Kaweah Delta Health Care District
Board Of Directors Committee Meeting

***Health** is our Passion. **Excellence** is our Focus. **Compassion** is our Promise.*

NOTICE

The Quality Council Committee of the Kaweah Delta Health Care District will meet at the Kaweah Health 4T Multipurpose Room on Thursday, December 11, 2025:

- 7:30AM Closed meeting.
- 8:00AM Open meeting.

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 meeting.

All Kaweah Delta Health Care District regular board meeting and committee meeting notices and agendas are posted 72 hours prior to meetings (special meetings are posted 24 hours prior to meetings) in the Kaweah Health Medical Center, Mineral King Wing near the Mineral King entrance.

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

KAWEAH DELTA HEALTH CARE DISTRICT

David Francis, Secretary/Treasurer

Kelsie Davis

Board Clerk / Executive Assistant to CEO

DISTRIBUTION:

Governing Board, Legal Counsel, Executive Team, Chief of Staff, www.kaweahhealth.org

Kaweah Delta Health Care District
Board Of Directors Committee Meeting

***Health** is our Passion. **Excellence** is our Focus. **Compassion** is our Promise.*

Kaweah Delta Health Care District Board of Directors Quality Council
Meeting held: Thursday, December 11, 2025 • Kaweah Health 4T Multipurpose Room
Attending: Board Members: Michael Olmos (Chair), Dean Levitan, MD; Gary Herbst, CEO; Schlene Peet, Chief Nursing Officer; Paul Stefanacci CMO/CQO; Jag Batth, Chief Operating Officer; Michael Tedaldi, MD, Vice Chief of Staff and Quality Committee Chair; LaMar Mack, MD, Quality and Patient Safety Medical Director; Marc Mertz, Chief Strategy Officer; Ryan Gates, Chief Ambulatory Officer; Ben Cripps, Chief Compliance and Risk Management Officer; Evelyn McEntire, Director of Risk Management; Cindy Vander Schuur, Patient Safety Manager; and Kyndra Licon, Recording.

OPEN MEETING – 7:45 AM

1. **CALL TO ORDER –** Mike Olmos, 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 jurisdictions 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 (Kelsie Davis 559-624-2330) or kedavis@kaweahhealth.org to make arrangements to address the Board.

3. **ADJOURN OPEN MEETING –** Mike Olmos, Committee Chair

CLOSED MEETING – 7:46 AM

1. **CALL TO ORDER –** Mike Olmos, Committee Chair

2. **Review of the November Quality Council Closed Session Minutes –** Mike Olmos, Committee Chair; Dean Levitan, Board Member

3. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – Michael Tedaldi, MD, Vice Chief of Staff and Quality Committee Chair

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

Kaweah Delta Health Care District
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5. **ADJOURN CLOSED MEETING –** Mike Olmos, Committee Chair

OPEN MEETING – 8:00 AM

1. **CALL TO ORDER -** Mike Olmos, 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. **Close Meeting Report Out**

4. **Review of November Quality Council Open Session Minutes -** Mike Olmos, Committee Chair; Dean Levitan, Board Member

5. **Written Quality Reports –** A review of key quality metrics and actions associated with the following improvement initiatives:

    a. **HAPI Quality Report**
    b. **Hand Hygiene Dashboard**
    c. **Subacute Quality Report**
    d. **Diabetes Committee Report**

6. **Emergency Department Quality Report –** A review of current performance and actions focused on the clinical goals for Emergency Department. *Scott Baker, RN, Director of Director of Emergency and Trauma Services.*

7. **Kaweah Health Chronic Dialysis Report –** A review of key performance indicators and action associate with care of dialysis patient population. *Amy Baker, MSN, RN, Director of Specialty Clinics; Connie Green, Nurse Manager, Chronic Dialysis.*

8. **Clinical Quality Goals Update –** A review of current performance and actions focused on the clinical quality goals for Healthcare Acquired Infection and Patient Safety Indicator (PSI) 90 Composite. Shawn Elkin, Infection Prevention Manager; Chris Patty, Clinical Practice Guidelines Program Manager.

9. **ADJOURN OPEN MEETING -** Mike Olmos, Committee Chair

Kaweah Delta Health Care District

Board Of Directors Committee Meeting

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Agenda item intentionally omitted

OPEN Quality Council Committee
Thursday, November 13, 2025
The Executive Office Conference Room

Attending: Board Members: Mike Olmos (Chair) & Dr. Dean Levitan, Board Member; Gary Herbst, CEO; Sandy Volchko, Director of Quality & Patient Safety; Schlene Peet, Chief Nursing Officer; Dr. Lamar Mack, Quality and Patient Safety Medical Director; Marc Mertz, Chief Strategy Officer; Dr. Michael Tedaldi, Vice Chief of Staff and Chair; Jag Batth, Chief Operation Officer; Ryan Gates, Chief Ambulatory Officer; Malinda Tupper, Chief Financial Officer; Shawn Elkin, Infection Prevention Manager; Dr. Paul Stefanacci, Chief Medical Officer; Chris Patty, Clinical Practice Guidelines Program Manager; Kyndra Licon – Recording.

Mike Olmos called to order at 7:30 AM.

Review of Closed Session Agenda: Dr. Dean Levitan made a motion to approve the closed agenda, there were no objections.

Mike Olmos adjourned the meeting at 7:31 AM.

Public Participation – None.
Mike Olmos called to order at 8:00 AM.

4. **Review of October Quality Council Open Session Minutes –** Mike Olmos, Committee Chair; Dr. Dean Levitan, Board Member.
    - Reviewed and acknowledged the October Quality Council Open Session Minutes by Dr. Dean Levitan and Mike Olmos. No further actions.

5. **Written Quality Reports –** a review of key quality metrics and actions associated with the following improvement initiatives: Reports reviewed and attached in minutes. No action taken.
    a. **Falls Reduction Initiative Report**
    b. **Trauma Committee Quality Report**

6. **Leapfrog Update –** A review of Kaweah Health letter grad eon performance in preventing medical errors, infections, and other patient safety issue. *Sandy Volchko, RN, DNP, Director of Quality and Patient Safety.* Report reviewed and attached in minutes. No action taken.

7. **Healthgrades Update -** A review of Kaweah Healthgrades methology Star Ratings & Specialty Awards. *Chris Patty, DNP, RN, clinical Guideline Program Manager.* Report reviewed and attached in minutes. No action taken.

8. **Clinical Quality Goals Update**- A review of current performance and actions focused on the clinical quality goals for Healthcare Acquired Infections and Patient Safety Indicator (PSI) 90 Composite. – Reports reviewed and attached to minutes. No action taken.

Adjourn Open Meeting – *Mike Olmos, Committee Chair*

Mike Olmos adjourned the meeting at 9:05 AM.

PATIENT SAFETY PRIORITY

Hospital Acquired Pressure Injury (HAPI) Reduction Initiative

November 2025

Abbi Amankwa APRN, MSN, FNP-C
Chika Agulanna APRN, MSN, FNP-BC

Kaweah Health
MORE THAN MEDICINE. LIFE.

Calendar Year 2025 PLAN

High Level Action Plan

Standardize and enculturate evidence- based prevention practices with 100% compliance:

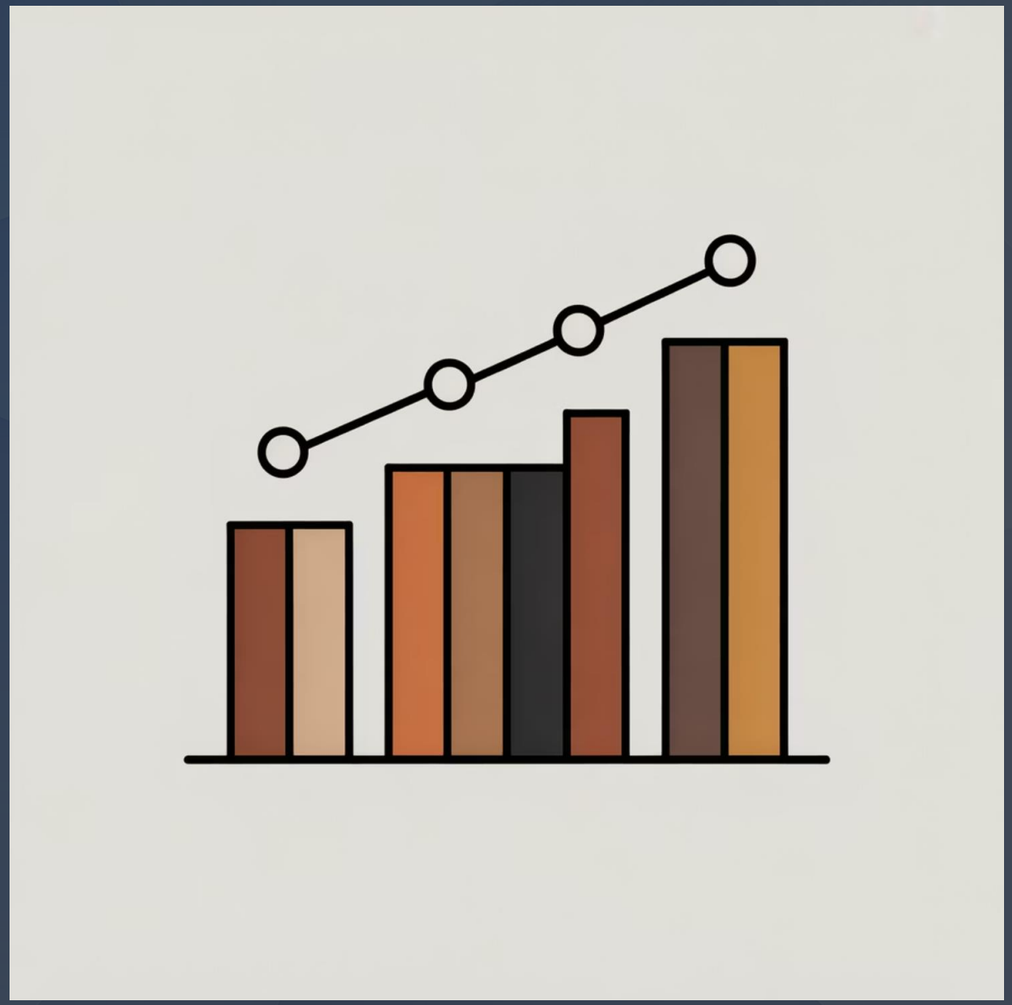
Skin assessments	Q2 hour turning	Shift handoff on prevention strategies

- Focus: Improve wound documentation accuracy, nutritional monitoring, and interdisciplinary communication related to Hospital-Acquired Pressure Injuries (HAPIs).
- Initial goal: 100% compliance sustained over three consecutive months.
- Revised goal (approved 9/22/25 by Patient Safety Committee): 95% compliance for three consecutive months to reflect realistic operational capacity.

- Key metrics monitored include:
  - Meal percentage documentation
  - Timely Registered Dietitian (RD) consults
  - Turning and handoff compliance
  - Wound assessment accuracy and wound care documentation

Kaweah Health

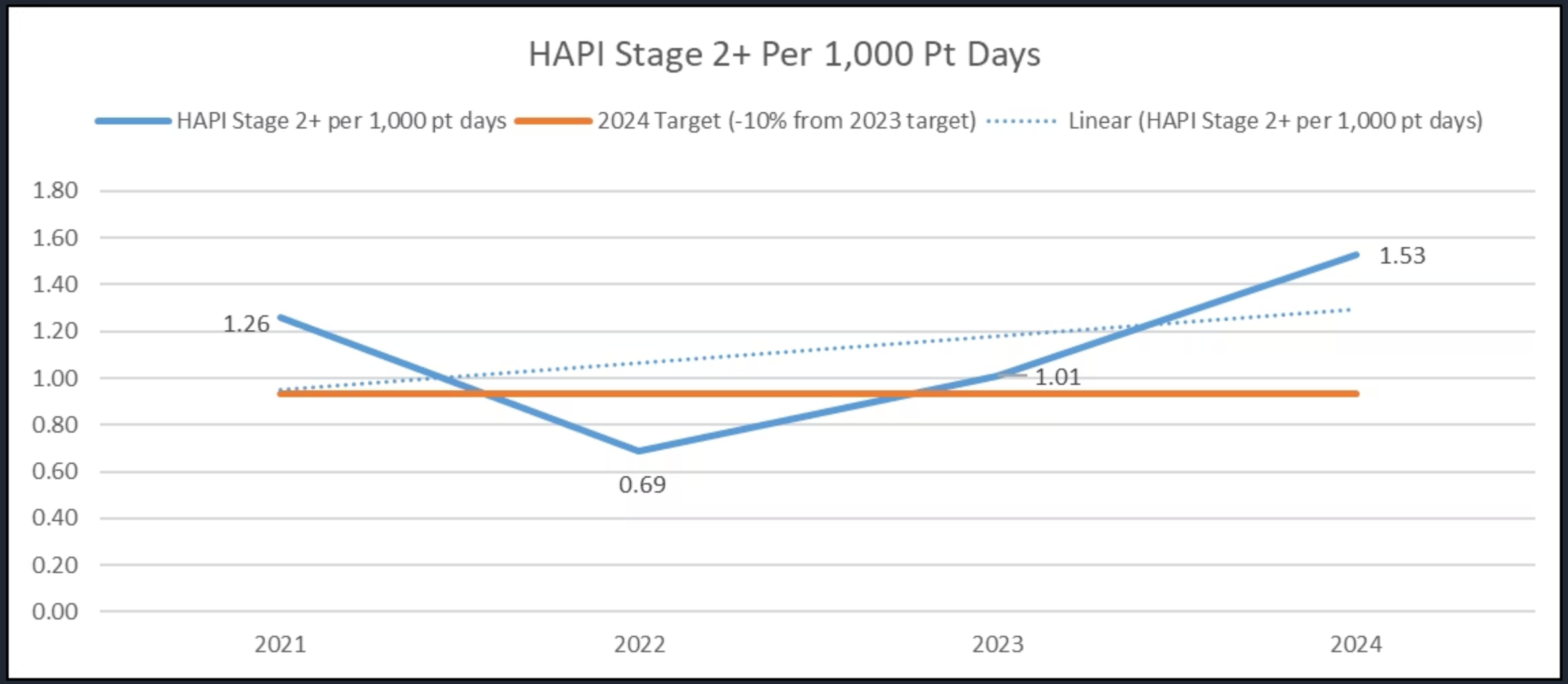
HAPI Reduction Update..



Kaweah Health

2025 GOAL

HAPI Stage 2+ per 1,000 pt days was reduced to 0.54 in Jan 2025. The previous benchmark was an internal target set by the committee. The current benchmark of 0.54 per 1000 patient days is a result of a review of the current literature.



Kaweah Health

HAPI Reduction Update

PROGRESS ON 2024-2025 PLAN

High Level Action Plan

Standardize and enculturate evidence-based prevention practices with 100% compliance:

1. **Skin assessments** – All units met goal & moved to quarterly audit starting June 1, 2025.
2. **Q2 hour turning**- All units met compliance & moved to quarterly audits starting June 1, 2025.
3. **Shift handoff on prevention strategies** –Steady improvement to full compliance → measure closed.

Wound Care Team Expansion

- Expanded the Wound Care Team to include **two Wound Care Nurse Practitioner (NP) Leads**, who oversee and support a multidisciplinary team of RNs and LVNs.
- Focus: Improve patient outcomes through real-time bedside support, nurse education, and implementation of best practices in wound prevention and treatment.

Night Coverage & Support

- **Night Wound Care Consult Pilot** launched to provide wound care coverage, education and support across all inpatient units, including new admissions.

Braden Score Validation and Education

- Wound Care Team now **reviews and documents current Braden Scores** in every consult note.
- Identifies and addresses discrepancies between shifts.

Kaweah Health

HAPI Reduction Update

Skin Champions Program

- **Launched September 2025** in collaboration with **Smith & Nephew**.
- A **five-part educational series** combining lectures and hands-on training designed to enhance pressure injury prevention, wound care and promote best practices in skin care.
- The program develops **unit-based Skin Champions** who serve as key educators, resources, and wound prevention leaders within their departments.

- **47 participants enrolled; 32 successfully completed** the certification.
- First class completed October 18th, 2025

Education and Rounding Initiatives

- **APPLE PIE Rounding – "Show on the Road"** remains **tentative for launch**, pending final scheduling and resource allocation.
- **Wound Care Class** currently undergoing **revamp** to integrate updated, evidence-based practices.
    - 100% of licensed staff who were identified as priority (approximately 380 staff) completed training by April 30, 2025.
        - Classes are temporarily on hold until the new curriculum is finalized and approved for relaunch.

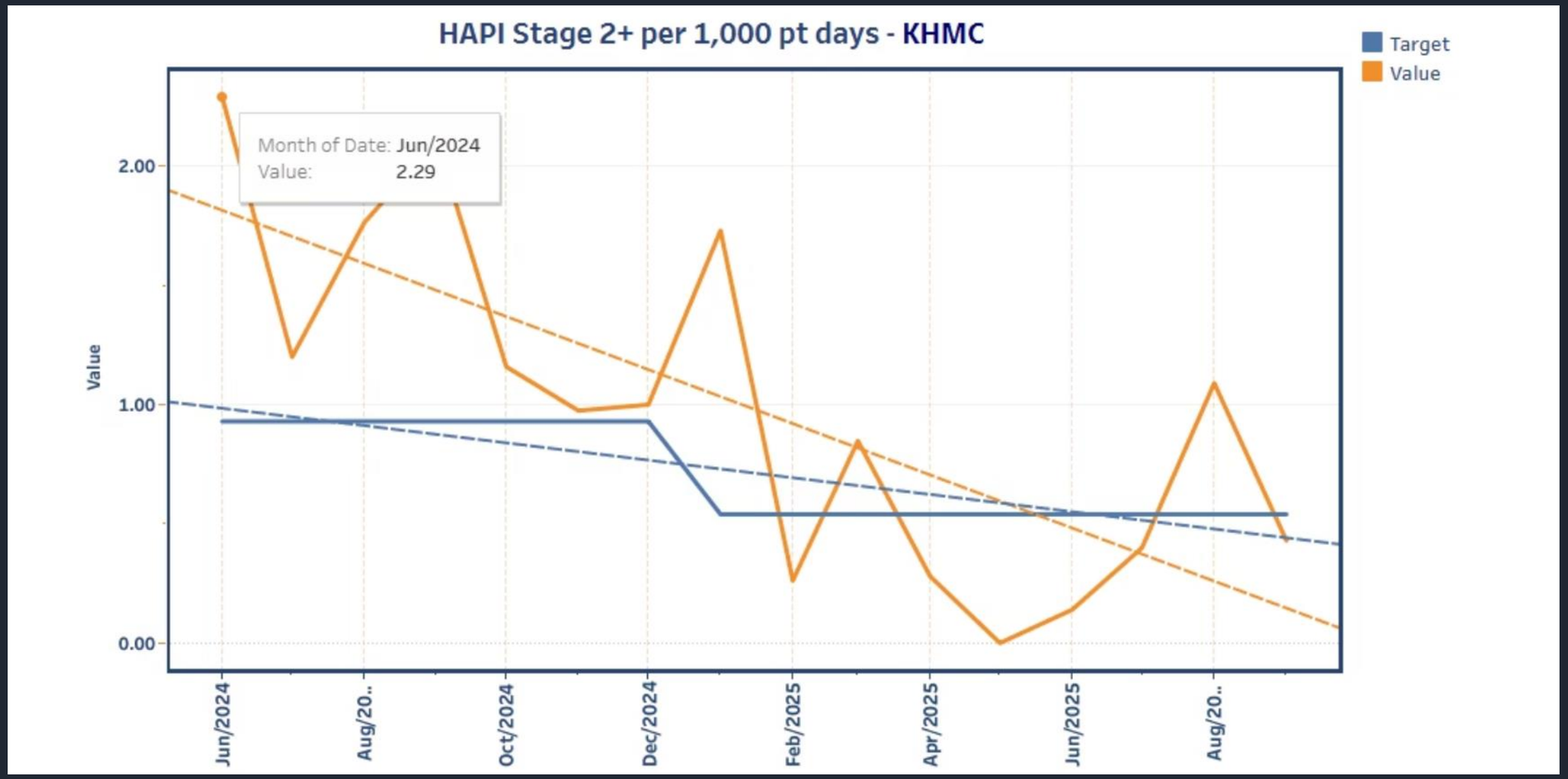
100% of wounds are treated when identified – November 2025- 90% No orders in place or not documented-leadership coach and council staff

Kaweah Health

HAPI Reduction Update

2025 GOAL

Both actual rate and target show a downward trend. Actual performance improved faster than the target line, indicating successful interventions.



HAPI Stage 2+ per 1,000 Patient Days – KHMC Summary
Overall Trend

Both **actual rate** and **target** show a **downward trend**.

Actual performance improved faster than the target line, indicating **successful interventions**.

Key Period Insights

- **Starting Point (June 2024):**
  - Rate: **2.29 per 1,000 patient days** — significantly above target.
- **Mid-Period (Late 2024 – Early 2025):**
  - Fluctuation in monthly values, but **clear downward trend** overall.
  - **Feb–Apr 2025:** Sharp reduction; rates approached **zero**.
- **Recent Period (Summer 2025):**
  - Slight increase in rates, but **remained below 1.0**, showing **sustained improvement**.

Kaweah Health

Measure of Success – Documentation of Meal Percentage Consumed

Purpose: Ensure consistent EHR documentation of % of meal consumed, as poor intake is a known risk factor for pressure injury development.

Audit Details:

- 70 random meal audits per month across critical care, step-down, med/surg, and acute rehab units.
- Goal: ≥95% compliance for 3 consecutive months.

Results:

- **June 2025:** 89.6% — below target; Smartsheet access issues disrupted data collection.
- **July 2025:** 94.1% — near goal; breakfast/lunch documentation high (97%), dinner lowest (88%).
- **August 2025:** 86.8% — regression due to missed dinner entries and off-unit patients without NPO documentation.
- **September 2025:** 95.7% — goal met; strong recovery after interventions.

HAPI Reduction Update

Measure of Success – Registered Dietitian Consults for Poor Oral

Purpose: Ensure that patients with poor PO intake receive timely RD consults per policy FNS.801.

Audit Details:

- 70 patients audited monthly from all inpatient areas.
- Goal: 100% compliance.

Results:

- **June 2025:** 95.7%
- **July 2025:** 90.5% — decline linked to inconsistent consult triggers.
- **August 2025:** 100% — goal met.
- **September 2025:** 100% — sustained goal for second consecutive month.

Kaweah Health

Aggregate RCA – HAPI Committee Measures

Purpose: Evaluate process compliance in turning, handoff, and secondary skin assessment practices.

Turning Episodes:

- Target: 30 observed turns per unit per month.
- Achieved and sustained ≥3 months → measure closed.

Change-of-Shift Handoff:

- June: 88.3%; July: 98.8%; August & September: 100%.
- Steady improvement to full compliance.

Secondary Skin Assessment:

- 30 audits per month; goal sustained at 100% for ≥3 months.
- Achieved and closed.

Outcome:

- All three process measures achieved and maintained.
- Indicates consistent adoption of best practices for HAPI prevention.

HAPI Reduction Update

4T Unstageable HAPI – Measure of Success - Wound Assessment Documentation Accuracy

Purpose: Ensure bedside nurses' wound documentation matches Wound Care RN assessment and staging.

Audit Details:

- 50 random wound assessments reviewed monthly (med/surg, step-down, critical care).
- Goal: 100% compliance for 3 consecutive months.

Results:

- **July 2025:** 100% compliance.
- **August 2025:** Data not available.
- **September 2025:** 68% compliance — significant decline.

Kaweah Health

HAPI Reduction Update

4T Unstageable HAPI – Measure of Success #2: Wound Care Documented as Ordered

Purpose: Ensure wound care treatments are provided and documented per wound RN or provider order.

Audit Details:

- 30 random wound care opportunities per month (or 100% if fewer are available).
- Goal: 100% compliance for 3 consecutive months.

Results:

- Compliance achieved and sustained → **measure closed.**

Outcome:

- Reflects strong nursing accountability and consistent adherence to wound care orders.
- Supports continuity of treatment and prevention of wound deterioration.

Kaweah Health

Targeted Opportunities (What Specifically Is Causing the Fallouts?)

Documentation of Meal Percentage Consumed

- Forgetfulness or lack of awareness of documentation requirements.
- Patients off unit without NPO order placed.
- Trays removed by family or ancillary staff without communication to CNAs.
- HUCs not running reports consistently after Smartsheet access ended.

Actions Taken:

- Created new Microsoft 365 tracking tool to replace Smartsheet for meal auditing.
- Re-educated HUCs on how to run and distribute meal % reports every shift.
- Required host staff to bring unused meal tickets to HUC/nurse for documentation.
- Developed signage and visual reminders to prompt staff documentation.

Outcome:

- September 2025 achieved 95.7% compliance, meeting the revised goal.
- Indicates effective process correction and improved staff engagement.
- Dinner documentation remains the most common opportunity for improvement.

Kaweah Health

Registered Dietitian Consults for Poor Oral Intake

- Occasional delays in initiating RD consults when low intake noted.

Actions Taken:

- Reinforced consult triggers and workflow in EHR with nursing staff.
- Improved communication between nursing and dietitians.

Outcome:

- Two consecutive months at 100% reflect sustained success and improved interdisciplinary coordination.
- Measure considered stabilized.

Aggregate RCA – HAPI Committee Measures

Purpose: Evaluate process compliance in turning, handoff, and secondary skin assessment practices.

Turning Episodes:

- Target: 30 observed turns per unit per month.
- Achieved and sustained ≥3 months → measure closed.

Change-of-Shift Handoff:

- June: 88.3%; July: 98.8%; August & September: 100%.
- Steady improvement to full compliance → measure closed.

Secondary Skin Assessment:

- 30 audits per month; goal sustained at 100% for ≥3 months.
- Achieved and closed.

Outcome:

- All three process measures achieved and maintained.
- Indicates consistent adoption of best practices for HAPI prevention.

Targeted Opportunities

4T Unstageable HAPI – Measure of Success Wound Assessment Documentation Accuracy

- Discrepancies between bedside and wound nurse documentation tools and charting options.
- Inconsistent interpretation of “fallout” between auditors.
- Clinically accurate but non-standard descriptive terms (e.g., “discolored” vs. “necrotic”) flagged incorrectly.
- Multiple auditors entering data without standardization.

Actions Taken:

- Standardized audit tools and clarified fallout definitions.
- Provided staff education to align bedside and wound nurse documentation.
- Initiated collaboration with IT to align EHR templates for wound charting.

Outcome:

- Temporary decline possibly attributed to audit inconsistency rather than clinical error.
- Education and standardization expected to restore accuracy and sustainability.

Overall Summary

- Out of all monitored measures, **six are achieved or closed**, and **one (wound documentation accuracy)** remains under active improvement.

- Nutritional and handoff metrics have reached and sustained goals, showing strong interdisciplinary engagement.
- Documentation and data collection challenges (e.g., platform changes, EHR limitations, variable audit interpretation) temporarily affected accuracy but are being addressed through system alignment and education.
- The overall trend demonstrates a **maturing quality culture**, with increasing compliance, stronger cross-department collaboration, and clear accountability processes for sustained improvement.
- The September 2025 data confirm **significant progress** in reducing risk factors contributing to HAPI development and improving reliability in clinical documentation.

Kaweah Health

Live with passion.

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

Kaweah Health

Thank You

Hand Hygiene (HH) Dashboard

Measure Description	Benchmark/ Target	2022Q3	2022Q4	2023Q1	2023Q2	2023Q3	2023Q4	2024Q1	2024Q2	2024Q3	2024Q4	2025Q1	2025Q2	2025Q3	Oct-25	25-Nov
OUTCOME MEASURES																
HH Overall Compliance	95%	96.42	96.47	96.52	96.08	95.95	95.21	94.94	94.27	93.85	93.9%	93.9%	93.53	93.60	94.23	94.6
Number of HH Audits Performed	n/a	3,226,589	2,648,996	2,872,214	2,776,657	3,181,447	3,563,381	3,846,150	3,967,112	4,041,305	4,531,199	4,716,280	4,954,673	5,266,095	1,745,272	1,695,180
HH Overall Compliance - Patient Care Areas	95%	96.91	96.60	96.57	96.18	95.95	95.22	94.94	94.27	93.86	93.9%	93.9%	93.54	93.60	94.23	94.6
Number of HH Audits Performed - Patient Care Areas	n/a	2,816,731	2,422,678	2,623,609	2,488,916	3,181,417	3,562,355	3,846,085	3,965,771	4,035,120	4,523,634	4,708,634	4,946,140	5,258,471	1,742,336	1,691,731
PROCESS MEASURES - Patient Care Units																
Hand Hygiene By Day/time																
HH Overall Compliance - AM Shift	95%	96.84	96.56	96.52	96.12	95.88	95.16	94.66	94.70	94.35	93.6%	93.7%	93.93	93.21	93.7	94.3
Number of HH Audits Performed - AM Shift	n/a	1,788,791	1,537,477	1,692,071	1,581,236	2,009,845	2,231,993	2,364,156	1,860,837	1,913,533	2,876,676	2,982,305	2,355,765	2,750,986	1,098,264	1,076,071
HH Overall Compliance - PM Shift	95%	97.02	96.67	96.67	96.29	96.08	95.32	95.39	93.89	93.42	94.5%	94.4%	93.17	94.02	95.0.9	95.2
Number of HH Audits Performed - PM Shift	n/a	1,027,940	885,201	931,538	907,680	1,171,572	1,330,362	1,481,929	2,104,934	2,121,587	1,646,958	1,726,329	2,590,375	2,507,485	644,072	615,660
HH Overall Compliance - Weekdays	95%	96.90	96.53	96.52	96.14	95.91	95.19	94.94	94.32	93.84	93.8%	94.0%	93.52	93.59	94.17	94.5
Number of HH Audits Performed - Weekdays	n/a	2,161,631	1,831,097	2,036,012	1,896,628	2,439,272	2,729,350	2,947,875	3,022,708	3,098,453	3,469,987	3,560,529	3,735,547	4,006,882	1,355,689	1,211,739
HH Overall Compliance - Weekends	95%	96.94	96.82	96.77	96.33	96.10	95.33	94.93	94.11	93.91	94.0%	93.8%	93.59	93.61	94.46	94.9
Number of HH Audits Performed - Weekends	n/a	655,100	591,581	587,597	592,288	742,145	833,005	898,210	943,063	936,667	1,053,647	1,148,005	1,210,593	1,251,589	386,647	479,992
Hand Hygiene By Patient Care Unit Location (*biovgil data)																
2AcequiaCVC - HH Compliance	95%	95.10	95.52	94.88	95.95	94.64	88.56	90.03	91.08	91.83	92.6%	90.0%	90.33	89.95	92.08	91.62
2AcequiaCVC - HH Audits Performed	n/a	42,591	32,295	32,071	20,203	30,379	27,456	38,799	52,836	50,754	56,984	84,030	90,734	97,158	36,933	27,413
2EastLabor&Delivery - HH Compliance	95%	96.69	96.54	97.00	97.32	96.47	96.51	97.45	96.50	95.21	96.0%	92.2%	94.52	93.52	94.55	94.72
2EastLabor&Delivery - HH Audits Performed	n/a	103,004	97,575	83,086	80,939	105,147	133,487	164,481	193,305	207,139	208,764	219,409	173,287	168,510	55,460	51,259
2NorthMedTele - HH Compliance	95%	96.22	95.87	94.52	94.09	94.69	93.47	92.82	91.95	91.81	91.5%	93.0%	93.32	93.00	95.15	95.24
2NorthMedTele - HH Audits Performed	n/a	301,476	291,144	320,448	288,901	258,049	218,788	228,852	248,703	273,653	310,960	344,245	316,922	404,650	139,168	138,247
2SouthObservation - HH Compliance	95%	97.11	96.90	96.48	96.24	96.22	94.42	94.62	94.61	95.03	94.2%	92.8%	93.03	92.66	93.06	94.24
2SouthObservation - HH Audits Performed	n/a	198,488	166,970	177,196	171,920	102,651	116,697	100,185	174,225	171,910	204,900	251,501	291,600	274,087	66,450	62,060
2WestICU - HH Compliance	95%	97.21	97.10	97.00	97.36	96.78	96.02	94.65	94.09	92.56	92.5%	93.2%	94.29	94.92	94.9	95.18
2WestICU - HH Audits Performed	n/a	105,929	67,661	76,377	71,635	84,736	92,078	148,161	205,833	228,603	231,198	226,564	214,862	216,752	64,264	64,418
3AcequiaCVICU - HH Compliance	95%	95.01	93.00	92.72	92.48	94.35	92.72	91.83	92.76	91.93	91.2%	92.1%	91.92	92.58	94.43	93.47
3AcequiaCVICU - HH Audits Performed	n/a	124,390	102,607	103,381	92,509	115,903	173,181	163,191	202,163	204,423	242,723	230,329	222,832	237,621	88,193	87,057
3AcequiaMotherBaby - HH Compliance	95%	97.68	97.65	97.69	97.81	97.85	97.22	96.91	96.62	96.03	97.2%	97.1%	97.11	97.01	97.04	93.47
3AcequiaMotherBaby - HH Audits Performed	n/a	116,523	106,521	105,543	94,701	105,201	95,192	115,659	138,073	134,295	161,571	173,233	149,216	167,952	47,047	52,394
3EastPediatrics - HH Compliance	95%	97.57	96.73	97.47	97.97	98.12	97.85	98.01	98.42	97.87	98.3%	97.5%	97.89	97.47	97.69	97.79
3EastPediatrics - HH Audits Performed	n/a	22,493	22,872	17,139	10,637	11,742	15,975	23,144	22,990	24,605	28,464	42,355	28,480	33,138	7,312	8,071
3EastPostSurgery - HH Compliance	95%	98.98	98.97	99.08	99.06	98.30	98.09	98.08	97.76	97.80	97.7%	97.2%	96.55	96.16	96.73	96.69
3EastPostSurgery - HH Audits Performed	n/a	58,918	47,917	57,873	51,394	46,509	42,212	55,195	55,299	51,391	63,810	63,821	69,466	63,261	21,173	19,241
3NorthMedSurg - HH Compliance	95%	97.92	98.00	97.87	98.09	97.53	97.01	96.41	95.93	95.49	95.1%	94.9%	94.57	94.24	94.63	95.08
3NorthMedSurg - HH Audits Performed	n/a	224,411	192,247	222,652	231,303	219,481	223,080	240,077	265,947	280,239	320,913	334,943	336,806	345,334	104,716	109,997
3SouthOncology - HH Compliance	95%	95.25	95.40	95.44	95.35	94.12	93.44	92.49	91.91	91.84	93.3%	92.3%	91.53	92.19	93.07	94.29
3SouthOncology - HH Audits Performed	n/a	225,974	193,534	176,571	147,794	165,451	220,284	225,141	244,942	242,309	256,550	255,419	280,316	311,919	110,251	122,081
3WestICCU - HH Compliance	95%	96.31	96.09	96.08	95.87	96.09	95.46	95.45	95.81	95.44	94.7%	94.8%	94.88	95.11	95.31	95.04
3WestICCU - HH Audits Performed	n/a	148,644	110,365	125,766	125,183	148,545	165,983	157,895	178200	190627	197,081	213,834	243,233	242,376	80,073	69,971
4AcequiaMedicalTelemetry - HH Compliance	95%	97.32	97.68	97.57	95.71	95.58	96.31	95.66	94.15	93.70	95.5%	94.5%	94.25	93.44	92.57	92.52
4AcequiaMedicalTelemetry - HH Audits Performed	n/a	70,311	65,918	78,236	98,378	118,592	144,661	141,372	177,861	195,303	233,503	228,310	264,002	276,532	85,775	87,275
4NorthRenalMedSurg - HH Compliance	95%	97.13	96.79	96.61	96.65	96.50	96.31	95.96	95.82	95.80	94.6%	93.4%	93.20	93.65	94.29	95.52
4NorthRenalMedSurg - HH Audits Performed	n/a	316,114	291,368	345,759	317,058	317,811	295,493	286,135	268,715	291,865	307,451	343,010	379,969	368,852	137,931	139,635
4SouthOrthoNeuroMedSurg - HH Compliance	95%	96.64	97.30	96.82	94.14	92.79	92.75	91.83	92.28	91.84	93.0%	93.4%	92.74	93.11	95.34	96.57
4SouthOrthoNeuroMedSurg - HH Audits Performed	n/a	125,023	96,735	177,977	236,388	187,359	211,382	258,732	257,201	246,625	278,055	288,117	300,390	393,927	148,150	149,871
5AcequiaCVICCU - HH Compliance	95%	92.56	92.45	94.81	93.77	93.68	92.15	92.31	92.50	93.03	93.0%	93.4%	93.25	93.71	94.76	94.21
5AcequiaCVICCU - HH Audits Performed	n/a	139,610	121,686	97,962	80,545	112,133	186,268	180,019	220,258	222,680	279,200	321,992	341,628	347,963	115,715	105,032
6AcequiaNICU - HH Compliance	95%	99.41	99.14	99.47	99.47	99.40	99.20	99.31	99.31	99.27	99.2%	99.2%	99.06	98.95	98.88	98.99
6AcequiaNICU - HH Audits Performed	n/a	143,019	133,497	129,330	115,644	124,205	106,234	112,657	146,660	156,421	151,952	140,869	148,376	167,154	42,026	44,033
ASC - HH Compliance	95%	97.39	96.70	95.96	95.43	98.15	96.92	95.53	93.55	95.03	93.2%	88.2%	84.61	87.47	85.13	87.45
ASC - HH Audits Performed	n/a	34,642	18,641	22,676	8,529	11,220	16,140	17,423	28,745	23,582	42,774	31,649	32,104	50,070	15,975	16,584
Emergency Department - HH Compliance	95%	90.01	92.97	95.66	94.52	93.59	92.80	94.75	89.93	87.68	87.7%	89.3%	88.40	88.29	88.32	89.78
Emergency Department - HH Audits Performed	n/a	213,753	78,836	69,926	153,415	75,500	89,330	92,825	302,056	278,265	304,392	255,763	359,499	319,948	99,772	89,800
Endoscopy - HH Compliance	95%	97.44	97.27	97.10	96.89	97.38	95.51	94.27	94.57	94.70	95.4%	94.8%	92.94	93.75	92.69	90.88
Endoscopy - HH Audits Performed	n/a	21,297	16,987	15,787	10,717	19,661	17,607	27,187	26,503	19,219	13,399	18,818	11,230	14,033	4,759	4,833
Infusion - HH Compliance	95%	94.44	94.32	94.35	95.86	97.49	98.55	97.25	97.73	96.53	97.4%	97.0%	97.27	96.32	95.56	95.14
Infusion - HH Audits Performed	n/a	12,958	11,152	9,014	10,678	12,809	11,981	13,128	15,635	16,075	13,911	11,987	10,373	15,203	6,664	4,587
Mental Health - HH Compliance	95%	NULL	NULL	NULL	NULL	NULL	80.22	79.15	83.33	72.93	72.8%	70.4%	74.44	80.09	77.83	80
Mental Health - HH Audits Performed	n/a	NULL	NULL	NULL	NULL	NULL	465	2,422	10,899	6,146	3,882	1,700	13,331	29,624	11,501	8,564

SouthCampusSubAcuteCare - HH Compliance	95%	98.15	97.38	97.81	97.42	97.41	96.98	96.18	96.05	95.88	96.8%	96.7%	96.30	96.91	97.31	97.14
SouthCampusSubAcuteCare - HH Audits Performed	n/a	158,928	140,866	161,004	147,616	109,623	99,464	115,114	190,107	187,737	233,304	213,786	246,788	276,981	91,848	92,813
SouthCampusTCS - HH Compliance	95%	99.40	99.21	99.03	99.09	97.68	98.19	97.01	95.67	99.08	97.9%	NULL	NULL	NULL	NULL	NULL
SouthCampusTCS - HH Audits Performed	n/a	93,993	27,367	1,132	766	560	443	6,720	693	761	1,086	NULL	NULL	NULL	NULL	NULL
WestCampusAcuteCareRehab/ShortStay - HH Compliance	95%	97.99	97.20	97.54	97.49	96.99	95.84	96.44	96.71	96.60	95.4%	95.3%	96.09	95.74	95.52	95.52
WestCampusAcuteCareRehab/ShortStay - HH Audits Performed	n/a	139,598	145,829	166,567	126,061	109,124	126,968	168,056	244,405	232,201	268,483	304,312	308,203	307,215	112,475	96,304
WestCampusDialysis - HH Compliance	95%	96.77	96.38	96.29	96.33	96.40	96.43	95.30	94.91	94.36	93.8%	93.7%	92.60	92.60	93.11	91.43
WestCampusDialysis - HH Audits Performed	n/a	75,022	60,743	92,153	79,316	80,820	76,804	60,558	90,425	96,961	107,067	107,089	111,494	127,644	48,466	39,950
WestCampusWoundCare - HH Compliance	95%	97.60	97.52	97.18	90.70	96.06	96.74	96.09	96.12	98.35	97.9%	98.5%	97.70	99.29	98.33	98.76
WestCampusWoundCare - HH Audits Performed	n/a	9,595	8,154	7,017	4,883	6,068	4,205	4,829	3,092	1,331	1,257	1,549	999	567	239	241
Hand Hygiene by Role (>10 observations in one quarter, does not inlcude biovigil)																
Aide - HH Compliance	95%	96.59	97.46	96.44	95.94	95.72	95.66	95.51	93.58	94.17	95.7%	96.3%	97.07	97.81	98.17	98.54
Aide - HH Audits Performed	n/a	32,989	24,288	22,916	26,422	14,670	16,992	19,035	16,738	18,074	17,106	14,123	13,546	14,543	5,641	4,923
C.N.A. - HH Compliance	95%	96.00	95.61	95.53	93.79	94.00	93.06	92.73	92.59	92.15	92.2%	92.3%	93.07	93.01	94.08	94.36
C.N.A. - HH Audits Performed	n/a	712,329	579,885	668,698	617,169	648,793	746,829	767,452	739,455	723,766	852,569	982,392	1,069,177	1,134,019	390,434	370,903
EVS - HH Compliance	95%	96.38	96.51	96.60	97.47	95.77	95.58	93.18	92.78	93.45	96.9%	97.0%	95.83	94.87	94.79	95.08
EVS - HH Audits Performed	n/a	140,698	140,719	223,114	276,919	280,969	320,456	335,387	315,541	341,963	387,777	384,618	368,077	357,713	119,320	116,517
LVN/Tech - HH Compliance	95%	96.46	96.79	96.92	95.76	95.28	94.25	95.40	94.31	93.61	94.0%	93.5%	92.47	92.77	92.63	93.96
LVN/Tech - HH Audits Performed	n/a	295,512	236,036	254,785	289,104	185,829	211,115	232,407	218,284	230,443	251,686	218,597	209,556	212,731	67,090	58,771
Nurse - HH Compliance	95%	96.17	96.31	96.44	96.32	96.47	95.53	95.44	95.46	95.60	95.2%	94.0%	92.88	93.07	93.86	94.52
Nurse - HH Audits Performed	n/a	1,601,691	1,264,992	1,261,601	1,134,105	1,289,821	1,361,250	1,532,603	910,634	619,729	687,886	666,268	713,771	740,458	263,509	269,132
Other - HH Compliance	95%	98.17	98.11	98.12	98.29	98.72	98.59	98.49	98.28	97.96	97.8%	97.6%	97.29	97.18	97.25	97.49
Other - HH Audits Performed	n/a	349,458	329,884	371,111	352,523	244,310	240,312	244,292	262,127	277,458	269,047	275,315	282,877	318,953	104,668	98,294
Physician - HH Compliance	95%	98.99	97.06	99.89	97.19	95.62	98.06	99.28	97.78	99.56	99.4%	98.8%	98.74	99.49	77.96	82.45
Physician - HH Audits Performed	n/a	693	953	909	1,672	2,398	2,064	1,252	1,713	1,149	1,923	3,309	2,942	779	6,189	3,076
Respiratory - HH Compliance	95%	97.90	97.29	96.94	97.15	97.18	97.36	97.27	97.53	96.55	96.0%	96.0%	96.63	95.84	95.68	94.09
Respiratory - HH Audits Performed	n/a	61,923	52,783	49,344	69,457	12,273	12,262	16,606	16,667	14,183	14,200	12,626	15,084	18,145	5,672	3,543
Student - HH Compliance	95%	96.32	97.15	97.19	95.74	97.58	93.44	NULL	NULL	100.00	NULL	NULL	NULL	NULL	NULL	89.13
Student - HH Audits Performed	n/a	31,296	19,456	20,073	9,742	372	122	NULL	NULL	124	NULL	NULL	NULL	NULL	NULL	46

Outstanding Health Outcomes (OHO)
QUALITY & PATIENT SAFETY PRIORITY

Inpatient Diabetes Care – Hypoglycemia Reduction

December 2025

OHO Annual Plan: Inpatient Diabetes Care
Hypoglycemia Reduction in Critical Care (CC) Locations

- Glucommander IV

Hypoglycemia insights

% PATIENT DAYS < 70 AVG FOR TIME PERIOD SELECTED	BASELINE METRIC < 70	% PATIENT DAYS < 70 BENCHMARK
3.4%	5.7%	3.4%
Kaweah	Literature Baseline	Glytec Avg

% PATIENT DAYS < 40 AVG FOR TIME PERIOD SELECTED	BASELINE METRIC < 40	% PATIENT DAYS < 40 BENCHMARK
0.18%	1.51%	0.14%

FY25 GOAL

Achieve < 4.3% benchmark performance for hypoglycemia in Critical Care (CC) patient population, defined as percent patient days with blood glucose (BG) <70

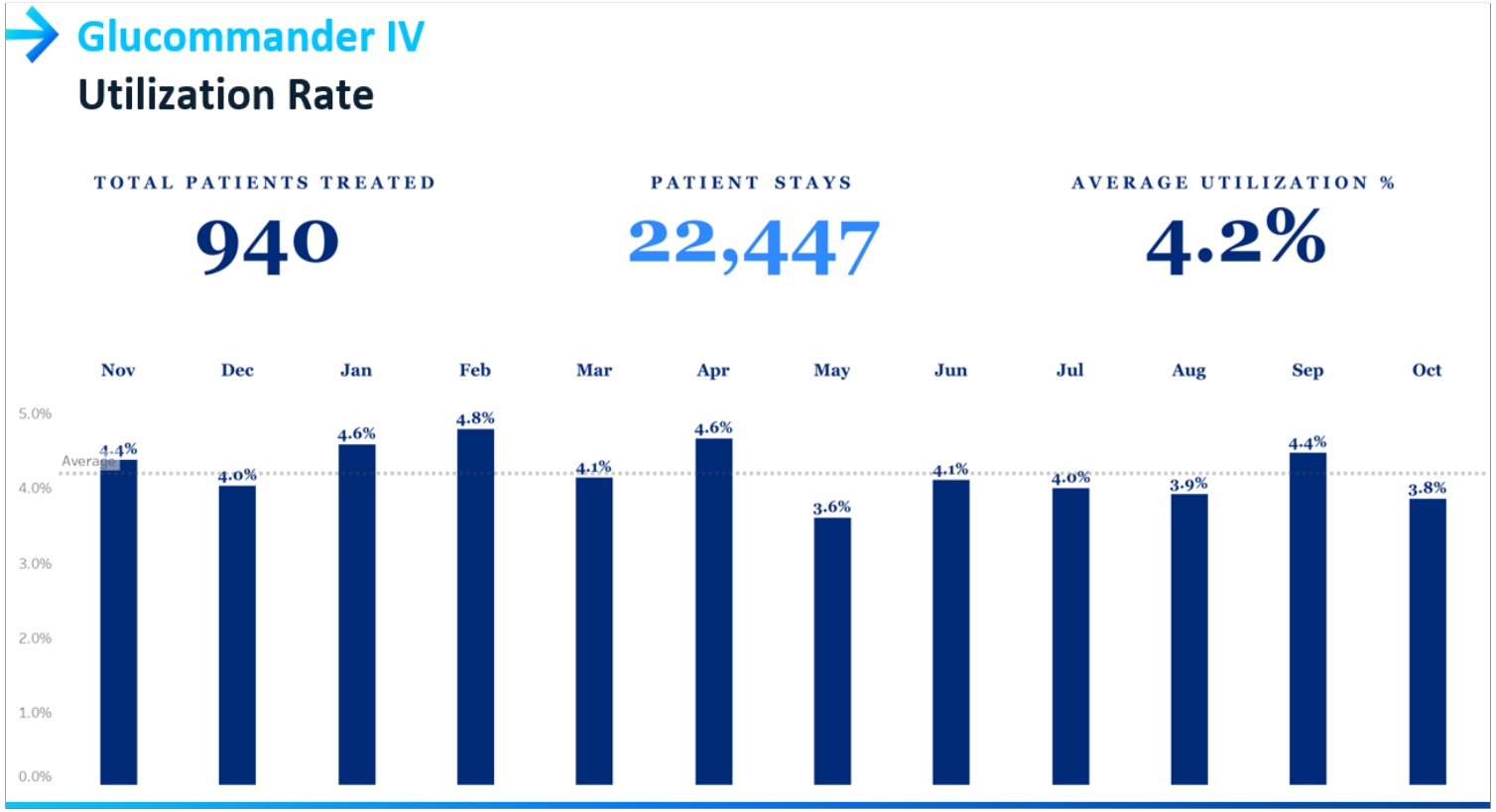
FY25 PLAN – Hypoglycemia Reduction

High Level Action Plan

- Increase IV insulin usage upon arrival to MICU from 170 to 187 (10% increase) by June 30, 2025. Currently on target for goal.
- APN will round 3 times per week to encourage use of IV Insulin usage providing rational and education to GME residents as needed.
- APN will monitor patients in the MICU using Glucometrics utilizing set parameters to avoid hypoglycemia or recurrent hypoglycemia (BG < 90 mg/dL)

OHO Annual Plan: Inpatient Diabetes Care

Hypoglycemia Reduction in Critical Care Locations



FY25 GOAL

Achieve < 4.3% benchmark performance for hypoglycemia in Critical Care (CC) patient population, defined as percent patient days with blood glucose (BG) <70

FY25 PLAN – Hypoglycemia Reduction

High Level Action Plan

- The metrics on this slide include both IV and SQ insulin in all critical care areas (MICU, CVICU, ICCU and CVICCU)
- Increase APN rounding in the MICU to encourage the use of IV Insulin for critically ill patients who are intubated and hemodynamically unstable. DM NP to met with Dr. Javed to establish a process. Dr. Javed will bring information forward with Sound group. DM NP to monitor for usage.

OHO Annual Plan: Inpatient Diabetes Care
Hypoglycemia Reduction in Critical Care Locations

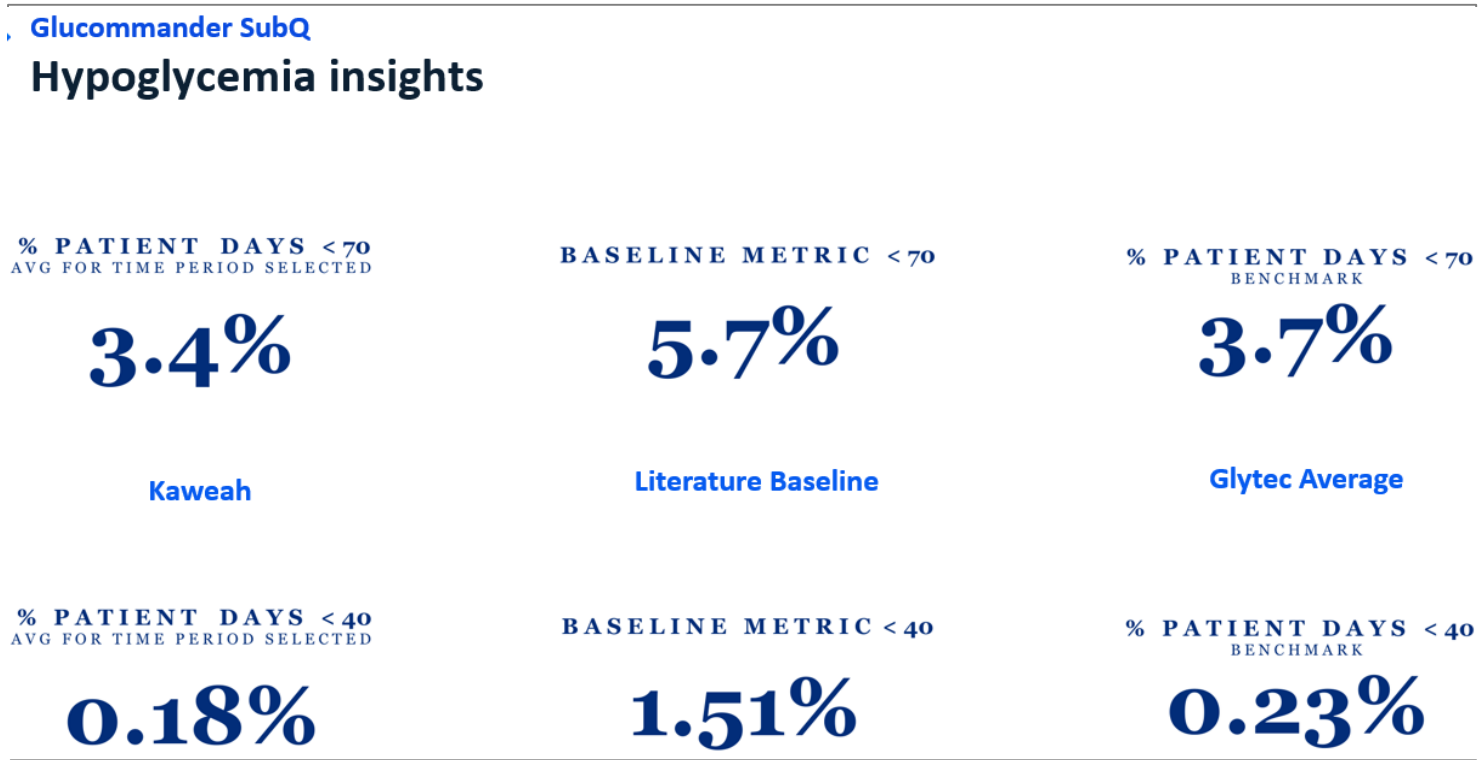
The last data point meet goal because:

- Great usage of subcutaneous/ IV insulin, continued support of IV insulin use in Critical Care(American Diabetes Association recommended practice) IV is first line therapy in Critical Care
- **Targeted Opportunities (What specifically is causing the fallouts?)**

1. Intensivist/GME managing patients in MICU has most opportunity as there is a higher volume of patients who require IV insulin
2. MICU Workflow ordering, nursing influence (labor intensive to manage a patient on IV insulin)

CURRENT IMPROVEMENT ACTIVITIES	COMPLETION DATE	BARRIERS
Glytec to help review hypoglycemic patient chart review to determine which patients are not treated according to best practice guidelines (started on SQ rather than IV insulin)	Ongoing	-New Sound TeleHealth Providers with education gaps
Upgrade in May assisted in EMR issues in transcribing diabetes management orders	May 2024	
Communicating inability to adjust basal insulin at anytime, currently have to wait for morning BG to be input in GM by the nurse	Spring 2026	1. Glytec upgrade in 2026 2. Nurses not inputting BG into GM in a timely manner
Improve knowledge and skillset of nursing, pharmacist and medical staff through education, training, consultative services.	Ongoing	

OHO Annual Plan: Inpatient Diabetes Care
Hypoglycemia Reduction in MED/SURG Locations



FY25 PLAN – Hypoglycemia Reduction

High Level Action Plan

- Optimize the difficult to manage patients (i.e. Renal, recurrent hypoglycemia, insulin resistant, steroid-induced hyperglycemia) using a non-GM power plan
- Continue to work with Glytec to improve glycemic control through product improvement recommendations: adjust basal dose prior to morning BG input into GM

FY25 GOAL

Achieve < 3.4% benchmark performance for hypoglycemia in Non-Critical Care (NCC) patient population, defined as percent patient days with blood glucose (BG) <70

OHO Annual Plan: Inpatient Diabetes Care

Hypoglycemia Reduction Inpatient

Continued struggles:

- 4N Patients, renal patients are complex as they lack renal system to metabolize insulin
- ADA guidelines indicate best practice to manage this population you need to ensuring Lantus (longer acting) is not 50% of insulin, and need close monitoring/management to successfully avoid hypoglycemia
- **Targeted Opportunities (What specifically is causing the fallouts?)**

1. Are there best practice guidelines for managing diabetes for renal insufficiency patients? Yes we are following best practice
2. Need very focused resources to closely manage patients who have renal insufficiency, very complex population, very dynamic with their glucose levels (factors include: timing of dialysis, times for eating, amount eaten, renal function)

CURRENT IMPROVEMENT ACTIVITIES	COMPLETION DATE	BARRIERS
Review patients with BG less than 90 mg/dL and adjust insulin as needed to avoid hypoglycemia or prevent recurrent hypoglycemia	Ongoing	No Inpatient Diabetes/Glycemic Management Support
Monitor patients on the non-GM power plan to ensure they are receiving correct dose of insulin. Discern report is used to identify patients on the non-GM power plan.	Ongoing	
Demonstrate return on investment (ROI) through improved throughput, decreased length of stay to increase time APN spends monitoring and caring for patients with diabetes.	12/27/2024	Denial of Inpatient Diabetes Management Team
Improve knowledge and skillset of nursing, pharmacist and medical staff through education, training, consultative services.	Ongoing	
Meeting with Dr. Javed from Sound Intensivist group to discuss underuse of insulin infusions.	3/11/2025	Practitioner practice difficult to change. Nursing staff still push for SQ insulin when patients are not medically ready for transition to SQ insulin.

Thank you

Live with passion.

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

Kaweah Health

QUALITY COMMITTEE REPORT

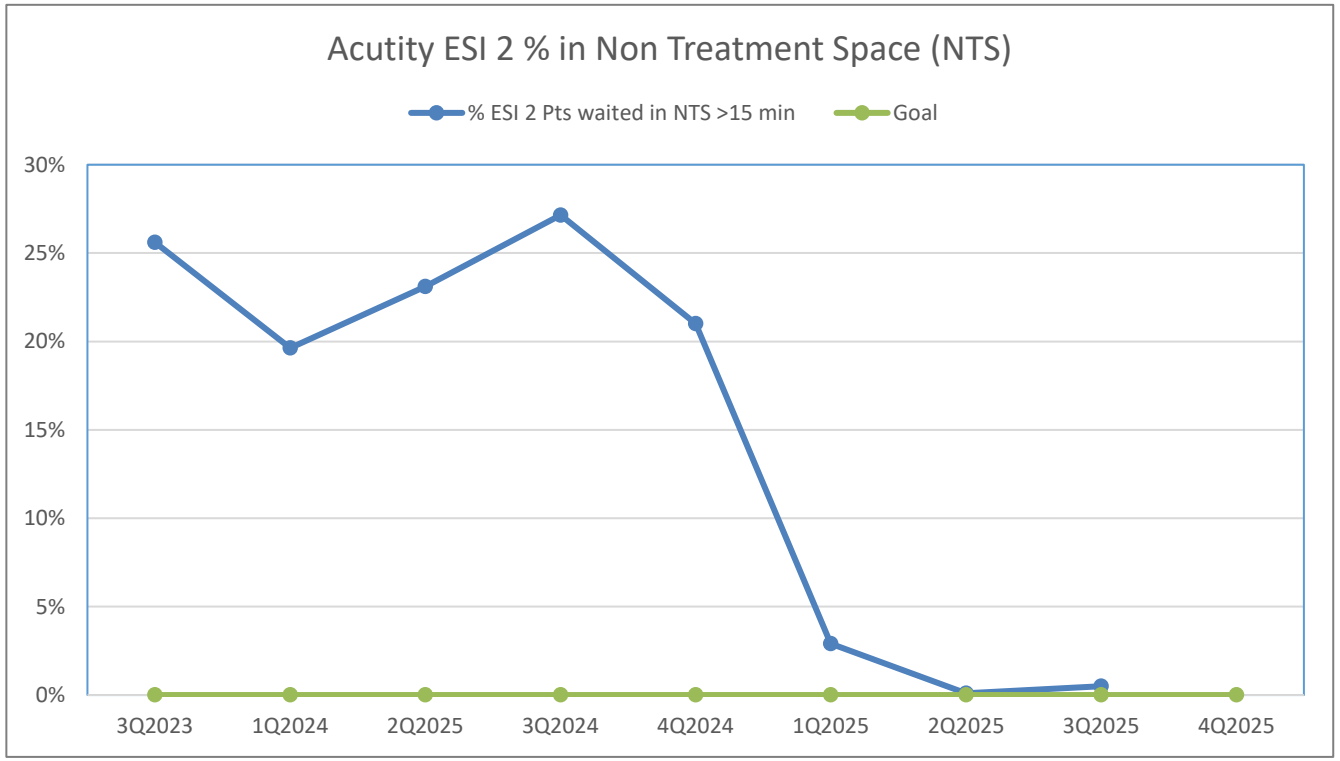
Emergency Department Quality Report

Scott D. Baker, DNP, MSN, RN, NEA-BC, CEN, CNL
Interim Director of Emergency & Trauma Services

November 2025

Refer to ED SBAR Reports, ED Kaizen Reports in QComm, and Patient Safety Committee Reports for detailed historical project information Pre Oct 2024.

ED Quality Report: Care of ESI 2 Patients in a Treatment Space



Emergency Department ESI 2 Management

High Level Action Plan

- Goal: 0% waiting greater than 15 min
- Current Performance: Quarter 3 – No Patients in Waiting Room
- No ESI 2 Patients waiting; 100% of patients (All ESI levels) have an MSE done in the Intake process. If a patient is determined to be a level II in triage, patient is moved directly back to an open bed for MSE and stabilization.

ESI level-2 patients are high priority, and placement and treatment should be initiated rapidly. ESI level-2 patients have the potential to be very ill and at high risk for decompensation. ESI is a triage acuity algorithm that is valid for evaluating patient acuity and resource needs as determined by a trained triage nurse upon the patient's presentation to the emergency department. It is a process to differentiate between those who are at risk of decompensation and those who are more stable.

- Emergency Severity Index Handbook Fifth Edition (2023), Emergency Nurses Association: https://californiaena.org/wp-content/uploads/2023/05/ESI-Handbook-5th-Edition-3-2023.pdf

ED Quality Report: Care of ESI 2 Patients in a Treatment Space

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ED Safe Care Patient Flow Dashboard

ESI-2 Patients Flow NTS: Non-Treatment Space	Target	May 2025	Jun 2025	Jul 2025	Aug 2025	Sept 2025	Oct 2025	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025	Rolling 12M Av
# ESI 2 pts waited in NTS >15 min	0	0	0	0	0	0	0	130	206	274	24	2	0	127
% ESI 2 Pts waited in NTS >15 min	0%	0%	0%	0%	0%	0%	0%	16%	22%	26%	2%	0.9%	0%	11%
Avg. LOS ESI 2 pts waited in NTS >15 min	0	0	0	0	0	0	0	59	53	59	42	21	0	40
Max LOS ESI 2 Pt's waiting in NTS >15 min	0	0	0	0	0	0	0	408	365	897	292	28	0	334

NTS: Non-Treatment Space where a complete care team (nurse and provider) is not assigned to the patient

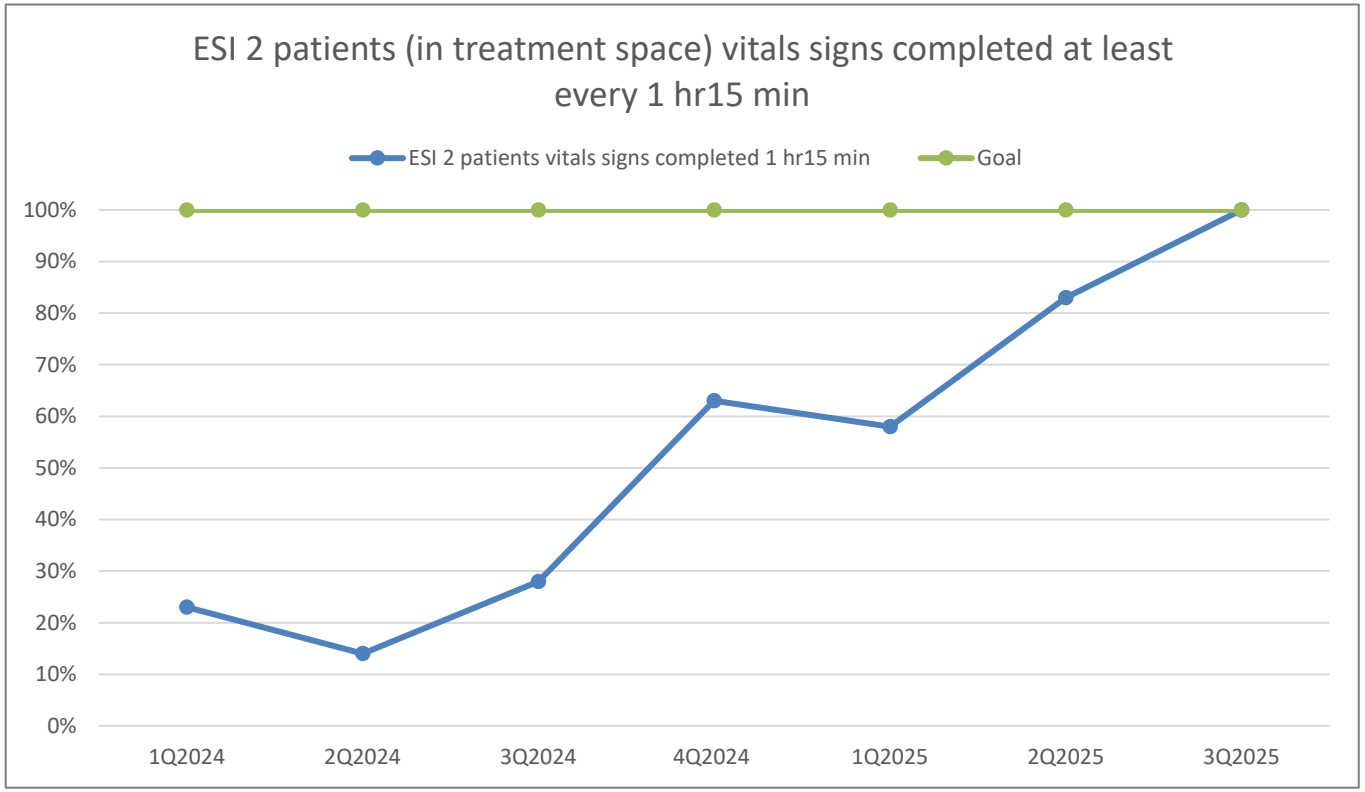
Targeted Opportunities (why goal not achieved in most recent month)

1. History: Goal is being achieved now. The report tracking these patients was pulling data from arrival, not at the point of triage when the patient is assigned the ESI level. Reporting process was changed in May to adjust the numbers to meet the actual assignment of the ESI level decision.
2. History: We should not be seeing any ESI level II's in the waiting room any longer with the redesigned front-end process as all patients are not being placed back in the waiting room without moving through our Intake process and receiving an MSE by a provider.
3. Following implementation of the new front-end design, designated treatment spaces were evaluated and corrected in the data report logic along with an adjustment to the way the data is collected.

ED Quality Report: Care of ESI 2 Patients in a Treatment Space

CURRENT IMPROVEMENT ACTIVITIES	EXPECTED COMPLETION DATE	BARRIERS/UPDATES
New Front End Design - Change in flow patterns • Re-opened intake space which added “MSE” spaces (Medical Screening Evaluation) • Opened Fast track which created an additional 8 rooms	March 2025	Completion of the new Front-End Re-design on March 1, 2025
Change in flow patterns (goal: Keeping patients who need beds in beds, and moving patient who can be treated in other care spaces (“vertical”) • Lower acuity is seen at front, moved to fast track if a treatment is needed, leaving ED beds in the back for ESI 2 patients and EMS patients • Zone 1 opened as “chest pain unit” • Increase in provider staffing, staggered shifts so MSEs are being done handoff times (no loss of flow during transitions)	February 2025	Barriers: We now have the ability to staff the department to full capacity barring any sick calls.
Identification of ESI 3-5 who’s acuity changes to ESI 2 • LVN and Tech in Waiting Room, rounding and checking vital signs	1/22/25	We now have the staff to place a clinical team member in the waiting room 24 hours a day to watch and re-assess patients.

ED Quality Report: ESI 2 Patient Vital Sign (VS) Monitoring



Emergency Department ESI 2 Management

High Level Action Plan

- Evaluate best practices and industry standards on:
  - frequency and components of VS checks
  - Policy adjusted to ensure national standards maintained for ESI vital signs assessment/reassessment
- July 2025 is 95% compliant
- 2nd Quarter 2025 83% complaint
- Q3 100% Compliant – Audit closed at October Patient Safety Committee

ESI level-2 patients are high priority, and placement and treatment should be initiated rapidly. ESI level-2 patients have the potential to be very ill and at high risk for decompensation.

Emergency Severity Index Handbook Fifth Edition (2023), Emergency Nurses Association: https://californiaena.org/wp-content/uploads/2023/05/ESI-Handbook-5th-Edition-3-2023.pdf

ED Quality Report: ESI 2 Patient Vital Sign Monitoring

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ED Safe Care Patient Flow Dashboard

ESI-2 Vital Signs (patients in treatment space)(

	May 2025	Jun 2025	July 2025	Aug 2025	Sept 2025	Oct 2025	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025	Rolling 12M Av
% Vital Signs completed per physician order	100%	94%	87%	95%	100%	100%	100%	50%	42%	33%	58%	65%	68%	75%
% VS completed excluding temp for all pts														

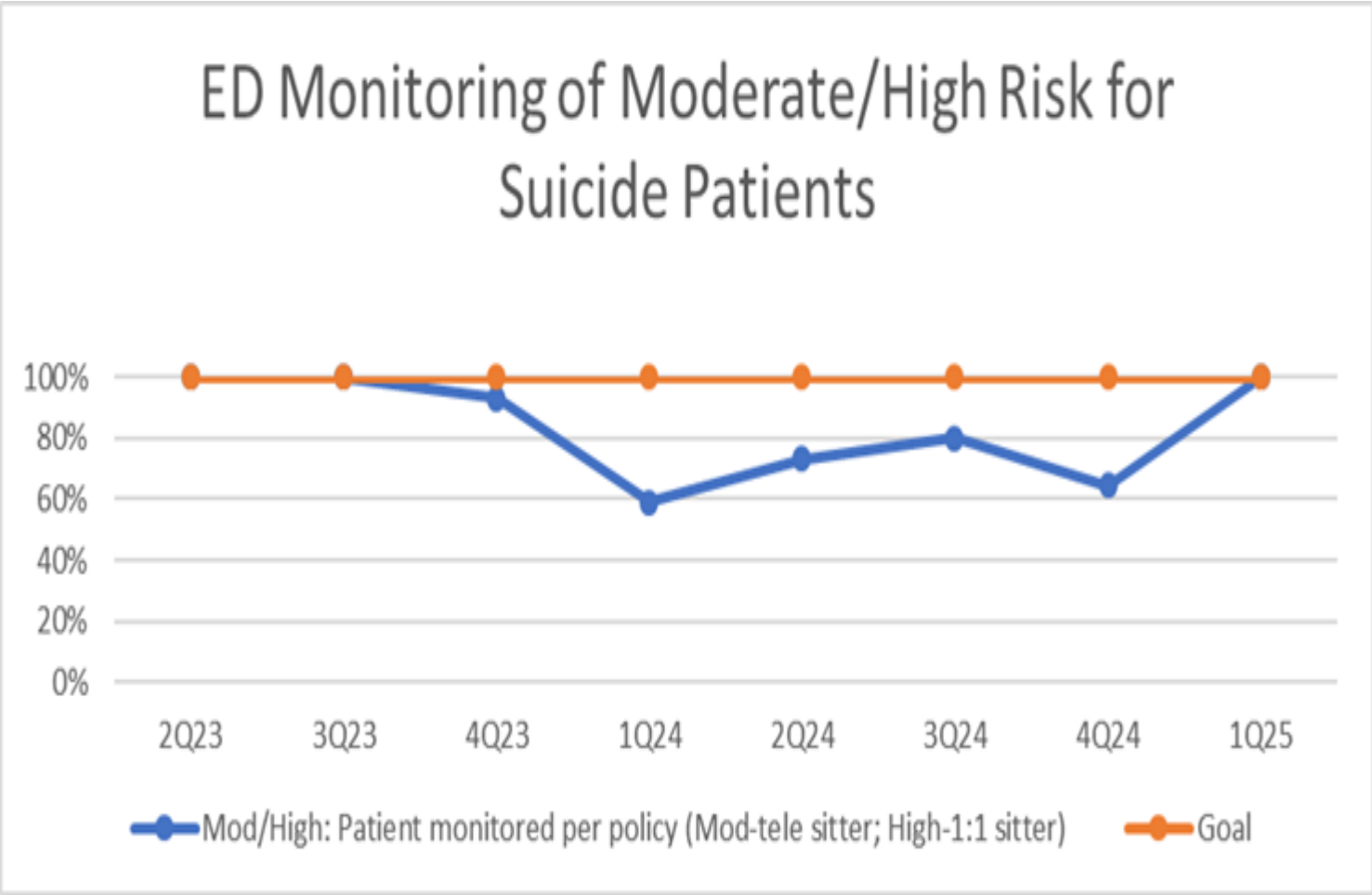
Targeted Opportunities (why goal not achieved in most recent month)

1. Following medical evaluation of an ESI 2 patient VS checks every hour are current practice, even though the patient's condition does not require VS checks every hour. Creates inefficient use of resources. – Most providers are now placing orders for changing the frequency of Vital Sign Assessment – this is not the case with all providers, however we are gaining better compliance.
2. Temperature checks – temperature checks have changed so it is assessed on arrival, change in condition (Sepsis, ICU patients) or provider reassessment request.
3. All behavioral health patients are designated as ESI 2, but do not require VS checks every 1 hour. These vital signs will be assessed every shift.
4. Revised the ED assessment/re-assessment policy to update the frequency of vital signs to be more aligned with other organizations/policy currently moving through the approval process. ENA has no specific guidelines regarding vital sign assessment based on ESI. Previous organizations were ESI Level 1, Q1 Hour, ESI Level 2, Q2 hours, ESI 3, Q4 hours, and ESI 4 & 5 on arrival and prior to discharge if in ED longer than 90 minutes. With the higher acuity ESI levels, or critical changes in condition, the vital signs will be reassessed more frequently for changes in condition.

ED Quality Report: ESI 2 Patient Vital Sign (VS) Monitoring

CURRENT IMPROVEMENT ACTIVITIES	EXPECTED COMPLETION DATE	BARRIERS
Revise standards of care (SOC) for VS check frequency and components of the VS checks that are aligned with best practice and industry standards. SOC revisions ensure that patients receive the appropriate monitoring based on provider medical evaluation. Currently policy revised and moving through policy approval process.	September 2025	Frontline Staff seeing the order from the physician indicating the revised frequency of vital sign reassessment for the patient.
Revise ESI assignment criteria at Triage for behavioral Health patients to ensure the correct acuity is assigned and necessary monitoring can occur based on medical need	Completed	No barriers. Behavioral health patients are screened at triage as ESI 2; they are promptly moved to Zone 4 for care based on the Columbia Suicide Risk scale.
Challenges with obtaining a higher percentage of vital sign re-assessment compliance.	September 2025	During the month of June, ED team was still auditing for ESI 2 V/S Q 1 hour- corrected to “per physician order” in July with higher compliance.

ED Quality Report: Monitoring of Moderate/High Risk for Suicide



ED – Monitoring of Mod/High Risk for Suicide

High Level Action Plan

- Goal: 100% monitored per policy (1:1)
- Q2 2025 Performance is 100%.
- Q3 Performance is 100%
- Ensure MHW/ED Tech staffing is maintained to ensure all high-risk patients are 1:1 monitored

ED Quality Report: Monitoring of Moderate/High Risk for Suicide

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Suicide Risk Daily Compliance Surveillance Data

*Non-compliance is corrected in the moment during daily rounds, or risk is mitigated by implementing strategies per PC.26

ED

Question	Goal	Sep-25	Oct-25	Nov-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
4a. Mod/High: Patient monitored per policy (Mod-tele sitter; High-1:1 sitter)	100%	100% 68/68	100% 76/76	69% 91/131	100% 51/51	100% 34/34	100% 21/21	100% 48/48	100% 84/84
4b. Mod/High: Patients without a Sitter- volume					0	0	0	0	3

Targeted Opportunities (why goal not achieved in most recent month)

1. We've hired additional ER Tech's and MHW's and as of April are meeting the 1:1 monitoring criteria
2. Ability to staff consistently has been better; with sick calls, the house has been able to support our needs.

CURRENT IMPROVEMENT ACTIVITIES	EXPECTED COMPLETION DATE	BARRIERS/UPDATES
Ensure training is complete for all new hire MHW's. Assure we are staffing high-risk patients 1:1 – meeting 100% compliance	4/1/2025	None
All MHW positions have been filled. We fully staffed with ER Techs	5/01/2025	None

ED Improving Lab and EKG Turnaround Times for Chest Pain Patients

CURRENT IMPROVEMENT ACTIVITIES	EXPECTED COMPLETION DATE	BARRIERS/UPDATES
Our Emergency Department (ED) aims to improve the turnaround time for laboratory tests and EKGs for patients presenting with chest pain. This is crucial for efficient patient care and timely diagnosis, especially for such a time-sensitive complaint.	On-going	Awaiting Reports to pull data.
Our strategy moving forward is to collect baseline data for key metrics, including: • **Check-in to Order Input:** Time from patient arrival to lab/EKG order entry. • **Order Input to Lab Draw/EKG Performed:** Time from order entry to the actual performance of the test. • **Lab Draw/EKG Performed to Results Completion:** Time from test performance to the availability of results. This data will allow us to establish a clear baseline reflecting the impact of our recent front-end changes.	August 2025	Awaiting Reports to be built by Melissa Nevers and her team. Met on 7/8/2025 and requested to expedite report build.

ED Improving Lab and EKG Turnaround Times for Chest Pain Patients

CURRENT IMPROVEMENT ACTIVITIES	EXPECTED COMPLETION DATE	BARRIERS
Left During Treatment (LDT) / AMA Rates: These also decreased to an all-time low of only **3% and 1%**, respectively.	On-Going	Continue monitoring rates along with LWBS rates.
Door to Stroke Identification/Notification to less than 10 minutes	On-Going	Identification and adjusting the triage process and how we call them overhead to simplify the process
Improve EKG Turnaround times to less than 10 minutes from arrival.	On-Going	Waiting on Final Report build to track times.

Thank you

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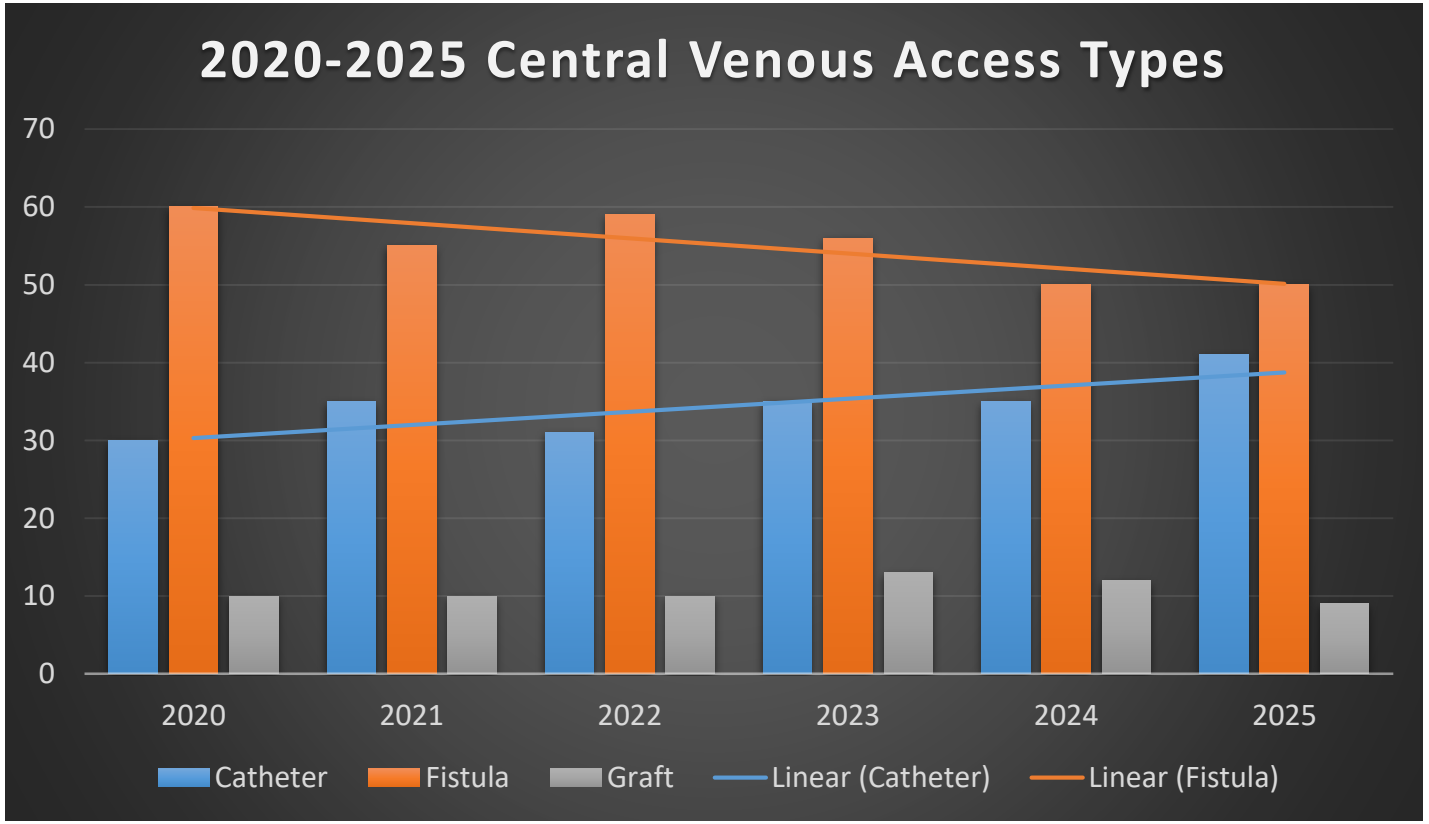
QUALITY & PATIENT SAFETY PRIORITY

Renal Services Quality Report

Quality Committee Report

October 2025

Renal Services Quality Report: Central Venous Access Management



Central Venous Access Management

High Level Action Plan CY 2025

- Increase number of patients with arteriovenous fistula
- Decrease the number of patients with central venous catheter (CVC)
- Decrease number of patients with CVC greater than 90 days- Goal: 10.7%

Patients who use an arteriovenous fistula (AVF) have an increased median life expectancy. These patients have a life expectancy that exceeds the secondary patency of arteriovenous grafts and central venous catheters. In this subset of patients, AVF remains the best hemodialysis option.

Arteriovenous Fistula Remains the Best Hemodialysis Access Choice for Some Elderly Patients, Pastor, M. Chris et al. Journal of Vascular Surgery, Volume 68, Issue 3e82. September 2018

Renal Services Quality Report: Central Venous Access Management

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KH Dialysis Central Venous Access Management

	Target	Oct. 2025	Nov. 2025	Dec. 2024	Jan. 2025	Feb. 2025	March 2025	April 2025	May 2025	June 2025	July 2025	Aug. 2025	Sept. 2025	Rolling 12M Av
Percent of patients with CVC		37.6	39.5	40.4	43.2	40.6	41.8	42.8	42.0	42.1	39.0	41.9	41.6	41.04
Percent of patients with AV Fistula	70%	51.1	49.2	50.17	45.4	48.4	47.3	36.8	45.2	44.6	47.2	45.2	44.8	47.0
Percent of patients with CVC >90 days	10%	33	33.3	29.27	30.3	32.0	32.5	34.1	31.5	32.2	32.5	31.7	31.2	32.04

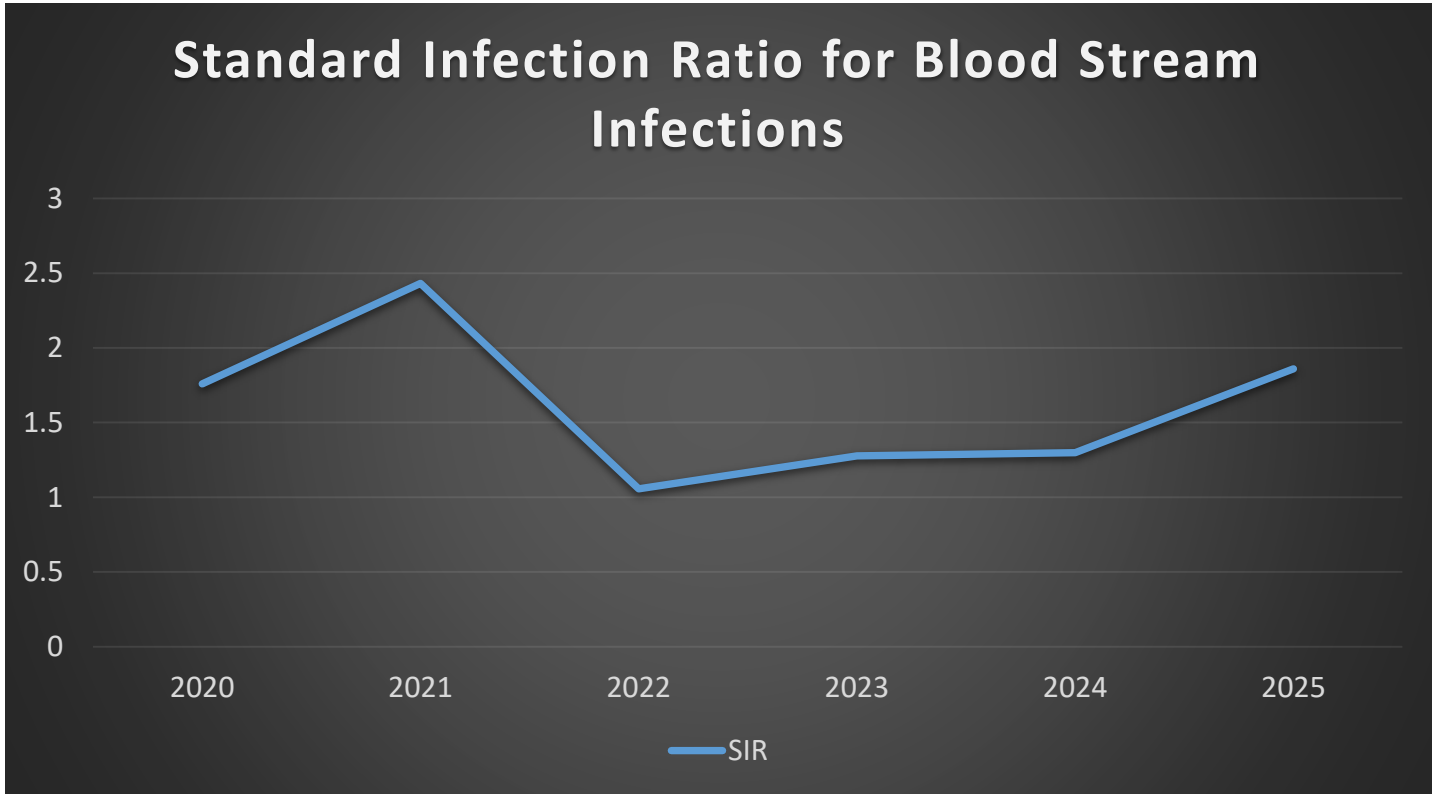
Targeted Opportunities (why goal not achieved in most recent month)

1. Lack of appointment availability for vascular access providers
2. Lack of Interventional Radiology availability for vascular providers
3. Patient refusal, which is multifactorial, can be related to knowledge deficit
4. Difficulties with new access (infiltrations/refusals) delaying TDC removals

Renal Services Quality Report: Central Venous Access Management

CURRENT IMPROVEMENT ACTIVITIES	EXPECTED COMPLETION DATE	BARRIERS/UPDATES
Efficient referral process - The clinical coordinator/ access manager has established an efficient workflow to speed up the vascular access referral process. New patients are referred immediately upon admission to Kaweah Health Dialysis Clinic.	Ongoing	This process generally takes longer than 90 days due to high volume of patients seeing vascular surgeons.
Patient Education on the benefits of AVF Providing education to the patient with regard to the many advantages of an AVF or AVG as opposed to a CVC. We are currently exploring new methods of providing patient education such as educational videos that play throughout the day on the dialysis center televisions.	Ongoing	Seeking patient education videos that feature high-quality content and are easy to understand to ensure accessibility for our broad patient population.
Improving Vascular Access Coordination through Direct Provider Engagement: A vascular surgeon was invited to visit the dialysis center to meet with staff and patients, increasing visibility and strengthening collaboration.	Completed	This initiative opened direct lines of communication between the provider and dialysis team, promoting timely referrals, improved follow-up on access issues, and earlier surgical evaluation.

Renal Services Quality Report: Central Venous Access Management



Blood Stream Infection Reduction

High Level Action Plan CY 2025

- Goal of zero bloodstream infections

Preventing bloodstream infections in outpatient hemodialysis is essential for ensuring patient safety. Closely monitoring infection trends allows us to identify areas of improvement and guide targeted interventions to reduce infection rates. These efforts enhance patient outcome, support regulatory compliance, and promote high-quality care.

Renal Services Quality Report: Central Venous Access Management

Kaweah Health
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KH Dialysis Central Venous Access Management

	Target	Oct. 2024	Nov. 2024	Dec. 2024	Jan. 2025	Feb. 2025	March 2025	April 2025	May 2025	June 2025	July 2025	Aug. 2025	Sept. 2025	Rolling 12M Av
NHSN Blood Stream Infection Ratio	0	3.88	2.805	0.8063	3.572	2.283	0.902	0.825	2.803	1.704	1.919	0	0.822	1.86
Actual Number of Blood Stream Infections	0	4	3	1	4	3	1	1	3	2	2	0	1	2

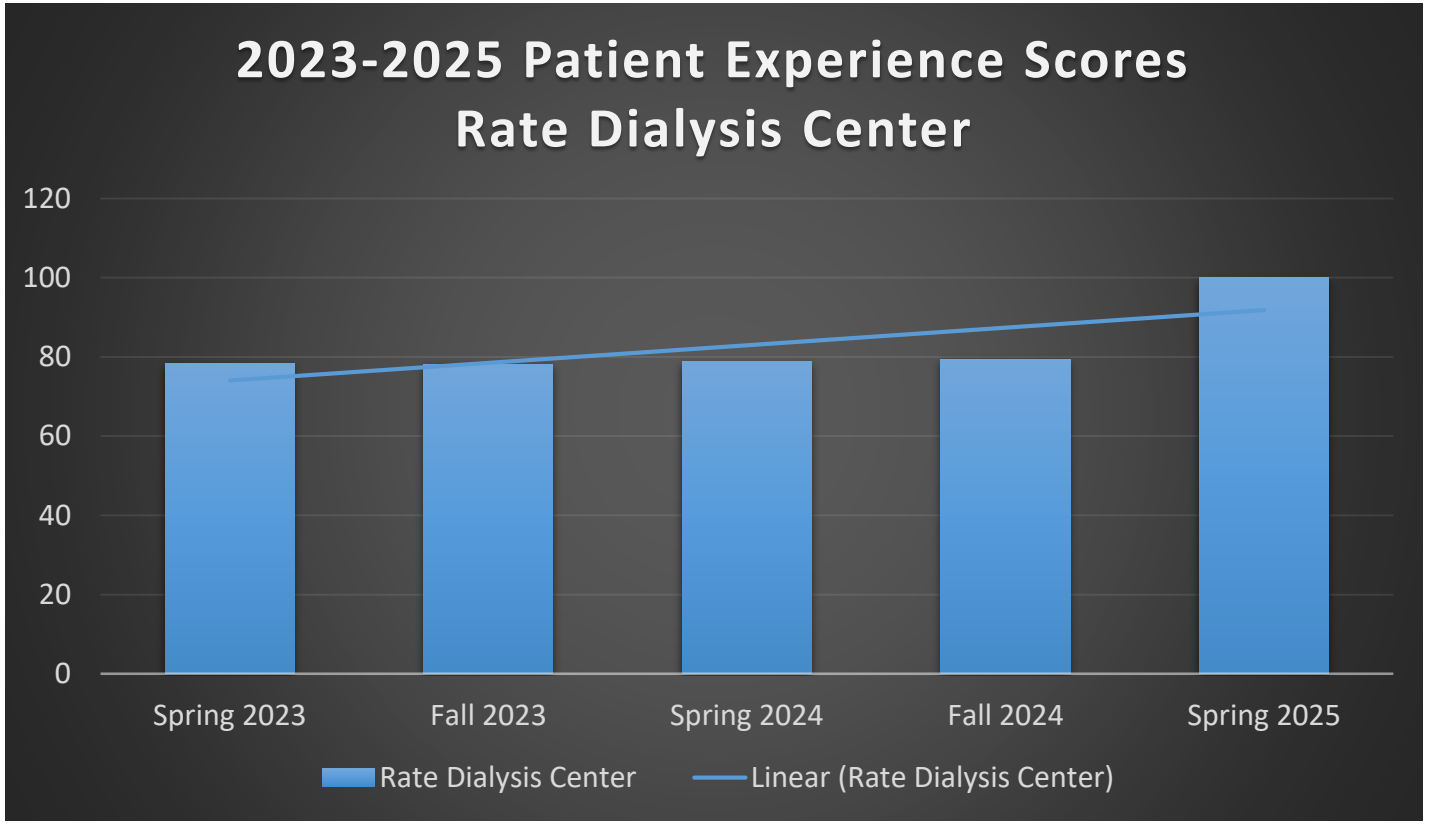
Targeted Opportunities (why goal not achieved in most recent month)

1. Biovigil Compliance
2. Staff Accountability to following standards of care

Renal Services Quality Report: Central Venous Access Management

CURRENT IMPROVEMENT ACTIVITIES	EXPECTED COMPLETION DATE	BARRIERS/UPDATES
Infection Prevention Audits: CDPH-style infection-control audits are conducted regularly, with immediate feedback provided for any identified fallouts. ➢ Working to revise the audit tool to include direct observation of BioVigil badge use, confirming that staff are wearing and appropriately activating their hand-hygiene monitoring devices following each opportunity. BioVigil compliance is required per Kaweah Health policy and is being closely monitored to promote consistent adherence to infection-prevention standards.	Ongoing	Staff continue to skip key elements of best practice standards. One on one meetings with employees to counsel/discuss and review policies, procedures, and expectations. Staff buy-in for BioVigil has been slow.
Patient Education: The dialysis team continues to reinforce patient education on infection prevention, with a particular focus on proper hand hygiene and the safe care of vascular access sites (fistula, graft, or catheter). Education is delivered during chairside interactions, monthly educational topics, and individualized teaching when access concerns are identified. These efforts aim to empower patients to participate actively in reducing their risk of infection.	Ongoing	Competing clinical demands sometimes limit time available for individualized patient education and completion of documentation. Available handouts are not always at a suitable literacy level for our patient population.

Renal Services Quality Report: Enhancing Patient Experience



Patient Experience Scores

High Level Action Plan CY 2025

- Goal is to be statistically significantly greater than benchmark
- Increase number of patient participation

High Patient Satisfaction Scores often reflect effective communication, compassionate care, and well- managed clinical outcomes. Feedback from patients helps pinpoint problems in service delivery or processes that need attention. Patient satisfaction scores are tied to reimbursement and performance based incentives through CMS.

Renal Services Quality Report: Enhancing Patient Experience

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KH Dialysis Patient Experience Scores

	Spring 2025	Fall 2024	Spring 2024	Fall 2023	Spring 2023
Total Number of Surveys	17	16	19	21	24
Rate Center	100%	87.5%	66.7%	90.5%	91.7%
Rate Staff	94.1%	81.3%	72.2%	81.0%	95.8%
Doctors Showed Respect	94.1%	87.5%	77.8%	71.4%	91.7%
Staff Behaved Professionally	88.2%	87.5%	94.7%	90.0%	91.7%

*Yellow indicates statistically significantly greater than benchmark

Targeted Opportunities (why goal not achieved in most recent month)

1. Staff accountability to following standards of care
2. Focus on education and communication with patient

Renal Services Quality Report: Enhance Patient Experience

CURRENT IMPROVEMENT ACTIVITIES	EXPECTED COMPLETION DATE	BARRIERS/UPDATES
Focused Communication: Continue emphasizing staff communication and patient education during daily huddles and monthly rounding.	Ongoing	Share results with the care team to reinforce positive performance and identify opportunities for continued improvement ahead of the Fall 2025 survey cycle.
Patient Education: Patients reported greater satisfaction with staff explanations and participation in care decisions, reflecting ongoing efforts to enhance patient education and empowerment.	Ongoing	Competing clinical demands sometimes limit time available for individualized patient education and completion of documentation.

Thank you

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Kaweah Health

Outstanding Health Outcomes (OHO)
QUALITY & PATIENT SAFETY PRIORITY

Healthcare Acquired Infection (HAI) Reduction

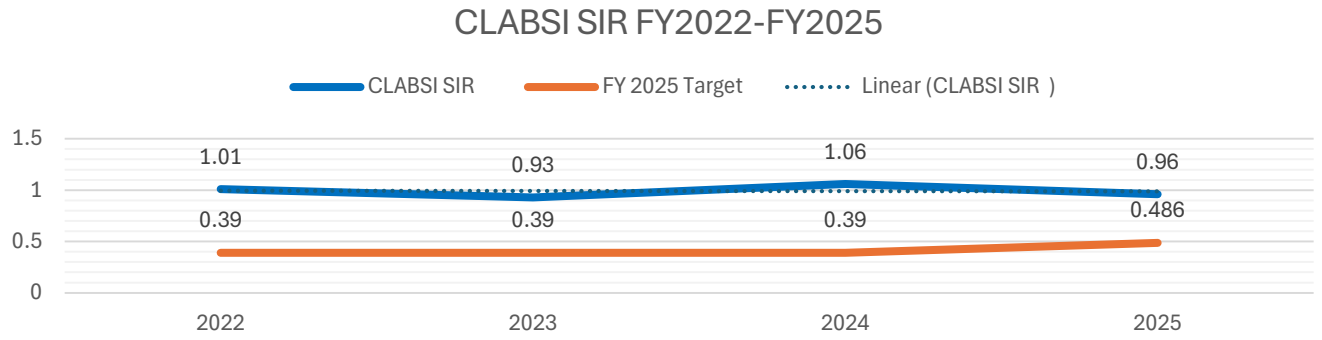
November 2025

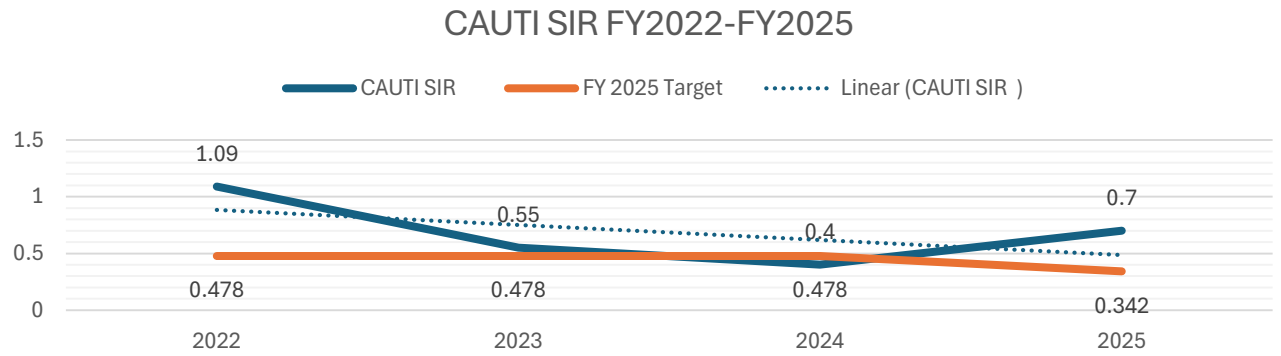
OHO FY25 Plan: HAI Reduction of Standardized Infection Ratio (SIR)

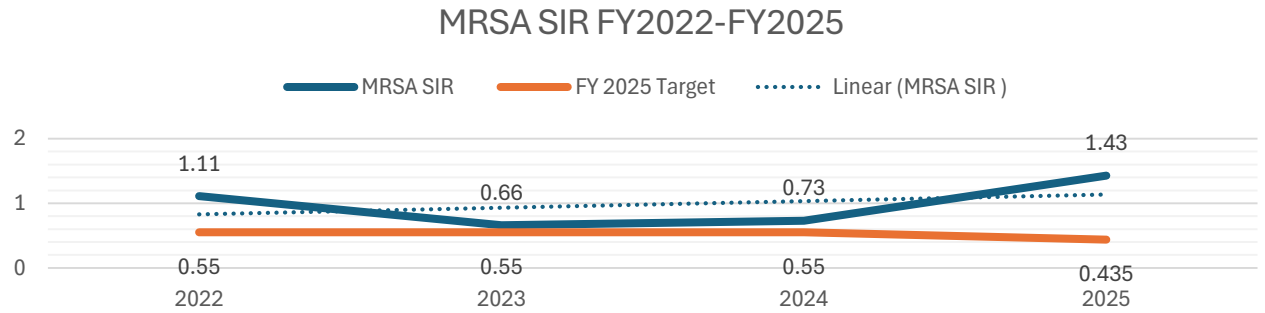
(number of actual infections/number of predicted infections by CMS)

CLABSI - Central Line-Associated Bloodstream Infection; CAUTI - Catheter-Associated Urinary Tract Infection; MRSA - Methicillin-Resistant Staphylococcus Aureus

Historical Baseline







FY25 PLAN – HAI Reduction CLABSI, CAUTI & MRSA SIR

High Level Action Plan

- Reduce line utilization; less lines, less opportunity for infections to occur
  - Goal: reduce central line utilization ratio to <0.66
  - Goal: reduce urinary catheter utilization ratio to <0.64
- MRSA nasal and skin decolonization for patients with lines.
  - Goal: 100% of at-risk patients nasally decolonized
  - Goal: 100% of patients with lines have a CHG bath
- Improve hand hygiene (HH) through increased use of BioVigil electronic HH monitoring system
  - Goal: 60% of staff are active users of BioVigil
  - Goal: 95% compliance with hand hygiene
- Improve environmental cleaning effectiveness for high-risk areas
  - Goal: 90% of areas in high-risk areas are cleaned effectively the first time (all area not passing are re-cleaned immediately)

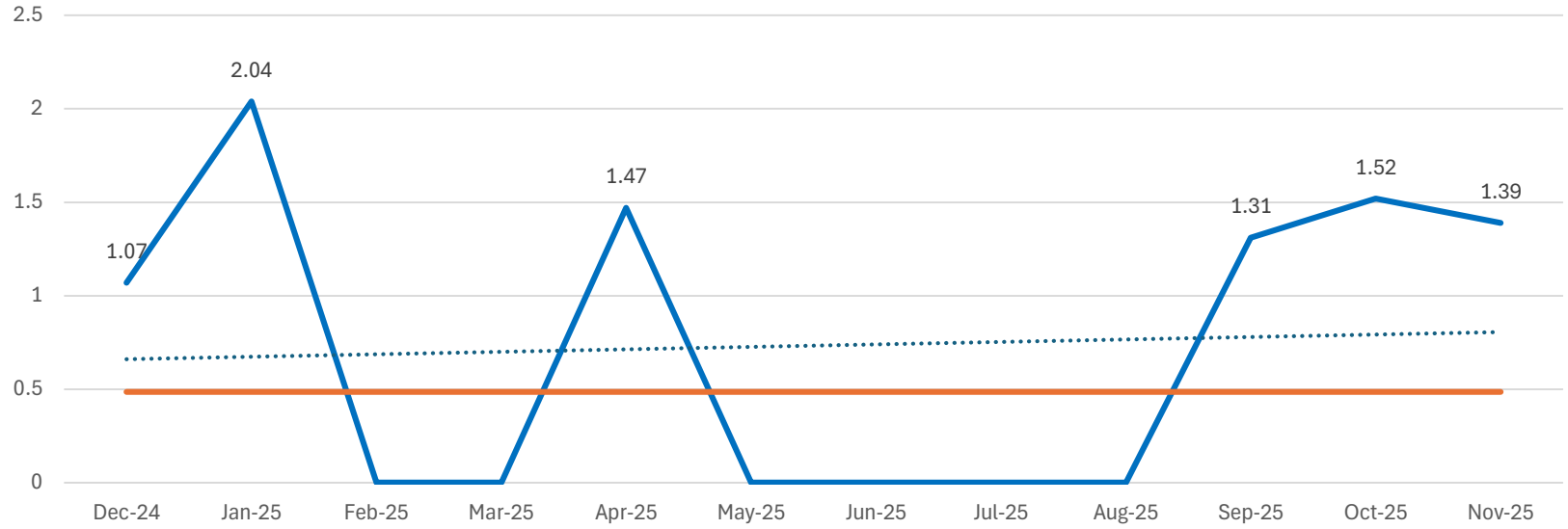
FY25 GOAL

Decrease: CLABSI SIR to <0.486; CAUTI SIR to < 0.342; MRSA <0.435

OHO FY25 Plan: HAI Reduction of Standardized Infection Ratio (SIR)
(number of actual infections/number of predicted infections by CMS)

Interventions:

- Device rounds performed by Charge Nurses and Infection Prevention
- New central line management kit
- CHG bathing for patients with central lines
- Hand Hygiene monitoring
- ATP testing post disinfection of the environment
- Avoiding femoral vessel cannulation

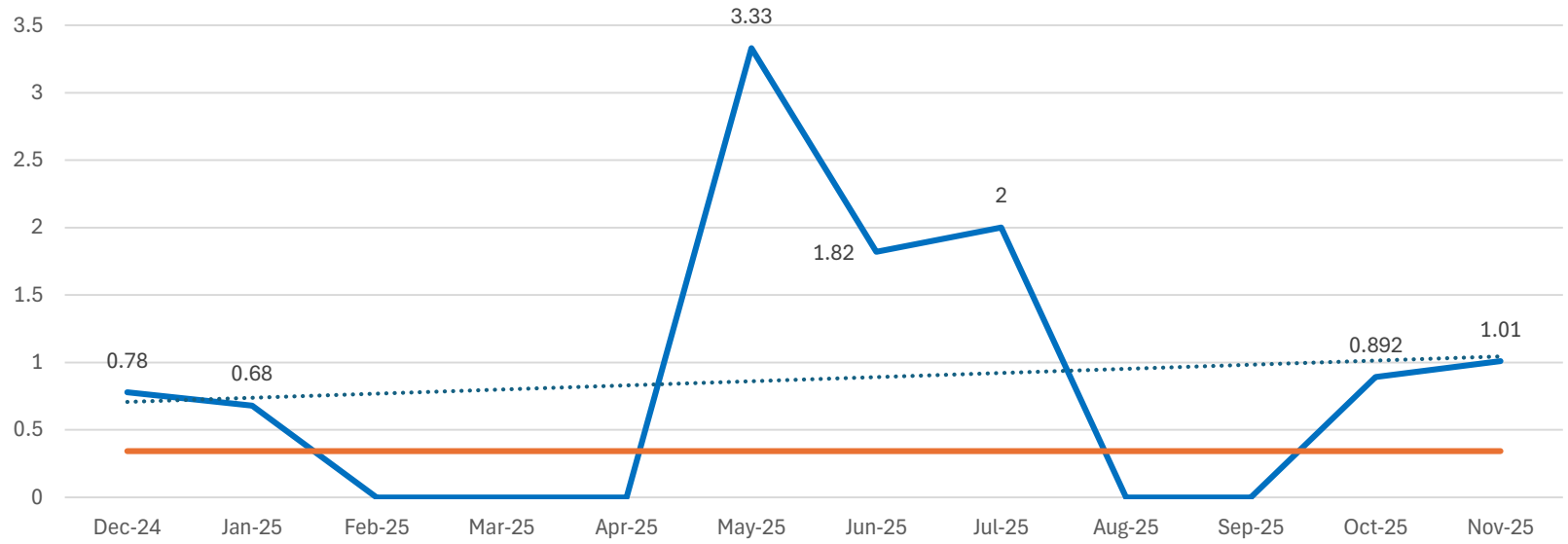


	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Total
CLABSI EVENTS	1	2	0	0	1	0	0	0	0	1	1	1	7
CLABSI Predicted	0.938	0.982	0.64	0.739	0.682	0.656	0.713	0.605	0.58	0.765	0.656	0.721	8.677
CLABSI SIR	1.07	2.04	0	0	1.47	0	0	0	0	1.31	1.52	1.39	0.81
CLABSI SIR Goal (70th percentile /top 30%)	0.486	0.486	0.486	0.486	0.486	0.486	0.486	0.486	0.486	0.486	0.486	0.486	0.486

OHO FY25 Plan: HAI Reduction of Standardized Infection Ratio (SIR)
(number of actual infections/number of predicted infections by CMS)

Interventions:

- Device rounds performed by Charge Nurses and Infection Prevention
- Piloting new alternatives to indwelling urinary catheters
- Nurse Driven Protocol – IUC removal
- Hand Hygiene monitoring

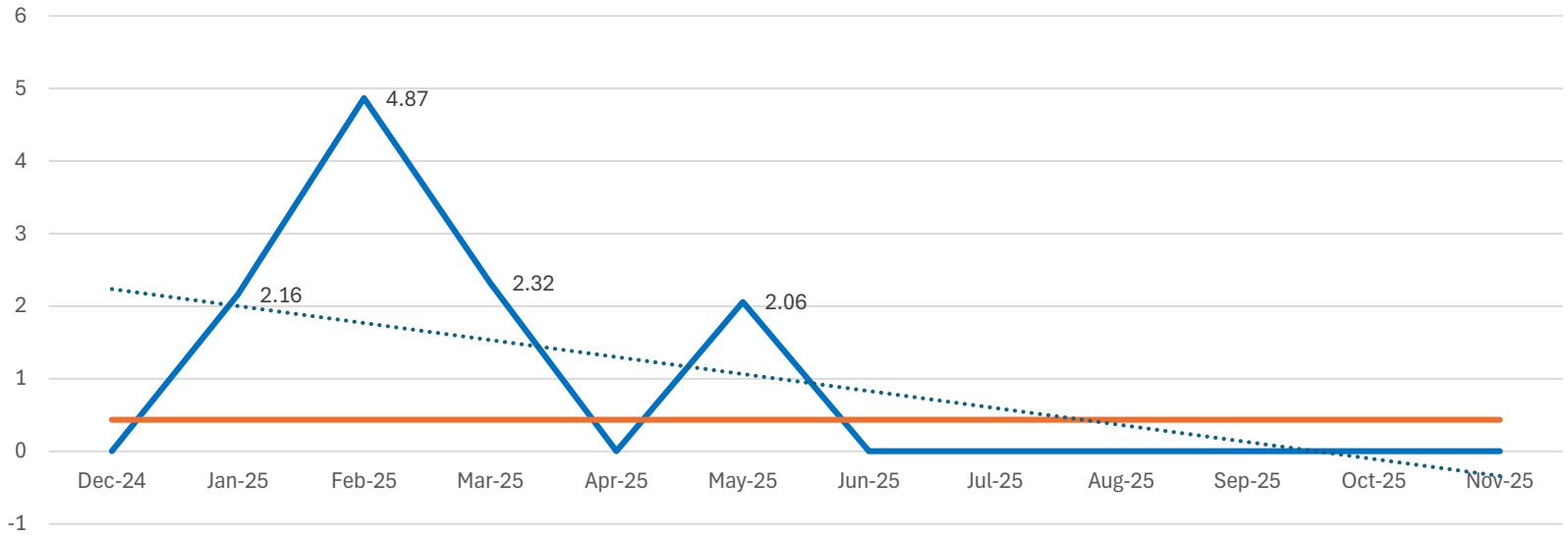


	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Total
CAUTI EVENTS	1	1	0	0	0	3	2	2	0	0	1	1	11
CAUTI Predicted	1.29	1.47	1	1.23	1.05	0.9	1.1	1	0.9	1.04	1.12	0.99	13.09
CAUTI SIR	0.78	0.68	0	0	0	3.33	1.82	2	0	0	0.892	1.01	0.84
CAUTI SIR Goal (70th percentile /top 30%)	0.342	0.342	0.342	0.342	0.342	0.342	0.342	0.342	0.342	0.342	0.342	0.342	0.342

OHO FY25 Plan: HAI Reduction of Standardized Infection Ratio (SIR)
(number of actual infections/number of predicted infections by CMS)

Interventions:

- MRSA nasal colonization testing for target patient populations
- Nasal decolonization for patients testing positive for MRSA in nares
- Hand hygiene monitoring
- ATP testing post disinfection of the environment



	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Total
MRSA EVENTS	0	1	2	1	0	1	0	0	0	0	0	0	5
MRSA Predicted	0.47	0.46	0.41	0.43	0.47	0.49	0.48	0.4	0.39	0.36	0.253	0.26	4.873
MRSA SIR	0	2.16	4.87	2.32	0	2.06	0	0	0	0	0	0	1.03
MRSA SIR Goal (70th percentile /top 30%)	0.435	0.435	0.435	0.435	0.435	0.435	0.435	0.435	0.435	0.435	0.435	0.435	0.435

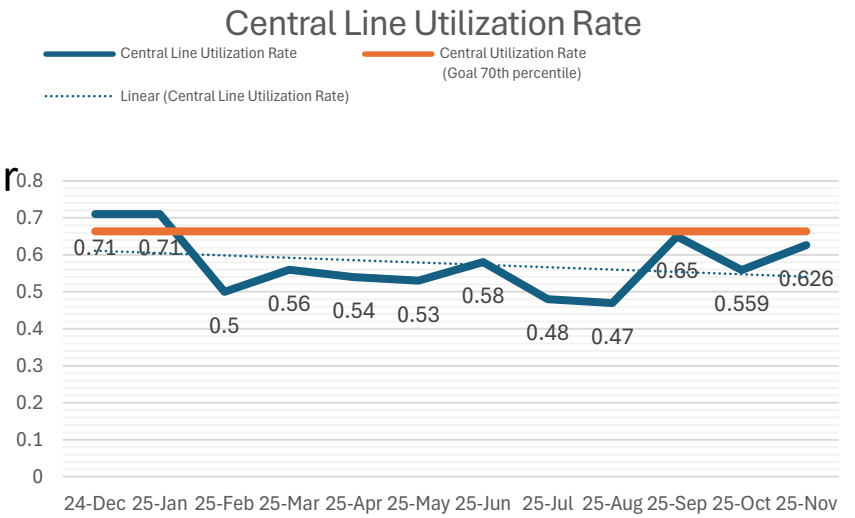
OHO FY25 Plan: HAI Reduction of Standardized Infection Ratio (SIR)

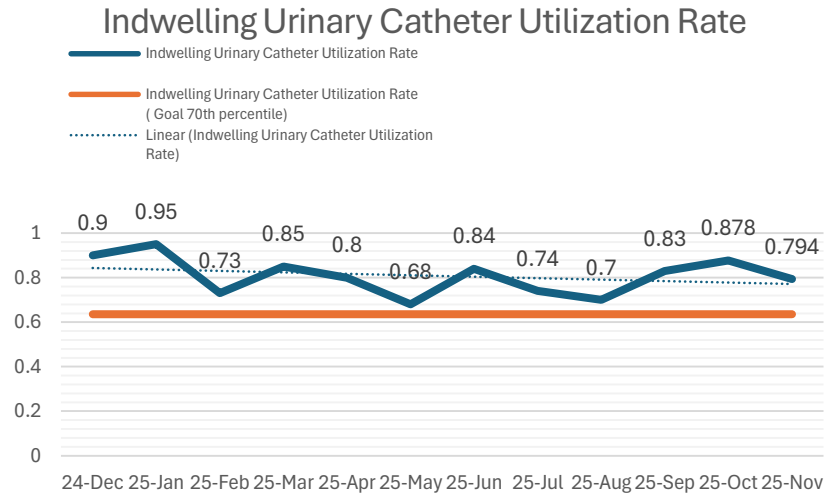
The last data point did not meet goal because:

- Evidenced-based prevention strategies to reduce HAIs are not occurring

Targeted Opportunities

- Reduce line utilization; less lines, less opportunity for infections to occur
  - Goal: reduce central line utilization ratio to <0.663
  - Dec 2024 – Nov 2025 (SUR = 0.577)
  - Goal: reduce urinary catheter ratio to <0.64
  - Dec 2024 – Nov 2025 (SUR = 0.810)
- MRSA nasal and skin decolonization for patients with lines.
  - Goal: 100% of at-risk patients nasally decolonized
  - July 2024 – Nov 2025 100% of screen patients nasally decolonized
  - Jul 2024 - Goal: 100% of line patients have CHG bathing
- Improve hand hygiene (HH) through increased use of BioVigil electronic HH monitoring system
  - Goal: 60% of staff are active users of BioVigil
  - FY2025 56% August 2025 to November 2025 61% of staff are active users
  - HH Compliance rate overall 94.6%
  - Improve environmental cleaning effectiveness for high-risk areas
  - Goal: >90% of areas in high-risk areas are cleaned effectively the first time (all areas not passing are re-cleaned immediately)
  - FY2025 88% Pass cleanliness effectiveness testing. November 2025 87% Pass rate.





OHO FY25 Plan: HAI Reduction of Standardized Infection Ratio (SIR)

CURRENT IMPROVEMENT ACTIVITIES	EXPECTED COMPLETION DATE	BARRIERS
Expand Multidisciplinary rounds to include other stakeholders to reduce line use; NEW device rounds with Charge RN and Infection Prevention started May 1, 2025, on all inpatient units	5/1/25	Completed, ongoing
Explore consensus statement on duration of femoral lines with medical staff	9/30/25	Buy in from physician stakeholders
Skin decolonization for all line patients through CHG bathing training for CNAs and implementation to all units Next Steps: Skin decolonization of MRSA at risk patients through workflow enhancements	11/19/24 10/30/25	Completed Cost analysis performed
MRSA screening form workflow changes to ensure patients who reside at a SNF and/or have been readmitted in past 30 days are automatically MRSA decolonized for a positive nasal swab result	3/31/25	Completed
Hand Hygiene compliance dashboard disseminated monthly to leadership (increased awareness and accountability). New BioVigil monthly leadership meetings start 7/16/25. Communication with managers of units that are not achieving goal to review their staff level HH compliance reports and follow up with staff.	7/16/25 and ongoing	Completed
Effective cleaning – Post staff competency, identify targeted equipment/surfaces for focused QI work. Bedrails most frequently failing testing. EVS leadership coaching consistently in staff huddles. Also evaluating different cleaning products with faster kill times that pass testing more often	3/31/25	In Progress (transitioning to Oxivir-364 with shorter dwell time)
Daily safety huddles to include device management-Device type, date of insertion medical necessity, ordering physician	4/14/25	Completed, ongoing
Nursing Competency Camp – plan to include MRSA screening information	5/19/25	Completed

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