

Kaweah Delta Health Care District Board of Directors Meeting

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



DATE POSTED: October 8, 2026

NOTICE

Date: Thursday, October 15, 2026

Location: Kaweah Health Medical Center – Executive Conference Room

Address: 305 W. Acequia Avenue, Visalia, California

Please join my meeting from your computer, tablet or smartphone.

<https://meet.goto.com/KelsieD/kaweahdeltahealthcaredistrictboardofdirectorsmeeting>

You can also dial in using your phone.

Access Code: 460-561-181

United States: [+1 \(646\) 749-3122](tel:+16467493122)

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)
 - 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).

Mike Olmos • Zone 1
Board Member

Jonna Schengel • Zone 2
Board Member

Dean Levitan, MD • Zone 3
Secretary/Treasurer

David Francis • Zone 4
President

Armando Murrieta • Zone 5
Vice President

Kaweah Delta Health Care District

Board of Directors Meeting

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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:

A handwritten signature in blue ink, appearing to read "Kelsie K. Davis", is written over a light blue horizontal line.

Kelsie K. Davis

Board Clerk / Executive Assistant to the CEO

DISTRIBUTION:

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

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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 – Executive Conference Room
305 W. Acequia, Visalia, CA

Thursday, October 15, 2026 {Committee Meeting}

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OPEN SESSION (LIMITED PURPOSE – CONVENING ONLY) – 8:00 AM

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

Thursday, October 15, 2026

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Board of Directors Meeting

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CLOSED SESSION – 8:01 AM

1. **CALL TO ORDER**
2. **REVIEW OF THE CLOSED MEETING MINUTES** – September 17, 2026
Possible reportable action - recommended for approval to the Regular Board Meeting
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 – *Ben Cripps, Chief of Compliance*
5. **ADJOURN CLOSED SESSION**

Thursday, October 15, 2026

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Board of Directors Meeting

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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 – September 17, 2026

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

5. MATERNAL CHILD HEALTH QUALITY REPORT

A review of current performance and actions focused on the care of maternal child health patient population. Rhonda Quinones, *Director of Maternal Child Health*; Stephanie Genetti, *Nurse Manager*; Daniel Castaneda, *Nurse Manager*; Felicia Vaughn, *Nurse Manager*.

6. RENAL SERVICES QUALITY 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*.

7. CLINICAL QUALITY GOALS UPDATE

A review of outstanding health outcomes initiatives for Safety Program Enhancement and Safety in Nursing Practice Oho Initiatives. Cindy Vander Schuur, *Patient Safety Manager*; Mara Lawson, *Director of Nursing Practice Professional Development*.

8. ADJOURN OPEN MEETING

Thursday, October 15, 2026

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Kaweah Delta Health Care District

Board of Directors Meeting

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Thursday, October 15, 2026

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Vice President

Quality Council Committee - CLOSED

Thursday, September 17, 2026

The Executive Office Conference Room

Attending: Board Members: Dr. Dean Levitan, Chair; Dave Francis, Board Member; Marc Mertz, CEO; Kevin Morrison, VP of Support Services; Jag Batth, Chief Operation Officer; Dr. Micheal Tedaldi, Vice Chief of Staff; Ben Cripps, Chief of Compliance; Max Heckhausen, VP of Strategy; Jewel Crisan Calub, Chief Nursing Officer; Dr. Paul Stefanacci, CMO/CQO; Farid Sheikh, Director of Quality and Patient Safety; Luke Schneider, VP of Information Systems and Services; Dr. Tedaldi, Vice Chief of Staff; Roxanna Mendez, Senior Quality and Patient Safety Project Manager; Chris Patty, Clinical Practice Guidelines Program Manager; Kyndra Licon, Quality Project Manager

Public Participation – None.

Dr. Dean Levitan called to order at 8:01 AM.

- **Review of the August Quality Council Closed Session Minutes** – Dr. Dean Levitan, Chair. Reviewed and acknowledged the August Quality Council Closed Session Minutes by Dr. Dean Levitan.
- **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – Report reviewed and attached to minutes. No Actions taken.
- **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – Report reviewed and attached to minutes.

Dr. Dean Levitan closed the meeting at 8:20 AM.

OPEN Quality Council Committee
Thursday, September 17, 2026
The Executive Office Conference Room

Attending: Board Members: Dr. Dean Levitan, Chair; Dave Francis, Board Member; Marc Mertz, CEO; Kevin Morrison, VP of Support Services; Jag Batth, Chief Operation Officer; Dr. Micheal Tedaldi, Vice Chief of Staff; Ben Cripps, Chief of Compliance; Max Heckhausen, VP of Strategy; Jewel Crisan Calub, Chief Nursing Officer; Dr. Paul Stefanacci, CMO/CQO; Farid Sheikh, Director of Quality and Patient Safety; Luke Schneider, VP of Information Systems and Services; Shawn Elkin, Infection Prevention Manager; Randy Kokka, Director of Laboratory Services; Lawrence Headley, Director of Food Nutritional Services; Roxanna Mendez, Senior Quality and Patient Safety Project Manager; Chris Patty, Clinical Practice Guidelines Program Manager; Kyndra Licon, Quality Project Manager

Closed Session:

Dr. Dean Levitan called to order at 8:00 AM.

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

Dr. Dean Levitan adjourned the meeting at 8:20 AM.

Open Session:

Public Participation – None.

Dr. Dean Levitan called to order at 8:30 AM.

- 4. Review of August Quality Council Open Session Minutes** – Dr. Dean Levitan, Chair Board Member
 - Reviewed and acknowledged the August Quality Council Open Session Minutes by Dr. Dean Levitan.
- 5. Laboratory Quality Report** – A review of current performance and actions focused on the clinical goals for Laboratory Services. *Randy Kokka, Director of Laboratory.* No further actions.
- 6. Food and Nutrition Services Quality Report** - A review of current performance, quality outcomes, and improvement initiatives focused on food and nutrition services. *Lawerence Headley, Director of Food & Nutrition Services.* No further actions.
- 7. Clinical Quality Report** – A review of outstanding health outcomes initiatives for Surgical Safety Program. *Chris Patty, Clinical Practice Guidelines Program Manager.* No further actions.

Adjourn Open Meeting – Dr. Dean Levitan

Dean Levitan adjourned the meeting at 9:30 AM.



Kaweah Health

Outstanding Health Outcomes
Safety Program Optimization
FY2027
October 2026

MORE THAN MEDICINE. LIFE.

OHO FY2027

Safety Program Optimization Champion: Cindy Vander Schuur

Metric Description	Baseline	FY2027 YTD	FY2027 Goal
Serious Safety Event Rate <i># of serious safety events</i> <i>(APD+(visits/1,000)) x 10,000</i>	3.2	2.01	2.88 10% Reduction from Baseline

Quality Initiatives:

1. Ensure consistent execution of core safety behaviors at the bedside
2. Promote safer care through leadership and engagement

Objectives:

Quality Initiative #1:

- Implement structured Hand-off process
- Establish real-time escalation of Change in Patient Condition

Quality Initiative #2:

- Conduct daily executive safety rounds with frontline staff



OHO FY2027 Safety Program Optimization



Serious Safety Event Dashboard

Calculation = # of serious safety events/(APD+(visits/1,000)) x 10,000

Monthly Metrics

of Serious Safety Events Scoring a E, F, G, H, or I at Incident Management

Serious Safety Event Rate

Baseline	25-Sep	25-Oct	25-Nov	25-Dec	26-Jan	26-Feb	26-Mar	26-Apr	26-May	26-June	26-Jul	26-Aug	Rolling 12 Months
48	1	3	1	6	1	0	5	4	2	2	2	3	30
3.29	0.82	2.49	0.83	4.16	0.83	0.00	4.15	3.29	1.55	1.62	1.61	2.40	1.97

Description: Serious Safety Event (source: Chartis)

E: An error occurred that may have contributed to or resulted in temporary harm to the patient and required intervention.

F: An error occurred that may have contributed to or resulted in moderate to severe temporary harm resulting in initial or prolonged hospitalization.

G: An error occurred that may have contributed to or resulted in permanent patient harm.

H: An error occurred that required intervention necessary to sustain life.

I: An error occurred that may have contributed to, or resulted in, death.

Events Scoring E	Events Scoring F	Events Scoring G-I	*N/A
24	4	0	2

*N/A:

1. Potential Suicide s/p Discharge. This event occurred after the patient had been discharged and, because of this, did not meet the Incident Management scoring criteria. An RCA is in progress due to the nature of the event.
2. L&D/RHC wrong procedure: Risk Management became aware of event 2 years after it occurred. An RCA was done due to the nature of the event.

OHO FY2027 Safety Program Optimization

Serious Safety Event Detail

Rolling 12 months (Sep 2025 to Aug 2026) n = 30

Event Type	Events
Nursing-sensitive harm	15
Hospital-acquired pressure injury	8
Fall with injury	7
Procedural	5
Retained foreign object	2
Wrong procedure*	2
Accidental puncture	1
Medication	2
Medication overdose	2

Event Type	Events
Delay in diagnosis or care	5
Missed stroke	2
Provider-related delay in care	1
Neurological decline/RRT	1
Delay in transfer from MH hospital to KHMC	1
Other	3
Potential suicide after discharge*	1
Improperly restrained patient	1
Injury during patient transfer	1

Total: 30 events. Pressure injuries and falls account for 15 of 30 (50%).

***Not scored at Incident Management (N/A on the dashboard):**

1. Potential suicide after discharge
2. L&D/RHC wrong procedure (1 of the 2 wrong procedures)



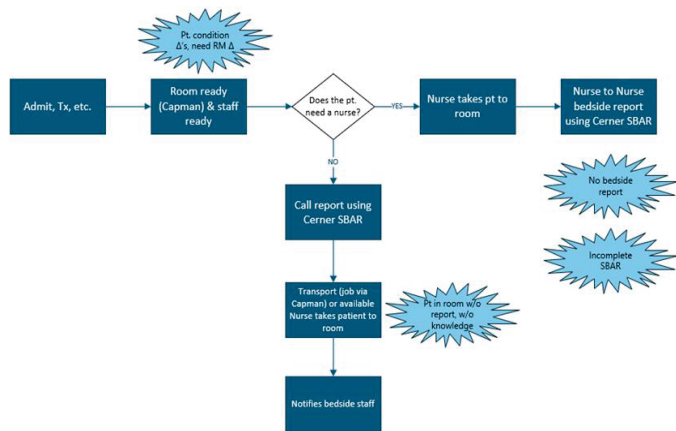
Safety Program Optimization Initiatives

Ensure consistent execution of core safety behaviors at the bedside	Actions	Next Steps	Status
Initiative: Implement structured Hand-off process	Baseline established: It was determined that we have an informal handoff process in place, however there is no formal process/policy for handoff. Current State mapped: Handoff processes have been mapped with clinical directors and gaps/opportunities have been identified.	- Identify evidence-based best practices. - Gather frontline staff input: - Professional Practice Council (PPC) in November - Licensed Nurse Residency groups (LNRG) in October and November - Strategize and implement a standardized process to close the identified gaps.	Planned presentations: - PPC: November - LNR: October and November

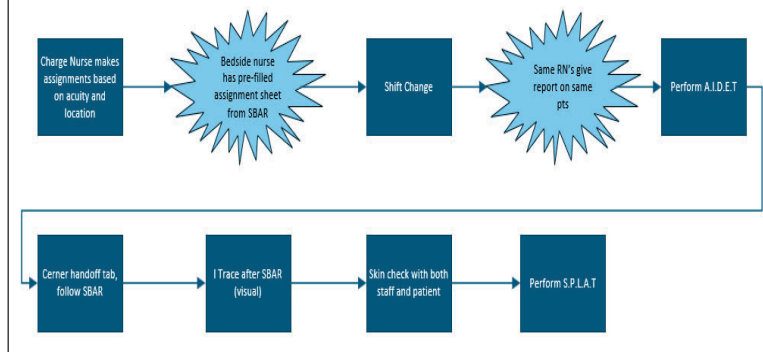
Safety Program Optimization Initiatives

Implement a Structured Handoff Process

HANDOFF PROCESS – IDEAL STATE WITH OPPORTUNITIES
(UNIT TO UNIT)



HANDOFF PROCESS – IDEAL STATE WITH OPPORTUNITIES
(SHIFT TO SHIFT)

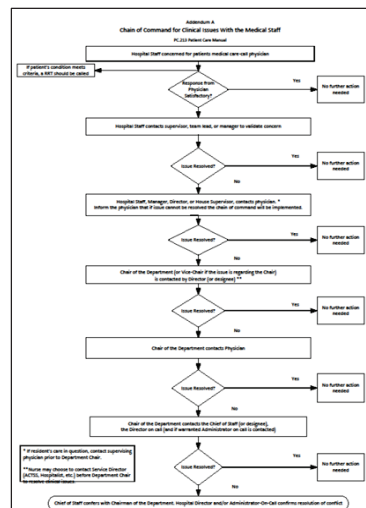
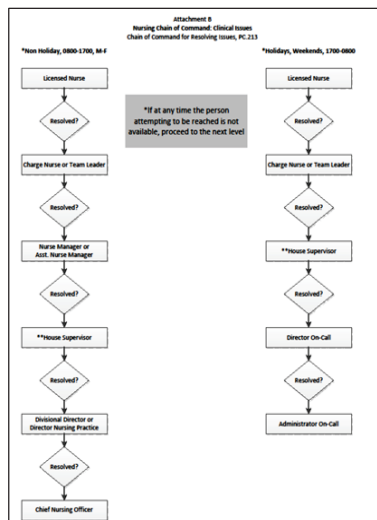


Safety Program Optimization Initiatives

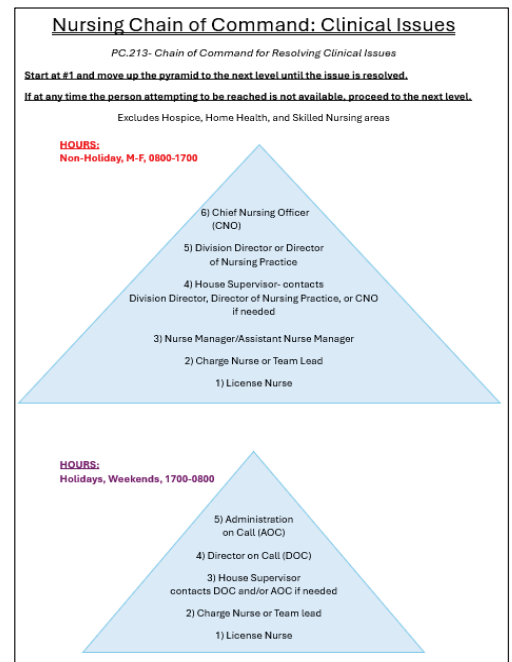
Ensure consistent execution of core safety behaviors at the bedside	Actions	Next Steps	Status
Initiative: Establish real-time escalation of Change in Patient Condition	Baseline established: A policy and process are in place, but escalation opportunities continue to be identified. Policy reviewed: The current policy and mapped process was reviewed with clinical directors to identify potential gaps.	- Identify evidence-based best practices. - Complete the gap analysis with subject matter experts and the Process Improvement Engineer. - Gather frontline staff input: - Professional Practice Council in November - Licensed Nurse Residency groups in October and November - Strategize and implement changes to close the identified gaps.	Planned presentations: - PPC: November - LNR: October and November

Safety Program Optimization Initiatives

Establish real-time escalation of Change in Patient Condition



Updated graphic 2024 (Education)



Safety Program Optimization Initiatives

Promote safer care through leadership and engagement	Actions	Next Steps	Status
Initiative: Conduct daily executive safety rounds with frontline staff	Purpose defined: Executive rounds will increase leadership visibility, surface frontline safety concerns, and remove barriers to safe care. Draft board created: A draft Safety Rounding board has been created and is ready for executive review.	• Finalize the rounding structure with executive team. This will include identifying participants, frequency, unit rotation, and duration. • Executive approval of the Safety Rounding board and development of a standardized rounding tool with consistent elements • Establish a process to log findings, assign owners, track concerns to closure, and close the loop with frontline staff. • Discuss how to communicate the program to unit leaders and staff before organizational launch.	In Progress

UNIT QUALITY & SAFETY BOARD

Kaweah Health • Quality, Patient Safety & Infection Prevention • Reviewed every shift



UNIT: _____

DATE: _____

QUALITY & PATIENT SAFETY

Date of last fall: _____

Date of last CAUTI: _____

Date of last CLABSI: _____

Date of last HAPI: _____

BCMA compliance: _____

Hand hygiene compliance: _____

Safety concern: how could the next patient be harmed?

YTD total: _____

YTD total: _____

YTD total: _____

YTD total: _____

PATIENT EXPERIENCE

Patient compliments: _____

Patient complaints: _____

Rounding compliance: _____

Patient survey results (HCAHPS): _____

Notes / voice of the patient

OUTSTANDING HEALTH OUTCOMES (OHO)

Outstanding Health Outcomes measures this unit influences.

DEPARTMENT GOALS

Limit to 3 to 5 specific goals tied to the health outcomes.

QAPI: PERFORMANCE IMPROVEMENT PROJECT

Current project: _____

Measure: _____

Baseline / Goal / Current: _____

Action this month (PDSA): _____

Owner / next report date: _____

SHIFT BRIEFING AND AWARENESS

CALLOUTS

Today: _____

NEED TO KNOW

RECOGNITION

e.g., Employee of the Month, patient compliment, good catch, certification, years of service.

EQUIPMENT & SUPPLIES

Date	What	Plan	Resolved

18/35



Kaweah Health

Outstanding Health Outcomes

Safety in Nursing Practice

October 2026

MORE THAN MEDICINE. LIFE.

OHO FY2027

Safety in Nursing Practice/ Champion: Mara Lawson

Metric Description	Baseline	FY2027 Goal
Falls with Injury (Per 1,000 Patient Days - per NDNQI)	0.33	<0.30

Quality Initiatives:

1. Risk Stratification & Prevention
2. Implementation of Evidence-Based Prevention & Management Bundles

Objectives:

Quality Initiative #1

Implement standardized fall-risk assessments

Quality Initiative #2

Hourly rounding focused on identified patient needs



Falls OHO Quality Initiative #1: Risk Stratification & Prevention

Implement standardized fall-risk assessments

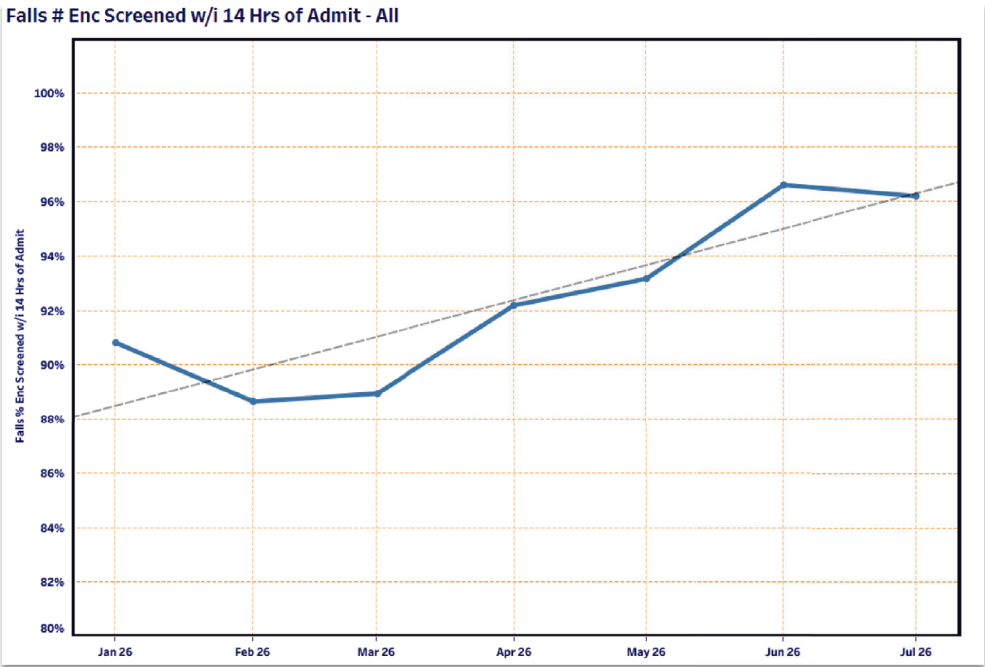
- Why is this patient at risk?
- What interventions address why the patient is at risk?

Current status: *In progress*

Opportunities for Improvement:

- 99.7% of patients in July had risk screens completed each shift
- 96.2% of patients had the initial risk screen completed timely upon admit
 - Engaging unit leaders with <100% (Leader rounding on at-risk & not identified patients)

Falls OHO Quality Initiative #1: Risk Stratification & Prevention



Falls OHO Quality Initiative #2:

Implementation of Evidence-Based Prevention & Management Bundles

1. Purposeful hourly rounding based on identified patient needs
2. Immediate post-fall huddle debrief using standardized tool
 - Why did this happen?
 - What needs to be put in place immediately for prevention?

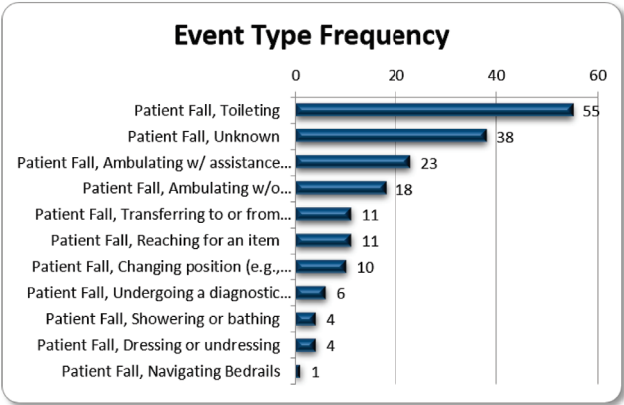
Current status: *In progress*

Areas of focus:

- Understanding why falls happen help us with purposeful rounding (toileting, need to mobilize, SPLAT)
- Analysis of why the post fall huddles were stopped to address barriers to a successful implementation
- Adopting standardized tool for our post fall huddles

Quality Initiative #2:

MIDAS Toolpack FY26 Data



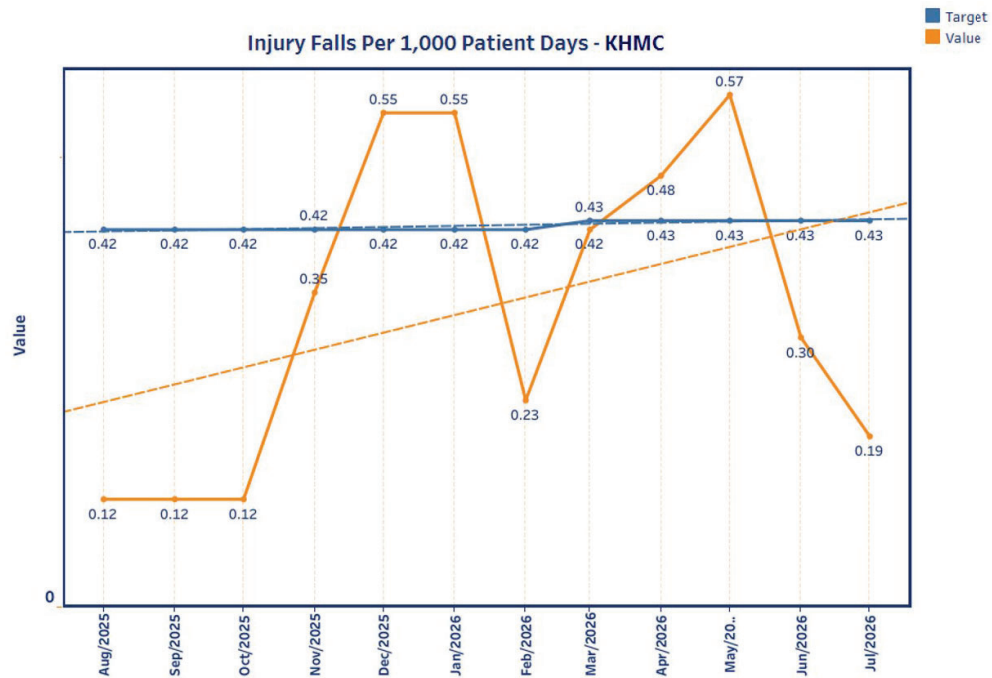
Event Times	# of Events
0	9
100	3
200	10
300	4
400	2
500	6
600	5
700	10
800	2
900	10
1000	8
1100	11
1200	11
1300	12
1400	7
1500	10
1600	6
1700	7
1800	7
1900	7
2000	12
2100	6
2200	6
2300	10
Grand Total	181

OHO FY27 Plan: Reduction of Falls with Injury

FY27 YTD: 0.19

Goal: Met

Injury falls per 1000 patient days =
<0.30



OHO FY2027

Safety in Nursing Practice/ Champion: Mara Lawson

Metric Description	Baseline	FY2027 Goal
Hospital Acquired Pressure Injuries (Stage 2+ per 1000 pt days)	0.51	<0.46

Quality Initiatives:

1. Risk Stratification & Prevention
2. Implementation of Evidence-Based Prevention & Management Bundles

Objectives:

Quality Initiative #1

Ensure effective use of skin assessment tools

Quality Initiative #2

Repositioning schedules and pressure-relieving surfaces



HAPI Quality Initiative #1:

Risk Stratification & Prevention

Ensure effective use of skin assessment tools

- Why is this patient at risk? (Braden subscales)
- What interventions address why the patient is at risk?

Current status: *In progress*

Opportunities for Improvement:

Outdated support surface algorithm, proper offloading, documentation of interventions

Quality Initiative #2:

Implementation of Evidence-Based Prevention & Management Bundles

Action plan – see next slides for draft version

Current status: *In progress*

Developed by WOCN certified RN (on WOCN's National Education Committee)

Reviewed and approved by Jewel Calub, CNO

Reviewed by Patient Care Directors - potential barriers addressed

Quality Initiative #2:

Implementation of Evidence-Based Prevention & Management Bundles

HAPI Committee Action Plan	30 day	60 day	90 days	120 days	Expected Outcome
Initiative	Intervention	Intervention	Intervention	Intervention	Expected outcome
Leadership Accountability to increase unit ownership of PI prevention	Begin daily HAPI leader rounds (by manager or CN) on all units using standardized leader rounding tool, evaluating at risk patients for appropriate interventions including bed surface. Directors will report compliance of both patient interventions and rounding monthly to HAPI Committee.	Identify and incorporate prevention metrics into quality reviews by HAPI Committee and provide to unit leaders for their specific data.	Establish sustainable leader HAPI prevention rounds on a weekly basis for the units who have seen improvement in metrics; continue daily for those units who have not improved.		Standardized leader prevention rounding daily on all units with incorporation of identified prevention needed
Braden Subscale Management to improve patient specific PI prevention interventions	Wound Nurses will create moisture management interventions for nursing and evaluate what can be done in scope vs. what needs an order? Begin process of adding orders to admission ordersets.	Develop standardized Interventions for remaining braden subscales and collaborate with Clinical Informatics to get them in EHR (either via PowerPlans, reference text, or documentation enhancements).	Collaborate with Clinical Informatics to set go-live date for EHR changes and/or optimization. Communicate changes to bedside staff.	Evaluate compliance and outcome data at the unit level and review at HAPI committee. Refine prevention interventions based on findings if needed, remediate staff as needed, and utilize Just Culture principals for fallouts.	Standardized interventions in place for patients at risk based on individualized braden subscales
Support Surface Optimization to ensure high risk pts receive appropriate pressure redistribution surfaces early	Update current bed algorithm to reflect current surfaces available. Utilize shared governance (PPC) for bedside nurses feedback on ease of use.	Educate bedside nurses on bed utilization and escalation, using a layered approach of rounding with nurses by leaders, vendors, NPD team, and wound nurses.	Evaluate bed utilization and escalation compliance by leaders during HAPI prevention rounding and report to HAPI Committee.	Evaluate support surface utilization compliance and outcome data at the unit level and review at HAPI committee. Refine prevention interventions based on findings if needed, remediate staff as needed, and utilize Just Culture principals for fallouts.	Earlier placement of at-risk patients on appropriate support surfaces, reduction in sacrum/coccyx and heel pressure injuries
Data Review and Continuous Improvement	Streamline notification of skin issue process so that wound nurses are entering initial MIDAS reports and eliminate duplicate work by wound nurses and Risk Management team.	Streamline MIDAS reporting and combine case reviews (merge CSI & ACA) so they are reviewed by the HAPI committee leaders and Risk Management. Revise policy (AP.87) to support this process. Transition from paper event review process to MIDAS focus study; evaluate which data can be pulled via report from the EHR to increase efficiency of review process.	Develop unit level scorecards to be shared with bedside nurses to show unit performance with specific goals and metrics.	Develop HAPI dashboard with even more detailed unit specific metrics and trends to be reviewed monthly at the HAPI committee.	Faster identification of trends

DRAFT

Quality Initiative #2:

Implementation of Evidence-Based Prevention & Management Bundles

HAPI Committee Action Plan	30 day	60 day	90 days	120 days	Expected Outcome
Unit Specific HAPI Reduction Strategies to establish targeted interventions to address unit specific causes of pressure injuries.	Identify trends by unit; review with unit leaders to identify gaps in practice or in hospital process.	Implement focused interventions for units with recurring trends. For Example, trial utilizing wedges for turning instead of pillows on 2N and 4N where HAPIs to the sacrum are an identified trend.	Share unit success stories and evaluate implementing on other units	Evaluate sustained interventions and outcome data at the unit level and review at HAPI committee. Refine prevention interventions based on findings if needed, remediate staff as needed, and utilize Just Culture principals for fallouts.	Reduction in HAPIs
Implement standardized admission skin assessment practice to improve identification of Presence on Admission skin alterations	Implement 2 person skin assessment on every admission and transfer between units. Establish process to track compliance through EHR documentation reports and leader rounding.	Implement admission skin photography process and define patient inclusion criteria. Reinforce expectations of weekly photos on existing skin issues.	Evaluate expanding photo process to weekly high risk skin photography	Evaluate sustained interventions and outcome data at the unit level and review at HAPI committee. Refine prevention interventions based on findings if needed, remediate staff as needed, and utilize Just Culture principals for fallouts.	Improved HAPI POA identification and reduced HAPI attribution discrepancies
Staff and Provider Education to improve prevention knowledge and clinical decision making	Wound Classes re-established & being taught by certified Wound Nurse. Notification to managers to get nurses enrolled as part of their core curriculum. Meet with GME leaders to explore education for residents. Establish education plan for all initiatives; both initial and ongoing.	Manual audit of which nurses have not attended Wound Class to prioritize their enrollment. Supplemental education provided to all staff through HAPI committee as needed. Wound Nurse leaders will collaborate with Med Staff to offer education to providers.	Reinforce interventions through weekly education topics and HAPI committee updates; include GME & Med Staff as appropriate. Follow up with managers for progress of enrollment & completions of wound class.	Evaluate sustained compliance with wound class attendance and knowledge retention by leaders at the unit level and review at HAPI committee. Refine process based on findings if needed, remediate staff as needed when knowledge gaps are identified, and utilize Just Culture principals for fallouts.	Increased confidence by bedside staff to implement HAPI prevention interventions.
Mobility Program - to increase early ambulation of patients	Phase 2/2 Implemented 8/4/26	Collaborate with project leaders to evaluate barriers and successes. Remediate staff as needed; implement new interventions as needed.	Evaluate the impact of the new mobility program by trending unit level mobility compliance alongside HAPI incidence and comparing HAPI rates before and after implementation.		

DRAFT

Quality Initiative #2:

Implementation of Evidence-Based Prevention & Management Bundles

WARNING: Anticipated Outcomes During Implementation

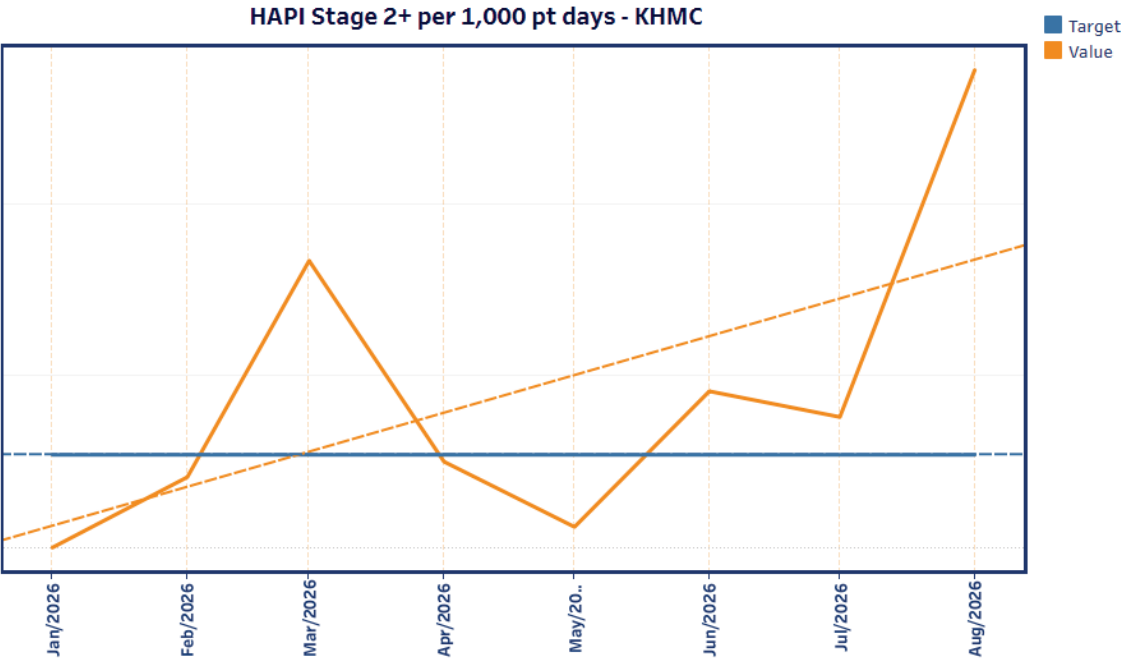
- As prevention rounding, leadership rounding, and skin surveillance processes are implemented, an initial increase in identified pressure injuries **may** occur. This is an expected finding and may reflect improved assessment practices, earlier identification of skin breakdown, and enhanced documentation rather than an **actual increase** in pressure injury **occurrence**.
- Increased surveillance frequently uncovers pressure injuries that may have previously gone unrecognized or been identified later in their progression. Early identification allows for prompt intervention, improved treatment planning, more accurate reporting, and targeted prevention efforts.
- Success during the initial implementation period should therefore be evaluated using multiple indicators, including prevention bundle compliance, turning and offloading compliance, support surface utilization, moisture management implementation, and timeliness of skin assessments, in addition to overall HAPI rates.
- As prevention practices become standardized and compliance improves, a subsequent reduction in preventable HAPI occurrence is anticipated.

FY27 Data:

FY27 YTD: 1.77

Goal: **Not Met**

Goal = <0.46



Rolling 12 Month Data:

2026 Stage 2+ HAPI Dashboard																		
Measure Description		Baseline	Baseline	Baseline														
Outcome Measures		2026 Benchmark	2023	2024	2025	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Rolling 12 Mos
HAPI Stage 2+ per 1,000 pt days		0.54	1.01	1.53	0.56	0.43	0.55	0.56	0.25	0.00	0.40	1.67	0.50	0.12	0.91	0.76	1.39	0.64
Device Associated HAPI per 1,000 pt days		0.29 (~10% from 2025 baseline starting July 2026)	0.28	0.65	0.32	0.43	0.41	0.28	0.12	0.00	0.00	1.31	0.13	0.00	0.00	0.13	0.35	0.26
PSI 3 - Claims-based HAPI Stage 3, 4, and Unstageable per 1,000 discharges		0.65 - Care Compare/CMS (Q3 2021-Q2 2023)	0.20	0.66	0.20	1.20	1.16	0.00	0.00	0.00	1.12	1.08	0.00	0.00	0.00	0.00	1.09	0.46
Process Measures		Benchmark (~10% from 2025 baseline starting July 2026)	Baseline 2023	Baseline 2024	Baseline 2025	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Rolling 12 Mos
Respiratory Device associated HAPI per 1,000 pt days		0.1	0.07	0.28	0.11	0.14	0.00	0.00	0.00	0.00	0.00	0.36	0.00	0.00	0.00	0.00	0.00	0.04
% of Respiratory Device associated HAPI's (out of all of the device associated HAPI's)		31%	23%	44%	34%	33%	0%	0%	0%	0%	0%	27%	0%	0%	0%	0%	0%	16%
Number of HAPI's Stage 2+			Baseline 2023	Baseline 2024	Baseline 2025	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Rolling 12 Mos
Total Number of HAPI's Stage 2+ (all units)			105	153	55	3	5	4	2	0	3	14	5	1	8	6	12	63
Unit Level		Benchmark (~10% from 2025 baseline starting July 2026)	Baseline 2023	Baseline 2024	Baseline 2025	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Rolling 12 Mos
4N - HAPI 2+ per 1,000 pt days		0.31	1.37	2.37	0.34	0.00	0.00	1.30	0.00	0.00	1.41	3.68	1.28	0.00	6.76	0.00	0.00	1.18
3W - HAPI 2+ per 1,000 pt days		0.60	1.47	5.07	0.67	2.17	0.00	2.28	0.00	0.00	0.00	0.00	2.01	0.00	0.00	2.04	2.01	0.89
KXU - HAPI 2+ per 1,000 pt days		1.15	5.29	6.40	1.28	0.00	3.50	0.00	0.00	0.00	0.00	10.93	5.49	0.00	0.00	10.10	2.70	2.89
CVKCU - HAPI 2+ per 1,000 pt days		1.06	3.05	2.05	1.18	0.00	0.00	0.00	3.15	0.00	0.00	5.97	0.00	3.56	0.00	0.00	3.57	1.39
2N - HAPI 2+ per 1,000 pt days		1.04	0.40	0.59	1.16	2.68	0.00	1.21	1.21	0.00	1.29	1.17	0.00	0.00	1.30	1.21	0.00	0.81
2S - HAPI 2+ per 1,000 pt days		0.00	0.00	1.04	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
3N - HAPI 2+ per 1,000 pt days		0.43	0.78	0.27	0.48	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	2.02	0.19
3S - HAPI 2+ per 1,000 pt days		0.33	0.09	1.33	0.37	0.00	1.12	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.09
4S - HAPI 2+ per 1,000 pt days		0.68	1.09	0.70	0.76	0.00	0.00	0.00	0.00	0.00	1.12	0.00	0.00	0.00	0.00	0.00	3.11	0.37
4T - HAPI 2+ per 1,000 pt days		0.38	0.69	1.43	0.42	0.00	0.00	1.72	0.00	0.00	0.00	1.64	0.00	0.00	0.00	0.00	4.81	0.69
BP - HAPI 2+ per 1,000 pt days		0	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Rehab - HAPI 2+ per 1,000 pt days		0.12	0.42	0.29	0.13	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
ST - HAPI 2+ per 1,000 pt days		0.34	0.77	1.36	0.38	0.00	3.64	0.00	0.00	0.00	0.00	4.26	0.00	0.00	1.67	0.00	1.36	0.90
Other Units		2026 Benchmark/ Target	Baseline 2023	Baseline 2024	Baseline 2025	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Rolling 12 Mos
Sub-Acute		decrease from baseline	7	6	2	0	1	0	0	0	0	0	0	0	1	0	0	2
TC (Short Stay at Rehab)		decrease from baseline	1	1	2	0	0	0	0	0	0	0	1	0	0	0	0	1
Meeting or Better than Target																		
Within 10% of goal																		
Does not meet Target																		

HAPI Prevention

Standardized communication to nursing leaders & bedside staff

HAPI Prevention Update

Best Practices to Implement Immediately

- Two-person skin assessment on admission and transfer.** Every patient. Every unit. Implement interventions. Continue two-person assessments each shift for Braden of 14 or less.
- Effective turning.** Patients must be turned far enough to offload pressure and encourage blood flow to the area.
- Protect the sacrum, other bony prominences, and anywhere devices/tubing touches the skin.** Use pressure injury prevention dressings.
- Offload heels.** Use waffle boots.
- Moisture management.** Barrier cream is a nursing intervention that does not require an order or wound consult. Anti-fungal cream can be ordered by a provider if yeast is present.

June HAPIs
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Lesson Learned From Event Reviews

- Heel pressure DTPIs are solely from pressure. Offloading with waffle boots is important
- ~~Catalase~~ barrier cream can be used on ~~open skin~~ and does not require an order. It is a nursing intervention that should be used for patients with moisture issues (see Braden Scale).

Wound Classes are in Workday!

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HAPI Prevention- Our Unit

Unit Specific Data: Monthly/Annually

Event review:

- Story of event-what happened?
- Why did it happen?
 - Fallouts in expected care
- What are we going to do to prevent it from happening again?

June HAPIs

2026 HAPIs
##

Take Action:

- Write what bedside staff can do to help in the prevention plan

Sign up for Wound classes in Workday!

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Falls Prevention

Standardized communication to nursing leaders & bedside staff

Falls Prevention Update

Best Practices for Fall Risk Patients

- Purposeful hourly rounding.** Does your patient have urinary frequency? Did they recently take a diuretic or eat a meal? At the 5:00 rounding, encourage toileting to decrease the likelihood they'll need to go during shift change.
- Attended toileting - always.** Do not leave the patient alone; call for assistance if you need supplies. Ask a coworker to assist other patients who call during this time.
- Mobility project.** Know your patients AMPAC score and their mobility goals. Ambulate your patients according to that tool. Utilize equipment as needed – including gait belts!
- Risk assessment.** Assess on admit & every shift. Look at your patient as a whole; for example: what meds they are getting – even if it's given on another shift.
- SPLAT the room before you leave.** Side rails up. Personal items within reach & clear path. Low bed, brakes on. Alarm on (bed or chair). Table at the bedside at all times.
- Communicate.** Let your patients and their families know staff must be present to ambulate, including toileting. Patients in custody require KH staff to be present during ambulation and toileting for Fall Risk patients.

July Falls
16

Lesson Learned From Event Reviews

- Patients need proactive interventions that are specific to their individual needs.
- Purposeful rounding that addresses patient specific needs.
- Patient and family collaboration is vital to preventing falls.
- Assume your patient will fall! What do they need in place to prevent it?

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August 2026

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Fall Prevention- Our Unit

July Falls

2026 Falls
##

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