Kaweah Delta Health Care District
Board of Directors Meeting

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

Kaweah Health
MORE THAN MEDICINE. LIFE.

DATE POSTED: February 15, 2026

NOTICE

Date: Thursday, February 19, 2026
Location: Kaweah Health Medical Cetner – 4 Tower Multipurpose Room
Address: 305 W. Acequia Avenue, Visalia, California

Please join my meeting from your computer, tablet or smartphone.
https://meet.goto.com/KelsieD/kaweahdeltahealthcaredistrictboardofdirectorsmeeti
You can also dial in using your phone.
Access Code: 460-561-181
United States: +1 (646) 749-3122

SCHEDULE:

- **8:00 AM** – Open Session (to approve the Closed Session agenda)
- **8:01 AM** – Closed Session
  Pursuant to:
  - Health & Safety Code §§1461 and 32155 (Confidential Quality Assurance/Medical Staff Matters)
- **8:30 AM** – Open Session

AMERICANS WITH DISABILITIES ACT (ADA) NOTICE:
In compliance with the Americans with Disabilities Act, if you need special assistance to participate in this meeting, please contact the Board Clerk at (559) 624-2330. Notification at least 48 hours prior to the meeting will enable the District to make reasonable arrangements to ensure accessibility to the meeting.

POSTING NOTICE:
All Kaweah Delta Health Care District regular Board and committee meeting notices and agendas are posted at least **72 hours** prior to the meeting (and **24 hours** prior to special meetings) in the Kaweah Health Medical Center, Mineral King Wing, near the Mineral King entrance, in accordance with Government Code §54954.2(a)(1).

PUBLIC RECORDS:
Disclosable public records related to this agenda are available for public inspection at:
Kaweah Health Medical Center – Acequia Wing, Executive Offices (1st Floor)
400 West Mineral King Avenue, Visalia, CA 93291
You may also request records by contacting the Board Clerk at (559) 624-2330 or **kedavis@kaweahhealth.org**, or by visiting the District's website at **www.kaweahhealth.org**.

KAWEAH DELTA HEALTH CARE DISTRICT
David Francis, Secretary/Treasurer

Prepared by:

Kelsie K. Davis
Board Clerk / Executive Assistant to the CEO

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

Kaweah Delta Health Care District
Board of Directors Meeting

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This agenda is posted in compliance with the Ralph M. Brown Act, including amendments enacted under Senate Bill 707.

KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS QUALITY COUNCIL COMMITTEE MEETING

Kaweah Health Medical Center – 4 Tower Multipurpose Room
305 W. Acequia, Visalia, CA

Thursday February 19, 2026 {Committee Meeting}

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Access Code: 460-561-181
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OPEN SESSION (LIMITED PURPOSE – CONVENING ONLY) – 8:00 AM

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1. **CALL TO ORDER**
2. **PUBLIC COMMENT ON CLOSED SESSION ITEMS ONLY –** 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.
3. **ADJOURN TO CLOSED SESSION**

CLOSED SESSION – 8:01 AM

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1. **CALL TO ORDER**
2. **REVIEW OF THE CLOSED MEETING MINUTES** – January 2026.

Possible reportable action - recommend for approval to the Regular Board Meeting

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

5. **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 Office

6. **ADJOURN CLOSED SESSION**

OPEN SESSION – 8:30 AM (OR IMMEDIATELY FOLLOWING CLOSED SESSION)

1. **CALL TO ORDER**
2. **PUBLIC 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 (5) 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.
3. **CLOSED SESSION ACTION TAKEN**
   Report on action(s) taken in closed session.
4. **REVIEW OF OPEN SESSION MINUTES –** January 2026**.**
   Possible reportable action - recommend for approval to the Regular Board Meeting
5. **WRITTEN QUALITY REPORTS–** A review of key quality metrics and actions associated with the following improvement initiatives:
   i. **Annual QAPI Review (AP 41 & AP 175)**
6. **CARDIAC SERVICE LINE:** A review of key process and outcome measures related to Cardiac Surgery Service Line. *Ayham Zoreikat, Director of Cardiovascular Services*
7. **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.*
8. **ADJOURN OPEN MEETING**

ADA Notice
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Thursday Febraury 19, 2026

Kaweah Delta Health Care District
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Agenda Posting and Public Records
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Thursday Febraury 19, 2026

WRITTEN QUALITY REPORTS–

Annual Review of Quality (AP.41) and Patient Safety Plan (AP.175)
Year End 2025 Quality and Patient Safety Initiatives & Quality Focus Team (QFT) Review

Quality Initiative	Type	Priority Category	Key Considerations	Measures of Success	Assigned Leader(s)
Quality Council (QC)	QAPI Oversight Committee - Board of Directors (BOD) Quality & Patient Safety Sub-Committee (per AP.41)	☒ High Risk ☒ Problem Prone ☒ High Volume	• Responsible for success of QAPI and Patient Safety Plans • Oversight committee where governance, medical staff leadership and hospital leadership oversee QAPI • QAPI reporting topics cover scope of services provided	• As determined by each QAPI program topic or service line report	Chaired by BOD Member
Quality Committee ("QComm")	QAPI Oversight Committee (Medical Staff) (per AP.41)	☒ High Risk ☒ Problem Prone ☒ High Volume	• Delegated responsibility for success of QAPI and Patient Safety Plans • Oversight committee where medical staff leadership and hospital leadership oversee QAPI • QAPI reporting topics cover scope of services provided	• As determined by each QAPI program topic or service line report	Chaired by the Vice-Chief of Staff
Patient Safety Committee (PSC)	Org Oversight Committee (per AP.175)	☒ High Risk ☒ Problem Prone ☒ High Volume	• Responsible per AP.175 Patient Safety Plan • Oversees Midas Event Triage and Ranking Committee (METER) and Quality-Risk Committee (QRC) • Oversees all action plans related to Root Cause Analysis and Focus Review teams • Oversees safety culture improvement action plan including Just Culture • Oversees patient safety priority QI work (ie. HAPI, Fall Prevention, National Patient Safety Goals).	• As determined by individual action plans • Reportable never events • Priority measures such as 2 identifier events, critical findings, and topic specific reported by committee listed below	Director of Quality and Patient Safety
Incident Management (IMM)	Patient Safety Committee	☒ High Risk ☒ Problem Prone ☒ High Volume	• (per AP.87) A multidisciplinary team including members from the organization and Medical Staff which reviews occurrence reports daily to rank and triage events so immediate notification of high-risk or unusual events can be made to hospital and Medical Staff leadership.	• Ranking task contributes to overall Serious Safety Event Rate reporting to QComm	• Director of Risk Management

Just Culture Committee	Org Committee	☒ High Risk ☒ Problem Prone ☒ High Volume	• Key strategy in organization safety culture improvement action plan • National Quality Forum (NQF) safe practice included in Leapfrog Safety Grade	• Just Culture measures included in the Safety Culture Survey	Director of Organizational Development
Medication Safety	Org Oversight Committee	☒ High Risk ☒ Problem Prone ☒ High Volume	• Oversees the Medication Error Reduction Program (MERP) per CA state requirements • Through analysis of medication management data, identifies actual or potential medication safety risk and takes actions to improve the organizational medication use process. Supports strategic goals established to advance the culture of safety, promote multidisciplinary oversight and accountability in improving the medication use process, and optimize the use of high leverage strategies and technology to reduce medication errors across the organization. • Collaborative partnership with Patient Safety Committee on medication elements of high risk processes such as anticoagulation, medication reconciliation and procedural sedation safety which are Joint Commission National Patient Safety Goals. • Utilizes externally reported medication events and best practice recommendations to evaluate potential risk in organizational process and procedures to evaluate risk and recommend improvements to improve medication use systems • Oversees Adverse Drug Event Committee review of all reported medication events and reviews high or potential high severity reported events	• Several measures monitored as determined annually by the committee through the MERP and Adverse Drug Event (ADE) committee work. • Examples of monthly trended data includes utilization reversal medications, BCMA utilization, smartpump metrics, rates of reported events, ADC overrides. • Home medication list review for high risk patients within 24 hours of hospital admission metrics include: number of medication histories completed, total admission discrepancies and total admission discrepancies per patient	Director of Pharmacy and Medication Safety Coordinator

Annual Review of Quality (AP.41) and Patient Safety Plan (AP.175)
Year End 2025 Quality and Patient Safety Initiatives & Quality Focus Team (QFT) Review

Adverse Drug Event (ADE) Committee	Org Sub-Committee Medication Safety	☒ High Risk ☒ Problem Prone ☒ High Volume	• Reviews, tracks and trends and makes recommendations for process improvements in response to adverse drug event Midas reports • Uses the Just Culture framework to identify organizations process and systems that contributed the medication event and make QI recommendations to improve medication safety • Make recommendations for Root Cause Analysis or Focused Review as determined necessary	• ADE volume and tracked trends as reported to Medication Safety Committee • Aggregated trends analysis annually to Medication Safety	Medication Safety Coordinator
Patient Care Medication Safety Committee	Org Sub-Committee Medication Safety	☒ High Risk ☒ Problem Prone ☒ High Volume	• Multidisciplinary team that develops, plans and implements QI strategies to improve medication safety related issues relative to nursing practice identified by ADE or Medication Safety Committee	• Metrics determined by topics identified, examples include BCMA utilization, diversion prevention measures.	Medication Safety Specialist
Sepsis QFT	OHO Strategic Initiative Quality Focus Team (QFT)	☒ High Risk ☒ Problem Prone ☒ High Volume	• Established QFT since 2016 • High volume diagnosis, high mortality rates nationally (problem prone) • Centers for Medicare and Medicaid Services (CMS) SEP-1 bundle compliance publically reported on CMS care compare website	• SEP-1 Bundle compliance • Mortality	Medical Director of Quality & Patient Safety; Manager of Quality and Patient Safety
Hospital Acquired Pressure Injury (HAPI) QFT 2026 – replace with "Harm Committee"	Quality Focus Team (QFT); reports to PSC	☒ High Risk ☒ Problem Prone ☐ High Volume	• PSI3 (HAPI) is a component of Leapfrog Safety Score & CMS public report • Mandated reporting to California Department of Public Health (CDPH)	• Percent of patients with stage 2+ • Proportion of HAPIs that are device related • PSI3 (>Stage 2+)	Director of Nursing Practice
Healthcare Associated Infections (HAI) QFT	OHO Strategic Initiative, QFT	☒ High Risk ☒ Problem Prone ☐ High Volume	• CMS Value-Based Purchasing (VBP) and star rating Measure • Leapfrog safety grade metric • TJC National Patient Safety Goal (hand hygiene)	• Standardized Infection Ratio (SIR) for Central Line Associated Blood Stream Infection (CLABSI), Catheter Associated Urinary Tract Infection (CAUTI),	Medical Director Quality & Patient Safety, Manager of Infection Prevention, Directors of: Quality & Patient Safety, Post

				and Methicillin-Resistant Staphylococcus Aureus (MRSA) • Standardized Utilization Ratios (SUR) for central lines and urinary catheter • HAI Bundle compliance measures • Hand Hygiene compliance	Acute Nursing, Renal Services and Environmental Services
Best Practice Team (HF, PN, COPD)	Org Committee	☒ High Risk ☒ Problem Prone ☒ High Volume	• CMS VBP and star rating Measure • High volume medical diagnosis (PN & HF) • CMS Readmission Reduction Program population	• Observed/expected (o/e) mortality and risk adjusted readmission rates • examples of key performance indicators (KPI) include discharge medications, inpatient medication management, order set utilization	Director of Respiratory Services; Medical Director of Best Practice Teams
Fall Prevention Committee 2026 – replace with "Harm Committee"	Org Committee, reports to PSC	☒ High Risk ☒ Proble m Prone ☐ High Volume	• Nursing sensitive quality indicator • Case reviews of fall events and collection an dissemination of contribution factors data	• Total falls and injury falls; contributing factors	Director of Nursing Practice
Falls University 2026 – replace with "Harm Committee"	Sub-Committee of Fall Prevention Committee	☒ High Risk ☒ Problem Prone ☐ High Volume	• Case reviews of fall events and collection and dissemination of contribution factors data • Reports to Fall Prevention Committee	• Contributing factors to falls	Director of Nursing Practice
Diabetes	Org Committee	☒ High Risk ☒ Problem Prone ☒ High Volume	• High volume, high risk volume patient population	• Hypo and Hyperglycemia rates	Director of Nursing Practice, Medical Director of Quality & Patient Safety
Trauma Quality Program	Org Committee	☒ High Risk ☒ Problem Prone ☒ High Volume	• Trauma program oversight and QI work related to ACS trauma designation	• Various measures through data registry including documentation of assessment findings, airway management, timeliness of diagnostic studies, timeliness of surgical intervention, mortality rates	Manager of Trauma Program, Medical Director of Trauma

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Stroke Quality Program	Org Committee	☒ High Risk ☒ Problem Prone ☒ High Volume	• The Joint Commission (TJC) certified program • High risk population • Oversees work of the ED Stroke Alert sub task force	• Various process measures through American Heart/Stroke Association including medication management, discharge indicators, timeliness of diagnostics studies and assessments	Manager of Stroke Program and Medical Director of Stroke Program
Health Equity	Org Committee	☒ High Risk ☒ Problem Prone ☒ High Volume	• TJC Sentinel Event issued January 2022 • New TJC Leadership standard 2023 • New TJC National Patient Safety Goal for 2024 • National and ACGME initiative	• Measures to identify disparities in care in key population; • 2024 Social Determinates of Health (SDOH). • Measures related to the effectiveness of demographic (REaL) collection (ie. Rate of "unknown" responses in a REaL field in the patients EMR)	Chief Population Health Officer, Director of Population Health
Patient Safety Indicator (PSI) Committee	Org Committee	☒ High Risk ☒ Problem Prone ☐ High Volume	• Review of coded complications of the surgical population • Reported on CMS Care Compare website • Component of CMS star rating, VBP program	• PSI rates	Medical Director of Surgical Quality, Director of Quality and Patient Safety
Surgical Quality Committee (SQIP)	Org Committee	☒ High Risk ☒ Problem Prone ☒ High Volume	• Oversees PSI (coded complications of care) • Oversees implementation of Enhanced Recovery After Surgery (ERAS) program (evidenced based care targeted at the surgical population	• ERAS measures • PSI measures • Surgical Site Infection measures	Director of Surgical Services, Medical Director of Surgical Quality
Population Health Steering Committee	Org Oversight Committee	☒ High Risk ☒ Problem Prone ☒ High Volume	• Quality Incentives Program (QIP) previously Public Hospital Redesign & Incentives Program (PRIME) • Oversees Population Health Quality Committee work	• In Calendar Year 2025 we will report on 8 quality measures to DHCS and 3 informational measures	Director of Population Health
Rapid Response/Code Blue	Org Committee	☒ High Risk ☒ Problem Prone ☒ High Volume	• TJC data monitoring requirements for accredited hospitals	• Several measures as submitted to American Heart Association registry including volume, location and outcome	Chief Nursing Officer, Director of Critical Care Services

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Mortality	Org Committee	☒ High Risk ☒ Problem Prone ☐ High Volume	• Review of unexpected deaths for follow up with quality of care concerns, coding or documentation	• Rates of cases with quality of care concerns, coding or documentation	Medical Director of Quality and Patient Safety, Manager of Quality Improvement
Infection Prevention Committee	Org Oversight Committee	☒ High Risk ☒ Problem Prone ☐ High Volume	• Oversees the Infection Prevention Plan • Oversees Surgical Site Infection task force • Oversees regulatory compliance with IP standards	• Several measures monitored through quarterly dashboard including surgical site infection rates, ventilator associated events, line infection rates, MRSA.	Manager of Infection Prevention, Medical Director of Infection Prevention
Accreditation Regulatory Committee	Org Oversight Committee	☒ High Risk ☒ Problem Prone ☒ High Volume	• Oversees compliance with regulatory standards and plans of correction	• Various measures determined by plans of correction • Regular tracer data for compliance with regulatory standards	Director of Quality & Patient Safety
Environment of Care Committee	Org Oversight Committee	☒ High Risk ☒ Problem Prone ☒ High Volume	• Oversees the EOC Plan and Workplace Violence Program (CA state mandate) • Oversees compliance with EOC regulatory standards per annual plan	• Various measures determined by annual plan; can include preventive maintenance completion rates, workplace violence, and employee injury rates.	Safety Officer
Emergency Management	Sub Committee of EOC	☒ High Risk ☒ Problem Prone ☐ High Volume	• Oversees the Emergency Operations Plan • Oversees compliance with EOP and Emergency Management regulatory standards.	• Various measured determined by annual plan and district wide exercises.	Safety Officer
Patient Throughput	Org Committee	☒ High Risk ☒ Problem Prone ☒ High Volume	• Committee that oversees various projects related to throughput including: work of 5 sub-groups: o Patient progression (includes discharge (d/c) management) o ED to inpatient admission process (includes RN to RN handoff, ED launch point enhancements)	• Various throughput measures including average length of stay (LOS) (obs and admitted patients) • ED throughput measures including ED boarding times, admit hold volume, ED LOS, visit volume. time to provider, time from door to admit, time from admit to arrival on unit.	CNO & COO

			○ Observation program (includes power plan enhancements, PCP and outpatient appointment processes) ○ Tests and treatments (ie. turnaround time)		

*All committees report to Quality Committee “QComm” per AP.41

Annual QAPI Review

Policy Number: AP41	**Date Created: Not Set**
Document Owner: Kelsie Davis (Board Clerk/Exec Assist-CEO)	**Date Approved: 02/26/2025**
Approvers: Board of Directors (Administration)	
Quality Improvement Plan	

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

I. Purpose

The purpose of Kaweah Health's Quality Improvement Plan is to have an effective, data-driven Quality AssessmentPerformance Improvement program that delivers high-quality, excellent clinical services and enhances patient safety.

II. Scope

All Kaweah Health facilities, departments, patient care delivery units and/or serviceareas fall within the scope of the quality improvement plan requirements.

III. Structure and Accountability

Board of Directors

The Board of Directors retain overall responsibility for the quality of patient care. The Board approves the annual Quality Improvement Plan and assures that appropriate allocation of resources is available to carry out thatplan.

The Board receives reports from the Medical Staff and Quality Council. The Board shall act as appropriate on the recommendations of these bodies and assure that efforts undertaken are effective and appropriately prioritized.

Quality Council

The Quality Council is responsible for establishing and maintaining the organization's Quality Improvement Plan and is chaired by a Board member. The Quality Council shall consist of the Chief Executive Officer, representatives of the Medical Staff and other key hospital leaders. It shall hold primary responsibility for the functioning of the Quality Assessment and Performance Improvement program. Because District quality improvement activities may involve both the Medical Staff and other representatives of the District, membership is multidisciplinary. The Quality Council requires the Medical Staff and the organization's staff to implement and report on the

activities for identifying and evaluating opportunities to improve patient care and services throughout the organization. The effectiveness of the quality

improvement and patient safety activities will be evaluated and reported to the Quality Council.

Quality Committee ("QComm")

In accordance with currently approved medical staff bylaws, shall be accountable for the quality of patient care. The Board delegates' authority and responsibility for the monitoring, evaluation and improvement of medical care to the Quality Committee "QComm", chaired by the Vice Chief of Staff and co-chaired by the CMO/CQO (or designee). The Chief of Staff delegates accountability for monitoring individual performance to the Clinical Department Chiefs. QComm shall receive reports from and assure the appropriate functioning of the Medical Staff committees. QComm provides oversight for medical staff quality functions including peer review.

QComm has responsibility for oversight of organizational performance improvement. Membership includes key medical staff and organizational leaders including the Chief of Staff, Medical Director of Quality and Patient Safety, Secretary-Treasurer, Immediate Past Chief of Staff, Chief Executive Officer, Chief Operating Officer, Chief Nursing Officer, Chief Informatics Officer, Chief Human Resources Officer, Chief Financial Officer, Chief Compliance and Risk Management Officer, Chief Strategy Officer, Directors of Quality and Patient Safety, Nursing Practice, Pharmacy, Accreditation, and Risk Management; Manager of Quality and Patient Safety, Manager of Infection Prevention and Environmental Safety Officer. This committee reports to Medical Executive Committee and the Quality Council.

The QComm shall have primary responsibility for the following functions:

1. **Health Outcomes:** The QComm shall assure that there is measureable improvement in indicators with a demonstrated link to improved healthoutcomes. Such indicators include but are not limited to measures reported to the Centers for Medicare and Medicaid Services (CMS) and The Joint Commission (TJC), and other quality indicators, as appropriate.

2. **Quality Indicators:**
   a. The QComm shall oversee measurement, and shall analyze and track quality indicators and other aspects of performance. These indicators shall measure the effectiveness and safety of services and quality of care.
   b. The QComm shall approve the specific indicators used for these purposes along with the frequency and detail of data collection.
   c. The Board shall ratify the indicators and the frequency and detail of data collection used by the program.

3. **Prioritization:** The QComm shall prioritize quality improvement activities toassure that they are focused on high- risk, high-volume, or problem- prone areas. It shall focus on issues of known frequency, prevalence or severity and shall give

precedence to issues that affect health

outcomes, quality of care and patient safety. The QComm is responsible to establish organizational Quality Focus Teams who:

a. Are focused on enterprise-wide high priority, high risk, problem prone QI issues
b. May require elevation, escalation and focus from senior leadership
c. Have an executive team sponsor
d. Are chaired by a Director or Vice President
e. May have higher frequency of meetings as necessary to focus work and create sense of urgency.
f. Report quarterly into the QAPI program

4. **Improvement:** The QComm shall use the analysis of the data to identifyopportunities for improvement and changes that will lead to improvement. The QComm will also oversee implementation of actions aimed at improving performance.

5. **Follow- Up:** The QComm shall assure that steps are taken to improve performance and enhance safety are appropriately implemented, measured and tracked to determine that the steps have achieved and sustained the intended effect.

6. **Performance Improvement Projects:** The QComm shall oversee quality improvement projects, the number and scope of which shall be proportional to the scope and complexity of the hospital's services and operations. The QComm must also ensure there is documentation of what quality improvement projects are being conducted, the reasons for conducting those projects, and the measurable progress achieved onthe projects.

Medical Executive Committee

The Medical Executive Committee (MEC) receives, analyzes and acts on performance improvement and patient safety findings from committees and is accountable to the Board of Directors for the overall quality of care

IV. Graduate Medical Education

Graduate Medical Education (Designated Institutional Official (DIO), faculty and residents, are involved in achieving quality and patient safety goals and improving patient care through several venues including but not limited to:

a. Collaboration between Quality and Patient Safety Department, Risk Management, and GME Quality Subcommittee
b. GME participation in Quality Improvement Committee and Patient Safety Committee
c. GME participation in KDHCD quality committees and root cause analysis (including organizational dissemination of lessons learned)

V. Methodologies:

Quality improvement (QI) models present a systematic, formal framework for establishing QI processes within an organization. QI models used include the following:

- Model for Improvement (FOCUS Plan-Do-Study-Act [PDSA] cycles)
- Six Sigma: Six Sigma is a method of improvement that strives to decrease variation and defects with the use of the DMAIC roadmap.
- Lean: is an approach that drives out waste and improves efficiency in work processes so that all work adds value with the use of the DMAIC roadmap.

1. The **FOCUS**-**Plan, Do, Check, Act (PDCA)** methodology is utilized to plan, design, measure, assess and improve functions and processes related to patient care and safety throughout the organization.

   - **F**—**Find** a process to improve
   - **O**—**Organize** effort to work on improvement
   - **C**—**Clarify** knowledge of current process
   - **U**---**Understand** process variation
   - **S**—**Select** improvement

   - **Plan:**

     - Objective and statistically valid performance measures are identified for monitoring and assessing processes and outcomes of care including those affecting a large percentage of patients, and/or place patients at serious risk if not performed well, or performed when not indicated, or not performed when indicated; and/or have been or likely to be problem prone.

     - Performance measures are based on current knowledge and clinical experience and are structured to represent cross-departmental, interdisciplinary processes, as appropriate.

   - **Do:**

     - Data is collected to determine:
       - ♦ Whether design specifications for new processes were met
       - ♦ The level of performance and stability of existing processes
       - ♦ Priorities for possible improvement of existing processes

   - **Check:**

     - Assess care when benchmarks or thresholds are reached in order to identify opportunities to improve performance or resolve problem areas

- **Act:**

  - Take actions to correct identified problem areas or improve performance
  - Evaluate the effectiveness of the actions taken and document the improvement in care
  - Communicate the results of the monitoring, assessment and evaluation process to relevant individuals, departments or services

3. **DMAIC (Lean Six Sigma):** DMAIC is an acronym that stands for Define, Measure, Analyze, Improve, and Control. It represents the five phases that make up the road map for Lean Six Sigma QI initiatives.

   - **Define** the problem, improvement activity, opportunity for improvement, the project goals, and customer (internal and external) requirements. QI tools that may be used in this step include:
     - Project charter to define the focus, scope, direction, and motivation for the improvement team
     - Process mapping to provide an overview of an entire process, starting and finishing at the customer, and analyzing what is required to meet customer needs
   - **Measure** process performance.
     - Run/trend charts, histograms, control charts
     - Pareto chart to analyze the frequency of problems or causes
   - **Analyze** the process to determine root causes of variation and poor performance (defects).
     - Root cause analysis (RCA) to uncover causes
     - Failure mode and effects analysis (FMEA) for identifying possible product, service, and process failures

     Improve process performance by addressing and eliminating the root causes.
     - Pilot improvements and small tests of change to solve problems from complex processes or systems where there are many factors influencing the outcome
     - Kaizen event to introduce rapid change by focusing on a narrow project and using the ideas and motivation of the people who do the work
   - **Control** the improved process and future process performance.
     - Quality control plan to document what is needed to keep an improved process at its current level. Statistical process control (SPC) for monitoring process behavior
     - Mistake proofing (poka-yoke) to make errors impossible or immediately detectable

VI. Confidentiality

All quality assurance and performance improvement activities and dataare protected under the Health Care Quality Improvement Act of 1986,as stated in the Bylaws, Rules and Regulations of the Medical Staff, and protected from discovery pursuant to California Evidence Code

§1157.

VII. Annual Evaluation

Organization and Medical Staff leaders shall review the effectiveness of the Quality Improvement Plan at least annually to insure that the collective effort is comprehensive and improving patient care and patient safety. An annual evaluation is completed to identify components of the plan that require development, revision or deletion.Organization and Medical Staff leaders also evaluate annually their contributions to the Quality Improvement Program and to the efforts inimproving patient safety.

VIII. Attachments (Click on “links & attachments” at the top right to open/view the documents.)

Components of the Quality Improvement and Patient Safety Plan:

Attachment 1: Quality Improvement Committee StructureAttachment 2: Kaweah Health Reporting Documents
Attachment 3: Quality and Patient Safety Priorities, Outstanding Health Outcomes Strategic Plan

"These guidelines, procedures, or policies herein do not represent the only medically or legally acceptable approach, but rather are presented with the recognition that acceptable approaches exist. Deviations under appropriate circumstances do not represent a breach of a medical standard of care. New knowledge, new techniques, clinical or research data, clinical experience, or clinical or bio-ethical circumstances may provide sound reasons for alternative approaches, even though they are not described in the document."

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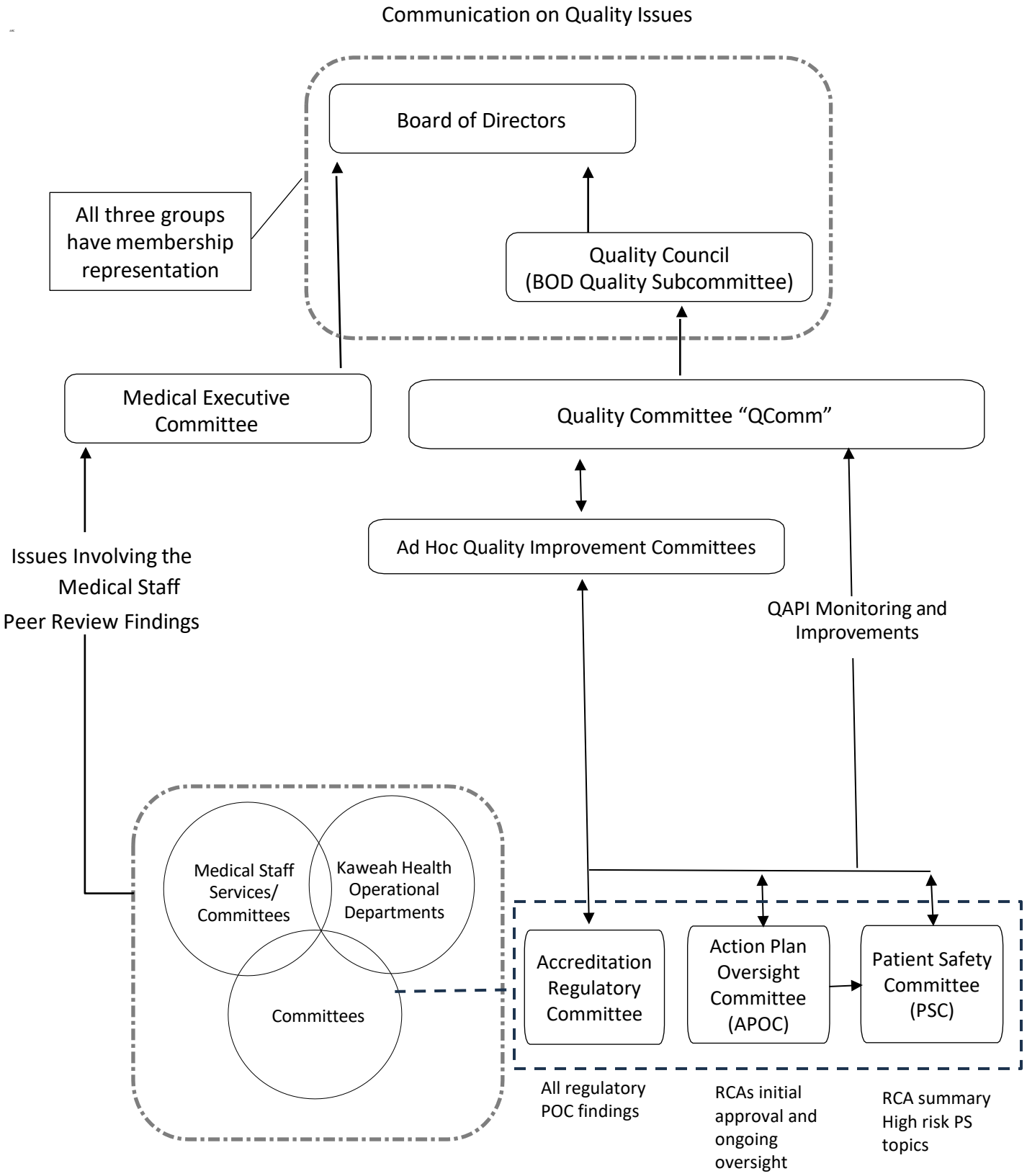
Attachment 1

Kaweah Health

QAPI Reporting Structure



Quality Committee "QComm" Participating Depts/Services/Committees

Departments within Kaweah Health participate in the Quality Improvement plan by prioritizing performance improvement activities based on high-risk, high-volume, or problem-prone areas. Department level indicators shall focus on issues of known frequency, prevalence or severity and shall give precedence to issues that affect health outcomes, quality of care and patient safety. Departments and committees include, but are not limited to:

Professional & Patient Care Services
Laboratory
Blood Utilization
Dept of Radiology/imaging Services (including Radiation Safety Report)
Dept of Emergency Medicine
Dept of Pathology
EOC (Security, Facilities, Clinical Engineering, EVS, Employee Health, Workplace Violence)
Peer Review
Patient Access
Population Health
Nutrition Services
Quality Incentives Program (QIP), includes all Rural Health Clinics (Exeter, Lindsay, Woodlake, Dinuba, Tulare)
Pharmacy
Inpatient Pharmacy
Med Safety & ADE (Quarterly)
MERP Annual Review
Chemo Annual Review
Infection Prevention Services
Infection Prevention Committee
Healthcare Acquired Infection Prevention Committee & Hand Hygiene
Risk Management
Risk Management (RCA and Focus Review Summary)
Patient Experience
Complaints & Grievances
Mental Health Services
Dept of Psychiatry, Mental Health Hospital
Maternal Child Health/ Dept of OB/GYN & Peds
Labor & Delivery
Mother Baby
Neonatal Intensive Care Unit
Pediatrics
Respiratory Services
Sleep Lab and EEG
Respiratory Therapy and Pulmonary Function Test
Care Management
Patient & Family Services
Case Management
Interpreter Services
Palliative Care Committee
Episodic Care
Emergency Dept. Quality Report
Trauma Service
Urgent Cares

Cardiovascular Services
Dept of Cardiovascular Services (ACC, STS); Cath lab, IR, CVCU, 4T and Cardiac Surgery
Telemonitoring Report
Non Invasive Inpatient Services
Critical Care Services
Intensive Care Unit, CVICU (non-cardiac), 3W, 5T
Organ Donation
Rehabilitation Services
Rehabilitation
Inpatient Therapies (KDMC, Rehab, South Campus)
Outpatient Therapies: Medical Office Building Akers (MOB), Exeter, Sunnyside, Dinuba, Lovers Lane, Therapy Specialists at Rehab/Neuro
Outpatient Wound Clinic at Rehab (included in Rehab report)
Post Acute Services
KH Home Infusion Pharmacy (KHHIP)
Hospice
Home Care Services (Home Health)
Short-Stay Rehab
Skilled Nursing Services (subacute and short-stay)
Surgical Services
SQIP - Surgical Quality Improvement Committee
Ambulatory Surgery Center/PACU/KATS
Operating Room
Sterile Processing Department
Inpatient units: Broderick Pavilion, 3N, 4S
Anesthesia Services
Orthopedics
Endoscopy
Renal Services/ Dept of Renal Services
KH Visalia Dialysis
Publically Reported Measures

Value Based Purchasing Report
Healthgrades
Leapfrog Hospital Safety Score
Committees
Health Equity
Falls Committee
RRT/Code Blue
HAPI Committee (includes inpatient wound care)
Sepsis Quality Focus Team
Healthcare Acquired Infection Committee (CAUTI, CLABSI, MRSA, Hand Hygiene)
Stroke Committee Report
Diabetes Committee Report
Accreditation Regulatory Committee Minutes & Audit Summary
Workplace Violence Committee
Throughput Committee
Mortality Committee
Patient Safety Committee
HIM - HIM Committee

Policy Number: AP175	Date Created: Not Set
Document Owner: Kelsie Davis (Board Clerk/Executive Assistant to CEO)	Date Approved: 08/11/2025
Approvers: Board of Directors (Administration), Kelsie Davis (Board Clerk/Executive Assistant to CEO)	

Patient Safety Plan

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

I. Purpose

- Encourage organizational learning about medical/health care risk events and near misses
- Encourage recognition and reporting of medical/health events and risks to patient safety using just culture concepts
- Collect and analyze data, evaluate care processes for opportunities to reduce risk and initiate actions
- Report internally what has been found and the actions taken with a focus on processes and systems to reduce risk
- Support sharing of knowledge to effect behavioral changes in itself and within Kaweah Delta Healthcare District dba Kaweah Health (Kaweah Health)

II. Scope

All Kaweah Health facilities, departments, patient care delivery units and/or service areas fall within the scope of the quality improvement and patient safety plan requirements.

III. Structure and Accountability

A. Board of Directors

The Board of Directors retains overall responsibility for the quality of patient care and patient safety. The Board approves annually the Patient Safety Plan and assures that appropriate allocation of resources is available to carry out that plan.

The Board receives reports from the Patient Safety Committee through the Professional Staff Quality Committee. The Board shall act as appropriate on the recommendations of these bodies and assure that efforts undertaken are effective and appropriately prioritized.

B. Quality Council

The Quality Council is responsible for establishing and maintaining the organization's Patient Safety Plan and is chaired by a Board member. The Quality Council shall consist of the Chief Executive Officer, representatives of the Medical Staff and other key hospital leaders. It shall hold primary responsibility for the functioning of the Quality Assessment and Performance Improvement program. Because District performance improvement activities may involve both the Medical Staff and other representatives of the District, membership is multidisciplinary. The Quality Council requires the Medical Staff and the organization's staff to implement and report on the activities for identifying and evaluating opportunities to improve patient care and services throughout the organization. The effectiveness of the quality improvement and patient safety activities will be evaluated and reported to the Quality Council.

C. Patient Safety Committee

The Patient Safety Team is a standing interdisciplinary group that manages the organization's Patient Safety Program through a systematic, coordinated, continuous approach. The Team will meet monthly to assure the maintenance and improvement of

Patient Safety in establishment of plans, processes and mechanisms involved in the provision of the patient care.

The scope of the Patient Safety Team includes medical/healthcare risk events involving the patient population of all ages, visitors, hospital/medical staff, students and volunteers. Aggregate data* from internal (IS data collection, incident reports, questionnaires,) and external resources (Sentinel Event Alerts, evidence based medicine, etc.) will be used for review and analysis in prioritization of improvement efforts, implementation of action steps and follow-up monitoring for effectiveness. The Patient Safety Committee has oversight of Kaweah Health activities related to the National Quality Forum's (NQF) Safe Practices (SP) Medication Safety, Section #4 Maternity Care, #5 ICU physician staffing, #6 A-D Culture of Safety Leadership Structures & System Documentation, Culture Measurement, Feedback & Intervention Documentation, Nursing workforce and Hand Hygiene, #7 Managing Serious Errors, and #8 Bard Code Medication Administration.

1. The Patient Safety Officer is the Chief Quality Officer
2. The Patient Safety Committee is chaired by the Patient Safety Officer or designee.
3. The responsibilities of the Patient Safety Officer include institutional compliance with patient safety standards and initiatives, reinforcement of the expectations of the Patient Safety Plan, and acceptance of accountability for measurably improving safety and reducing errors. These duties may include listening to employee and patient concerns, interviews with staff to determine what is being done to safeguard against occurrences, and immediate response to reports concerning workplace conditions.
4. Team membership includes services involved in providing patient care, such as: Pharmacy, Surgical Services, Risk Management, Infection Prevention, and Nursing. The medical staff representative on the team will be the Medical Director of Quality & Patient Safety.

D. Medication Safety Quality Focus Team

The Medication Safety Quality Focus Team (MSQFT) is an interdisciplinary group that manages the organizations Medication Safety Program including the District Medication Error Reduction Plan (MERP).

The purpose of the MSQFT is to direct system actions regarding reductions in errors attributable to medications promoting effective and safe use of medication throughout the organization. Decisions are made utilizing data review, approval of activities, resource allocation, and monitoring activities. Activities include processes that are high risk, high volume, or problem prone, some of which may be formally approved by the MSQFT as a District MERP goal (see Policy AP154 Medication Error Reduction Plan).

The MSQFT provides a monthly report to the Pharmacy and Therapeutics Committee and quarterly reports to the Professional Staff Quality Committee and directly to Quality Council. The MSQFT Chair is a member of the Patient Safety Committee. A quarterly report is presented at Patient Safety Committee in addition to active participation in patient safety activities related to medication use.

IV. Organization and Function

A. The mechanism to insure all components of the organization are integrated into the program is through a collaborative effort of multiple disciplines. This is accomplished by:

1. Reporting of potential or actual occurrences through the Occurrence Reporting Process Policy (AP10) by any employee or member of the medical staff. Examples of potential or actual occurrences include pressure ulcers, falls, adverse drug events, and misconnecting of: intravenous lines, enteral feeding tubes and epidural lines.
2. Reporting of potential or actual concerns in a daily leadership safety huddle which involves issues which occurred within the last 24 hours, a review the steps taken to resolve those matters when applicable, and anticipate challenges or safety issues in the next 24 hours. The daily safety huddle occurs Monday to Friday with the exception of holidays and includes directors and vice presidents that represent areas throughout the

organization. The purpose of the daily safety huddle is immediate organizational awareness and action when warranted. Examples of issues brought forth in the Daily Safety Huddle include, patients at risk for elopement, violence, or suicide, and also can include potential diversion events, patient fall events, and medication related events.

3. Communication between the Patient Safety Officer and the Chief Operating Officer to assure a comprehensive knowledge of not only clinical, but also environmental factors involved in providing an overall safe environment.
4. Reporting of patient safety and operational safety measurements/activity to the performance improvement oversight committee, Quality Committee "Qcomm". QComm is a multidisciplinary medical staff committee composed of various key organizational leaders including: Medical Staff Officers, Chief Executive Officer, Chief Operating Officer, Chief Medical Officer/Chief Quality Officer, Chief Nursing Officer, and Directors of Nursing, Quality Improvement & Patient Safety, Risk Management, Safety Officer and Pharmacy.
5. Graduate Medical Education
    i. Graduate Medical Education (Designated Institutional Official (DIO), faculty and residents, are involved in achieving quality and patient safety goals and improving patient care through several venues including but not limited to:
        1. Collaboration between Quality and Patient Safety Department, Risk Management, and GME Quality Subcommittee
        2. GME participation in Quality Improvement Committee and Patient Safety Committee
        3. GME participation in Kaweah Health quality committees and root cause analysis (including organizational dissemination of lessons learned)

B. The mechanism for identification and reporting a Sentinel Event/other medical error will be as indicated in Organizational Policies AP87. Any root cause analysis of hospital processes conducted on either Sentinel Events or near misses will be submitted for review/recommendations to the Patient Safety Committee, Quality Committee and Quality Council.

C. As this organization supports the concept that events most often occur due to a breakdown in systems and processes, staff involved in an event with an adverse outcome will be supported by:

1. A non-punitive approach without fear of reprisal (just culture concepts).
2. Voluntary participation into the root cause analysis for educational purposes and prevention of further occurrences.
3. Resources such as Pastoral Care, Social Services, or EAP should the need exist to counsel the staff
4. Safety culture staff survey administered at least every 2 years to targeted staff and providers.

D. As a member of an integrated healthcare system and in cooperation with system initiatives, the focus of Patient Safety activities include processes that are high risk, high volume or problem prone, and may include:

1. Adverse Drug Events
2. Nosocomial Infections
3. Decubitus Ulcers
4. Blood Reactions
5. Slips and Falls
6. Restraint Use
7. Serious Event Reports
8. DVT/PE

E. A proactive component of the program includes the selection at least every 18 months of a high risk or error prone process for proactive risk assessment such as a Failure Modes Effects Analysis (FMEA), ongoing measurement and periodic analysis. The selected process and approach to be taken will be approved by the Patient Safety Committee, QComm and Quality Council.

The selection may be based on information published by The Joint Commission (TJC) Sentinel Event Alerts, and/or other sources of information including risk management, performance improvement, quality assurance, infection prevention, research, patient/family suggestions/expectations or process outcomes.

F. Methods to assure ongoing inservices, education and training programs for maintenance and improvement of staff competence and support to an interdisciplinary approach to patient care is accomplished by:

1. Providing information and reporting mechanisms to new staff in the orientation training.
2. Providing ongoing education in organizational communications such as newsletters and educational bundles.
3. Obtaining a confidential assessment of staff's willingness to report medical errors at least once every two years.

G. Internal reporting – To provide a comprehensive view of both the clinical and operational safety activity of the organization:

1. The minutes/reports of the Patient Safety Committee, as well as minutes/reports from the Environment of Care Committee will be submitted through the Director of Quality Improvement and Patient Safety to the Quality Committee.
2. These monthly reports will include ongoing activities including data collection, analysis, and actions taken and monitoring for the effectiveness of actions.
3. Following review by Quality Committee, the reports will be forwarded to Quality Council.

H. The Patient Safety Officer or designee will submit an Annual Report to the Kaweah Health Board of Directors and will include:

1. Definition of the scope of occurrences including sentinel events, near misses and serious occurrences
2. Detail of activities that demonstrate the patient safety program has a proactive component by identifying the high-risk process selected
3. Results of the high-risk or error-prone processes selected for proactive risk assessment.
4. The results of the program that assesses and improves staff willingness to report medical/health care risk events
5. A description of the examples of ongoing in-service, and other education and training programs that are maintaining and improving staff competence and supporting an interdisciplinary approach to patient care.

V. Evaluation and Approval

The Patient Safety Plan will be evaluated at least annually or as significant changes occur, and revised as necessary at the direction of the Patient Safety Committee, Quality Committee, and/or Quality Council. Annual evaluation of the plan's effectiveness will be documented in a report to the Quality Council and the Kaweah Health Board of Directors.

VI. Confidentiality

All quality assurance and performance improvement activities and data are protected under the Health Care Quality Improvement Act of 1986, as stated in the Bylaws, Rules and Regulations of the Medical Staff, and protected from discovery pursuant to California Evidence Code §1157.

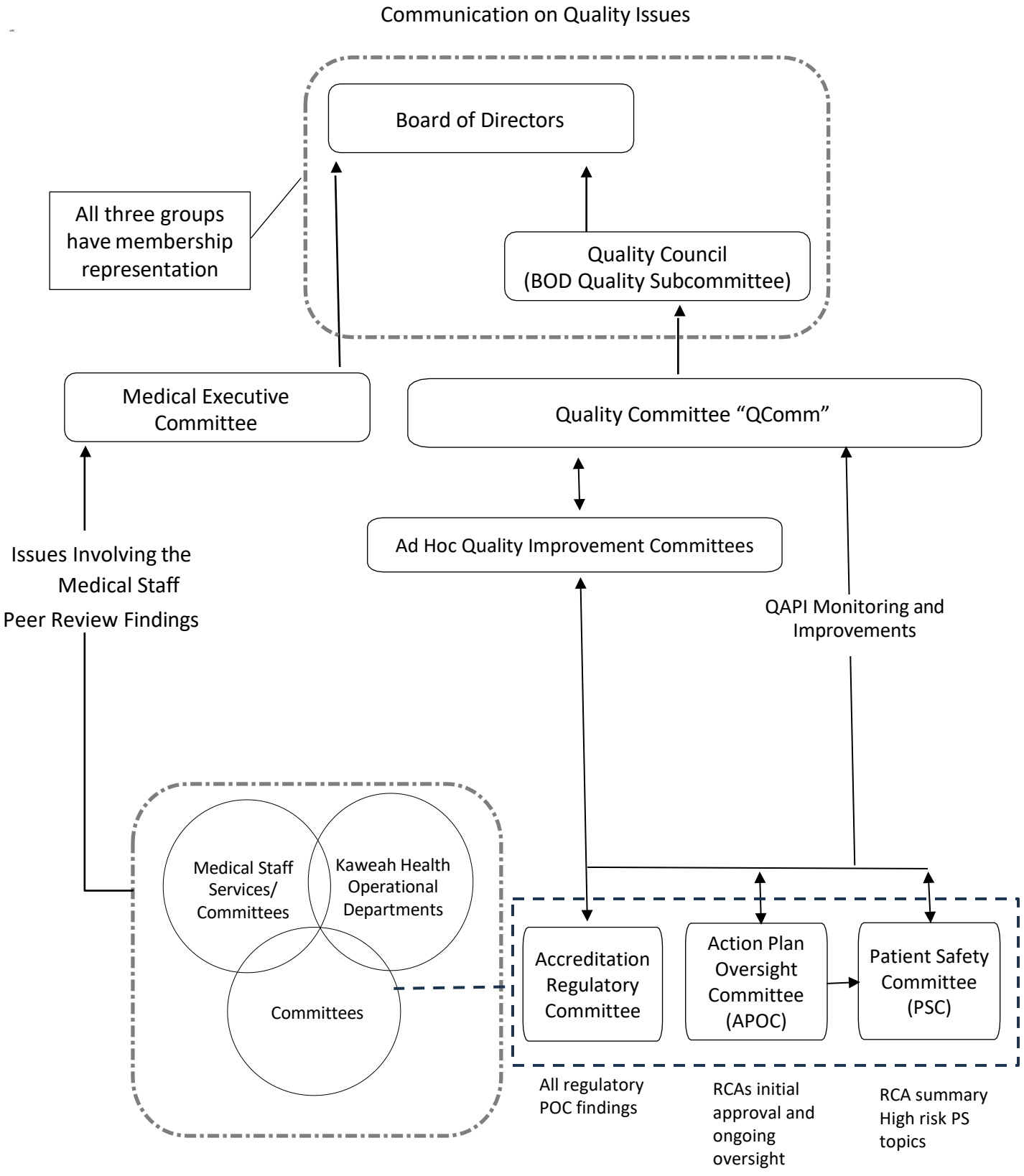
Attachments - Attachment 1: Quality Improvement/Patient Safety Committee Structure

"These guidelines, procedures, or policies herein do not represent the only medically or legally acceptable approach, but rather are presented with the recognition that acceptable approaches exist. Deviations under appropriate circumstances do not represent a breach of a medical standard of care. New knowledge, new techniques, clinical or research data, clinical experience, or clinical or bio-ethical circumstances may provide sound reasons for alternative approaches, even though they are not described in the document."

Attachment 1

Kaweah Health

QAPI Reporting Structure



CARDIAC SERVICE LINE:

Cardiac Surgery Service Line

Quality Council Report

Q3 2023 → Q2 2025

Risk-Adjusted Data

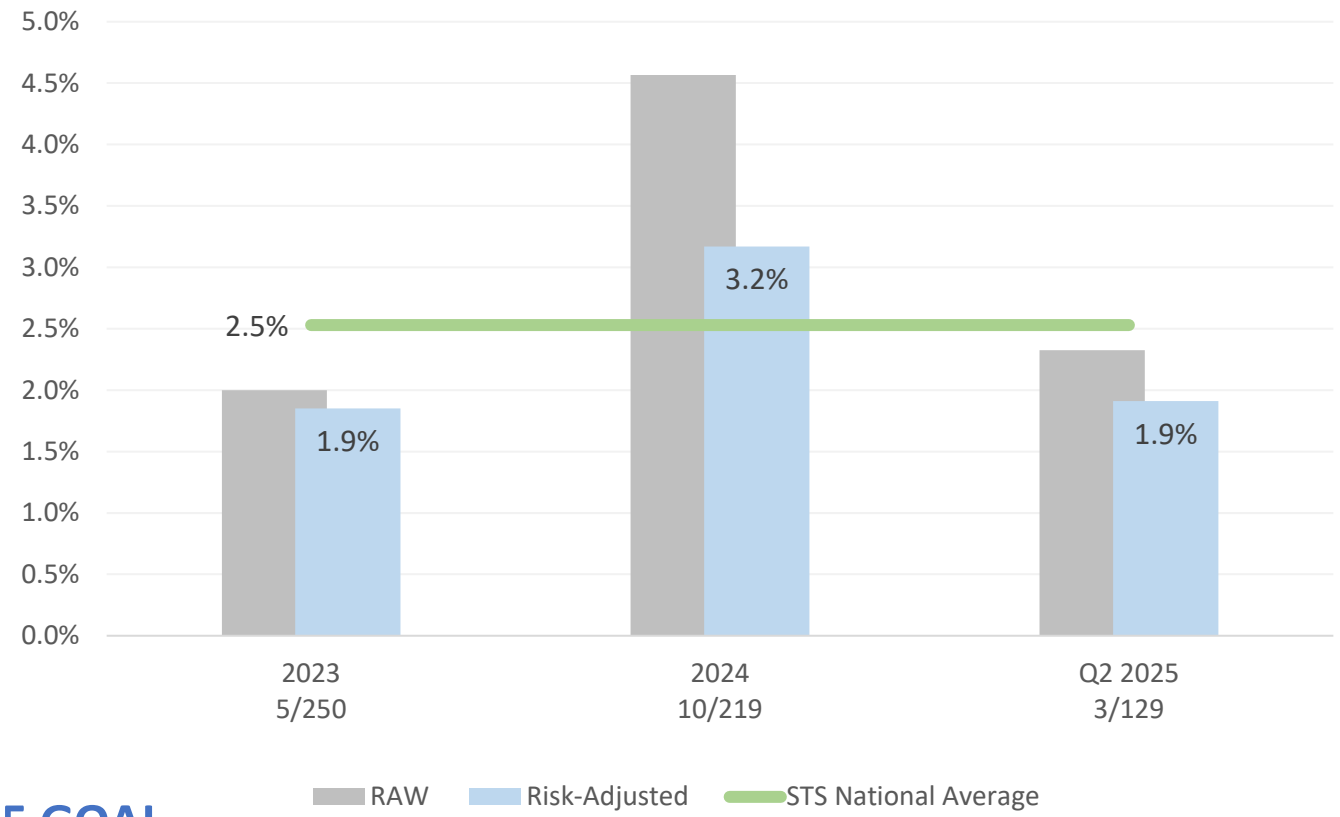
Blue = Risk-Adjusted data

Green = STS Average

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

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

Operative Mortality Reduction – Multiprocedural (All Analyzed Cardiac Surgery Procedures)



GOAL MET

FY25 GOAL

Decrease STS Operative Mortality to </= 2.5% (STS goal is national mean from Q2 2025)

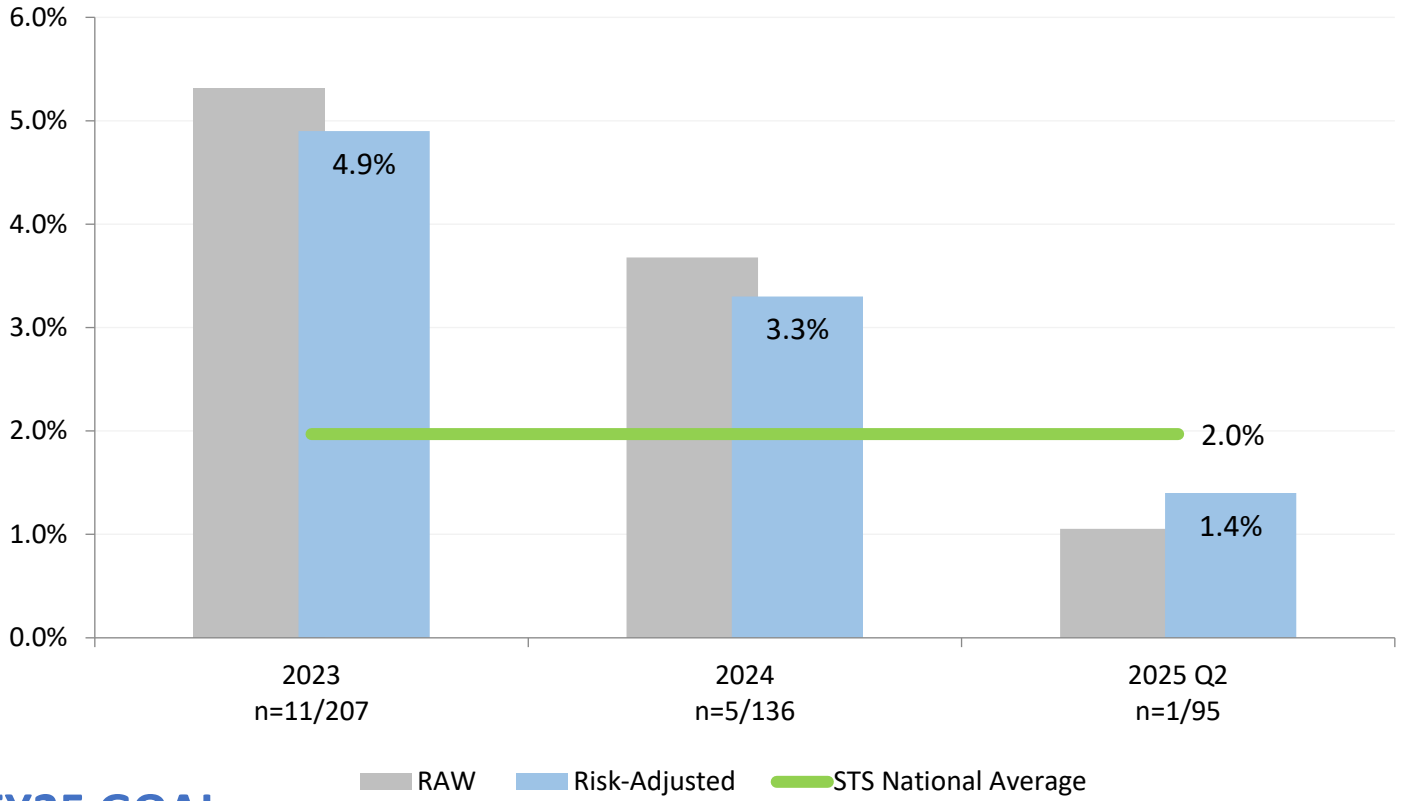
Operative Mortality Reduction – Multiprocedural (All Analyzed Cardiac Surgery Procedures)

The Targeted Opportunities

1. Further standardizing post-operative care
2. Setting expectations of post-op care immediately to staff
3. Educate nursing staff on emergent re-sternotomy procedures

CURRENT IMPROVEMENT ACTIVITIES	COMPLETION DATE	BARRIERS
Review mortalities with Cardiothoracic Surgeons	On-going	Manual chart review for possible care opportunities
Review mortalities in monthly CV M&M	On-going Monthly	Requires cardiothoracic and cardiologist participation
Recruiting new permanent cardiothoracic surgeons	06/30/2026	Recruiting CT surgeons to the area

Renal Failure Reduction - CABG patients



GOAL MET

FY25 GOAL

Decrease Risk-adjusted Renal Failure to ≤ 2.0% (STS goal is national average from Q2 2025)

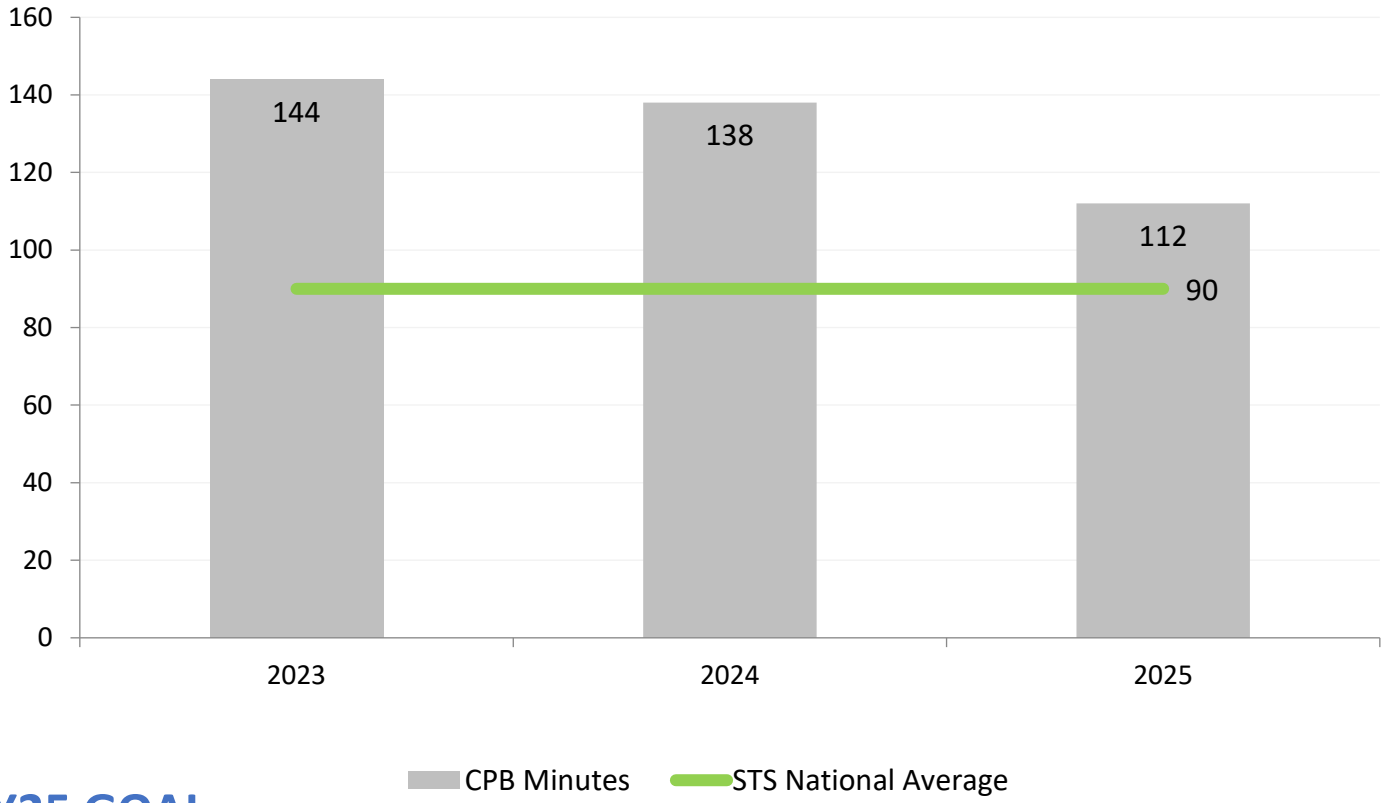
Renal Failure Reduction - CABG patients

Targeted Opportunities

1. Focus on the Pre-op care of chronic kidney disease patients
2. Fully optimize prior to surgery when time allows
3. Decrease time on pump
4. Lower hypotension events that require prolonged vasopressors

CURRENT IMPROVEMENT ACTIVITIES	COMPLETION DATE	BARRIERS
Review each fallout with cardiothoracic surgeon	On-going	NA
Involve nephrologist early and pre-operatively when necessary	On-going	NA
Pre-op medication reconciliation	On-going	Time for patient education in pre-op setting

Cardiopulmonary Bypass Time - CABG patients

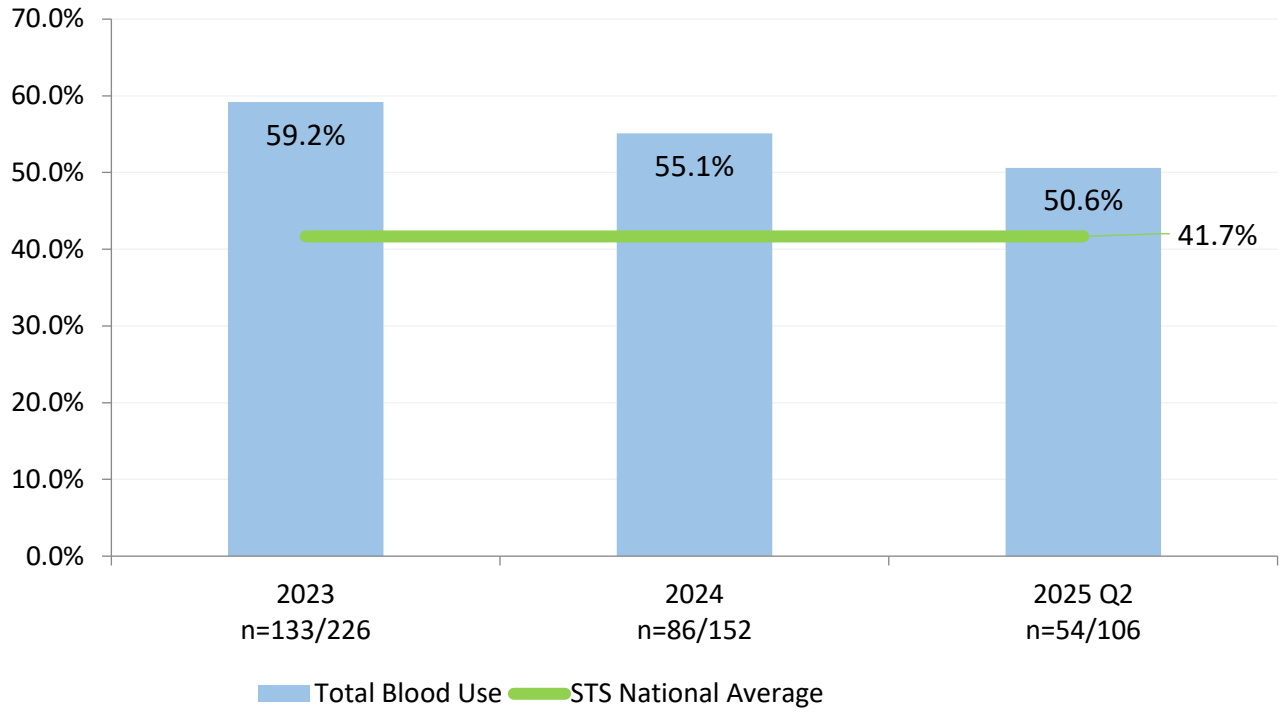


GOAL MET

FY25 GOAL

Decrease Risk-adjusted Renal Failure to ≤ 2.0% (STS goal is national average from Q2 2025)

Blood Use Reduction - CABG patients



IMPROVED

FY25 GOAL

Decrease Cardiac Surgery Blood Use Rate to </= 41.7% (STS goal is National Average from Q2 2025)

Blood Use Reduction - CABG patients

Targeted Opportunities

1. Decrease rate of patients that get a single unit packed red blood cell transfusion
2. Treat pre-operative anemia or transfusion as needed prior to the OR
3. Standardize post-op transfusion requirements
4. **Update Blood management system**

CURRENT IMPROVEMENT ACTIVITIES	COMPLETION DATE	BARRIERS
Optimize H&H prior to surgery	On-going	Epogen use inpatient vs outpatient
Audit of cases requiring a single unit of blood	On-going	Manual audit; resources to complete this
If trend identified with the above, develop plan to address (standardized Hgb cutoff for transfusion)	12/31/2025	NA

Thank you

Live with passion.

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

Kaweah Health

CLINICAL QUALITY

Outstanding Health Outcomes (OHO)
QUALITY & PATIENT SAFETY PRIORITY

Healthcare Acquired Infection (HAI) Reduction

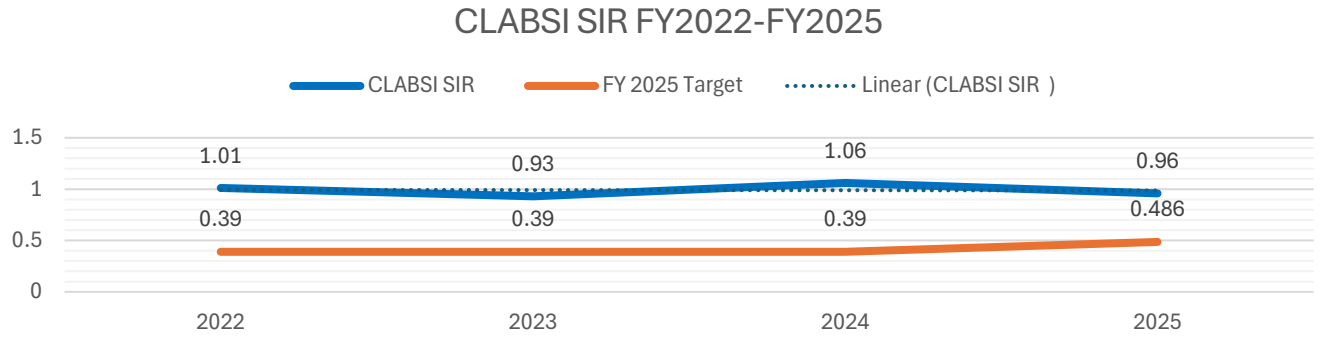
January 2026

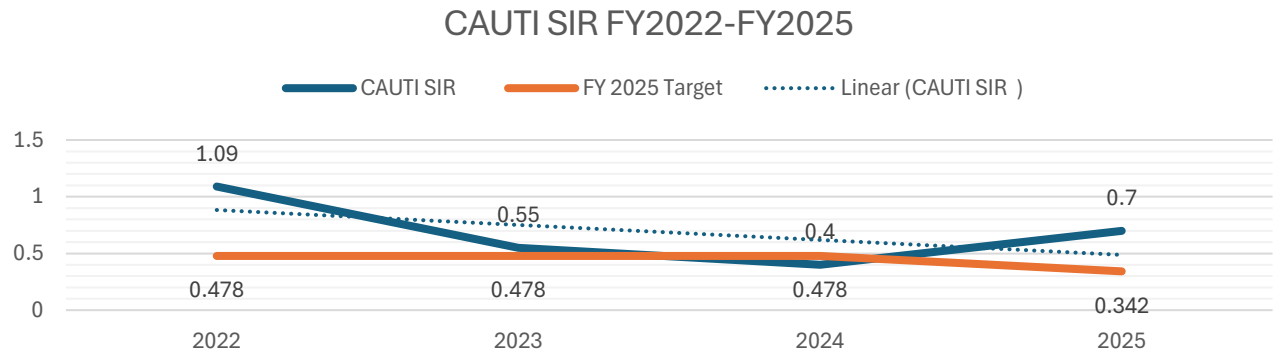
OHO FY26 Plan: HAI Reduction of Standardized Infection Ratio (SIR)

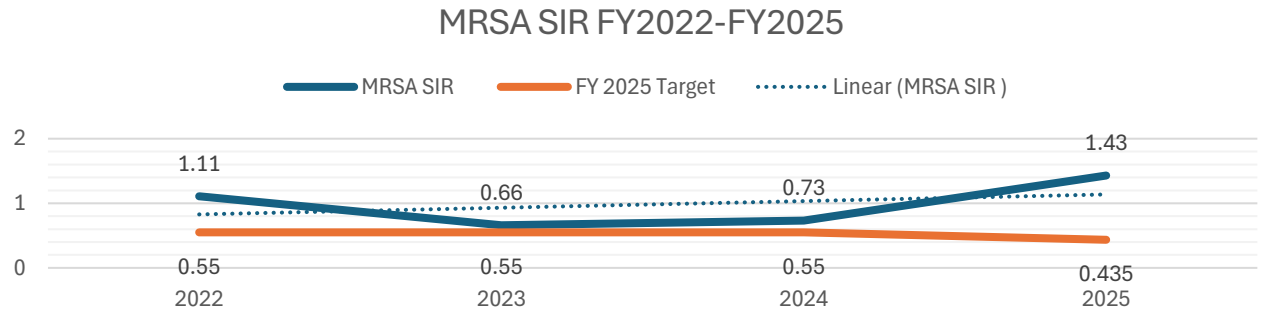
(number of actual infections/number of predicted infections by CMS)

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

Historical Baseline







FY26 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)

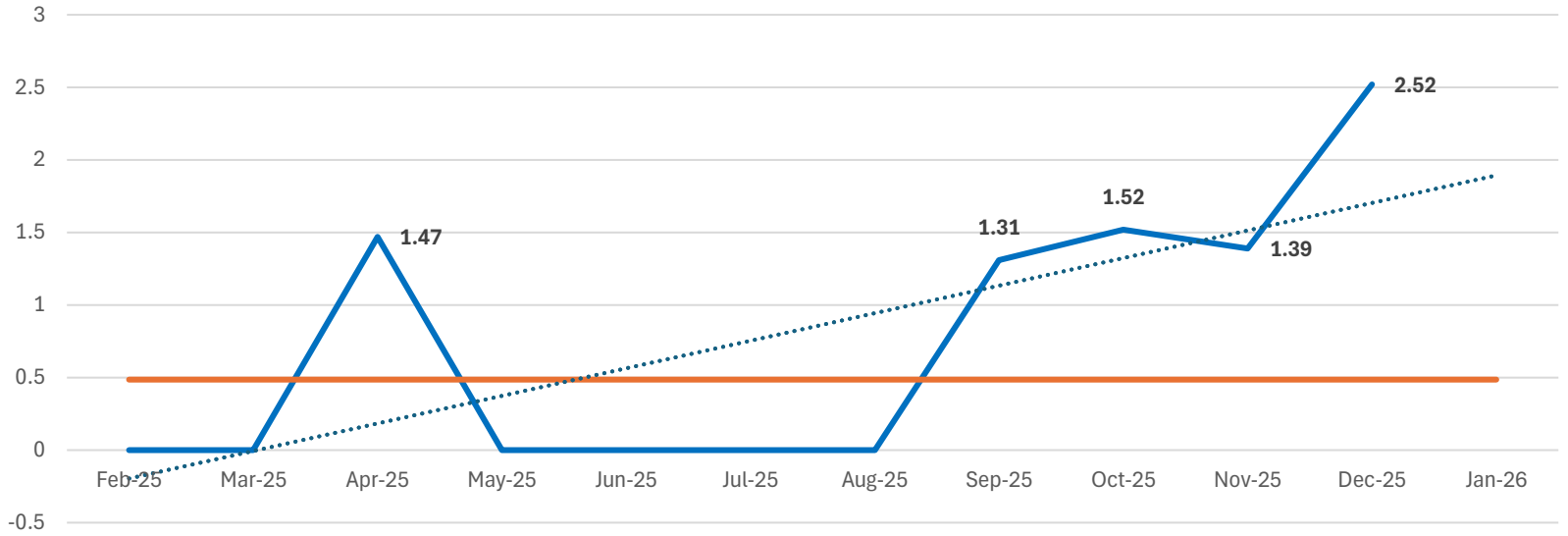
FY26 GOAL

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

OHO FY26 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

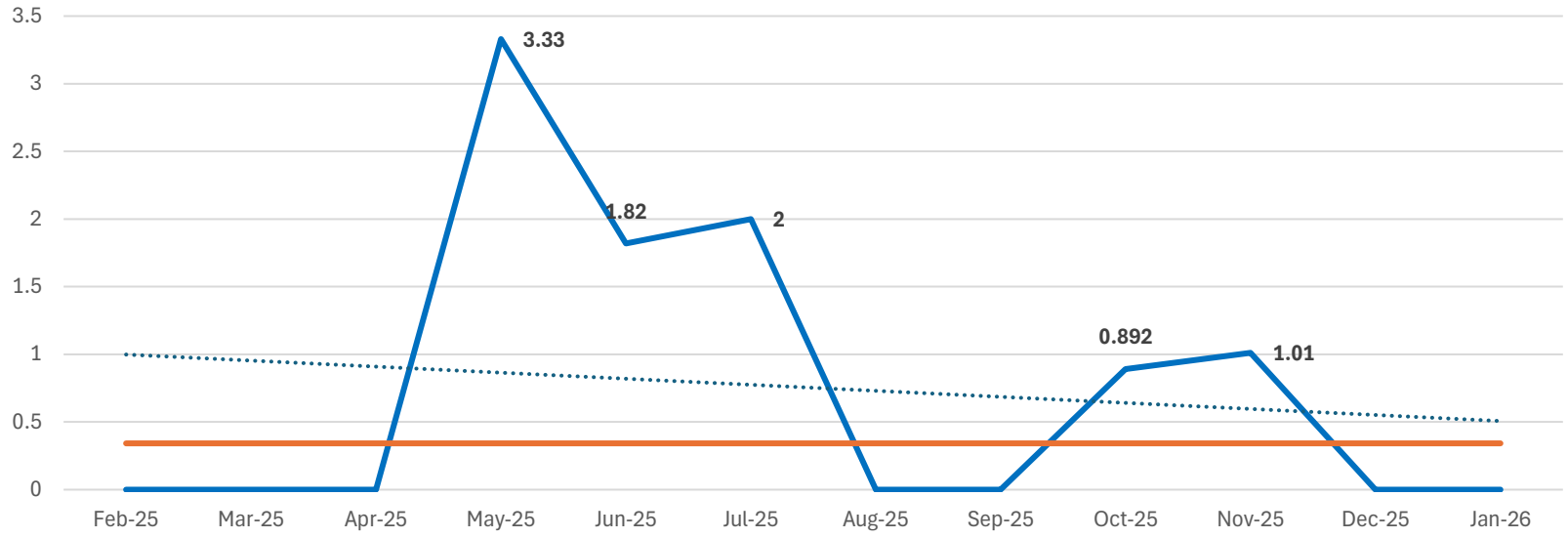


	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Total
CLABSI EVENTS	0	0	1	0	0	0	0	1	1	1	2	1	7
CLABSI Predicted	0.739	0.682	0.656	0.713	0.605	0.58	0.765	0.656	0.721	0.721	0.795	NA	7.633
CLABSI SIR	0	0	1.47	0	0	0	0	1.31	1.52	1.39	2.52		0.92
CLABSI SIR Goal (70th percentile /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 FY26 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
- Emphasizing interventions used to avoid inserting an indwelling urinary catheter
- Revising the Nurse Driven Protocol – IUC removal
- Hand Hygiene monitoring

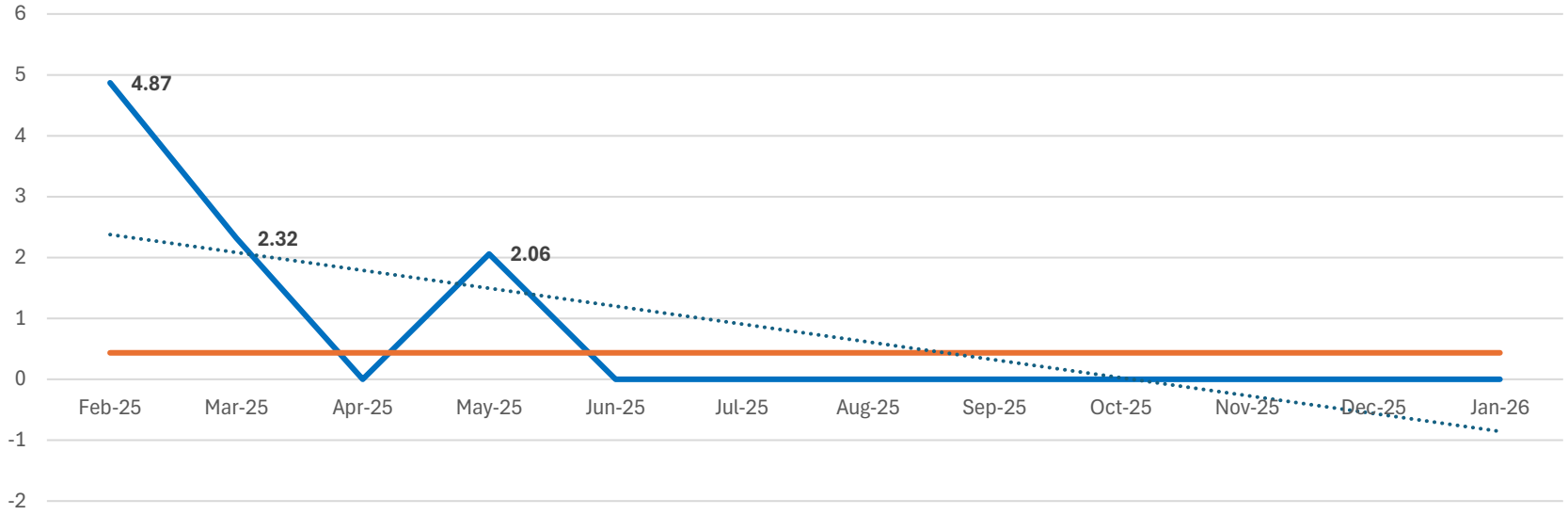


	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Total
CAUTI EVENTS	0	0	0	3	2	2	0	0	1	1	0	0	9
CAUTI Predicted	1	1.23	1.05	0.9	1.1	1	0.9	1.04	1.12	0.99	1.21		11.54
CAUTI SIR	0	0	0	3.33	1.82	2	0	0	0.892	1.01	0	0	0.78
CAUTI SIR Goal (70th percentile /top 30%)	0.342	0.342	0.342	0.342	0.342	0.342	0.342	0.342	0.342	0.342	0.342	0.342	0.342

OHO FY26 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



	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Total
MRSA EVENTS	2	1	0	1	0	0	0	0	0	0	0	0	4
MRSA Predicted	0.41	0.43	0.47	0.49	0.48	0.4	0.39	0.36	0.253	0.26	0.286		4.229
MRSA SIR	4.87	2.32	0	2.06	0	0	0	0	0	0	0	0	0.95
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

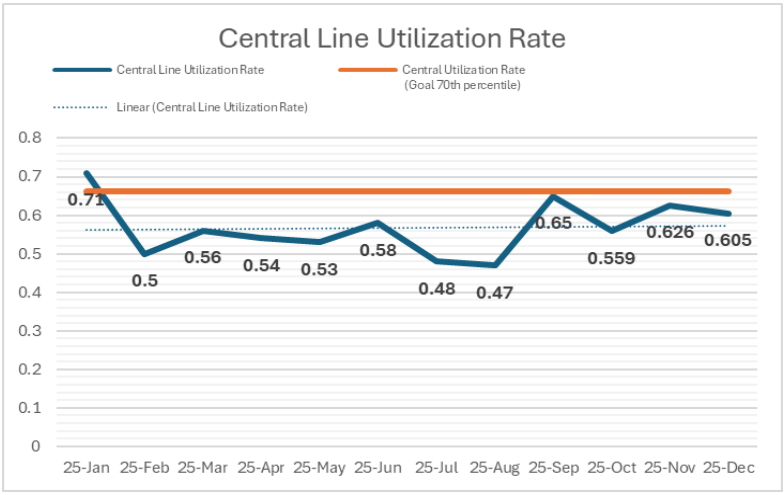
OHO FY26 Plan: HAI Reduction of Standardized Infection Ratio (SIR)

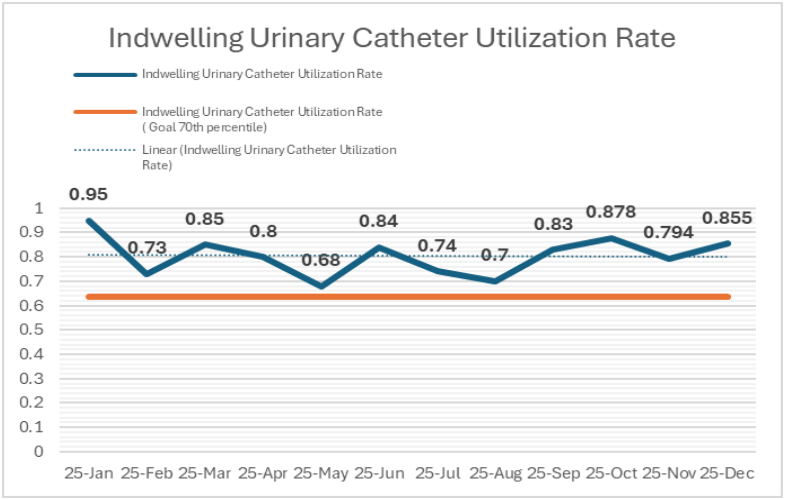
FY26 goals not met because:

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

Targeted Opportunities

- Reduce indwelling urinary catheter utilization; less devices, less opportunity for infections to occur
  - Goal: reduce central line utilization ratio to <0.663
  - Feb 2025 – Jan 2026 (SUR = 0.58)
  - Goal: reduce urinary catheter ratio to <0.64
  - Feb 2025 – Jan 2026 (SUR = 0.73)
- MRSA nasal and skin decolonization for patients with lines.
  - Goal: 100% of at-risk patients nasally decolonized
  - Feb 2025– Jan 2026 100% *(216 patients)* of screened patients nasally decolonized
  - Jan 2026 - Goal: 100% of line patients have CHG bathing
- Improve hand hygiene (HH) through increased use of BioVigil electronic HH monitoring system
  - Goal: 61% of staff are active users of BioVigil
  - FY2025 56% Feb 2025 to Jan 2026 61% of staff are active users
  - HH Compliance rate overall 94.2%
  - 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. December 2026 93% Pass rate.





OHO FY26 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

OHO FY26 Plan: HAI Reduction of Standardized Infection Ratio (SIR)

CURRENT IMPROVEMENT ACTIVITIES	EXPECTED COMPLETION DATE	BARRIERS
HAI Quality Focus Team dissolved	12/8/2025	Several leadership changes and lack of membership attendance prevented intervention implementation.
CAUTI & CLABSI Committee developed by Scott Baker, CNO. Committee replaced the HAI QFT committee. Purpose of new CAUTI & CLABSI Committee is to reduce the incidence of CLABSI and CAUTI by coordinating evidence-based practices, monitoring compliance and outcomes, and driving continuous improvement in device use, maintenance, and timely removal across the organization.	2/10/2026	Interest in expanding committee membership to include at least two physicians along with key clinical stakeholders. Currently committee comprises of, 2 APNs, 1 Nurse Director, Executive – CNO, 2 Nurse Managers, IP Manager and 3 IPs
Development of standardized shared document for joint IP and Clinical review of CLABSI/CAUTI events.	2/12/26	
Full committee review of all current evidence-based literature regarding prevention of CAUTI & CLABSI events, presented by IP Manager	3/10/26	
Significant revisions to current Nurse Driven Protocol for Indwelling Urinary Catheter Removal, to include a simple acronym to remember indications for an IUC. Modifications will be made to orders requiring an indwelling urinary catheter so that time limits are set requiring physician review of indication for device with emphasis for device removal. Consensus document regarding femoral central venous access to be reviewed and presented to MEC for approval.	3/10/26	

Thank you

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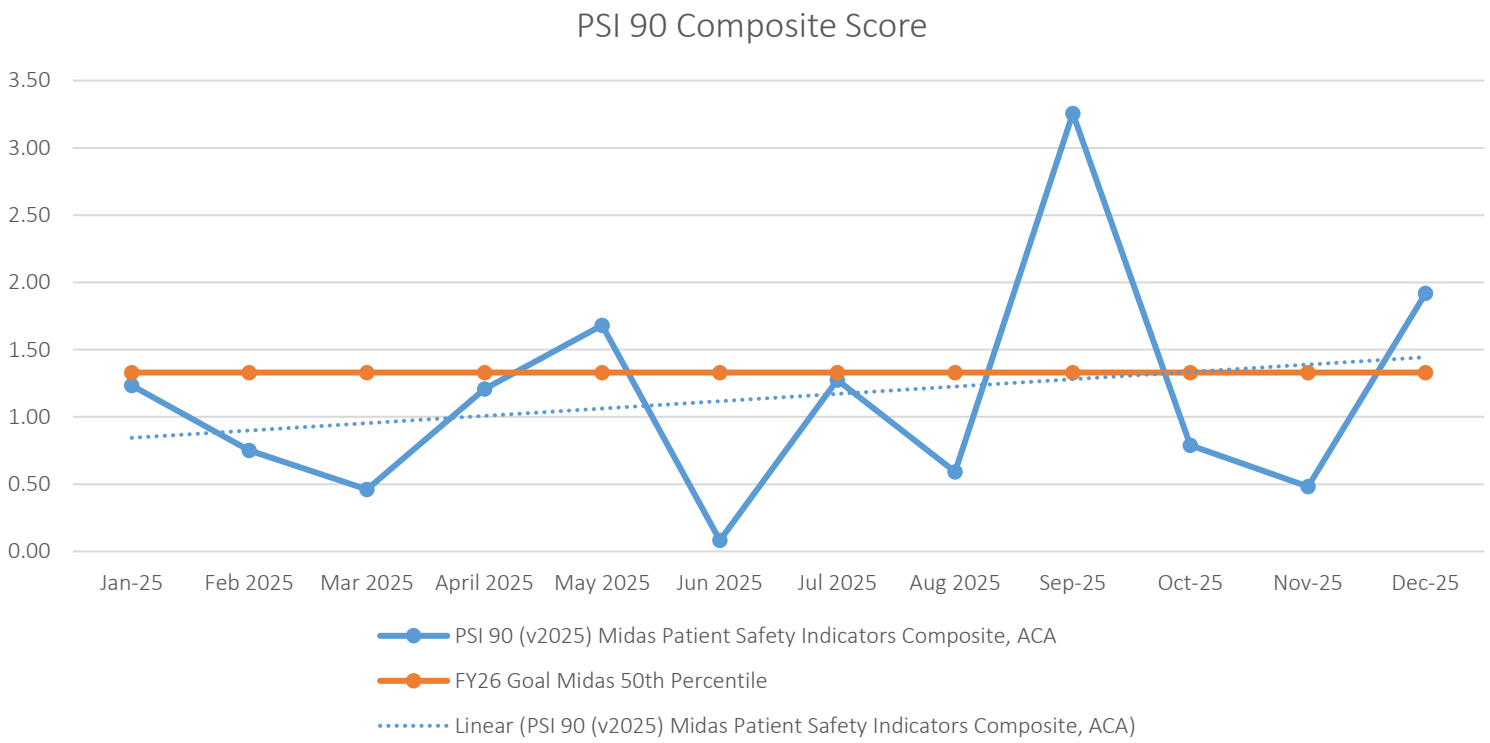
GOALS UPDATE

PATIENT SAFETY INDICATOR (PSI) 90 COMPOSITE

January 2026

OHO FY26 Monthly Update: Patient Safety Indicator (PSI) 90 Composite Score



FY26 PLAN – PSI 90

High Level Action Plan

- Concurrent case reviews and multi-departmental efforts to identify and act to address opportunities in documentation, coding and clinical care
- Analyze data to measure level to determine focused opportunity
- Timely case reviews for applicable application of evidenced-based practices
- FY25 PSI 90 rate = 1.20
- Goal Midas National 50th percentile = 1.33

- **FYTD 2026 = 1.424 (July-Dec 2025)**

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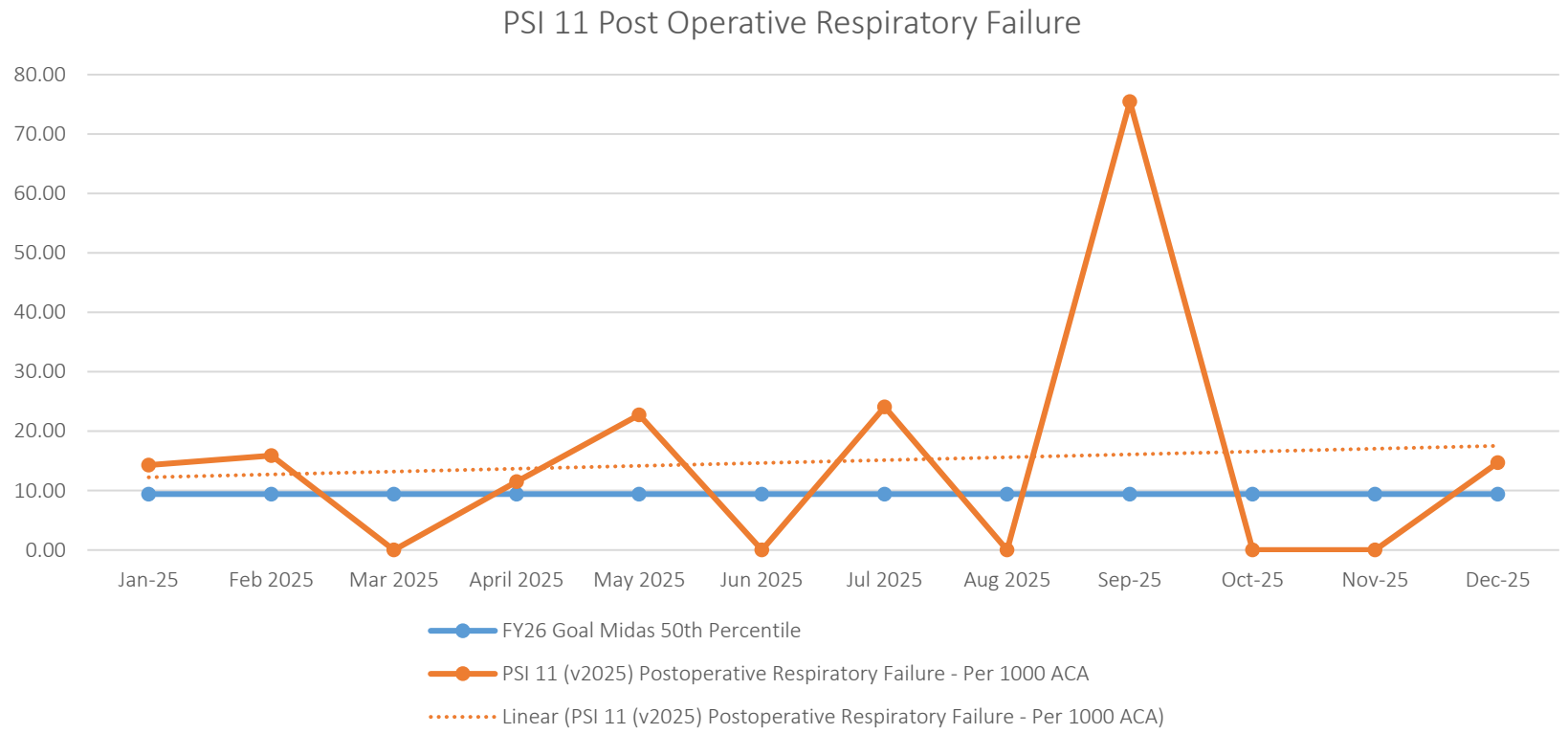
OHO FY26: Patient Safety Indicator (PSI) 11



FY25 PSI 11 rate = 11.03

Goal Midas National 50th percentile = 9.42

FYTD 2026 = 15.55, July-Dec 2025 (n=7)

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OHO FY25 Monthly Update: Patient Safety Indicator (PSI) 90

Targeted Opportunities

- Timely identification of new trends in any PSI 90 component
- Focus on PSI 11 – Respiratory failure (PSI 11 is the highest weighted PSI within the PSI 90 composite score)
- Emphasis on cardiovascular surgical population (5/11 cases during evaluation period)
- CMS counts any re-intubation as PSI 11, but ~50% of cases were for airway protection, not true respiratory failure, possibly inflating rates
- Evaluating evidence-based practices for PSI 11 including such as early warning of deterioration processes, ventilation management

CURRENT IMPROVEMENT ACTIVITIES	EXPECTED COMPLETION DATE	BARRIERS
Concurrent PSI case reviews to identify and ACT on opportunities and emerging trends in documentation, coding and clinical opportunity	Ongoing	Transitions of Quality & Patient Safety Resources
Collaboration with physician champion to further evaluate initial case reviews and evidence-based opportunities for PSI 11	11/28/25	Transitions of Quality & Patient Safety Resources
Discussion with HIM and finance to explore opportunities for adjustment in coding	11/28/25	Transitions of Quality & Patient Safety Resources

REFERENCE SLIDES

OHO FY26 Plan: Patient Safety Indicator (PSI) 90 Composite Measure

Summary

The PSI-90 composite score (Patient Safety and Adverse Events Composite) is a claims-based hospital safety measure that combines 10 preventable complications—such as blood clots after surgery, collapsed lungs from procedures, infections, and pressure ulcers—into a single rating, with a lower score meaning fewer problems and a higher score meaning more. **Each of these "patient safety indicators" is weighted and rolled into one score.**

PSI 90 Individual Components	Component Weight
*PSI 11 Postoperative Respiratory Failure	0.2152
PSI 12 Perioperative Pulmonary Embolism or DVT	0.1611
*PSI 10 Postop Acute Kidney Injury Requiring Dialysis	0.0507
PSI 09 Postoperative Hemorrhage or Hematoma	0.0338
PSI 03 Pressure Ulcer	0.2186
PSI 06 Iatrogenic Pneumothorax	0.0352
PSI 08 In-Hospital Fall-Associated Fracture	0.0506
*PSI 13 Postoperative Sepsis	0.1915
PSI 14 Postoperative Wound Dehiscence	0.0169
PSI 15 Accidental Puncture or Laceration	0.0263
PSI-90 Composite	1.00

PSI 90 is a publicly reported measure on CMS's Care Compare website and is a component in the CMS Star Rating, Leapfrog Safety Grade and includes many coded complications used in Healthgrades star ratings

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OHO FY26 Plan: Patient Safety Indicator (PSI) 90 Composite Measure

Historical Baseline

How Many PSI's Are Relevant to Surgical Patients?

Of the 10 PSIs:

•**7** are *surgical-only* (they include "postoperative," "perioperative," or surgical complications). These are:
PSI 09, PSI 10, PSI 11, PSI 12, PSI 13, PSI 14, and PSI 15.

•**3** apply to *all inpatients* (both medical and surgical):
PSI 03 (pressure ulcers), PSI 06 (iatrogenic pneumothorax), and PSI 08 (falls with hip fracture)

How Many PSIs Restricted to Elective Surgeries vs Any Surgery?

Some surgical component indicators are **limited to elective procedures**, while others apply broadly to all surgeries.
Based on specifications:

•**Elective-surgery-only** indicators (limited to elective admission or elective surgery discharges):

- **PSI 10** – Postoperative Acute Kidney Injury Requiring Dialysis
- **PSI 11** – Postoperative Respiratory Failure (for elective surgical discharges with specified criteria)
- **PSI 13** – Postoperative Sepsis (excludes non-elective admissions and certain infections present on admission)

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