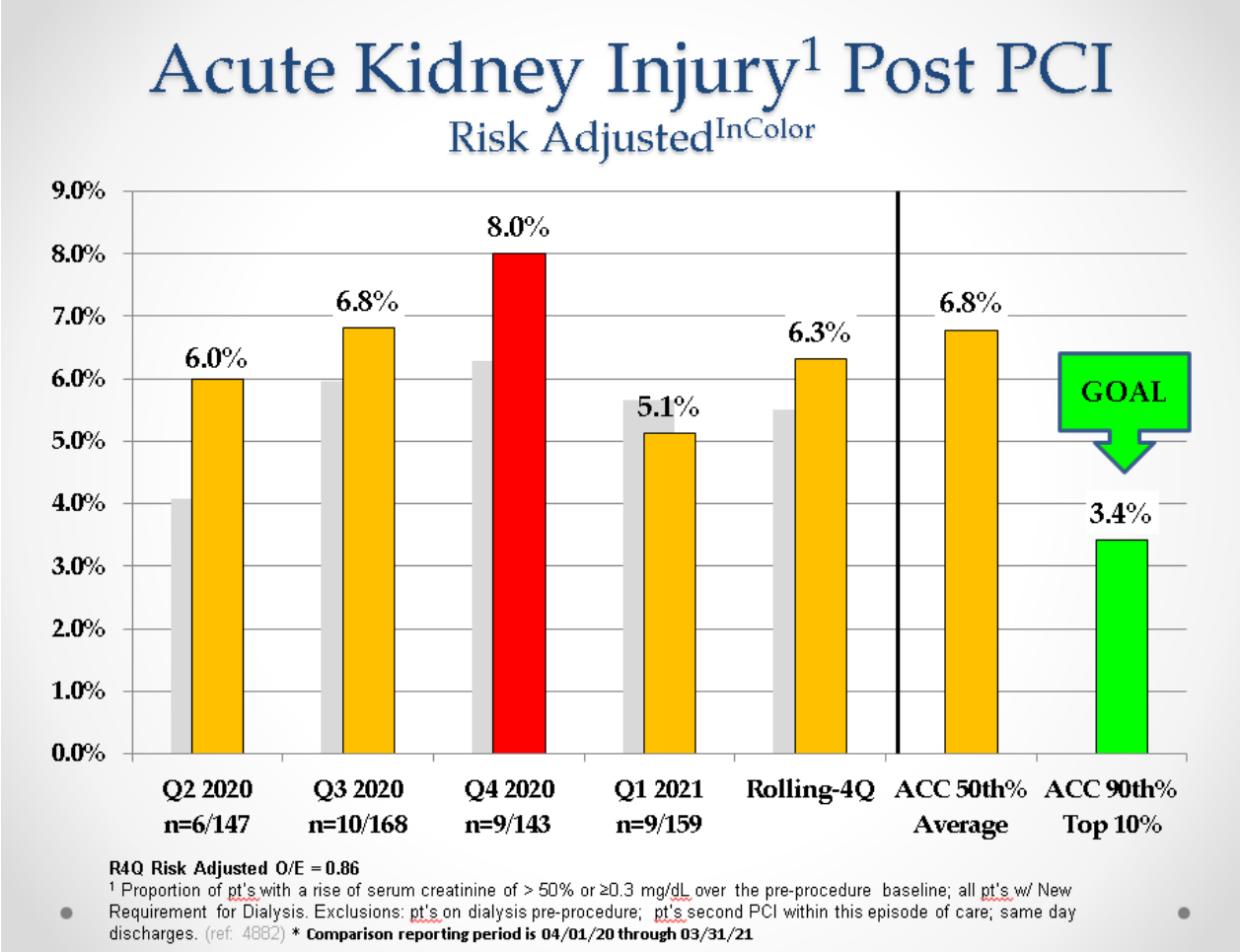
Next Steps/Recommendations/Outcomes:

- Structured reporting currently being worked on in collaboration with ISS and the Cath Lab Medical Director. Mandatory fields within structured reporting will ensure documentation of all risk factors. Target go live date for structured reporting is June 2021
- Meet with Cath Lab Medical Director to evaluate orders for intra procedure and post procedure and discuss potential algorithm for additional fluid bolus for patients which will be dependent on how much contrast is received in procedure
- Meet with Medical Director about realistic time frame for post procedure orders entered into Cerner

Submitted by Name:
Christine Aleman, RN
Leslie Archer, RN

Date Submitted:
September 14, 2021

Please submit your data along with the summary to your PI liaison 2 weeks prior to the scheduled report date.



Please submit your data along with the summary to your PI liaison 2 weeks prior to the scheduled report date.

Central Line Blood Stream Infection (CLABSI) Quality Focus Team (QFT) Report February 2022

Amy Baker, Director of Renal Services (Chair)
Emma Camarena, Interim Director of Nursing Practice(Co-Chair)
Shawn Elkin, infection Prevention Manager (IP Liaison)

Post Kaizen- Gemba Data

- **For December 2021 all measures within 5% of Target**
- **We will continue to focus in areas on CLABSI reduction until we are at our target goal**

Measure Description	Benchmark/ Target	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
OUTCOME MEASURES																					
Number of CLABSI	0	0	5	2	1	2	0	1	2	1	2	0	0	1	1	0	4	3	3	1	1
FYTD SIR	≤0.596		1.63			1.28*			1.2*			0.933				0.000			1.993	1.372	1.261
PROCESS MEASURES CL Gemba																					
% of pts with bath within 24 hrs	99%	78%	80%	84%	88%	88%		95%	96%	96%	96%	96%	97%	93%		97%			96%	97%	97%
% of CL with valid rationale order	100%	93%	97%	96%	95%	96%		98%	98%	97%	99%	98%	98%	98%		99%			99%	96%	96%
% of CL dressings clean, dry and intact	100%	92%	95%	91%	92%	95%		97%	95%	94%	97%	95%	95%	97%		97%			97%	96%	98%
% of CL that had drsg change no > than 7 days	100%	90%	90%	89%	96%	98%		98%	98%	99%	99%	99%	99%	98%		98%			99%	99%	99%
% of patients with proper placed gardiva patch	100%	81%	93%	90%	89%	92%		93%	94%	94%	93%	95%	94%	94%		96%			97%	88%	97%
% of CL pts with app & complete documentation	100%	81%	86%	86%	87%	87%		92%	91%	93%	95%	90%	91%	94%		94%			96%	96%	97%
# of Pt Central Line days rounded on	n/a	1050	1315	1194	1087	1372		1084	1194	1067	1010	1179	1198	968		1092			1240	1265	1047

CLABSI QFT- Plans for Improvement

- Subcommittees continue to meet to help reduce different aspects of CLABSI
  - Culture of Culturing Committee- work on reduce number of pan culturing and discuss TPN utilization related to CLABSI's
    - Presented to Hospitalist Group data on Pan Culturing practices at Kaweah Health
  - HAI Review Committee- Review each CLABSI case to identify learning opportunities, barriers and identify root causes
    - Continue to encourage Nurse Managers and front line RN's to attend this monthly review meeting when a CLABSI occurs on their unit
    - Infection Prevention identifies key takeaways to investigate
  - MRSA Subcommittee- develop plan to address MRSA infections. Discussing nasal decolonization
    - Trialing a nasal MRSA decolonization process on 4 North and ICU
    - Reviewing our MRSA screening process to ensure accurate information is captured

CLABSI QFT- Plans for Improvement

In addition to subcommittees the CLABSI QFT has been working on…

- We teamed up with the CAUTI QFT to present an Educational Hospital Acquired Infection Forum to the Intensive Care Department
  - Targeted Education provided to Intensive Care Department due to high number of CLABSI's occurring in that department. 8 out of 13 CLABSI's happened in the ICU
  - 11 out of 13 CLABSI's have happened in all Critical Care Departments (ICU, CVICU, 3W and 5T)
  - HAI Forum covered many educational topics including:
    - Accurate Temperatures
    - Importance of Chlorohexidine bathing
    - Hand Hygiene and BioVigil usage
    - Indications for Central Line versus a Peripheral IV
    - Documentation requirements in Cerner Powerchart

CLABSI QFT- Plans for Improvement

- We teamed up with BD to complete a Vascular Access Management Assessment to gain knowledge and insight into what we could do to improve our Central Line Process
- This was a week long assessment to identify opportunities for improvement January 17 to 21, 2022
- Team included a BD Clinical Nurse Specialist, a BD Vascular Access Territory Manager, Kaweah Health Director of Renal Services and a Kaweah Health Advance Practice RN
    - We interviewed RN's on Central Line topics including dressing changes, dressing supplies and care management
    - We observed all central lines and half of peripheral IV's at Kaweah Health in ICU, 3W, 4N and 3S on January 19, 2022
    - We observed RN demonstrations of a medication pass, central line dressing change and peripheral IV insertion via simulation.
    - All policies about central lines was reviewed
- At the end of the week we received feedback on our Vascular Access Management Process and areas to improve upon
- Key takeaways included information on proper device selection and care and maintenance and policy improvement
- Overall they were impressed by RN knowledge and skill set demonstrated

End of Fiscal Year Performance

FY22 Clinical Quality Goals

	July-Nov 2021 (Higher is Better)	FY22 Goal	FY21	FY21 Goal
SEP-1 (% Bundle Compliance)	73%	≥ 75%	74%	≥ 70%

Percent of patients with this serious infection complication that received "perfect care". Perfect care is the right treatment at the right time for our sepsis patients.

Our Mission

Health is our passion. Excellence is our focus. Compassion is our promise.

Our Vision

To be your world-class healthcare choice, for life

Lower is Better	July 2021	Aug 2021	Sept 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	June 2022	Estimated Annual Number Not to Exceed to Achieve Goal*	FYTD SIR** (number of actual/ number expected)	FY22 Goal	FY21 FY20
CAUTI Catheter Associated Urinary Tract Infection COVID-19 PATIENTS	1 (0)	3 (1)	5 (5)	2 (0)	2 (1)	1 (0)							16 (12 predicted over 6 months)	1.177	≤0.676	0.54 1.12
CLABSI Central Line Associated Blood Stream Infection COVID-19 PATIENTS	0 (0)	4 (3)	3 (3)	3 (0)	1 (1)	1 (0)							11 (9.5 predicted over 6 months)	1.261	≤0.596	0.75 1.20
MRSA Methicillin-Resistant Staphylococcus Aureus	2	0	1	3	0	2							5 (3.6 predicted over 6 months	2.293	≤0.727	2.78 1.02

*based on July-Dec 2021 NHSN predicted

**Standardized Infection Ratio is the number of patients who acquired one of these infections while in the hospital divided by the number of patients who were expected.

- Our estimated volume of predicted events for the entire FY is 19 based on the actual predicted events in the first half of FY22
- Our estimated annual number not to exceed to achieve our goal was decreased from 16 to 11; our goal is set to the achieve the pre-pandemic CMS national SIR mean of ≤0.596
- What does this mean? Kaweah Health has had 12 events in FY22 exceeding the estimated goal so far

Questions?

Live with passion.

Health is our passion. Excellence is our focus. Compassion is our promise.

Kaweah Health

Unit/Department Specific Data Collection Summarization

Board of Directors Quality Council

Unit/Department: **Orthopedic Service Line Surgical Site infection** **Report Date:** **02/17/2022**

Submitted by: Daniel Allain, NP-C

Measure Objective/Goal: Measuring the percentage of total arthroplasty surgical patients who experienced a **surgical site infection** within 90 days after surgery. An incidence rate calculation is determined using the total number of Total Hip Replacement (THR) and Total Knee Replacement (TKR) surgeries performed during a 12-month period of 2021 versus the total number of infections using CDC/NHSH criteria. The goal of this data collection is to identify opportunities to prevent infections with total arthroplasty procedures.

Date range of data evaluated: January 1, 2021 to December 2021 (12 months)

Analysis of all measures/data: (Include key findings, improvements, opportunities)

Overall, total joint procedures performed on hips and knees from January 1, 2021, through December 2021 at Kaweah Delta resulted in one infection in total Knee Arthroplasty and an overall standardized infection ratio (SIR) of 0.664% with a 1.506% predicted number of infections. Total hip replacement surgery had an overall SIR of 0% with a predicted number of infections at 2.99%.

Spine procedures, fusion and laminectomy for the calendar year of 2021 resulted in five infections associated with spine fusion surgery with a predicted 4.31 infections and a SIR of 1.162. Laminectomy surgeries had one infection with a 2.499 predicted infections and a SIR of 0.4.

Type of SSI	Total # Procedures	Actual # SSI	Predicted # Infections	Standardized Infection Ratio
HPRO	212	0	2.99	0.000
KPRO	239	1	1.506	0.664
FUSN - Spine	252	5	4.31	1.162
LAM - Spine	314	1	2.499	0.4

Improvement opportunities identified, provide action plan and expected resolution date:

1. Enhanced Recovery After Surgery (ERAS) initiative will be implement starting March 2, 2022.
2. The ERAS program will be led by the orthopedic program's Nurse Practitioner. The Joint Camp will return to an in-person format as the COVID-19 infection rate allows. In the meantime, the joint camp power point is being updated along with the development of a Facebook live stream learning option. The live online forum will allow for better patient engagement and education.
3. Discussing standard of practice among orthopedic surgeons with variances presented at the monthly Co-Management meeting as appropriate.
4. Evaluation of nasal decolonization prior to surgery for those patients who screen positive for nasal MRSA.

Next Steps/Recommendations/Outcomes:

Orthopedic NP continues to attend monthly surgical site infection (SSI) subcommittee meeting to stay current with SSI topics related to prevention and best practices. This information is shared with orthopedic surgeons on a regular basis. Continue to hardwire ERAS program with nursing staff, therapies, and surgeons in the coming year.

Total Knee/Hip Arthroplasty Complication Rate

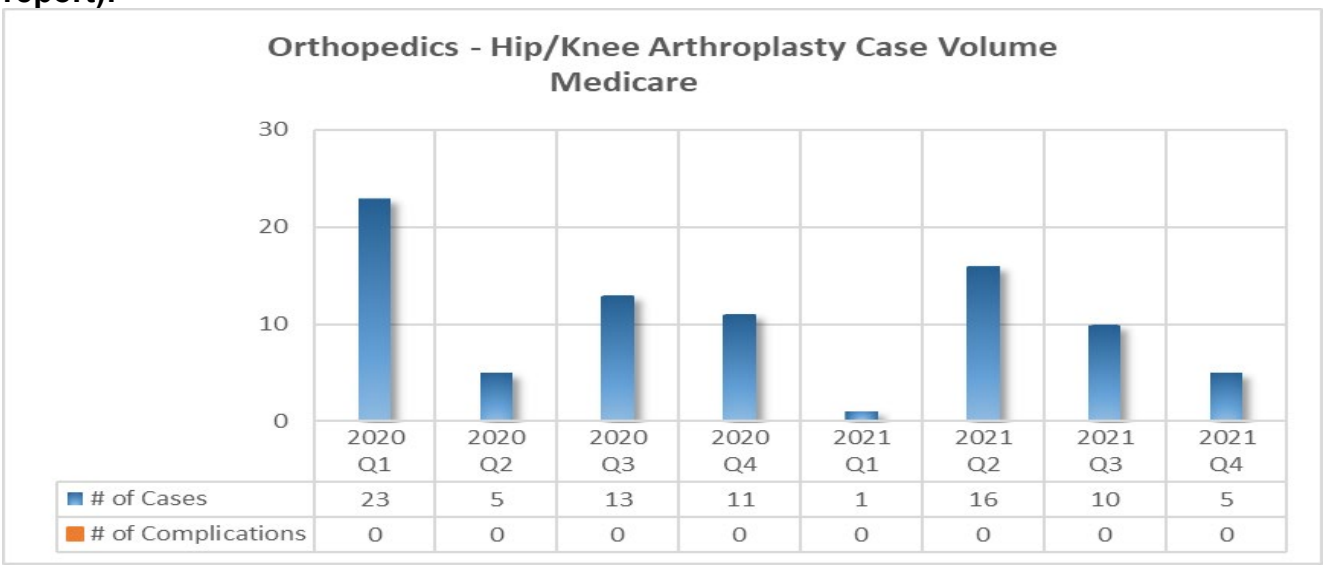
Measure Objective/Goal: Monitor and measure the **complication rate** for total arthroplasty patients who underwent either a total hip or knee joint replacement. The benchmark sources are both CMS and hospitals within the STATIT database. The CMS benchmark is 0.9**%** for Medicare patients and **1.1%** benchmark for all payers within the Midas database.

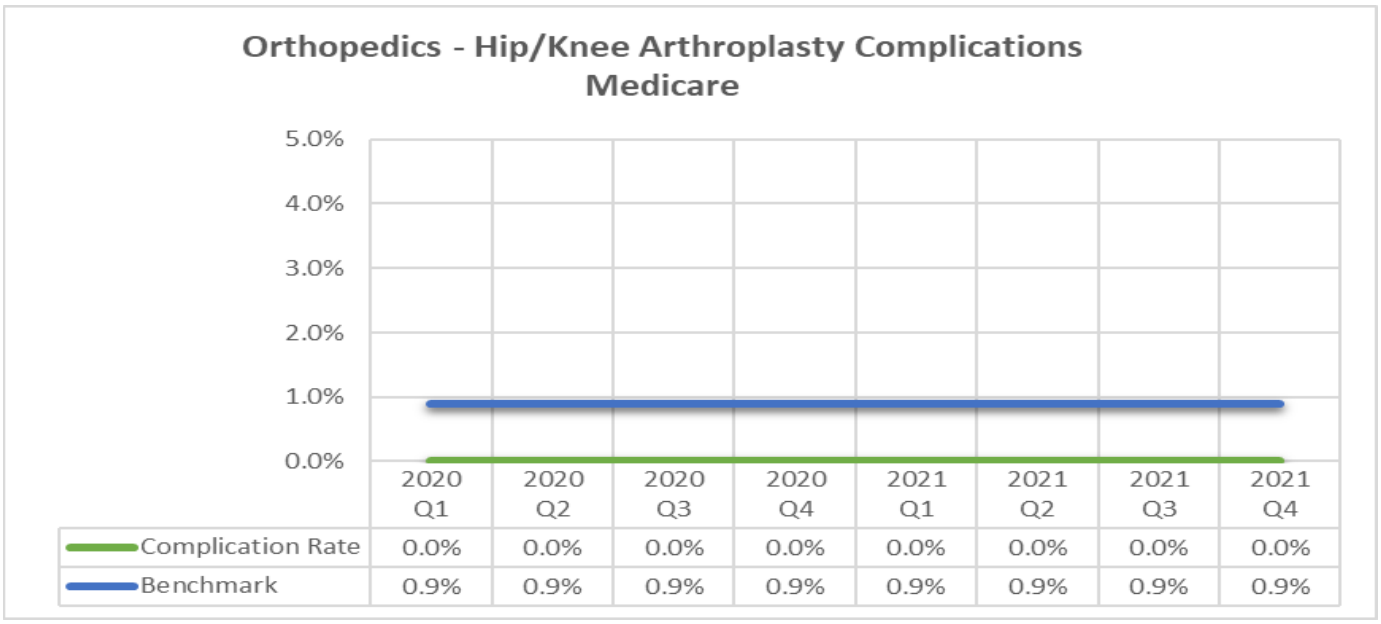
The inclusion criteria for complication include the following:

1. Mechanical complication within 90 days
2. Wound Infection or periprosthetic joint infection within 90 days
3. Surgical site bleeding within 30 days
4. Pulmonary embolism within 30 days
5. Death within 30 days
6. Acute myocardial infarction with 7 days
7. Pneumonia within 7 days
8. Sepsis, septicemia, or shock within 7

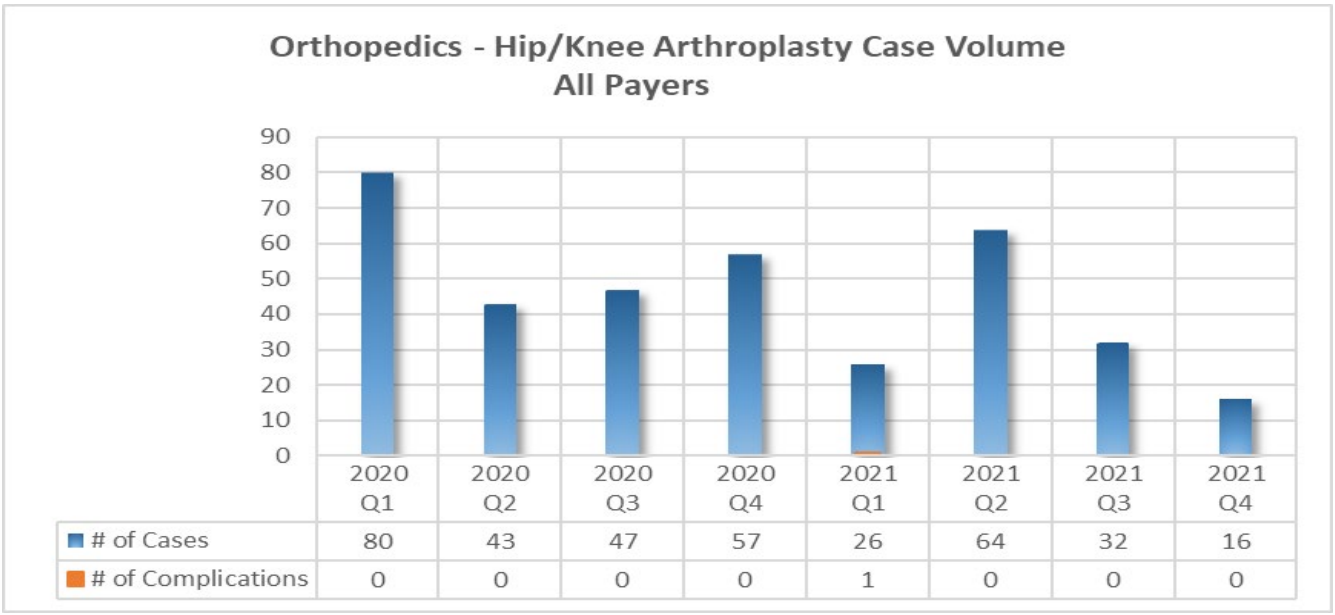
Date range of data evaluated: Quarter 1, 2020 to Quarter 4, 2021

Analysis of all measures/data: (Include key findings, improvements, and opportunities) (If this is not a new measure, please include data from your previous reports through your current report):

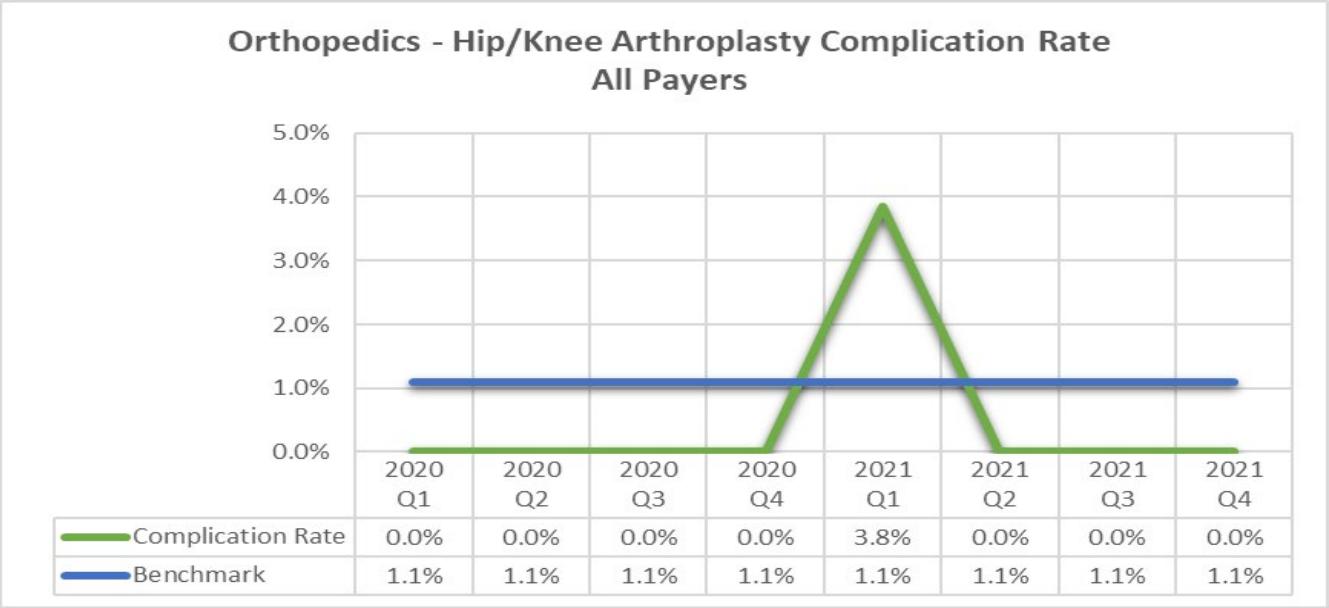




	2020 Q1	2020 Q2	2020 Q3	2020 Q4	2021 Q1	2021 Q2	2021 Q3	2021 Q4
Complication Rate	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Benchmark	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%



	2020 Q1	2020 Q2	2020 Q3	2020 Q4	2021 Q1	2021 Q2	2021 Q3	2021 Q4
# of Cases	80	43	47	57	26	64	32	16
# of Complications	0	0	0	0	1	0	0	0



	2020 Q1	2020 Q2	2020 Q3	2020 Q4	2021 Q1	2021 Q2	2021 Q3	2021 Q4
Complication Rate	0.0%	0.0%	0.0%	0.0%	3.8%	0.0%	0.0%	0.0%
Benchmark	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%

If improvement opportunities identified, provide action plan and expected resolution date:

Overall, the orthopedic service line performing well within all payers group as well as with the Medicare group. One complication (3.8% complication rate) occurred in Quarter 1, 2021 in the all payers group, which is higher than the benchmark of 1.1%. The Medicare complication rate was zero for the same reported time-period. Given the challenges faced with the COVID pandemic, the orthopedic service line continues to perform exceptionally well.

Next Steps/Recommendations/Outcomes:

1. Working with the surgeons to coordinate same day discharges along with home health physical therapy (HHPT) prior to discharge from the Ambulatory Surgery Center. The focus with HHPT will include home safety assessment, strength/ROM exercises, and gait/balance training.
2. Increased focus at the Joint Camp class related to home safety and modifications prior to surgery as well as caregiver training.
3. Introduce the patient and the family to the ERAS initiative.
4. With the move from inpatient qualified stays to outpatients stays and a focus on same day discharge, the orthopedic nurse practitioner is working closely with physical therapy to evaluate for safe discharge home.

Total Knee/Hip Arthroplasty Readmission Rate

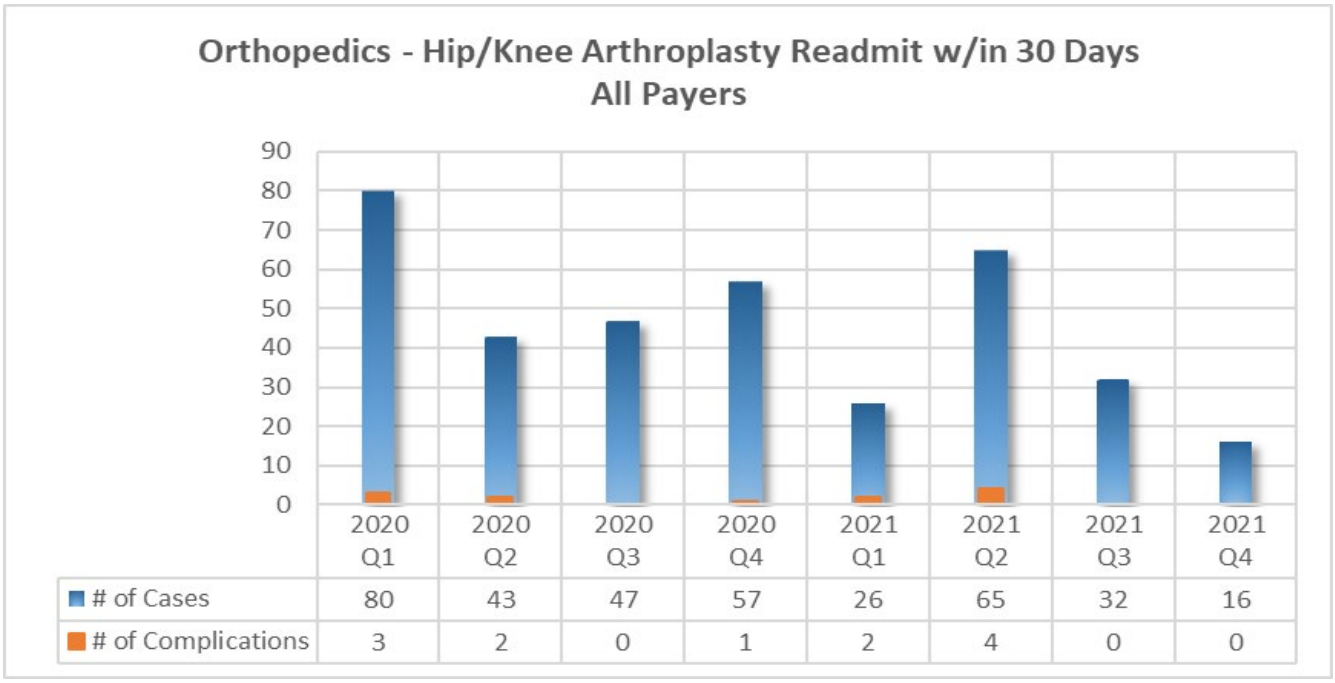
Measure Objective/Goal: Monitor and measure any cause 30-day **readmission rate** for total hip and knee arthroplasty patients who underwent a joint replacement. The benchmark sources are both CMS and hospitals within the Midas database. The CMS benchmark is 3**%** for Medicare patients and 3.2**%** benchmark for all payers.

Unit/Department Specific Data Collection Summarization

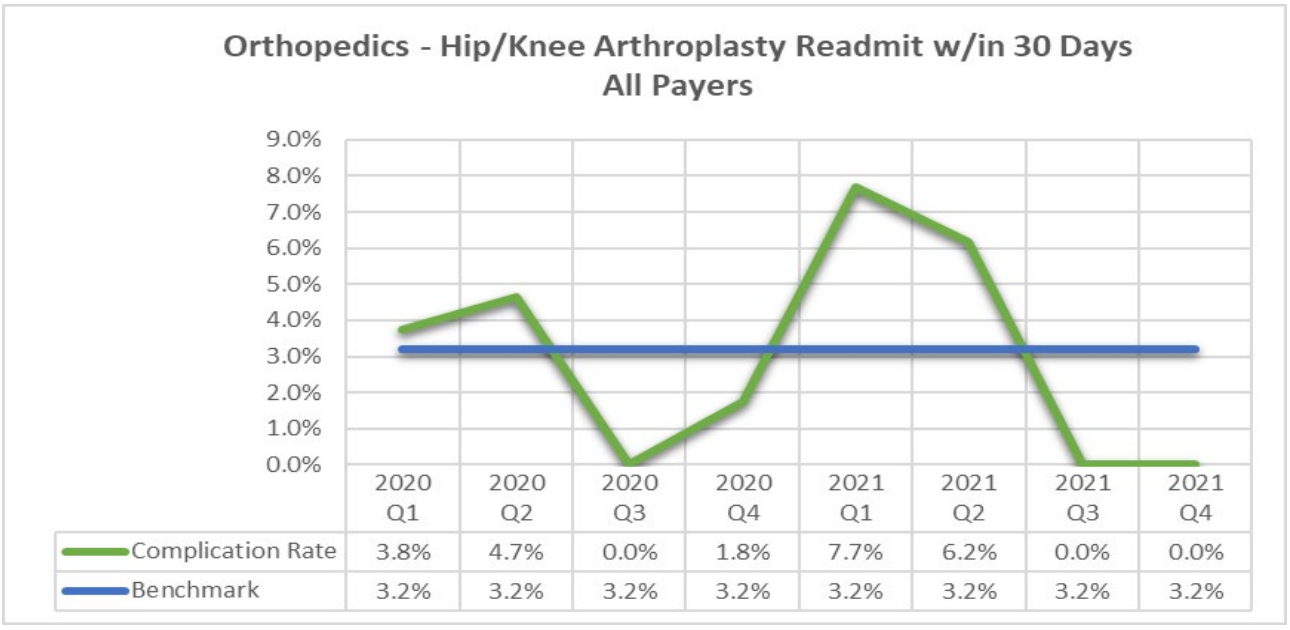
Board of Directors Quality Council

Date range of data evaluated: Quarter 1, 2020 to Quarter 4, 2021

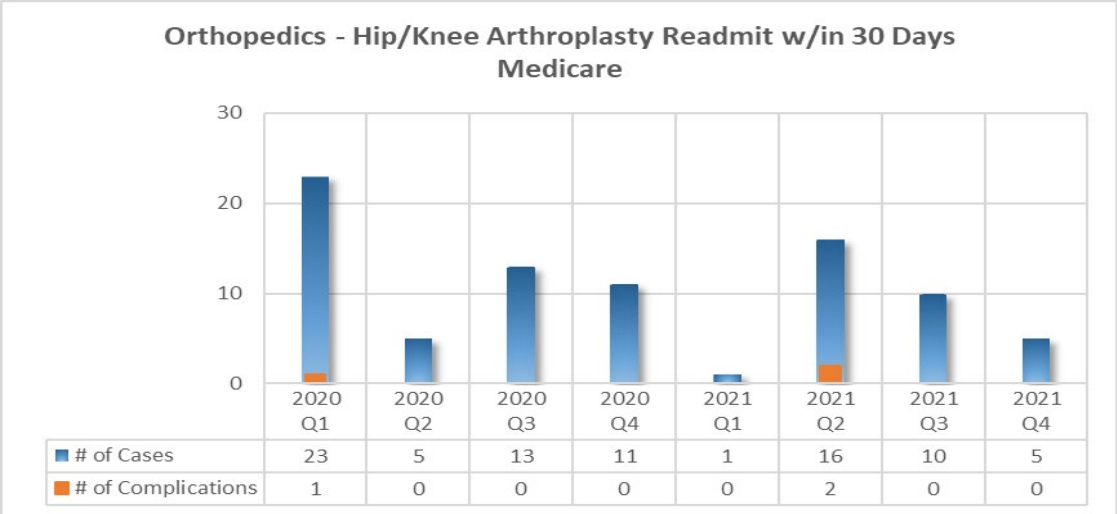
Analysis of all measures/data: (Include key findings, improvements, opportunities)
(If this is not a new measure, please include data from your previous reports through your current report):

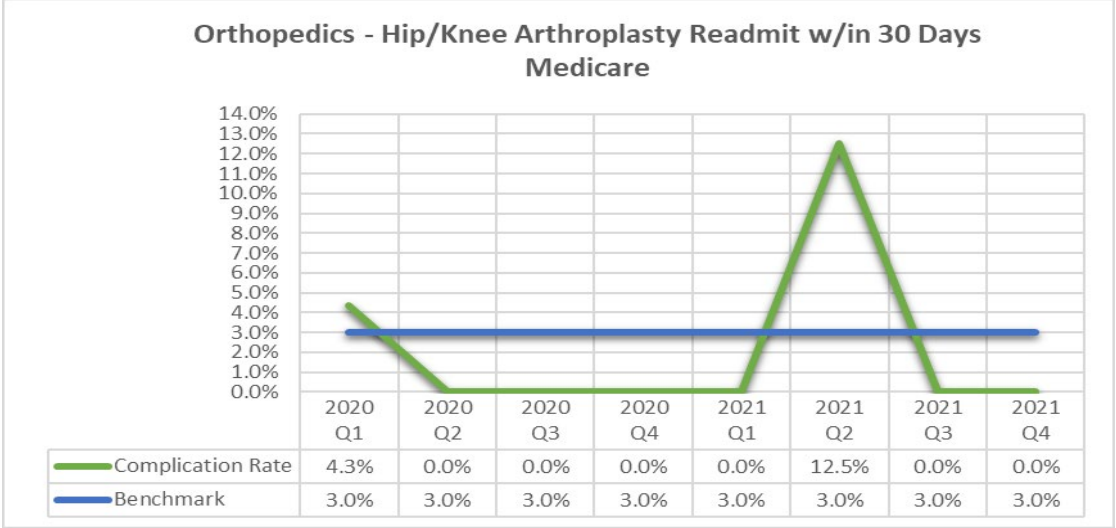


	2020 Q1	2020 Q2	2020 Q3	2020 Q4	2021 Q1	2021 Q2	2021 Q3	2021 Q4
# of Cases	80	43	47	57	26	65	32	16
# of Complications	3	2	0	1	2	4	0	0



	2020 Q1	2020 Q2	2020 Q3	2020 Q4	2021 Q1	2021 Q2	2021 Q3	2021 Q4
Complication Rate	3.8%	4.7%	0.0%	1.8%	7.7%	6.2%	0.0%	0.0%
Benchmark	3.2%	3.2%	3.2%	3.2%	3.2%	3.2%	3.2%	3.2%





<u>If improvement opportunities identified, provide action plan and expected resolution date:</u>

Overall, performing well with the Medicare patients in regards to re-admissions. There were a total of three re-admissions out of 87 Medicare cases over a 2-year period. The readmission were as follows; 1 for joint revision, 2 for medical reasons. The all payer readmission rate was higher than the national benchmark with 12 re-admissions out of 366 in the last 2-year period. . benchmark. Ten of the readmission were related to medical reasons; one was for a joint revision surgery and one for a wound infection. No readmissions involved the joint or required wash out.

Next Steps/Recommendations/Outcomes:

1. Standardized education and increased emphasis with prevention of surgical site infections during the pre-op Joint Camp education class.
2. Focus on post-operative care of surgical sites and plan of care if signs and symptoms of infection occur with plan to call surgeon and not to report to Emergency room.
3. Implement ERAS for all orthopedic joint surgeries as of March 2, 2022

Submitted by Name: Daniel Allain, NP-C **Date Submitted:** 8/24/2021

Pain Management Committee Quality Report

Sandy Volchko DNP, RN, CPHQ, CLSSBB
Director Quality & Patient Safety

Tom Gray, MD
Medical Director of Quality & Patient Safety

February 2022

Pain Management at Kaweah

Committee Mission:

- Responsible for oversight of pain management and safe opioid prescribing
- Develop measures and monitor quality improvement (QI) activities
- Ensure our pain management practices meet the highest standards
- Continually evaluate how pain is managed within our institution to ensure our procedures and protocols address the needs of our patients and empower our staff to provide excellent care.

Pain committee membership includes Nursing, Physical Therapy, Pharmacy (Pain Service), Quality, Physician stakeholders such as Palliative Care, Anesthesia, Emergency Medicine, GME Residents, Medical Director of Quality & Patient Safety, as well as consultation with Medical Director of Surgical Quality.

Pain Management at Kaweah

Committee Goals:

Monitor appropriate and effective pain management; prioritize and focus QI activities on:

1. Pain assessment – completed accurately and at appropriate time intervals (includes reassessment)
2. Types of interventions – pharmacological (opioid vs multimodal) and non-pharmacological. Decrease opioid interventions, Increase use of multi-modal intervention in high risk groups (surgical, chronic opioid use patients and end of life). Ensure safe prescribing habits.
3. Effectiveness – decrease is opioid use, increase in multi-modal use, & discharge prescribing
4. Safety measures – Narcan use (Medication Safety Committee), and claims based measure of adverse drug events related to opioids

Key Activities 2021:

1. Development of pain management measures and dashboard
2. Completion of a gap analysis for all Joint Commission standards related to pain management
   - All standards compliant
   - Opportunities to enhance processes identified and included in 2022 plan
3. Completion of the Cal Hospital Compare (CHC) Opioid Safe Hospital Organizational Assessment
   - CHC is a non-profit organization that is helping to address California's opioid epidemic and accelerate hospital progress to reduce opioid related deaths. CHC uses the Opioid Management Hospital Self-Assessment to assess performance and progress across the following 4 domains of care: 1) Safe & effective opioid use, 2) Identifying and treating patients with Opioid Use Disorder, 3) Overdose prevention, 4) Applying cross-cutting opioid management best practices
   - Hospitals score each element on a 1-4 scale (higher score indicates high degree of progress); items <4 included in 2022 action plan

KH Pain Management Committee

Pain Management & Opioid Safety Initiatives

Pain Management QI Initiative	Status 2021	Action Plan 2022
1. Ensure opioid safety through monitoring of Adverse Drug Events per 1,000 Inpatient admission (Medicare FFS Part A claims) **Goal:** Surpass national benchmark of 1.86 per 1,000 patients (as reported by Health Services Advisory Group HSAG 9/1/20-8/31/21)	• Lower is better. 2019 = 2.29 per 1,000(17/7430); 2020 = 1.15 per 1,000 (7/6074); Jan-Aug 2022 = 0.82 per 1,000 (3/3623). Goal achieved.	• Resident QI project 2022 focused on evaluation of each adverse drug event from Jan 2021-June 2021 using the Naranjo Adverse Drug Reaction Probability Scale (a tool that standardized assessment of causality for all adverse drug reactions)
2. Ensure opioid safety through monitoring of Adverse Drug Events collected through Rapid Response Team (RRT) case review. Number of RRTs where Narcan was effective (Narcan is a reversal agent used to treat overdoses) **Goal:** 0	• n/a	• Data pending resident review • Resident QI project focused on evaluating/validating RRT events preliminarily identified by RRT RNs as event where Narcan was used and was effective

KH Pain Management Committee

Pain Management & Opioid Safety Initiatives

Pain Management QI Initiative	Status 2021	Action Plan 2022
3. Ensure Opioid safety through discharge prescribing. NEW! CMS Measure: Safe Use of Opioids-Concurrent Prescribing (eCQM - Electronic Clinical Quality Measures). Benchmark not yet released	• Measure description - Inpatient hospitalizations for patients 18 years of age and older prescribed, or continued on, two or more opioids or an opioid and benzodiazepine concurrently at discharge • Denominator exclusions: Inpatient hospitalizations where patients have cancer that overlaps the encounter or are receiving palliative or hospice care (including comfort measures, terminal care, and dying care) during the encounter • 2021 = 18.70% (1053/5642) Benchmark not yet released by CMS • CMS reports this measure will be publically reported in 2022 (date not yet released)	• Operationalize Centers for Disease Control (CDC) opioid discharge prescribing guidelines hospital wide through accessible venues and evaluate electronic functionality that supports best practices (ie. alerts upon discharge prescribing) • Data request submitted to analyze the numerator population by: principal procedure, principal diagnosis, drug name prescribed at discharge, drug names included in admission medication reconciliation list (was patient admitted on 2 opioids or opioid & benzodiazepine?). Current data set includes attending provider and discharge disposition.

KH Pain Management Committee

Type of Pain Management Intervention & Effectiveness Initiatives

Pain Management QI Initiative	Status 2021	Action Plan 2022
1. Increasing peripheral nerve blocks (Anesthesia) **Goal:** Increase volume from baseline; reduces need for opioids	• 37 peripheral nerve blocks completed CY 2021 • Volume of compatible pumps noted as a barrier to increase peripheral nerve block use; volume increased at the end of July. OR leadership developed check out process.	• Focusing increasing nerve blocks on the amputation surgical population. Baseline data report request pending.
2. Increasing Multimodal use when opioids are prescribed in surgical and chronic opioid patient populations **Goal:** Increase % of patients with opioid and multimodal administered from baseline	Data (higher is better): • % of opioid and multimodal administration surgical patients: 2020 = 57.5%; Jan-Nov 2021 = 65.3%. Goal to increase 5% points in CY 2021, achieved • % of opioid and multimodal administration chronic opioid patients: 2020 = 52.9%; Jan-Nov 2021 = 50.5%. Goal to increase 5% points in CY 2021, not achieved • Power plans evaluated for presence of multimodal order options available to providers. • Enhanced Recovery After Surgery (ERAS) in place for elective colorectal surgical patients and also initiated for C-Section patients in 4Q 2021	• ERAS expanding to Orthopedic populations 1Q 2022 • ERAS expanding to non-elective colorectal and gynecological surgical patients populations in 2022 • Update provider Kaweah Health onboarding materials for pain management • Develop a standardized approach to providing alternatives to opioids for pain management (including at least 1 non-pharmacological alternative)

KH Pain Management Committee

Type of Pain Management Intervention & Effectiveness Initiatives		
Pain Management QI Initiative	**Status 2021**	**Action Plan 2022**
3. Develop a standardized approach to providing alternatives to opioids for pain management, including non-pharmacological **Rationale**: Reduce opioid administration	• Opioid overall use data pending (measured by oral morphine equivalents "OMEs") • Comfort menu developed and non-pharmacological pain management tools for Broderick Pavilion patients	• Evaluate measures and supportive pathways that promote team-based approach to identifying opioid alternatives such as order sets with non-opioid analgesic, multi-modal pain management program, and non-pharmacological pain management interventions
4. Review and revise patient education materials for pain management **Rationale:** Reduce opioid administration	• n/a	• New project for committee 2022; includes review of current materials, gap analysis and revisions
5. Assess stigma associated with provider pain management for patients with Substance Use Disorder (SUD)	• n/a	• Under development – resident project focused on provider survey & data analysis

KH Pain Management Committee

Pain Assessment Initiatives

Pain Management QI Initiative	Status 2021	Action Plan 2022
1. RN knowledge of pain score assessment prior to & after pain med admin **Goal:** 95%	• Knowledge of pain score assessment prior. Baseline (June-July 2021) = 88%; Aug-Dec 2021 = 98% Goal achieved • Knowledge of pain score assessment post – baseline (June-July 2021) = 79%; Aug-Dec 2021 = 99%. Goal achieved	Continue to monitor to sustain
2. RN knowledge of appropriate us of PAIN-AD scale to assess pain for non-verbal pts **Goal:** 95%	• Baseline (June-July 2021) = 88%; Aug-Dec 2021 = 98% Goal achieved	Continue to monitor to sustain
3. Reassessing patients pain within 75 min of opioid administration **Goal:** under evaluation due to documentation timing	• Evaluation of nursing processes indicated that the reassessment is occurring within appropriate timeframe, but not documented until later in the shift. Broad Nursing education assigned to RNs in August 2021.	Plan in progress, performance related to timing of documentation under review with nursing leadership; monitor RRT data for outcomes related to reassessment timing

Questions?

Live with passion.

Health is our passion. Excellence is our focus. Compassion is our promise.

Kaweah Health

Clinical Quality Goal Update

Sandy Volchko DNP, RN, CPHQ, CLSSBB
Director Quality & Patient Safety

Quality Improvement Committee
February 2022

FY22 Clinical Quality Goals

	July-Nov 2021 Higher is Better	FY22 Goal	FY21	FY21 Goal
SEP-1 (% Bundle Compliance)	73%	≥ 75%	74%	≥ 70%

Percent of patients with this serious infection complication that received "perfect care". Perfect care is the right treatment at the right time for our sepsis patients.

Our Mission

Health is our passion.
Excellence is our focus.
Compassion is our promise.

Our Vision

To be your world-class healthcare choice, for life

Lower is Better	July 2021	Aug 2021	Sept 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	June 2022	Estimated Annual Number Not to Exceed to Achieve Goal*	FYTD SIR** (number of actual/ number expected)	FY22 Goal	FY21 FY20
CAUTI Catheter Associated Urinary Tract Infection COVID-19 PATIENTS	1 0	3 1	5 5	2 0	2 1	1 0							16 (12 predicted over 6 months)	1.177	≤0.676	0.54 1.12
CLABSI Central Line Associated Blood Stream Infection COVID-19 PATIENTS	0 0	4 3	3 3	3 0	1 1	1 0							11 (9.5 predicted over 6 months)	1.261	≤0.596	0.75 1.20
MRSA Methicillin-Resistant Staphylococcus Aureus	2	0	1	3	0	2							5 (3.6 predicted over 6 months	2.293	≤0.727	2.78 1.02

*based on July-Dec 2021 NHSN predicted

**Standardized Infection Ratio is the number of patients who acquired one of these infections while in the hospital divided by the number of patients who were expected.

Questions?

Live with passion.

Health is our passion. Excellence is our focus. Compassion is our promise.

Kaweah Health