March 10, 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, March 16, 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, March 16, 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, March 16, 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

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, March 16, 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 Sylvia Salinas, Recording.

OPEN MEETING – 7:30AM

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

CLOSED MEETING – 7:31AM

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

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

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

OPEN MEETING – 8:00AM

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

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

3. **Written Quality Reports –** A review of key quality metrics and actions associated with the following improvement initiatives:
    - 3.1. Hospital Acquired Pressure Injury (HAPI) Committee
    - 3.2. Infection Prevention Dashboard
    - 3.3. Cardiac Surgery Society of Thoracic Surgery (STS) Quality Report
    - 3.4. Maternal Child Health Quality Report
    - 3.5. Orthopedics Quality Report

4. **Fall Prevention Committee-** A review of current performance and actions focused on Fall Prevention. *Emma Camarena, DNP, RN, ACCNS-AG, CCRN, Director of Nursing Practice*

5. **Handoff Communication Quality Focus Team-** A review of current performance and actions focused on the Handoff Communication. *Franklin Martin, BSN, Director of Trauma Services*

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.

Unit/Department Specific Data Collection Summarization

Quality Improvement Committee

Unit/Department: HAPI QFT & Inpatient Wound Prevention **Report Date:** December 2022

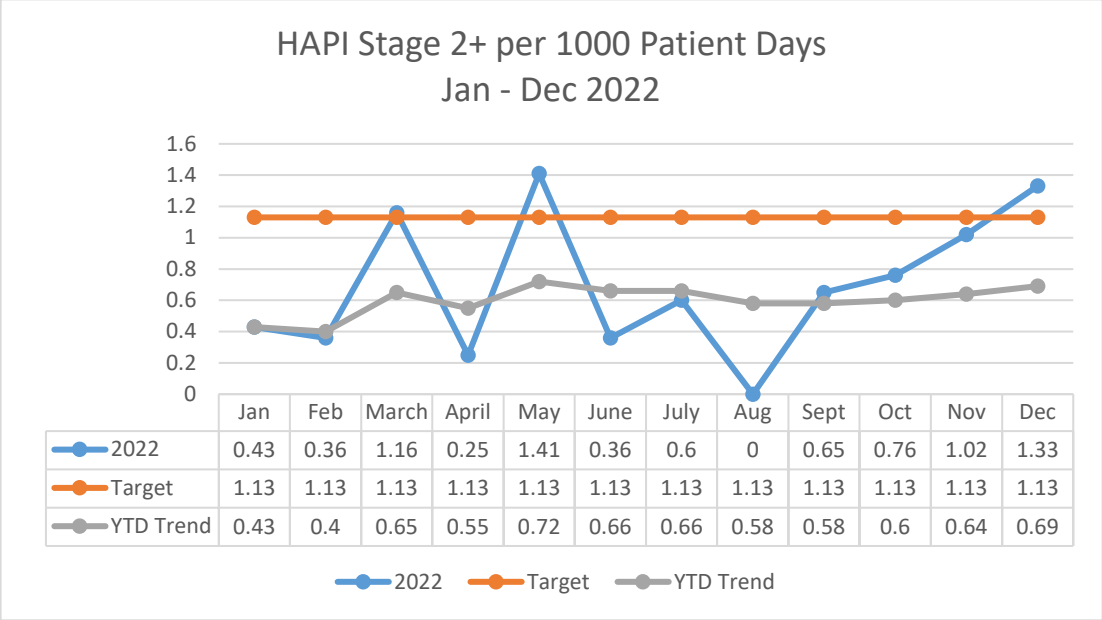
Measure Objective / Goal:

Hospital Acquired Pressure Injuries (HAPI), Total and Device-Related
Incidence data compiled from staff/unit-level self-report, with and without prompting from wound nurse consultant. Includes Stage 1-4, unstageable, suspected deep tissue pressure injury (DTPI).

Indicator #1 HAPI Stage 2+ per 1000 Patient Days

Goal 1.13 (-10% from 2021)

Date Range June 2022 – December 2022



	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
2022	0.43	0.36	1.16	0.25	1.41	0.36	0.6	0	0.65	0.76	1.02	1.33
Target	1.13	1.13	1.13	1.13	1.13	1.13	1.13	1.13	1.13	1.13	1.13	1.13
YTD Trend	0.43	0.4	0.65	0.55	0.72	0.66	0.66	0.58	0.58	0.6	0.64	0.69

Analysis of Measures / Data: (include key findings, improvements, opportunities)

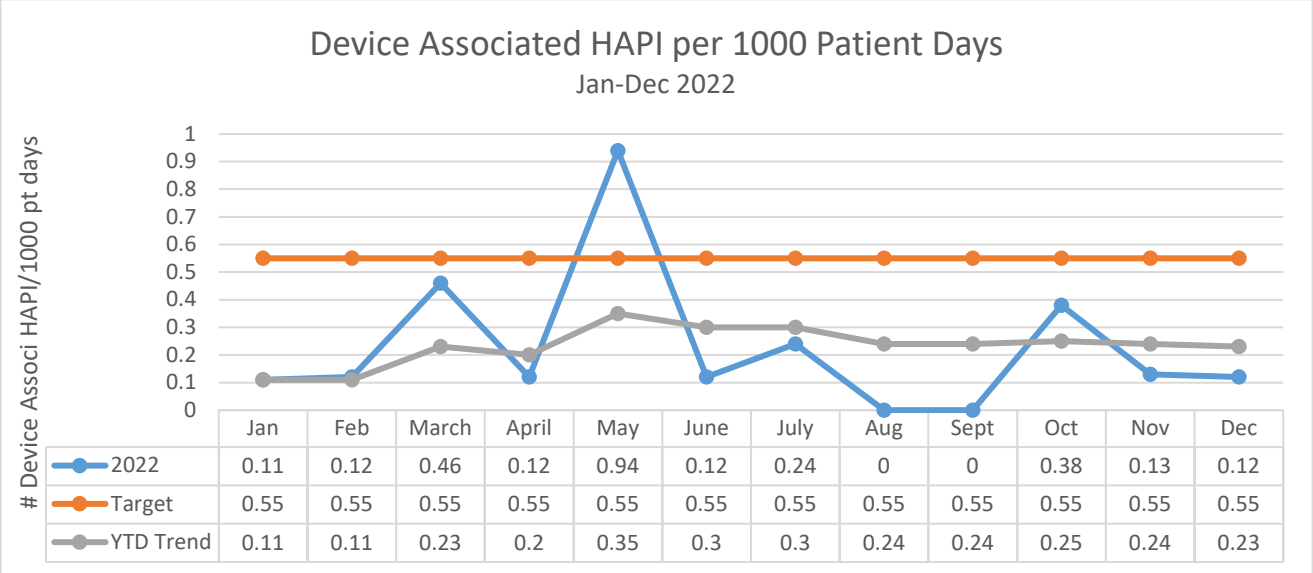
- ✓ **Goal #1** Partially Met: Met for Months of Sept (.65), October (.76), November (1.02), but not met in December (1.33)
- ✓ Met: Cumulative YTD below target (.69)

We have officially stopped the CSI meetings, but continue to collect the data from the managers on a monthly basis. Continued education sent to the bedside care from our CSI takeaways. The wound care team is attending NPC meetings quarterly and sharing the latest and greatest wound care and common issues the team might encounter. Respectfully requesting that we end HAPI as a QFT focus. 2/28/23 Update: CSI has been reinstituted starting February 1st due to the increase in HAPIs last 2 months of 2022. More education to come for the teams and regular communication of takeaways for CSI.

Indicator #2 Device Associated HAPI per 1000 Patient Days

Goal 0.55 (-10% from 2021)

Date Range June 2022 – December 2022



	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
2022	0.11	0.12	0.46	0.12	0.94	0.12	0.24	0	0	0.38	0.13	0.12
Target	0.55	0.55	0.55	0.55	0.55	0.55	0.55	0.55	0.55	0.55	0.55	0.55
YTD Trend	0.11	0.11	0.23	0.2	0.35	0.3	0.3	0.24	0.24	0.25	0.24	0.23

Analysis of Measures / Data: (include key findings, improvements, opportunities)

- ✓ **Goal #1** Met: Met for Months of Sept (0), October (.38), November (.13) and December (.12)
- ✓ Met: Cumulative YTD below target (0.23)

With the decrease in COVID admissions, our device related HAPIs have remained low throughout the year. Respectfully request that we end HAPI as a QFT focus at this time. Will continue to monitor trends and continue to track data.

Unit/Department Specific Data Collection Summarization

Quality Improvement Committee

2022 Stage 2+ HAPI QFT Dashboard

Measure Description Outcome Measures	2022 Benchmark/ Target	2019 Baseline	2020 Baseline	2021 Baseline	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	YTD 2022
HAPI Stage 2+ per 1,000 pt days (all HAPIs)	1.13 (-10% from 2021)	1.64	1.61	1.26	0.43	0.36	1.16	0.25	1.41	0.36	0.60	0.00	0.65	0.76	1.02	1.33	0.69
Device Associated HAPI per 1,000 pt days	0.55 (-10% from 2021)	0.74	0.72	0.61	0.11	0.12	0.46	0.12	0.94	0.12	0.24	0.00	0.00	0.38	0.13	0.12	0.23
PSI 3 - Claims-based HAPI Stage 3, 4, and Unstageable per 1,000 discharges	**0.6** - Hospital Compare (Q3 2017-Q2 2019) **0.35** - Midas 50th Percentile (2019)	0.79	0.95	1.42	0.00	0.00	0.00	1.16	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.15	0.19
Process Measures	(-10% from 2021)	2019	2020	2021	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	YTD 2022
Respiratory Device associated HAPI per 1,000 pt days	0.36		0.44	0.40	0.11	0.00	0.00	0.00	0.24	0.00	0.12	0.00	0.00	0.13	0.00	0.00	0.05
% of Respiratory Device associated HAPI's (out of all of the device associated HAPI's)	58%		61%	65%	100%	0%	0%	0%	25%	0%	50%	0%	0%	33%	0%	0%	22%
Unit Level	(-10% from 2021)	2019	2020	2021	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	YTD 2022
4N - HAPI 2+ per 1,000 pt days	1.09	1.34	2.02	1.22	0.00	1.28	0.00	0.00	0.00	0.00	0.00	0.00	0.00	2.43	0.00	0.00	0.31
3W - HAPI 2+ per 1,000 pt days	2.29	2.26	3.2	2.55	0.00	0.00	0.00	0.00	0.00	0.00	3.85	0.00	0.00	1.98	4.00	0.00	0.79
ICU - HAPI 2+ per 1,000 pt days	3.72	7.1	7.44	4.14	0.00	0.00	3.98	0.00	0.00	0.00	0.00	0.00	6.44	0.00	5.33	13.82	2.38
CVICU - HAPI 2+ per 1,000 pt days	3.87	5.2	6.23	4.31	5.68	0.00	2.78	3.55	0.00	0.00	3.88	0.00	0.00	0.00	0.00	0.00	1.51
2N - HAPI 2+ per 1,000 pt days	0.63	0.1	0.22	0.71	0.00	0.00	1.15	0.00	0.00	0.00	0.00	0.00	0.00	0.00	2.28	0.00	0.30
2S - HAPI 2+ per 1,000 pt days	0.81	0.7	1.51	0.90	0.00	0.00	0.00	0.00	0.00	3.52	0.00	0.00	0.00	0.00	0.00	0.00	0.30
3N - HAPI 2+ per 1,000 pt days	0.99	0.86	0.72	1.11	0.00	0.00	0.00	0.00	6.92	1.00	0.00	0.00	0.00	0.00	0.00	2.31	0.87
3S - HAPI 2+ per 1,000 pt days	0.08	0.46	0.5	0.09	0.00	0.00	0.00	0.00	0.00	0.00	1.10	0.00	0.00	0.00	0.00	0.00	0.09
4S - HAPI 2+ per 1,000 pt days	1.03	1.37	0.66	1.15	1.96	0.00	2.02	0.00	3.33	0.00	0.00	0.00	1.16	0.00	1.13	1.06	0.91
4T - HAPI 2+ per 1,000 pt days	0.25	1.23	0.45	0.28	0.00	1.65	0.00	0.00	3.38	0.00	0.00	0.00	0.00	0.00	0.00	1.50	0.55
BP - HAPI 2+ per 1,000 pt days	0	0	0.62	0	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Rehab - HAPI 2+ per 1,000 pt days	0.14	0.75	0	0.16	0.00	2.38	0.00	2.11	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.85	0.48
5T - HAPI 2+ per 1,000 pt days	1.31		0.4	1.46	0.00	0.00	5.35	0.00	0.00	0.00	1.27	0.00	1.39	4.27	1.36	0.00	1.11
Other Units	2022 Benchmark/ Target	2019	2020	2021	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	YTD 2022
ED	n/a	4	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Sub-Acute	n/a	5	6	5	0	0	0	0	0	0	0	0	0	0	1	1	2
Surgery	n/a	6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Cath Lab	n/a	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pediatrics	n/a	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0
Mother Baby	n/a	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Transitional Care (South Campus)	n/a	1	1	1	0	0	0	0	0	0	0	0	0	1	0	0	1
Short Stay (at Rehab)	n/a	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0
Lab	n/a				0	0	0	0	0	0	0	1	0	0	0	0	1

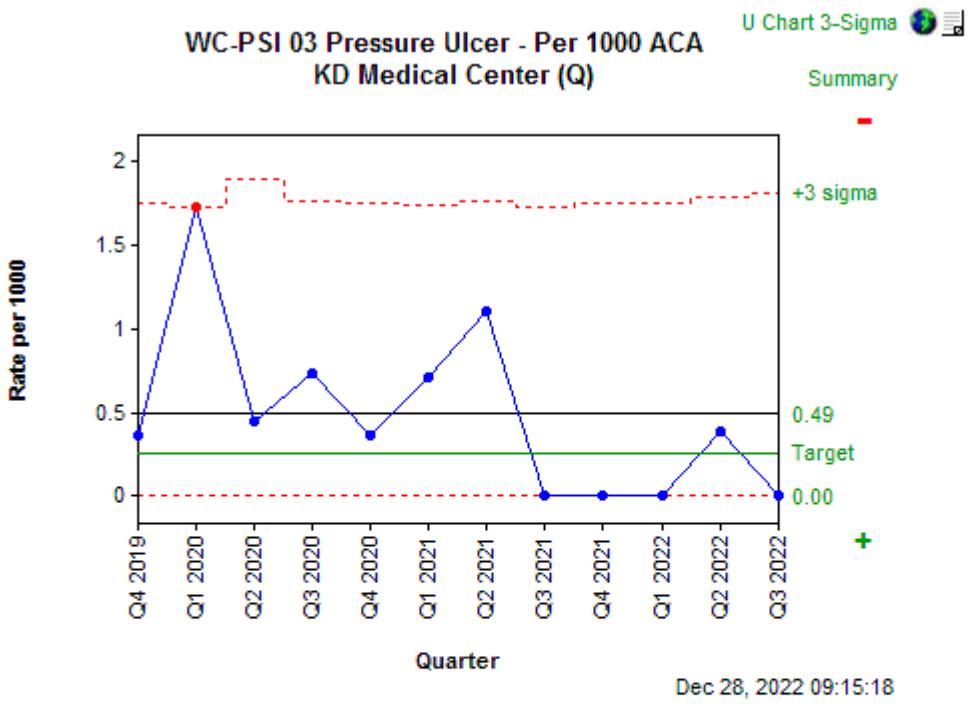
PSI 03: Pressure Ulcer Rate

Pressure ulcers have been associated with an extended length of hospitalization, sepsis, and mortality. The Agency for Healthcare Research an Quality (AHRQ) developed measures that health providers use to identify potential in-hospital patient safety problems for targeted institution-level quality improvement efforts. Patient Safety Indicator (PSI) 03 includes stage 3 or 4 pressure ulcers or unstageable (secondary diagnosis) per 1000 discharges among surgical or medical patients ages 18 years and older. *Exclusions: stays less than 3 days; cases with principal stage 3 or 4 (or unstageable) pressure ulcer diagnosis; cases with a secondary diagnosis of stage 3 or 4 pressure ulcer (or unstageable) that is present on admission; obstetric cases; severe burns; exfoliative skin disorders.*

Indicator #3 PSI-03 Claim-based HAPI Stage 3, 4, Unstageable per 1000 discharges

Goal 0.26 (Hospital Compare)

Date Range Q3 2022



Quarter	Numerator	Denominator	Rate per 1000
Q3 2022	0	2543.00	0.00
Q2 2022	1	2615.00	0.38

Analysis of Measures / Data: (include key findings, improvements, opportunities)

- ✓ **Goal #3 Not** Met for Quarter 2 2022 (1)

Possible PSI 3 for September was ruled out. Data continues to trend in the right direction.

Improvement Opportunities Identified, Action Plan and Expected Resolution Date / Next Steps, Recommendations, Outcomes:

We are requesting that the HAPI QFT be taken off as a quality focus team at this time. We will continue to meet as a committee to track and trend our data and quality measures surrounding HAPIs, but would like to move this meeting to a quarterly basis. Ongoing education and support from the wound care team and clinical education are happening on all floors and at NPC. Competency now required yearly for all bedside nurses. Reporting avenue and review is occurring regularly on all floors. We will continue to monitor and report findings as needed. Thank you for your consideration.

<u>Ongoing</u>

- ✓ Due to a huge decrease in participation, we have ended holding regular CSI meetings. Weren't getting the staff participation and managers able to attend less than 50% of the time. Continue to send out review sheets to managers monthly to fill out and we send CSI takeaways out to units monthly to share. UPDATE 2/28/23 – CSI reimplemented with slight changes, but will continue to send out takeaways and trends to staff as we saw an uptick in HAPIs towards the end of last year.

- ✓ Quarterly education at NPC for bedside staff. Rotating topics shared with latest supplies and wound techniques to share with their units.

- ✓ Monthly inservices scheduled with vendors for wound vacs, waffle boots and mattresses, turn academy, etc. Multiple dates/times scheduled to accommodate both day and night shift staff.

<u>Parking Lot</u>

- ☐ It was determined by the HAPI QFT committee that we will hold the 5-day Kaizen until our traveler numbers decrease across the hospital due to rapid turnover of staff.

Submitted By: **Date Submitted:** February 28, 2023
Rebekah Foster, Director of Care Management and Specialty Care

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2022							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
I. Environmental Surveillance							
A. **Sterilization and High Level Disinfection Quality Control**							
Goal <2% of Immediate Use Sterilization		1.93%	2.49%	2.07%	1.74%		**1st QTR:** The quarter average was just below 2%. IUSS during the month of March was very high and related to Cardiac Surgery. The instruments involved in the increase of IUSS are retractors and forceps. There is work underway to address processing times to shore-up the IUSS activity. **2nd QTR:** IUSS activity continues to be higher than goal. **3rd QTR:** IUSS activity is improving, almost meeting goal. 7 events are due to instrument turnaround time; 8 events are due to instruments not being available; 2 events due to a contaminated instrument during surgery ; and 1 event in which the instrument was not available due to turnaround time. **4th QTR:** There were a total of 46 IUSS events out of 2,633 procedures performed (both general and cardiac surgeries). IUSS generally performed for orthopedic line surgeries. Common trends (holder & bipolar forcep x 4 events; hip retractors x 2 events; several other retractors x 4 events, accounts for 22% of the IUSS events this quarter).
B. Dialysis Water/Dialysate Quality Control (AAMI RD52:2004) (% of machines that did not exceed limits)							
Acute Dialysis (Inpatient) RO Water [Target: <200cfu] [Action: > or = 50cfu] Endotoxin [Target: <2EU] [Action: > or = 1EU]		0%	0%	0%	0%		**1st QTR:** 51 Acute Dialysis RO Outlet samples and 6 Dialysis Machine samples were tested for bacterial & endotoxin counts and all results were within acceptable parameters. **2nd QTR:** 51 Acute Dialysis RO outlet samples and 6 Dialysis Machine samples were tested for bacterial & endotoxin counts and all results were within acceptable parameters. **3rd QTR:** 51 Acute Dialysis RO outlet samples and 5 Dialysis Machine samples were tested for bacterial & endotoxin counts and all results were within acceptable parameters. **4th QTR:** 51 Acute Dialysis RO outlet samples and 2 Dialysis Machine samples were tested for bacterial & endotoxin counts and all results were within acceptable parameters.

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2022							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
Outpatient Dialysis RO Water [Target: <200cfu] [Action: > or = 50cfu] Endotoxin [Target: <2EU] [Action: > or = 1EU]		0%	0%	0%	0%		**1st QTR:** 6 Outpatient Dialysis RO Outlet samples and 7 Dialysis Machine samples were tested for bacterial & endotoxin counts and all results were within acceptable parameters. **2nd QTR:** 7 Outpatient Dialysis RO Outlet samples and 8 Dialysis Machine samples were tested for bacterial endotoxin counts and all results were within acceptable parameters. **3rd QTR:** 6 Outpatient Dialysis RO Outlet samples and 6 Dialysis Machine samples were tested for bacterial endotoxin counts and all results were within acceptable parameters. **4th QTR:** 6 Outpatient Dialysis RO Outlet samples and 6 Dialysis Machine sample were tested for bacterial endotoxin counts and all results were within acceptable parameters.
C. Environmental Cleaning (ATP testing surfaces)							
Pass/Fail based on a threshold of ATP score of <200. Multiple high-touch surfaces tested each month.	Goal 100%	69%	83.4%	80.3%	65.49%		**1st QTR:** A total of 589 samples were tested, 406 passed on first sweep, 182 failed. For all failed results the room was re-cleaned. **2nd QTR:** A total of 339 samples were tested with 283 passing on first sweep, 59 failed. For all failed results the room was re-cleaned. Areas tested include (CVICU, MB, ICU, 4N, 5T, 3S, CVOR, OR, Main OR, OBOR, Cath Lab, 2E, 2N, 3N, 4S, BP, and PEDS.). Surfaces with greatest fallout are: Room sink, Rest Room sink, OR Table, Bedside Telephone. **3rd QTR:** A total of 418 samples were tested (79 or 23% increase from 2nd QTR), and 336 samples passed on first sweep, 82 failed. For all failed results the room was re-cleaned. Areas tested include (4T, 4S, ICU, 3N, 3S, 2E, 5T, 2S, 3W, Peds, Cath Lab, CVOR, CVICU, Main OR, 4N, BP, MB, OR). Sufaces with greatest fallout are: Overbed table, Calllight Button, Room Doorknob, Room Chair. EVS Leadership is working on streamlining and standardizing ATP testing to 30 specimens for each location. **4th QTR** A total of 648 samples were tested (35% increase from 3rd QTR), and 425 samples passed on first sweep, 223 failed. For all failed results the room was re-cleaned. Surfaces with greatest fallout are: Overbed/Bedside table, Room doorknob, Call button, Bedrails, and chair. EVS Leadership is working on refining sampling process to ensure timely sampling in advance of any potential recontamination of a clean surface to be tested.
II. Antimicrobial Stewardship Measures							

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2022							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
# of antibiotic IV to PO conversion		257	271	182	173	883	**1st QTR:** There were a total of 257 IV to PO conversion ABS interventions. The majority occurred CVICU and 3S. **2nd QTR:** There were a total of 271 IV to PO conversion ABS interventions. The majority occurred CVICU and ICU. The least occured in the ED. **3rd QTR:** There were a total of 182 IV to PO conversion ABS intervention. The majority occurred in CVICU, 3W and 1E/ED. **4th QTR:** There were a total of 173 IV to PO conversion ABS interventions. The majority occurred in CVICU and ICU.
Average Days of Therapy per 1,000 patient days - Fluoroquinolones		Not available	Not available	Not available	Not available		**1st QTR:** This information is unavailable for 1st QTR. It will be presented at next IP Committee meeting. **2nd QTR:** This information is unavailable for 2nd QTR. It will be presented at next IP Committee meeting. **3rd QTR:** This information is unavailable for 3 QTR. A new ID Pharmacist has started and 2nd/3rd QTR information should be available by 4th QTR. **4th QTR:**
Average Days of Therapy per 1,000 patient days - Carbapenems		Not available	Not available	Not available	Not available		**1st QTR:** This information is unavailable for 1st QTR. It will be presented at next IP Committee meeting. **2nd QTR:** This information is unavailable for 2nd QTR. It will be presented at next IP Committee meeting. **3rd QTR:** This information is unavailable for 3 QTR. A new ID Pharmacist has started and 2nd/3rd QTR information should be available by 4th QTR. **4th QTR:**
III. Employee Health							
A. Needlestick Injuries							

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2022							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
Number of sharps/needle stick reports		11	15	NA	19		**1st QTR:** 6 events involved GME Residents. 5 RNs account for the remaining needlestick events. There were 5 events related to a needle with safety mechanism, 3 events related to an insulin syringe with safety mechanism, and 2 events involving sutures. **2nd QTR:** 8 events with the majority involving RNs (5) followed by LVNs (1) and Aides (1). Most needle sticks occur when engaging the needle safety mechanism with 3 of the devices involved in events being insuling syringes with a safety mechanism. There were additional events reported for 2nd QTR (3rd QTR data not yet available). An additional 7 sharps exposures occurred involving primarily needles with a safety mechanism, insulin syringes and sutures. This events are chiefly distributed among nurses and GME Residents. GME Residents account for the greatest number of sharps exposure during 2nd QTR. **3rd QTR:** Date not available yet. Late report - there were 18 needlestick/sharps events, most associated with needle-safety and suture usage. The greatest majority of sharps exposures were related to Lab personnel with (5) events, followed by GME residents with (3) events. **4th QTR**: 19 events with GME residents incurring the greatest volume of needlesticks (8), with 3 events involving suture and 2 events with a scape, and 1 event with a guide wire. The remaining events were primarily associated with Registered Nurses (7) involving syringes. Thereafter, are isolated events involving an LVN (1), EVS worker (1), Aide (1) and phlebotomy tech (1).
B. Blood/Body Fluid Exposures							
Number of blood/body fluid exposures		3	0	NA	NA		**1st QTR:** 1 event with blood to eye from IV pigtail. 1 event blood to eye with drawing lab specimen. 1 event involving IV fluid/blood present during disconnecting the IV. **2nd QTR:** No splash events reported. **3rd QTR:** Data not available yet. **4th QTR:** Data not available.
IV. Healthcare Associated Infection Measures							
I. Overall Surgical Site Infections (SSI)	**IR/SIR**						**SSIs calculated internally though standard incidence rate and externally through Standardized Infection Ratio (SIR) from National Health and Safety Network (NHSN).**
A. #Total Procedure Count		764	918	999	522		**Cumulative Ct:** 3,203
B. Total Infection Count *[note: SSI events can be identified up to 90 days from the last day of the month in each quarter and only DIP and Organ Spc SSI are reported in NSHN]*		5	5	10	7	27	**1st QTR:** 5 **Predicted:** 11.627 **2nd QTR:** 5 **Predicted:** 12.993 **3rd QTR:** 10 **Predicted:** 12.933 **4th QTR:** 7 **Predicted:** 8.252

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		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
C. Incidence Rate (IR) [# of total SSI infections/# total procedures x 100]	Internal 0.70 Goal	0.654	0.54	1	1		**1st QTR:** Better than State benchmark. **2nd QTR:** Better than State benchmark. **3rd QTR:** No different than State benchmark. **4th QTR:** No different than State benchmark.
D. SIR Confidence Interval (CI-KDHCD predicted range, based on risks)		0.158, 0.953	0.141, 0.853	0.393, 1.378	0.371, 1.878		**1st QTR:** With 95% confidence the SSI event incidence rate appropriately reflects the population. **2nd QTR:** With 95% confidence the SSI event incidence rate appropriately reflects the population. **3rd QTR:** With 95% confidence the SSI event incidence rate appropriately reflects the population. **4th QTR:** With 95% confidence the SSI event incidence rate appropriately reflects the population.
E. Standardized Infection Ratio (SIR)	NHSN	0.43	0.385	0.773	0.848		**1st QTR:** There were 1 CSEC, 1 KPRO, 1 SB, 2 XLAP SSI events. All events were superficial incision primary events. Continuing to monitor SSI events for particular trends. **2nd QTR:** There were 2 APPY, 2 COLO, 2 CSEC, 1 GAST, 2 KPRO, 1 SB SSI events in total. There 5 events of deep SSI events, amongst the total the following were deep SSI events 2 APPY, 2 CSEC, 1 KPRO. Findings for deep SSI events include: excessive entry/exit during surgery, clean closure procedure not performed, pre-op antibiotic administration not documented (uncertain if it occured), documentation to support PATOS or infection present at start of surgery. **3rd QTR:** There were 2 COLO, 1 CBGB, 1 CSEC, 1 KPRO, 1 HYST, 2 HER, 1 FX, 1 SB **4th QTR:** There were 3 COLO, 2 APPY, 2 FUSN, 1 HYST, 1 FX *two cases met SIP criteria and don't count in NHSN for reporting purposes
V. Specific Surgical Review	**SIR**						
A. Colon Surgery (COLO) CMS/VBP							
1. #Total Procedure Count		28	37	28	31		**Cumulative Ct:** 124
2. Total Infection Count		0 [0]	0 [0]	2 [0]	3 [1]	5 [1]	**1st QTR:** 0 **Predicted:** 1.983/**CMS** 0 **Predicted:** 0.874 **2nd QTR:** 0 **Predicted:** 2.186/**CMS** 0 **Predicted:** 1.206 **3rd QTR:** 2 **Predicted:** 1.797 /**CMS** 0 **Predicted:** 0.909 **4th QTR:** 3 **Predicted:** 1.838 /**CMS** 1 **Predicted:** 0.976
3. SIR CI (KDHCD predicted range, based on risks)		, 1.511	, 1.370	0.187, 3.678	0.415, 4.442		**1st QTR:** With 95% confidence the absence of COLO SSI events appropriately reflects the population. **2nd QTR:** With 95% confidence the absence of COLO SSI events appropriately reflects the population. **3rd QTR:** With 95% confidence that absence of COLO SSI events appropriately reflects the population. **4th QTR:** With 95% confidence that absence of COLO SSI events appropriately reflects the population.

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		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
4. SIR (Standardized Infection Ration) total Value Based Purchasing (VBP) SIR = [ ]	VBP Goal <0.717	0.00	0	1.113	1.532		**1st QTR:** No COLO SSI events. **2nd QTR:** No COLO SSI events. **3rd QTR:** 2 COLO SSI events, both involve substitution of Cefotetan to Cefoxitan pre-op prophylactic antibiotic treatment. Hair removal in the O.R. was true for one case. Surgeon left 50 minutes prior to closure in the second case - patient had many comorbidities. **4th QTR:** 3 COLO SSI events. One event due to no clean closure. 2 events due to incision dehiscence and pooring healing wounds.
B. Cesarean Section (CSEC)							
1. #Total Procedure Count		230	220	279	139		**Cumulative Ct:** 868
2. Total Infection Count		1	2	1	0	4	**1st QTR:** 1 **Predicted:** 2.064 **2nd QTR:** 2 **Predicted:** 2.022 **3rd QTR:** 1 **Predicted:** 2.433 **4th QTR:** 0 **Predicted:** 1.336
3. SIR CI (KDHCD predicted range, based on risks)		0.024, 2.390	0.166, 3.268	0.021, 2.027	, 2.242		**1st QTR:** With 95% confidence the 1 CSEC event is representative of the population of CSEC procedures performed. **2nd QTR:** With 95% confidence the 1 CSEC event is representative of the population of CSEC procedures performed. **3rd QTR:** With 95% confidence the 1 CSEC event is representative of the population of CSEC procedures performed. **4th QTR:** With 95% confidence the 1 CSEC event is representative of the population of CSEC procedures performed.
4. SIR (Standardized Infection Ration) total	Goal SIR <1.00	0.49	0.989	0.411	0.00		**1st QTR:** There was 1 superficial Cesarean section SSI event 3 days post-op. Pre-op antibiotics not documented. **2nd QTR:** Both CSEC events were deep. One involved a patient with peripartum fever and infection 14 days post-op. The second event involved a procedure in which pre-op antibiotics were not documented making difficult to ascertain whether antibiotics were administered. **3rd QTR:** There was 1 superficial Cesarean section SSI event 9 days post-op involving a patient with a large pannus. Opsite was placed over incision site. Patient would have likely benefited from a Provena dressing over incision site instead. **4th QTR:** There were no CSEC SSI events.
C. Spinal Fusion (FUSN)							
1. #Total Procedure Count		44	62	67	51		**Cumulative Ct:** 224
2. Total Infection Count		0	0	0	2	2	**1st QTR:** 0 **Predicted:** 0.792 **2nd QTR:**0 **Predicted:** 1.133 **3rd QTR:** 0 **Predicted:** 0.917 **4th QTR:** 2 **Predicted:** 0.953

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		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
3. SIR CI (KDHCD predicted range, based on risks)		NA	NA	NA	NA		**1st QTR:** With 95% confidence the absence of FUSN SSI events appropriately reflects the population. **2nd QTR:** NA **3rd QTR:** NA **4th QTR:** NA
4. SIR (Standardized Infection Ration) total	Goal SIR <1.00	0.00	**0**	**0**	**0.953**		**1st QTR:** No Spinal Fusion surgical site infections reported. **2nd QTR:** No Spinal Fusion surgical site infections reported. **3rd QTR:** No Spinal Fusion surgical site infections reported. **4th QTR:** There were 2 Spinal Fusion surgical site infections. One developed a deep infection caused by E. cloacae 11 days post-op. The second developed a superficial infection caused by P. aeruginosa 23 days post-op. Infection noted at Kaweah Rehab.
D. Hysterectomy (HYST) CMS/VBP							
1. #Total Procedure Count		14	15	15	10		**Cumulative Ct:** 54
2. Total Infection Count		**0** **[0]**	**0** **[0]**	**1** **[1]**	**0** **[0]**	1	**1st QTR:** 0 **Predicted:** 0.298/**CMS** 0 **Predicted:** 0.108 **2nd QTR:** 0 **Predicted:** 0.275 **/CMS** 0**Predicted:** 0.126 **3rd QTR:** 1 **Predicted:** 0.298/**CMS** 1 **Predicted:** 0.136 **4th QTR:** 0 **Predicted:** 0.225/**CMS** 0 **Predicted:** 0.089
3. SIR CI (KDHCD predicted range, based on risks)		NA	NA	NA	NA		**1st QTR:** With 95% confidence the absence of HYST SSI events appropriately reflects the population. **2nd QTR:** NA **3rd QTR:** NA **4th QTR:** NA
4. SIR (Standardized Infection Ration) total Value Based Purchasing (VBP) SIR = [ ]	VBP Goal <0.738	**0.00**	**0**	**3.36**	**0**		**1st QTR:** There were no Abdominal Hysterectomy surgical site infection. **2nd QTR:** There were no Abdominal Hysterectomy surgical site infection. **3rd QTR:** There was one deep Abdominal Hysterectomy surgical site infection 5 days post-op. Very minimal operative documentation. Uncertain whether clean-closure performed. **4th QTR:** There were no Abdominal Hysterectomy surgical site infection.
VI. Ventilator Associated Events (VAE)	**SIR**						
A. Ventilator Device Use SUR (standardized utilization ratio)		**1.83**	**1.221**	**0.823**	**1.858**		**1st QTR:** 1,080 **Predicted:** 591.467 **2nd QTR:** 901 **Predicted:** 350.600 **3rd QTR:** 3,052 **Predicted:** 3,707.978 **4th QTR:** 805 **Predicted:** 486.015
B. Total VAEs ICU (NHSN Reportable)	Includes IVAC Plus						

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		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
1. SIR Total VAE CI (KDHCD predicted range, based on risks)		0.006, 1.587	, 0.886	0.300, 2.278	,0.471		**1st QTR:** With 95% confidence the VAE event appropriately reflects the population of patients on a ventilator. **2nd QTR:** With 95% confidence the VAE event appropriately reflects the population of patients on a ventilator. **3rd QTR:** With 95% confidence the VAE event appropriately reflects the population of patients on a ventilator. **4th QTR:** With 95% confidence the VAE event appropriately reflects the population of patients on a ventilator.
2. Total VAEs SIR	<1.0	**0.32**	**0**	**0.944**	**0**		**1st QTR:** Less than predicted number of events. **2nd QTR:** Less than predicted number of events. **3rd QTR:** Slightly less than predicted number of events. **4th QTR:** Less than predicted number of events.
C. Total IVAC Plus -ICU		**1**	**0**	**3**	**0**	**4**	**1st QTR:** Patient had a IVAC event after 5 days of ventilation. **2nd QTR:** No IVAC events. **3rd QTR:** There were 3 IVAC(+) events. **4th QTR:** No IVAC events.
1. Total IVAC Plus CI (KDHCD predicted range, based on risks)		0.016, 1.557	, 2.387	0.486, 5.195	,1.269		**1st QTR:** With 95% confidence the VAE event appropriately reflects the population of patients on a ventilator. **2nd QTR:** Less than predicted number of events. **3rd QTR:** With 95% confidence the VAE event appropriately reflects the population of patients on a ventilator. **4th QTR:** With 95% confidence the VAE event appropriately reflects the population of patients on a ventilator.
2. Total IVAC *Plus* ICU SIR		**0.117**	**0**	**1.909**	**0**		**1st QTR:** Less than predicted number of events. **2nd QTR:** Less than predicted number of events. **3rd QTR:** Greater than predicted number of events. **4th QTR:** Less than predicted number of events.
1. Process Measures							
% of patients with head of bed >30 dregrees per visual inspection.	**Goal = 100%**	**84.7%**	**79.5%**	**93.8%**	**Not performed**		**1st QTR:** 50 of 59 rounds demonstrated a patient with the head of bed at or beyond 30 degrees elevation on visual inspection. **2nd QTR:** 35 responses out of 44 responses. VAE prevention committee is meeting with Respiratory to determine ways in which to increase auditing and compliance. **3rd QTR:** 15 of 16 rounds demonstrated a patient whose head of bed was at >30 degrees. (low sample) **4th QTR:** Limited resources prevented audits during this time.

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		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
% Sedation Vacation	Goal = 100%	92.3%	38.6%	100.0%	Not performed		**1st QTR:** 24 of 26 rounds demonstrated a patient who received a sedation vacation while on the ventilator. **2nd QTR:** 17 responses out of 44 responses. VAE prevention committee is meeting with Respiratory to determine ways in which to increase auditing and improve sedation vacation and mobility efforts. **3rd QTR:** 5 of 5 rounds demonstrated a patient who received a sedation vacation. (very low sample) **4th QTR:** Limited resources prevented audits during this time.
% Oral Care Provided (per visual inspection)	Goal = 100%	93.8%	100.0%	100.0%	Not performed		**1st QTR:** 60 of 64 rounds demontrated a patient who received oral care based on visual inspection of the mouth. **2nd QTR:** 44 responses out of 44 responses. **3rd QTR:** 17 of 17 rounds demonstrated a patient who received oral care based on visual inspection of the mouth. (low sample) **4th QTR:** Limited resources prevented audits during this time.
% CHG Bath within last 24 hours	Goal = 100%	95.3%	100.0%	NA	Not performed		**1st QTR:** 61 or 64 rounds demonstrated a patient who received a CHG bath within the last 24 hours prior to the round. **2nd QTR:** 43 responses out of 43 responses. **3rd QTR:** CHG bathing information no longer monitored as part of the VAP prevention bundle. **4th QTR:** Limited resources prevented audits during this time.
% Vent Tubing Position Appropriately (drain away from patient - visual inspection)	Goal = 100%	90.6%	95.5%	100.0%	Not performed		**1st QTR:** 58 or 64 rounds demonstrated a patient with ventilator tubing positioned appropriately (draining away from the patient's airway). **2nd QTR:** 42 responses out of 44 responses. **3rd QTR:** 17 of 17 rounds demonstrated a patient with ventilator tubing positioned appropriately (draining away from the patient's airway). (low sample) **4th QTR:** Limited resources prevented audits during this time.
VII. Central Line Associated Blood Stream Infections (CLABSI) CMS/VBP	**NHSN SIR**						
A. Total number of Central Line Days (CLD)		4284	3795	2,848	4,121		**Cumulative Ct:** 15,048
B. Central Line Device Use SUR (standardized utilization ratio)		0.736	0.718	0.668	0.751		**1st QTR:** 4284 CLD **Predicted:** 5819.971 **2nd QTR:** 3795 CLD **Predicted:** 5,284.516 **3rd QTR:** 2,848 CLD **Predicted:** 4,265.645 **4th QTR:** 4,121 CLD **Predicted:** 5,484.254
C. Total Infection Count Valule Based Purchasing (VBP) # events = [ ]		3 [0]	5 [3]	3 [2]	5 [3]	16	**1st QTR:** 3 **Predicted:** 4.213/**CMS:** 0 **Predicted:** 2.558 **2nd QTR:** 5 **Predicted:** 3.726/**CMS:** 3 **Predicted:** 2.257 **3rd QTR:** 3 **Predicted:** 2.816/**CMS:** 2 **Predicted:** 2.502 **4th QTR:** 5 **Predicted:** 4.052/**CMS:** 3 **Predicted:** 2.559
D. SIR Confidence Interval		0.181, 1.938	0.492, 2.974	0.271, 2.899	0.452, 2.735		**1st QTR:** Worst than national benchmark. **2nd QTR:** Worst than national benchmark. **3rd QTR:** Worst than national benchmark. **4th QTR:** Worst than national benchmark

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		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
E. SIR (Standardized Infection Ratio) total Value Based Purchasing (VBP) SIR = [ ]	≤ 0.589 excluding COVID population	0.712	1.342	1.065	1.234		**1st QTR:** January event due to limited patient bathing and pan-culture practices. February events due to extended Femoral access, limited patient bathing, poor assessment of surgical site; Another extended Femoral access, poor adherance to hand hygiene practice. **2nd QTR:** Events related to source control (i.e. osteomyelitis and endocarditis), family manipulating the patient's vascular line, patient scratching and pinching skin at vascular line insertion site, femoral line access in a patient that it was inappropriate for, and poor hand hygiene practice amongst healthcare workers. **3rd QTR:** First event involved a dislodged port and late orders for cultures. Second event was likely due to respiratory secretions contaminating the insertion site. Last case would have benefited from prophylactic Diflucan to avoid Candidemia. **4th QTR:** (Event-1) Femoral access, blood culturing practices, poor hand hygiene compliance, Candidemia. (Event-2) High risk for Candidemia and translocation of GI bacteria, culturing practices, hand hygiene compliance, Candidemia. (Event-3) Source control, MRSA treatment increased risk of fungal infection, Osteomyelitis in spine due to MRSA, poor hand hygiene compliance, Candidemia. (Event-4) Poor hand hygiene compliance, non-compliant patient pulling out lines, central line used for dialysis, night-shift driving requests for blood cultures. (Event-5) Serial blood cultures for a non-MDRO gram neg organism, persistent positive blood cultures from beginning of admission, late identification of septicemia-5 days post admission, source control-osteomyelitis of lumbar spine.
F. Process Measures							
% of patients with a bath within 24 hours	Goal 100%	96.0%	89.5%	87.1%	95.0%		**1st QTR:** 1,642 responses out of 1,703 rounds. **2nd QTR:** 1,281 responses out 1,432 responses. **3rd QTR:** 2,596 responses out of 2,979 rounds. **4th QTR:** 1,838 responses out of 1,928 rounds.
% of central lines inserted with a valid rationale	Goal 100%	97.0%	96.8%	95.8%	96.0%		**1st QTR:** 1,046 responses out of 1,703 rounds. **2nd QTR:** 822 responses out of 849 responses. **3rd QTR:** 1,517 responses out of 1,584 rounds. **4th QTR:** 2,157 responses out of 2,250 rounds.
% of central line dressings clean, dry and intact	Goal 100%	98.0%	98.5%	97.1%	97.0%		**1st QTR:** 1,042 responses out of 1,703 rounds. **2nd QTR:** 836 responses out of 849 responses. **3rd QTR:** 1,542 responses out of 1,588 rounds. **4th QTR:** 2,190 responses out of 2,250 rounds.
% of central line dressing changes no > than 7 days	Goal 100%	98.0%	91.6%	97.2%	98.0%		**1st QTR:** 1,048 responses out of 1,703 rounds. **2nd QTR:** 772 responses out of 843 responses. **3rd QTR:** 1,543 responses out of 1,588 rounds. **4th QTR:** 1,953 responses out of 1,995 rounds.

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		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
% of patients with properly placed CHG patch	Goal 100%	98.0%	90.4%	51.9%	97.0%		**1st QTR:** 541 responses out of 552 rounds. **2nd QTR:** 481 responses out 532 responses. **3rd QTR:** 824 responses out of 1,588 rounds. **4th QTR:** 1,038 responses out of 1,070 rounds.
% of patients with appropriate & complete documentation	Goal 100%	95.0%	90.9%	95.0%	94.0%		**1st QTR:** 1,250 responses out of 1,333 rounds. **2nd QTR:** 768 responses out of 845 responses. **3rd QTR:** 1,507 responses out of 1,587 rounds. **4th QTR:** 2,100 responses out of 2,223 rounds.
# of central line days rounded on		2,871	844	1,584	2,223		**1st QTR:** Approximately, 957 central lines rounds a month. **2nd QTR:** Approximately, 488 central lines rounds a month. **3rd QTR:** Approximately 528 central line rounds a month. **4th QTR:** Approximately 741 central line rounds a month.
Skilled Nursing/Acute Rehab % of central dressing clean/dry/intact	Goal 100%	95.9%	99.0%	98.3%	100.0%		**1st QTR:** 47 of 49 central dressing were clean, dry and intact. **2nd QTR:** 190 respones out of 192 responses. **3rd QTR:** 119 responses out of 121 rounds. **4th QTR:** 118 responses out of 118 rounds.
Skilled Nursing/Acute Rehab % of central line dressings changed no > 7 days	Goal 100%	NA	98.2%	98.3%	99.2%		**1st QTR:** There were no reports provided for this metric. **2nd QTR:** 167 responses out of 170 responses. **3rd QTR:** 119 responses out of 121 rounds. **4th QTR:** 118 responses out of 119 rounds.
VIII. Catheter Associated Urinary Tract Infections (CAUTI) CMS/VBP	**NHSN SIR**						
A. Total number of Catheter Device Days (CDD)		4713	3494	3052	4,435		**Cumulative Ct:** 15,694
B. Catheter Device Days SUR (Standardized Utilization Ratio)		0.915	0.751	0.823	0.928		**1st QTR:** 4713 CDD **Predicted:** 5150.948 CDD **2nd QTR**: 3494 CDD **Predicted:** 4650.527 CDD **3rd QTR:** 3052 CDD **Predicted**: 5,943.111 CDD **4th QTR:** 4435 CDD **Predicted:** 5484.254 CDD
C. Total Infection Count Value Based Purchasing (VBP) # of events = [ ]		8 [5]	3 [3]	4 [4]	6 [2]	21	**1st QTR:** 8 **Predicted:** 6.115/**CMS:** 5 **Predicted:** 3.240 **2nd QTR:** 3 **Predicted:** 4.549/**CMS:** 3 **Predicted:** 2.089 **3rd QTR:** 4 **Predicted:** 3.970/**CMS:** 4 **Predicted:** 3.216 **4th QTR:** 6 **Predicted:** 5.783 /**CMS:** 2 **Predicted:** 3.218
D. SIR Confidence Interval		0.608, 2.484	0.168, 1.795	0.395, 3.00	0.421, 2.158		**1st QTR:** Worst than national benchmark. **2nd QTR:** Worst than national benchmark. **3rd QTR:** Worst than national benchmark. **4th QTR**: Worst than national benchmark.

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		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
E. SIR (Standardized Infection Ratio) total Value Based Purchasing (VBP) SIR = [ ]	**≤ 0.650 excluding COVID population**	**1.308**	**0.66**	**1.244**	**1.038**		**1st QTR:** January events: pan-culturing practices, poor hand hygiene compliance, specimen collection practices, minimal patient bathing. February events: one fever impetus for ordering cultures, pan-culturing practices, specimen collection practices, questionnable indication for indwelling urinary catheter, antimicrobial stewardship, minimal patient bathing. **2nd QTR:** Events related to: single fever as an impetus to culture, peri-care not provided, culture-of-culturing, pan-culturing, and unnecessary cultures. **3rd QTR:** First event may be due to catheter insertion practices. Second event could have been prevented with better hand hygiene compliance, also uncertain why Q1hr. I&Os (rationale for catheter) really was needed considering the patient was on a Med/Surg unit. Third event due to inappropriate culturing practices and inappropriate rationale for indwelling urinary catheter. Fourth case due to insufficient patient bathing and patient pulling on his catheter. **4th QTR:** [Event-1] No rationale provided for indwelling urinary catheter, poor hand hygiene compliance, urine culture sought when patient's death was imminent. [Event-2] Protocol for Bladder Management, urinary retention not followed, missing pericare, pan-culturing activities, poor hand hygiene compliance [Event-3] Pan-culturing activities, not following antimicrobial stewardship, not attempting alternatives to an indwelling urinary catheter [Event-4] Pan-culturing practices, late detection of septicemia, poor patient compliance, poor hand hygiene compliance, not attempting alternative to an indwelling urinary catheter
							[Event-5] Ordering cultures in response to a single elevated temperature reading, pan-culturing practices, likely stool contaminants identified in urine culture, poor hand hygiene compliance [Event-6] Pan-culturing practices, poor hand hygiene compliance.
F. Process Measures							
% of patients with appropriate cleanliness (a minimum of peri-care in the last 12 hours)	**Goal 99%**	**99.0%**	**96.9%**	**96.3%**	**99.0%**		**1st QTR:** 1,991 responses out of 2,126 rounds. **2nd QTR:** 751 responses out 775 responses. **3rd QTR:** 1735 responses out of 1803 rounds. **4th QTR:** 1,798 responses out of 1,808 rounds.
% of IUCs with order and valid rationale	**Goal 100%**	**96.0%**	**95.8%**	**94.9%**	**93.0%**		**1st QTR:** 1,171 responses out of 1,240 rounds. **2nd QTR:** 738 responses out 770 responses. **3rd QTR:** 1,714 responses out of 1,807 rounds. **4th QTR:** 2,016 responses out of 2,175 rounds.
% of IUCs where removal was attempted		**6.3%**	**1.8%**	**4.4%**	**5.0%**		**1st QTR:** 56 responses out of 890 rounds. **2nd QTR:** 14 responses out 770 responses. **3rd QTR:** 80 responses out of 1,804 rounds. **4th QTR:** 66 responses out of 1,346 rounds.

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		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
% of patients where alternatives have been attempted		10.4%	6.7%	7.6%	6.0%		**1st QTR:** 129 responses out of 1,235 rounds. **2nd QTR:** 52 responses out 773 responses. **3rd QTR:** 137 responses out of 1,799 rounds. **4th QTR:** 92 responses out of 1,482 rounds.
% of IUCs removed because of unit "GEMBA" rounds		5.2%	4.4%	3.0%	2.0%		**1st QTR:** 64 responses out of 1,237 rounds. **2nd QTR:** 28 responses out of 770 responses. **3rd QTR:** 76 responses out 1,782 rounds. **4th QTR:** 41 responses out of 2,175 responses.
# of IUCs removed because of unit "GEMBA" rounds		64	28	76	41		**1st QTR:** Approximately, 21 indwelling urinary catheters a month were removed as a results of Gemba rounds. **2nd QTR:** Approximately, 9 indwelling urinary catheters a month were removed as a result of Gemba rounds. **3rd QTR:** Approximately, 25 indwelling urinary catheters a month were removed as a result of Gemba rounds. **4th QTR:** Approximately, 41 indwelling urinary catheters a month were removed as a result of Gemba rounds.
# of Indwelling Urinary Catheter days rounded on		2,607	764	1,803	2,175		**1st QTR:** Approximately, 869 rounds on indwelling urinary catheters a month. **2nd QTR:** Approximately, 255 rounds on indwelling urinary catheters a month. **3rd QTR:** Approximately, 601 rounds on indwelling urinary catheters a month. **4th QTR:** Approximately, 725 rounds on indwelling urinary catheter a month.
Skilled Nursing/Acute Rehab % of complete baths performed within 24 hours *(Modification to this measure to start 2022 1st QTR - % of completed baths performed within 48 hours for patients with central lines)*	**Goal 100%**	95.6%	98.1%	98.7%	96.6%		**1st QTR:** 87 of 91 complete baths were performed within 24 hours. **2nd QTR:** 305 responses out of 311 responses. **3rd QTR:** 77 responses out of 78 rounds. **4th QTR:** 226 responses out 234 rounds.
Skilled Nursing/Acute Rehab % of peri care performed within in a 12 hour shift	**Goal 100%**	98.1%	97.9%	94.9%	94.2%		**1st QTR:** 53 of 54 pericare actions were completed and documented within the 12 hour shift. **2nd QTR:** 185 responses out of 189 responses. **3rd QTR:** 74 responses out of 78 rounds. **4th QTR:** 162 responses out of 172 rounds.
IX. Catheter Associated Urinary Tract Infections Long Term Care/Rehabilitation	**Goal = 0**						
Short Stay (# of Infections/ Incidence Rate)		0	0	0	0	0	**1st QTR:** There were no CAUTI events. **2nd QTR:** There were no CAUTI events. **3rd QTR:** There were no CAUTI events. **4th QTR:** There were no CAUTI events.
Transitional Care (# of Infections/ Incidence Rate)		0	1	0		1	**1st QTR:** There were no CAUTI events. **2nd QTR:** There was 1 Symptomatic Catheter Associated Urinary Tract Infection events with a foley catheter in place. The CAUTI rate = 2.571 **3rd QTR:** There were no CAUTI events. **4th QTR:** Transitional Care unit has been closed permanently.

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2022							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
Subacute (# of Infections/ Incidence Rate)		0	0	0	0	0	**1st QTR:** There were no CAUTI events. **2nd QTR:** There were no CAUTI events. **3rd QTR:** There were no CAUTI events. **4th QTR:** There were no CAUTI events.
Acute Rehabilitiation (# of Infections/ Incidence Rate)		0	0	0	0	0	**1st QTR:** There were no CAUTI events. **2nd QTR:** There were no CAUTI events. **3rd QTR:** There were no CAUTI events. **4th QTR:** There were no CAUTI events.
X. LTC Symptomatic Urinary Tract Infections	**Goal = 0**						
Short Stay (# of Infections/ Incidence Rate)		2	1	1	1	5	**1st QTR:** There were 2 Symptomatic Urinary Tract Infection events without a foley catheter in place. 1 occurred during February the other during March. The SUTI rate = 0.464. **2nd QTR:** There was 1 Symptomatic Urinary Tract Infection event without a foley catheter in place. The SUTI rate = 0.241 **3rd QTR:** There was 1 Symptomatic Urinary Tract Infection event without a foley catheter in place. SUTI rate = 0.58 **4th QTR:** There was 1 Symptomatic Urinary Tract Infection event without a foley catheter in place. SUTI rate = 0.31.
Transitional Care (# of Infections/ Incidence Rate)		0	0	2		2	**1st QTR:** There were no SUTI events. **2nd QTR:** There were no SUTI events. **3rd QTR:** There were 2 SUTI events. SUTI rate = 2.03. **4th QTR:** Transitional Care unit has been closed permanently.
Subacute (# of Infections/ Incidence Rate)		0	0	0	0	0	**1st QTR:** There were no SUTI events. **2nd QTR:** There were no SUTI events. **3rd QTR:** There were no SUTI events. **4th QTR:** There were no SUTI events.
XI. Clostridium *difficile* Infection (CDI) CMS/VBP	**SIR**						
A. Total Infection Count	All units	9	8	10	16	33	**1st QTR:** 9 **Predicted:** 18.253 **2nd QTR:** 8 **Predicted:** 17.250 **3rd QTR:** 10 **Predicted:** 18.158 **4th QTR:** 16 **Predicted:** 17.181
B. SIR CI (KDHCD predicted range, based on risks)		0.240, 0.905	0.215, 0.881	0.280, 0.982	0.551, 1.480		**1st QTR:** Better than National benchmark. **2nd QTR:** Better than National benchmark. **3rd QTR:** Better than National benchmark. **4th QTR:** Worse than National benchmark.

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2022							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
C. SIR (Standardized Infection Ratio) total Value Based Purchasing (VBP) SIR = [ ]	VBP Goal <0.520	0.493	0.464	0.551	0.931		**1st QTR:** Infection Prevention is reminding nursing and providers about the C-difficile algorithm. Stools are being collected later during the patient's stay when while receiving a bowel regimen or on Lactulose. **2nd QTR:** Infection Prevention continues to remind nursing and providers about the C-difficile algorithm. Information was also shared at GME orientation with new Residents. **3rd QTR:** Infection Prevention is closely monitoring the upward trend in the HO CDIFF rate. There has been a couple of months without an Antimicrobial Stewardship Pharmacist. A new hire has been approved and waiting for this Antimicrobial Stewardship Pharmacist to start - history demonstrates this position has been integral in reducing and sustaining a reduction in C. difficile rates. **4th QTR:** The longstanding gains in control of C. difficile rates are gradually slipping away. Inappropriate orders for C. difficile testing at the source of increased rates (e.g. an order that was not fulfilled for 3 days because the patient didn't have a stool for this time duration, or a patient receiving a bowel regimen resulting in diarrhea and subsequent orders for C. difficile testing). The Antimicrobial Stewardship and Infection Prevention Programs will be working on initiatives to regain ground and to identify true instances of C. difficile infection.
XII. Hand Hygiene	**95%**						
A. Total Hand Hygiene Observations (combination of manual and electronic hand hygiene surveillance)		2,277,368	2,535,346	3,223,855	2,646,388	10,682,957	**1st QTR:** BioVigil electronic hand hygiene surveillance system was installed at South and West campuses. Go-Live with nearly systemwide surviellance occurred on 3/26/2022. The only areas were manual hand hygiene compliance rates are gathered on clinics and Mental Health. **2nd QTR:** BioVigil electronic hand hygiene surveilance system is gathering information throughout the majority of Kaweah Health. **3rd QTR:** BioVigil electronic hand hygiene surveillance system gathered a significant amount of hand hygiene opportunities. **4th QTR:** A moderate drop in overall hand hygiene opportunities noted this quarter.

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2022							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
B. All units Percentage of Hand Hygiene compliance based on observations/opportunities (>200 observations/ month/unit)		97.1%	97.3%	96.4%	96.5%		**1st QTR:** Overall hand hygiene compliance is remains above the 95% threashold. Work is underway to ensure there is compliance all healthcare workers using BioVigil where it is available. There are currently 3,656 users on the system. **2nd QTR:** Now there are 4,147 registered users on BioVigil. A total of 2,466,892 hand hygiene opportunities were performed appropriately. **3rd QTR:** A total of 3,110,649 hand hygiene opportunities were performed appropriately. **4th QTR:** A total of 2,553,235 hand hygiene opportunities were performed appropriately.
C. Percentage of Hand Hygiene compliance performed during "Day Shift"		97.0%	97.6%	96.8%	96.6%		**1st QTR:** Day shift and night shift have equal compliance rates. Will continue to encourage hand hygiene compliance. **2nd QTR:** 1,330,634 HHOs performed appropriately out of 1,363,355 opportunities. **3rd QTR:** Out of a total of 1,788,594 hand hygiene opportunites 1,731,359 HHOs were performed appropriately. **4th QTR:** Out of 1,027,825 hand hygiene opportunities, 992,879 HHOs were performed appropriately.
D. Percentage of Hand Hygiene compliance performed during "Night Shift"		97.0%	97.3%	97.0%	96.7%		**1st QTR:** Night shift and day shift have equal compliance rates. Will continue to encourage hand hygiene compliance. **2nd QTR:** 745,837 HHOs performed out of 766,533 opportunities. **3rd QTR:** Out of a total of 1,027,825 hand hygiene opportunities, 996,990 HHOs were performed appropriately. **4th QTR:** Out of a total of 884,531 hand hygiene opportunities, 855,341 HHOs were performed appropriately.
XIII. VRE (HAI) Blood-Hospital Onset (HO)							
A. Total Infection Count		0	1	0	1	2	**1st QTR:** 0 **Predicted:** 0 **2nd QTR:** 1 **Predicted:** 0 **3rd QTR:** 0 **Predicted:** 0 **4th QTR:** 1 **Predicted:** 0
B. Prevalence Rate (x100)		0	0.024	0	0.016		**1st QTR:** Better than National benchmark. **2nd QTR:** Better than National benchmark **3rd QTR:** Better than National benchmark **4th QTR:** Better than National benchmark
C. Number Admissions		4,244	4,158	6,464	6,426		**Cumulative Ct:** 21,292
XIV. MRSA (HAI) Blood CMS/VBP	**SIR**						
A. Total Infection Count (IP Facility-wide)		2	2	2	2	8	**1st QTR:** 2 **Predicted:** 1.247 **2nd QTR:** 2 **Predicted**:1.123 **3rd QTR:** 2 **Predicted:** 1.187 **4th QTR:** 2 **Predicted:** 1.685

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2022							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
B. SIR CI (KDHCD predicted range, based on risks)		0.269, 5.297	0.679, 7.268	0.282, 5.565	0.199, 3.922		**1st QTR:** Worst than National benchmark. **2nd QTR:** Worst than National benchmark. **3rd QTR:** Worst than National benchmark. **4th QTR:** Worst than National benchmark.
C. SIR (Standardized Infection Ration) total Value Based Purchasing (VBP) SIR = [ ]	**≤ 0.726 excluding COVID population**	**1.603**	**1.78**	**1.684**	**1.187**		**1st QTR:** 2 HO MRSA BSI events. **2nd QTR:** 2 HO MRSA BSI events. Related to source control (osteomyelitis/endocarditis) and positive test results that exceed 14 days post admission. Note, there was 1 additional HO MRSA reported during May 2022, but this was not actually an event the case involved MSSA and not MRSA (Lab corrected this information). **3rd QTR:** 2 HO MRSA BSI events. Both events were related to serial blood cultures obtained across different nursing units. Both events involve patients with MRSA in bloodstream present-on-admission. Per NHSN criteria these events shouldn't impact the hospital SIR as positive cultures didn't exceed 14 days repeat-infection-period. IP Manager is contacting the State CDPH HAI Program to determine why hospital SIR is being effected when it should not. **4th QTR:** [Event-1] late detection of MRSA BSI [Event-2] Source control - serial positive MRSA blood cultures exceeding 14 day repeat infection window period, Endocarditis ruled-out, osteomyelitis of spinous process suspected source of infection.
XV. MDRO LABID - Long Term Care							
Short Stay (# of Infections/ Incidence Rate)		**0**	**0**	**0**	**0**	0	**1st QTR:** There were no MDRO reported. **2nd QTR:** Gap analysis performed and risk assessment updated. Contact isolation fallouts noted with patients requiring isolation. In response, staff were inserviced and audits performed specifically for: isolation order, signage, caddie on door, PPE utilization and shift handoff. Improvements noted with audits for: signage, caddies, and PPE. Still working on orders and shift handoff. **3rd QTR:** There were no MDRO reported. **4th QTR:** There were no MDRO reported.
Transitional Care (# of Infections/ Incidence Rate)		**1**	**0**	**0**		1	**1st QTR:** There was 1 Clostridium difficile infection event involving a patient transferred from Kaweah Health downtown campus to Transitional Care. Patient received antimicrobial therapy for an extended period of time. **2nd QTR:** There were no MDRO reported. Enhanced Standard Precautions staff education completed and new Powerform due for go-live during August. **3rd QTR:** There were no MDRO reported. **4th QTR:** There was 1 C. difficile infection in skilled nursing over the entire 2022 calendar year. Transitional Care unit has been closed permanently.

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2022

		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
Subacute (# of Infections/ Incidence Rate)		0	0	0	0	0	**1st QTR:** There were no MDRO reported. **2nd QTR:** There were no MDRO reported. Enhanced Standard Precautions staff education completed and new Powerform due for go-live during August. **3rd QTR:** There were no MDRO reported. **4th QTR:** There were no MDRO reported.
XVI. Influenza Rates (Year 2020-2021)	**NHSN**						
A. All Healthcare Workers		87.0%					**1st QTR:** Total number of healthcare personnel having worked at least 1 day at Kaweah Health during Oct. 1, 2021 through March 30, 2022 = 5,142 with 4,470 receiving influenza vaccine rate. LIP =87% (475), Employees-only = 86% (3,434), Students/Volunteers = 96% (561).
XVII. COVID-19 Vaccination Rates (Year 2020-2021)							
A. All Healthcare Workers with a completed series of COVID-19 vaccinations.		4,805	4,875	3,951	3,519		**1st QTR:** There were 702 COVID-19 vaccines administered to employees. Of a total 5,907 employees, 4,805 employees are completed the series of COVID-19 vaccinations as of March 31st, 2022. This demonstrates an 81.3% complete vaccination rate. **2nd QTR:** Of 5,979 employees 4,875 have completed their series of COVID-19 vaccinations as of June 30, 2022. This demonstrates an 81.5% complete vaccination rate. **3rd QTR:** Of a total 4,727 employees 3,951 employees were vaccinated for COVID-19 (last week of 3rd QTR), accounting for 83.6% vaccination rate. Of the 3,951 employee vaccinated there were 2,662 "Up-To-Date" with vaccinations accounting for 56.3% of employees being "Up-to-Date". **4th QTR:** Of 5,123 employees, 4,151 (81%) received at least one COVID vaccine, and 3,519 (69%) are up-to-date or fully vaccinated against COVID.

Approved IPC: 4/28/2022
Approved IPC: 7/28/2022
Approved IPC: 10/27/2022
Approved IPC:

Prepared by: Shawn Elkin, Infection Prevention Manager

Cardiac Surgery Data Quality Analysis

Q4 2021 → Q3 2022

Risk Adjusted Data

Green = Better or Equal to the STS National Average

Red = Worse than the STS National Average

Gray = Non-Risk Adjusted Value (for Reference only)

Data Analysis by the Society of Thoracic Surgeons National Adult Cardiac Surgery Database

Kaweah Health
MORE THAN MEDICINE. LIFE.

Star Ratings 2022
Isolated Coronary Artery Bypass Grafting

Star Ratings are only calculated ending Q2 & Q4 each year

The Society of Thoracic Surgeons

STS CABG Composite Quality Rating
Participant: 30045
STS Period Ending Jun 2022

Domain	Rating	Participant		STS				
		Score	95% CI	Score	Min - Max	10th	50th	90th
Overall	★★	97.22%	(96.40-97.90)	96.79%	(91.56-99.02)	95.29%	96.96%	98.03%
Absence of Mortality	★★	97.69%	(96.63-98.53)	97.45%	(92.14-99.27)	96.17%	97.62%	98.53%
Absence of Morbidity	★★	90.95%	(88.72-92.92)	89.81%	(76.87-96.22)	85.74%	90.20%	93.38%
Use of IMA	★★	98.96%	(97.96-99.61)	99.51%	(92.62-99.99)	98.93%	99.71%	99.92%
Medications	★★★	98.87%	(97.81-99.57)	94.91%	(47.41-99.97)	87.74%	97.38%	99.57%

★ Worse than Expected. Participant's performance is significantly worse than expected for their specific case-mix.

★★ As Expected. Participant's performance is not statistically different than expected for their specific case-mix.

★★★ Better than Expected. Participant's performance is significantly better than expected for their specific case-mix.

Kaweah Health

Star Ratings 2022
Aortic Valve Replacement

Star Ratings are only calculated ending Q2 & Q4 each year

The Society of Thoracic Surgeons

STS AVR Composite Quality Rating
Participant: 30045
STS Period Ending Jun 2022

Domain	Rating	Participant		STS				
		Score	95% CI	Score	Min - Max	10th	50th	90th
Overall	★★	95.22%	(92.63-97.12)	95.49%	(87.39-98.47)	93.55%	95.73%	97.16%
Absence of Mortality	★★	97.87%	(96.31-98.89)	97.80%	(94.23-99.21)	96.87%	97.91%	98.60%
Absence of Morbidity	★★	89.02%	(84.39-92.65)	89.89%	(79.68-95.43)	86.72%	90.14%	92.74%

★ Worse than Expected. Participant's performance is significantly worse than expected for their specific case-mix.

★★ As Expected. Participant's performance is not statistically different than expected for their specific case-mix.

★★★ Better than Expected. Participant's performance is significantly better than expected for their specific case-mix.

Kaweah Health

STAR RATINGS 2022
CABG w/ AORTIC VALVE REPLACEMENT

STAR RATINGS ARE ONLY CALCULATED ENDING Q2 & Q4 EACH YEAR

The Society of Thoracic Surgeons

STS AVR + CABG Composite Quality Rating
Participant: 30045
STS Period Ending Jun 2022

Domain	Rating	Participant		STS				
		Score	95% CI	Score	Min - Max	10th	50th	90th
Overall	★★	92.29%	(88.83-95.07)	91.95%	(79.46-97.32)	88.36%	92.36%	94.99%
Absence of Mortality	★★	95.87%	(92.87-97.92)	95.77%	(87.47-98.80)	93.63%	96.04%	97.55%
Absence of Morbidity	★★	83.57%	(77.06-88.99)	83.30%	(65.62-93.18)	77.57%	83.75%	88.43%

★ Worse than Expected. Participant's performance is significantly worse than expected for their specific case-mix.

★★ As Expected. Participant's performance is not statistically different than expected for their specific case-mix.

★★★ Better than Expected. Participant's performance is significantly better than expected for their specific case-mix.

Kaweah Health

Healthgrades

Specialty Clinical Quality Awards & Ratings

Hospital Quality Awards

America's 100 Best Hospitals Award™ (2023)
Top 2% in the nation for consistently delivering clinical quality year over year

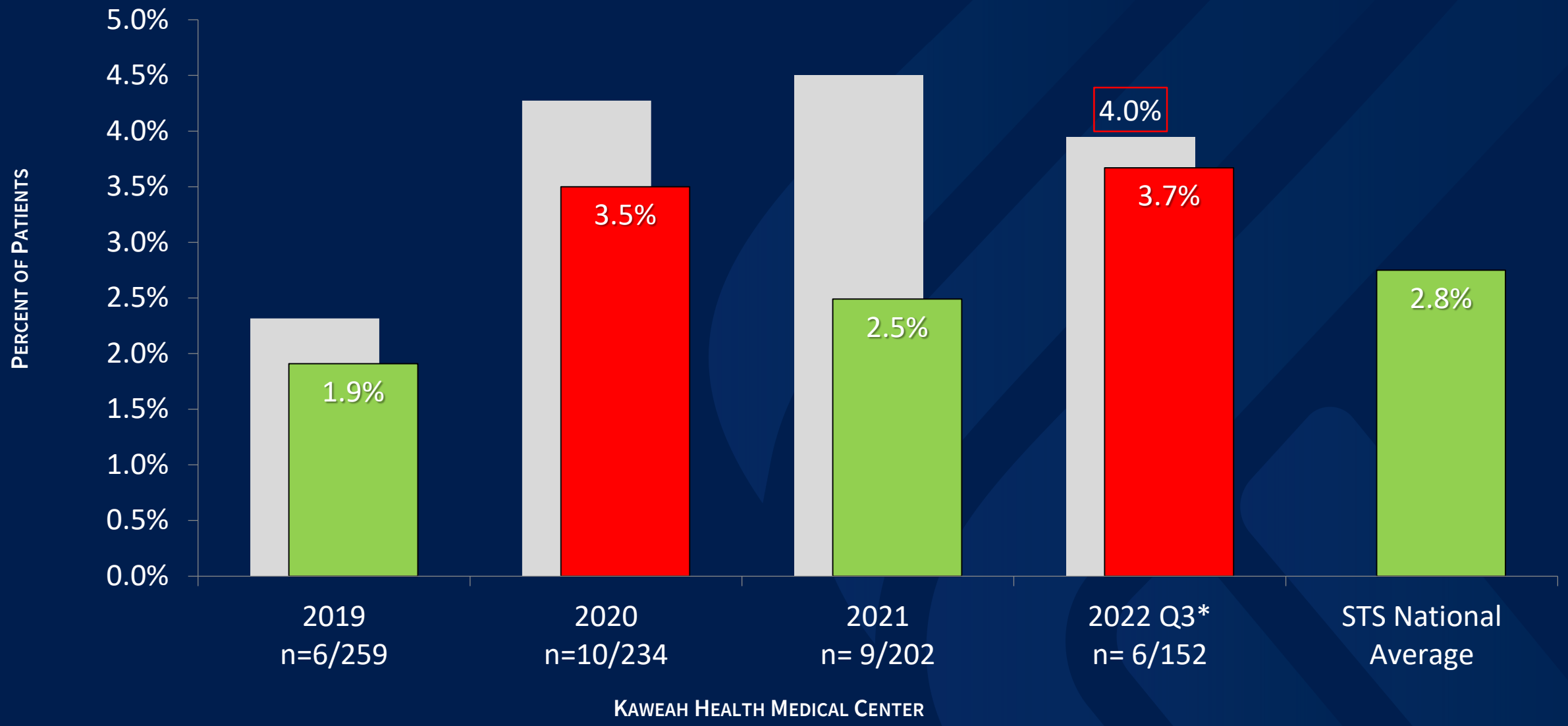
America's 250 Best Hospitals Award™ (2023, 2022, 2021)
Top 5% in the nation for consistently delivering clinical quality

Specialty Clinical Quality Awards

America's 50 Best Hospitals for Cardiac Surgery Award™ (2023, 2022, 2021)
Superior clinical outcomes in heart bypass surgery and heart valve surgery

Resource 02/01/2023 https://www.healthgrades.com/hospital-directory/california-ca-southern/kaweah-health-medical-center-hgst3d418d46050057

All Operative Mortality[1]
Risk Adjusted in Color

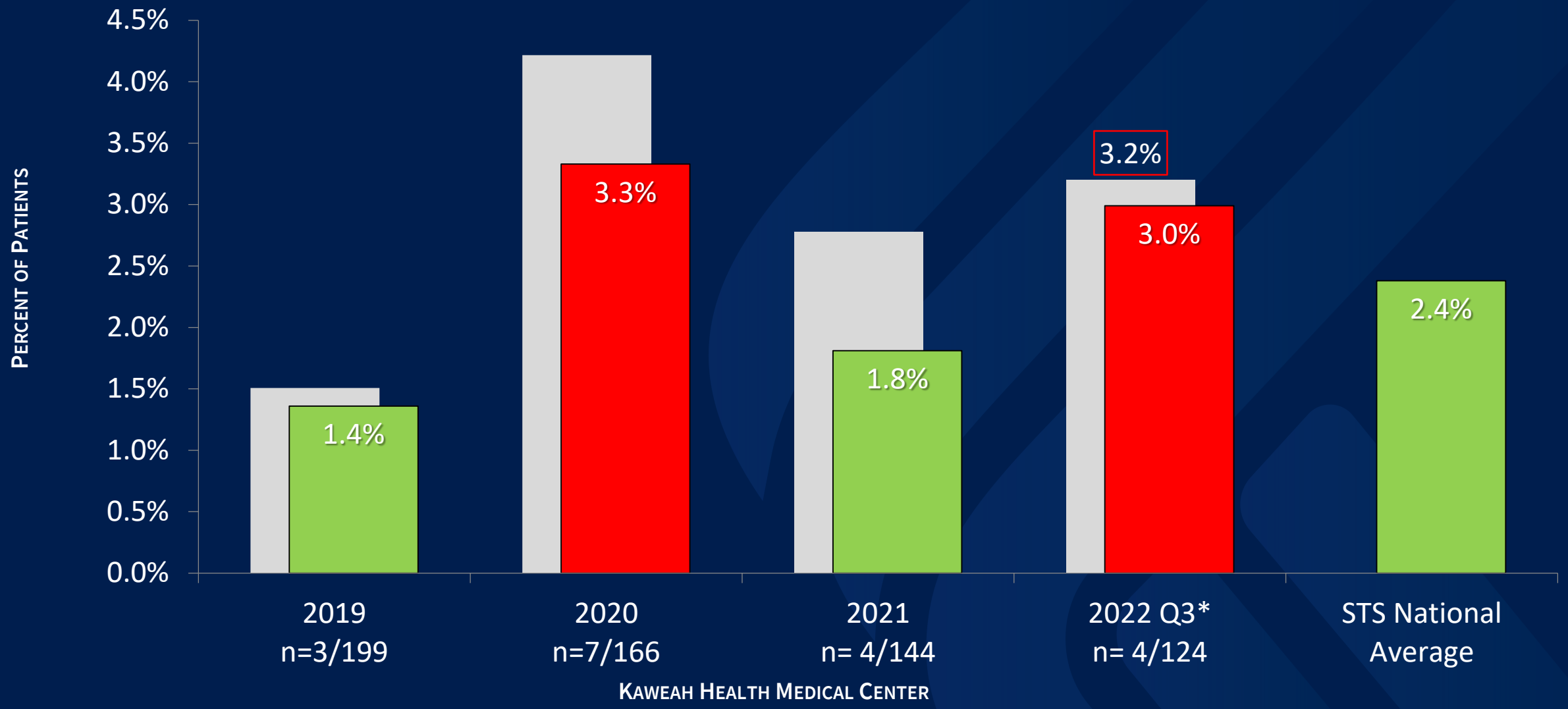


2022 Risk-adjusted O/E = 1.33

*STS National Average Comparison reporting period 01/01/2022 through 09/30/2022

[1] Includes all 7 Major Procedure Categories (CABG, AVR, AVR+CABG, MVR, MVR+CABG, MVP, MVP+CABG) Excludes Other category procedures, Q3-2020 -2021 COVID+ pt.'s Excluded.

CABG Operative Mortality
Risk Adjusted in Color

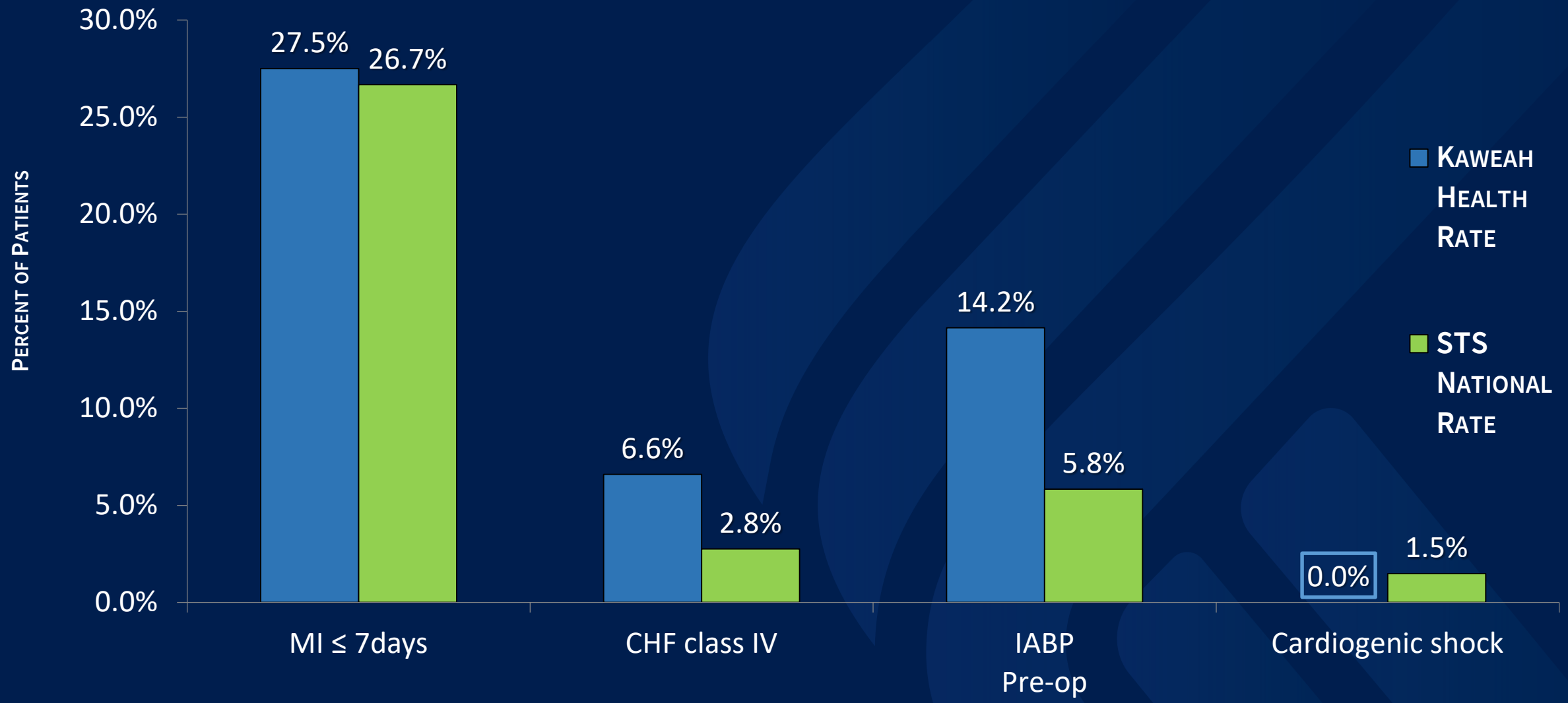


*2022 Risk-adjusted O/E = 1.26

*STS National Average Comparison reporting period 01/01/2022 through 09/30/2022

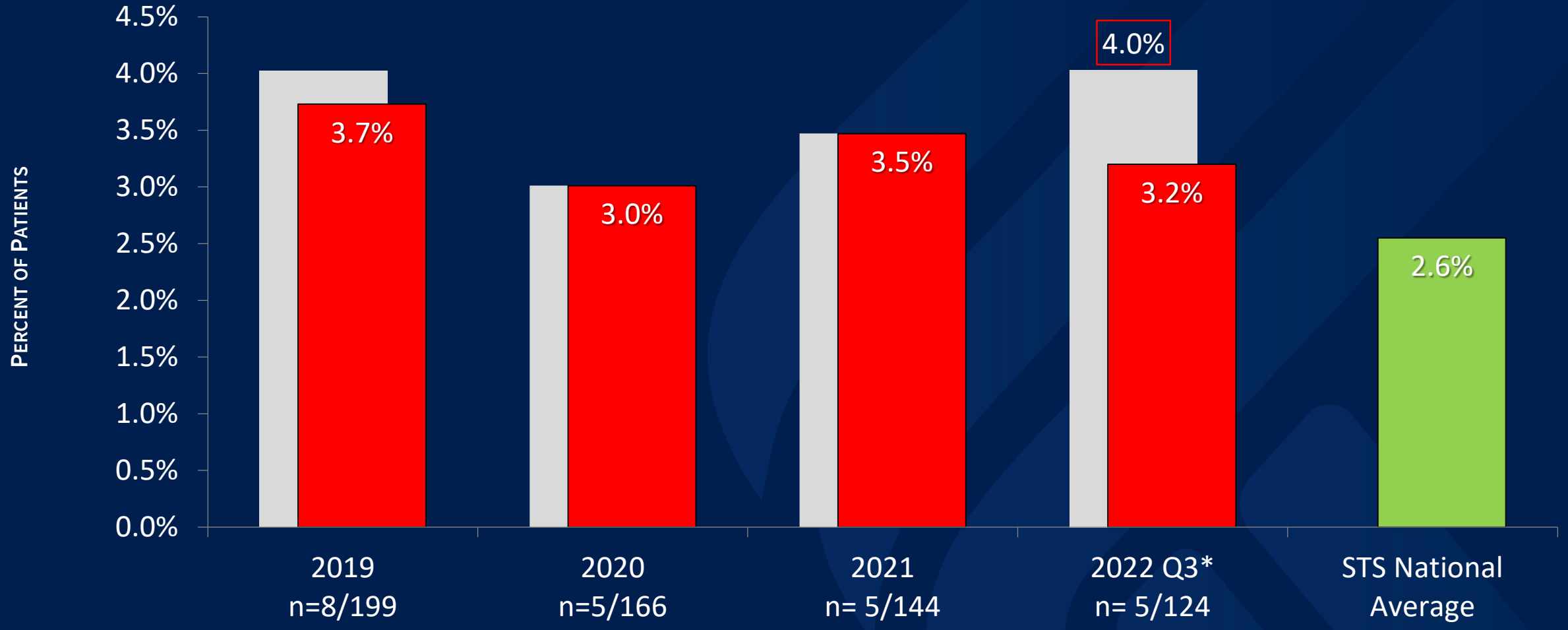
Q3-2020-2021 COVID+ pt.'s Excluded.

Kaweah Health Pt. Populations



*STS National Average Comparison reporting period 01/01/2022 through 09/30/2022– Isolated CABG cases ONLY

CABG Re-Operation[1]
Risk Adjusted in Color



2022 Risk-adjusted O/E = 1.25

*STS National Average Comparison reporting period 01/01/2022 through 09/30/2022

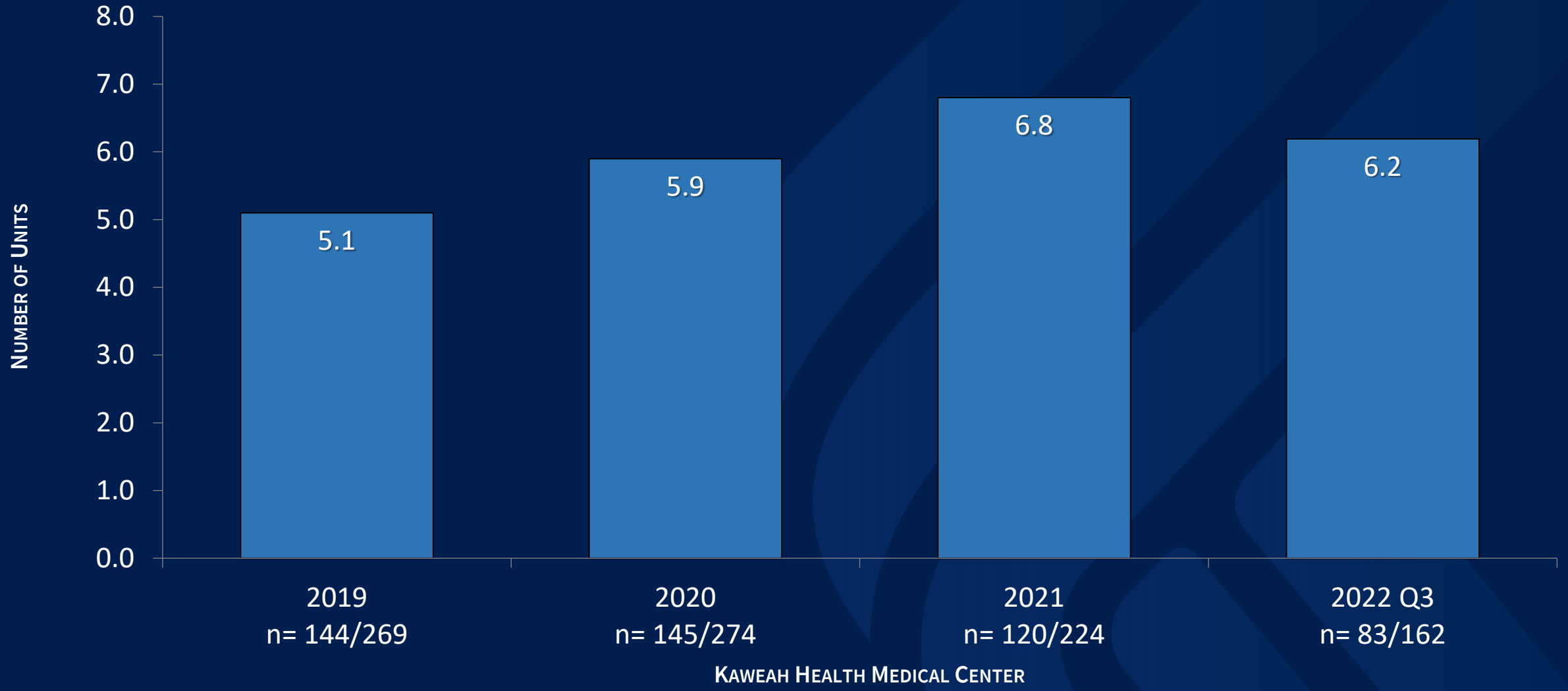
[1]Surgeries include Reoperation for bleeding/tamponade, valvular dysfunction, unplanned coronary artery intervention, aortic reintervention or other cardiac reason, Q3-2020-2021 COVID+ pt.'s Excluded.

Quality Initiative:

Intra-operative Patient Safety

- Time out performed with entire surgical team (Surgeon, Anesthesia, RN, Techs and Perfusion)
- Surgeon led briefing on procedure expectations with entire surgical team after each Time out
- Perfusion check list completed prior to each case
- Minimize trips to the Sterile Core by Nursing staff
- Minimize OR traffic (i.e.: coordinated switching of staff for breaks)
- Noise reduction implemented during cases:
  - Discussions about current surgical case only
  - Avoid conversations about other issues
  - Music to be calming and at a lower volume
  - All phones & beepers at the Nurses desk

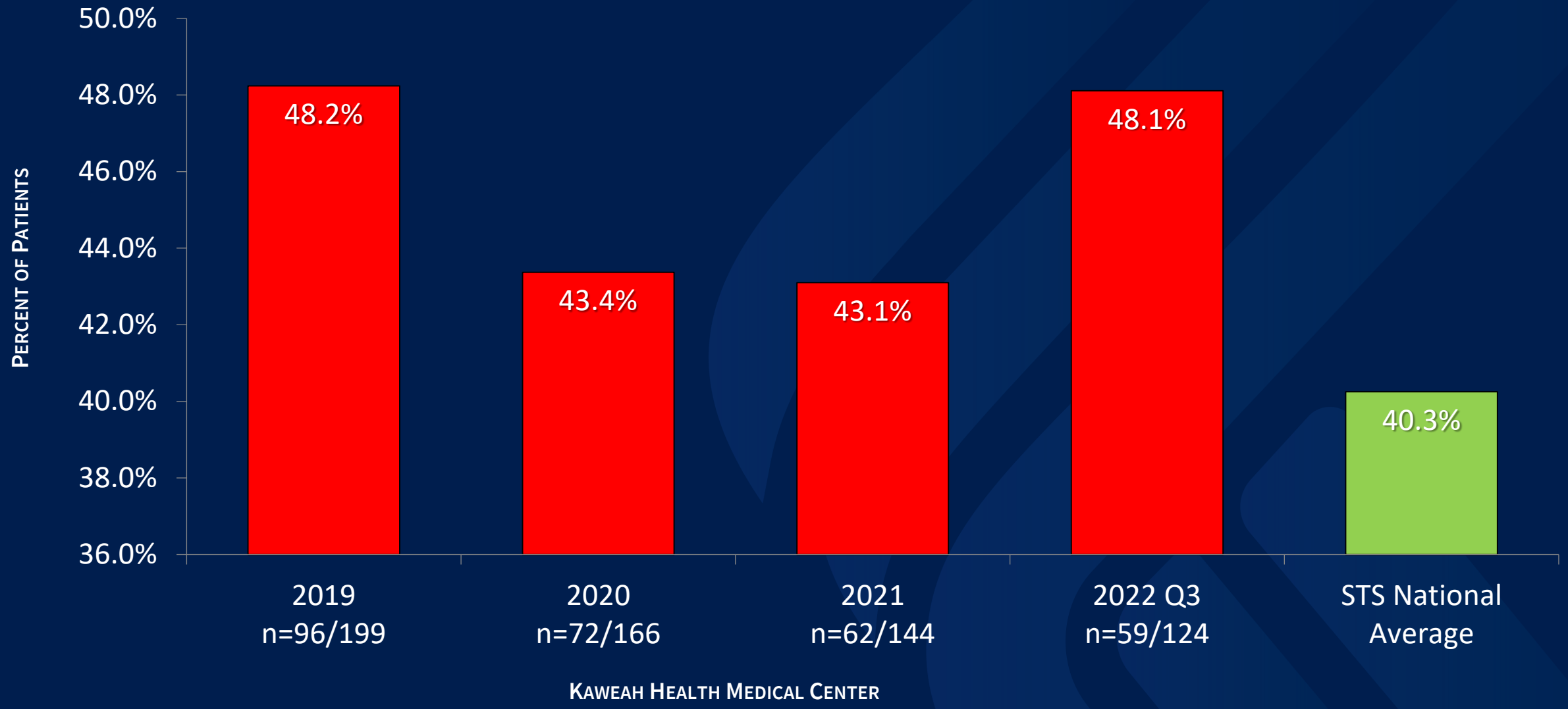
Red Blood Cell Usage - Average Units / Pt. receiving RBC[1] (No National Comparison Data)



[1] All STS surgeries – Includes any blood given Intra-op and Post-op (Excludes patients that did not receive any blood from Average; excludes pre-op Hgb<8, Emergent/Salvage, COVID+ patients Q3 2020-2021)

*Comparison Data is not reported on the STS National Outcomes Report

CABG Intra & Post-Op Blood Product Usage[1]



2022 O/E = 1.2

*STS National Average Comparison reporting period 01/01/2022 through 09/30/2022

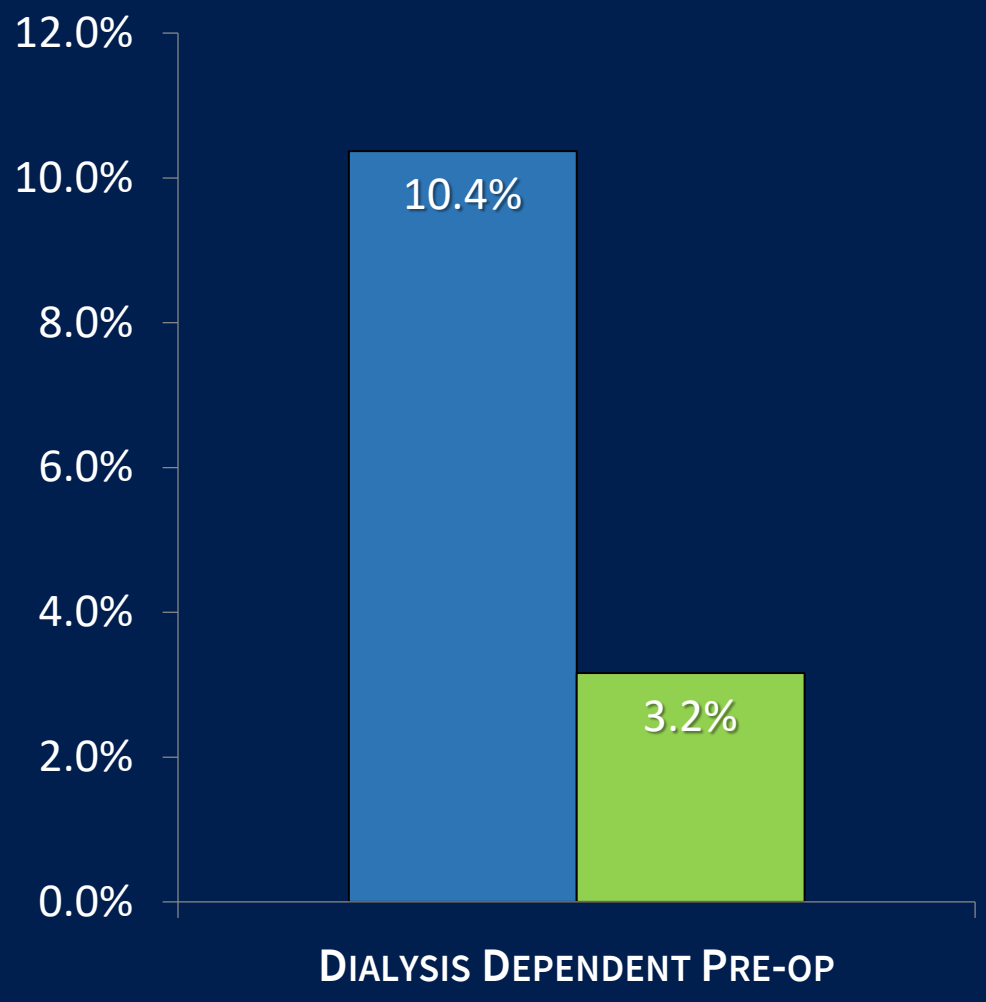
[1]Surgeries where at least one unit of Red Blood Cells, Fresh Frozen Plasma, Platelets or Cryoprecipitate was given Intra-and/or Post-operatively. Q3-2020-2021 COVID+ pt.'s Excluded.

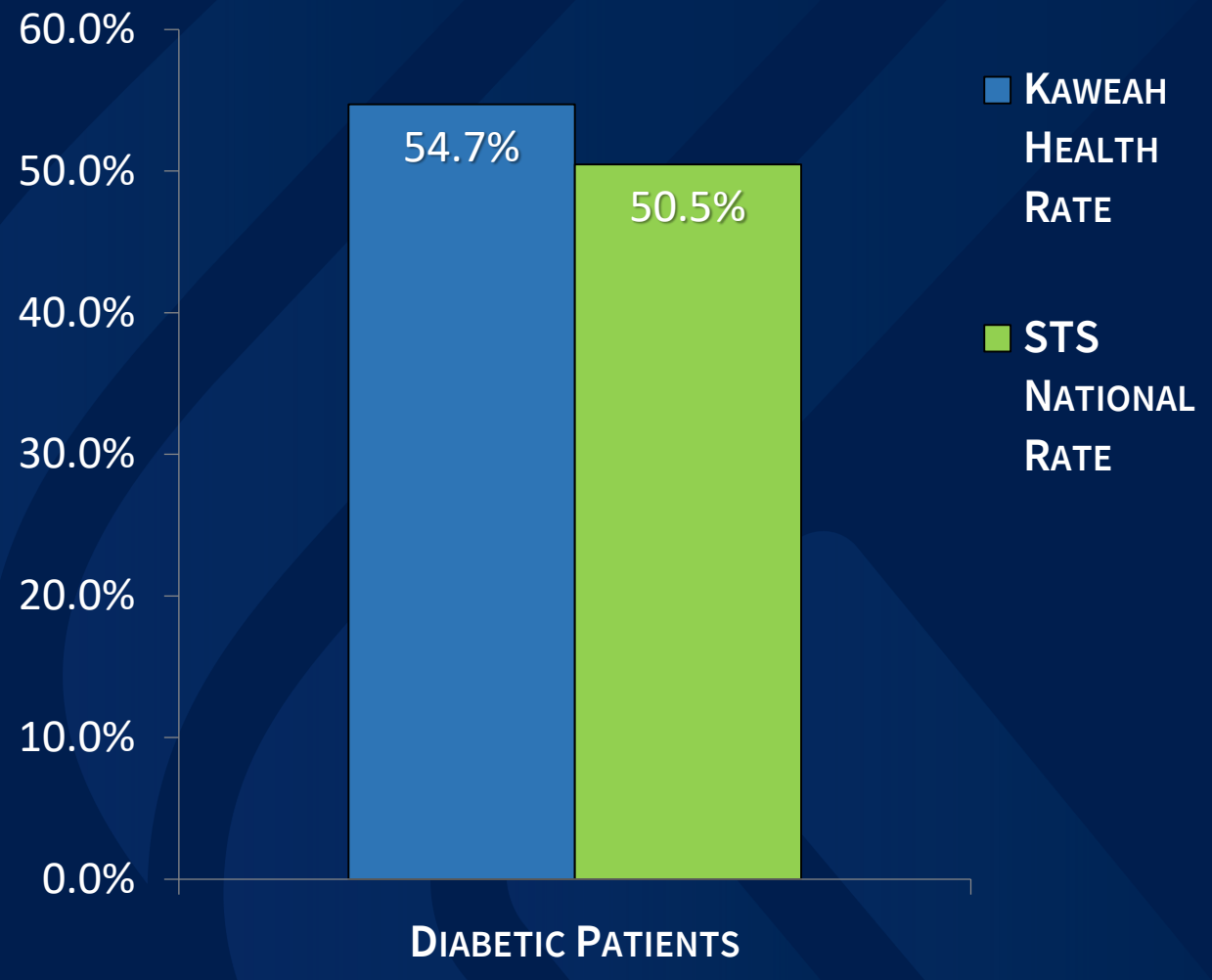
Quality Initiative:

Bleeding Event & Blood Product Usage

- Quarterly review of blood usage throughout Pt. stay
- TEG coagulation monitoring
- Antifibrinolytic agents
- Heparin monitoring
- Heparin coated circuits
- Hemostasis achieved during procedure
- Cell saver utilized during surgery
- Restrictive transfusion criteria
- Surgeon approval of each transfusion
- Treatment of pre-operative anemia or transfusion as needed

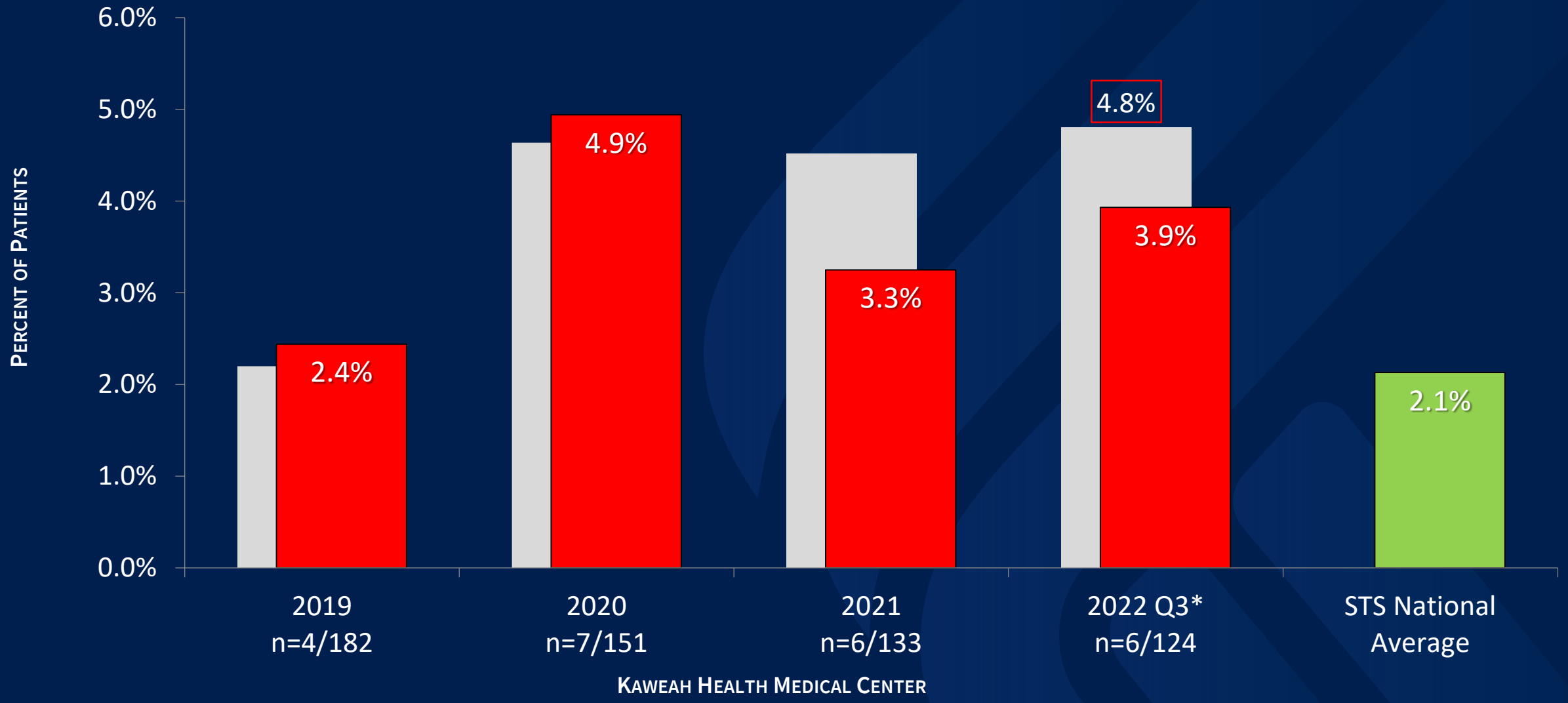
Kaweah Health Pt. Populations





*STS National Average Comparison reporting period 01/01/2022 through 09/30/2022- Isolated CABG cases ONLY

CABG Post-Op Renal Failure[1]
Risk Adjusted in Color



2022 Risk-adjusted O/E = 1.84

*STS National Average Comparison reporting period 01/01/2022 through 09/30/2022

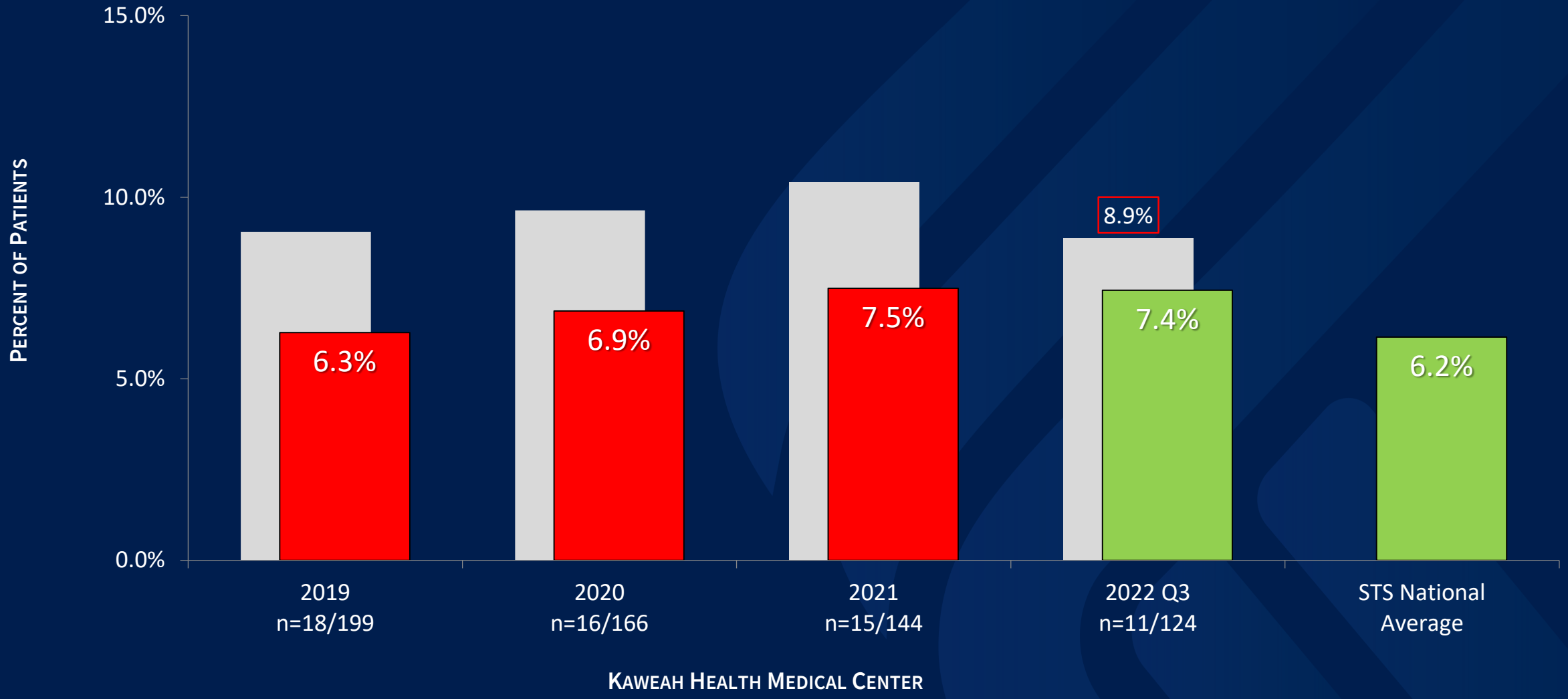
[1] Excludes patients with preoperative dialysis or preoperative Creatinine ≥ 4, Q3-2020-2021 COVID+ pt.'s Excluded.

Quality Initiative:

Renal Failure

- Risk factor evaluation pre-operatively
- Timing of surgery considered
- Diabetes control
- Liberal hydration
- Intra-operative blood flow & pressure controlled by perfusion and anesthesia
- Blood pressure management peri-operatively

CABG Prolonged Ventilation
Risk Adjusted in Color



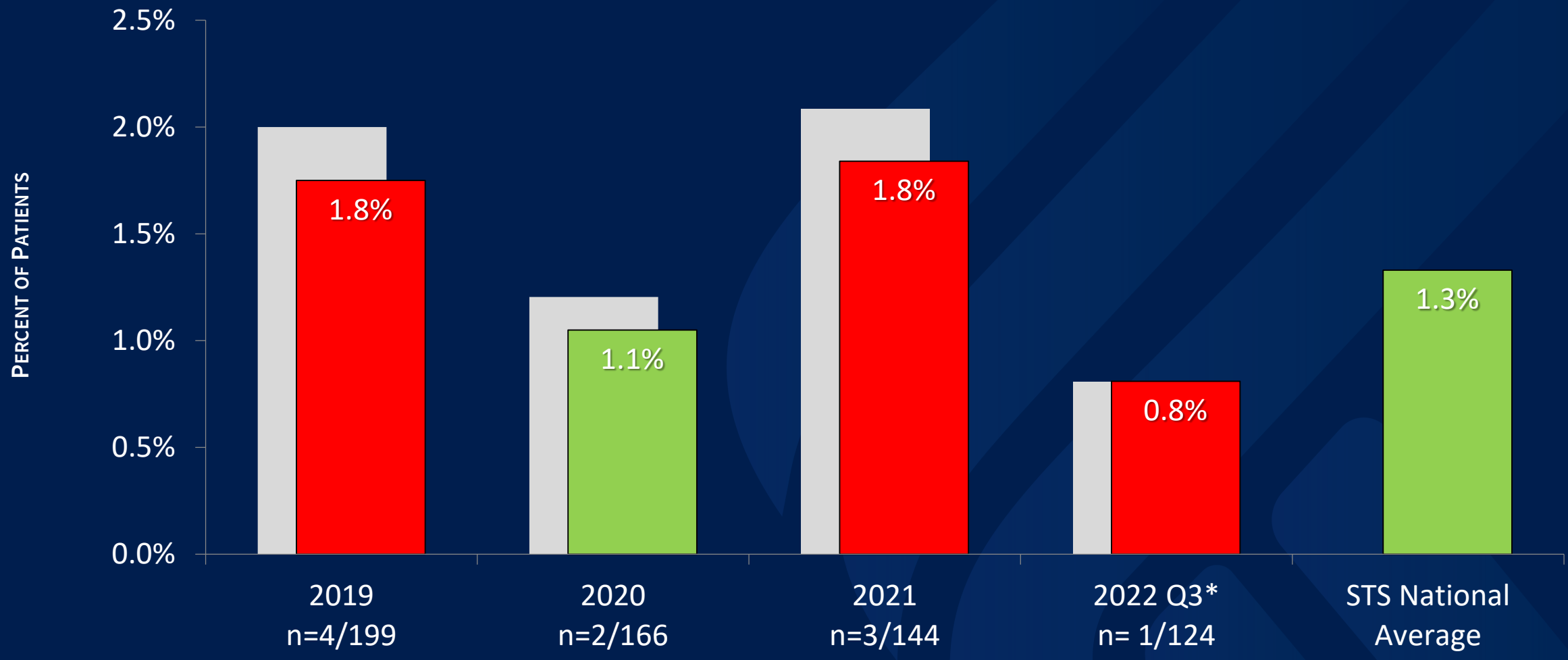
2022 Risk-adjusted O/E = 1.21
*STS National Average Comparison reporting period 01/01/2022 through 09/30/2022
2020Q3-2021 COVID+ pt.'s Excluded.

Quality Initiative:

Prolonged Ventilation

- Monthly audit & analysis of prolonged ventilation times and delayed Extubation due to medical necessity
- Action Plan for 100% completion of Cardiac Extubation Tool ~ monitored by CVICU nurse manager
- Sedation and Analgesia to be used in an appropriate and conservative manner
- Avoid Benzodiazepines and narcotic drips
- To illicit calm awakening utilize Propofol & precedex drips when medically necessary
- Train nursing, medical and ancillary staff on the Fast Track Extubation Protocol available in PolicyTech
- Address ventilation time of each Pt. in rounds and shift reports by RN, RT & MD
- Promote Respiratory Therapy Education Tool for patients
- Review of Anesthesia Protocols
- Positive Base excess or > -2.0 on CVICU arrival
- Core Temperature > 36.0°C on CVICU arrival

CABG Post Op Permanent Stroke
Risk Adjusted in Color



Kaweah Health Medical Center

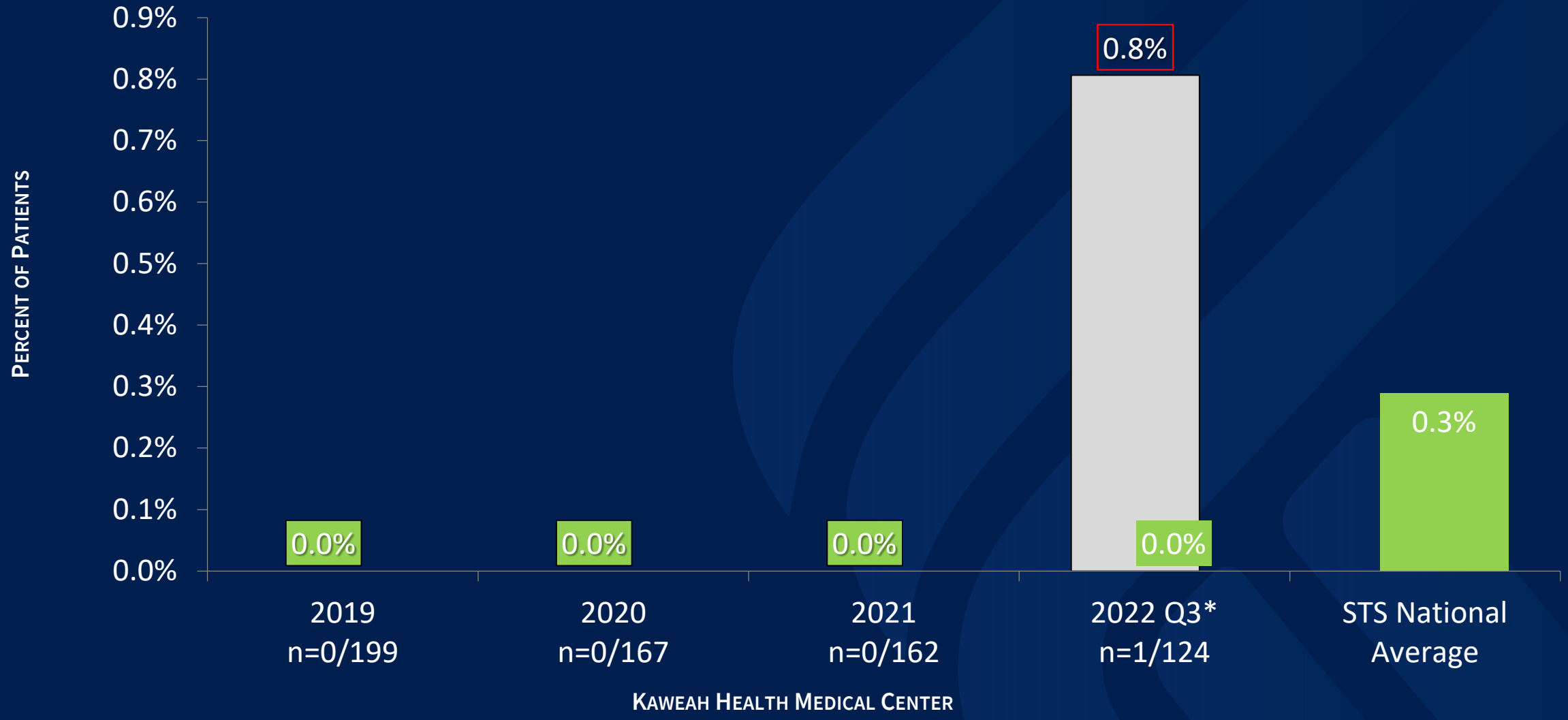
2022 Risk-adjusted O/E = 0.61
*STS National Average Comparison reporting period 01/01/2022 through 09/30/2022
Q3-2020 - 2021 COVID+ pt.'s Excluded.

Quality Initiative:

Stroke Prevention

- Risk factor, neurological evaluation
- TEE, CT of the aorta with evaluation as needed
- Carotid Doppler ~ Ultrasound
- Invox cortical brain monitoring
- Intraoperative blood flow & pressure control by perfusion and anesthesia
- Intraoperative temperature control

CABG Post Op Deep Sternal Wound Infection
Risk Adjusted in Color



2022 Risk-adjusted O/E = 0

*STS National Average Comparison reporting period 01/01/2022 through 09/30/2022

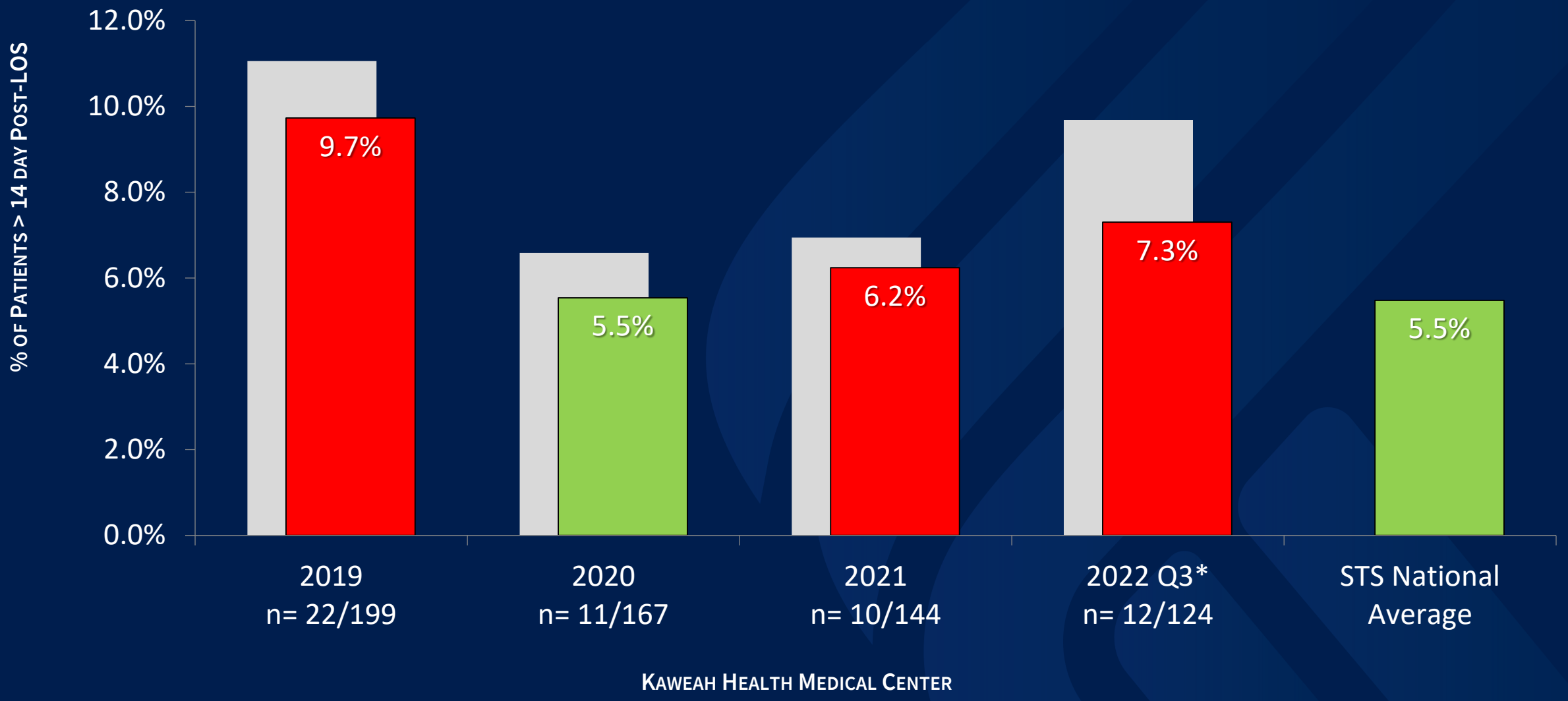
Q3-2020 - 2021 COVID+ pt.'s Excluded.

Quality Initiative:

Infection Prevention

- Glucose control w/ Glucommander – insulin drip or subcutaneous
- Two Chlorhexidine baths prior to surgery
- Chlorhexidine mouth wash used morning of surgery
- MRSA screening of each patient
- Terminal cleaning of operating rooms monitored daily
- Disposable ECG monitoring cables on each patient
- Use of Early closure technique for vein harvest incisions
- Vancomycin paste for sternal application
- Silver Nitrate or Prevena suction dressing applied to sternum
- Prophylactic antibiotic treatment for 48 hours
- Early removal of central lines and Foley catheter

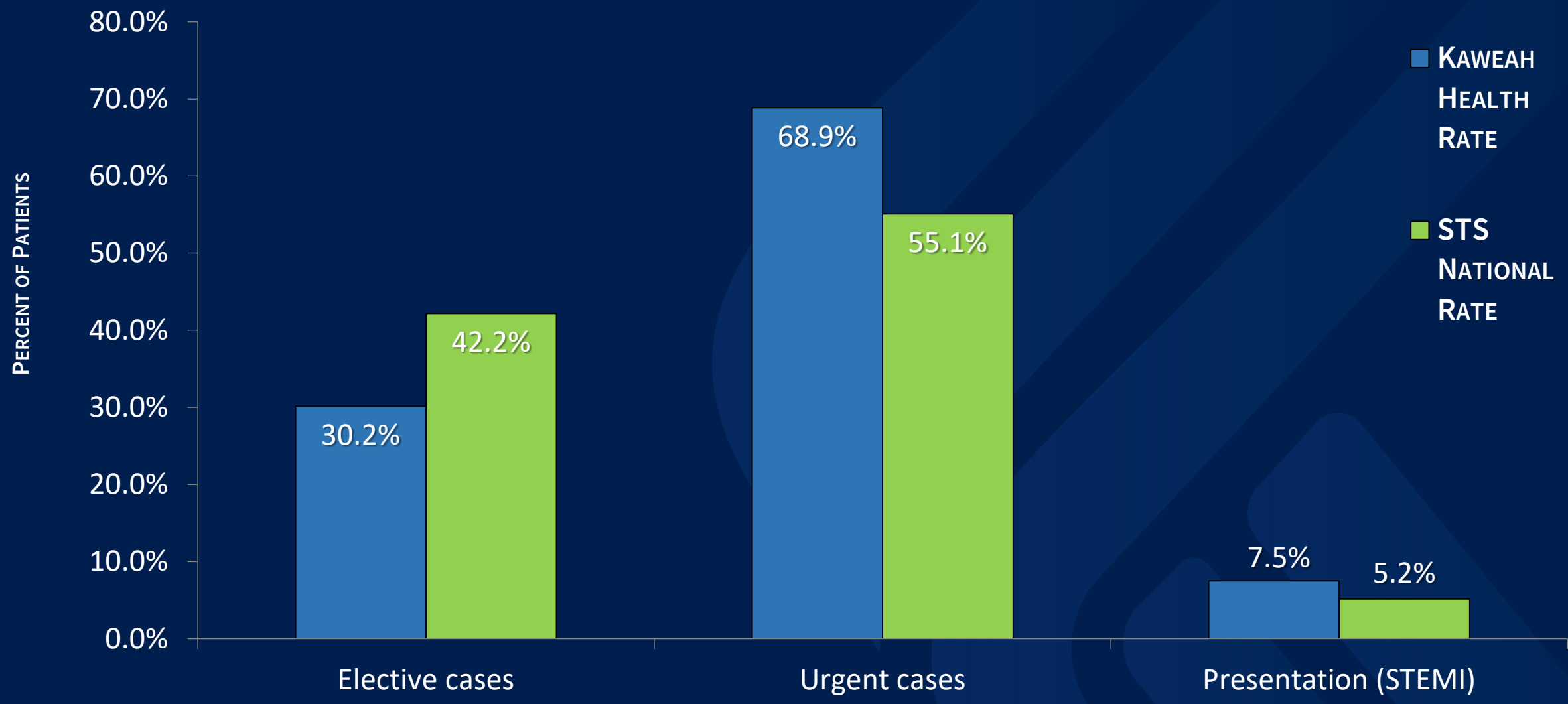
CABG Post Op Length of Stay >14 Days
Risk Adjusted in Color



Kaweah Health Medical Center

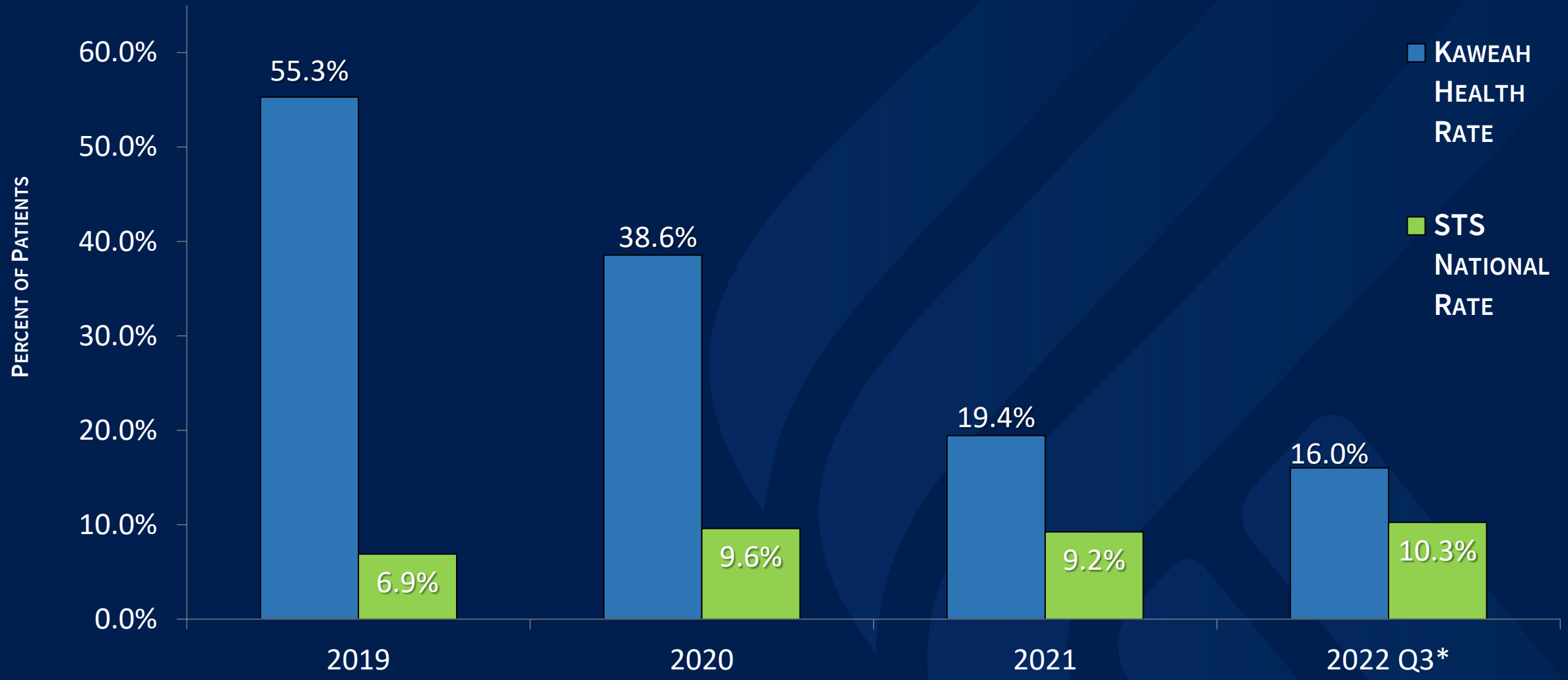
2022 Risk-adjusted O/E = 1.833*STS National Average Comparison reporting period 01/01/2022 through 09/30/2022
Post-operative Length of Stay: Long Stay is greater than 14 days (PLOS > 14 Days), Q3-2020 - 2021 COVID+ pt.'s Excluded.

Kaweah Health Pt. Populations



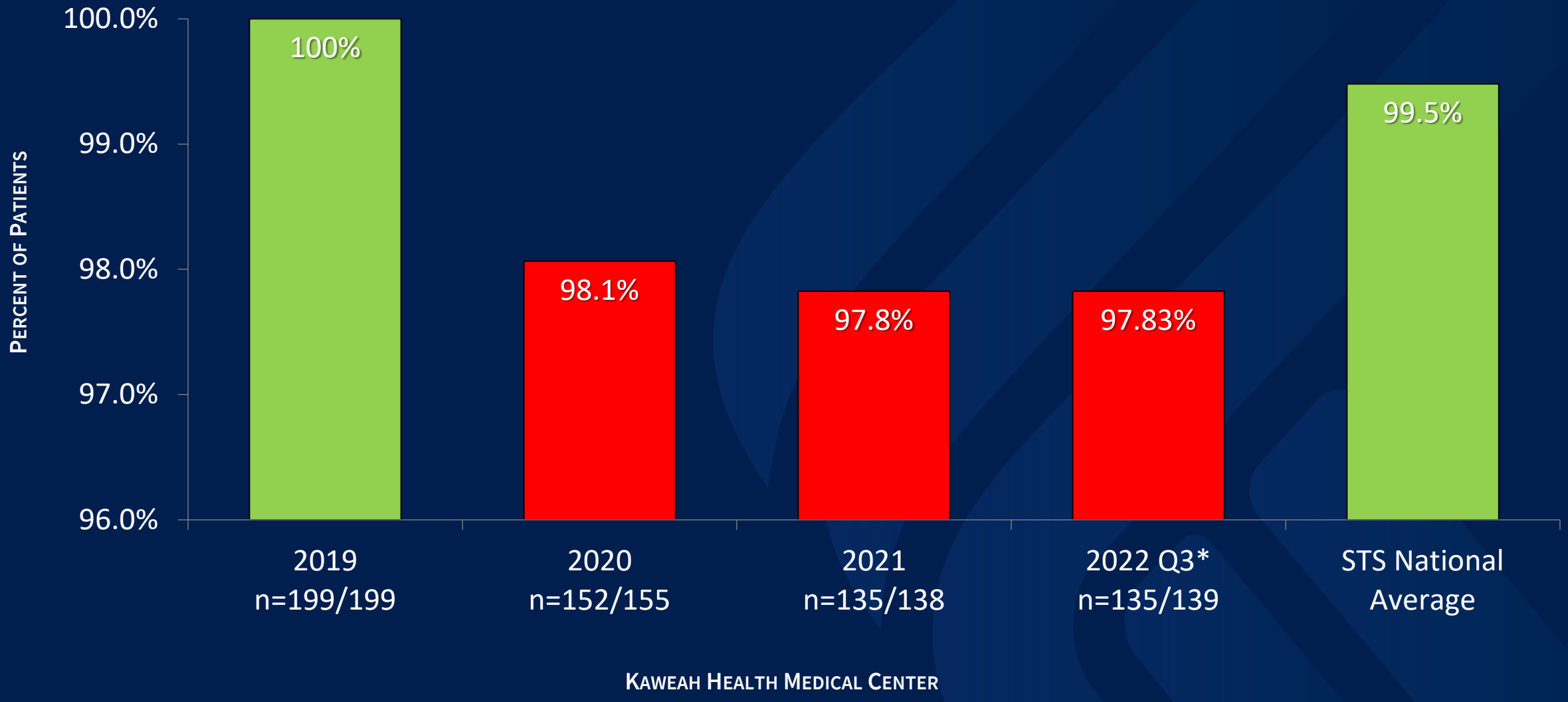
*STS National Average Comparison reporting period 01/01/2022 through 09/30/2022– Isolated CABG cases ONLY

Kaweah Health Radial Artery Usage



*STS National Average Comparison reporting period - 1/1 through 12/31 of each year (except 2022Q3 1/1 through 9/30) – Isolated CABG cases ONLY

CABG Internal Mammary Artery Usage[1]



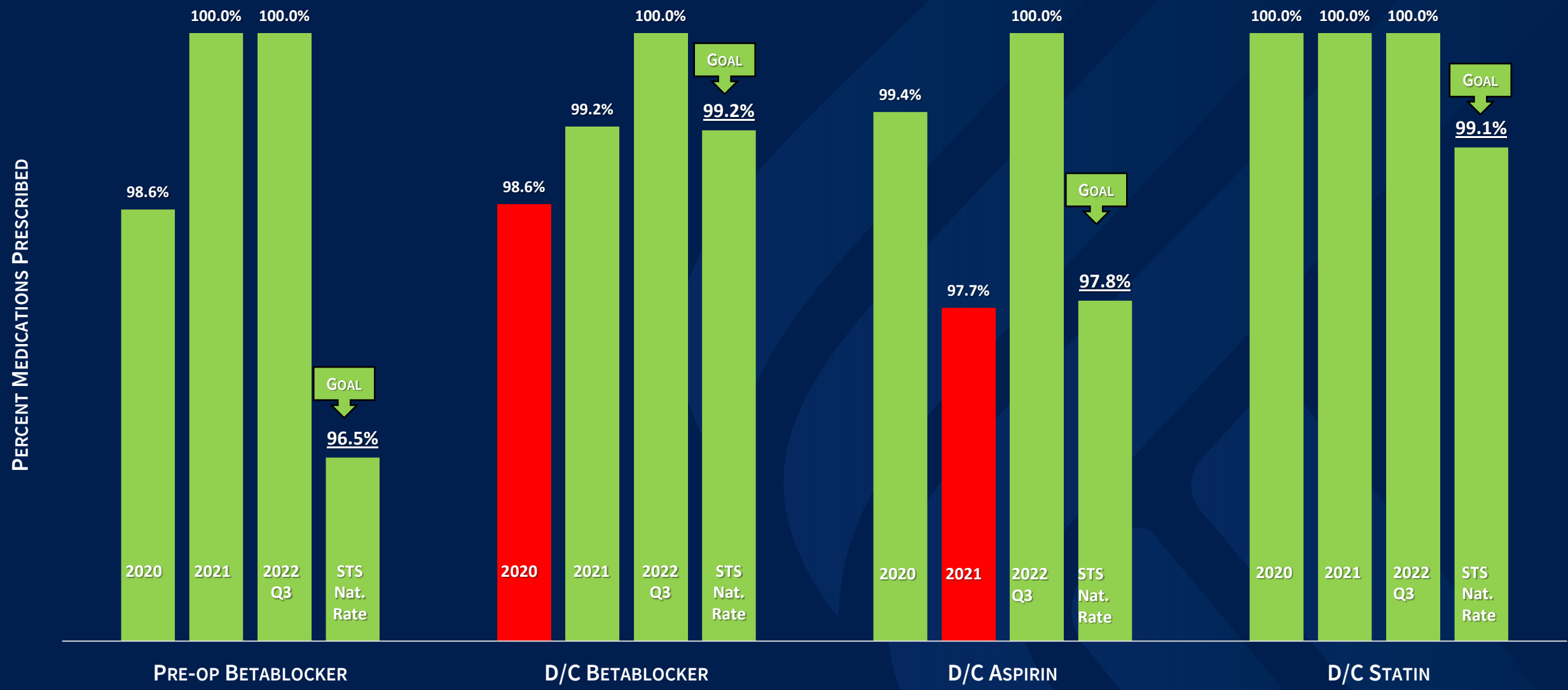
Kaweah Health Medical Center

2022 O/E = 0.98

*STS National Average Comparison reporting period 01/01/2022 through 09/30/2022

[1]Surgeries where at least one internal mammary artery, left or right, was used as a bypass graft. Excludes emergent or salvage cases, No LAD disease, previous thoracic or cardiac surgery, subclavian stenosis or Hx of mediastinal radiation. Q3-2020 – 2021 COVID+ pt.'s Excluded.

CABG Prescribed Medications Pre-op & Discharge



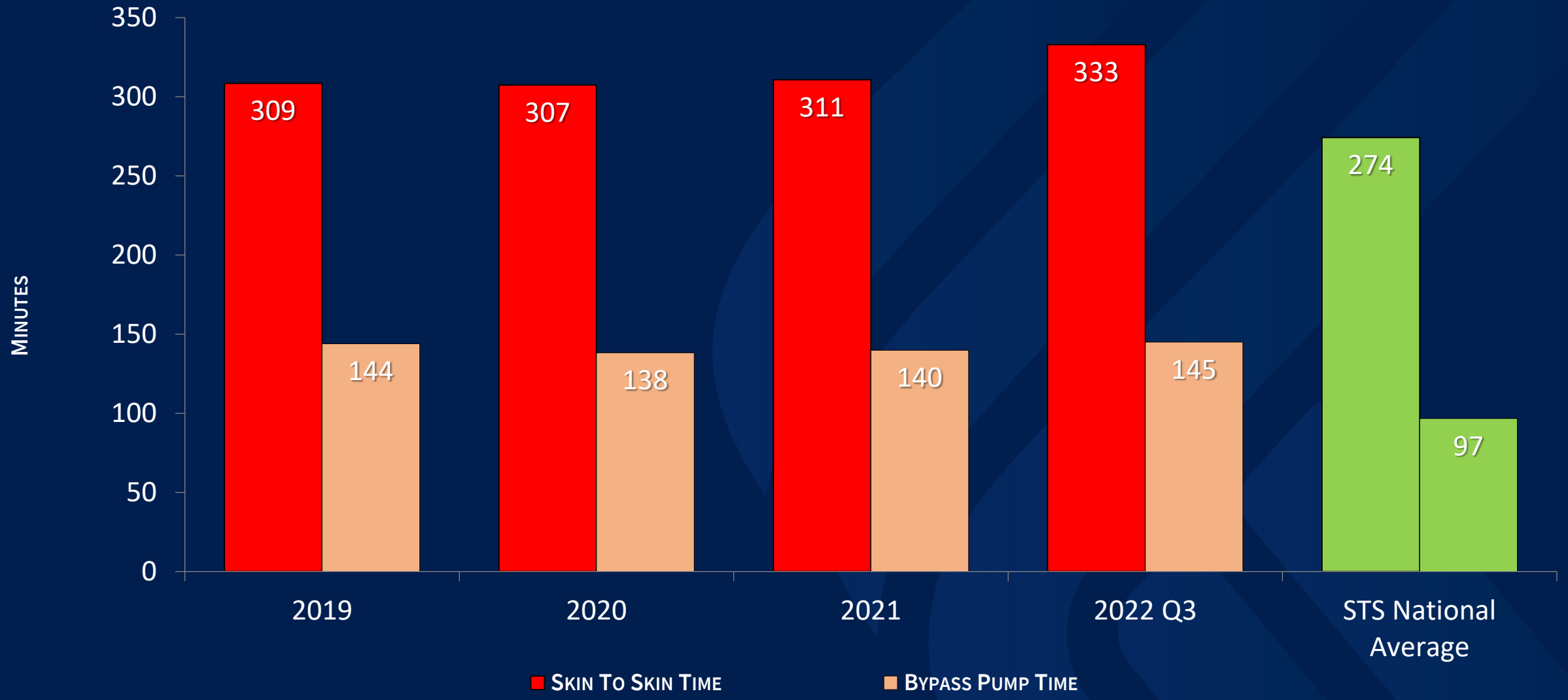
2022 O/E = 1.0

*STS National Average Comparison reporting period 01/01/2022 through 09/30/2022

Performance is measured by the proportion of patients who receive all of the perioperative medications for which the patient is eligible . The required perioperative medications are: 1) preoperative beta blockade therapy; 2) discharge anti-platelet medication; 3) discharge beta blockade therapy; and 4) discharge anti-lipid medication.

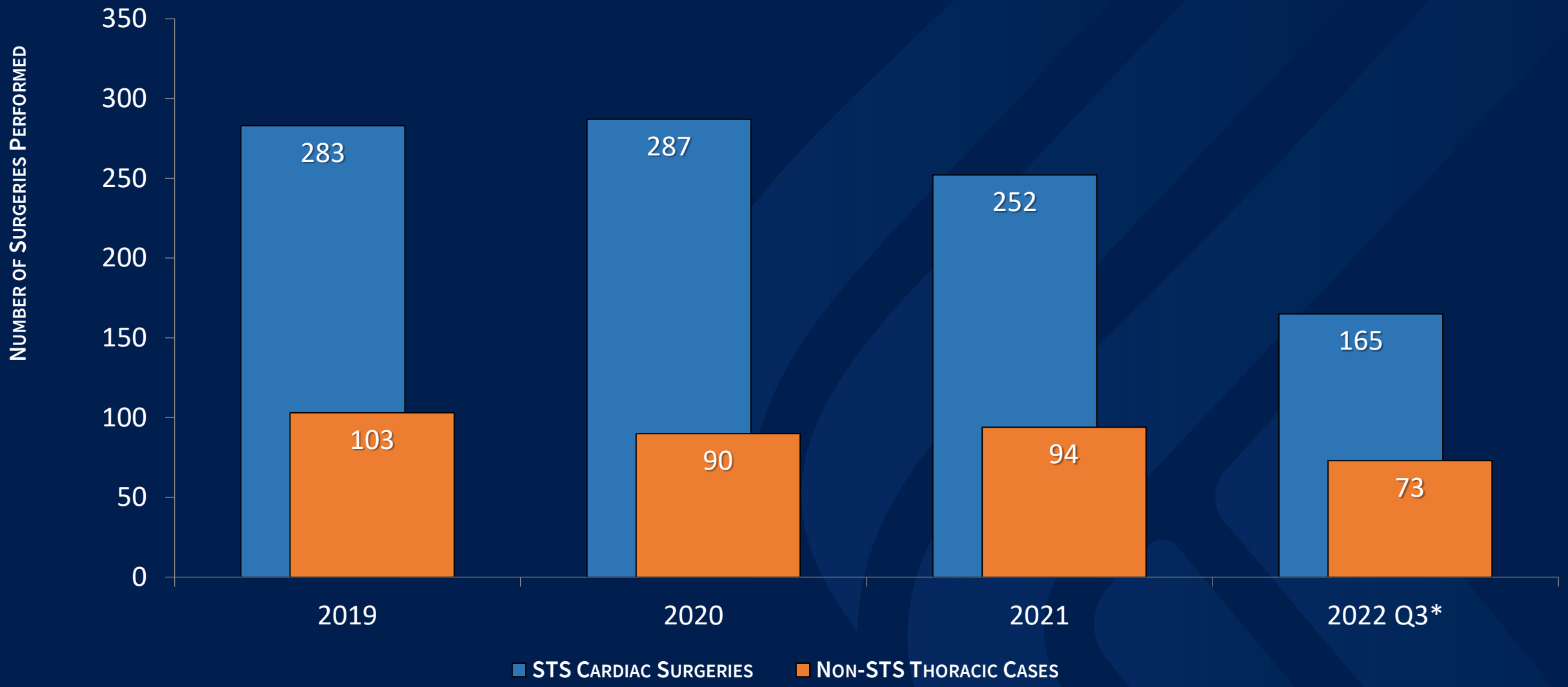
Note: patients who die prior to discharge are not eligible for discharge medications; contraindicated medications are considered non-eligible.

CABG Skin-to-Skin and Bypass Pump Durations



2022 O/E Skin Times = 1.2
2022 O/E Pump Times = 1.5
*STS National Average Comparison reporting period 01/01/2022 through 09/30/2022

Kaweah Health Cardiothoracic Surgery Volumes[1]



[1] Cardiac surgery as defined per STS database. Includes all 7 Major Procedure Categories (CABG, AVR, AVR+CABG, MVR, MVR+CABG, MVP, MVP+CABG) + Other Heart only procedures.

Live with passion.

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

Kaweah Health

Unit/Department Specific Data Collection Summarization

Unit/Department: Pediatrics **ProStaff Report Date: January 2023**

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

Date range of data evaluated:
July-December 2022

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

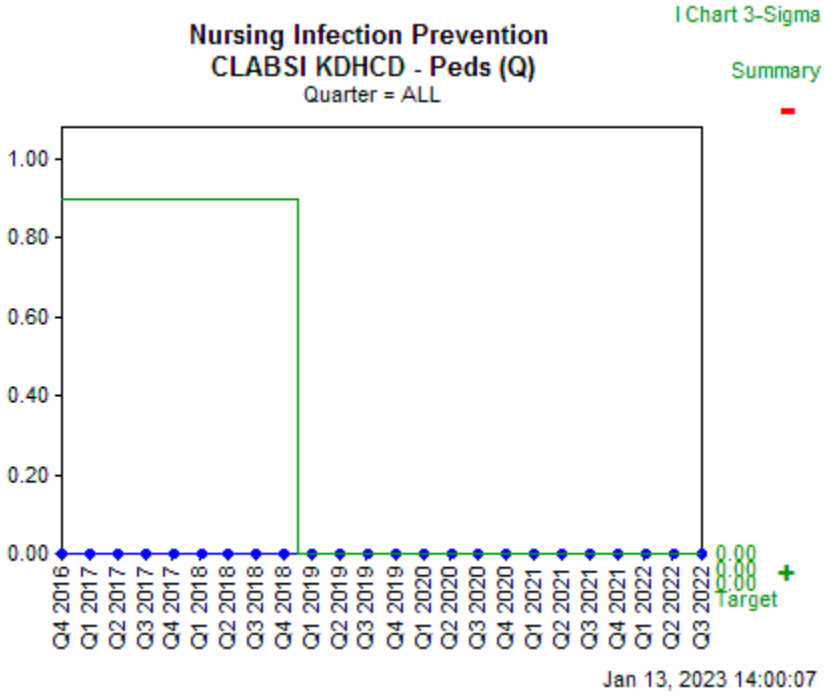
If improvement opportunities identified, provide action plan and expected resolution date:

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:	**Date Submitted:**
Danielle Grimaldi, RN, BSN, CPN	01/13/23

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



Date	KDHCD	Target
Q3 2022	0.00	0.00
Q2 2022	0.00	0.00
Q1 2022	0.00	0.00
Q4 2021	0.00	0.00
Q3 2021	0.00	0.00
Q2 2021	0.00	0.00
Q1 2021	0.00	0.00
Q4 2020	0.00	0.00
Q3 2020	0.00	0.00
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

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 2023**

Measure Objective/Goal:

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

Date range of data evaluated:

July-December 2022

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

Using data received within the last 180 days, we have had an overall 94% 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:

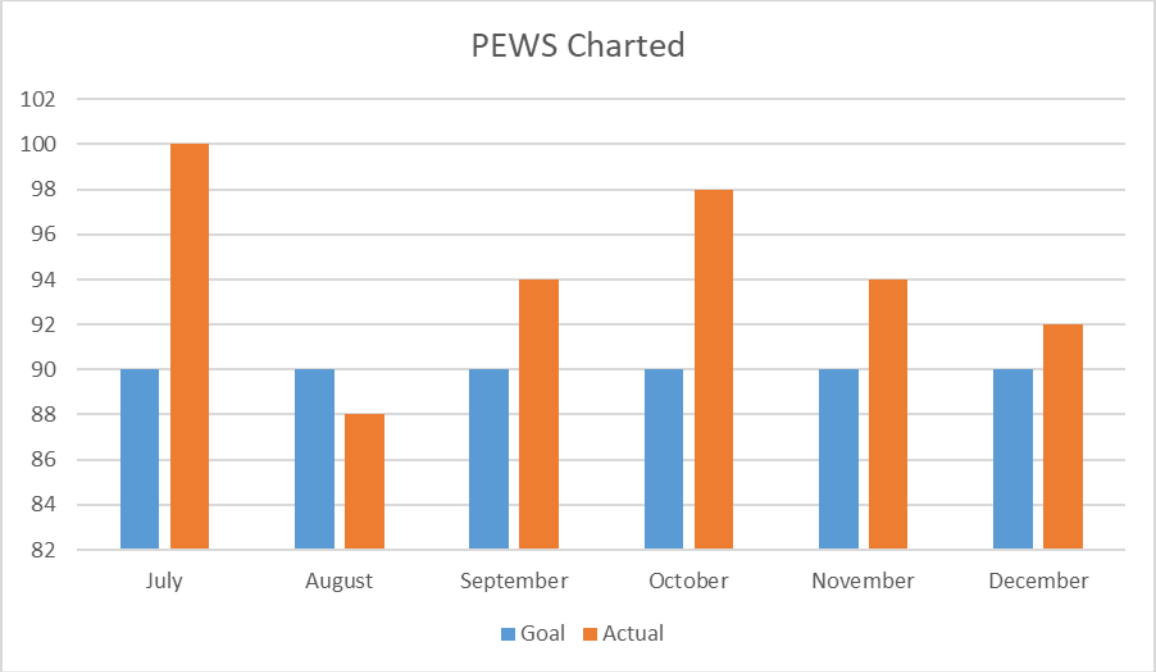
Continue to maintain PEWS scoring greater than 90% expected with next report date.

Submitted by Name:	**Date Submitted:**
Danielle Grimaldi, RN, BSN, CPN	01/13/23

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



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 2023**

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

Date range of data evaluated:
July-December 2022

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:

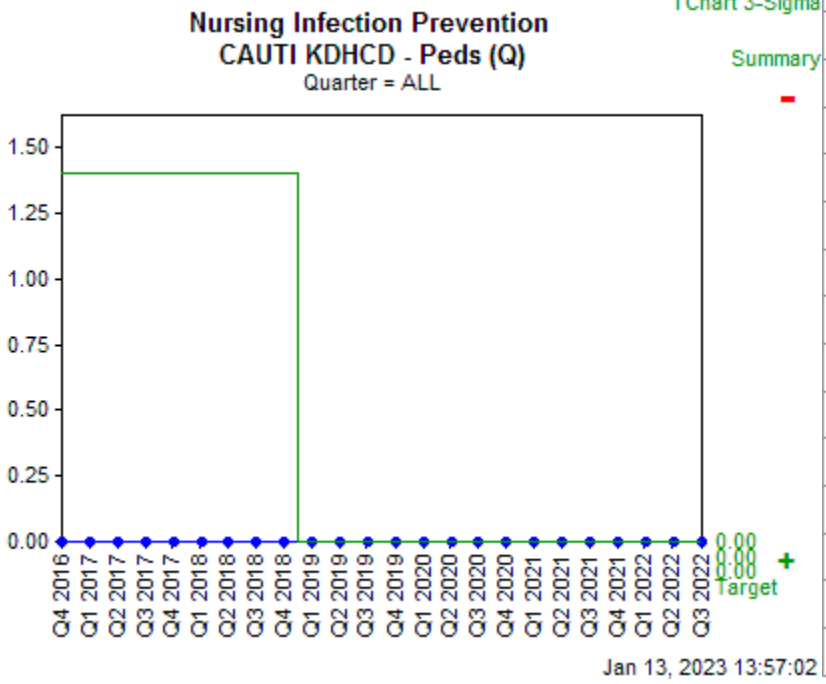
Next Steps/Recommendations/Outcomes:
We will continue to use aseptic technique to insert urinary catheters, and we will continue to provide perineal care every shift. We will also continue to evaluate need for urinary catheter on a daily basis.

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

Date Submitted: 01/13/23

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee



Date	KDHCD	Target
Q3 2022	0.00	0.00
Q2 2022	0.00	0.00
Q1 2022	0.00	0.00
Q4 2021	0.00	0.00
Q3 2021	0.00	0.00
Q2 2021	0.00	0.00
Q1 2021	0.00	0.00
Q4 2020	0.00	0.00
Q3 2020	0.00	0.00
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

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee

Unit/Department: Pediatrics **ProStaff Report Date: January 2023**

Measure Objective/Goal:

Percent of patients with stage 2 or greater HAPI: 0.00
Goal: N/A
Goal Met

Date range of data evaluated:

July-December 2022

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

We had 0 HAPIs stage 2 or greater for this quarter on Peds. Raw data attached reports 2 HAPI's on Peds in 2021. These 2 events were adult pts that were located on the Pediatrics floor as part of the Peds Pod overflow.

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: Danielle Grimaldi, RN, BSN, CPN

Date Submitted: 01/13/23

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

2022 Stage 2+ HAPI QFT Dashboard

Measure Description Outcome Measures	2022 Benchmark/ Target	2019 Baseline	2020 Baseline	2021 Baseline	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	YTD 2022
HAPI Stage 2+ per 1,000 pt days (all HAPIs)	1.13 (-10% from 2021)	1.64	1.61	1.26	0.43	0.36	1.16	0.25	1.41	0.36	0.60	0.00	0.65	0.76	1.02		0.64
Device Associated HAPI per 1,000 pt days	0.55 (-10% from 2021)	0.74	0.72	0.61	0.11	0.12	0.46	0.12	0.94	0.12	0.24	0.00	0.00	0.38	0.13		0.24
PSI 3 - Claims-based HAPI Stage 3, 4, and Unstageable per 1,000 discharges	0.6 - Hospital Compare (Q3 2017-Q2 2019) 0.35 - Midas 50th Percentile (2019)	0.79	0.95	1.42	0.00	0.00	0.00	1.16	0.00	0.00	0.00	0.00	0.00	0.00	0.00		0.11
Process Measures	(-10% from 2021)	2019	2020	2021	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	YTD 2022
Respiratory Device associated HAPI per 1,000 pt days	0.36		0.44	0.40	0.11	0.00	0.00	0.00	0.24	0.00	0.12	0.00	0.00	0.13	0.00		0.05
% of Respiratory Device associated HAPI's (out of all of the device associated HAPI's)	58%		61%	65%	100%	0%	0%	0%	25%	0%	50%	0%	0%	33%	0%		23%
Unit Level	(-10% from 2021)	2019	2020	2021	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	YTD 2022
4N - HAPI 2+ per 1,000 pt days	1.09	1.34	2.02	1.22	0.00	1.28	0.00	0.00	0.00	0.00	0.00	0.00	0.00	2.43	0.00		0.34
3W - HAPI 2+ per 1,000 pt days	2.29	2.26	3.2	2.55	0.00	0.00	0.00	0.00	0.00	0.00	3.85	0.00	0.00	1.98	4.00		0.86
ICU - HAPI 2+ per 1,000 pt days	3.72	7.1	7.44	4.14	0.00	0.00	3.98	0.00	0.00	0.00	0.00	0.00	6.44	0.00	5.33		1.39
CVICU - HAPI 2+ per 1,000 pt days	3.87	5.2	6.23	4.31	5.68	0.00	2.78	3.55	0.00	0.00	3.88	0.00	0.00	0.00	0.00		1.62
2N - HAPI 2+ per 1,000 pt days	0.63	0.1	0.22	0.71	0.00	0.00	1.15	0.00	0.00	0.00	0.00	0.00	0.00	0.00	2.28		0.33
2S - HAPI 2+ per 1,000 pt days	0.81	0.7	1.51	0.90	0.00	0.00	0.00	0.00	0.00	3.52	0.00	0.00	0.00	0.00	0.00		0.31
3N - HAPI 2+ per 1,000 pt days	0.99	0.86	0.72	1.11	0.00	0.00	0.00	0.00	6.92	1.00	0.00	0.00	0.00	0.00	0.00		0.75
3S - HAPI 2+ per 1,000 pt days	0.08	0.46	0.5	0.09	0.00	0.00	0.00	0.00	0.00	0.00	1.10	0.00	0.00	0.00	0.00		0.10
4S - HAPI 2+ per 1,000 pt days	1.03	1.37	0.66	1.15	1.96	0.00	2.02	0.00	3.33	0.00	0.00	0.00	1.16	0.00	1.13		0.90
4T - HAPI 2+ per 1,000 pt days	0.25	1.23	0.45	0.28	0.00	1.65	0.00	0.00	3.38	0.00	0.00	0.00	0.00	0.00	0.00		0.46
BP - HAPI 2+ per 1,000 pt days	0	0	0.62	0	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00		0.00
Rehab - HAPI 2+ per 1,000 pt days	0.14	0.75	0	0.16	0.00	2.38	0.00	2.11	0.00	0.00	0.00	0.00	0.00	0.00	0.00		0.35
5T - HAPI 2+ per 1,000 pt days	1.31		0.4	1.46	0.00	0.00	5.35	0.00	0.00	0.00	1.27	0.00	1.39	4.27	1.36		1.22
Other Units	2022 Benchmark/ Target	2019	2020	2021	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	YTD 2022
ED	n/a	4	3	0	0	0	0	0	0	0	0	0	0	0	0		0
Sub-Acute	n/a	5	6	5	0	0	0	0	0	0	0	0	0	0	1		1
Surgery	n/a	6	0	0	0	0	0	0	0	0	0	0	0	0	0		0
Cath Lab	n/a	1	0	0	0	0	0	0	0	0	0	0	0	0	0		0
Pediatrics	n/a	0	0	2	0	0	0	0	0	0	0	0	0	0	0		0
Mother Baby	n/a	1	0	0	0	0	0	0	0	0	0	0	0	0	0		0
Transitional Care (South Campus)	n/a	1	1	1	0	0	0	0	0	0	0	0	0	1	0		1
Short Stay (Rehab)	n/a	0	0	3	0	0	0	0	0	0	0	0	0	0	0		0
Lab	n/a				0	0	0	0	0	0	0	1	0	0	0		1

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 2023**

Measure Objective/Goal:

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

Date range of data evaluated:

July-December 2022

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

Using data received within the last 180 days, we have had an overall 94% 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:

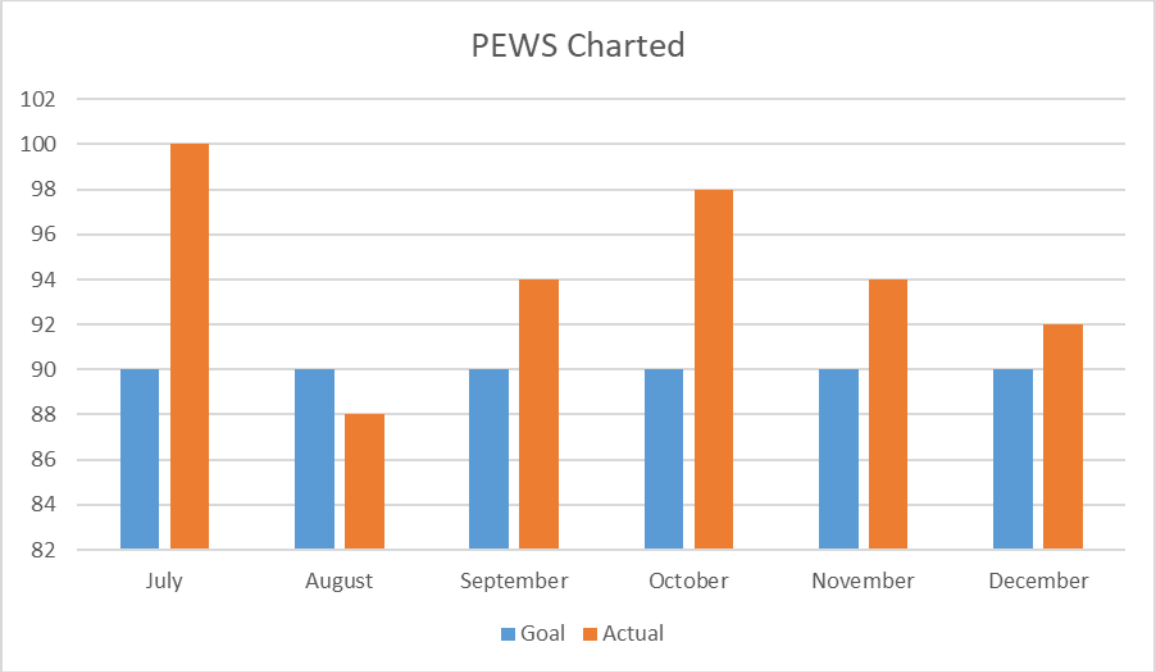
Continue to maintain PEWS scoring greater than 90% expected with next report date.

Submitted by Name:	**Date Submitted:**
Danielle Grimaldi, RN, BSN, CPN	01/13/23

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



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 2023

Measure Objective/Goal:

1. Early Elective Induction of patient with no medical indication
    a. **Goal is 0%**
2. Decision to ready time for unscheduled Cesareans Sections less than or equal to 30 minutes
    a. **Goal is 90%**
3. Pitocin use for labor induction/augmentation to be started in less than or equal to 1 hour of order received
    a. Goal is 90%
4. Pitocin increased by 2 mu/minor 5mu/min(depending on order) every 30 minutes until regular uterine contractions achieved defined as contractions every 2-3 minutes, lasting 80-90 seconds
    a. Goal is 90%
5. ERAC Data:
    No Data at this time due to staffing issues in Quality Dept.
6. Bio-vigil Compliance:
    a. Goal is 95%

Date range of data evaluated:

July 2022 – December 2022

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 not met, only 1 of 4 months at 0%. We do not have data for November and December 2022 as CMQCC is 2 months behind.
2. A recent change in leadership occurred 1/8/2023. After further review there was no data collection for this measure during the time frame July 2022 – December 2022.
3. A recent change in leadership occurred 1/8/2023. After further review there was no data collection for this measure during the time frame July 2022 – December 2022.
4. A recent change in leadership occurred 1/8/2023. After further review there was no data collection for this measure during the time frame July 2022 – December 2022.

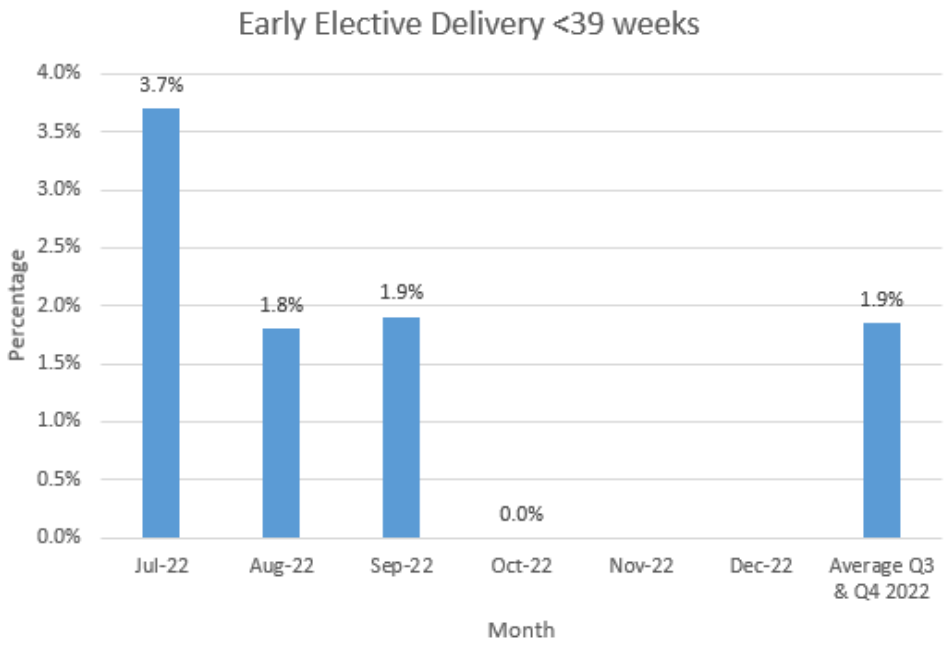
Please submit your data along with the summary to your PI liaison 2 weeks prior to the scheduled report date.

5. No Data at this time due to staffing issues in Quality Department.
6. Goal met at 96.3%

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

1. Goal met only 1 of 4 months, Will continue to monitor and work with the providers to meet this goal.
2. We will start fresh collecting data for this measure January 2023.
3. We will start fresh collecting data for this measure January 2023.
4. We will start fresh collecting data for this measure January 2023.
5. We will work with the Quality Department to establish a timeline on when we can expect data.
6. Goal met, we will continue to monitor.

Submitted by Name: **Melissa Filiponi** **Date Submitted:** **01/18/2023**



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

BIOVIGIL®

Kaweah Health

Department Compliance

6/30/2022 11:00:00 PM (-08:00) - 12/31/2022 5:32:00 PM (-08:00)

Department	Total Compliant (HHO)	Total (HHO)	Entry Compliance	Exit Compliance	Total Compliance	Entries Cross-Contaminated Non-Compliant
Labor Delivery	124,358	129,142	95.1%	97.4%	96.3%	0.64%
	124,358	129,142				

Non-Compliant (<= 95.0%)	OFI (Opportunity for Improvement) (<= 97.5%)	Compliant (> 97.5%)

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, 2023*

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:

July 2022 through December 2022 (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 37 months. 587 Central line days in this reporting timeframe.* ***Goal met.***

CLABSI Rate for KDMC NICU 2022

Month	Indicator Value	Benchmark Value	Central line days in this month	# of CLABSI	Year to date # of Central Line Days
1st quarter					
January	0/1000	1.32/1000	64	0	64
February	0/1000	1.32/1000	37	0	101
March	0/1000	1.32/1000	34	0	135
2nd Quarter					
April	0/1000	1.32/1000	47	0	182
May	0/1000	1.32/1000	35	0	217
June	0/1000	1.32/1000	73	0	290
3rd Quarter					
July	0/1000	1.32/1000	67	0	357
August	0/1000	1.32/1000	33	0	390
September	0/1000	1.32/1000	29	0	419
4th Quarter					
October	0/1000	1.32/1000	54	0	473
November	0/1000	1.32/1000	49	0	522
December	0/1000	1.32/1000	65	0	587

Indicator 1: CLABSI Rate at KDMC NICU

Benchmark Source: NHSN/CDC 2012 NICU Level II/III

Level of benchmark: 1.32/1000 patient days. Pooled mean all weights

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

2. *KD NICU VAP- No VAP in the NICU. 82 vent days in this reporting timeframe.* ***Goal met***

	VAP Rate NICU 2022		
1st Quarter	Indicator Value	Benchmark Value	Vent Days
January	0	1.15/1000	0
February	0	1.15/1000	9
March	0	1.15/1000	5
2nd Quarter			
April	0	1.15/1000	21
May	0	1.15/1000	11
June	0	1.15/1000	7
3rd Quarter			
July	0	1.15/1000	17
August	0	1.15/1000	5
September		1.15/1000	6
4th Quarter			
October	0	1.15/1000	5
November	0	1.15/1000	8
December	0	1.15/1000	2
			Total Vent days for the Year- 82

Indicatory 1: VAP Rate at KDMC NICU

Benchmark Source: NHSN 2012 Pooled mean of all weight groups

Level of Benchmark: 1.15/1000 patient days. NICU Level II/III

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

3. *Hand Hygiene Opportunities > 97.5%- Over all Hand Hygiene date for the given reporting timeframe-96.47% Goal not met*

BIOVIGIL®
Kaweah Health

Compliance by Month
5/31/2022 11:00:00 PM (-08:00) - 12/31/2022 2:40:00 PM (-08:00)

Month	Total Compliant (HHO)	Total Non Compliant (HHO)	Total (HHO)	Entry Compliance	Exit Compliance	Total Compliance
December 2022	778,729	28,555	807,284	95.35%	97.47%	96.46%
November 2022	807,210	29,580	836,790	95.29%	97.54%	96.47%
October 2022	958,433	34,750	993,183	95.38%	97.53%	96.50%
September 2022	969,454	35,405	1,004,859	95.34%	97.52%	96.48%
August 2022	1,076,471	40,910	1,117,381	95.20%	97.38%	96.34%
July 2022	1,064,872	39,030	1,103,902	95.38%	97.46%	96.46%
June 2022	1,124,774	39,843	1,164,617	95.49%	97.58%	96.58%
May 2022	956	32	988	96.35%	97.13%	96.76%
Total	6,780,899	248,105	7,029,004	95.35%	97.50%	96.47%

Non-Compliant (<= 95.0%) | *OFI (Opportunity for Improvement) (<= 97.5%)* | *Compliant (> 97.5%)*

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. Daily GEMBA rounding on all central lines.*
2. *NICU VAP policy and bundle in place-continue to work towards quicker extubation rates.*
3. *Soap and water as well as hand sanitizer available in every patient room. Continue to monitor compliance beyond reporting requirements. Continue to monitor opportunities for success 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.*

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

Submitted by Name:
Felicia T. Vaughn

Date Submitted:
January 12th, 2023

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: January 2023**

Measure Objective/Goal:

Our goal is to increase communication and patient awareness in their plan of care through use of the whiteboards installed in each room. The whiteboards are updated at the beginning of every shift and throughout the shift as the plan of care changes. Our internal benchmark is 100%.

Date range of data evaluated:

July 2022 – December 2022

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

We currently are performing below the benchmark of 100%. Our current measure of success is as follows:

- July - September 2022 94.33%
- October - December 2022 94.67%

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

We participated in the hospital wide initiative and audits occur once per shift every week. Those fallouts are addressed individually with the responsible care team and corrected in the moment.

Next Steps/Recommendations/Outcomes:

We will continue to monitor this measure until we achieve and sustain 100% compliance rate.

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

Date Submitted: 01/18/2023

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: January 2023**

Measure Objective/Goal:

CDPH Model Hospital policy directs us to assess the infant at the breast for early identification of latch-on difficulties and direct observation of the infant at breast to assure adequate breastfeeding prior to discharge. We utilize the LATCH assessment tool and it is required to be assessed at least one time during the shift while the infant is at the breast. Our internal benchmark is 100%.

Date range of data evaluated:

July 2022 – December 2022

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

We currently are performing below the goal of 100%. Our measure of success was as follows:

- July - September 2022 86.60%
- October - December 2022 70.00%

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

Education has been provided through several avenues including unit huddles, breastfeeding education class and UBC group discussions and minutes. Reminders are occurring shift to shift and peer to peer as well. Individuals who have fall outs are addressed individually and provided with education.

Next Steps/Recommendations/Outcomes:

We will continue to monitor this measure until we achieve and sustain 100% compliance rate.

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

Date Submitted: 01/18/2023

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: January 2023**

Measure Objective/Goal:

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

Date range of data evaluated:

July 2022 – December 2022

- July – September 2022 61.76%
- October – December 2022 62.56%

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

We currently are performing above the benchmark of 52.2% however we have seen a decline in our exclusive breastfeeding rates and we believe there is a direct correlation with allowing an additional visitor.

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

We are currently fully staffed with 7 days 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 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 continue to follow-up on those babies who receive formula when mom's choice was exclusive breastfeeding through 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. We relaunched our FREE breastfeeding classes (virtually) in February 2022 in hopes to provide more education to our community.

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: 01/18/22

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: January 2023**

Measure Objective/Goal:

To ensure that those providing direct patient care are performing hand hygiene in an effort to reduce hospital acquired infections. The internal goal is 95%.

Date range of data evaluated:

July 2022 – December 2022

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

We currently are performing above the benchmark of 95%. Our measure of success is as follows:

- July – September 2022 97.70%
- October – December 2022 97.50%

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

Those who are non-compliant are addressed individually.

Next Steps/Recommendations/Outcomes:

We will continue to monitor this measure until we achieve and sustain 95% compliance rate.

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

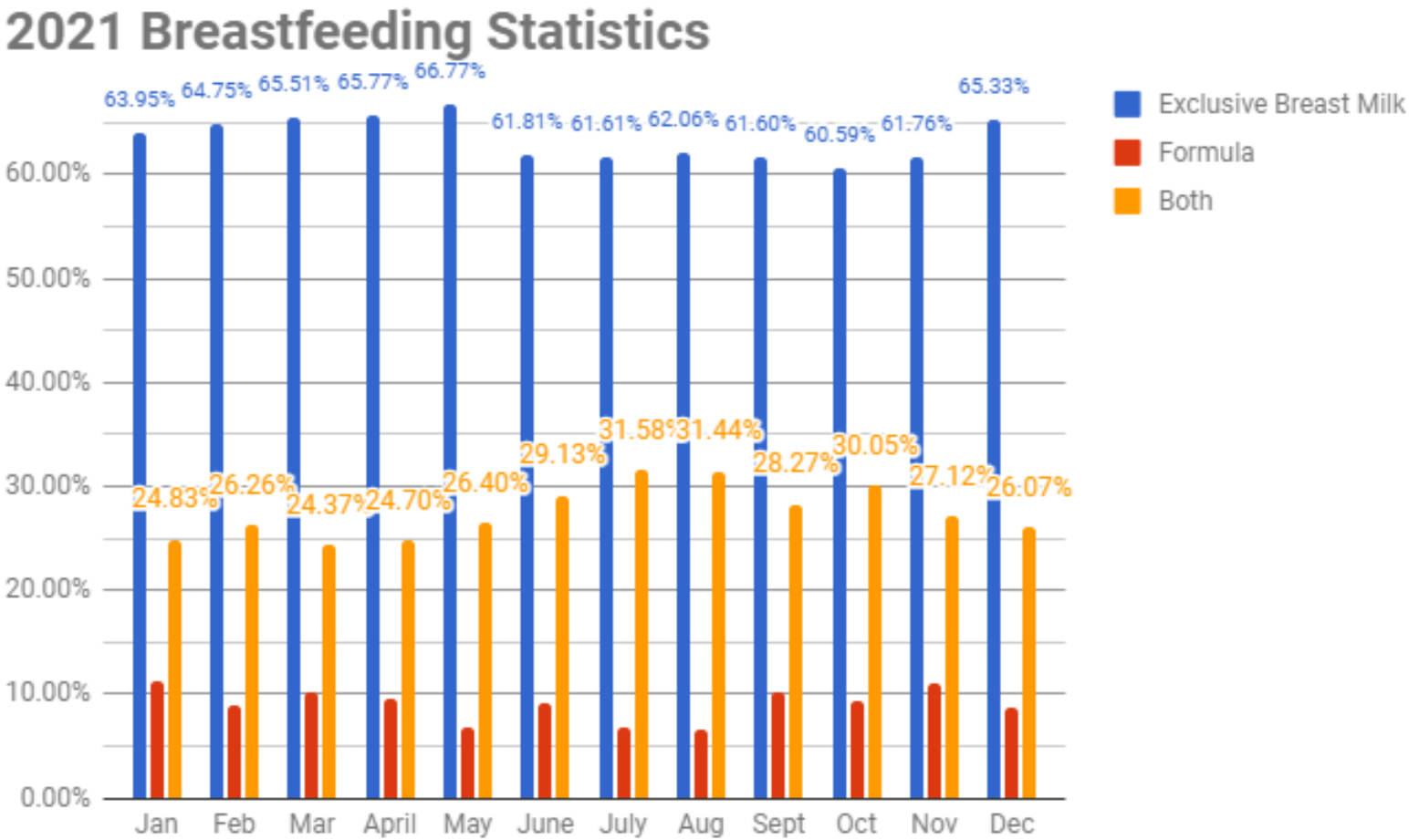
Date Submitted: 01/18/2023

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

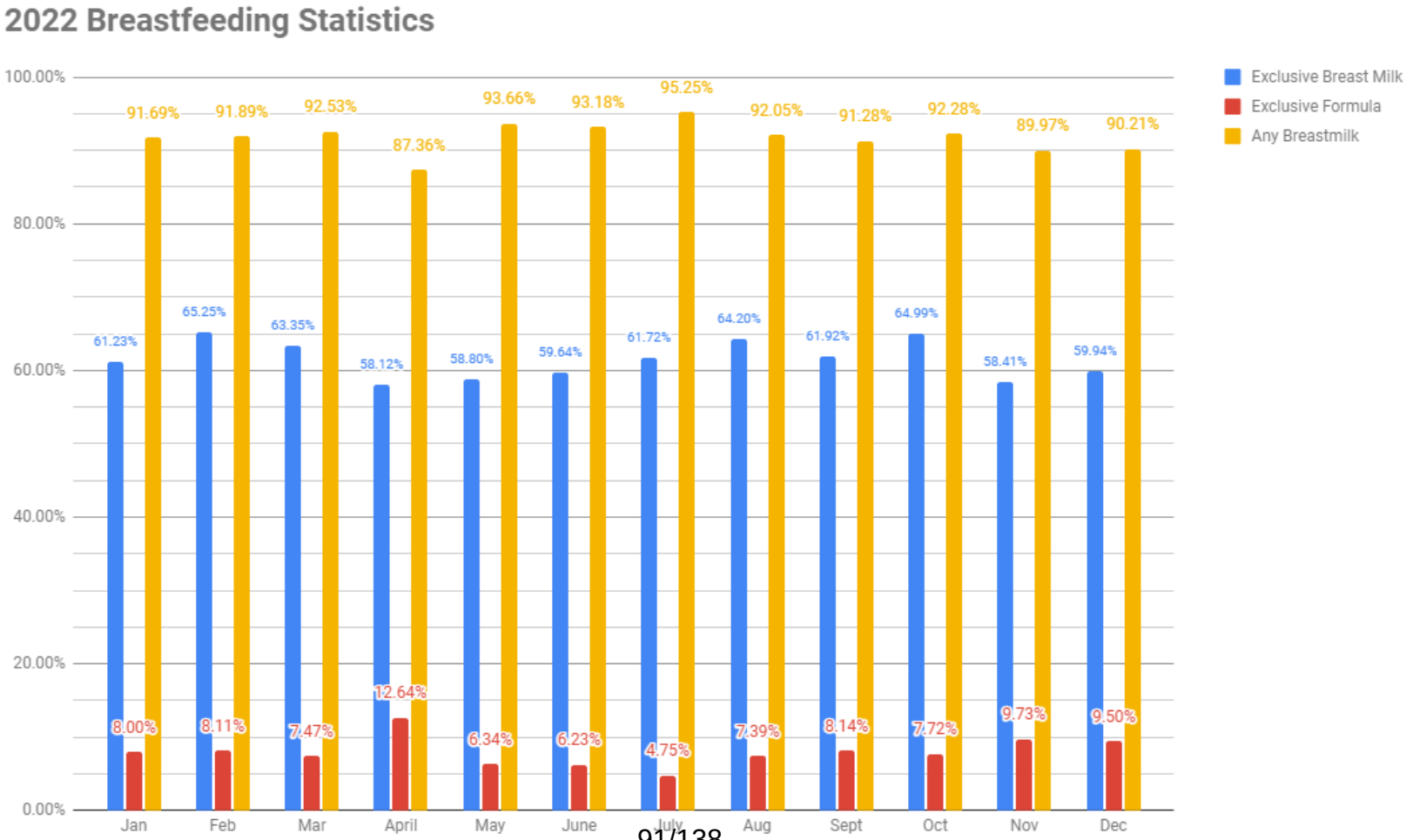
MOTHER/BABY QUALITY DATA

JULY – DECEMBER 2022

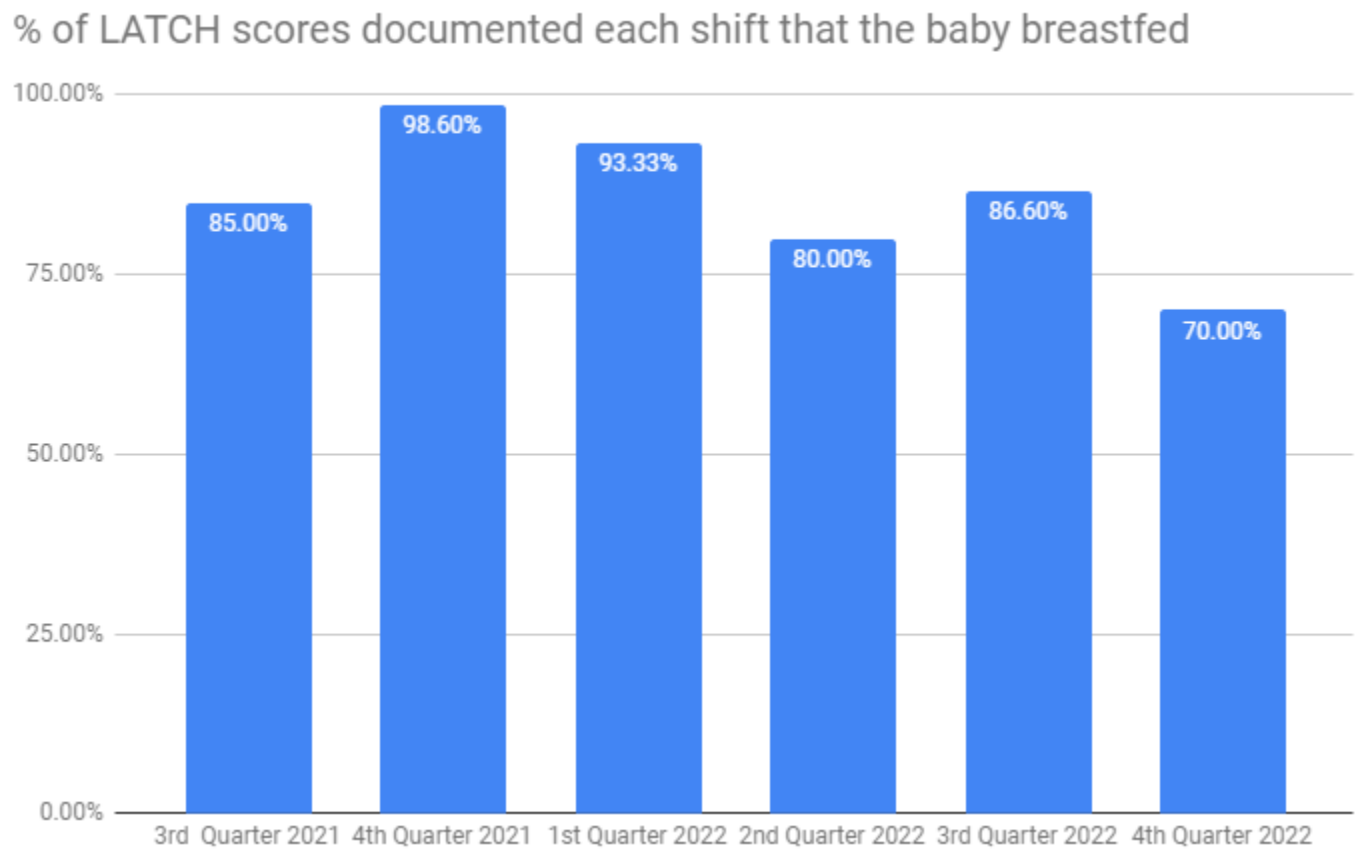
BREASTFEEDING STATS - 2021



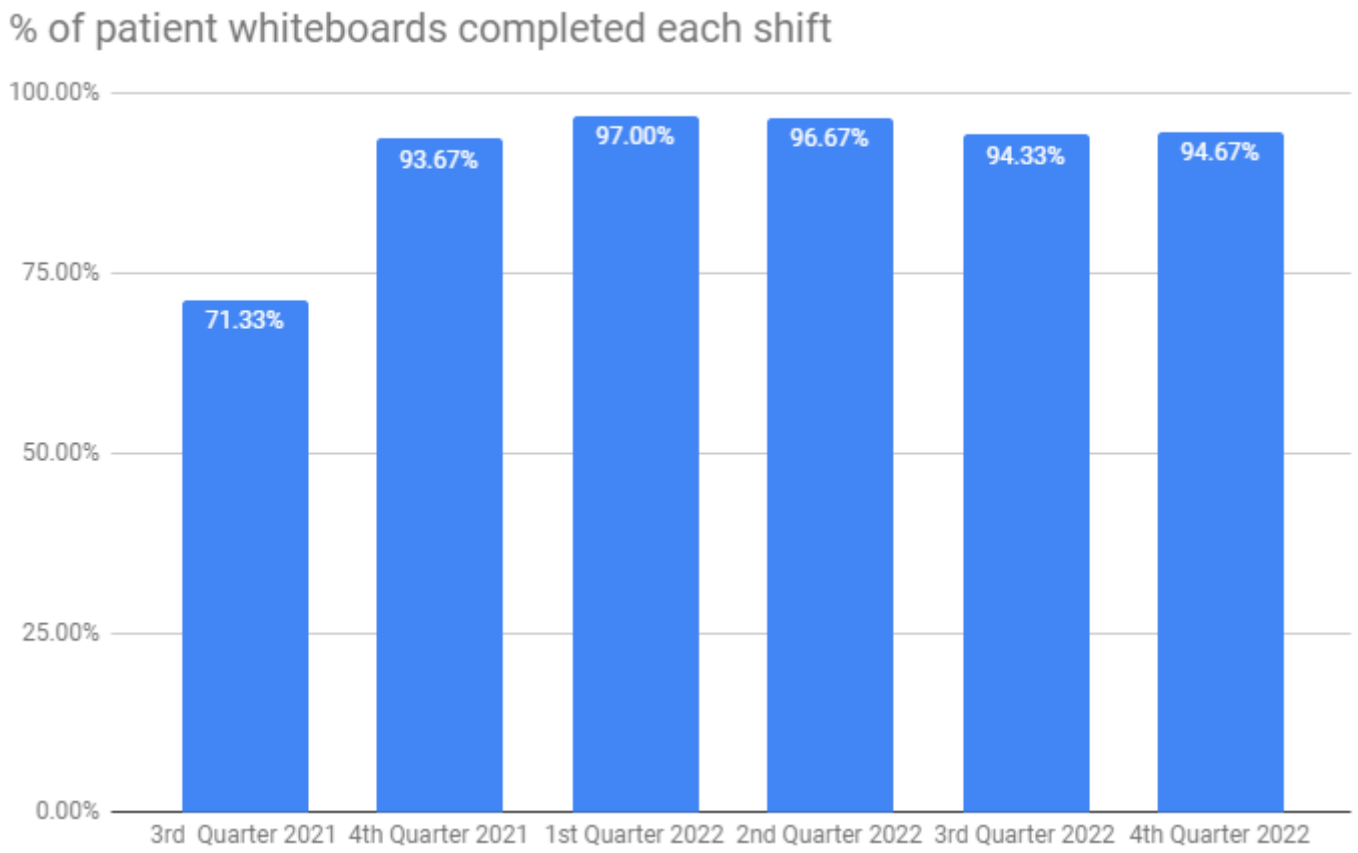
BREASTFEEDING STATS – 2022



LATCH SCORES (AUDITS STARTED JULY 2021)



COMPLETION OF WHITEBOARDS



BIOVIGIL HAND HYGIENE

BIOVIGIL®

Kaweah Health

Nursing Unit Compliance

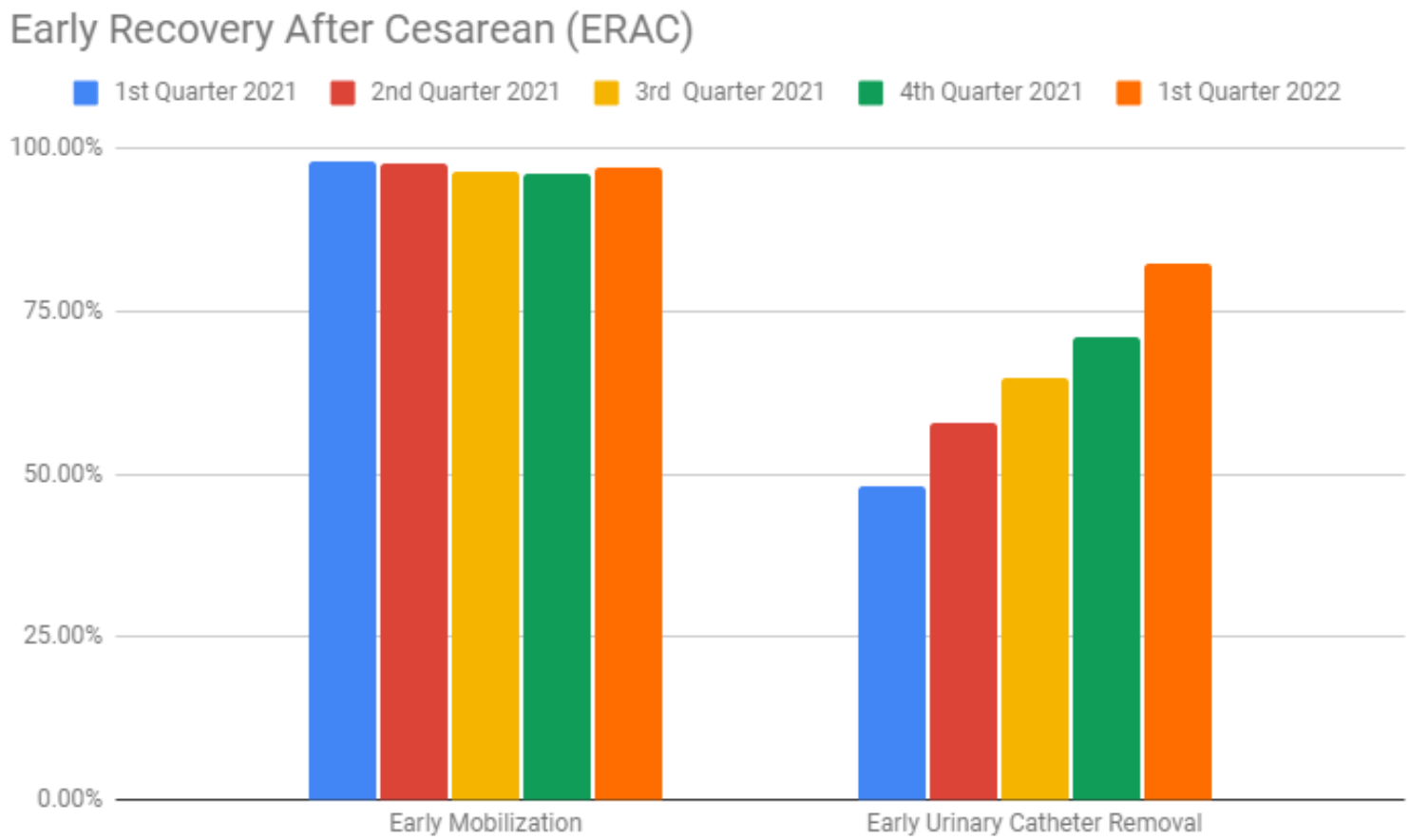
6/30/2022 11:00:00 PM (-08:00) - 12/31/2022 (-08:00)

Nursing Unit	Total Compliant (HHO)	Total (HHO)	Entry Compliance	Exit Compliance	Total Compliance	Entries Cross-Contaminated Non-Compliant
3AcequiaMotherBaby	217,548	222,749	97.3%	98.0%	97.7%	0.39%
	217,548	222,749	97.3%	98.0%	97.7%	(

Non-Compliant (<= 95.0%)	OFI (Opportunity for Improvement) (<= 97.5%)	Compliant (> 97.5%)

EARLY RECOVERY AFTER C-SECTION (ERAC) BUNDLE

(WE DO NOT HAVE DATA FOR 3RD AND 4TH QUARTER 2022 DUE TO STAFFING IN QUALITY DEPARTMENT)



Unit/Department Specific Data Collection Summarization

Quality Council Committee

Unit/Department: **Orthopedic Service Line Surgical Site infection** **ProStaff Report Date:** **03/16/2023**

Submitted by: Kevin Bartel, Director of Orthopedic Service Line

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

Date range of data evaluated: January 1, 2022 – December 31, 2022 (12 months)

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

Overall, the joint procedures performed on hips and knees from January 1, 2022, through December 31, 2022 at Kaweah Health resulted in 6 infections (5 knee, 1 hip) and an overall standardized infection ratio (SIR) of 3.06, or 306% of predicted number of infections based on procedures performed and risk-adjusted elements. Infections are most prevalent with total knee arthroplasties, with an SIR of 2.70, or 270% of predicted number of infections.

5 of the 6 reported infections were either superficial or deep incisional primary infections, most likely indicating that questionable post-surgical incision site care can be inferred.
Interestingly, 4 of the 5 knee infections occurred within a total timeframe of 10 weeks in early 2022 (Feb – Apr). No known correlation is known between OR surgery practices and this higher incidence of infections during this timeframe, so this may just be coincidence. The other knee infection involved a 2-stage revision surgery, where pre-surgical knee infection was known and managed. However, this patient went to jail shortly after surgery, so post-operative incision care quality is unknown.

Year total hip SIR (0.356) is well below predicted levels indicating a much better than national average comparison of Kaweah Health to other organizations who perform hip arthroplasty.

Type of SSI	Total # of Procedures	Actual # of Infections	Predicted # of Infections	Standardized Infection Ratio
KPRO	260	5	1.849	2.704
HPRO	197	1	2.807	0.356
Total	457	6	4.656	3.06

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

1. The ERAS program is led and monitored by the orthopedic program's Nurse Practitioner. This program helps to support a standardized approach to pre and post-surgical care protocols in order to enhance recovery after a total joint surgery. Orthopedic service line leadership will continue to monitor compliance with this program.
2. The Joint Camp for THA/TKA patients has returned to an in-person format, offered alongside the existing online educational video as options for patient education on all topics related to a patient's surgery. Compliance with Joint Camp attendance (30% in December) has not reached pre-pandemic compliance levels (~70%). Opportunity exists to exert more resources and effort into improving patient attendance compliance with this Joint Camp educational resource.
3. Discussing standard of practice among orthopedic surgeons with variances being presented at the monthly Co-Management meeting as appropriate. This will continue to be done monthly through case reviews, discussion and reviewing data/reports related to SSI data.

Next Steps/Recommendations/Outcomes:

Orthopedic NP and Service Line Director continue to attend monthly surgical site infection (SSI) subcommittee meeting to stay current with SSI topics related to prevention and best practices, as well as timely review of known orthopedic SSI cases. SSI data and information will be shared with orthopedic surgeons on a regular basis. Continue to hardwire ERAS program with nursing staff, therapies, and surgeons in the coming year.

Submitted by Name: Kevin Bartel, DPT **Date Submitted**: 3/16/23

Orthopedic Service Line
Complication Rate **03/16/2023**

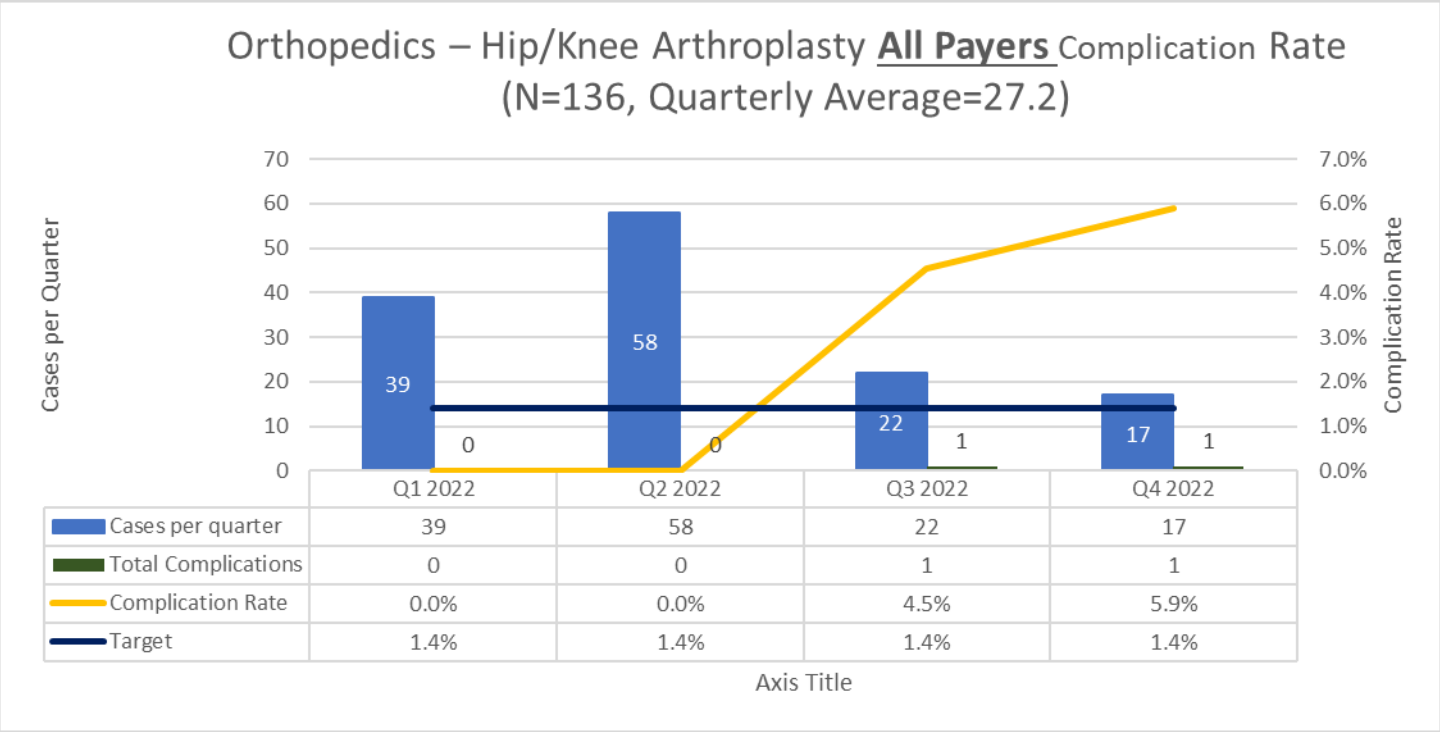
Measure Objective/Goal: Monitor and measure the **complication rate** for total arthroplasty patients who underwent either a total hip or knee joint replacement. The benchmark sources are both CMS and hospitals within the STATIT database. The CMS target is **2.3%** for Medicare patients and **1.4%** target for all payers within the Midas database.

The inclusion criteria for complication include the following:

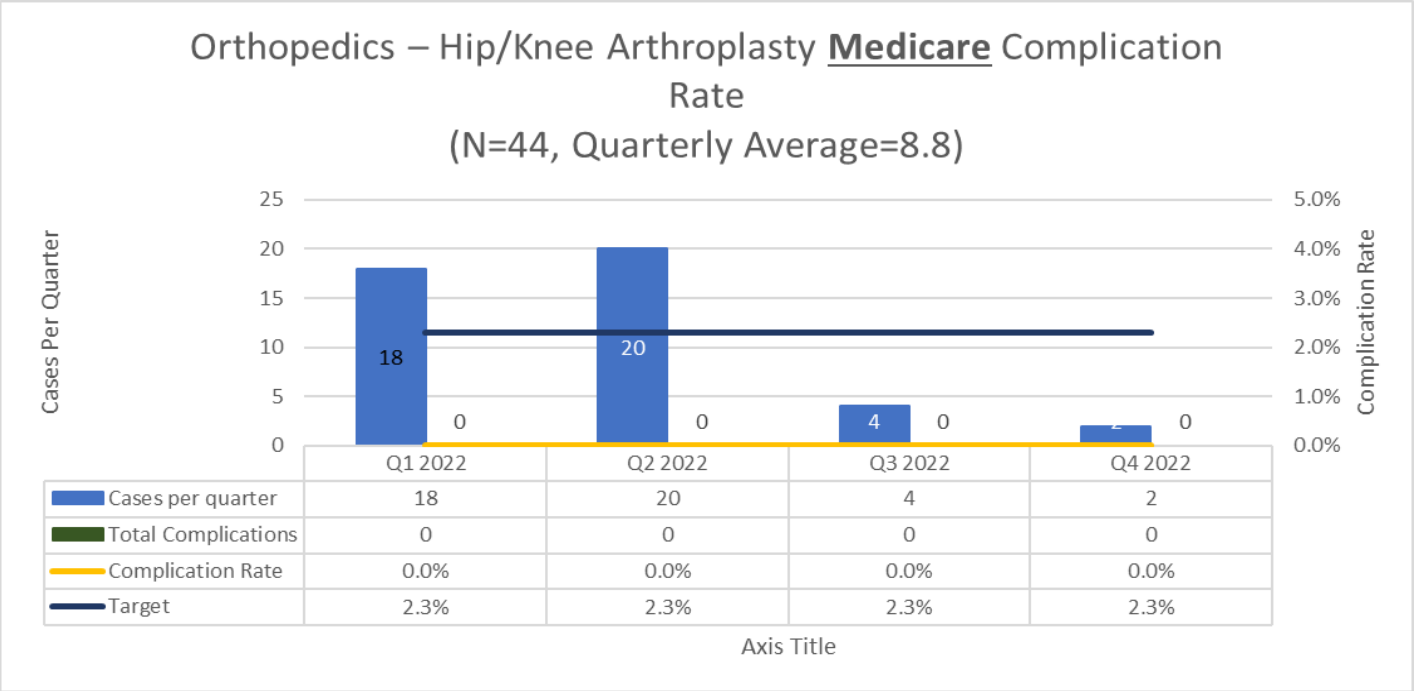
1. Mechanical complication within 90 days
2. Wound Infection or periprosthetic joint infection within 90 days
3. Surgical site bleeding within 30 days
4. Pulmonary embolism within 30 days
5. Death within 30 days
6. Acute myocardial infarction with 7 days
7. Pneumonia within 7 days
8. Sepsis, septicemia,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

Date range of data evaluated: Quarter 1, 2022 through Quarter 4, 2022 (12 months of data)

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



	Q1 2022	Q2 2022	Q3 2022	Q4 2022
Cases per quarter	39	58	22	17
Total Complications	0	0	1	1
Complication Rate	0.0%	0.0%	4.5%	5.9%
Target	1.4%	1.4%	1.4%	1.4%



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

Across the reported date range, 2 total complications were seen in the All Payers group, resulting in a 1.47% complication rate overall, slightly above the benchmark of 1.4%. The complication in Q3 involved a patient who sustained a patellar tendon rupture 2-3 weeks after their TKA, resulting in a subsequent hospital admission and surgery with eventual transfer to acute rehab. The complication in Q4 was due to the presence of a pulmonary embolism 3 weeks after surgery, which was treated at the hospital.
Within the Medicare Payer group, overall performing well with zero reported complications.
In Q3 2022, CMS updated exclusion criteria to exclude index encounters with a principal diagnosis code of COVID-19 or with a secondary diagnosis code of COVID-19 coded as present on admission. This change resulted in reduced total qualifying encounters for Q3 and Q4.

Next Steps/Recommendations/Outcomes:

1. Coordinate daily patient rounding involvement from Ortho NPs to facilitate routine patient assessment, patient care management and coordination of care.
2. With the move from inpatient qualified stays to outpatients stays and a focus on same day discharge, the orthopedic nurse practitioner is working closely with physical therapy to evaluate for safe discharge home.
3. Orthopedic NPs will continue to facilitate patient transfer to next level of rehabilitation care (i.e. inpatient rehab, short stay, SNF, home health) in effort to optimize patient access to recovery and education, as appropriate.
4. The vast majority of total knee and hip arthroplasty surgeries are now done on an outpatient basis with same-day discharge. For future reporting, will plan to track and report relevant complication data related to outpatient surgeries, in addition to continuing to report inpatient data.

Submitted by Name: Kevin Bartel, DPT **Date Submitted**: 3/16/23

Unit/Department Specific Data Collection Summarization

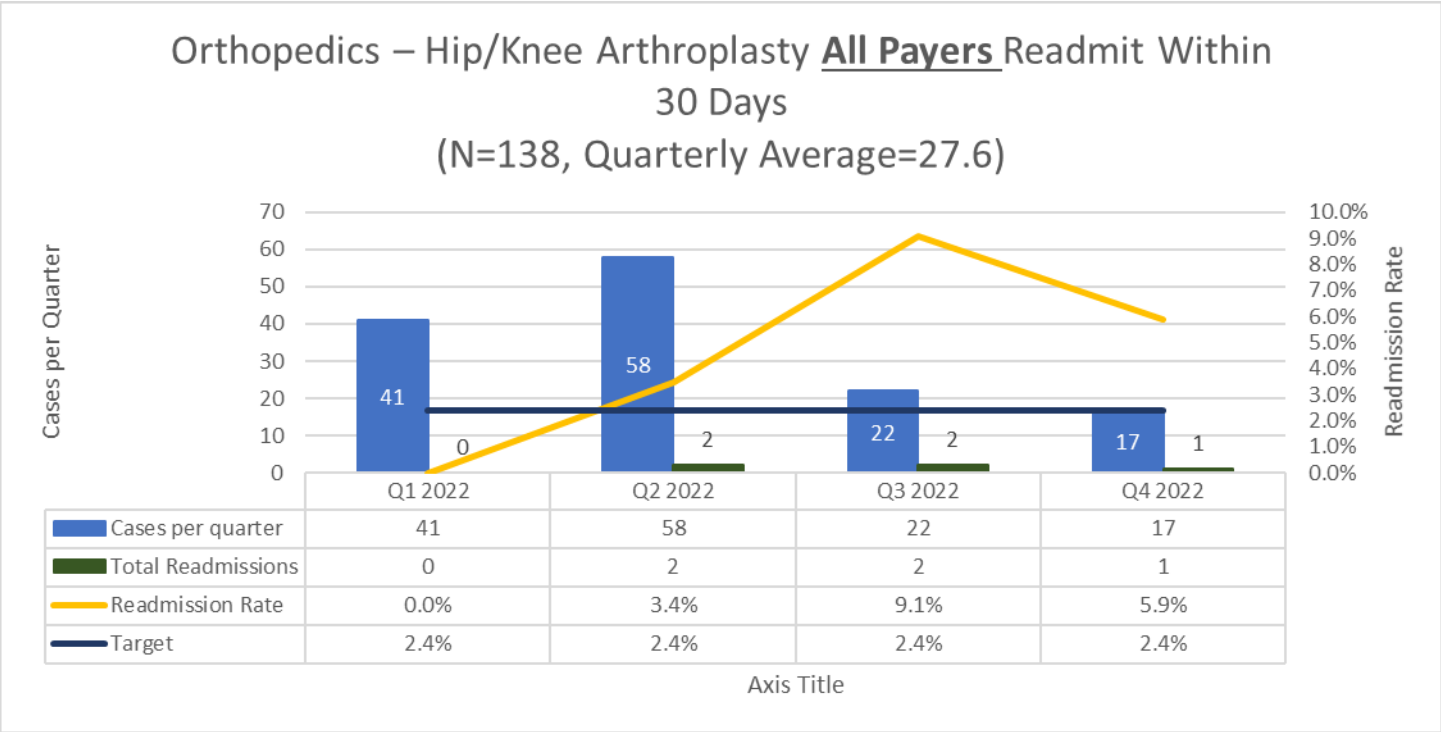
Quality Council Committee

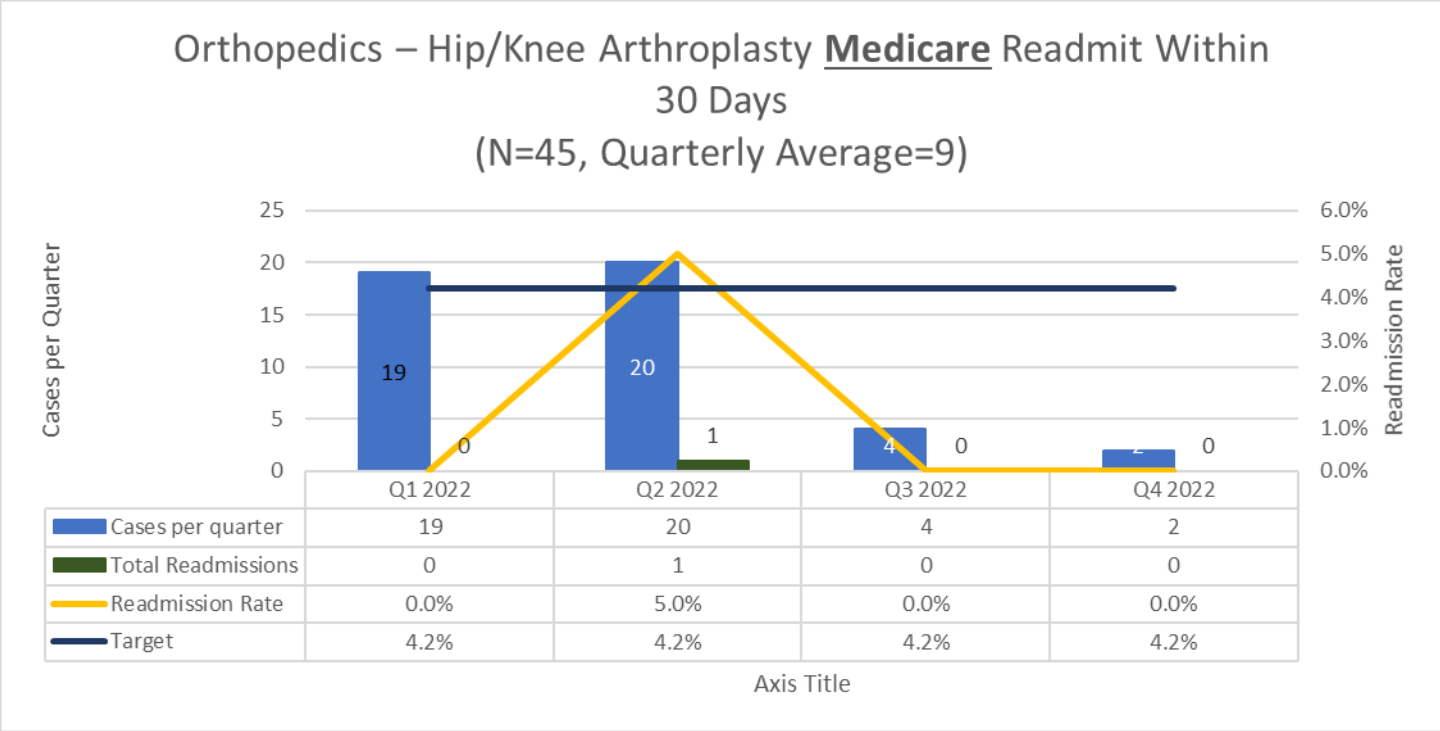
Unit/Department: **Orthopedic Service Line Readmission Rate** **ProStaff Report Date:** **03/16/2023**

Measure Objective/Goal: Monitor and measure any cause 30-day **readmission rate** for total arthroplasty patients who underwent a joint replacement. The benchmark sources are both CMS and hospitals within the Midas database. The CMS target is **4.2%** for Medicare patients and **2.4%** target for all payers.

Date range of data evaluated: Quarter 1, 2022 through Quarter 4, 2022 (12 months of data)

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):





	Q1 2022	Q2 2022	Q3 2022	Q4 2022
Cases per quarter	19	20	4	2
Total Readmissions	0	1	0	0
Readmission Rate	0.0%	5.0%	0.0%	0.0%
Target	4.2%	4.2%	4.2%	4.2%

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

Overall, performing well with the Medicare patients in regards to re-admissions, with 3 of the 4 quarters in 2022 containing no re-admissions. Total of one re-admission out of 45 Medicare cases within the reporting period, resulting in a 2.2% overall readmission rate for the reporting period, lower than the 4.2% readmission rate benchmark.

The all payer readmission rate was higher than the national benchmark at 5 re-admissions out of 138, averaging a 3.6% re-admission rate compared to 2.4% target. Two readmissions were secondary to re-injury of the surgical knee; one due to fall at home, the other due to patellar tendon rupture during transition into the car. One readmission was due to symptoms of acute kidney failure. One readmission was due to altered mental status related to acute kidney injury and metabolic acidosis, with patient readmitting 1 day after surgery. The final readmission was due to the presence of a pulmonary embolism 3 weeks after surgery.

In Q3 2022, CMS updated exclusion criteria to exclude index encounters with a principal diagnosis code of COVID-19 or with a secondary diagnosis code of COVID-19 coded as present on admission. This change resulted in drastically reduced total qualifying encounters for Q3 and Q4 for readmissions.

Next Steps/Recommendations/Outcomes:

1. Standardized education and increased emphasis with prevention of surgical site infections during the pre-op Joint Camp education class. Focus on post-operative care of surgical sites and plan of care if signs and symptoms of infection occur with plan to call surgeon and not to report to Emergency room.
2. Orthopedic NPs will continue to facilitate patient transfer to next level of rehabilitation care (i.e. inpatient rehab, short stay, SNF, home health) in effort to optimize patient access to recovery and education, as appropriate.
3. The vast majority of total knee and hip arthroplasty surgeries are now done on an outpatient basis with same-day discharge. For future reporting, will plan to track and report relevant complication data related to outpatient surgeries, in addition to continuing to report inpatient data.

Submitted by Name: Kevin Bartel, DPT **Date Submitted:** 3/16/23

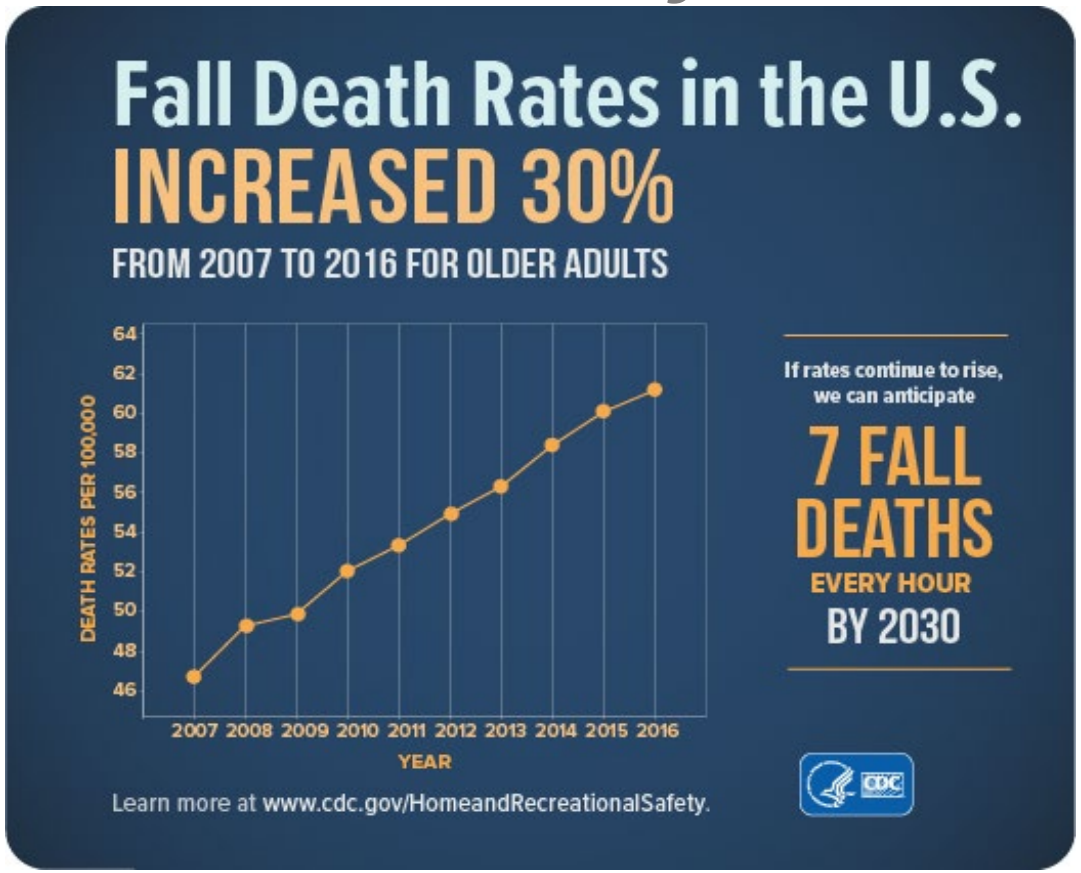
Falls Prevention Committee

Board of Directors
March 16, 2023
Emma Camarena, Director of Nursing Practice

Facts about Falls

Millions of people, 65 and older fall each year

- **More than 1 out of 4 will fall each year**
- **Falls are Serious and Costly**
  - **Each year, 3 million older people seek treatment in the ED**
  - **Over 800,00 patients are hospitalized each year**
- **In 2015, falls totaled more than $50 billion in medical costs (75% paid by Medicare/Medicaid)**



Centers for Disease Control and Prevention. https://www.cdc.gov/falls/facts.html

Kaweah Health

The Problem of Falls

In Hospital

- **Each year, between 700,00 and 1,000,000 patients will fall in the hospital**
- **Falls increase health care utilization due to injuries**
- **2008: CMS does not reimburse hospitals for certain types of traumatic injuries which may occur after a fall**
- **Difficult to manage-competing priorities:**
  - **Treating problem patient was admitted with**
  - **Keeping the patient safe**
  - **Helping the patient maintain or recover physical and mental function**
- **Fall prevention involves managing the patient's underlying fall risk factors**

Agency for Healthcare Research and Quality. https://www.ahrq.gov/patient-safety/settings/hospital/fall-prevention/toolkit/overview.html#Problem

Kaweah Health

Falls Definitions

The NDNQI Definitions for Injury follow:

Definition: unplanned descent to the floor with or without injury to the patient

Injury level:

- None—patient had no injuries (no signs or symptoms) resulting from the fall, if an x-ray, CT scan or other post fall evaluation results in a finding of no injury.
- Minor—resulted in application of a dressing, ice, cleaning of a wound, limb elevation, topical medication, bruise or abrasion.
- Moderate—resulted in suturing, application of steri-strips/skin glue, splinting or muscle/joint strain.
- Major—resulted in surgery, casting, traction, required consultation for neurological (basilar skull fracture, small subdural hematoma) or internal injury (rib fracture, small liver laceration) or patients with coagulopathy who receive blood products as a result of the fall.
- Death—the patient died as a result of injuries sustained from the fall (not from physiologic events causing the fall).

AHRQ website. https://www.ahrq.gov/patient-safety/settings/hospital/fall-prevention/toolkit/measurefallrates.html

Kaweah Health

Kaweah Health Falls Prevention Program Nursing Falls Data, Benchmarked Nationally:

Measure Objective/Goal:

1. Kaweah Health Nursing Falls Data:
   - Total Falls per 1000 patient days
   - Injury Falls per 1000 patient days
   - Percent of Falls with Moderate or Greater Injury
2. Total Falls with Injury level (2019-2022)
3. Falls University Root Cause Analysis

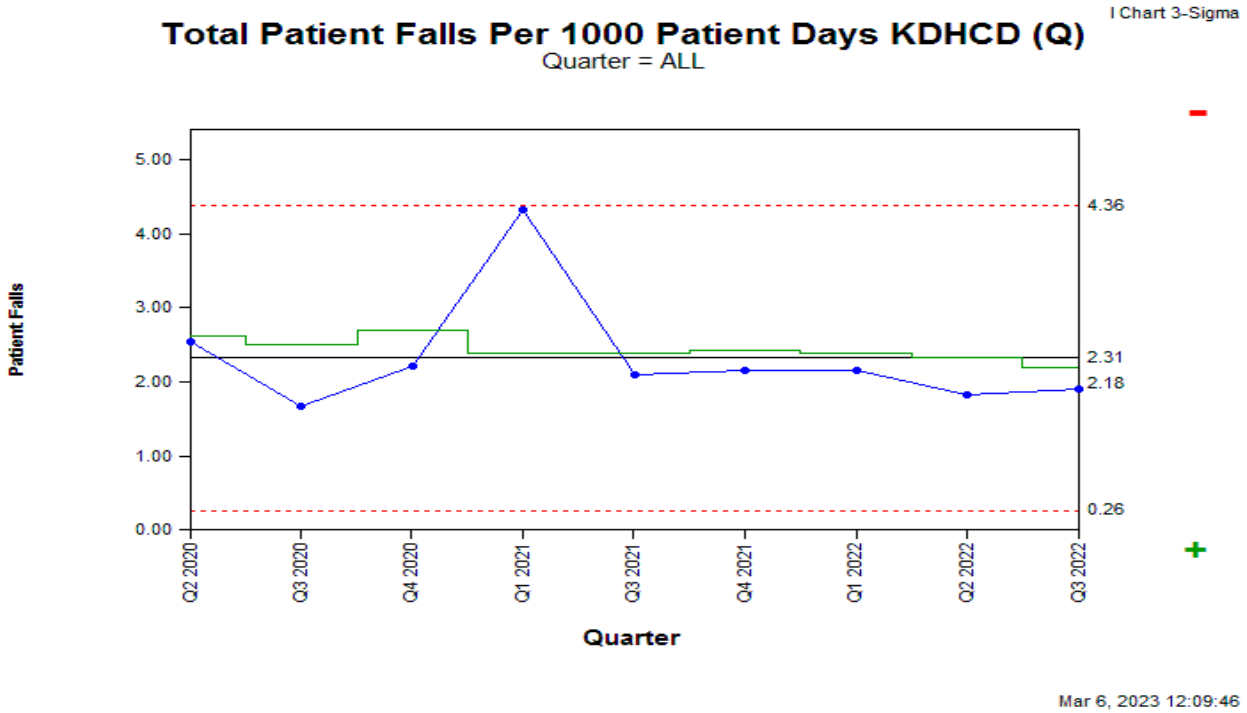
** The National Database of Nursing Quality Indicators® (NDNQI®) provides a national database of more than 2,000 U.S. hospitals that features nursing-sensitive outcome measures used to monitor relationships between quality indicators and outcomes.*
Participating Kaweah Health nursing units include: 2North, 2South, 3North, 3South, 3West, 4North, 4South, 4Tower, Broderick Pavilion, ICU, CV-ICU, CV-ICCU (5Tower), Mental Health, Pediatrics, and Acute Rehab.

Kaweah Health

KH Nursing Falls Data

Total Falls per 1000 patient days

Goal met: The total falls per 1000 patient days for Q3-2022 is 1.89, below the target of 2.18. KH has remained below the targeted benchmark since Q1 of 2021.



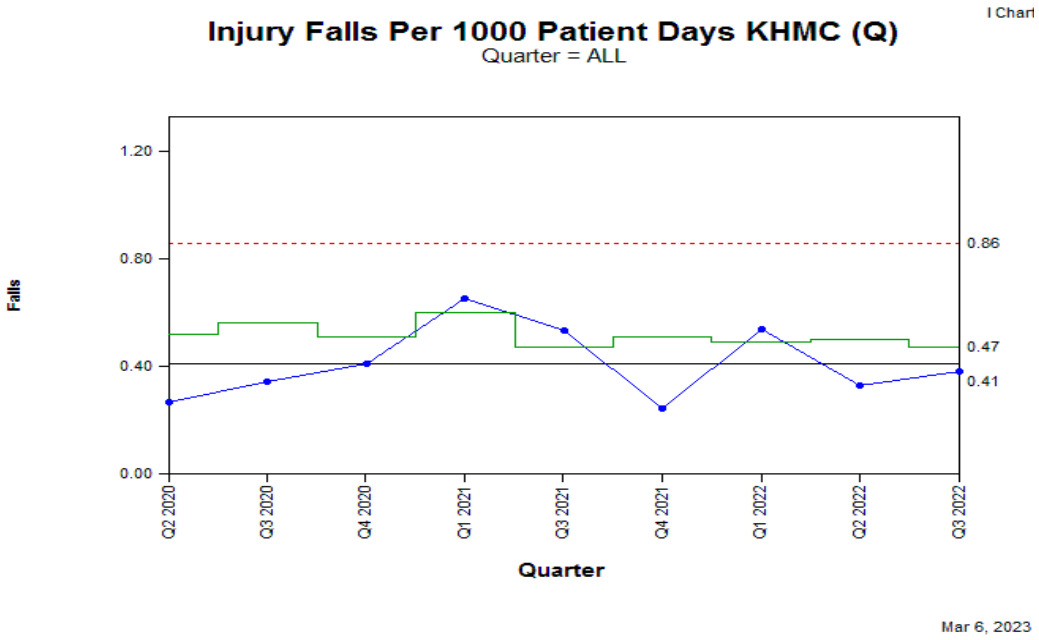
	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022
Patient Falls	2.53	1.66	2.19	4.32	2.09	2.14	2.14	1.82	1.89
Target	2.60	2.50	2.69	2.37	2.38	2.42	2.37	2.32	2.18

Kaweah Health

KH Nursing Falls Data

Injury Falls per 1000 Patient Days

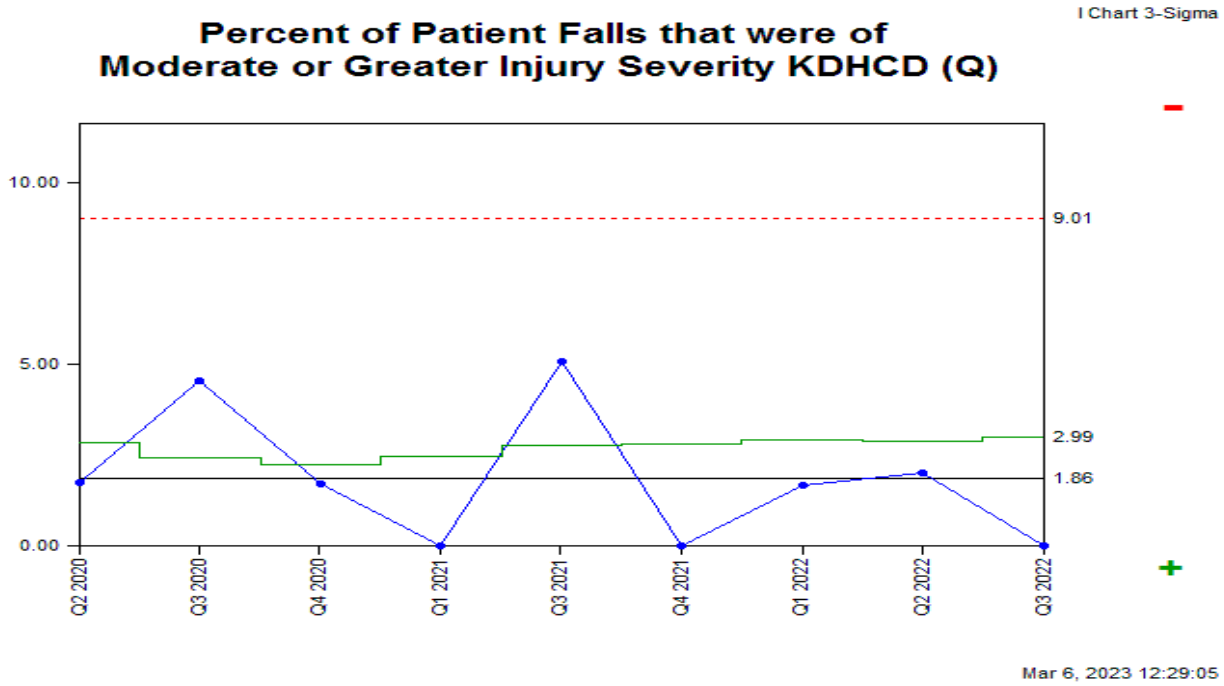
Goal met: The injury falls per 1000 patient days for Q3-2022 is 0.38, below the target of 0.47.



	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022
Falls	0.27	0.34	0.41	0.65	0.53	0.24	0.53	0.33	0.38
Target	0.52	0.56	0.51	0.60	0.47	0.51	0.49	0.50	0.47

Percent of Patient Falls with Moderate or Greater Injury

Goal met: The percent of falls with moderate or greater injury for Q3-2022 is 0 below target of 2.93, maintaining goal from Q4-2021



	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022
KDHCD	1.75	4.55	1.69	0.00	5.08	0.00	1.67	2.00	0.00
Target	2.85	2.41	2.23	2.46	2.75	2.80	2.93	2.88	2.99

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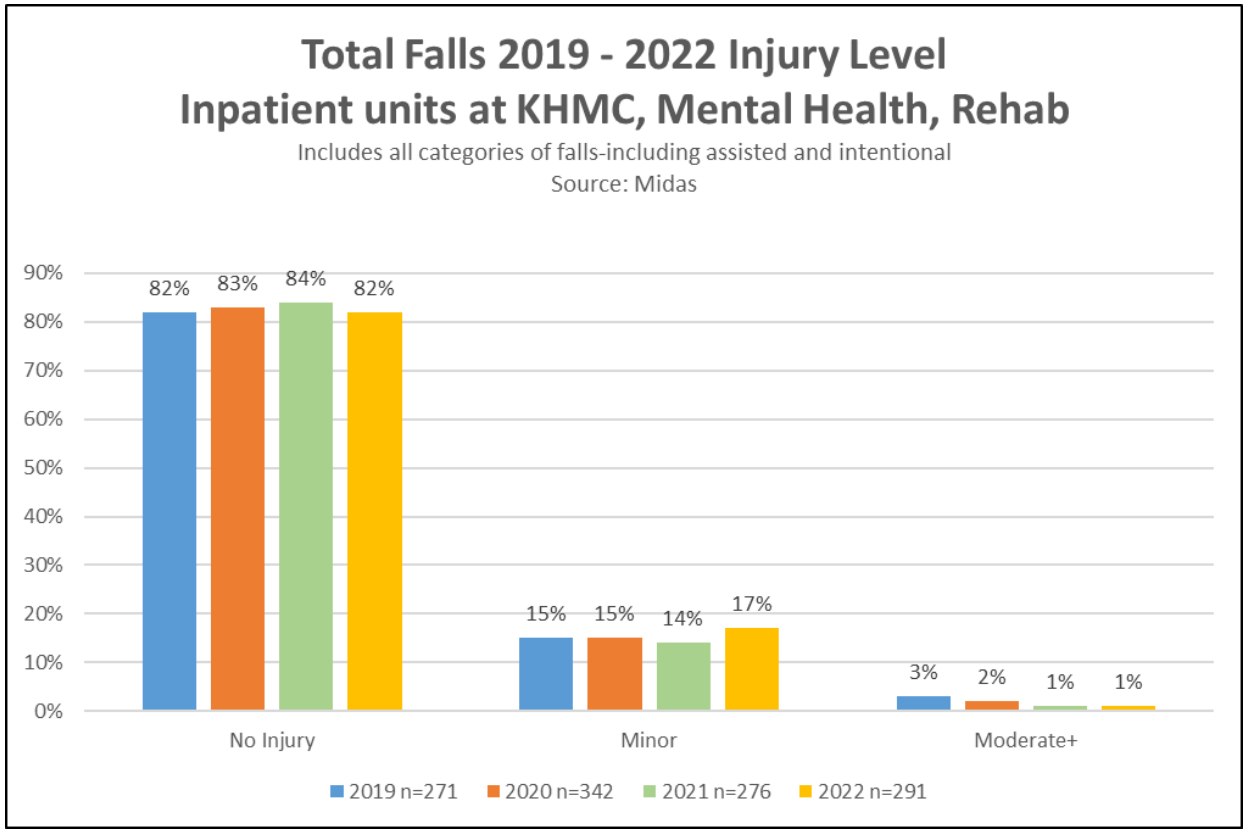
Total Falls with Injury Level CY 2019-2020

Goal: Increase the number in the no injury category and decrease the number of minor and moderate + injuries.

Goal not met:

- Minor injury level falls had a 21% increase from 2021 to 2022
- No change for moderate + injury level falls.



Kaweah Health

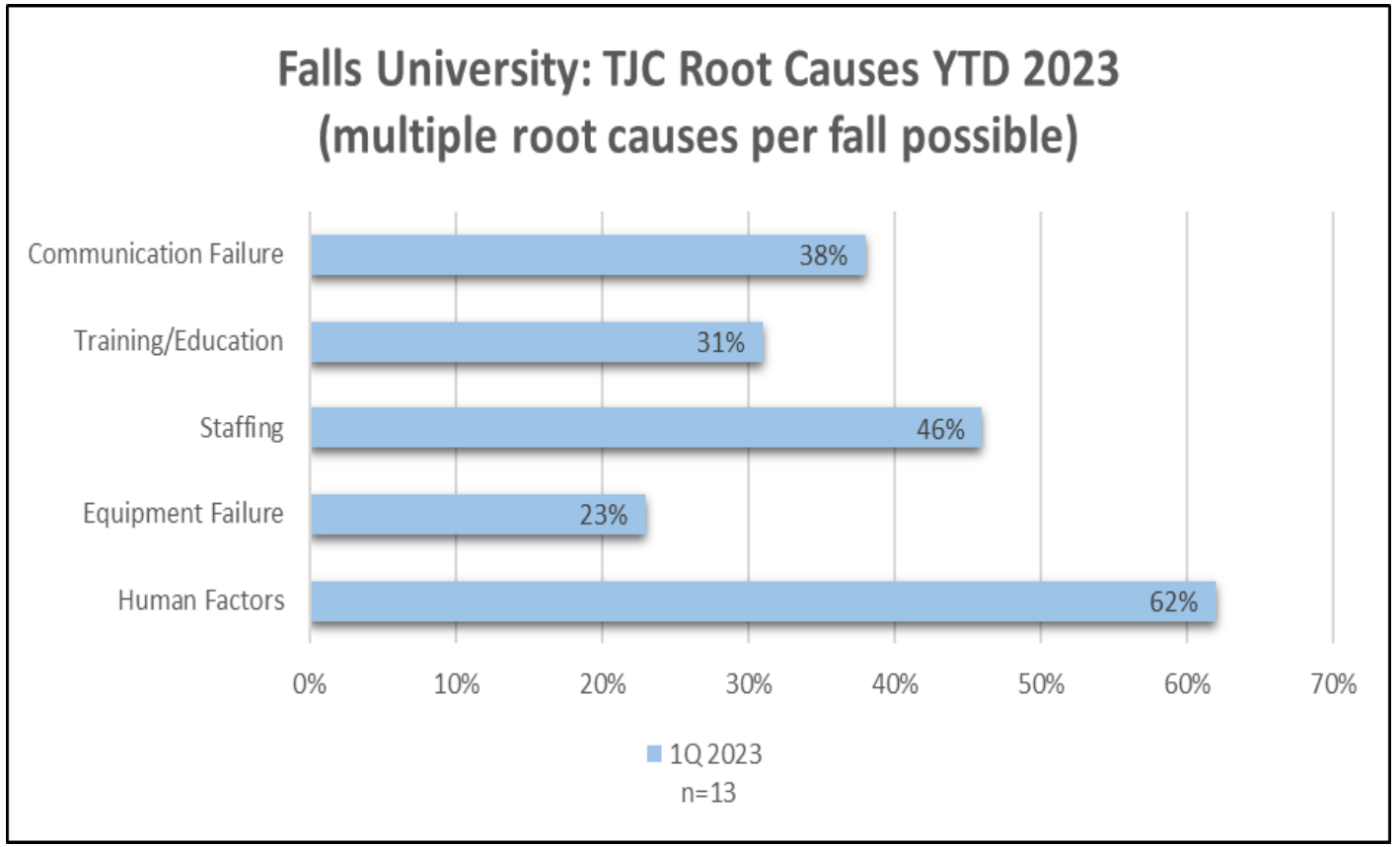
Root Cause Analysis Questions

Falls University 2023

After a brief pause at the end of 2022, Falls U restarted in January 2023. YTD, human factors, staffing, and communication failures were the highest root cause of falls.

- Human factors: 62%
- Staffing: 46%
- Communication failure: 38%

Human Factor root causes are comprised of fatigue, lack of critical thinking, failure to follow policy, inability to focus on task, inattentional blindness or rushing to complete a task.



Kaweah Health

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Improvement Opportunities

Background

- Prior to the pandemic, staff learned about fall prevention strategies through didactic education and yearly follow up competency testing
- Education included use of the Johns Hopkins Falls risk assessment, fall prevention strategies, use of bed alarms and fall prevention devices, and documentation of individualized plans of care (IPOC)
- The pandemic caused a disruption in the normal care of patients and supplies
- With surge charting, staff were only required to chart risk assessments once per shift and with changes and IPOCs were completed if time permitted
- Staff turnover also played a part in the disruption of care with experienced staff leaving, stepping away from patient care and retiring
- Contract staff, unfamiliar with Kaweah Health policies and procedures are now staffing all patient care units, although this number has since decreased significantly

Kaweah Health

Improvement Opportunities

Recommended Next Steps

1. The Falls Committee resumed monthly meetings to :
    - Review current falls data
    - Discuss improvement opportunities
    - Recommend prevention strategies
2. Restarted biweekly Falls University meetings:
    - Allows staff opportunities to review falls and identify potential root causes
3. PC.88: Fall Assessment, Identification of At Risk Patients and Prevention-revised
4. Standardize Falls prevention equipment: in-services begin March 2023
5. Optimize EMR charting: post falls documentation
6. Educational opportunities:
    - Falls Prevention booth at Safety Fair March 2023
    - Community Outreach: Tai Chi, Matter of Balance
7. Re-educate staff: updated policy, IPOCs, Falls equipment and post falls charting

Thank you for your time

Kaweah Health

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Kaweah Health

Handoff

03/07/2023

Franklin Martin

Background

- A Sentinel Event Alert (SEA) was issued by The Joint Commission (TJC) in September 2017. After the alert was issued, a review of internal event reporting data and a gap analysis were conducted based on the recommendations by TJC in the SEA. The gap analysis indicated that Kaweah Health at the time had several opportunities to adequately address TJCs recommendations and improve the handoff process. Gaps included:
  a. No institutional approach to handoff that identifies/defines critical content of the handoff.
  b. Utilize/enhance handoff with EMR capabilities (Cerner implementing at the time)
  c. Measure and monitor use of standardized handoff forms and impact of poor handoff

Team Mission

- Implement a standardized structure for a nurse-to-nurse handoff when admitting a patient or handoff between shifts.

- 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 timely patient handoff (transfer) 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. 80% compliance and adherence to the EMR handoff tool.
2. Reduction of handoff-related Midas Events

Handoff Tool Builds

- Completed departments include: 2 north, 2 south, ICU, CVICU, 3 West, 3 North, 3 South, 4 North, 4 South, Pediatrics, Emergency Department, 4 Tower, and 5 Tower.
- Audits for these floors are in progress
- Currently have 14 departments with completed EMR handoff tools
- Maternal Child Health (labor and delivery, NICU, and Mother/Baby) build is presently underway (ETA end of March)
- We have prioritized the remaining areas to be completed over the rest of this year (Rehab, Behavioral Health, and the surgical areas)
  - Build for Behavioral Health will be started in May
- Each build is created based on the needs of each floor.

Education and Training

- Education Video and Mandatory training created in October 2022
  - The video addresses why, how, where, and when to use the new tool.
- Overall organization compliance is currently at 90%
- Handoff education added to all new hire orientation packets to complete (this includes travelers)

Handoff Audit

- Universal audit tool created and approved by the nursing leadership team
- Audit process
  - Each department is to complete 5 weekly audits
  - The goal is an 80% monthly compliance rate utilizing the SBAR EMR tool.
  - When each department is successful for three consecutive months with an 80% success rate, they will move to a quarterly audit.
- The audit started Jan 16th, 2023.
- The audit started with a low floor compliance rate, but as the weeks progressed, the compliance increased.
  - Three email reminders are sent out every week to all leaders.
  - One-on-one emails are sent to those who do not respond.
- So far, the data shows that when the nurse fails to utilize the EMR SBAR tool during handoff, there are missing items reported. (Slide 9)
- We will add a spot on the SBAR audit form for leader comments when there is a report of missing items during handoff.

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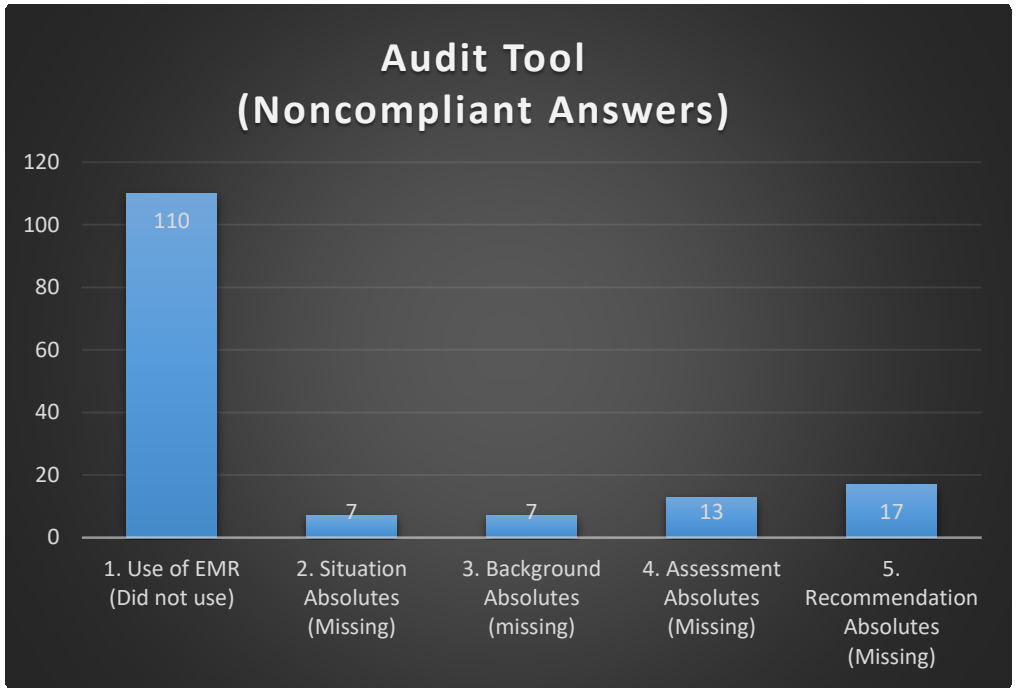
SBAR Handoff

SBAR handoff Tracking	Benchmark	Jan - 23	Feb - 23	Mar - 23	Apr - 23	May - 23	June - 23
2 North	80%	90.00%	93.00%				
2 South	80%	98.00%	94.00%				
ICU	80%	84.00%	85.00%				
3 North	80%	38.00%	48.00%				
3 South	80%	98.00%	99.00%				
3 West	80%	50.00%	92.00%				
4 North	80%	96.00%	88.00%				
4 South	80%	40.00%	72.00%				
Peds	80%	0.00%	0.00%				
Broderick Pavillion	80%	40.00%	62.00%				
Emergency Department	80%	72.00%	99.00%				
CVICU	80%	42.00%	75.00%				
4 Tower	80%	42.00%	60.00%				
5 Tower	80%	100.00%	100.00%				
Labor and Delivery	80%	n/a	n/a				
Mother Baby	80%	n/a	n/a				
NICU	80%	n/a	n/a				
Midas Event	0	4	5				
Overall							
All Patients	80%	44.0%	76.0%				

KEY	>10% below goal/benchmark	Within 10% of goal/benchmark	Outperforming/meeting goal/benchmark



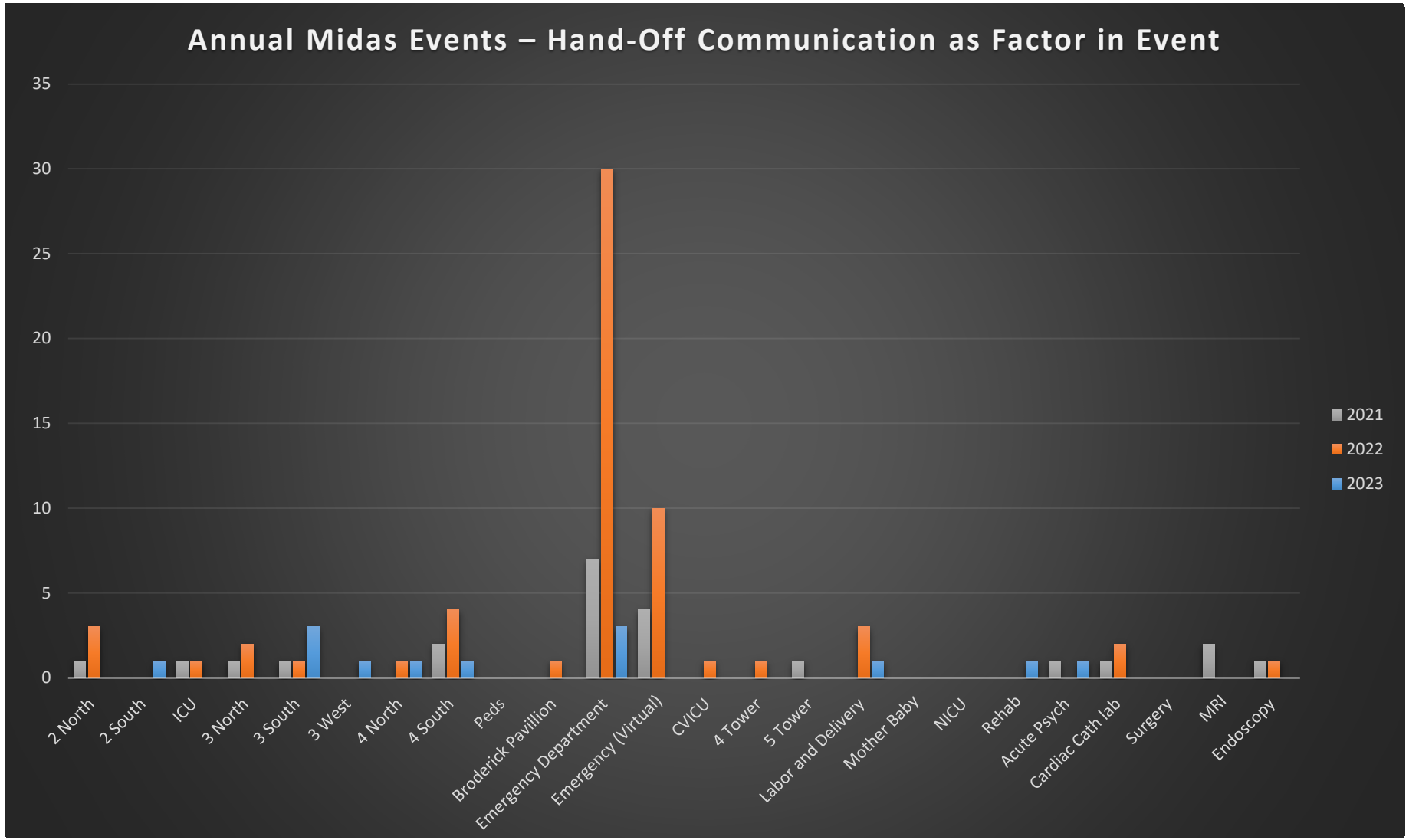
HANDOFF AUDIT

DATE: Unit/Floor:

RN Giving Handoff: RN Receiving Handoff:

		Yes	No	Why not?
1	When giving report did you use the electronic SBAR Handoff tool? If no, why?	YES	NO	
	When receiving report did the nurse giving report give			**Missing**
2	**Situation Absolutes**: name, age, allergies, code status, admitting provider, diagnosis, and family/support?	YES	NO	
	If "NO", what was missing?			
3	**Background Absolutes:** pertinent history, meds and tx received, pertinent labs & results?	YES	NO	
	If "NO", what was missing?			
4	**Assessment Absolutes**: Head to Toe, Mobility, Risk Assessments/Precautions, V.S., Blood Glucose?	YES	NO	
	If "NO", what was missing?			
5	**Recommendation Absolutes:** Next Steps or Action List: any new orders/tests, clinical notes?	YES	NO	
	If "NO", what was missing?			

- Audit tool consists of 5 questions. To date 395 total audits completed.
  1. If the nurse giving the report used the EMR for handoff
  2. If they received the Situation Absolutes
  3. If they received the Background Absolutes
  4. If they received the Assessment Absolutes
  5. If they received the Recommendation Absolutes


Annual Midas Events – Hand-Off Communication as Factor in Event
35
30
25
20
15
10
5
0
2021
2022
2023
2 North
2 South
ICU
3 North
3 South
3 West
4 North
4 South
Peds
Broderick Pavillion
Emergency Department
Emergency (Virtual)
CVICU
4 Tower
5 Tower
Labor and Delivery
Mother Baby
NICU
Rehab
Acute Psych
Cardiac Cath lab
Surgery
MRI
Endoscopy

Next steps

- Complete builds for Maternal Child Health and Start Behavioral Health build in May
- Change the audit form to include a section for leader follow-up when deficits identified
- Review potential needs for changes in the SBAR tool as the audit continues
- Continue to monitor Midas Reports

Questions?

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Handoff

Date: 3/7/2023

For Presentation To: Quality Improvement Committee (QIC)

Project Leader: Franklin Martin

Facilitator: Cindy Vander Schuur

Situation

During Greeley mock survey (April 4-6, 2022) There were several instances in which staff were asked to discuss handoff communication for unit-to-unit transfers. Currently, there is no standardize SBAR process consistently used.

Background

1. A Sentinel Event Alert (SEA) was issued by The Joint Commission (TJC) September 2017. Following a review of internal event reporting data and a gap analysis was conducted based on the recommendations by TJC in the SEA. The gap analysis indicated that Kaweah Health at the time had several opportunities in adequately addressing TJCs recommendations and improving the handoff process. Gaps included:
    a. No institutional approach to handoff that identifies/defines critical content of the handoff.
    b. Utilize/enhance handoff with EMR capabilities (cerner implementing at the time)
    c. Measure and monitor use of standardized handoff forms and impact of poor handoff
2. As a result a Quality Focus Team (QFT) was established by our Executive Team and Quality Council (QC) in 2018 to address these gaps. Baseline data was collected using TJC survey tool. Measures included the “defective” rate of handoff as reported by the handoff receiver and sender. Kaweah Health “defective” handoff rate was significantly higher (lower is better) than the comparative from TJC (data included in table 1 below)
3. Since 2018 leadership over the project has switch several times, but the goals remained continuous and efforts put forth to continue to standardized handoff to reduce the defective rate and decrease reported events related to. The team continues to report into QC quarterly.
4. In Aug 2018, post Cerner implementation, the QFT completed an RN survey on use of the Cerner handoff tool. Consistent use of the handoff tool was 42% (results are in table 2)

5. In 2019 there were 65 Midas events reports submitted under Handoff event type, 14 of which resulted in some level of harm to patients

Table 1 – Baseline Handoff Data 2018

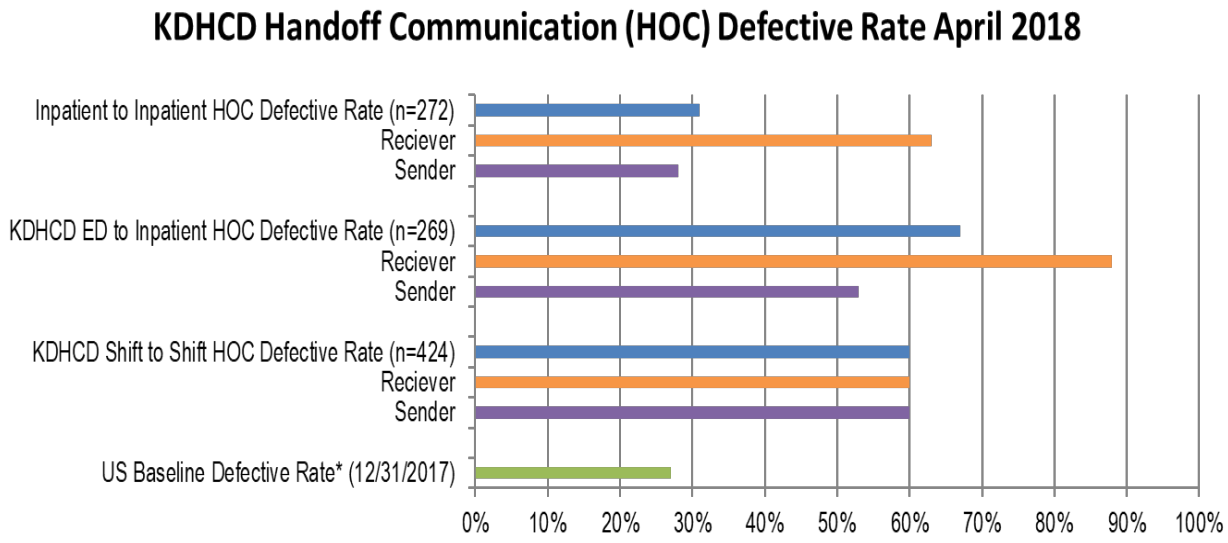


Table 2 – QFT Survey of Use of Cerner Handoff Tool

Handoff Communication Pre QFT – September 2018
Results of Handoff Survey (staff surveyed August 2018)

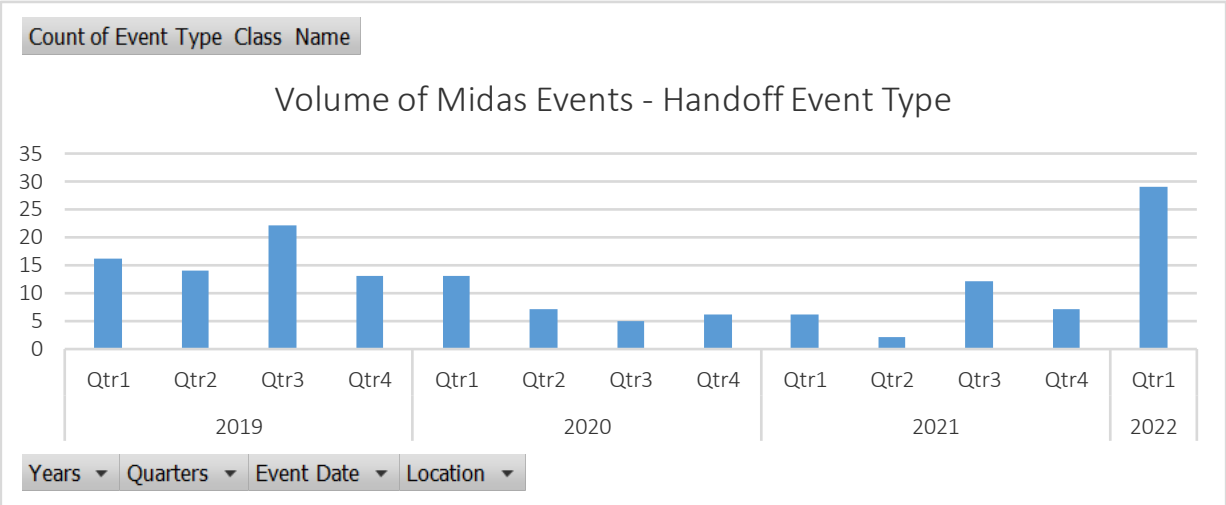
Do you use the Cerner Handoff Communication Tool during shift to shift report and transferring patients in/out of your department?

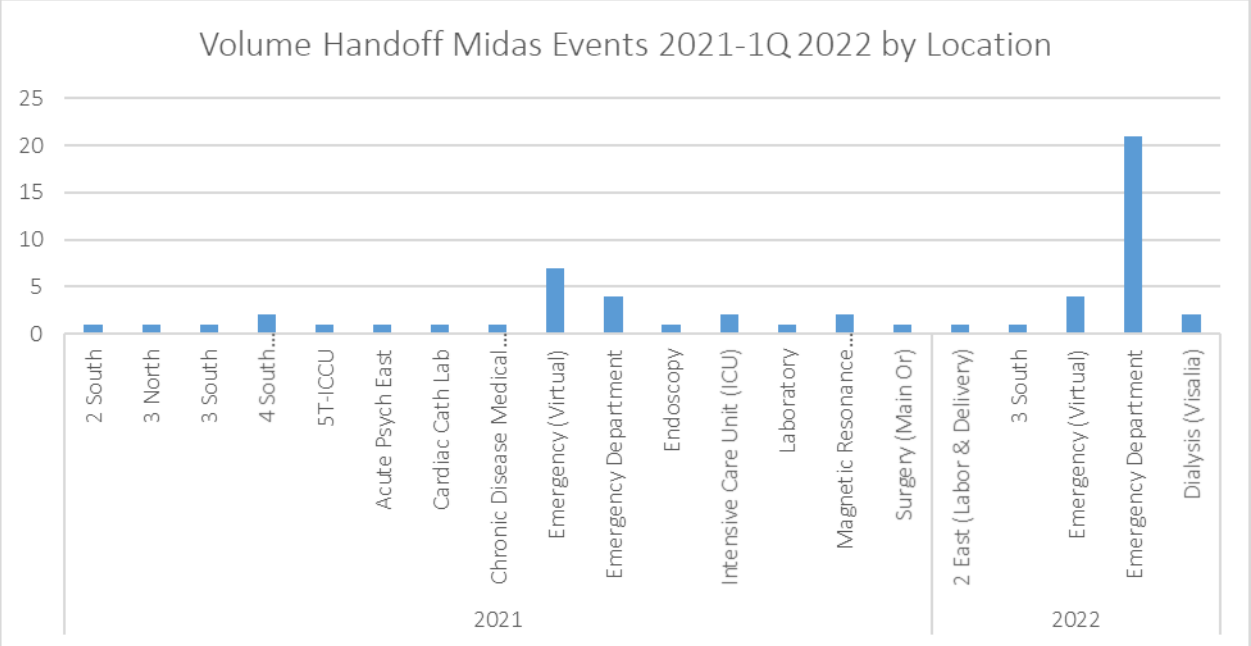
Yes	No	Sometimes	Total
80	74	38	192
42%	39%	20%	100%

Analysis

1. The defective rate or the use of Cerner tools has not been remeasured broadly since 2018.
2. Midas event report data from 2019-1Q 2022 indicates decreasing events submitted in 2020 through 2Q 2021 compared to 2019. However increasing events starting 3Q21 through 1Q22. An overall decrease in event reports was noted overall during 2020 due to decrease volumes at the start of the pandemic. Also, several event reports were submitted for the 1E location in 1Q 22 once new leadership was established for that location as a way to measure/track & trend handoff events for awareness of the issue

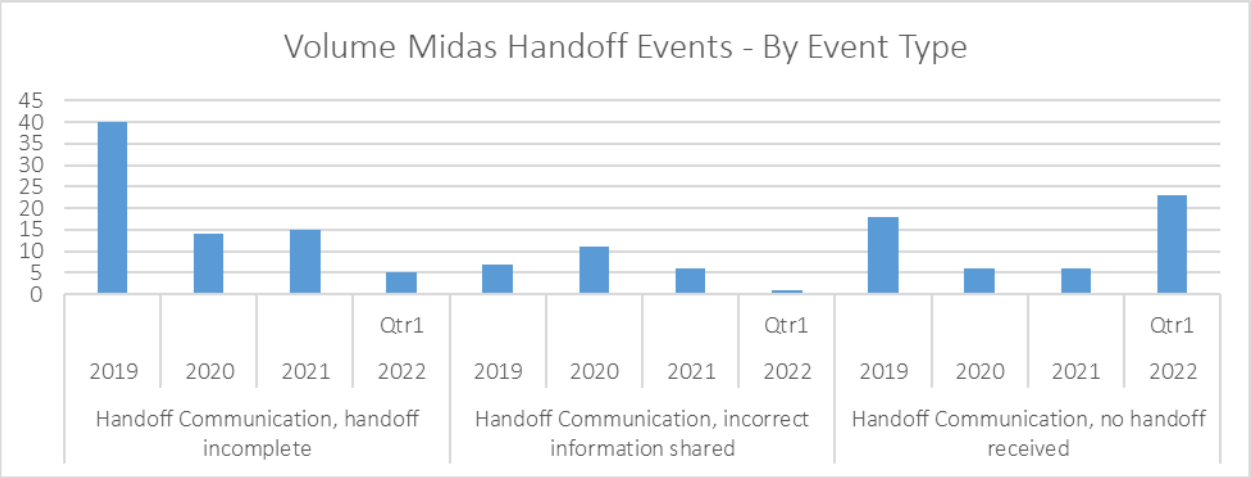
and to help direct future improvement efforts. 23/29 Handoff Midas events in 1Q 2022 were categorized under "no handoff received" event type.





Count of Significance	Column Labels				
Row Labels	2019	2020	2021	1Q 2022	Grand Total
E-Medication Event, Causing Temporary Harm & Intervention	1				1
Near Miss Safety Event, Early Barrier Catch	4	1	1	1	7
Near Miss Safety Event, Last Strong Barrier Catch	1		3	2	6
Near Miss Safety Event, Unplanned Catch	7	1	1		9
Not a Safety Event	2			1	3
Precursor Safety Event, Minimal Temporary Harm	3	2	3	1	9
Precursor Safety Event, No Detectable Harm	24	19	14	11	68

Precursor Safety Event, No Harm	12	5	5	12	34
Serious Safety Event, Moderate Temporary Harm	9	3		1	13
Serious Safety Event, Severe Permanent Harm	1				1
Serious Safety Event, Severe Temporary Harm	1				1
Grand Total	**65**	**31**	**27**	**29**	**152**



Recommended Next Steps

Who Is Recommending	What (Action/IOU)	When Due (Status)	Action Responsibility
Interim Process			

Who Is Recommending	What (Action/IOU)	When Due (Status)	Action Responsibility
Kassie Waters & Michelle Peterson	ED & acute care units will utilize SBAR (Situation, Background, Assessment, and Recommendation) handoff tool until Cerner tool is completed. ED educator will provide education for all staff and include tool on-boarding new employees. • Added risk assessments to tool. • ED also making condense flyers to post in key areas where handoff occurs. House wide SBAR tool was sent out via Essential Information to Know with generic form to use.	Complete Complete	Kassie Waters & Michelle Peterson Kassie Waters & Lacey Jensen
Long Term Process – Cerner Electronic Handoff Tool			
Kassie Waters/ Handoff QFT	• ISS presented New Cerner Handoff best practices. Presented tool to key stakeholders. • Surgery & Cath Lab – will use current tool until OR elements can be added. • ED – Good to go with EMR tool. • Peds – Likes EMR tool but need peds elements to be built in. • Mental Health – pending. • Sub-acute/Rehab – go live in Oct or Nov with ECD build • Mother/Baby – good process just need titles of SBAR placed into it.	Complete TBD 8/11/22 8/8/22 8/16/22 Pending Pending	Kassie Waters & Leah Daugherty

Who Is Recommending	What (Action/IOU)	When Due (Status)	Action Responsibility
Kassie Waters/ Handoff QFT	• Finalize and build handoff tool	8/22/2022	Leah Daugherty & Kim Roller
Kassie Waters/ Handoff QFT	Go-Live • Rollout and educate staff. Aug-Sept (will review best time for education with Directors) ○ Via mandatory classroom teaching of the EMR. ○ Handoff QFT reviewed final live EMR handoff made minor changes. **CONCERN-Nursing Tasks are loading slowly for staff to view. Will test on department computers.** ○ Video showing poor and well done handoff using the EMR tool. Video will address why, how, where and when. Handoff will be done in front of a computer at a nurses station to review the EMR SBAR and then they will be required to go into each room and complete: 1. Introductions 2. Check Patient Condition 3. Check Lines/Devices 4. Check Room Safety • Builds to be completed. MCH, Mental Health, Subacute, Rehab/short stay ,and Procedural areas.	Aug-Sept 2022 ECD Education DONE ECD Handoff go-live Sept 20th Video filmed 9/13/2022 Educations has gone out as mandatory education for staff starting December 5th with a deadline of Jan 5th. Organization compliance 90% with education. All new hires will complete education. Module listed on orientation packet to complete. MCH meeting 1/31/23 – complete: currently waiting on build time update.	Frank Martin, Lacey Jensen, & Leah Daugherty

Who Is Recommending	What (Action/IOU)	When Due (Status)	Action Responsibility
Kassie Waters/ Handoff QFT	• Audit	Tool completed. The audit started on Jan 16th, 2023.	Frank Martin

Audit

We currently have 14 departments participating in the weekly audits.

Guidelines

- Each department completes five shift-to-shift audits per week.
- Goal is an 80% monthly compliance rate utilizing the SBAR EMR tool.
- When each department is successful for three consecutive months with an 80% success rate, they will move to a quarterly audit.

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SBAR Handoff

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Overall							
All Patients	80%	44.0%	76.0%				

KEY: >10% below goal/benchmark | Within 10% of goal/benchmark | Outperforming/meeting goal/benchmark

Audit Progress

- The audit started with a low floor compliance rate, but as the weeks progressed, the compliance increased.
  - Three email reminders are sent out every week to all leaders.
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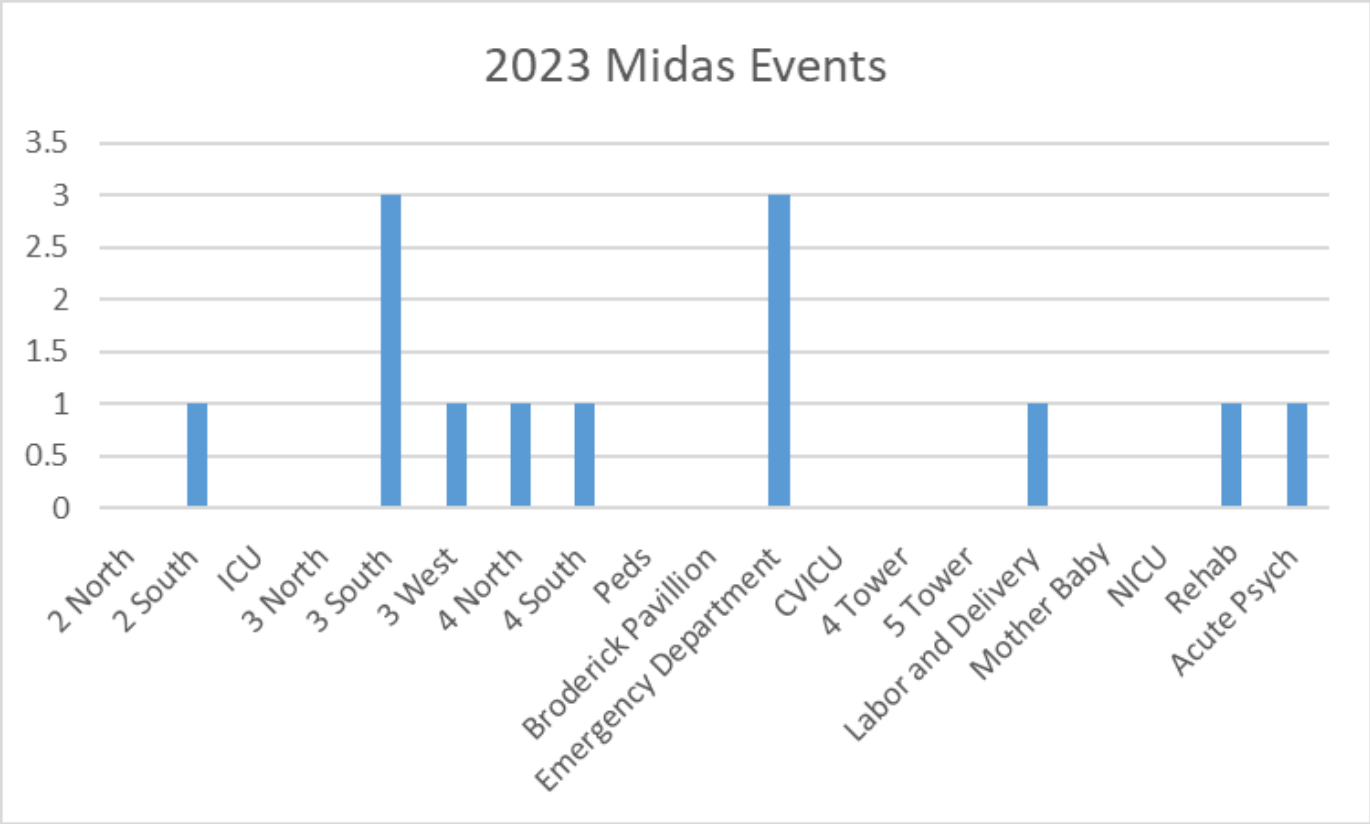
- So far, the data shows that when the nurse fails to utilize the EMR SBAR tool during handoff, there are missing items reported.
- We will add a spot on the SBAR audit form for leader comments when there is a report of missing items during handoff.

Midas Events by Category

	2023			
Count of Significance	**1Q (Jan-Feb)**	**2Q**	**3Q**	**4Q**
E-Medication Event, Causing Temporary Harm & Intervention				
Near Miss Safety Event, Early Barrier Catch				
Near Miss Safety Event, Last Strong Barrier Catch	3			
Near Miss Safety Event, Unplanned Catch	1			
Not a Safety Event	1			
No Harm Detected - Precursor Safety Event	7			
Precursor Safety Event, Minimal Temporary Harm				
Serious Safety Event, Moderate Temporary Harm				
Serious Safety Event, Severe Permanent Harm				
Serious Safety Event, Severe Temporary Harm	1			
Total	13			



Midas Events

- We will continue to monitor Midas events and reports to identify any opportunities for improvement related to the SBAR EMR.

Outstanding Health Outcomes Update

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

March 2023

FY23 Clinical Quality Goals

	July-Dec 22 Higher is Better	FY23 Goal	FY22	FY22 Goal
SEP-1 (% Bundle Compliance)	76%	≥ 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.

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 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 0	1 0	2 0	1 1	2 0	3 0	0 0	1 0					14 (23 predicted over 12 months)	0.680 0.748 Including COVID	≤0.650	1.092 0.54 1.12
CLABSI Central Line Associated Blood Stream Infection Excluding COVID INCLUDING COVID-19 PATIENTS	3 1	0 0	0 0	0 0	1 0	3 1	1 0	1 0					10 (17 predicted over 12 months)	0.786 0.982 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	2 0	1 1	0 0					5 (8 predicted over 12 months	0.662 0.827 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.