January 13, 2023

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, January 19, 2023, in the Kaweah Health Lifestyle Fitness Center Conference Room, 5105 W. Cypress Avenue, Visalia, CA 93277.
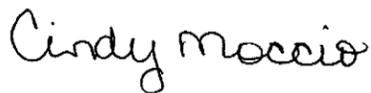
The Board of Directors of the Kaweah Delta Health Care District will meet in a Closed Quality Council Committee at 7:31AM on Thursday, January 19, 2023, in the Kaweah Health Lifestyle Fitness Center Conference Room, 5105 W. Cypress Avenue, Visalia, CA 93277, pursuant to Health and Safety Code 32155 & 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, January 19, 2023, 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
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, January 19, 2023
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, Chief Nursing Officer; William Brien, MD, CMO/CQO, 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, Chief Compliance and Risk Management Officer; Evelyn McEntire, Director of Risk Management; and Jennifer Cooper, 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
   o **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Daniel Hightower, MD, and Professional Staff Quality Committee Chair; James McNulty Director of Pharmacy Services*
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; James McNulty, Director of Pharmacy Services*

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

David Francis	*Lynn Havard Mirviss*	*Garth Gipson*	*Mike Olmos*	*Ambar Rodriguez*
President	*Vice President*	*Board Member*	*Secretary/Treasurer*	*Board Member*

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. Operating Room Quality Improvement Report
   3.2. Stroke Quality Committee Report
   3.3. Methicillin-Resistant Staphylococcus Aureus (MRSA) Quality Focus Team Report

4. **Rapid Response Team/Code Blue Quality Committee Report** - A review of key metrics and action plans associated with rapid response and code blue processes. Shannon Cauthen MSN, RN, CCRN-K, Director of Critical Care Services

5. **Quality Council 2023 Reporting Calendar** – A review of planned committee schedule of reports for the calendar year 2023 that represents the scope of Kaweah Health Services. *Sandy Volchko, RN, DNP, Director of Quality and Patient Safety.*

6. **Clinical Quality Goals Update**- A review of current performance and actions focused on the clinical quality goals for Sepsis, and Healthcare Acquired Infections. *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.

KAWEAH DELTA HEALTH CARE DISTRICT

QUALITY COUNCIL - CLOSED MEETING

THURSDAY JANUARY 19, 2023

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 4-13

KDHCD - QUALITY COUNCIL - CLOSED MEETING

THURSDAY JANUARY 19, 2023

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KDHCD - QUALITY COUNCIL - CLOSED MEETING

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KAWEAH DELTA HEALTH CARE DISTRICT

QUALITY COUNCIL - CLOSED MEETING

THURSDAY JANUARY 19, 2023

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KAWEAH DELTA HEALTH CARE DISTRICT

QUALITY COUNCIL - CLOSED MEETING

THURSDAY JANUARY 19, 2023

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KDHCD - QUALITY COUNCIL - CLOSED MEETING

THURSDAY JANUARY 19, 2023

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PAGES 4-13

Unit/Department Specific Data Collection Summarization
Professional Staff Quality Committee/Quality Improvement Committee

Unit/Department: Surgery   **ProStaff Report:** December 15, 2022

Measure Objective/Goal:

1. **First case delays:** Goal is 650 min in delays a month.
2. **Assigned Block Utilization:** 60%
3. **Turnover: National Average: <u>30 min</u>   Surgical Services Goal: <u>28 minutes</u>**
4. **Non-Operative Time "Surgeon Wait Time":** 70 minutes

Date range of data evaluated:

1. **November 2021 – November 2022**

Overall Surgical Services Throughput Initiatives	Goal	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22
First Case Delay Minutes in O.R.	650	640	746	650	621	757	624	488	579	461	505	323	418	484
Block Utilization	60%	46%	45%	38%	43%	49%	56%	56%	44%	51%	58%	68%	59%	57%
OR Utilization	63%	61%	55%	49%	54%	58%	56%	61%	57%	49%	54%	50%	52%	52%
Patient Safety	**Goal**	**Percentage**												
Immediate Use Steam Sterilization (IUSS)	2%	1%	2%	2%	2%	3%	2%	3%	2%	2%	1%	1%	2%	2%
O.R. Efficiency	**Goal**	**Minutes**												
Patient In to Surgery Start	30	33	32	33	33	32	33	32	33	33	33	34	32	34
Surgery End to Patient Out	10	12	10	12	11	12	10	10	12	10	11	11	12	12
Turnover Data	28	28	27	31	31	29	29	30	29	31	30	31	28	30
Surgeon (Non-Op) Wait Time	70	75	73	79	80	75	74	79	77	79	87	69	76	75

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. **First Case Delays:**
2. **Assigned Block Utilization:**
3. **Turnover:**
4. **Non-Operative Time "Surgeon Wait Time":**

If improvement opportunities identified, provide action plan and expected resolution 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/Quality Improvement Committee

1. **First Case Delays:**
   a. Educate staff in pre-op and intra-op on proper delay codes.
      i. The use of appropriate delay codes continues to be an issue. Staff have been re-educated.
   b. Delay codes will be reported to the OR Governance Committee, Department of Surgery, and Department of Anesthesia.
   c. Trends with specific surgeons will be addressed by the OR Governance Committee representatives. Trends with specific surgeons could affect their allotted block time.
      i. The top (3) three surgeons who have had trends in the last 6 months have met with the O.R. Governance. Surgery Director and the Chief Operating Officer meet with the top three surgeons to see what support was needed to ensure first case starts.
      ii. Surgeons have been reminded that the expectation is a 0715 arrival time.
   d. First case delays due to anesthesia are reported to the Medical directors and reported at the Department of Anesthesia. They have given education to the all providers.

2. **Block Utilization:**
   a. There is a need for block time in the Operating Room and there are underutilized block times surgeons currently have.
   b. Utilization is defined as total allotted minutes for a specific surgeon compared to the total minutes used.
   c. The goal is to decrease wasted OR utilization time and give time to current surgeons who need more time and to new surgeons who are entering the district.
   d. The O.R. Governance has created a formalized way to track utilization time.
      i. Formula: Surgery minutes + Turnover minutes / Block minutes – Released block minutes = Block Utilization.
   e. O.R. Governance and Department of Surgery have approved block to release 1 week in advance instead of 72 hours in advance.
      i. Provides more time for other surgeons looking for block to schedule.
   f. O.R. Governance and Department of Surgery approved for schedules to be finalized 48° in advance. This created more efficiency on the operations side.

3. *Turnover:* Turnover is when a patient leaves the room and the next patient rolls into the room.
   a. Standardize all of the supply and storage rooms within the department.
   b. Completed an STA boot camp. The boot camp reinforced the importance of being efficient, education on equipment, and room set-ups.
   c. Created a staging area in the department so that surgical technicians would not have to take their dirty cart to the Acequia sterile processing. An aide from sterile processing acts as a runner to take things to SPD and to surgery. This allows the surgical tech to be present and assist with turnover.

4. **Non-Operative "Surgeon Wait" Time: Time when a patient leaves the room to when the surgeon makes an incision on the next case.** *Non-Operative time does not have a national average and we surgical services has set it as a goal to increase volume.*
   a. Anesthesia and OR Staffing is currently challenging and we are in the middle of hiring.
   b. STA Boot Camp was completed and the team has started staging the next cases equipment outside the room.

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

Next Steps/Recommendations/Outcomes:

1. First Case Delays:

    a. Clean current delay codes up from the EMR. *Completed*

    b. Educate staff on proper coding. *Ongoing education*

    c. Present at the above committees for transparency. *Ongoing*

    d. Display First case start (pt. in the room) broken down into minutes. *Ongoing*

    e. Hold surgeons accountable for delaying first cases. *In progress through the O.R. Governance*

    f. Anesthesia accountability. *In process*

3. Block Utilization:

    a. Complete data extraction, present the data to the OR Governance Committee, and have a letter sent to individual surgeons who have underutilization. *Ongoing*

    b. Give the surgeons who have underutilized time 1 quarter to increase their volume. *Every quarter*

    c. After the quarter, remove time currently allotted to surgeons who have not met criteria and give the new time to surgeons who need more block and to new surgeons.

4. Turnover:

    a. Completed a Surgical Team Assistant Boot camp with the help of Alexandra Bennett.

    b. Budgeting for an additional 3 STAs. 1 will be for the day to day operations and 2 will be for supply management. The focus of the supply is to ensure it is always there and stock supply in between cases.

    c. This will help with staff having appropriate supply in all areas. Ongoing

5. Non-Operative "Surgeon Wait" Time.

    a. Launch "Operation Roll Back". Operation Rollback is a collaborative test of change that focusing on reduction of surgeon wait time during flip room cases. Plan to start January 2023.

Submitted by Name:
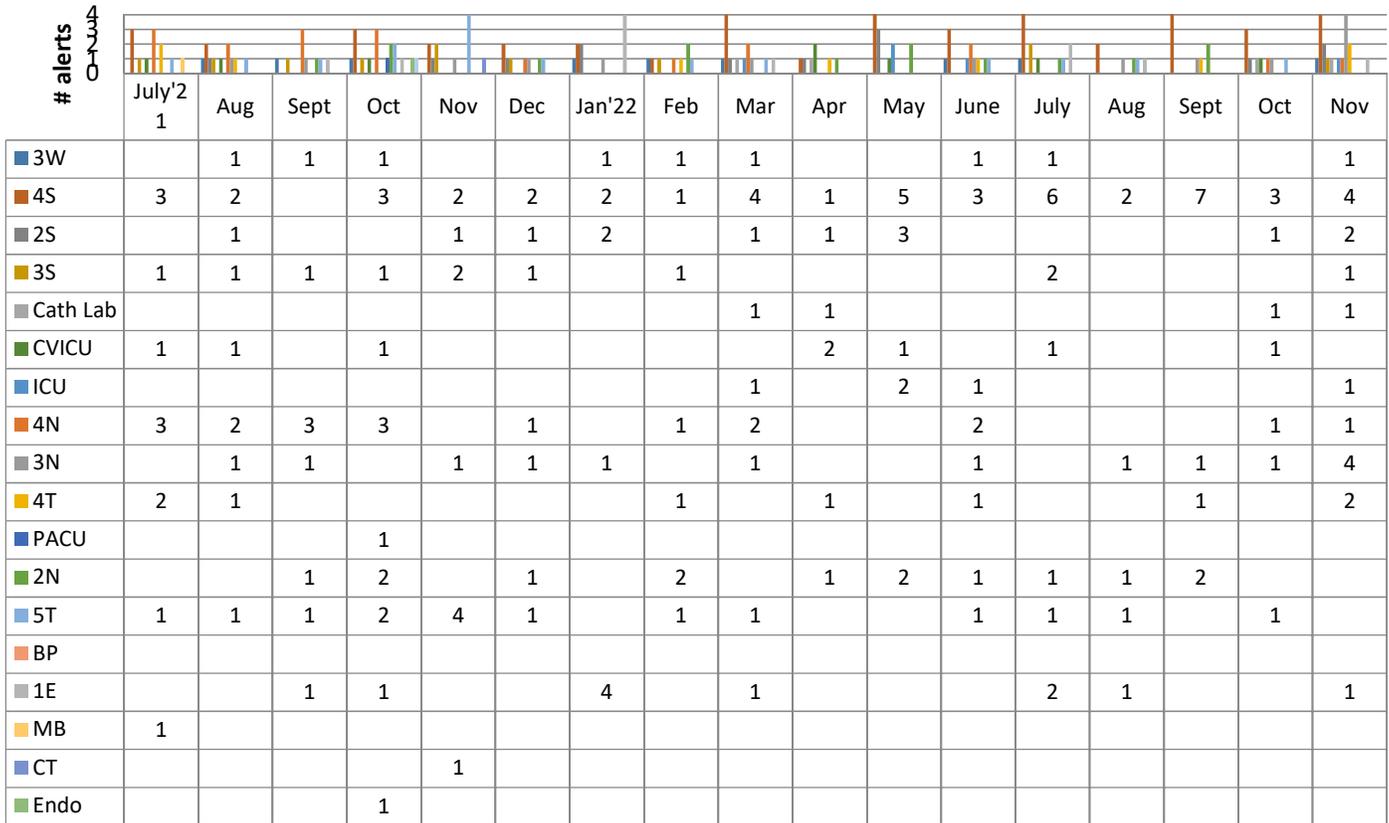Christine Aleman, Director Surgical Services
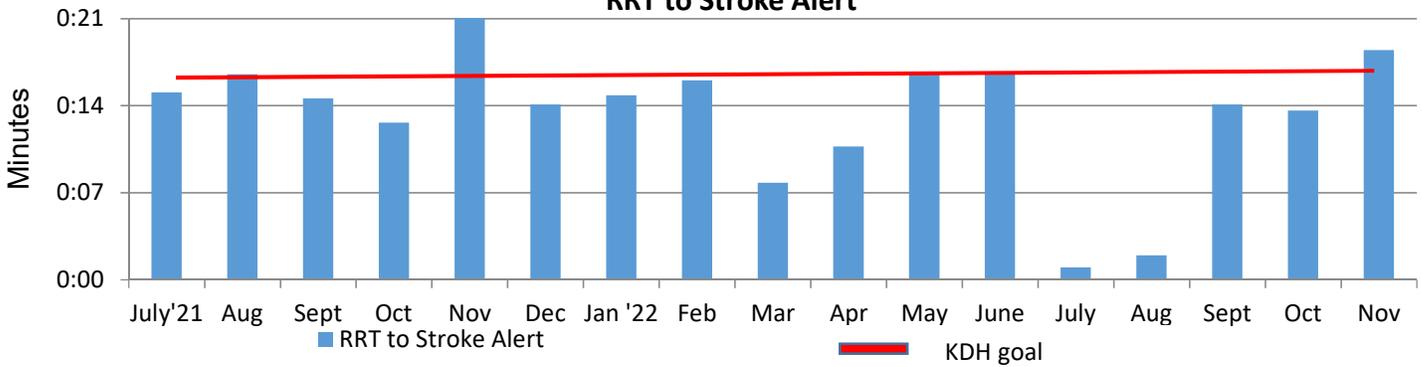
Date Submitted:
December 15, 2022

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

2021-2022
In-House Stroke Alert Dashboard

Stroke Alert Location

|	July'21	Aug	Sept	Oct	Nov	Dec	Jan'22	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov
3W		1	1	1			1	1	1			1	1				1
4S	3	2		3	2	2	2	1	4	1	5	3	6	2	7	3	4
2S		1			1	1	2		1	1	3					1	2
3S	1	1	1	1	2	1		1						2			1
Cath Lab									1	1						1	1
CVICU	1	1		1						2	1		1		1		
ICU									1	2	1						1
4N	3	2	3	3		1		1	2			2				1	1
3N		1	1		1	1	1		1			1		1	1	1	4
4T	2	1						1		1		1			1		2
PACU			1														
2N			1	2		1		2		1	2	1	1	1	2		
5T	1	1	1	2	4	1		1	1			1	1	1		1	
BP																	
1E			1	1			4		1				2	1			1
MB	1																
CT				1													
Endo				1													

RRT to Stroke Alert

If patients exhibit any new or worsening neuro deficits while in the hospital; RNs are to call an RRT. The RRT RN will evaluate and determine if a stroke alert should be called. The goal from calling RRT to stroke alerts should be <15 minutes.
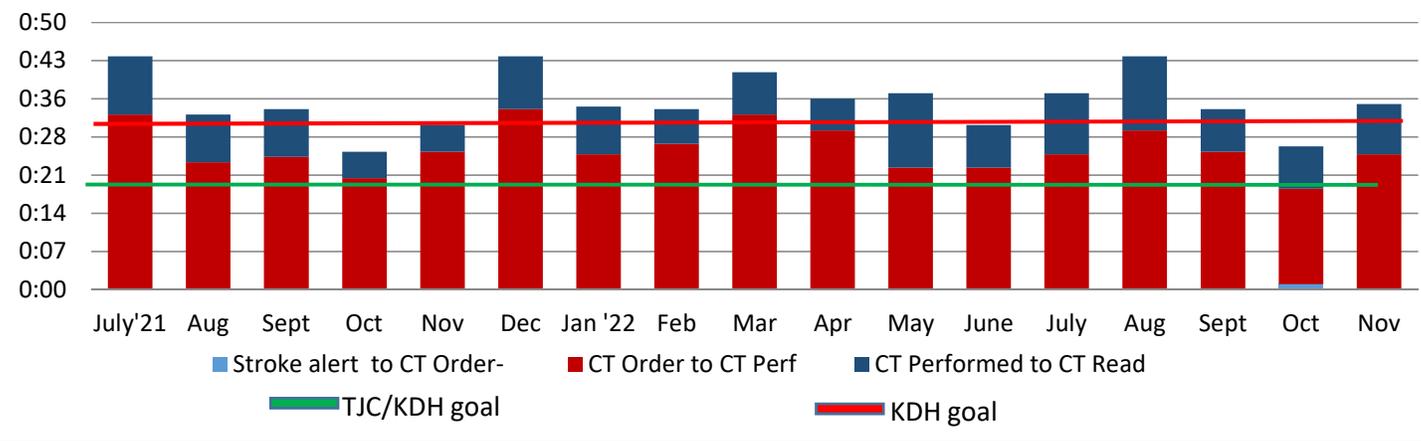
RRT to RRT RN arrival
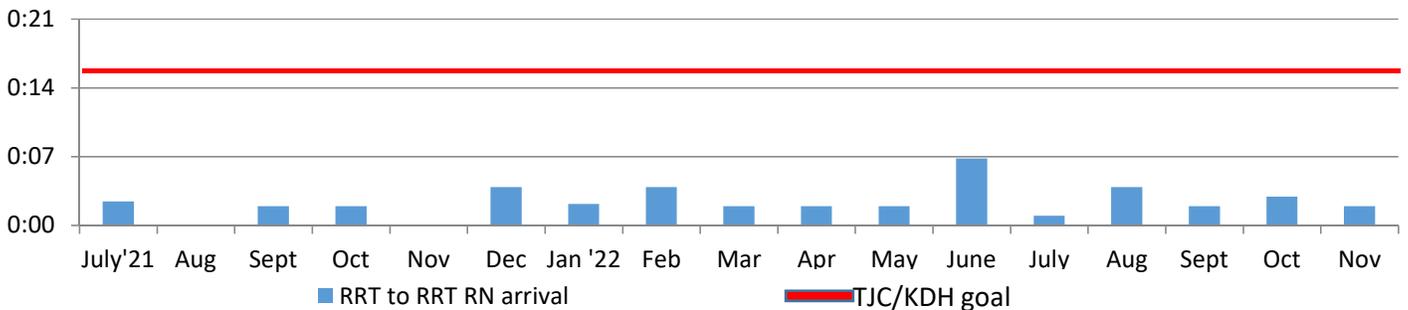
TJC expectation is that a designated provider is at the bedside within 15 minutes of stroke alert. KDH has designated the RRT RN as the provider for in-house stroke alerts.

2021-2022
In-House Stroke Alert Dashboard

Stroke Alert to CT Times

| | Stroke alert to CT Order- | CT Order to CT Perf | CT Performed to CT Read | TJC/KDH goal | KDH goal |

TJC expectation is that the CT will be read within 45 minutes of arrival. KDH's goal is 30 minutes **(red line).** TJC added a new metric in 2018; the expectation is that the CT will be performed within 20 minutes of alert **(green line).**

% neuro contact

■ % neuro contact
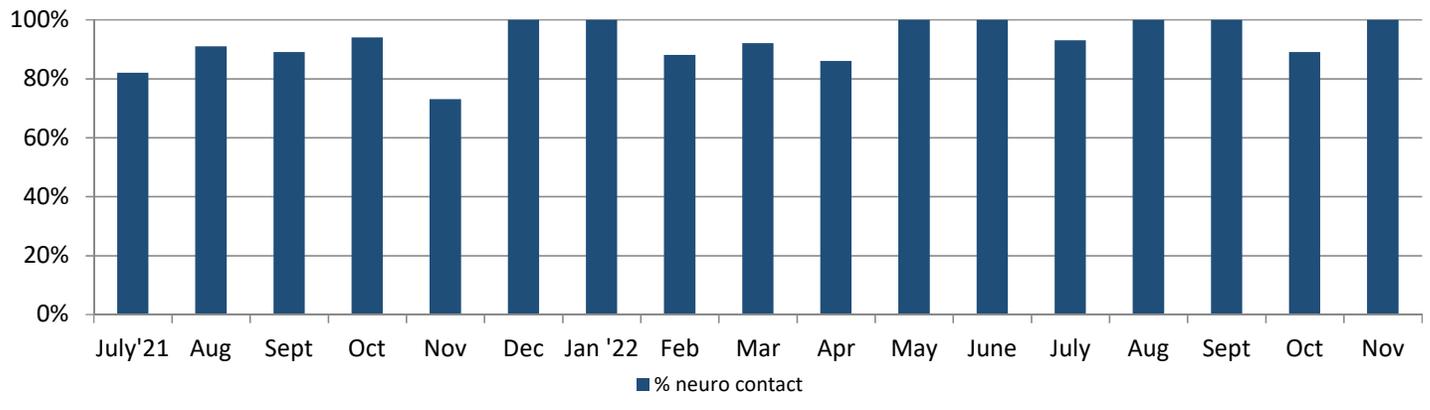
Neurology consultation should occur on all in-house stroke alerts.
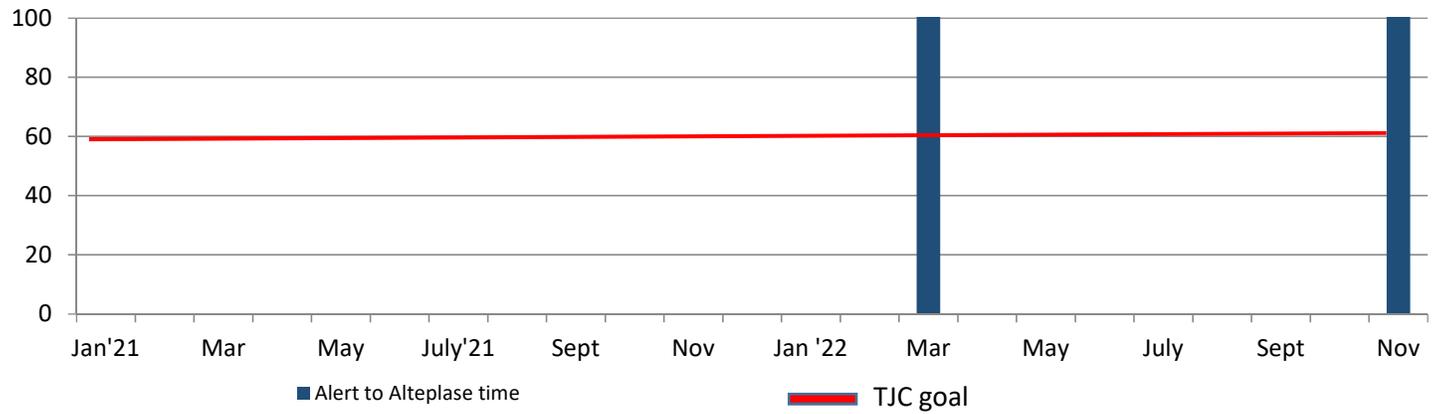
% dysphagia screen done

■ % dysphagia screen done   ▬ KDH goal
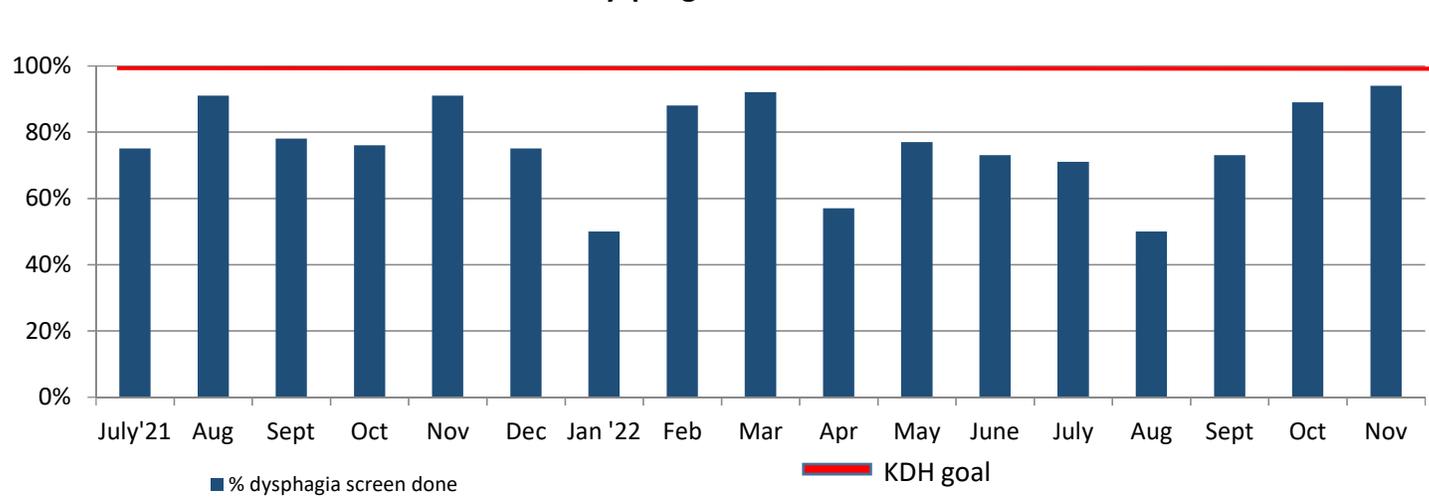
Whenever there are new or worsening neurological deficits ≥3 points, the RN should perform a dysphagia screen to evaluate the patient's ability to swallow.
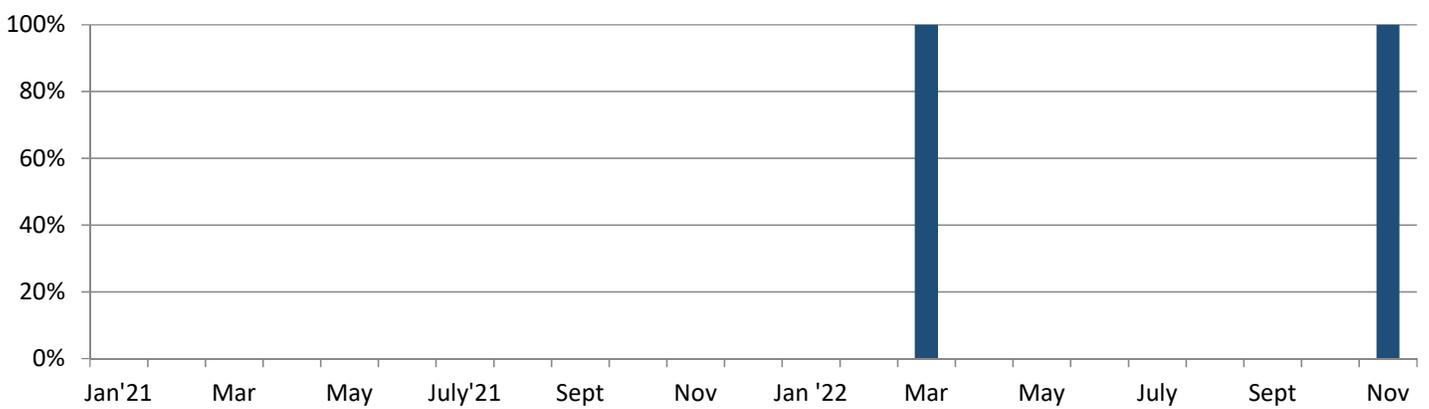
2021-2022
In-House Stroke Alert Dashboard

Alert to Alteplase time

ED Patients: TJC expectation is that IV thrombolytics are given within 60 minutes to eligible patients who present for stroke care at least 50% of the time. In-House Stroke alerts: KDH expectation is that IV thrombolytics are given within 60 minutes to eligible patients who have been identified with new or worsening stroke symptoms. In-house alteplase administration rarely occurs; however it is tracked to ensure compliance throughout the continuum of care.
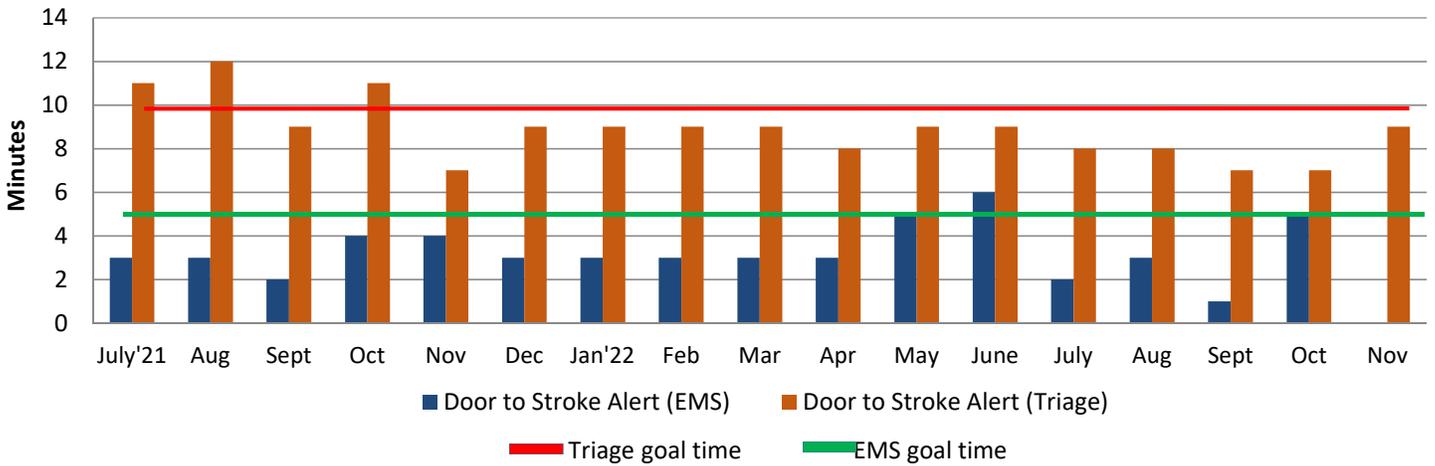
Alteplase flowsheet completed

KDH expectation is that post Alteplase monitoring is in compliance with our standardized protocol. All key elements must be completed to be determined as compliant.
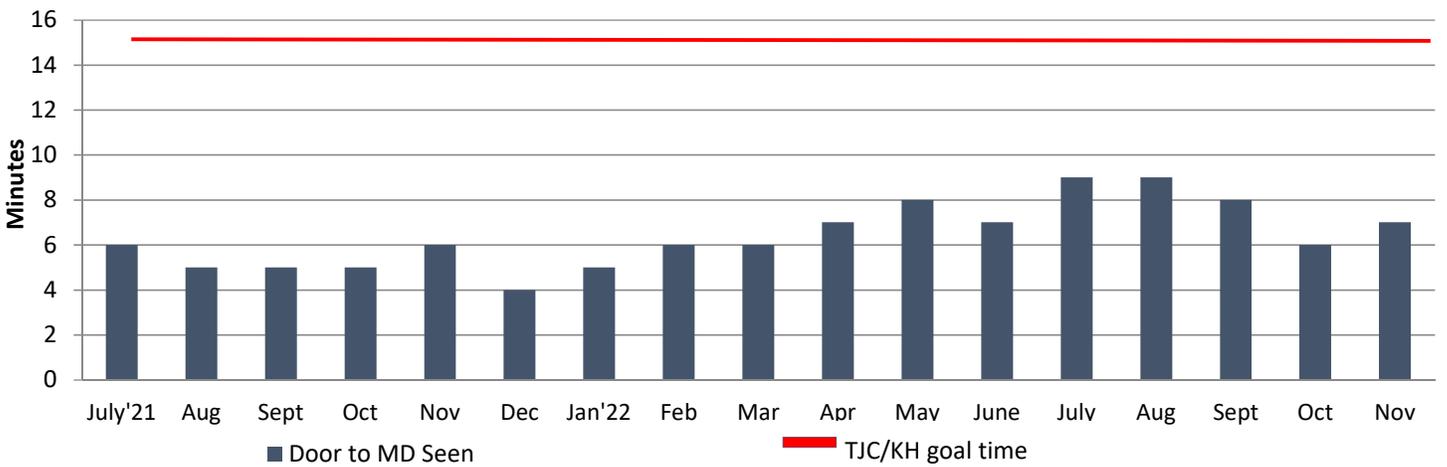
2021-2022 Stroke Alert Dashboard

Door to Stroke Alert (median times)

Per KH ED Stroke Alert process; stroke alerts to be called within 5 min for EMS and 10 min for Triage. Since the opening of the new Triage/zone 5 areas (summer of 2021), significant improvements have been noted in the Triage process.

Door to MD Seen (median time)

The expectation is that the physician will see the stroke alert patient within 15 minutes of arrival. Improvements made throughout the past year include: early notification from EMS, MD meets the pt at the door upon arrival, scribe documents first seen time in the record.
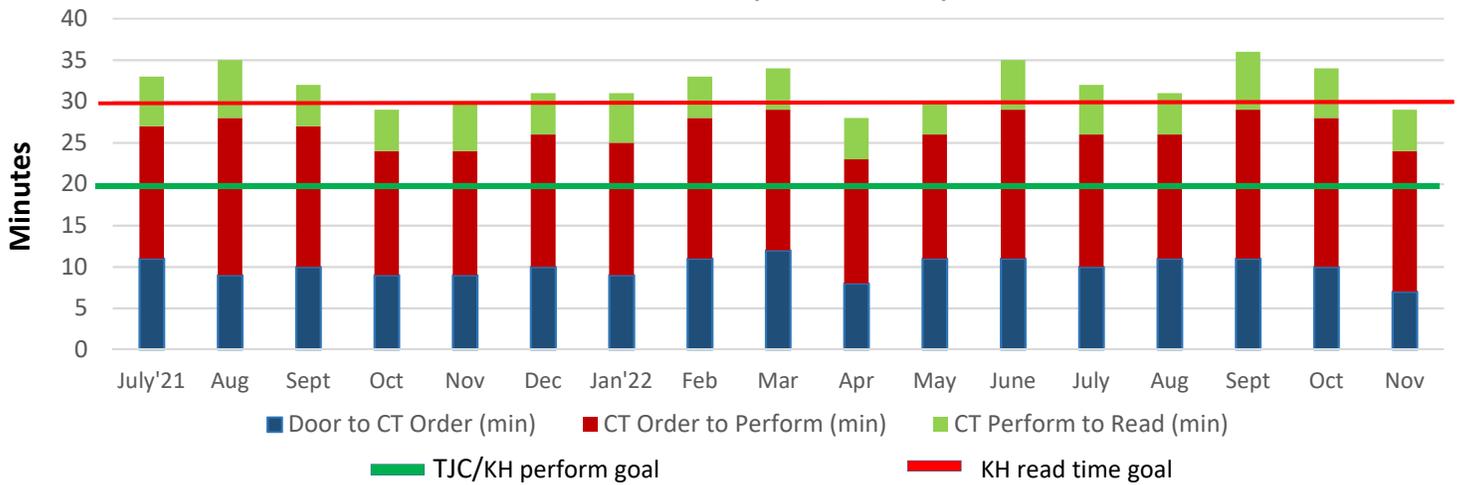
% NIHSS Complete

The expectation is that all stroke alert patients will have a NIHSS completed by a certified ED staff member and/or the attending physician; the primary responsible person is the attending/resident physician. This audit ONLY tracks if attending/resident physician have completed a full NIHSS in the ED record.
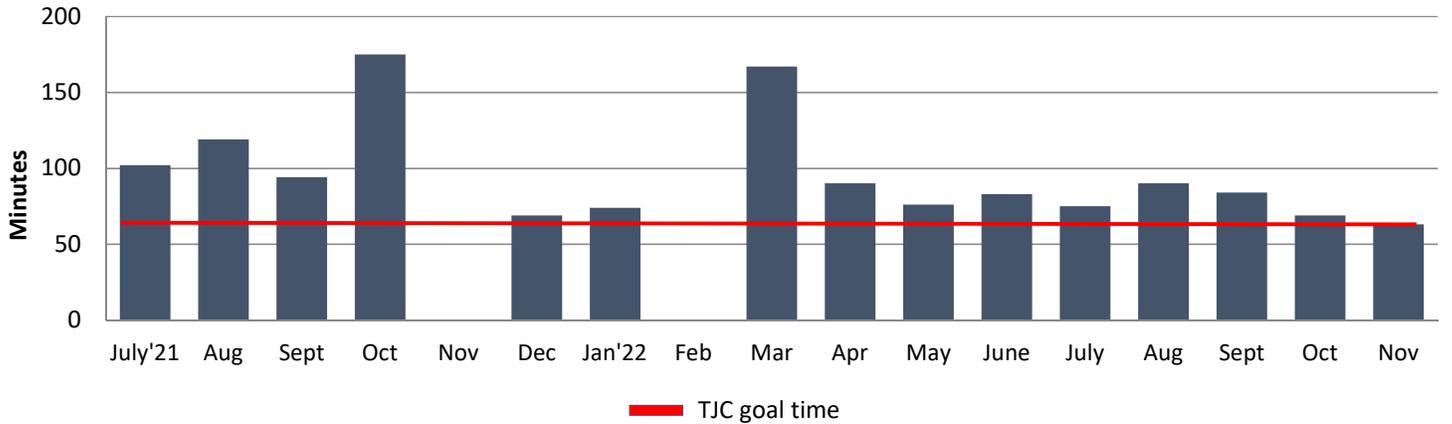
2021-2022 Stroke Alert Dashboard

Door to CT Times (median times)

Legend: Door to CT Order (min) · CT Order to Perform (min) · CT Perform to Read (min) · TJC/KH perform goal · KH read time goal

CMS and TJC expectation is that the CT will be performed by 20 minutes and read by 45 minutes of arrival. KH's CT read time goal is 30 minutes

Door to Alteplase (median time)

Legend: TJC goal time

The data in this graph includes all Alteplase patients which differs from the TJC rate because exclusion criteria is not used. TJC expectation is that IV thrombolytics are given within 60 minutes to eligible patients who present for stroke care. AHA/ASA GWTG expectations were update in 2019 with new IV thrombolytic goal time to 45 minutes at least 75% of the time (when applicable). To meet this goal, continued changes to the stroke alert process have been made.

ED Stroke Alert Volume

Legend: # stroke alerts that met criteria · Discarded stroke alerts
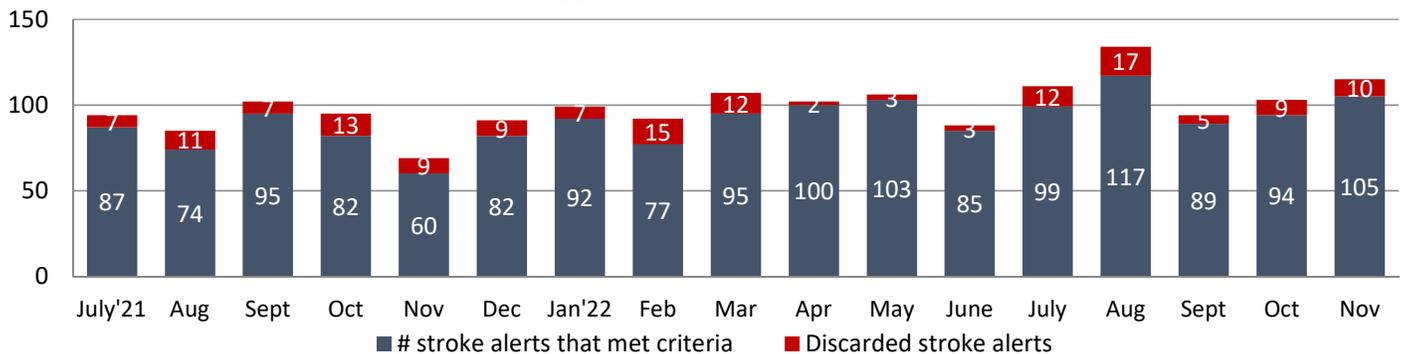
Stroke alert criteria includes: pt presenting with stroke like symptoms +BE FAST screen, stroke alerts called prior to arrival and up to 1 hour after arrival. Excluded cases: >1 after arrival or if stroke alert was cancelled.

2021-2022 Stroke Alert Dashboard

Door to Lab Time (median times)
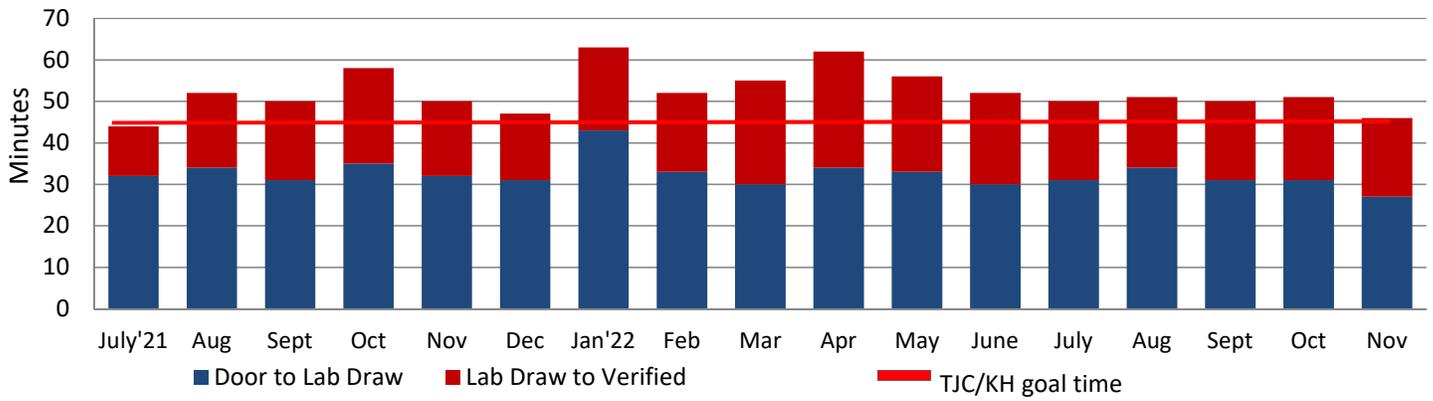
TJC expectation is that laboratory tests are completed within 45 minutes of arrival. Changes in stroke alert process has been made early 2019 to improve lab verified times. Action items taken: IV start kits in CT rooms with lab tubes, lab label makers in both CT rooms and specimens taken immediately down to lab.

Door to EKG Time (median time)
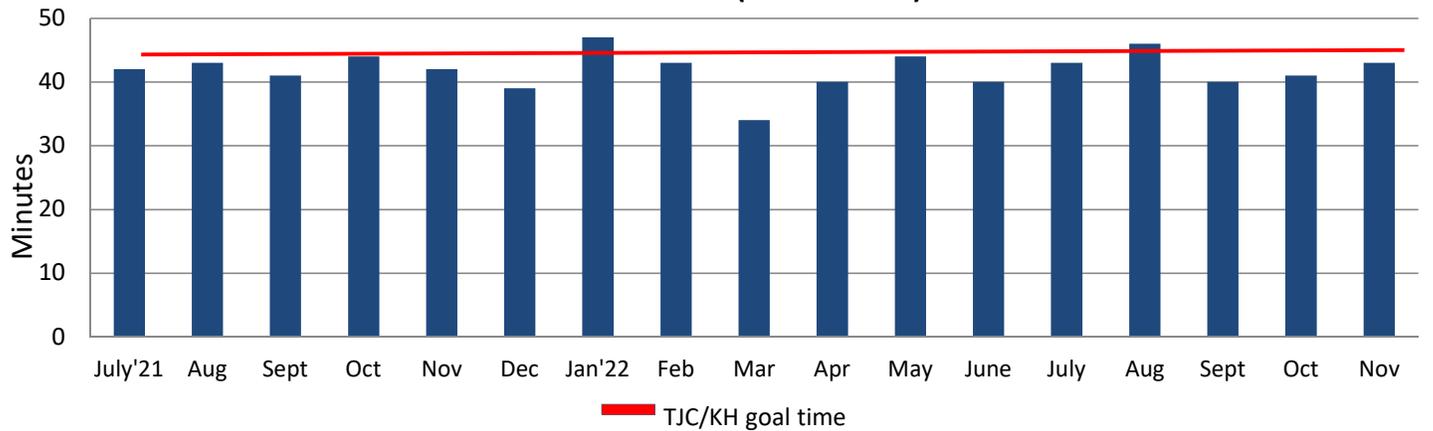
TJC expectation is that EKGs are completed within 45 minutes of arrival.

% Dysphagia screen completed when ordered

Dysphagia screening should be completed by the RN on all stroke alert patients prior to any po intake, including meds. Dysphagia screening is part of the ED stroke alert order sets. Goal is 100% compliance.

2021-2022 TRANSFERS FROM ED TO ANOTHER ACUTE CARE FACILITY
Median Time by Minutes - Goal 120 Minutes

Hemorrhagic Stroke Transfer Time (Median)

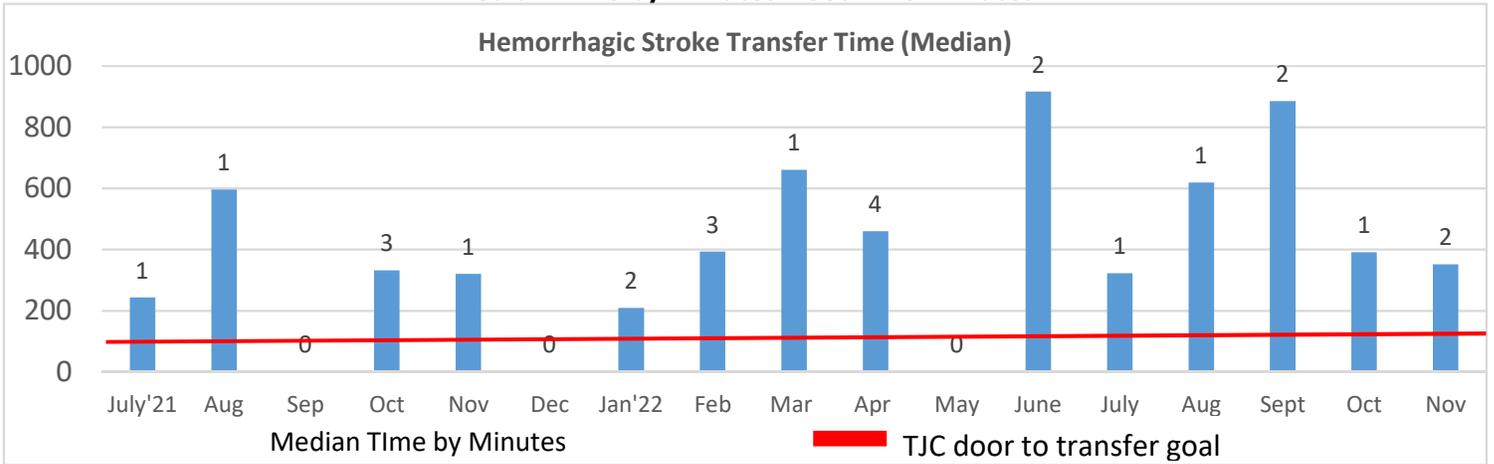Median TIme by Minutes — TJC door to transfer goal

Hemorrhagic patients are transferred out for other procedures not done at KH, specifically coiling/clipping of aneurysms or bleeds. The ED Stroke Alert Committee reviews the process on an ongoing basis to help streamline the process, all action items are captured in PDSA document. The Covid 19 pandemic had caused delays in transfer times in 2021 with continued adverse effects due to staffing/resource availability in 2022.

IV Alteplase Transfer Time (Median)

Median TIme by Minutes — TJC door to transfer goal
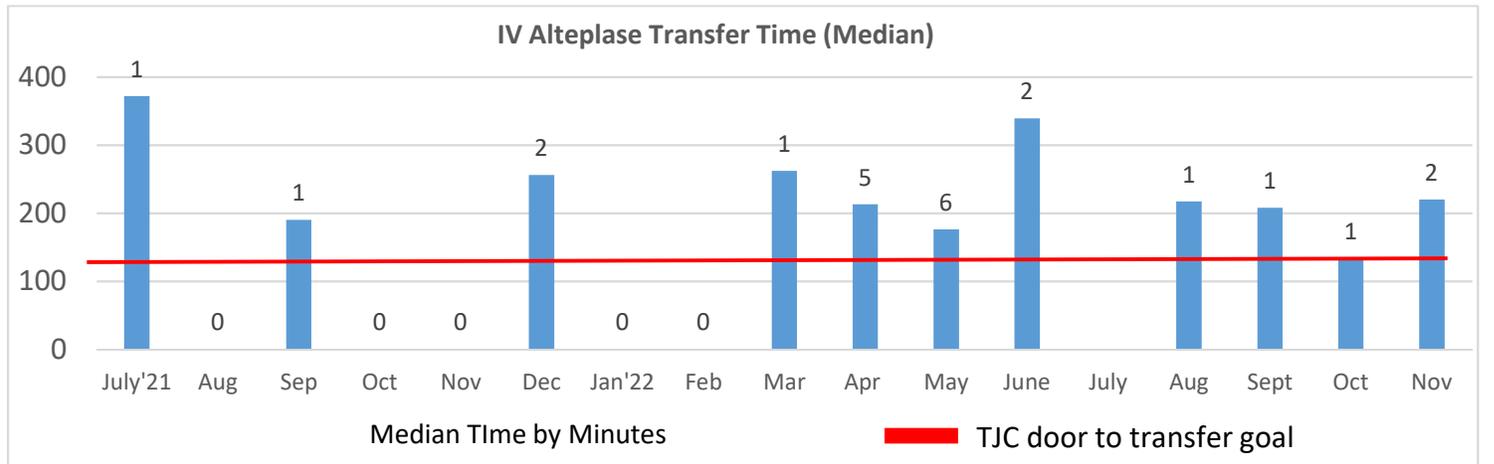
Transfers for ischemic strokes occur primarily if a large vessel occlusion is noted and would be eligible for endovascular treatment. As a result of the efforts made by the ED Stroke Alert Committee door to transfer times have improved; however Covid 19 pandemic had caused delays in transfer times in 2021 with continued adverse effects due to staffing/resource availability in 2022.

No IV Alteplase, LVO Eligible

Median Time by Minutes — TJC door to transfer goal
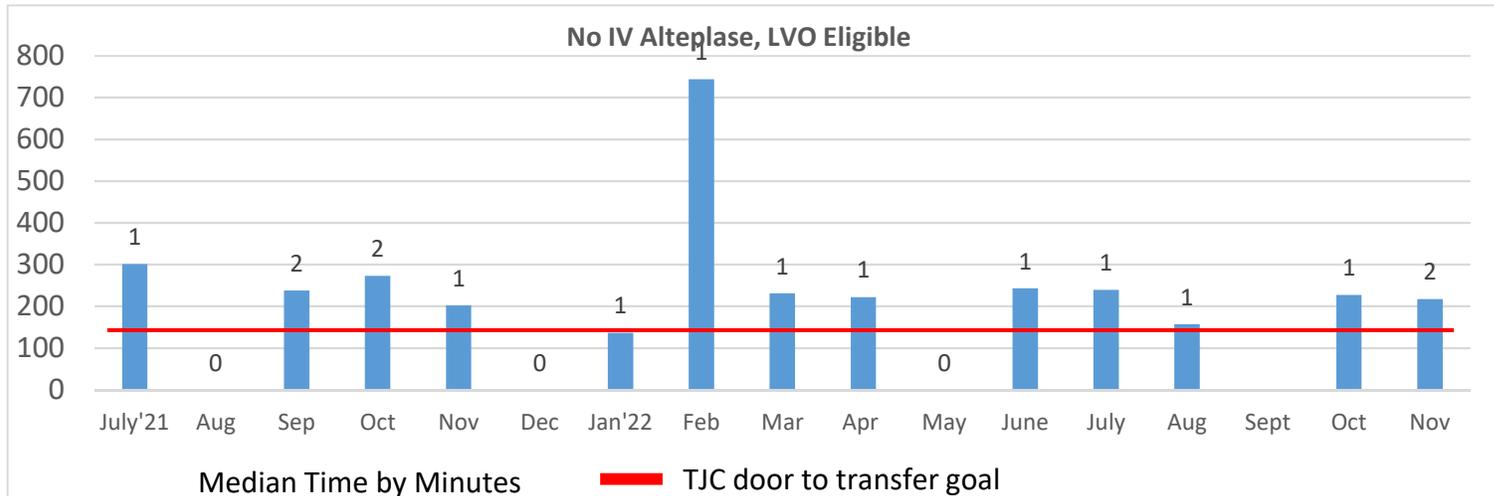
This cohort of patients have a large vessel occlusion that would be eligible for endovascular treatment and do not meet criteria for Alteplase administration. The Covid 19 pandemic had caused delays in transfer times in 2021 with continued adverse effects due to staffing/resource availability in 2022.

	Bench-marks	Jan'21	Feb	Mar	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan'22	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct
Grouping of Stroke Patients																							
Ischemic		34	33	32	36	39	37	33	38	37	35	22	33	36	25	33	43	33	24	23	45	26	29
Hemorrhagic		5	12	8	5	9	12	7	7	8	3	8	9	4	6	7	14	7	10	8	4	11	5
TIA (in-patient and observation)		18	18	26	19	20	16	19	14	17	19	18	17	13	15	26	20	25	16	12	24	21	7
Transfers to Higher Level of Care (Ischemic)		3	1	2	4	4	2	2	0	3	2	1	2	1	1	2	1	5	3	2	1	1	2
Transfers to Higher Level of Care (Hemorrhagic)		2	2	2	0	0	2	1	1	0	3	1	0	2	3	1	4	0	2	1	1	2	1
TOTAL NUMBER OF PATIENTS		62	66	70	64	72	69	62	60	65	62	50	61	56	50	69	82	70	55	46	75	61	44
Total # of Pts who rec'd Alteplase (Admitted/Transferred)		1	2	1	5	7	5	3	3	7	2	0	4	4	0	4	3	7	4	4	5	5	2
% of Alteplase - Inpatient & Transfers		3%	6%	3%	13%	16%	13%	9%	8%	18%	5%	0%	11%	11%	0%	11%	9%	18%	15%	16%	11%	19%	6%
% Appropriate vital sign monitoring post Alteplase	90%	100%	100%	100%	80%	100%	100%	100%	66%	63%	0%	NA	100%	100%	100%	25%	100%	86%	50%	50%	100%	80%	100%
Rate of hemorrhagic complications for Alteplase pts	0%	0%	0%	0%	0%	14%	0%	33%	0%	29%	0%	NA	0%	0%	NA	0%	0%	0%	0%	0%	0%	0%	0%
Core Measure: OP-23 Head CT/MRI Results	72%	NA	100%	100%	100%	67%	50%	67%	NA	100%	100%	50%	50%	100%	NA	67%	100%	100%	67%	0%	100%	33%	100%
% Appropriate stroke order set used (In-Patient)	90%	93%	96%	95%	90%	88%	87%	97%	94%	92%	91%	89%	91%	96%	97%	96%	94%	96%	91%	96%	97%	96%	94%
% Appropriate stroke order set used (ED)	90%	86%	88%	86%	91%	92%	88%	95%	83%	95%	78%	77%	84%	90%	80%	83%	91%	95%	92%	82%	88%	88%	93%
STK-1 VTE (GWTG, TJC)	85%	89%	92%	91%	90%	95%	70%	83%	91%	88%	88%	95%	85%	79%	88%	100%	89%	96%	89%	79%	83%	88%	83%
STK-2 Discharged on Antithrombotic (GWTG, TJC)	85%	100%	97%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
STK-3 Anticoag for afib/aflutter ordered at Dc (GWTG, TJC)	85%	100%	100%	NA	50%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
STK-4 Alteplase Given within 60 min (GWTG, TJC)	75%	NA	NA	NA	100%	100%	100%	NA	NA	67%	NA	NA	NA	100%	0%	NA	NA	NA	NA	100%	NA	50%	100%
STK-5 Early Antithrombotics by end of day 2 (GWTG, TJC)	85%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
STK-6 Discharged on Statin (GWTG, TJC)	85%	90%	94%	100%	100%	100%	100%	100%	97%	93%	96%	100%	100%	100%	100%	100%	100%	100%	94%	100%	100%	100%	100%
STK-8 Stroke Education (GWTG, TJC)	75%	95%	97%	100%	100%	94%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
STK-10 Assessed for Rehab (GWTG, TJC)	75%	100%	100%	100%	100%	100%	100%	100%	100%	100%	96%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
% Dysphagia Screen prior to po intake (GWTG)	75%	78%	90%	88%	71%	90%	88%	89%	94%	91%	77%	88%	83%	84%	83%	88%	87%	79%	85%	74%	77%	83%	71%
% Smoking Cessation (GWTG)	85%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
% LDL Documented (GWTG)	75%	100%	100%	100%	100%	100%	100%	100%	98%	94%	96%	100%	100%	100%	100%	100%	100%	100%	96%	100%	100%	100%	100%
Intensive Statin Therapy (GWTG)	75%	90%	94%	100%	100%	88%	100%	100%	97%	93%	94%	96%	100%	97%	96%	100%	97%	93%	88%	94%	100%	100%	100%
% tPA Arrive by 3.5 Hrs; Treat by 4.5 Hrs (GWTG)	75%	100%	NA	100%	100%	100%	100%	100%	NA	100%	NA	NA	100%	100%	NA	100%	100%	100%	100%	100%	100%	100%	100%
% NIHSS Reported (GWTG)	75%	100%	100%	90%	100%	100%	97%	95%	97%	97%	97%	96%	100%	97%	96%	97%	97%	100%	96%	100%	98%	96%	100%
Ischemic ALOS/GMLOS excess	<1.0	1.9	2.76	3.63	0.75	1.43	2.3	1.13	2.06	2.2	3.06	0.97	2.87	3.43	8.74	2.49	4.69	5.04	1.32	4.31	3.55	1.54	1.2
Hemorrhagic ALOS/GMLOS excess	<1.0	3.46	3.05	11.17	1.12	6.2	2.26	0.58	-1.26	3.33	2.1	0.77	11.84	3.43	23.45	8.39	5.61	2.99	6.83	2.42	7.68	10.93	14.18
Ischemic Mortality ACA O/E Ratio (Midas)	<1.0	1.4	1.6	0	1.4	1.3	1.4	2.4	1.6	0	3.1	0	0	1.3	0	0.8	0.5	0	1.3	0	0	1.3	1.1

Methicillin-resistant Staphylococcus aureus
(MRSA) Quality Focus Team Report
Jan 2023

Quality Focus Team Members
Jag Batth - Chief Operating Officer (ET)
Kylie Jarrell – Admin Assistant Environmental Services, Laundry/Linen, & Patient Transport Service (Recorder)
Tendai Zinyemba - Director of Environmental Services. Laundry/Linen, & Patient Transport Service (Chair)
Shane Reynolds - Assistant Nurse Manager 4N (Co-Chair)
Justin Ma – Infectious Disease Pharmacist
Amy Baker – Director of Renal Services
Sandy Volchko - Director of Quality & Patient Safety
Shawn Elkin – Infection Prevention & Control Manager
Joetta Denny – Infection Prevention
Gloria Dickerson – Clinical Educator
Johnny Mata – Respiratory Care Manager

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MRSA- FY22 Goals

Healthcare onset MRSA bloodstream infection rate that does not exceed a standardized infection ratio of 0.748 or (<0.63 cases a month/2.52 cases a quarter/7.57 cases a year)

We reported 12 MRSA BSI events (only 3 of which were related to COVID-19, during prior FY)

*based on July-Dec 2021 NHSN predicted
**Standardized Infection Ratio (SIR) is the number of patients with a healthcare acquired infection (HAI) divided by the number of patients who were predicted to have an HAI. MRSA Bloodstream Infection is impacted by the number of inpatient days for a given time period.

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MRSA- FY23 Goals

Healthcare onset MRSA bloodstream infection rate that does not exceed a standardized infection ratio of 0.726 or (<0.5 cases a month/1.5 cases a quarter/6 cases a year)

We reported 2 MRSA BSI events during the first 2 months of current FY. None for the remaining part of 2022 (September 2022 – November 2022)

*based on July-August 2022 NHSN predicted
**Standardized Infection Ratio (SIR) is the number of patients with a healthcare acquired infection (HAI) divided by the number of patients who were predicted to have an HAI. MRSA Bloodstream Infection is impacted by the number of inpatient days for a given time period.

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Background Data – MRSA Blood Stream Infection events

Number of MRSA Bloodstream Infection events at Kaweah Health from over calendar years 2017 through July 2022 with emphasis on implementation of MRSA Quality Focus Team and MRSA Nasal Decolonization Pilot Study.
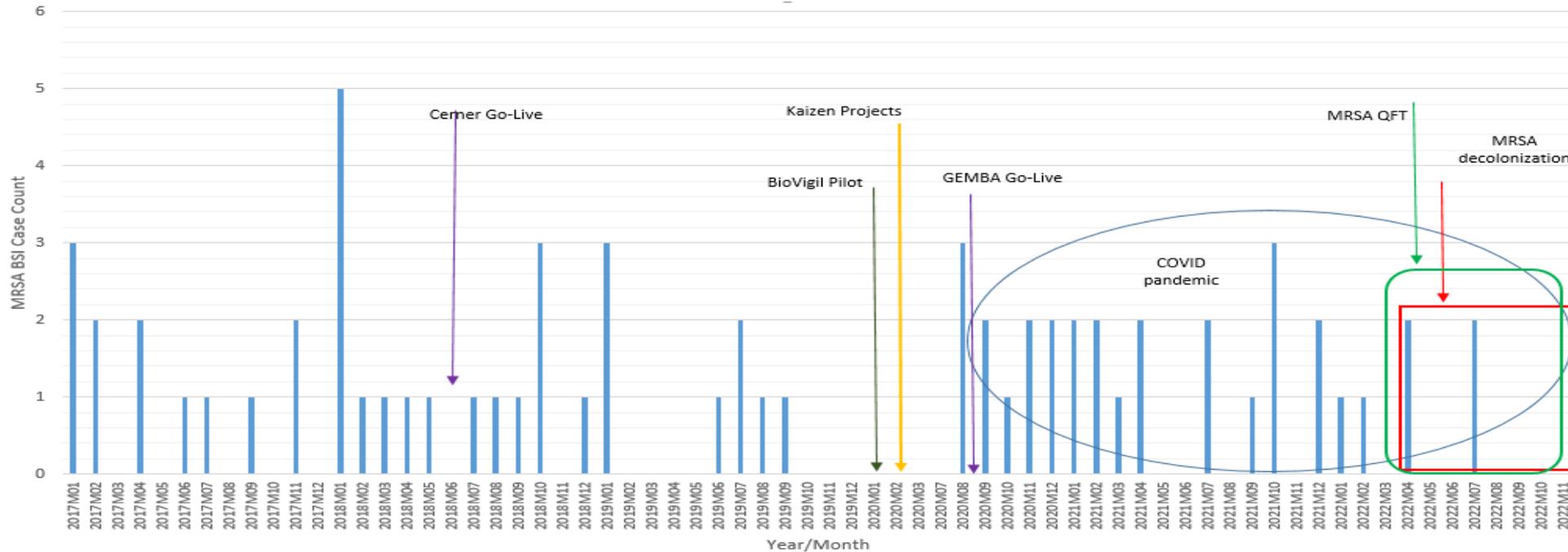

Fiscal Year	Number of Infections	Standardized Infection Ratio
FY2017-2018	13	2.152
FY2018-2019	7	1.97
FY2019-2020	4	0.923
FY2020-2021	17	2.648
FY2021-2022	12	1.585
FY2022-2023	2	0.71

Number of MRSA BSI events dipped during November 2019 through March of 2020 in part due to the electronic hand hygiene system pilot on 4N, and ICU and the added attention given to healthcare associated infections (e.g. CLABSI/CAUTI) with Kaizen Projects and initiation of GEMBA Rounds. The increase in MRSA BSI events after March 2019 was associated with the COVID-19 pandemic, extended lengths of stays, blood culturing practices, and source control of the primary infection site.

Background Data – MRSA Blood Stream Infections & Standardized Infection Ratio trend

Fiscal Year	Number of Infections	Standardized Infection Ratio
FY2017-2018	13	2.152
FY2018-2019	7	1.97
FY2019-2020	4	0.923
FY2020-2021	17	2.648
FY2021-2022	12	1.585
FY2022-2023	2	0.71

MRSA Infections vs Standardized Infection Ratio
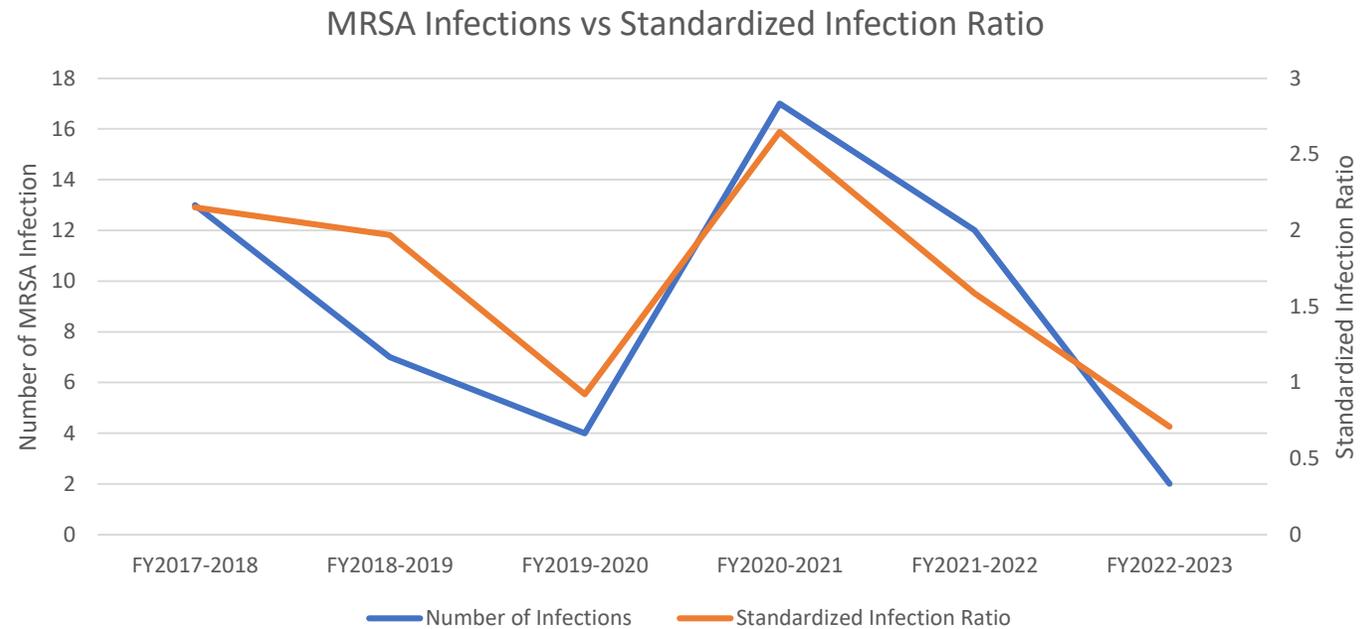
Background Data - MRSA Blood stream Infections vs Patient days

Comparison of Healthcare Onset Methicillin Resistant Staphylococcus aureus bloodstream infection (HO-MRSA BSI) events to patient days data at Kaweah Health from calendar years 2017 through 2022.
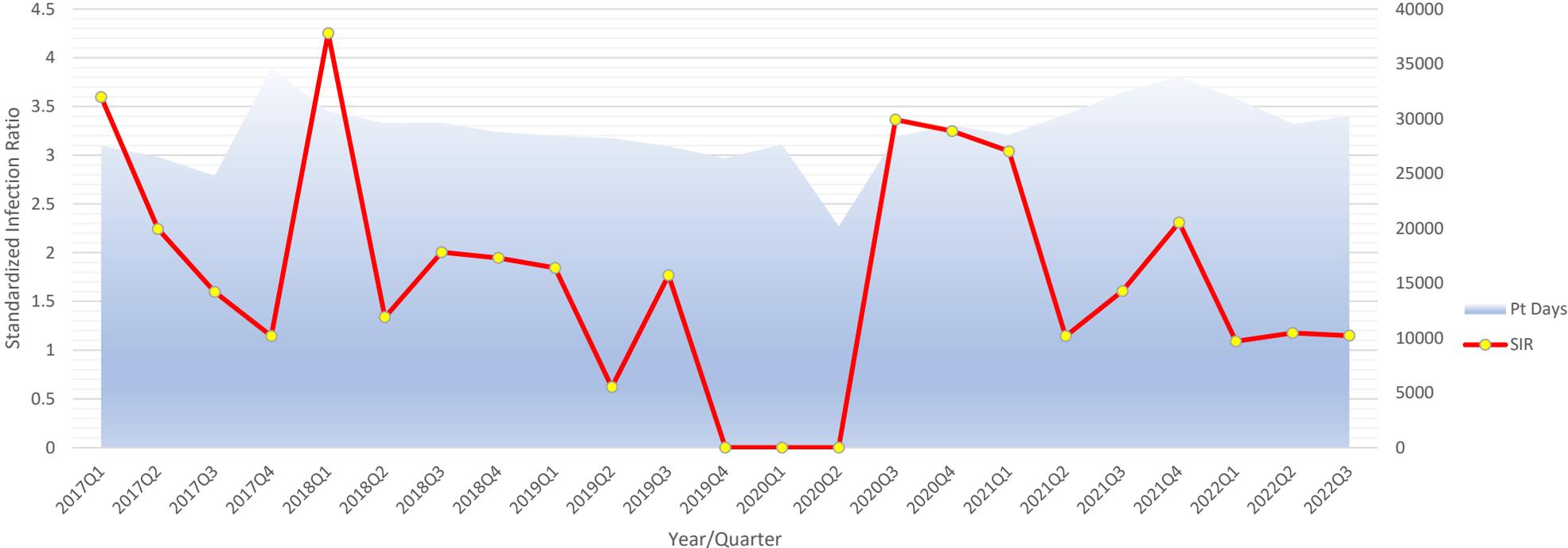
Key Takeaways: Based on data depicted above, there is a positive correlation between Standardized Infection Ratio vs. Patient days

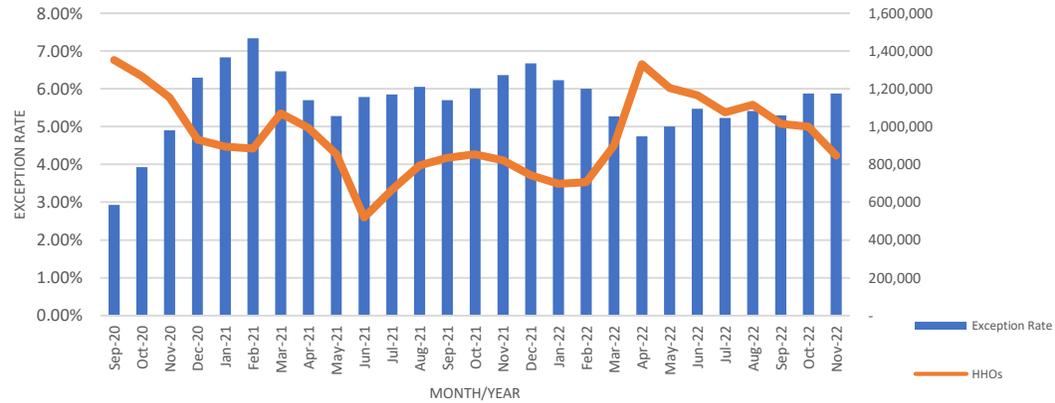# Background Data - BioVigil Hand Hygiene Opportunities and ATP Testing

BioVigil Hand Hygiene Opportunites & Exception Rates

Comparison between hand hygiene opportunities and exception rate (overriding the BioVigil Badge).
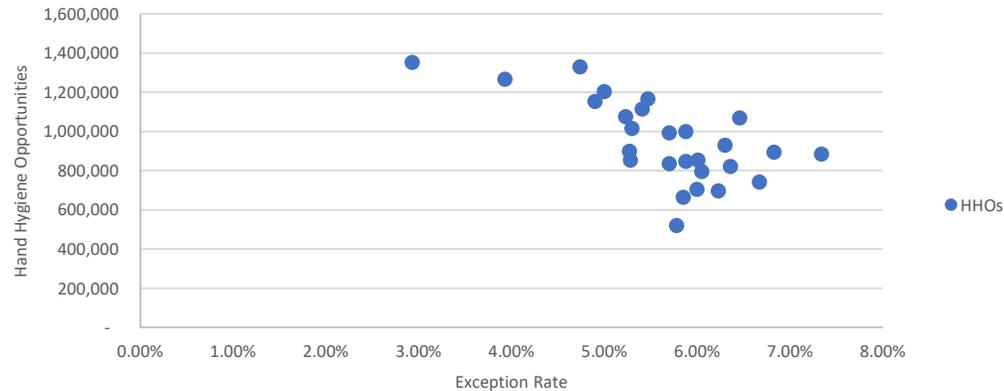
Procedural room surface cleaning ATP quality control testing results based on initial room cleaning.

	2021Q1	2021Q2	2021Q3	2021Q4	2022Q1	2022Q2	2022Q3
Pass %	67.0%	43.1%	90.7%	85.8%	69.0%	83.4%	80.3%
Passed	103	65	54	366	589	339	418
Failed	34	37	6	52	182	59	82
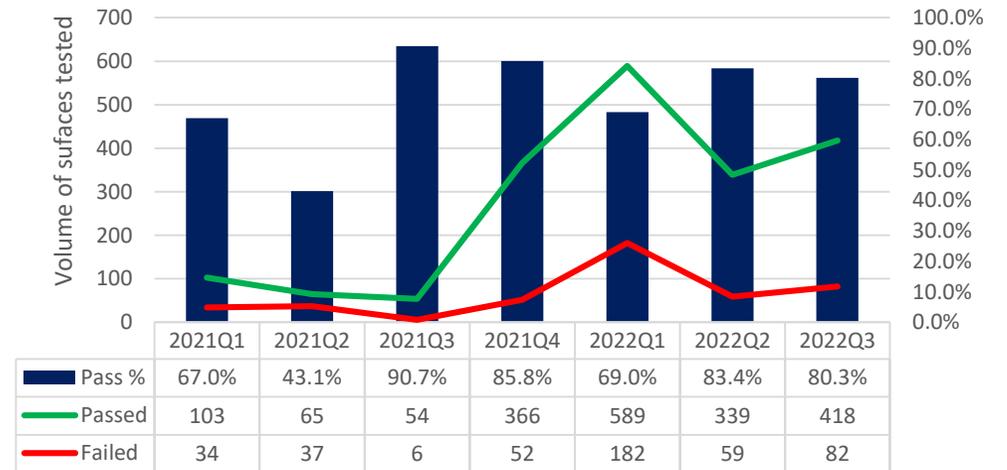
Root Causes identified

Culturing Practices

- Late blood cultures when a patient presents with early evidence of infection. Example patient: receives urine culture in E.D. for urosepsis, then on day 4 into admission patient receives blood cultures that are positive for MRSA.

- Serial blood cultures that exceed 14 days. Evidence supports serial blood cultures for patients identified with MRSA septicemia until the first negative blood culture is identified. The first negative result sets the duration of continued antimicrobial therapy.

- Positive MRSA serial blood cultures that exceed 14 days are considered a new event and healthcare acquired.

Source Control

- Too many Kaweah Health MRSA bloodstream infection events are related to positive serial blood cultures that well exceed 14 days.

- In these cases endocarditis (Life-threatening inflammation of the inner lining of heart chambers and valves) or osteomyelitis (Inflammation or swelling that occurs in the bone) maybe a contributing factor to seeding of the bloodstream.

- For these events either required diagnostic testing to rule-in/out endocarditis wasn't performed, and/or osteomyelitis was not addressed with surgical intervention.

- In these situations, patients test positive for MRSA bloodstream infection for up to a month while on appropriate treatment for MRSA. The primary source continues to spread in the bloodstream, making treatment ineffective.

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MRSA QFT- Key Strategies

- Improvement in MRSA screening/testing
- MRSA Decolonization Pilot (Mupirocin treatment/CHG bathing)
- BioVigil electronic hand hygiene surveillance system
- Clinic based 'Patient as observer' hand hygiene program
- Do You Disinfect Every time (D.U.D.E.) Campaign
- Environmental cleaning – quality metrics Adenosine Triphosphate (ATP) monitoring
- Targeted use of Electrostatic Disinfectant Sprayer that produces an electrical charge so that disinfectant attaches to surfaces directly and indirectly facing the sprayer, ensuring thorough coverage over surfaces
- Culture of culturing taskforce for ICU (Effective February 2023)

Quality Focus Team Recommendations

Strides have been made to better understand root-cause, and continuously assess impact of key strategies. The following are recommendations:

- Provider involvement is needed to help determine a process to effectively order/perform blood cultures (i.e. when treatment will be implemented or changed as a result of what is identified by culture).
- Provider involvement is needed to help devise a protocol to diagnostically determine the presence of endocarditis that is consistent with NHSN criteria.
- Provider involvement is needed to help determine a process by which source control can be better managed.

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RRT/Code Blue ProStaff Report
Q3 2022

Shannon Cauthen and Stacey Cajimat

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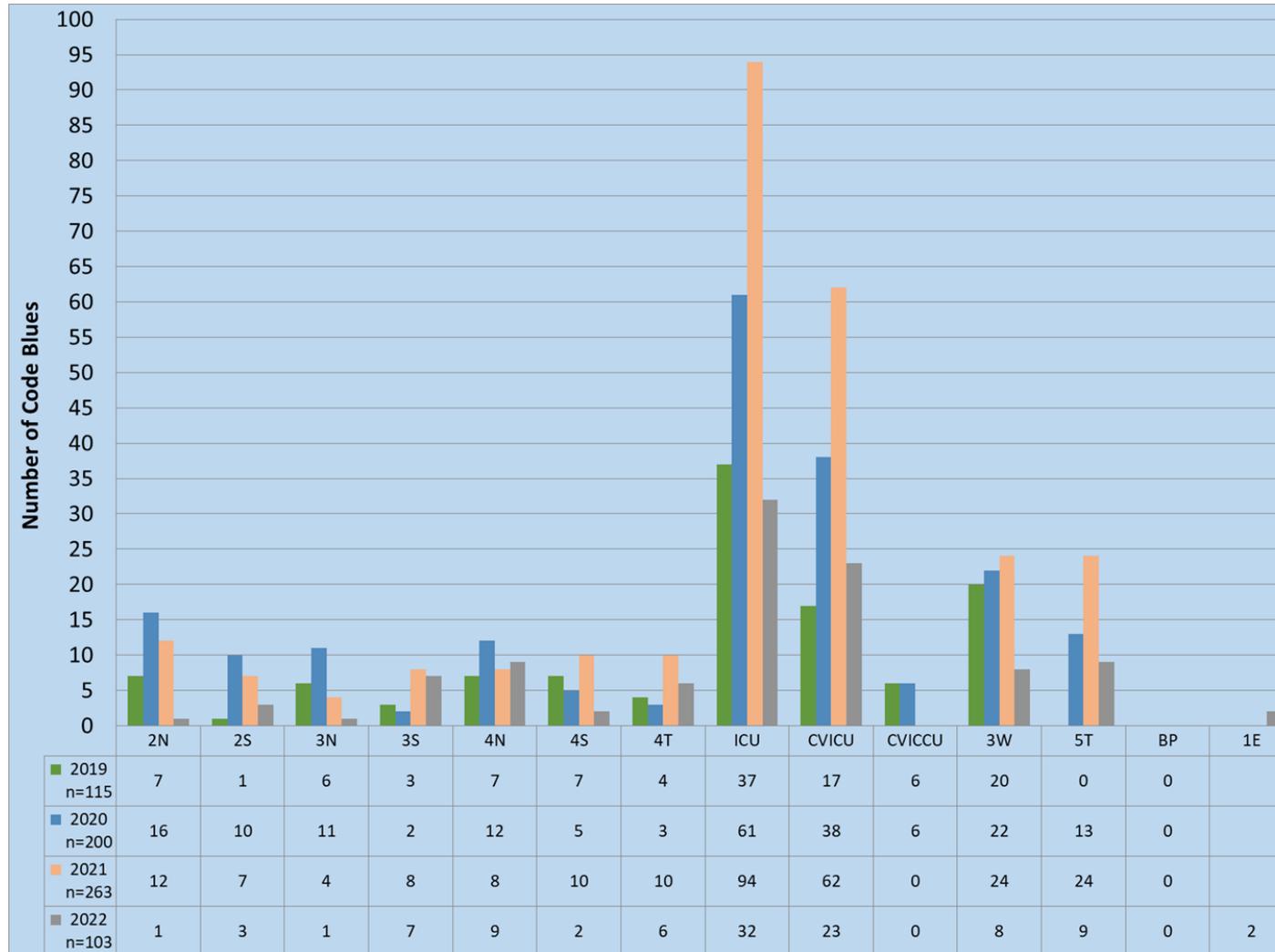**Kaweah Health**
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The Rapid Response Team Mission Statement

"To facilitate learning opportunities and build relationships with patient care staff to foster a trust that encourages earlier activation of the RRT system."

RRT and Resuscitation Scorecard

Measure Description	All GWTG Hospitals (External Benchmark)	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Mean (CY 2021- YTD 2022)
Code Blue Data														
Total Code Blues		34	37	20	17	16	10	9	9	16	7	12	7	16
Total COVID-19 Positive Code Blues		15	16	8	8	4	2	0	0	3	1	1	1	5
Code Blues per 1000 Discharges Med Surg/ICCU		14	8	3	8	9	3	5	4	3	2	2	3	5
Code Blues per 1000 Discharges Critical Care		12	23	12	4	4	4	3	3	9	4	8	3	7
Percent of Codes in Critical Care	66% (↑ is better)	47%	73%	80%	35%	31%	50%	44%	33%	75%	71%	83%	57%	57%
Code Blue: Survival to Discharge	20% (↑ is better)	6%	3%	10%	0%	13%	20%	44%	11%	19%	29%	17%	57%	19%
Deaths from Cardiac Arrest		14	14	10	9	5	0	3	5	6	3	3	0	6
Overall Hospital Mortality Rate		4.866	6.023	4.105	4.47	4.399	2.632	2.853	2.399	3.094	2.048	2.061	2.889	3.49
RRT Data														
Total RRTS		182	124	110	137	112	103	100	93	115	94	111	98	115
RRTs per 1000 Patient Discharge Days		139	104	85	102	93	77	78	71	90	72	85	86	93
RRT Mortality	21% (↓ is better)	39% n-54	50% n-51	30% n-29	26% n-36	21% n-24	13% n-13	14% n-14	19% n-18	19% n-22	20% n-19	18% n-18	14% n-14	23%
RRTs Within 24 hours of Arriving to Inpatient Unit	15% (↓ is better)	17% n-31	17% n-21	26% n-29	20% n-27	17% n-19	26% n-27	21% n-21	24% n-22	17% n-19	17% n-16	22% n-24	21% n-21	20%
RRT- Med-Surg to Intermediate Critical Care Transfers	9%				12% n-16	16% n-18	9% n-9	18% n-18	14% n-13	21% n-24	19% n-18	17% n-19	20% n-20	16%
RRT- Med-Surg to Critical Care Transfers	29%				8% n-14	9% n-10	11% n-11	10% n-10	6% n-6	23% n-27	3% n-3	10% n-11	9% n-9	10%
RRT-Intermediate Critical Care Transfers to Critical Care	32%				10% n-14	5% n-6	8% n-8	4% n-4	6% n-6	6% n-7	6% n-6	11% n-12	5% n-5	7%

Green	Better than Target
Yellow	Within 10% of Target
Red	Does not meet Target

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Code Blues by Location

	2N	2S	3N	3S	4N	4S	4T	ICU	CVICU	CVICCU	3W	5T	BP	1E
2019 n=115	7	1	6	3	7	7	4	37	17	6	20	0	0	
2020 n=200	16	10	11	2	12	5	3	61	38	6	22	13	0	
2021 n=263	12	7	4	8	8	10	10	94	62	0	24	24	0	
2022 n=103	1	3	1	7	9	2	6	32	23	0	8	9	0	2

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RRTs by Location

	3W	4S	5T	2S	3N	2N	4N	3S	4T	1E	CVICU	ICU	BP
2019 n=1457	305	212	0	73	134	137	121	151	106	49	59		
2020 n=1563	265	188	159	156	152	147	137	134	85	50	30	23	16
2021 n=1500	210	175	230	137	148	131	110	111	98	103	15	8	22
2022 n=928	107	108	142	67	87	75	66	61	67	98	20	19	11

GWTG Recognition Measures

Get With the Guidelines Recognition Measures (GWTG) include:

1. Time to Intravenous/Intraosseus (IV/IO) epinephrine; target <5 minutes for asystole or Pulseless Electrical Activity (PEA) (higher is better).
> Goal: >85% compliance.
> Quarter 3 2022= 100%
> Cumulative CY 2022= 94.4%

2. Confirmation of airway device placement in trachea (higher is better).
> Goal: >85% compliance.
> Quarter 3 2022=100%
> Cumulative CY 2022= 96.6%

3. Time to first shock; target<2 mins for Ventricular Fibrillation (Vfib) or Ventricular Tachycardia (VT) first documented rhythm (higher is better).
> Goal: >85% compliance.
> Quarter 3 2022= 100%
> Cumulative CY 2022= 86.7%

3. Percent Pulseless Cardiac events are monitored or witnessed (higher is better).
> Goal: >85% compliance.
> Quarter 3 2022= 100%
> Cumulative CY 2022= 89.5%

Analysis in following slides

GWTG Analysis and Next Steps

Year to date, we are outperforming the benchmark for all four metrics- and, for the first time ever, we achieved 100% compliance in all four metrics for Quarter 3!

1. Time to first IV/IO epinephrine.
   -Continue efforts to maintain and secure IV/IO access for medication administration
   -Continue to correctly identify rhythm and treat with IV/IO epinephrine as indicated

2. Confirmation of airway device placement in the trachea
   -Continue to encourage use of video laryngoscope for endotracheal intubations
   -Continue to verify placement with carbon dioxide (CO_2) detector and document it on the Code Blue Record

3. Time to first shock
   -Continue to teach and encourage staff to utilize Automated External Defibrillator (AED) feature on our in-house defibrillators
       -Especially important for staff to analyze and defibrillate before the arrival of the Rapid Response Team (RRT)

4. Percent of pulseless cardiac events that are monitored or witnessed
   -Updated code blue form in April 2021. New form has improved our compliance tremendously
   -Ensure updated form stays in all forms boxes and crash carts to prevent accidental use of the old form

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GWTG Analysis

Analysis

- Observed a continual increase in the percentage of code blues occurring in critical care areas. Code Blues in critical care are preferred because the units are rich with resources and advanced monitoring capabilities. The American Heart Association (AHA) does not recognize our Intermediate Critical Cares as a Critical Care Unit for the purposes of data collection.

- Observed notable improvements in all areas of RRT and Code Blue performance over the past year. In Calendar Year 2022, the Rapid Response/Code Blue Team not only achieved meeting all four benchmarks at or above 85% for one quarter, they achieved meeting all four benchmarks at 100% and maintained a CY average above 85%! This accomplishment qualifies the team for a Silver Award from the AHA.
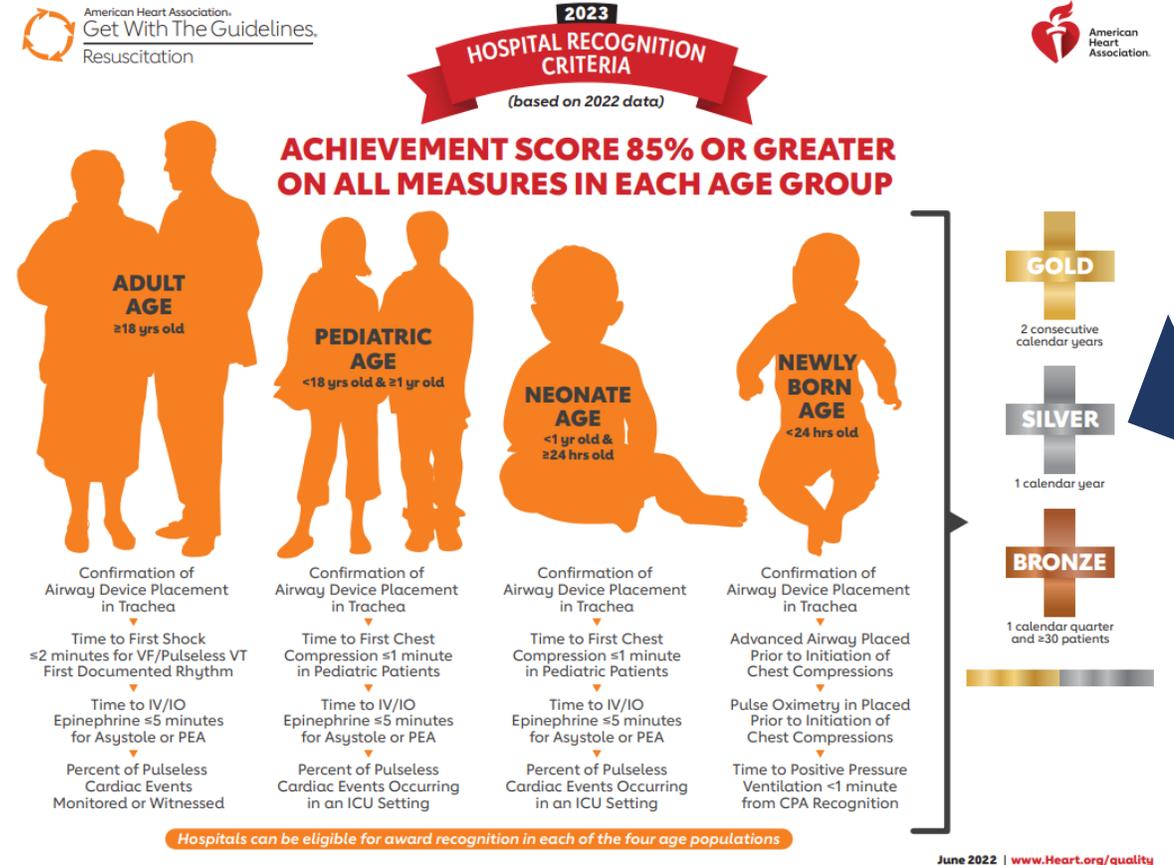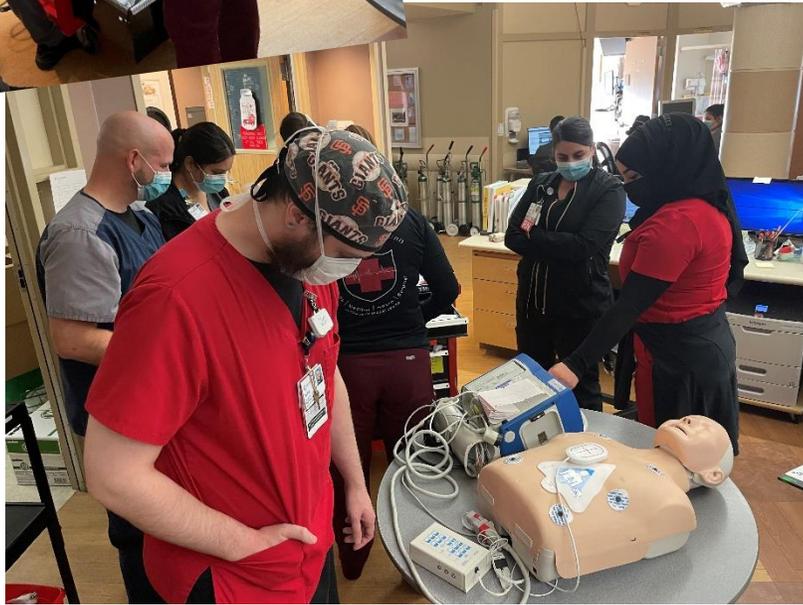
Where we're at and what we've done...

- Recruit and fill Medical Director Position- Vacant since December 2021. In-progress.
- Discussing opportunities for increasing knowledge and awareness surrounding the 10 Signs of Vitality (SOV) education that staff receive on hire. Working with Kristina, Critical Care Educator. In-progress.
- Re-instate in-situ mock code blues (high-fidelity when feasible). Involved Clinical Education and submitted a work ticket to start to establish next steps for house-wide roll-out/involvement. Receiving assistance from Critical Care Educator, Kristina. In-progress.
- Develop education surrounding COPES Algorithm (Algorithm created to remind staff what to do in the event of a code blue). In-progress.

- Updated Code Blue Resuscitation Form. Complete.
- Teach all staff to use Automated External Defibrillator (AED) feature on Zoll to deliver earlier defibrillation. Complete.
  - Invited to speak at American Heart Association Hospital Forum about this work!
- Met (virtually) with leaders from Sutter Roseville, on 10/26 to discuss their RRT/Code Blue program and their successes. Developed a relationship and shared encouragement and ideas about on-going projects. They were impressed and inspired by a lot of work that we are already doing! We will meet with them quarterly to review on-going projects and share work that could be used with our teams. Complete.
- Filmed "The First 2 Minutes." Complete.

Education Activities

TOPIC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Annual Review of Quality and Patient Safety Plans	X B											
Leadership Clinical Quality Goals	X	X	X	X	X	X	X	X	X	X	X	X
Leapfrog Hospital Safety Score						X					X B	
Healthgrades											X B	
Value Based Purchasing						X B						
Length of Stay					X B						X	B
Safety Culture – SAQ & Action Plan						X B						X
Fall Prevention Committee			X B						X			
Diabetes Committee				X					X			
Pain Committee		X						X				
Infection Prevention Dashboard Hand Hygiene, SSI, C Diff, CAUTI & CLABSI			X			X B			X			X
Hand Hygiene Report (Leapfrog requirement)						X B						X
CAUTI Committee				X					X			
Diversion Prevention			X			X			X B			X
CARDIAC SERVICES												
Cardiac Surgery Society of Thoracic Surgery(STS)			X		B				X			
Cardiology American College of Cardiology (ACC) Data		X						X	B			
CRITICAL CARE												
Emergency Dept Report						X	B					X
Rapid Response Team (RRT)	X	B		X				X			X	
Trauma Committee				X							X	
SURGICAL SERVICES Surgical Quality Improvement Program					X B						X	
ORTHO/NEURO/REHAB												
Stroke	X						X	B				

Revised: Dec 2022

2023 Quality Council/Board Quality Review Schedule

TOPIC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Rehabilitation		X						x				
Orthopedics		X						x				
MATERNAL CHILD HEALTH												
Perinatal Core Measures, Pediatrics, NICU,			X	B					X			
Labor & Delivery, Obstetrics			x	B					X			
RENAL SERVICES												
Renal Services - Network 18						X						X
MENTAL HEALTH												
CMS Core Measures				X						X		
POST ACUTE SERVICES												
Subacute						X						X
Hospice, Home Health				X						X		
2022 QUALITY FOCUS TEAMS												
SEPSIS Quality Focus Team (QFT)	X			X			X			X	B	
HAPI QFT			X			X			X			X
Handoff Communication QFT			X			X			X			X
CLABSI QFT		X			X			X			X	
MRSA QFT	X			X			X			X	B	
2022 BEST PRACTICE TEAMS												
Heart Failure BPT			X			X			X			X
Pneumonia (PN) BPT			X			X			X			X
COPD BPT			X			X			X			X
AMI (non-STEMI) BPT			X			X			X			X
CLOSED AGENDA ITEMS												
Pro-Staff Report	X	X	X	X	X	X	X	X	X	X	X	X
Medication Safety *J McNulty* (Pro-staff)	X			X			X			X		
MERP Annual Review (Pro-staff)							X					
Root Cause Analysis (Pro-staff)	X	X	X	X	X	X	X	X	X	X	X	X

Revised: Dec 2022

Outstanding Health Outcomes Update

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

January 2023

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FY23 Clinical Quality Goals

	July-Nov 22 **Higher is Better**	FY23 Goal	FY22	FY22 Goal
SEP-1 (% Bundle Compliance)	**79%**	≥ 77%	76%	≥ 75%

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.

Lower is Better	July 2022	Aug 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	June 2023	Estimated Annual Number Not to Exceed to Achieve Goal*	FYTD SIR** (number of actual/ number expected)	FY23 Goal (VBP 2024; National Mean 2019)	FY22 FY21 FY20
CAUTI Catheter Associated Urinary Tract Infection Excluding COVID INCLUDING COVID-19 PATIENTS	**1** 1	**1** 0	**2** 0	**1** 0	**2** 0								14 (23 predicted over 12 months)	0.668 0.779 Including COVID	≤0.650	1.092 0.54 1.12
CLABSI Central Line Associated Blood Stream Infection Excluding COVID INCLUDING COVID-19 PATIENTS	**3** 0	**0** 0	**0** 0	**0** 1	**1** 0								10 (17 predicted over 12 months)	0.627 0.784 Including COVID	≤0.589	1.132 0.75 1.20
MRSA Methicillin-Resistant Staphylococcus Aureus Excluding COVID INCLUDING COVID-19 PATIENTS	**2** 0	**0** 0	**0** 0	**0** 0	**0** 0								5 (8 predicted over 12 months	0.873 0.873 Including COVID	≤0.726	1.585 2.78 1.02

*based on July 2021-June 2022 NHSN predicted
**Standardized Infection Ratio is the number of patients who acquired one of these infections (excluding COVID patients) while in the hospital divided by the number of patients who were expected.

More than medicine. Life.

Kaweah Health

Questions?