March 11, 2021

NOTICE

The Board of Directors of the Kaweah Delta Health Care District will meet in a Quality Council Committee meeting at 7:00AM on Thursday, March 18, 2021, in the Kaweah Delta Support Services Building, Copper Room, 520 W. Mineral King Avenue, or via GoTo Meeting from your computer, tablet or smartphone. https://global.gotomeeting.com/join/881426077 or call (224) 501-3412 - Access Code: 881-426-077.

The Board of Directors of the Kaweah Delta Health Care District will meet in a Closed Quality Council Committee at 7:01AM on Thursday, March 18, 2021, in the Kaweah Delta Support Services Building, Copper Room, 520 W. Mineral King Avenue, pursuant to Health and Safety code 32155 & 1461. Board members and Quality Council closed session participants will access closed meeting via Confidential GoTo Meeting phone number provided to them.

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 March 18, 2021, in the Kaweah Delta Support Services Building, Copper Room, 520 W, Mineral King Avenue, or via GoTo Meeting via computer, tablet or smartphone. https://global.gotomeeting.com/join/881426077 or call (224) 501-3412 - Access Code: 881-426-077.

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 Delta Medical Center, Mineral King Wing entry corridor between the Mineral King lobby and the Emergency Department waiting room.

Due to COVID 19 visitor restrictions to the Medical Center - the disclosable public records related to agendas can be obtained by contacting the Board Clerk at Kaweah Delta Medical Center – Acequia Wing, Executive Offices (Administration Department) {1st floor}, 400 West Mineral King Avenue, Visalia, CA via email: cmoccio@kdhcd.org, via phone: 559-624-2330 or on the Kaweah Delta Health Care District web page http://www.kaweahdelta.org.

KAWEAH DELTA HEALTH CARE DISTRICT
Garth Gipson, Secretary/Treasurer

Cindy Moccio

Cindy Moccio
Board Clerk, Executive Assistant to CEO

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

KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS
QUALITY COUNCIL

Thursday, March 18, 2021
520 W. Mineral King Avenue
Copper Room, 2nd Floor – Support Services Building
GoToMeeting: https://global.gotomeeting.com/join/881426077
Call in option: 1-224-501-3412 Access Code: 881-426-077

ATTENDING: Board Members; David Francis – Committee Chair, Mike Olmos; Gary Herbst, CEO; Keri Noeske, RN, BSW, DNP, VP & CNO; Byron Mendenhall, MD, Chief of Staff; Monica Manga, MD, Professional Staff Quality Committee Chair; Daniel Hightower, MD, Secretary/Treasurer; Harry Lively, MD, Past Chief of Staff; Lori Winston, MD, DIO & VP of Medical Education; Tom Gray, MD, Quality and Patient Safety Medical Director; Sandy Volchko DNP, RN CLSSBB, Director of Quality and Patient Safety; Ben Cripps, Chief Compliance Officer, and Michelle Adams, Recording.

OPEN MEETING – 7:00AM

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. **Approval of Quality Council Closed Meeting Agenda** – 7:01AM
   - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Monica Manga, MD, and Professional Staff Quality Committee Chair;*
   - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Alexandra Bennett, BSN, CMSRN, Director of Risk Management*
4. **Adjourn Open Meeting** – *David Francis, Committee Chair*

CLOSED MEETING – 7:01AM

1. **Call to order** – *David Francis, Committee Chair & Board Member*
2. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Monica Manga, MD, and Professional Staff Quality Committee Chair*
3. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 — *Alexandra Bennett, BSN, CMSRN, Director of Risk Management*

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

OPEN MEETING – 8:00AM

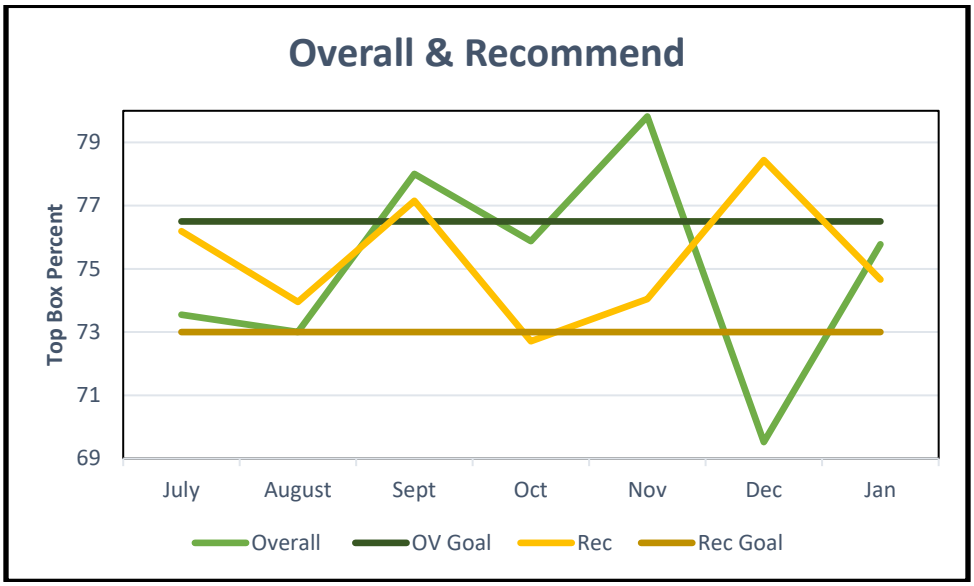
1. **Call to order** – *David Francis, Committee Chair*
2. **Public / Medical Staff participation –** Members of the public wishing to address the Committee concerning items not on the agenda and within the subject matter jurisdiction of the Committee may step forward and are requested to identify themselves 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. **Patient Experience**
   - 3.2. **Maternal Child Health Service Line**
4. **Best Practice Teams** – A review of current measures, goals, and Best Practice Team prioritization and timelines for Pneumonia, Heart Failure, Acute Myocardial Infarction and Chronic Obstructive Pulmonary Disease populations. *Tom Gray, MD, Medical Director of Quality and Patient Safety; Sandy Volchko, RN, DNP, Director of Quality and Patient Safety.*
5. **Update: Clinical Quality Goals -** A review of current performance and actions focused on the FY 2021 clinical quality goals. *Sandy Volchko, RN, DNP, Director of Quality and Patient Safety.*
6. **Handoff Quality Focus Team –** A review of measures and plan to enhance handoff communication between departments. *Kassie Waters, BSN, MPA, CPHQ, Director of Cardiac Critical Care Services.*
7. **Adjourn Open Meeting** – *David Francis, Committee Chair*

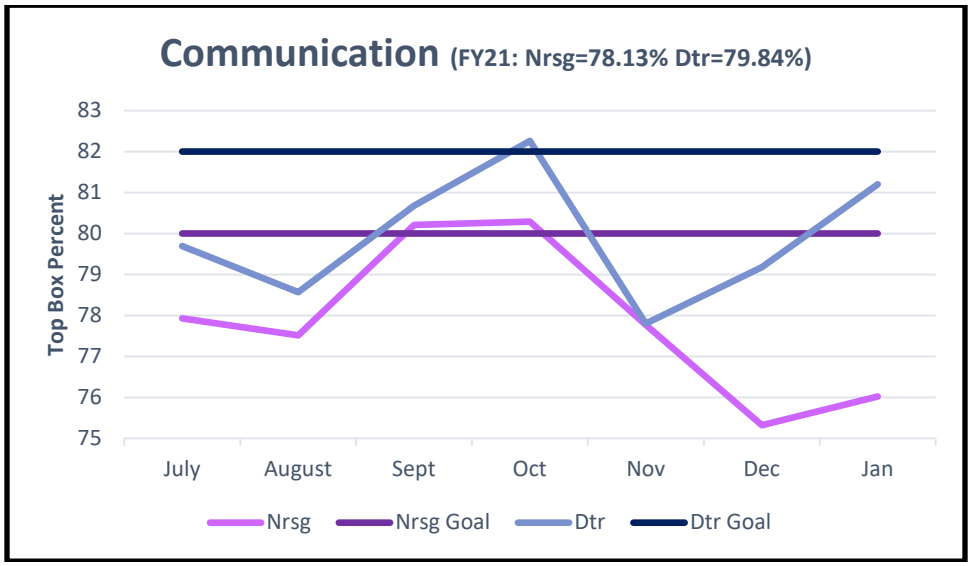
In compliance with the Americans with Disabilities Act, if you need special assistance to participate at this meeting, please contact the Board Clerk (559) 624-2330. Notification 48 hours prior to the meeting will enable the District to make reasonable arrangements to ensure accessibility to the Kaweah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

Quality Council Update
Patient Experience (HCAHPS) Performance: Dec 2020

Time Period	1Q19 -4Q19		July – December 2020	
HCAHPS Measure	**Full Adj** *(Mode Adj + Pt Mix Adj)*	**CMS** 50th percentile ***National***	**Scores** *(Mode Adj Only)*	**Comments/Improvement Efforts**
# of surveys 22% response rate	2026	-	1074	-
Communication with Nurses	**77%** Below CMS	81%	78%	-Installed **new communication white boards (most units)**
Communication with Doctors	**76%** Below CMS	82%	80%	-**Standardize communication** between consulting and attending physicians. -Quality **introductions** -**Explaining** findings and treatment plans
Responsiveness of Staff	**67%** Below CMS	70%	**69%**	-**Hourly rounding** (4 South)
Communication about Meds	**60%** Below CMS	66%	**69%**	-**Medicine guide** for chemotherapy and immunotherapy (3 South)
Cleanliness of Environment	**68%** Below CMS	76%	70%	-**Tent cards** to inform patients and increase EVS accessibility -**Increased rounding** on units with low cleanliness scores
Quietness of Environment	**49%** Below CMS	62%	57%	-**Increased staff awareness**, engagement, and commitment (4 North)
Discharge Information *(Yes)*	**87%** Below CMS	87%	**90%**	-**Discharge rounds** to identify and address discharge needs
Care Transition *(Strongly Agree)*	**47%** Below CMS	54%	48%	-**Discharge rounds** to identify & address discharge needs
Overall Rating of Hospital (0 = worst; 10 = best)	**71% *(9 or 10)*** Below CMS	73%	**75%**	**OPERATION ALWAYS** *Purpose: Consistently provide world-class service* →**Restart Leader Rounding** (Clinical and non-clinical) →**Kaweah Care Service Standards Class**
Willingness to Recommend *(Definitely Recommend)*	**70%** Below CMS	72%	**75%**	*Same as above*

Patient Experience (HCAHPS) Trended Data: July-Dec 2020





Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee

Unit/Department: Pediatrics **ProStaff Report Date: January 2021**

Measure Objective/Goal:
Injury Falls per 1000 patient days
Goal: 0.33
Goal Met

Date range of data evaluated:
July-December 2020

Analysis of all measures/data: (Include key findings, improvements, opportunities)
We had 0 injury falls during this quarter. This is better than benchmark for Injury Falls per 1000 patient days during this data range.

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

Next Steps/Recommendations/Outcomes:
We will continue to implement fall risk precautions and educate families on safe sleep as well as monitored activities within room by caregiver. We will continue to have parents sign waivers when they decline Safe Sleep. We will trial using soft play mats on the floor next to the bedside of active toddlers.

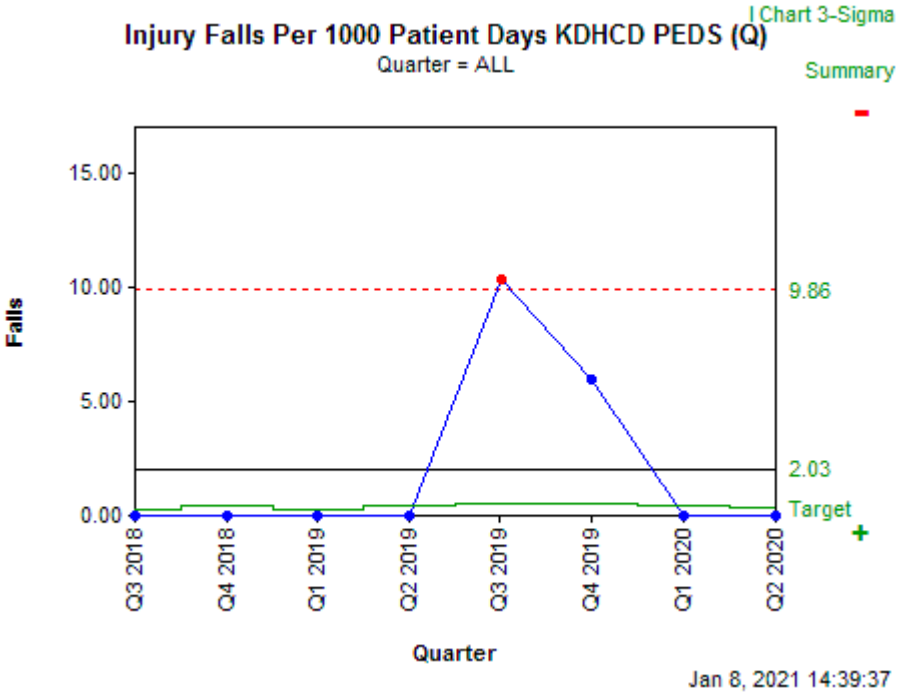
Submitted by Name: Danielle Grimaldi, RN, BSN, CPN

Date Submitted: 01/08/21

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

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee



Quarter	Falls	Target
Q2 2020	0.00	0.33
Q1 2020	0.00	0.44
Q4 2019	5.92	0.51
Q3 2019	10.31	0.53
Q2 2019	0.00	0.42
Q1 2019	0.00	0.26
Q4 2018	0.00	0.42
Q3 2018	0.00	0.26

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

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee

Unit/Department: Pediatrics **ProStaff Report Date: January 2021**

Measure Objective/Goal:
Catheter Associated Urinary Tract Infection
Goal: 0.00
Goal met.

Date range of data evaluated:
July- December 2020

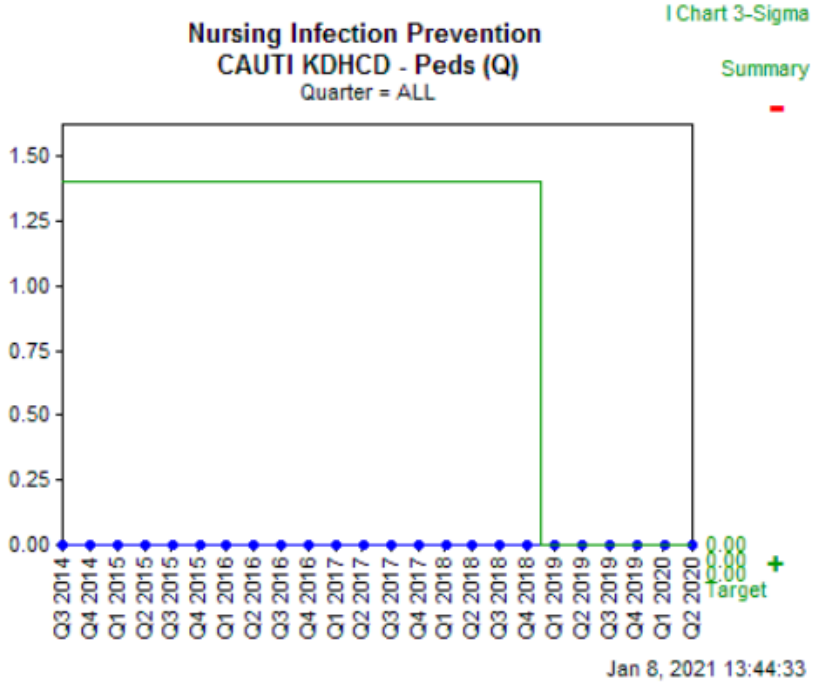
Analysis of all measures/data: (Include key findings, improvements, opportunities)
We had 0 CAUTIs for this quarter. We are performing equal to the benchmark.

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

Next Steps/Recommendations/Outcomes:
We will continue to use aseptic technique to insert urinary catheters, and we will continue to provide perineal care every shift. We will also continue to evaluate need for urinary catheter on a daily basis.

Submitted by Name: Danielle Grimaldi, RN, BSN, CPN

Date Submitted: 01/08/21



Date	KDHCD	Target
Q2 2020	0.00	0.00
Q1 2020	0.00	0.00
Q4 2019	0.00	0.00
Q3 2019	0.00	0.00
Q2 2019	0.00	0.00
Q1 2019	0.00	0.00
Q4 2018	0.00	1.40
Q3 2018	0.00	1.40
Q2 2018	0.00	1.40
Q1 2018	0.00	1.40
Q4 2017	0.00	1.40
Q3 2017	0.00	1.40
Q2 2017	0.00	1.40
Q1 2017	0.00	1.40
Q4 2016	0.00	1.40
Q3 2016	0.00	1.40
Q2 2016	0.00	1.40
Q1 2016	0.00	1.40
Q4 2015	0.00	1.40
Q3 2015	0.00	1.40
Q2 2015	0.00	1.40
Q1 2015	0.00	1.40
Q4 2014	0.00	1.40
Q3 2014	0.00	1.40

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee

Unit/Department: Pediatrics **ProStaff Report Date: January 2021**

Measure Objective/Goal:
Central Line Associated Blood Infections
Goal: 0.00
Goal Met.

Date range of data evaluated:
July-December 2020

Analysis of all measures/data: (Include key findings, improvements, opportunities)
We had 0 CLABSIs for this quarter. We are performing equal with the benchmark.

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

Next Steps/Recommendations/Outcomes:
We will continue to use aseptic technique to perform scheduled dressing and cap changes. We will also continue to evaluate need for central line on a daily basis.

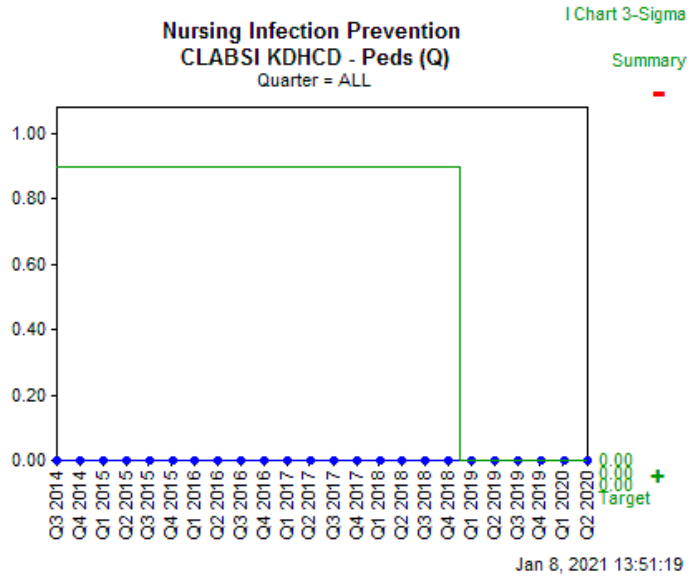
Submitted by Name: Danielle Grimaldi, RN, BSN, CPN

Date Submitted: 01/08/21

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

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee



Date	KDHCD	Target
Q2 2020	0.00	0.00
Q1 2020	0.00	0.00
Q4 2019	0.00	0.00
Q3 2019	0.00	0.00
Q2 2019	0.00	0.00
Q1 2019	0.00	0.00
Q4 2018	0.00	0.90
Q3 2018	0.00	0.90
Q2 2018	0.00	0.90
Q1 2018	0.00	0.90
Q4 2017	0.00	0.90
Q3 2017	0.00	0.90
Q2 2017	0.00	0.90
Q1 2017	0.00	0.90
Q4 2016	0.00	0.90
Q3 2016	0.00	0.90
Q2 2016	0.00	0.90
Q1 2016	0.00	0.90
Q4 2015	0.00	0.90
Q3 2015	0.00	0.90
Q2 2015	0.00	0.90
Q1 2015	0.00	0.90
Q4 2014	0.00	0.90
Q3 2014	0.00	0.90

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

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee

Unit/Department: Pediatrics **ProStaff Report Date: January 2021**

Measure Objective/Goal:

Percent of patients with stage 2 or greater HAPI: 0.00
Goal: 0.63
Goal Met

Date range of data evaluated:

July-December 2020

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

We had 0 HAPIs stage 2 or greater for this quarter. This is better than the benchmark.

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

Next Steps/Recommendations/Outcomes:

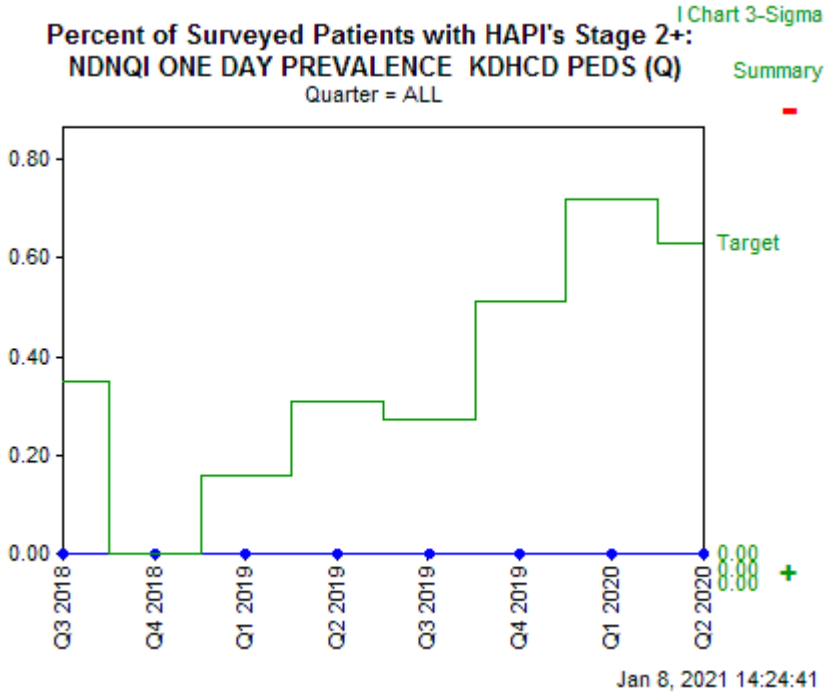
We will continue identifying patients at risk for skin breakdown and implement appropriate preventative measures.

Submitted by Name:	**Date Submitted:**
Danielle Grimaldi, RN, BSN, CPN	01/08/21

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

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee



Date	KDHCD	Target
Q2 2020	0.00	0.63
Q1 2020	0.00	0.72
Q4 2019	0.00	0.51
Q3 2019	0.00	0.27
Q2 2019	0.00	0.31
Q1 2019	0.00	0.16
Q4 2018	0.00	0.00
Q3 2018	0.00	0.35

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

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee

Unit/Department: Pediatrics **ProStaff Report Date: January 2021**

Measure Objective/Goal:

Percent of PEWS fallouts-PEWS score charted every 4 hours on every patient.
Goal: 90% or greater no fallouts.
Goal Met-100%

Date range of data evaluated:

July-December 2020

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

Using data received within the last 180 days, we have had a 100% success rate in PEWS score being charted every 4 hours. Results are better than benchmark for PEWS score.

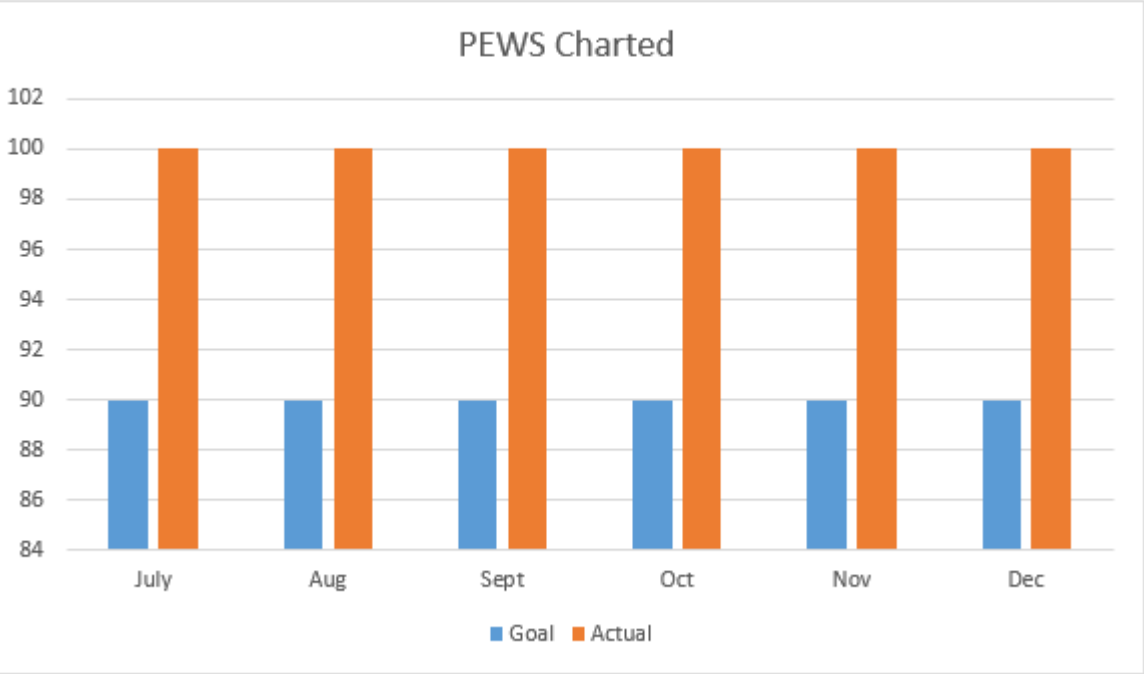
If improvement opportunities identified, provide action plan and expected resolution date

Next Steps/Recommendations/Outcomes:

Continue to maintain PEWS scoring greater than 90% expected with next report date.

Submitted by Name:	**Date Submitted:**
Danielle Grimaldi, RN, BSN, CPN	01/08/21

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.

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee

Unit/Department: Pediatrics **ProStaff Report Date: January 2021**

Measure Objective/Goal:
Total Patient Falls per 1000 patient days
Goal: 1.09
Goal met

Date range of data evaluated:
July-December 2020

Analysis of all measures/data: (Include key findings, improvements, opportunities)
We have 0 Patient falls during this quarter. This is better than the benchmark.

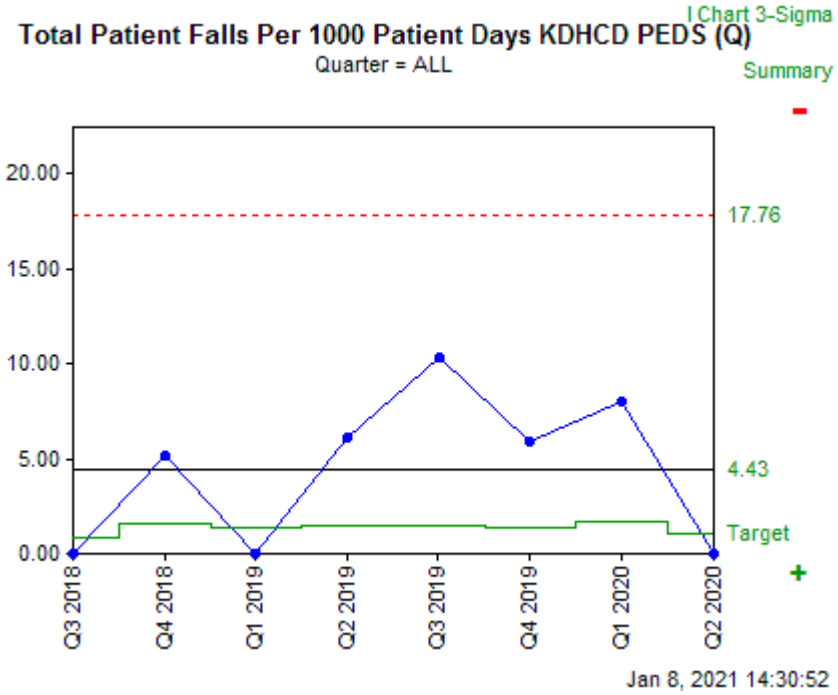
If improvement opportunities identified, provide action plan and expected resolution date:

Next Steps/Recommendations/Outcomes:
We will continue to implement fall risk precautions and educate families on safe sleep as well as monitored activities within room by caregiver. We will continue to have parents sign waivers when they decline Safe Sleep.

Submitted by Name: Danielle Grimaldi, RN, BSN, CPN

Date Submitted: 01/08/21

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



Date	KDHCD	Target
Q2 2020	0.00	1.09
Q1 2020	8.02	1.68
Q4 2019	5.92	1.34
Q3 2019	10.31	1.47
Q2 2019	6.06	1.46
Q1 2019	0.00	1.35
Q4 2018	5.13	1.60
Q3 2018	0.00	0.83

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

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

Unit/Department: ***NICU*** **ProStaff/QIC Report Date:** *January, 2021*

Measure Objective/Goal:

1. *CLABSI per 1000 device days: Goal-Meet or exceed benchmark*
2. *VAP per 1000 ventilator device days: Goal-Meet or exceeds benchmark*
3. *Monthly hand hygiene compliance: Goal-Meet or exceeds benchmark*

Date range of data evaluated:

June 2020 through December 2020 (Central line days and vent days for entire year)

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):

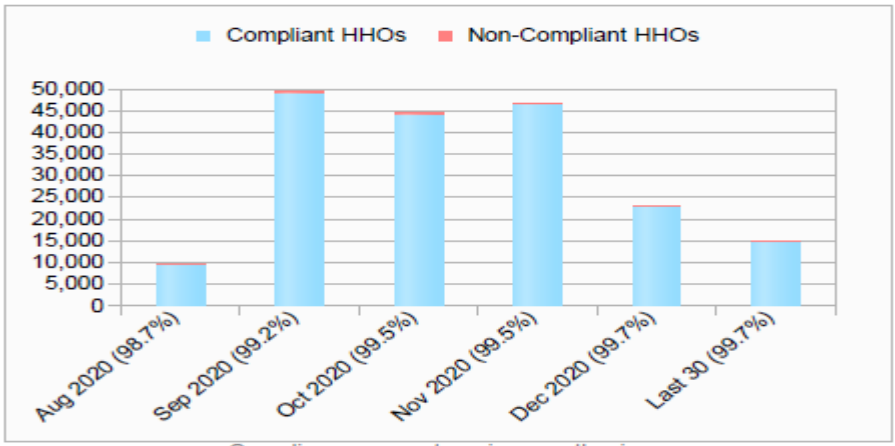
1. *KD NICU 0/1000 central line days. No CLABSI in 19 months. 511 Central line days in 2020. Goal met.*
    a. *Improvements & Opportunities: Continue to follow central line bundle-Gemba round daily*
2. *KD NICU VAP- No VAP in 2020. 140 vent days in 2020. Goal Met*
3. *Monthly hand hygiene- Since the go live of Biovigl in late August the NICU has collectively been captured with exceptional hand hygiene compliance-99.6%*

BIOVIGIL®

Performance Summary Dashboard By Department
From: 10/9/2020 11:00:00 PM (-08:00); To: 1/8/2021 12:52:00 PM (-08:00)

Department
Neonatal ICU-NICU

Total HHOs ***100,541*** Total Compliance ***99.6%***



Compliance percentage in parenthesis

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

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

1. *Continue to participate in CLABSI collaborative. Maintain central line bundle. Report findings to CPQCC.*
2. *NICU VAP policy and bundle in place.*
3. *Soap and water as well as hand sanitizer available in every patient room. Continue to monitor compliance beyond reporting requirements. Include NICU parents in hand hygiene monitoring. Continue to monitor success and opportunities with Biovigil data.*

Next Steps/Recommendations/Outcomes:

1. *Continue with current standardized insertion practice and care of all central lines.*
2. *No VAP. Benchmark met; continue to support current P&P.*
3. *Continue to monitor HH compliance through Biovigil.*

Submitted by Name:
Felicia T. Vaughn

Date Submitted:
January 8th, 2021

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

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

Unit/Department: **2E Labor and Delivery**

ProStaff/QIC Report Date: **January 8, 2021**

Measure Objective/Goal:

1. Early Elective Delivery of patients with no medical indication/ Goal is 0%
   This goal is met at 0%
2. Physician notification and Timely treatment in identified women with acute onset of severe hypertension within 60 minutes./ Goal is 90%
   This goal is met at 92%
3. Decision to ready time of less than or equal to 30 minutes in identified nonscheduled cesarean section/ Goal is 90%
   This goal is not met at 60%

Date range of data evaluated:

July 2020 to December 2020

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):

1. Goal met – Will continue to monitor
2. Goal met – Will continue to montor
3. Goal not met – Improvements have been made since previous goal at 25%. Opportunities were ISS to expand documentation of cesarean sections to include measure. This allowed for more accurate data collection.

If improvement opportunities identified, provide action plan and expected resolution data
Next Steps/Recommendations/Outcomes:

In measures 1 and 2 will continue to audit and report monthly to maintain at or better than the benchmark.

In measure 3 will continue to audit and report monthly. In order to boost goal, UBC is currently developing an action plan to educate staff on the unit by defining process of measure and how to document in Cerner.

Submitted by Name: Roberta DeCosta **Date Submitted:** 01-08-2021

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

Unit/Department Specific Data Collection Summarization

Quality Improvement Committee

Unit/Department: Mother Baby **QIC Report Date: Jan 2021**

Measure Objective/Goal:

Babies receiving any breast milk while in the hospital 91.63% (CDPH 2018 benchmark of 93.8%)

Date range of data evaluated:

July 2020 – December 2021

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

We currently are performing below the benchmark of 93.9%.

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

We are currently fully staffed with 7 day a week coverage spanning an average of 21 hours a day. We implemented coverage on Labor/Delivery to see our new mom's prior to delivery providing them with education so they can make an informed decision on how they want to feed their baby while in the hospital. We have implemented our our breastfeeding bundle which included the following: change in lactation scheduling, mandatory breastfeeding education for RN's, breastfeeding education provided to our pediatricians, selection preference form to be collected on admission to Labor and Delivery and an investigative form for nursing to complete when formula is given. In addition to the above bundle, our lactation team has now changed their focus to include assisting with the first feed post-delivery and following the mothers who choose to do both breast and formula encouraging only breastfeeding while in the hospital. We most recently implemented BIB University (Breast is Best), very similar to Falls U, where staff are invited to share their stories so we can identify gaps in care.

Next Steps/Recommendations/Outcomes:

We continue to support our mother's choice for feeding her baby(ies).

Submitted by Name: Melissa Filiponi, RNC-MNN, BSN

Date Submitted: 01/08/2021

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

Unit/Department Specific Data Collection Summarization

Quality Improvement Committee

Unit/Department: Mother Baby **QIC Report Date: Jan 2021**

Measure Objective/Goal:

Monitoring c-section respiratory rates to ensure they are performed and documented as ordered within the first 24 hours post c-section. For this reporting period, we are at 87% compliance. (Internal benchmark 80.0%)

Date range of data evaluated:

July 2020 – December 2020

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

We currently are performing above the benchmark of 80.0%.

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

We recently experienced changes in these orders as ordered by our anesthesia team. Education has been provided to the staff and respiratory rate charting is being audited during bedside report.

Next Steps/Recommendations/Outcomes:

We will continue to monitor this measure until we achieve and sustain 80% compliance rate.

Submitted by Name: Melissa Filiponi, RNC-MNN, BSN

Date Submitted: 01/08/2021

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

Unit/Department Specific Data Collection Summarization

Quality Improvement Committee

Unit/Department: Mother Baby **QIC Report Date: Jan 2021**

Measure Objective/Goal:

Babies receiving exclusive breast milk while in the hospital 63.97% (TJC PC-05 Benchmark 52.2%)

Date range of data evaluated:

July 2020 – December 2020

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

We currently are performing above the benchmark of 52.2%.

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

We are currently fully staffed with 7 day a week coverage spanning an average of 21 hours a day. We implemented coverage on Labor/Delivery to see our new mom's prior to delivery providing them with education so they can make an informed decision on how they want to feed their baby while in the hospital. We have implemented our our breastfeeding bundle which included the following: change in lactation scheduling, mandatory breastfeeding education for RN's, breastfeeding education provided to our pediatricians, selection preference form to be collected on admission to Labor and Delivery and an investigative form for nursing to complete when formula is given. In addition to the above bundle, our lactation team has now changed their focus to include assisting with the first feed post-delivery and following the mothers who choose to do both breast and formula encouraging only breastfeeding while in the hospital. We most recently implemented BIB University (Breast is Best), very similar to Falls U, where staff are invited to share their stories so we can identify gaps in care.

Next Steps/Recommendations/Outcomes:

We continue to support our mother's choice of exclusive breastfeeding.

Submitted by Name: Melissa Filiponi, RNC-MNN, BSN

Date Submitted: 01/08/2021

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

Unit/Department Specific Data Collection Summarization

Quality Improvement Committee

Unit/Department: Mother Baby **QIC Report Date: Jan 2021**

Measure Objective/Goal:

To initiate NICU mom's pumping within 2-4 hours of separation from their baby 89.28% (Internal benchmark of 75%).

Date range of data evaluated:

July 2020 – December 2020

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

We currently are performing above the benchmark of 75%.

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

Education provided to staff on the importance of pumping for both mother and babies well-being. We have been auditing the charts of NICU moms and providing one on one education to staff so that they are charting in the correct location within the EHR.

Next Steps/Recommendations/Outcomes:

We continue to audit, monitor and support the mother's choice of pumping.

Submitted by Name:	**Date Submitted:**
Melissa Filiponi, RNC-MNN, BSN	01/08/2021

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

Unit/Department Specific Data Collection Summarization

Quality Improvement Committee

Unit/Department: Mother Baby **QIC Report Date: Jan 2021**

Measure Objective/Goal:

District wide CAUTI bundle was implemented on May 1, 2020. In collaboration with Labor and Delivery we ensure that all aspects of the bundle are met. The aspects include daily GEMBA patient rounding to check for securement device, foley care provided, and timely discontinuance. The data collection began on May 1, 2020. The district's goal SIR <0.828.

Date range of data evaluated:

July - September

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

Our current bundle compliance rate for 3rd Quarter 2020 is 99.83%.

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

Education was implemented. Staff is ensuring that upon arrival to the unit the patient has a securement device in place as well as providing foley care at minimum of once per shift. Daily rounding occurs with unit leadership, clinical educator and bedside staff to ensure compliance.

Next Steps/Recommendations/Outcomes:

We continue to round daily to monitor for compliance.

Submitted by Name: Melissa Filiponi, RNC-MNN, BSN

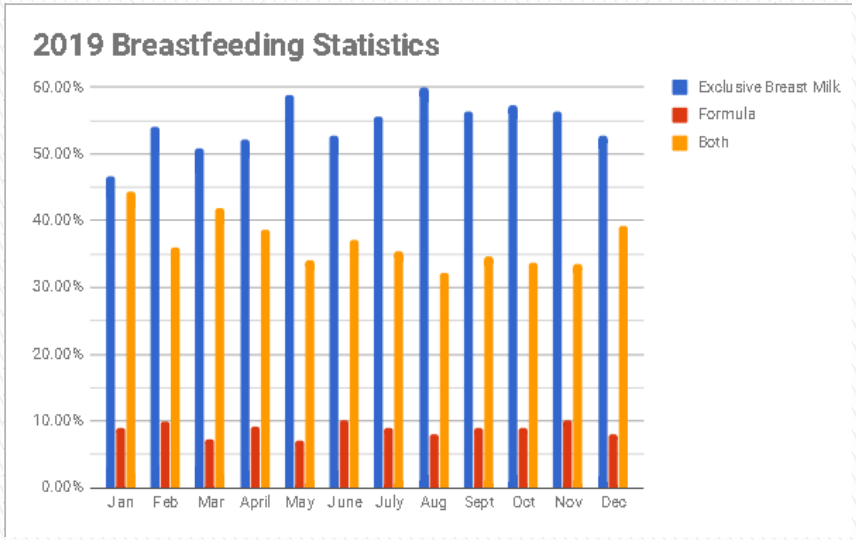
Date Submitted: 01/08/2021

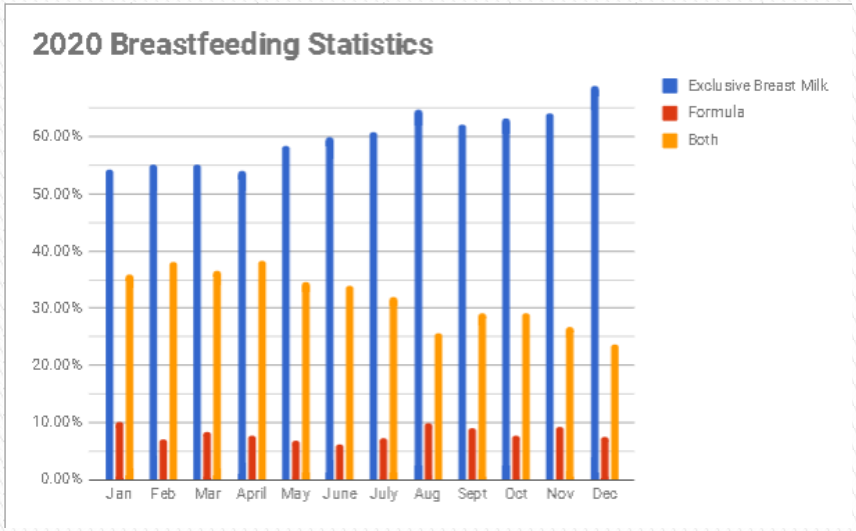
Please submit your data along with the summary to your PI liaison 2 weeks prior to the scheduled report date.

Mother/Baby Quality Data

July – December 2020

Breastfeeding Stats

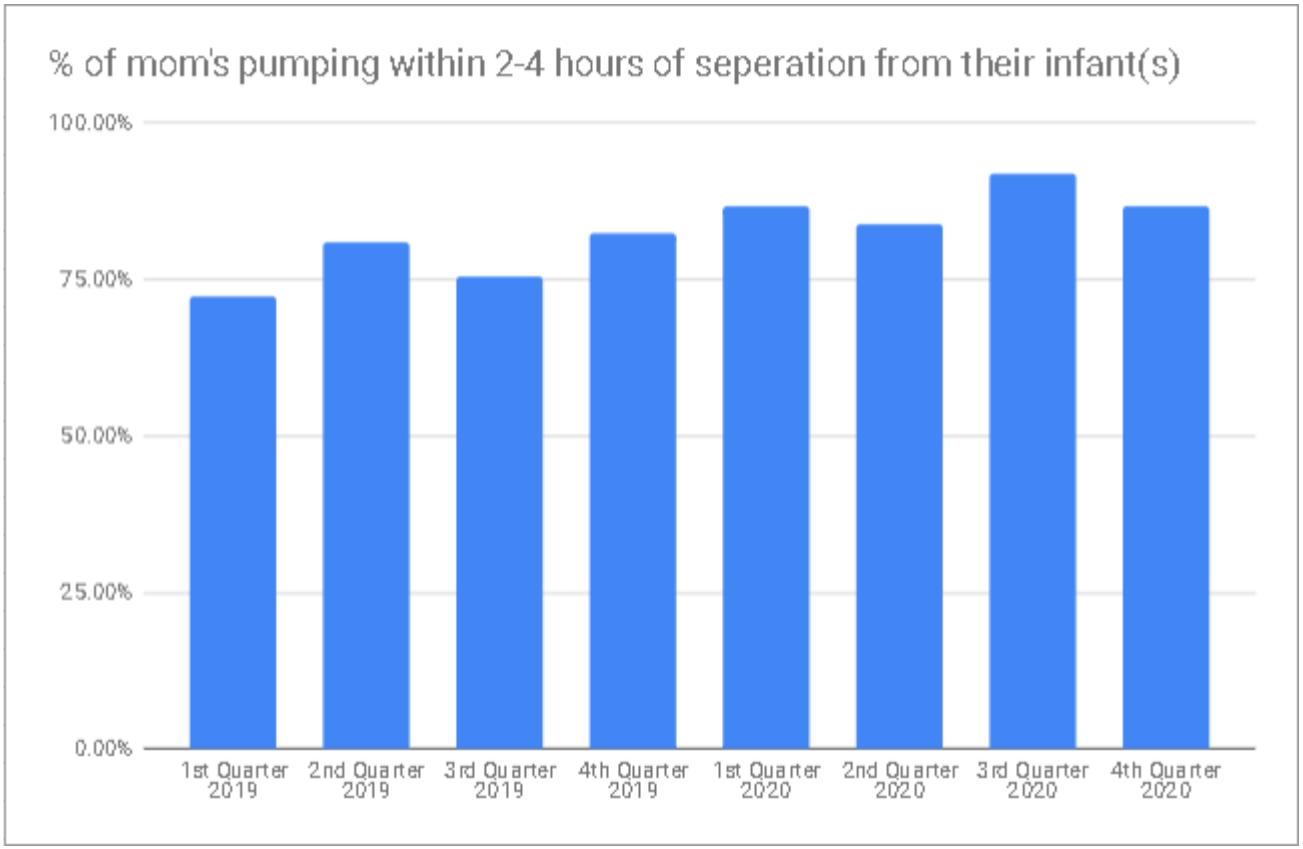




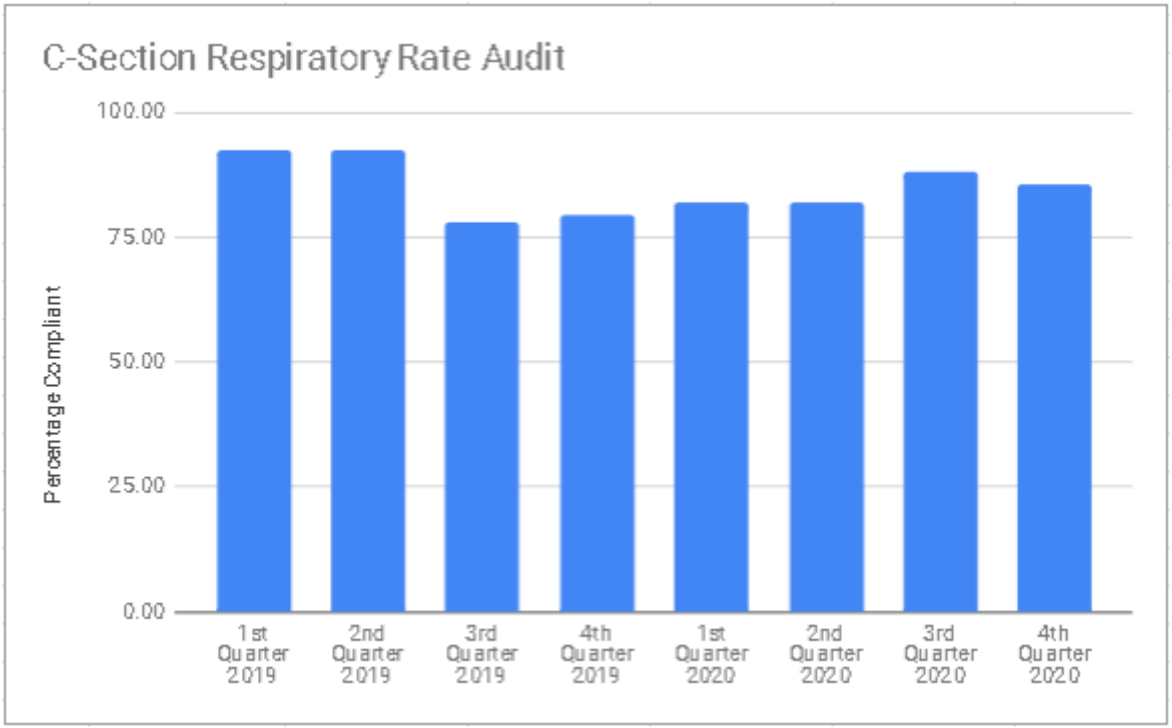
2019

2020

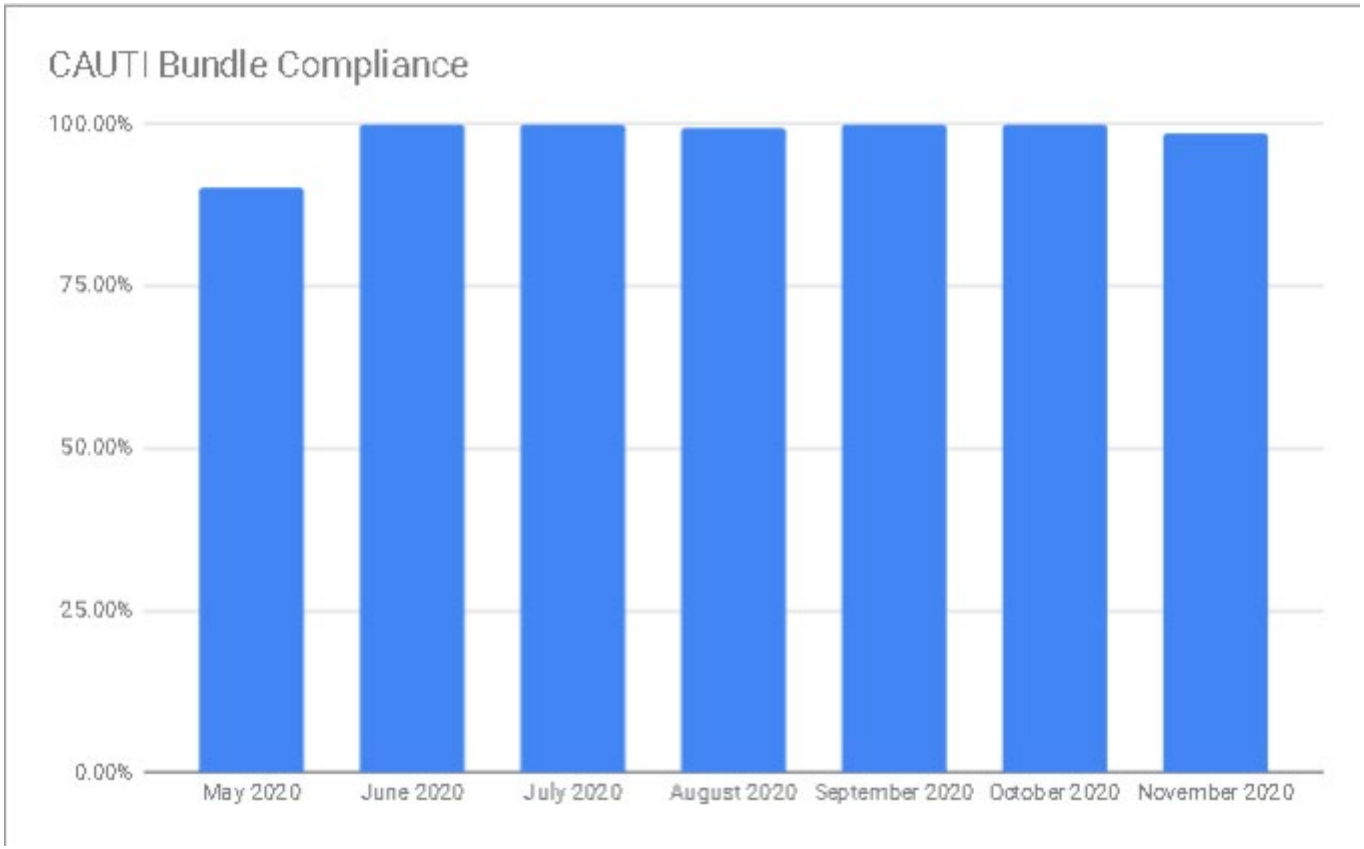
NICU MOM'S PUMPING



C-SECTION RESPIRATORY RATE AUDIT



CAUTI Bundle Compliance



Kaweah
Best Practice Teams 2021
Prioritization & Timelines

Best Practice Teams

AMI (non-STEMI), COPD, Heart Failure & Pneumonia

ACROYMS:

- AMI – Acute Myocardial Infarction
- BPT – Best Practice Team
- COPD – Chronic Obstructive Pulmonary Disease
- HF – Heart Failure
- PN – Pneumonia
- Non-STEMI – Non ST Elevated Myocardial Infarction
- KPI – Key Performance Indicator
- LOS – Length of Stay
- QI – Quality Improvement
- F/U – Follow Up

Best Practice Teams

AMI (non-STEMI), COPD, Heart Failure & Pneumonia

Initiation

- Prioritized & staggered
- Team identification: Q&P/S Facilitator, MD Champion, RN Director, process stakeholders
- Best Practice Guideline selection

Goal: Identify clinical processes that will yield optimal patient outcomes

Phase I

- Clinical KPIs Selection
- Measures defined
- Dashboard developed
- Initial QI work (ie. power plan optimization/ work flow) to achieve targets

Goal: Identify KPIs that will reduce mortality o/e & complications (2° LOS & Readmission)

Phase II

- Care Pathway developed
- Integrated into Cerner power plans & workflow
- QI Measures added to dashboard
- QI work to achieve targets

Goal: Improve efficiency and further reductions in LOS, mortality o/e & readmission

Best Practice READMISSION Teams

AMI (non-STEMI), COPD, Heart Failure & Pneumonia

Six Sigma Approach with Kaizen/Rapid Improvement Event

Define

- Prioritized & staggered
- SIPOC - Team identification: Q&P/S Facilitator, MD Champ, RN Director, process stakeholders
- Current state map

Measure

- CTQ characteristics
- Process capability
- Outcome measures (readmission & EDAC)

Analyze

- Readmission population analysis

Improve

- Kaizen
- Process redesign and implementation

Control

- A3

Best Practice Teams - Mortality

Goals - AMI (non-STEMI), COPD, Heart Failure & Pneumonia

Medicare Population

	Volume		Mortality o/e		Mortality Observed		Mortality Expected		Goals Based off 2019 o/e Mortality		Goals Based off 2020 o/e Mortality		Midas Percentile Benchmark (Southwest Region)			
Population	**2019**	**2020**	2019	2020	2019	2020	2019	2020	**FY21**	**FY22**	**FY21**	**FY22**	**2019 50th**	**2019 10th**	**2020 50th**	**2020 10th**
AMI v3.0, Medicare MRA 104	92	58	0.75	1.15	6	9	7.99	7.82	0.71 (-5%)	0.67 (-5%)	1.04(-10%)	0.94 (-10%)	0.97	0.59	0.99	0.64
COPD v3.0, Medicare MRA 104	109	42	2.40	3.92	3	2	1.25	0.51	1.92 (-20%)	1.0 (-48%)	2.00(-49%)	1.00 (-50%)	1.08	0.60	0.81	0.51
HF v3.0, Medicare MRA 139	317	245	1.78	1.46	18	13	10.12	9.79	1.42 (-20%)	1.14 (-20%)	1.17(-20%)	0.936 (-20%)	0.97	0.54	0.96	0.52
PN-Bacterial v3.0, Medicare MRA 114	70	23	1.85	1.80	5	3	2.70	1.67	1.48 (-20%)	1.18 (-20%)	1.44(-20%)	1.152 (-20%)	0.88	0.00	1.00	0.64
PN-Viral v3.0, Medicare MRA 271	128	111	1.34	1.95	7	9	5.20	4.61	1.07 (-20%)	0.96 (-10%)	1.51 (-20%)	1.20 (-20%)	0.89	0.45	1.05	0.59

ALL PAYOR Population

	Volume		Mortality o/e		Mortality Observed		Mortality Expected	
Population	**2019**	**2020**	2019	2020	2019	2020	**2019**	2020
AMI v3.0 MRA 104	265	210	0.88	0.90	6	18	23.91	19.97
COPD v3.0 MRA 131	348	180	1.96	0.98	3	4	3.06	4.07
HF v3.0 MRA 139	1078	1014	1.58	1.23	18	37	27.93	30.15
PN-Bacterial v3.0 MRA 114	222	99	1.16	1.77	5	7	5.15	3.94
PN-Viral v3.0 MRA 271	392	365	1.20	1.32	7	18	12.46	13.58

Note:

- Midas mortality o/e is based on a population that is not an exact match to CMS
- AMI includes STEMI and Non-STEMI
- "MRA" – nomenclature that identifies a population in the Midas system

Best Practice Teams – Length of Stay

Goals - AMI (non-STEMI), COPD, Heart Failure & Pneumonia

ALL PAYOR Population

	Volume		ALOS*		GMLOS*		ALOS/GMLOS Difference		Goals Based off 2019 ALOS/GMLOS Difference		Goals Based off 2020 ALOS/GMLOS Difference	
Population	**2019**	**2020**	2019	2020	2019	2020	**2019**	2020	**FY21**	**FY22**	**FY21**	FY22
AMI v3.0 MRA 104	265	210	4.15	3.94	3.18	2.98	0.97	0.96	0.87 (-10%)	0.78 (-10%)	0.86(-10%)	0.77(-10%)
COPD v3.0 MRA 131	348	180	4.33	4.14	3.40	3.23	0.93	0.91	0.74 (-20%)	0.59(-20%)	0.73 (-20%)	0.58 (-20%)
HF v3.0 MRA 139	1078	1014	4.92	4.69	3.79	3.64	1.13	1.05	0.90 (-20%)	0.72 (-20%)	0.84(-20%)	0.67(-20%)
PN-Bacterial v3.0 MRA 114	222	99	5.63	5.62	4.19	1.28	1.44	4.34	1.15 (-20%)	0.92 (-20%)	3.47(20%)	2.78(-20%)
PN-Viral v3.0 MRA 271	392	365	4.19	4.91	3.32	3.58	0.87	1.33	0.70 (-20%)	0.56 (-20%)	1.06(20%)	0.85(-20%)

*from Midas toolpak

Note:

- 20% reduction in ALOS/GMLOS difference is approximately 0.20- 0.25 day reduction in LOS
- ALOS and GMLOS is from Midas system and reflects time patient is admitted to discharged by hour

Best Practice Teams - Readmission

Goals - AMI (non-STEMI), COPD, Heart Failure & Pneumonia

Medicare Population

Population	CMS Readmit % (95% limits)	Readmit % Midas CMS		Readmission o/e		Readmission Observed		Readmission Expected		Goals Based off 2019 % Midas CMS Readmission		Goals Based off 2020 % Midas CMS Readmission		Midas Percentile Benchmark % Readmission (Southwest)			
	3Q16-2Q19	2019	2020	2019	2020	2019	2020	2019	2020	FY21	FY22	FY21	FY22	2019 50th	2019 10th	2020 50th	2020 10th
AMI v3.0, Medicare MRA 104	16.2% (14.0%, 18.5%)	12.34	7.45	1.53	0.91	15	5	7.99	5.50	11.01 (-10%)	9.99 (-10%)	7.08 (-5%)	6.73 (-5%)	7.69	0.00	7.69	0.00
COPD v3.0, Medicare MRA 104	19.6% (19.3%, 24.2%)	16.09	30.56	2.41	1.65	3	10	1.25	6.06	12.87 (-20%)	10.30 (-20%)	24.45(-20%)	19.56 (-20%)	13.04	0.00	13.04	0.00
HF v3.0, Medicare MRA 139	21.9% (18.6%, 22.7%)	18.22	15.90	1.00	0.99	48	40	10.12	40.36	14.58(-20%)	11.66 (-20%)	12.72(-20%)	10.18 (-20%)	14.29	2.86	14.29	2.86
PN-Bacterial v3.0, Medicare -MRA 114	16.6% (14.4%, 17.8%)	14.13 combined bact/viral	15.07 combined bactviral	1.40	0.68	13	2	2.70	2.95	11.30 (-20%)	9.04 (-20%)	12.01(-20%)	9.6 (20%)	11.32	0.00	11.32	0.00
PN-Viral v3.0, Medicare-MRA 271				0.80	0.98	13	13	5.20	13.25								

ALL PAYOR Population

Population		Readmit % Midas CMS		Readmit o/e		Readmissions Observed		Readmissions Expected	
		2019	2020	2019	2020	2019	2020	2019	2020
AMI v3.0 MRA 104		11.434	8.95	17.60	0.95	41	20	233.00	21.21
COPD v3.0 MRA 131		22.222	24.51	1.31	1.45	86	48	65.88	33.00
HF v3.0 MRA 139		22.796	22.48	1.28	1.23	254	228	198.01	185.69
PN-Bacterial v3.0 MRA 114		15.321 combined bact/viral	14.56 combined bact/viral	1.37	0.78	41	10	29.89	12.79
PN-Viral v3.0 MRA 271				0.93	1.08	48	50	51.36	46.41

Note:

- Midas Readmission o/e is based on a population that is not an exact match to CMS
- Midas Readmit % is based on CMS populations
- **Readmission rates for COPD can only be reported as observed and expected quarterly; % reported every 6-12 months

Best Practice Teams

PROPOSED Prioritization AMI (non-STEMI), COPD, Heart Failure & Pneumonia

Project Prioritization Matrix: CMS Dx Best Practice & Readmission QI Teams 2021

Based on 2019 Data

Dx Specific QI Team	MEDICARE VOLUME Rate 5 to 1 High = 5 Low = 1		MEDICARE MORTALITY O/E Rate 5 to 1 High = 1 Low = 5		DIFFERENCE IN ALOS AND GMLOS (ALLPAYOR) Rate 5 to 1 High = 5 Low = 1		LEVERAGE (Team's positive Impact on reduced CMS readmissions) Rate 5 to 1 High = 5 Low = 1		Total Project Priority
Weight (degree of importance)	2	Weighted score	3	Weighted score	3	Weighted score	1	Weighted score	n/a
AMI Best Practice Team	1	2.0	1	3.0	2	6	3.0	3.0	**11**
COPD Best Practice Team	3	6.0	5	15.0	1	3	1.0	1.0	**24**
PN Best Practice Team	4	8.0	3	9.0	5	15	5.0	5.0	**32**
HF Best Practice Team	5	10.0	4	12.0	4	12	1.0	1.0	**34**

* HF carepathway already established

Readmission QI Team	CMS READMISSION OBSERVED VOLUME Rate 5 to 1 High = 5 Low = 1		CMS READMIT O/E Rate 5 to 1 High = 1 Low = 5		CMS EDAC (3Q16-2Q19) Rate 5 to 1 High = 5 Low = 1		LEVERAGE (Team's positive Impact on reduced CMS mortality) Rate 5 to 1 High = 5 Low = 1		Total Project Priority
Weight (degree of importance)	2	Weighted score	5	Weighted score	1	Weighted score	1	Weighted score	n/a
AMI - Readmissions	2	4.0	3	15.0	5	5	5	5.0	**29**
COPD - Readmissions	1	2.0	5	25.0	1	1	5	25.0	**57**
PN - Readmissions	4	8.0	2	10.0	5	5	5	25.0	**48**
HF - Readmissions	5	10.0	2	10.0	5	5	5	25.0	**50**

* COPD not included in CMS reported EDAC

Prioritization:

1. COPD Readmissions
2. HF Readmissions
3. PN Readmissions
4. HF Best Practice team
5. PN Best Practice Team
6. AMI Readmissions
7. COPD Best Practice Team
8. AMI Best Practice Team

Best Practice Teams

PROPOSED Prioritization AMI (non-STEMI), COPD, Heart Failure & Pneumonia

Project Prioritization Matrix: CMS Dx Best Practice & Readmission QI Teams 2021

Based on 2020 Data

Dx Specific QI Team	MEDICARE VOLUME Rate 5 to 1 High = 5 Low = 1		MEDICARE MORTALITY O/E Rate 5 to 1 High = 1 Low = 5		DIFFERENCE IN ALOS AND GMLOS (ALLPAYOR) Rate 5 to 1 High = 5 Low = 1		LEVERAGE (Team's positive Impact on reduced CMS readmissions) Rate 5 to 1 High = 5 Low = 1		Total Project Priority
Weight (degree of importance)	2	Weighted score	3	Weighted score	3	Weighted score	1	Weighted score	n/a
AMI Best Practice Team	2	4.0	2	6.0	2	6	3.0	3.0	**16**
COPD Best Practice Team	2	4.0	5	15.0	1	3	1.0	1.0	**22**
PN Best Practice Team	4	8.0	4	12.0	5	15	5.0	5.0	**35**
HF Best Practice Team	5	10.0	3	9.0	4	12	1.0	1.0	**31**

* HF carepathway already established

Readmission QI Team	CMS READMISSION OBSERVED VOLUME Rate 5 to 1 High = 5 Low = 1		CMS READMIT O/E Rate 5 to 1 High = 1 Low = 5		CMS EDAC (3Q16-2Q19) Rate 5 to 1 High = 5 Low = 1		LEVERAGE (Team's positive Impact on reduced CMS mortality) Rate 5 to 1 High = 5 Low = 1		Total Project Priority
Weight (degree of importance)	2	Weighted score	5	Weighted score	1	Weighted score	1	Weighted score	n/a
AMI - Readmissions	1	2.0	2	10.0	5	5	5	5.0	**22**
COPD - Readmissions	2	4.0	5	25.0	1	1	5	5.0	**39**
PN - Readmissions	4	8.0	2	10.0	5	5	5	5.0	**28**
HF - Readmissions	5	10.0	3	15.0	5	5	5	5.0	**35**

* COPD not included in CMS reported EDAC

Prioritization:

1. COPD Readmissions
2. HF Readmissions
3. PN Readmissions
4. HF Best Practice team
5. PN Best Practice Team
6. AMI Readmissions
7. COPD Best Practice Team
8. AMI Best Practice Team

Best Practice Teams

AMI (non-STEMI), COPD, Heart Failure & Pneumonia

Proposed Prioritization:

1. COPD Readmissions
2. HF Readmissions
3. PN Readmissions
4. PN Best Practice team
5. HF Best Practice Team
6. AMI Readmissions
7. COPD Best Practice Team
8. AMI Best Practice Team

ACTION:

- Physician stakeholders assigned, review with Prostaff Chair
- Leader and staff stakeholders assigned/confirmed
- Gantt chart to communicate timelines:
  - Phase 1 - 3 months
  - Phase 2 - 3 months
  - Phase 3 - 6 months
  - Timeline dependent on timeliness of data reports
- Readmission teams and BPTs staggered; Dedicated time outside of 1hr/month team allocation for readmission work

Best Practice Teams - READMISSION

AMI (non-STEMI), COPD, Heart Failure & Pneumonia

Proposed Prioritization:

1. COPD Readmissions
2. HF Readmissions
3. PN Readmissions
4. PN Best Practice team
5. HF Best Practice Team
6. AMI Readmissions
7. COPD Best Practice Team
8. AMI Best Practice Team

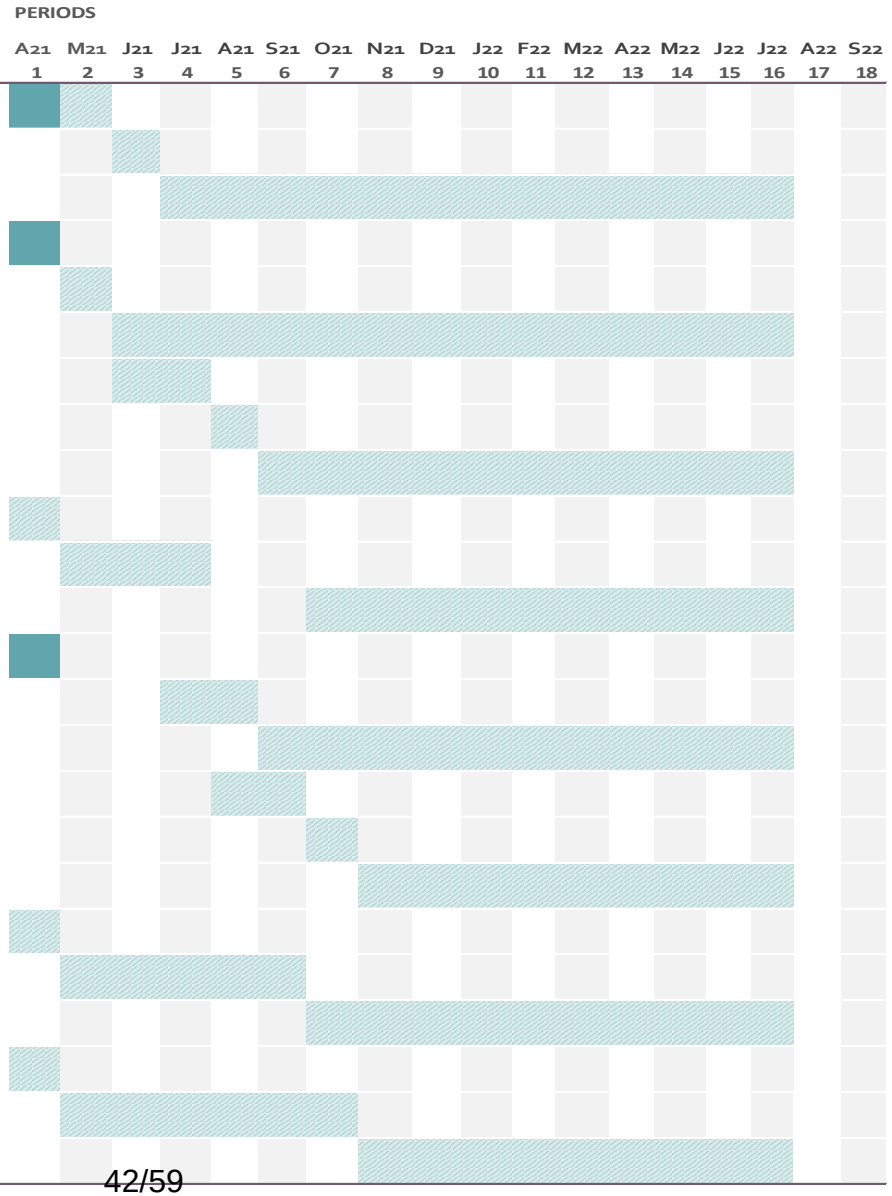
ACTION:

- Physician stakeholders assigned, review with Prostaff Chair
- Leader and staff stakeholders assigned/confirmed (COPD and HF readmission team established, may need additional review of team members)
- Gantt chart to communicate timelines:
  - Current state review pre-work – 2 months (define, measure & analyze)
  - Readmission Event(s) – 1 month (current state team review, design of new process)
  - Readmission Post Event Work – 6-8 months (measure, analyze, improve & control)
  - Timeline dependent on timeliness of data reports
- Readmission teams and BPTs staggered; Dedicated time outside of 1hr/month team allocation for readmission work

Kaweah Best Practice Teams

2021-2022

ACTIVITY	PLAN START	PLAN DURATION	ACTUAL START	ACTUAL DURATION	PERCENT COMPLETE
COPD Readmissions Pre Work	1	2	1		80%
COPD Readmissions Event	3	1			0%
COPD Readmissions Post Event F/U	4	13			0%
HF Readmissions Pre Work	1	1	1		70%
HF Readmissions Event	2	1			0%
HF Readmissions Post Event	3	14			0%
PN Readmissions Pre Work	3	2			0%
PN Readmissions Event	5	1			0%
PN Readmissions Post Event F/U	6	11			0%
PN BPT Initiation	1	1			0%
PN BPT Phase 1 KPI	2	3			0%
PN BPT Phase II Care Pathway	7	10			0%
HF BPT initiation	1	1	1		80%
HF BPT Phase I KPI	4	2			50%
HF BPT Phase II Care Pathway	6	11			50%
AMI-NS Readmissions Pre Work	5	2			0%
AMI-NS Readmissions Event	7	1			0%
AMI-NS Readmissions Post Event F/U	8	9			0%
COPD BPT Initiation	1	1			0%
COPD BPT Phase I KPI	2	5			0%
COPD BPT Phase II Care Pathway	7	10			0%
AMI-NS BPT Initiation	1	1			0%
AMI BPT-NS Phase I KPI	2	6			0%
AMI BPT-NS Phase II Care Pathway	8	9			0%



Best Practice Teams

AMI (non-STEMI), COPD, Heart Failure & Pneumonia

Kaweah Best Practice Teams
Physician Champion Roles & Responsibilities

The goal of the Best Practice Teams (BPTs) is to standardize care and processes to achieve optimal patient outcomes. Specifically to reduce observed to expected mortality, readmission rates and length of stay.

Each BPT has an organizational leader assigned and a six sigma trained Quality RN facilitator who will work closely with each physician champion to ensure the team is moving forward in achieving goals.

The Role of the Physician Champion includes:

- Subject matter expertise on the population of interest
- Selected a best practice guideline(s) in which to base standardized care for targeted diagnosis specific population (i.e. COPD, Heart Failure, AMI (non-STEMI), and Pneumonia).
- Work in partnership with the team to identify Key Clinical Performance Indicators (KPIs); 2-4 measures that are deemed critical in the outcomes of the patient (i.e. discharge medications provided for HF patients, Abx selection for PN patients)
- Collaborate with the team to improve performance on KPIs by evaluating challenges and barriers to improvement and developing strategies to operationalize which will address identified barriers. This could be in the form on developing EMR workflow/order enhancements, or process changes.
- Attend scheduled meetings when Physician Champion input is needed (scheduled around the physician champion's availability), and provide ad hoc support through email communications or ad hoc follow up meetings with team leader and facilitator.
- Champion work with peers, assist with creating awareness of process changes

Questions?

Clinical Quality Goal Update
March 2021

FY 21 Clinical Quality Goals

Jul-Dec 2020		Higher is Better	FYTD %	FY21 Goal	FY20	Last 6 Months FY20
SEP-1 (% Bundle Compliance)	National Av = 66% Top 10% = 82%	75%	75%	≥ 70%	67%	69%

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 2020	Aug 2020	Sept 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Estimated Annual Number Not to Exceed to Achieve Goal*	FYTD SIR** (number of actual divided by number expected)	FY21 Goal	FY20
CAUTI Catheter Associated Urinary Tract Infection	3	0	1	1	1	2	0	1	13	0.84	≤0.727	1.12
CLABSI Central Line Associated Blood Stream Infection	2	1	2	0	1	2	1	2	9	1.33	≤0.633	1.2
MRSA Methicillin-Resistant Staphylococcus Aureus	2	4	2	2	1	1	2	0	5-6	2.53	≤0.748	1.02

*based on FY20 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.

CAUTI & CLABSI Near Misses February 2021

Cultures resulted on line patients that did NOT indicate CAUTI or CLABSI infection or criteria was not met after case evaluation

CLABSI Near Miss Event	Amt.	Unit	LOS	CAUTI Near Miss Event	Amt.	Unit	LOS
2/2/2021	1	4T	10	2/1/2021	1	4S	23
2/3/2021	1	2N	38	2/3/2021	1	2S	11
2/10/2021	1	CVICU	1	2/16/2021	1	3S	76
2/10/2021	1	CVICU	29	2/17/2021	1	4S	8
2/20/2021	1	CVICU	11	2/19/2021	1	5T	14
2/22/2021	1	4N	10				
2/26/2021	1	3W	14				
TOTAL	7			TOTAL	5		

Key Strategies 1Q 2021

- Provider notification of sepsis alert
- Sepsis, CAUTI & CLABSI prevention RN New hire, retro fit & annual – in process
- Resident required learning module and test on CAUTI & CLABSI prevention (ie. insertion, line appropriateness, culture of culturing); to be completed by March 1st
- Learning barriers and addressing central line dressing changes and gardiva patch placement
- “Thoughtful pauses” before obtaining cultures on line patients

Key Strategies 2Q 2021

Culture of Culturing

- Culturing the most likely source of infection:
  - Remove BC on admit to ICU order (sputum cultures rather than blood cultures when respiratory infection suspected)
  - Review all power plans for blood culture orders
- Culture ordering before previous culture results known
  - Display previous culture results when ordering new culture
- Providers to attend Healthcare Acquired Infection (HAI) review meetings to help identify barriers and challenges to HAIs/cultures
- Culture orders based on fever
  - Develop algorithm to guide ordering practices for providers, draft nursing algorithm drafted
  - Fever workup training for providers, residents and nursing

Key Strategies 2Q 2021

MRSA

- Nasal Decolonization – options under consideration:
  a) On admit for all patients
  b) Decolonize all, on a two day week schedule
  c) Decolonize based on screen results

- CHG Bathing – review of process in Med/Surg locations
- BioVigil
  - Transitioning to KD badge use – allows efficient management of system and accurate identification of staff using the system and hand hygiene compliance results

Questions?

Handoff Quality Focus Team
03/11/2020

Kassie Waters, Director of Cardiac Critical Care Services
& Brad Danby, Director of Emergency Services

Team Mission

Implement standardize structure for nurse to nurse handoff when admitting a patient from the Emergency Department to in-patient departments.

Standardize structure will:
- Include critical content to eliminate communication errors.
- Provide accurate and complete information to the receiver.
- Meet the needs of the sender and receiver to handoff and receive care.
-Accomplish a timely handoff (transfer) of the patient to the admitting department by removing barriers.

Team Deliverables & Goals

Deliverables

1. Establish standard process
2. Standardize critical content elements
3. Build standard handoff tool utilizing EMR
4. Standardize training & education

Goals

<u>Quality of Handoff Measurement</u>

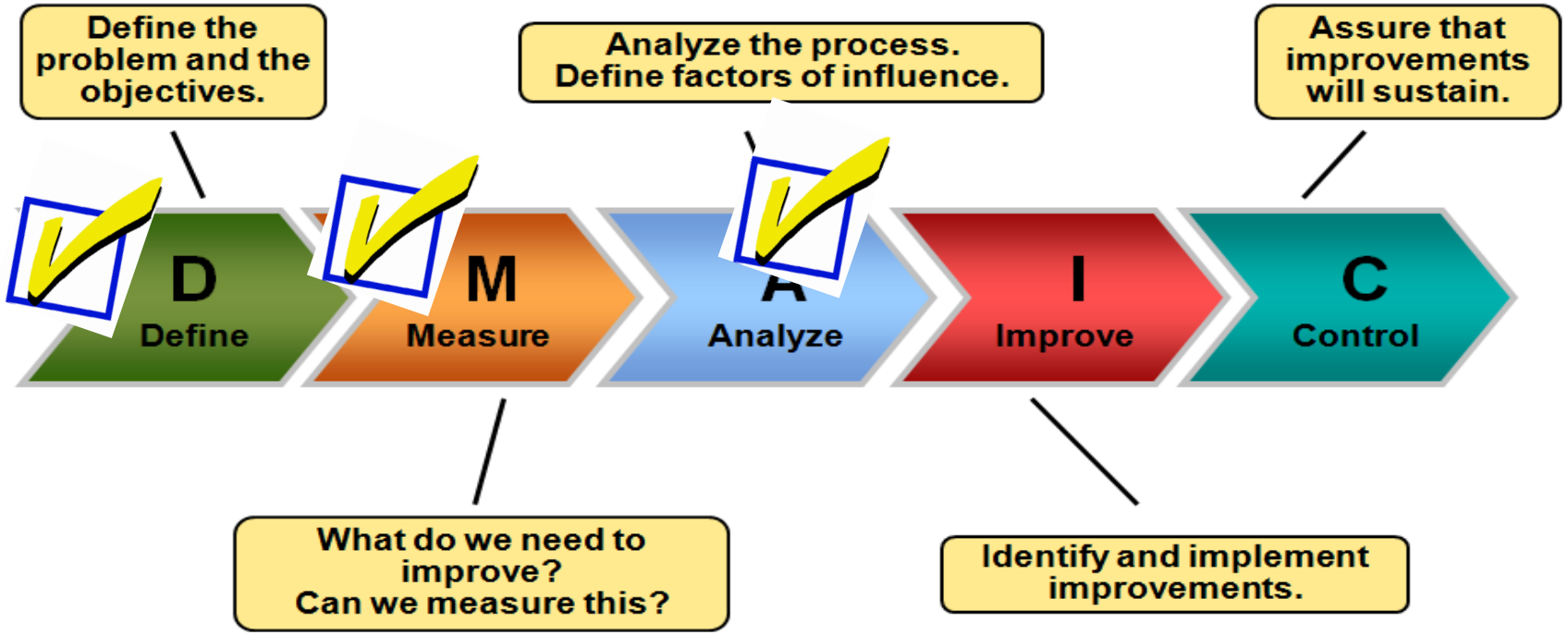
1. ED nurse "sender" provided accurate and complete information with 80% of handoffs (Current state is 15%)

<u>Timeliness Measurement</u>

2. Handoff completed and bed occupied with in 30 minutes of the bed being ready. (Current state is 1hour 18 minutes)

DMAIC

DMAIC Roadmap



10 Absolutes Handoff Tool

HANDOFF TOOL

Please try to follow this as close as possible so that report becomes more streamline.

If you don't know something, then just say, "I don't know," so that the next RN can follow up

10 ABSOLUTES (in this order)	Example
Situation	
1. Patient, age, allergies, code status, admitting provider (If not sure, say "I don't know") language spoken if not English	I am calling report on Ms. Betty. She is an 86-year-old female. Full code.
2. Diagnosis: (why is patient being kept here?)	Pt came in with SOB, being admitted for LLL pneumonia.
Background	
3. Pertinent History (items that will affect care for this visit)	Pt has history of HTN, DM, AKI, CVA 2012
4. MEDS and tx received **location of IV** and when placed, if the IV is started by EMS state "**Field Start**" **devices** – Chest tubes, cardiac pacer, NGT	We gave her an hour long neb and started azithromycin Pt has a 20g to RAC placed today
5. Pertinent Labs & Results	Pt's x-ray showed LLL pneumonia, WBC was 21.
Assessment	
6. ASSESSMENT: Neurological Status	She is alert and oriented x4, She has no neuro deficits, and equal strength bilaterally.
Cardiac	Her cardiac is NSR on the monitor in the 90s.
Respiratory	Respiratory: Left side sounds diminished with crackles, right side clear. Does not give respiratory effort.
GI/GU	GI/GU: No difficulties or pain at this time
Skin INTEGUMENTARY	Skin: is intact, with some scattered bruising to BUE. Backside is intact with no skin breakdown. Pt is on a waffle mattress for comfort
Muskoskeletal **MOBILITY** (If pt has not got up yet, then state that) Is the patient a fall risk?	Pt's ROM is good, no limitations. Pt is able to stand and move to chair with assistance.
7. Current 10 SOV (Vital signs and pain score) that have been taken within the last hour	Afebrile, 144/88, 20 RR, 92 HR, NC 1L saturating at 96%, Denies any chest pain
8. Current Blood Sugar (taken within last 30 minutes if diabetic or here for a glycemic issue) AND diet if known	Last blood glucose check was 124, and unsure of diet, but pt currently not hungry.
Recommendations & Questions	
9. Patients NEXT STEPS or Action List: any new orders/tests Transfusion of blood products Next Antibiotic Timing of anticoagulants	EKG and blood work in AM
10. Any last questions the receiving RN has	Answer then say, THANK YOU

Kaweah Delta
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4T/ED Handoff Pilot

Feedback 4T – Handoff has improved and receiving complete report, but slowly returning to old processes. Transfer barriers continue.

Goals

Quality of Handoff Measurement

1. ED nurse "sender" provided accurate and complete information with 80% of handoffs
   - Baseline 15% → improved to 43% (14 observations)
     - Opportunity for improvement was that the sender had little knowledge or the patient. This could be due to staff changing patient assignments. ED leadership are performing review of the individual cases.

Timeliness Measurement

1. Handoff completed and bed occupied with in 30 minutes of the bed being ready (Clean to occupied 1hr. 18 min hospital wide).
   - No improvement noted

Clean to Occupied Times		
	Aug-Oct 2020	November
MS (Mineral King) Time	1 hr 24 min	1 hr 20 min
4T	1 hr 30 min	1 hr 27 min

ED to 4T November Transfer Data		
	Total Events	Percentage
Greater Than 2 Hours	23	18%
1-2 Hours	65	50%
Less Than 1 Hour	41	32%
Total	129	

ED to 4T November Transfers at Shift Change		
	Total Events	Events Greater Than 2 Hours
Handoff at Shift Change PM	17	8
Handoff at Shift Change AM	4	1

Improvement Action Plan

1. Align Handoff EMR with the 10 Absolute Handoff Tool. In-Process.
   - Review EMR Handoff with 10 Absolutes – Analysis Done
2. Emergency Department utilizing handoff tool for all department reports. Done
3. Established standard structure to receive emergency department handoff at shift change. Done
4. Implementing standard process to utilize the LVN break nurse to receive handoff between departments for admissions and transfers when the primary RN not available. In-Process
5. Assigned ED nurse to oversee all patients that need to be admitted. In-Process
   A. Standardizes care and improves throughput. In-Process

Questions