Kaweah Delta Health Care District
Board Of Directors Committee Meeting

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

NOTICE

The Quality Council Committee of the Kaweah Delta Health Care District will meet at the Kaweah Health Lifestyle Fitness Center Conference Room {5105 W. Cypress Avenue, Visalia, CA} on Thursday, August 21, 2025:

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

In compliance with the Americans with Disabilities Act, if you need special assistance to participate at this meeting, please contact the Board Clerk (559) 624-2330. Notification 48 hours prior to the meeting will enable the District to make reasonable arrangements to ensure accessibility to the Kaweah Delta Health Care District Board of Directors meeting.

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

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

KAWEAH DELTA HEALTH CARE DISTRICT

David Francis, Secretary/Treasurer

Kelsie Davis

Board Clerk / Executive Assistant to CEO

DISTRIBUTION:

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

Kaweah Delta Health Care District
Board Of Directors Committee Meeting

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

Kaweah Delta Health Care District Board of Directors Quality Council
Meeting held: Thursday, August 21, 2025, Kaweah Health Lifestyle Fitness Center Conference Room
Attending: Board Members: Michael Olmos (Chair), Dean Levitan, MD; Gary Herbst, CEO; Schlene Peet, Interim Chief Nursing Officer; Paul Stefanacci CMO/CQO; Michael Tedaldi, MD, Vice Chief of Staff and Quality Committee Chair; LaMar Mack, MD, Quality and Patient Safety Medical Director; Sandy Volchko, Director of Quality and Patient Safety; Ben Cripps, Chief Compliance and Risk Management Officer; Evelyn McEntire, Director of Risk Management; Cindy Vander Schuur, Patient Safety Manager; and Kyndra Licon, Recording.

OPEN MEETING – 7:30 AM

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

2. **PUBLIC / MEDICAL STAFF PARTICIPATION** – Members of the public may comment on agenda items before action is taken and after it is discussed by the Board. Each speaker will be allowed five minutes. Members of the public wishing to address the Board concerning items not on the agenda and within the jurisdictions of the Board are requested to identify themselves at this time. For those who are unable to attend the beginning of the Board meeting during the public participation segment but would like to address the Board, please contact the Board Clerk (Kelsie Davis 559-624-2330) or kedavis@kaweahhealth.org to make arrangements to address the Board.

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

CLOSED MEETING – 7:31 AM

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

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

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

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

5. **ADJOURN CLOSED MEETING –** Mike Olmos, Committee Chair

Kaweah Delta Health Care District
Board Of Directors Committee Meeting

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OPEN MEETING – 8:00 AM

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

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

3. **Close Meeting Report Out**

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

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

    a. **Emergency Department Quality Report**

6. **Incident Management –** A review summary of the Incident Management meeting process & RCAs and event scoring. Evelyn McEntire, Director of Risk Management.

7. **Clinical Quality Goals Update –** A review of current performance and actions focused on the clinical quality goals for Healthcare Acquired Infection and Sepsis. Sandy Volchko, RN, DNP, Director of Quality and Patient Safety.

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

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Agenda item intentionally omitted

OPEN Quality Council Committee
Thursday, July 17, 2025
The Lifestyle Center Conference Room

Attending: Board Members: Mike Olmos (Chair) & Dr. Dean Levitan, Board Member; Gary Herbst, CEO; Sandy Volchko, Director of Quality & Patient Safety; Schlene Peet, Interim Chief Nursing Officer; Mark Mertz, Chief Strategy Officer; Ryan Gates, Chief Ambulatory Officer; Dr. Lamar Mack, Medical Director of Quality & Patient Safety; Amy Baker, Director of Specialty Clinics; Connie Green, Nurse Manager; Cody Ericson, RN-Advanced Practice Nurse; Shawn Elkin, Infection Prevention Manager; Erika Pineda, Quality Improvement Manager; Kyndra Licon – Recording.

Mike Olmos called to order at 7:30 AM.

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

Mike Olmos adjourned the meeting at 7:31 AM.

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

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

4. **Written Quality Reports –** A review of key quality metrics and actions associated with the following improvement initiatives: **–** Reports reviewed and attached to minutes. No action taken.
    4.1 Best Practice Teams
    4.2 Diabetes Committee Quality Report

5. **Kaweah Health Dialysis Report –** A review of key performances indicators and actions associate with care of dialysis patient population. – Reports reviewed and attached to minutes. No action taken. Trend on volume and not percentage.

6. **Clinical Quality Goals Update**- A review of current performance and actions focused on the clinical quality goals for Healthcare Acquired Infections and Sepsis. – Reports reviewed and attached to minutes. No action taken.

Adjourn Open Meeting – *Mike Olmos, Committee Chair*

Mike Olmos adjourned the meeting at 9:09 AM.

QUALITY COMMITTEE REPORT

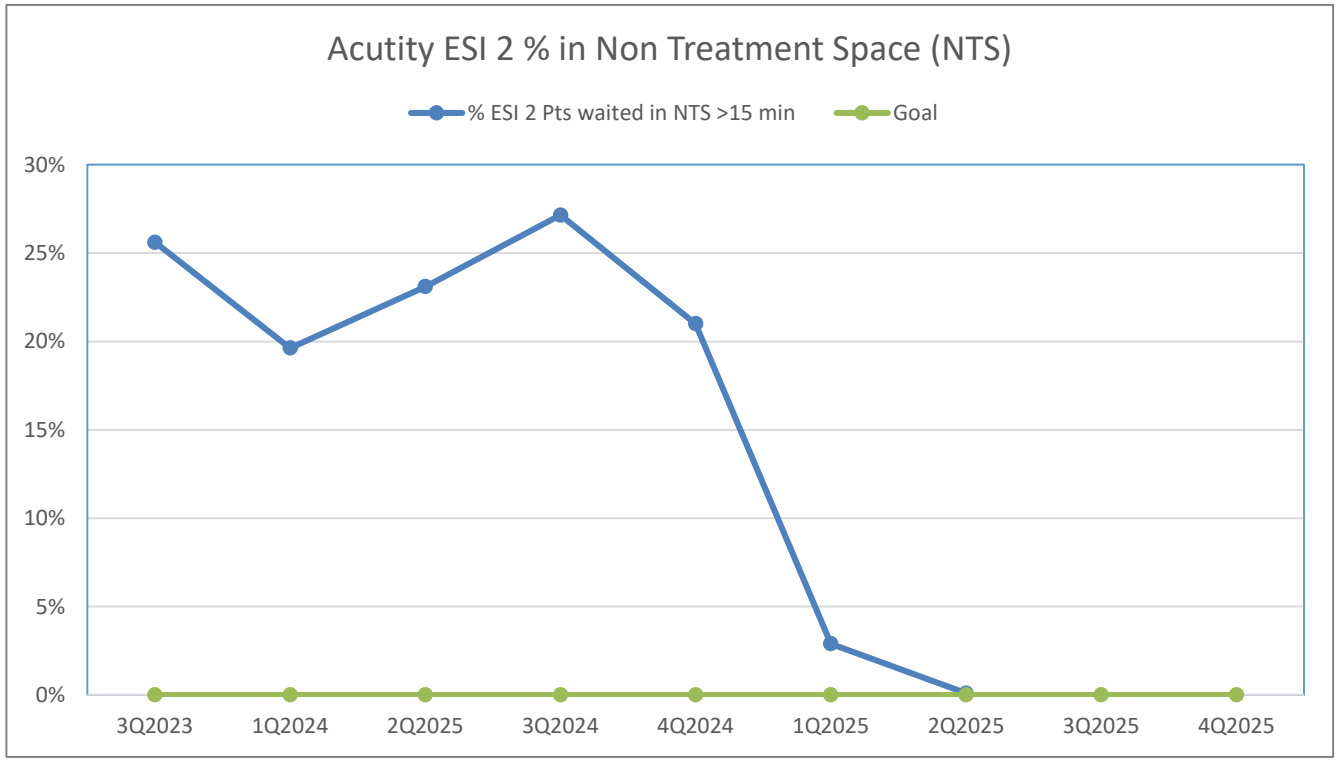
Emergency Department Quality Report

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

August 2025

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

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



Emergency Department ESI 2 Management

High Level Action Plan

- Goal: 0% waiting greater than 15 min
- Current Performance: May & June 0%; 0.1% for 2nd Quarter 2025
- No ESI 2 Patients waiting; 100% of patients (All ESI levels) have an MSE done in the Intake process. If a patient is determined to be a level II in triage, patient is moved directly back to an open bed for MSE and stabilization.

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

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

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

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ED Safe Care Patient Flow Dashboard

ESI-2 Patients Flow NTS: Non-Treatment Space	Target	May 2025	Jun 2025	Jul 2025	Aug 2024	Sept 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025	Rolling 12M Av
# ESI 2 pts waited in NTS >15 min	0	0	0	0	141	125	160	130	206	274	24	2	0	134
% ESI 2 Pts waited in NTS >15 min	0%	0%	0%	0%	17%	16%	20%	16%	22%	26%	2%	0.9%	0.1%	15%
Avg. LOS ESI 2 pts waited in NTS >15 min	0	0	0	0	79	62	67	59	53	59	42	21	8	58
Max LOS ESI 2 Pt's waiting in NTS >15 min	0	0	0	0	741	288	650	408	365	897	292	28	15	490

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

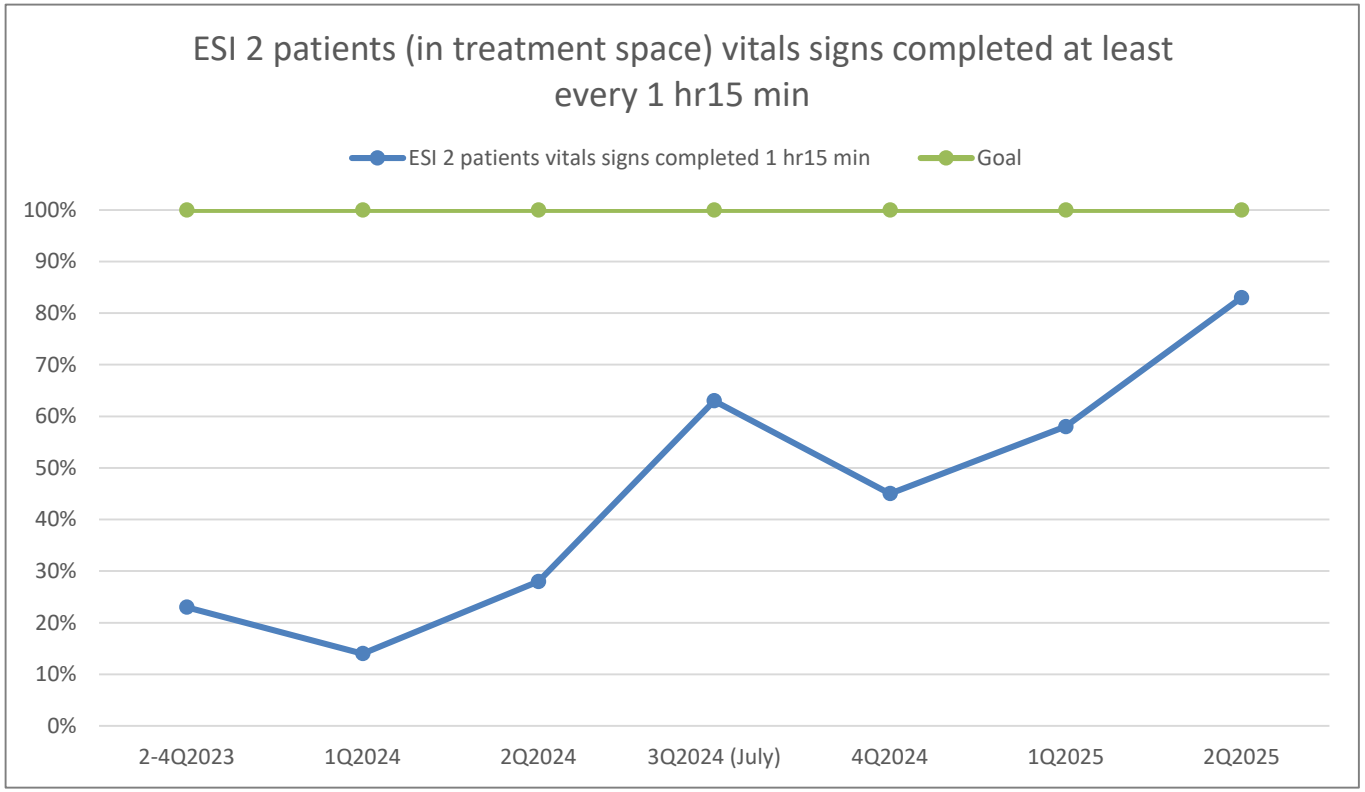
Targeted Opportunities (why goal not achieved in most recent month)

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

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

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

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



Emergency Department ESI 2 Management

High Level Action Plan

- Evaluate best practices and industry standards on:
  - frequency and components of VS checks
  - Policy adjusted to ensure national standards maintained for ESI vital signs assessment/reassessment
- July 2025 is 95% compliant
- 2nd Quarter 2025 83% complaint

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

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

ED Quality Report: ESI 2 Patient Vital Sign Monitoring

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ED Safe Care Patient Flow Dashboard

ESI-2 Vital Signs (patients in treatment space)(		July 2024	Aug 2024	Sept 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025	Rolling 12M Av
Retired Metric Feb 2025 – VS completed per SOC for ESI 2	100%	63%	No Audit	45%	42%	50%	42%	33%						
Evidence that vital signs are completed per provider orders									58%	66%	72%	94%	87%	54%

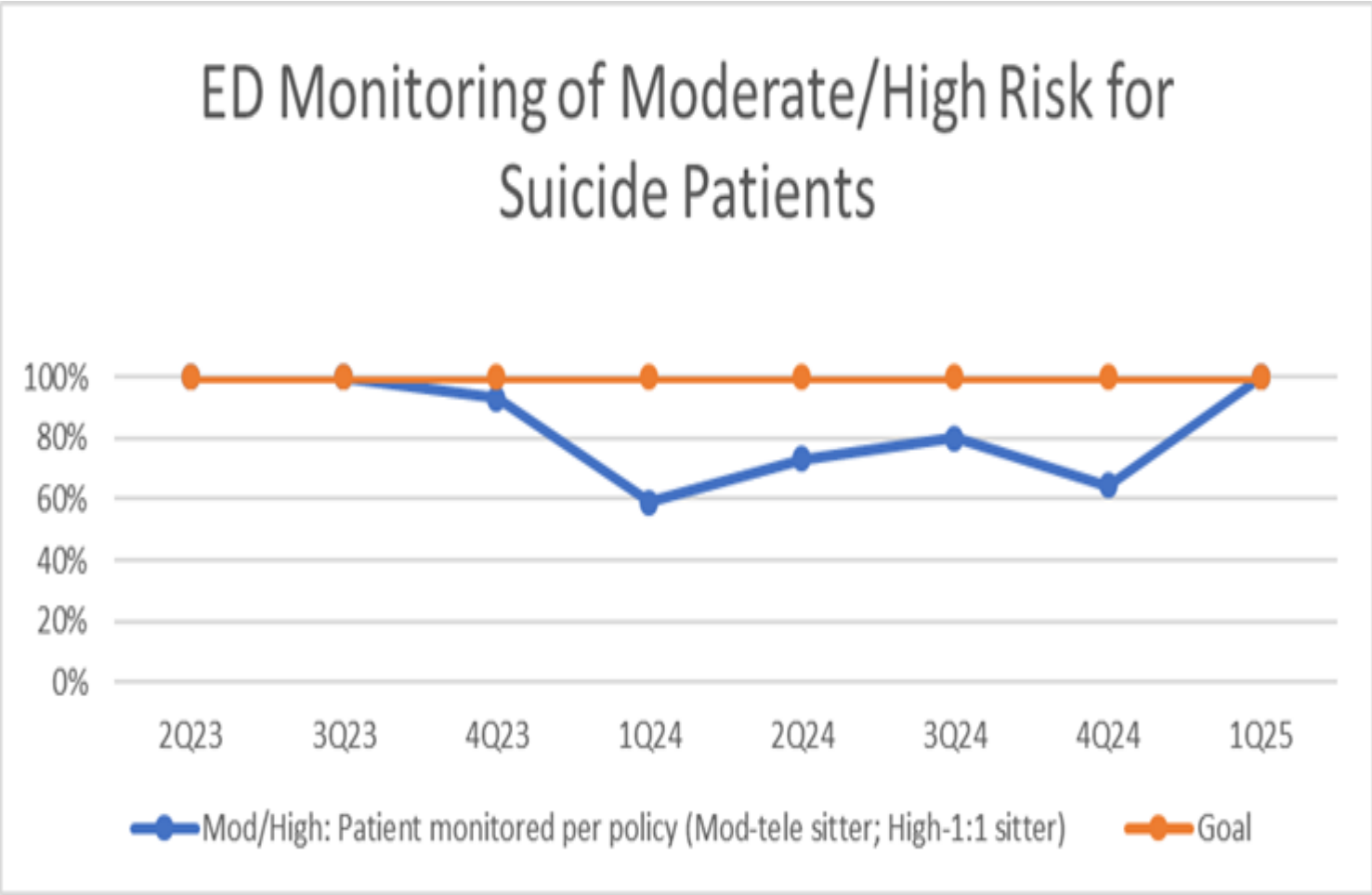
Targeted Opportunities (why goal not achieved in most recent month)

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

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

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

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



ED – Monitoring of Mod/High Risk for Suicide

High Level Action Plan

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

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

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Suicide Risk Daily Compliance Surveillance Data

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

ED

Question	Goal	Jan-24	Feb-24	Mar-24	Apr-25	May-25	Jun-25	Jul-25	Aug-24
4a. Mod/High: Patient monitored per policy (Mod-tele sitter; High-1:1 sitter)	100%	68% 68/100	46% 76/166	69% 91/131	100% 51/51	100% 34/34	100% 21/21	100% 48/48	75.00% 84/112
4b. Mod/High: Patients without a Sitter- volume					0	0	0	0	3

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

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

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

ED Improving Lab and EKG Turnaround Times for Chest Pain Patients

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

ED Improving Lab and EKG Turnaround Times for Chest Pain Patients

CURRENT IMPROVEMENT ACTIVITIES	EXPECTED COMPLETION DATE	BARRIERS
Left During Treatment (LDT) / AMA Rates: These also decreased to an all-time low of only **3% and 1%**, respectively.	On-Going	Continue monitoring rates along with LWBS rates.
Assessing revision of the assessment/re-assessment policy for frequency of vital signs assessment.	September 2025	Assessment frequency not consistent with standards for ESI assessment/reassessment.

Thank you

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Kaweah Health

Incident Management Meeting

QComm

August 2025

Evelyn McEntire, Director of Risk Management

Incident Management Process

Overview

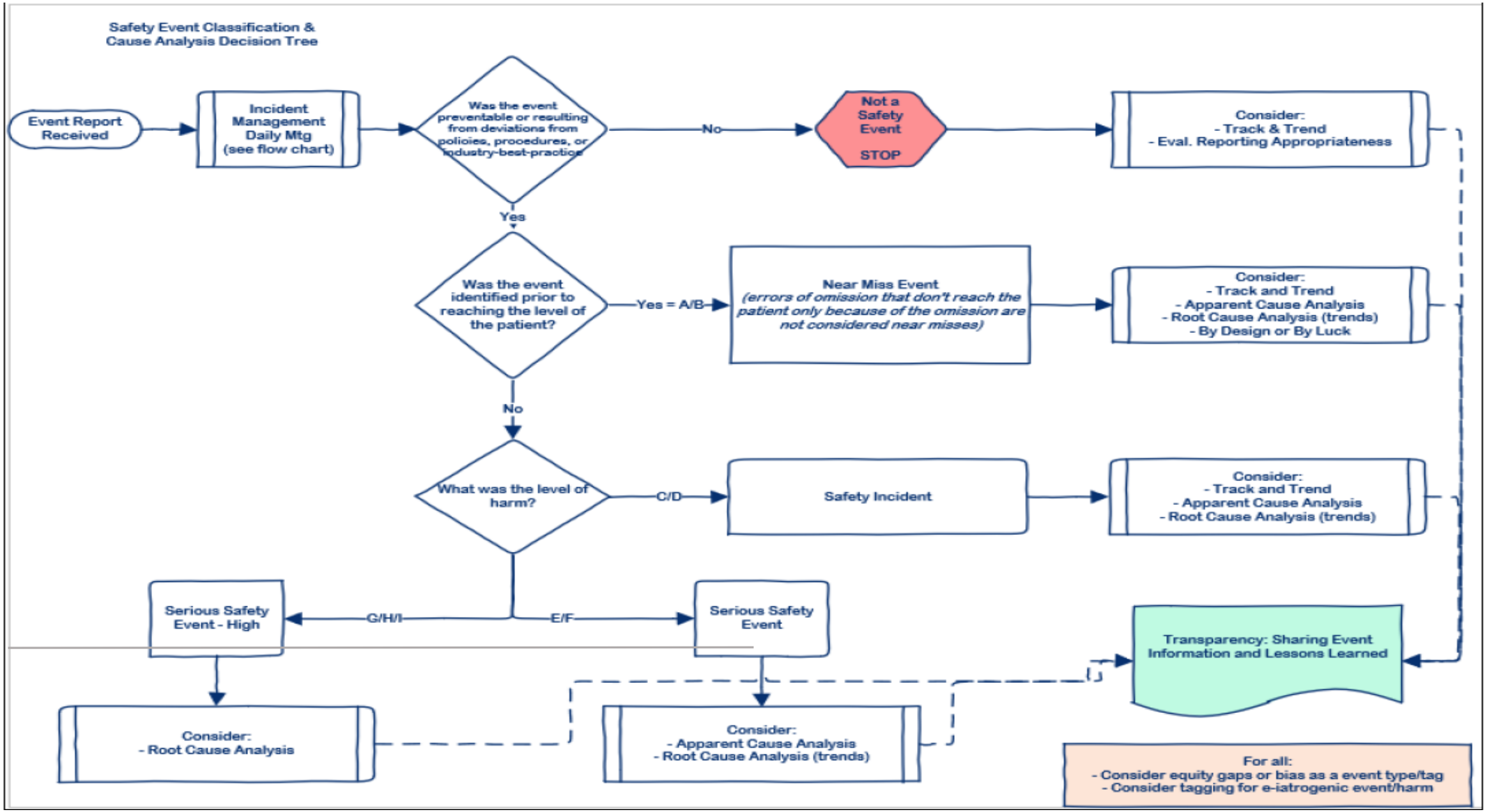
Every Midas event report is now assigned a score (A – I), based on the new Kaweah Event Severity Scale. Events are scored a level ***B through E*** by the Risk Management department. They are referred to the appropriate unit leaders who investigate the events and present their findings at the Incident Management Meeting (IMM) each business day at 11:15 a.m.

Using the IMM decision tree, the unit leader's investigation will determine:

1) Was there a deviation from policy or industry best practices?
2) Did the event reach the patient?
3) What was the level of harm to the patient?

The IMM process allows Kaweah leaders to obtain information about the events much quicker and escalate them to IMM for timely review and further escalation, if necessary. This also shows staff that we care about safety events in the organization and want to improve our communication with them and provide feedback on the outcome.

Incident Management Meeting Decision Tree



Event Scoring

Severity*	Description	Also Consider	Example(s) for patients and caregivers
A	Circumstances or events that have the capacity to cause harm (unsafe conditions)		• Report of ice routinely forming on the stairs of parking garage • Plastic doors on medication dispensing machine bins often missing increasing chance of mis-loads
B1 – Design	An error occurred but the error did not reach the patient (an "error of omission" does reach the patient**) because of being caught by a barrier build into the system	Employee education needs regarding definition of reportability. For example, if an alert in the EMR fires and identifies an error that is corrected in the moment, it is still MIDAS reportable.	• An RN scans a medication prior to administration and discovers the incorrect concentration was loaded into the medication dispensing machine. • Wrong patient brought to OR identified during time out • An electrician conducts a required double check before performing work and recognizes lock-out/tag-out was not completed.
B2 – Chance	An error occurred but the error did not reach the patient (an "error of omission" does reach the patient) because it is caught by chance or incidentally by a barrier not built into the system		• Family member identifies incorrect medication just prior to administration. • EVS worker identifies confused patient climbing out of bed and intervenes to prevent a fall. • A caregiver stops a colleague from standing on a wheeled office chair to obtain items from a top shelf.
C	An error occurred that reached the patient but did not cause patient harm	Clear evidence must be evident that no harm exists.	• Transfusion of blood intended for another patient yet of the correct blood type • Preventable fall with imaging taken to confirm no injury
D	An error occurred that reached the patient and required monitoring to confirm that it resulted in no harm to the patient and/or required intervention to preclude harm	Minor treatments (first aid) or ongoing monitoring fall into this category.	• Administration of insulin to a non-diabetic requiring blood glucose monitoring, resolved through eating and orange juice • Procedure performed with un-sterile instruments with no noted post-procedure infection or complications
E	An error occurred that may have contributed to or resulted in temporary harm to the patient and required intervention	"Intervention" generally described as care beyond "first aid." Intervention/ care that can only be provided by a licensed provider. May include change in therapy or active medical/surgical treatment.	• Overdose of pain medication requiring infusion of naloxone • IV infiltration of medication requiring administration of antidote • Fall resulting in laceration requiring suturing in non-cosmetic area • Caregiver suffers laceration while cleaning kitchen utensils requiring an ER visit, sutures, and returns to work
F	An error occurred that may have contributed to or resulted in temporary harm to the patient and required initial or prolonged hospitalization	Caregivers: injury or distress requiring medical intervention resulting in lost time or extended restricted duty.	• Medication error resulting in arrhythmia resulting in hospital admission and administration of IV anti-arrhythmic medications • Fall resulting in subdural hematoma and upgrade to ICU
G	An error occurred that may have contributed to or resulted in permanent patient harm	Caregivers: permanent disability, permanent inability to return to work or unable to return into previous position.	• Delayed diagnosis of stroke resulting in permanent impairment • Overdose of IV contrast resulting in kidney damage and need for permanent dialysis • Intra-operative burn resulting in scarring • Wrong site surgery resulting in amputation of a healthy limb
H	An error occurred that required intervention necessary to sustain life	Interventions include cardiovascular and respiratory support (CPR, intubation, defibrillation)	• Delayed diagnosis of fluid overload resulting in intubation and ICU transfer • Medication error inducing cardiac arrest with successful resuscitation
I	An error occurred that may have contributed to, or resulted in, death		• Medication error inducing cardiac arrest without successful resuscitation
Non-Event	A non-preventable event not related to deviations from policies, procedures, or best practices		• Unanticipated complication with evidence of appropriate care, timely recognition and treatment. Determined non-preventable.

Incident Management & RCAs

Events scored level ***F through I*** are not presented at IMM because they resulted in serious harm or death. A Root Cause Analysis (RCA) will be conducted for these events to ensure a formal systematic review is completed.

RCA Facilitators – A group of trained individuals from various departments throughout Kaweah Health such as Population Health, Food & Nutrition Services, HR, ISS, Pharmacy, Risk Management, Quality & Patient Safety, Employee Health.

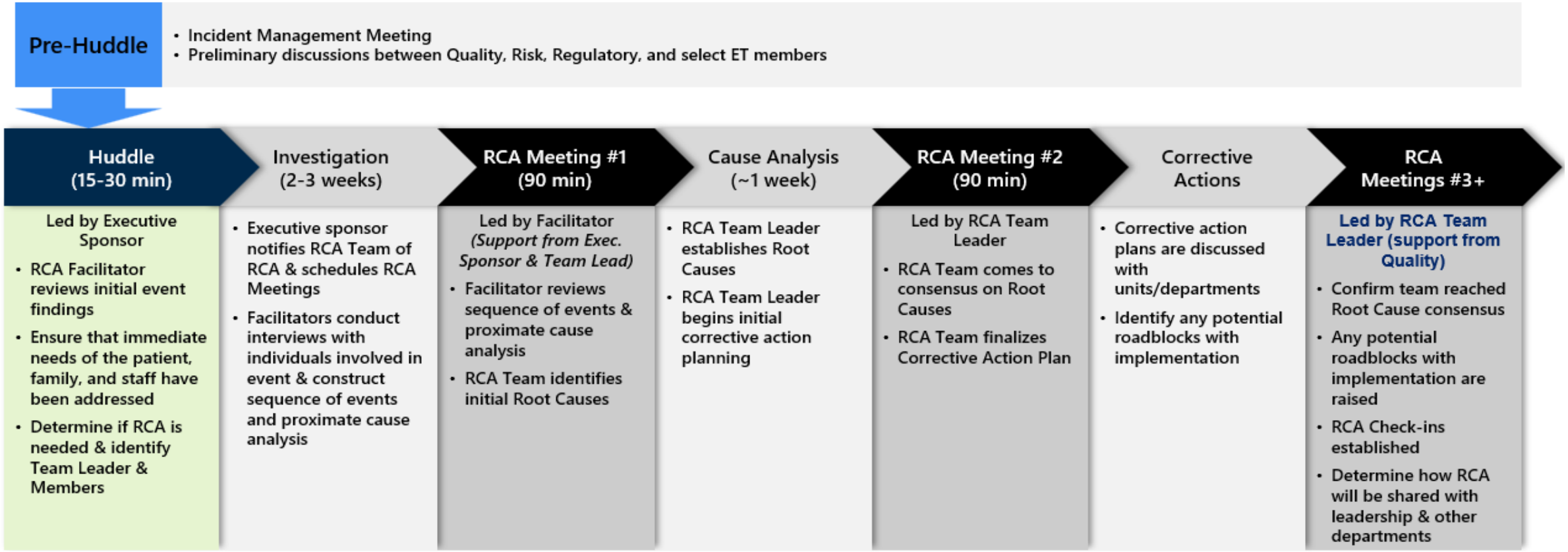
Huddle + 3-Meeting Model:

- ✓ Huddle (within 72 hours);
- ✓ Facilitator investigation (2-3 weeks);
- ✓ Meeting 1 – Facilitator reviews timeline and initial root causes (90 minutes);
- ✓ Meeting 2 – Root cause identification and action plan (90 minutes);
- ✓ Meeting 3 - APOC review and approval (30 – 60 minutes).

New due date timeline – 45 days as recommended by The Joint Commission

Incident Management & RCAs

New RCA Completion Due Date: ***45 days***



IMM Wins

- Unit leaders are investigating and responding to Midas reports within one week or less of submission
- Leaders' investigations are more thorough and corrective actions more meaningful
- Leaders and staff sharing positive experiences – Earlier investigations and earlier resolutions
- Increased number of Midas reports submitted by 40% (improved safety culture)
- Decreased number of events that reached the patient (67% → 48%)
- Decreased number of Anonymously reported events (19% → 7%)

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Serious Safety Events

IHI Definition: A SSE is an incident where a deviation from generally accepted performance standards reaches the patient and results in [temporary or permanent] moderate to severe harm or death. This includes E-I events

Severity	Description	Examples
E	An error occurred that may have contributed to or resulted in temporary harm to the patient and required intervention	• Overdose of pain medication requiring infusion of naloxone • IV infiltration of medication requiring administration of antidote • Fall resulting in laceration requiring suturing in non-cosmetic area
F	An error occurred that may have contributed to or resulted in temporary harm to the patient and required initial or prolonged hospitalization.	• Medication error resulting in arrhythmia resulting in hospital admission and administration of IV anti-arrhythmic medications • Fall resulting in subdural hematoma and upgrade to ICU
G	An error occurred that may have contributed to or resulted in permanent patient harm.	• Delayed diagnosis of stroke resulting in permanent impairment • Overdose of IV contrast resulting in kidney damage and need for permanent dialysis • Intra-operative burn resulting in scarring • Wrong site surgery resulting in amputation of a healthy limb
H	An error occurred that required intervention necessary to sustain life.	• Delayed diagnosis of fluid overload resulting in intubation and ICU transfer • Medication error inducing cardiac arrest with successful resuscitation
I	An error occurred that may have contributed to, or resulted in, death.	• Medication error inducing cardiac arrest without successful resuscitation

Note: Not all E events require an RCA

Serious Safety Event Rate

The serious safety event rate (SSER) is a measure used in healthcare to track the frequency of serious safety events.

Potential Impact of Tracking Serious Safety Events:

- **Identification of Trends:** Tracking enables organizations to identify patterns and trends in SSEs over time. This helps to identify areas where safety interventions are needed and to assess the effectiveness of implemented changes.
- **Targeted Improvement Efforts:** By understanding the types of SSEs that are occurring most frequently, organizations can focus their efforts on specific interventions to address those issues.

Combining robust tracking systems with a supportive safety culture creates a proactive environment where risks are detected early, safety protocols are followed, and staff are engaged in continuous improvement—ultimately enhancing patient safety and care quality.

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

$$\frac{8}{12374 + \frac{22916}{1000}} \times 10000$$

1. Calculate $\frac{22916}{1000}$:

$$22916/1000 = 22.916$$

2. Add to 12374:

$$12374 + 22.916 = 12396.916$$

3. Divide 8 by this sum:

$$\frac{8}{12396.916} \approx 0.0006453$$

4. Multiply by 10,000:

$$0.0006453 \times 10000 = 6.453$$

Final result:

$$\boxed{6.453}$$

Example Numbers
Serious Safety Events = 8 Avg pt days =12374 Avg Visits =22916

Serious Safety Event Dashboard

Kaweah Health
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Serious Safety Event Dashboard

Monthly Metrics	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Rolling 12 Months
# of Serious Safety Events scoring an E - I at Incident Management													
Serious Safety Event Rate													

Description: Serious Safety Event – High (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 temporary harm to the patient and required 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.

RCA's in progress:

	Event Date	Name of RCA and Midas Event #	Status	Meeting Timeline? If not, explain	Comments
1					
2					
3					
4					
5					

Outstanding Health Outcomes (OHO)
QUALITY & PATIENT SAFETY PRIORITY

Healthcare Acquired Infection (HAI) Reduction

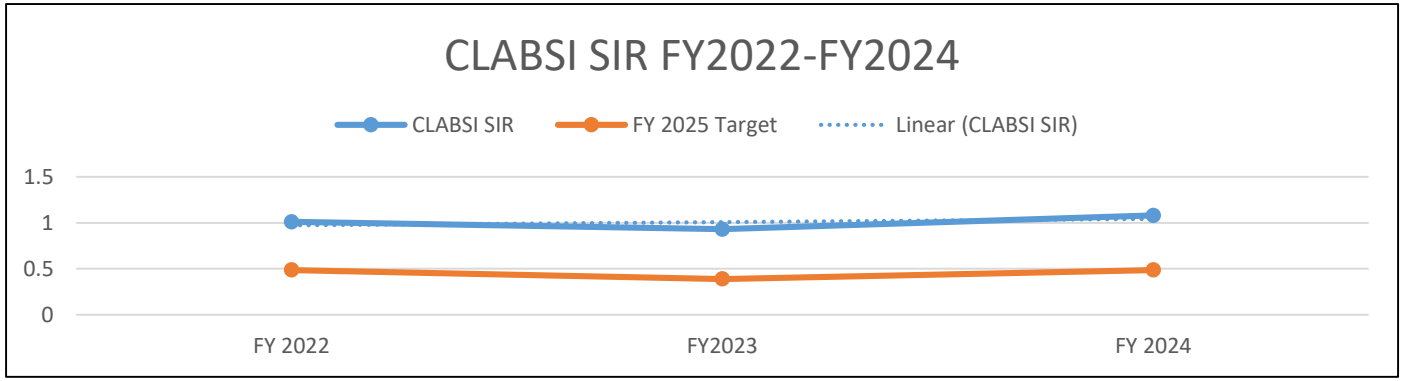
August 2025

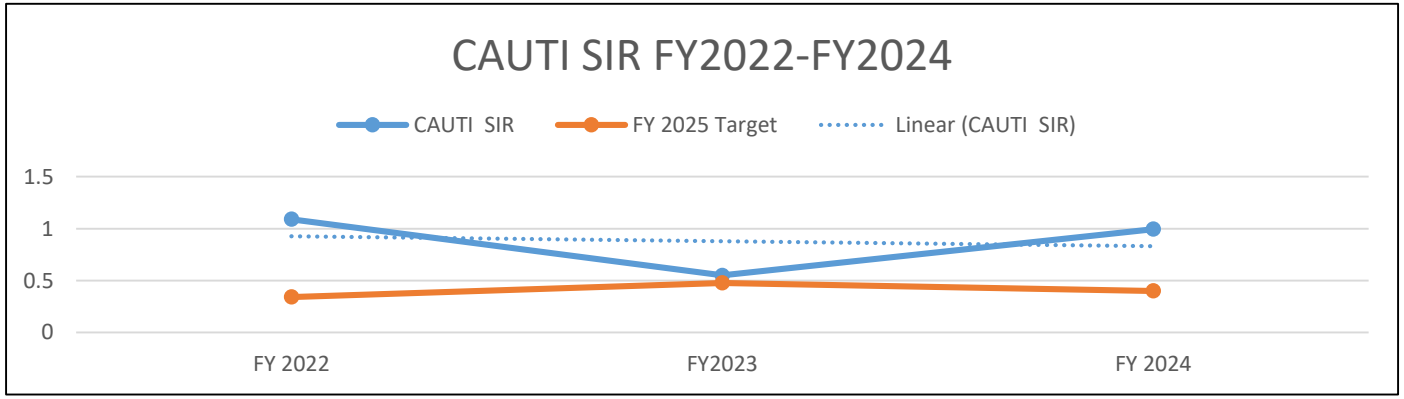
OHO FY25 Plan: HAI Reduction of Standardized Infection Ratio (SIR)

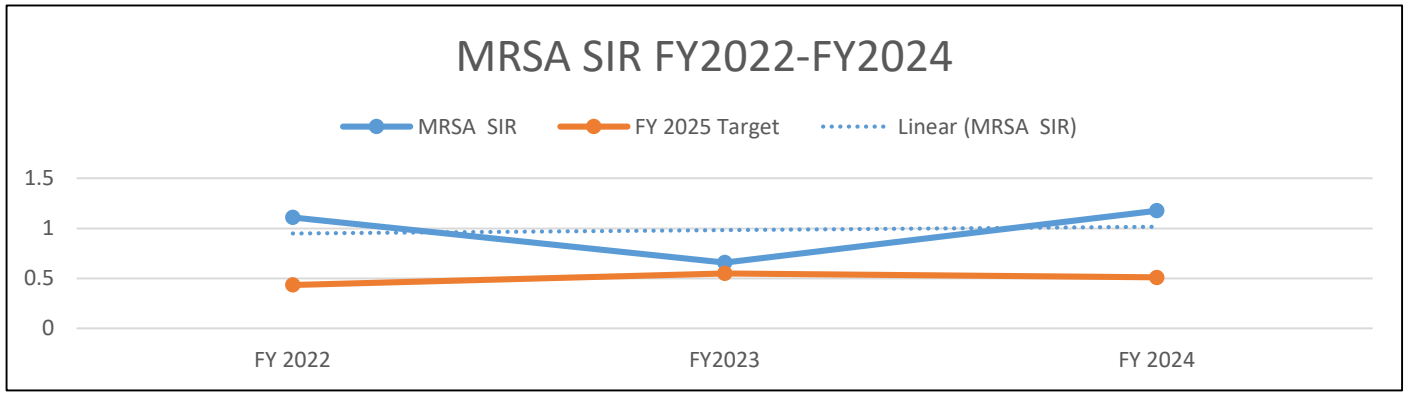
(number of actual infections/number of predicted infections by CMS)

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

Historical Baseline







FY25 PLAN – HAI Reduction CLABSI, CAUTI & MRSA SIR

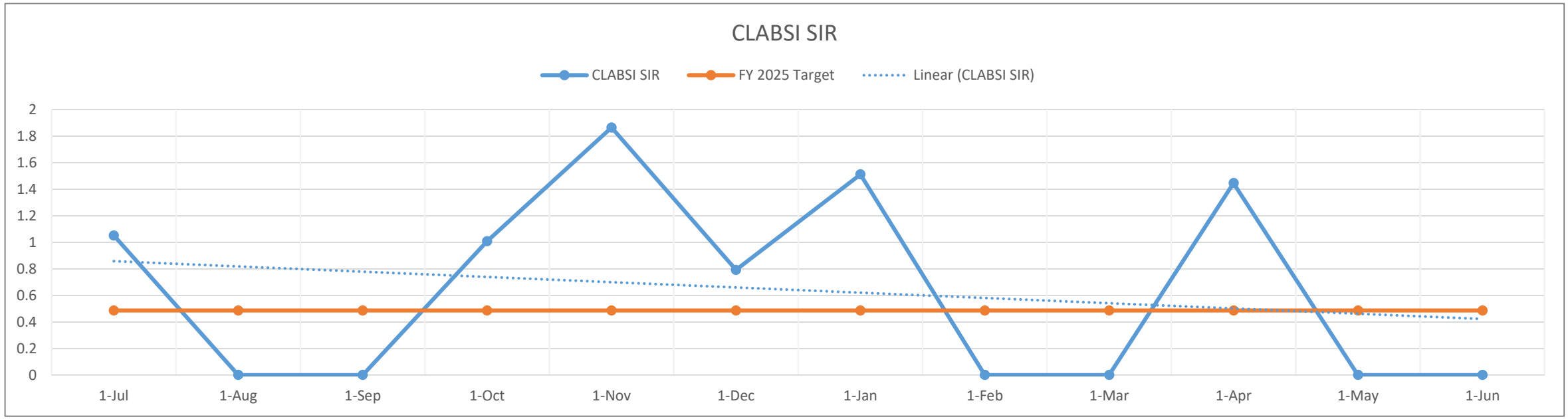
High Level Action Plan

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

FY25 GOAL

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

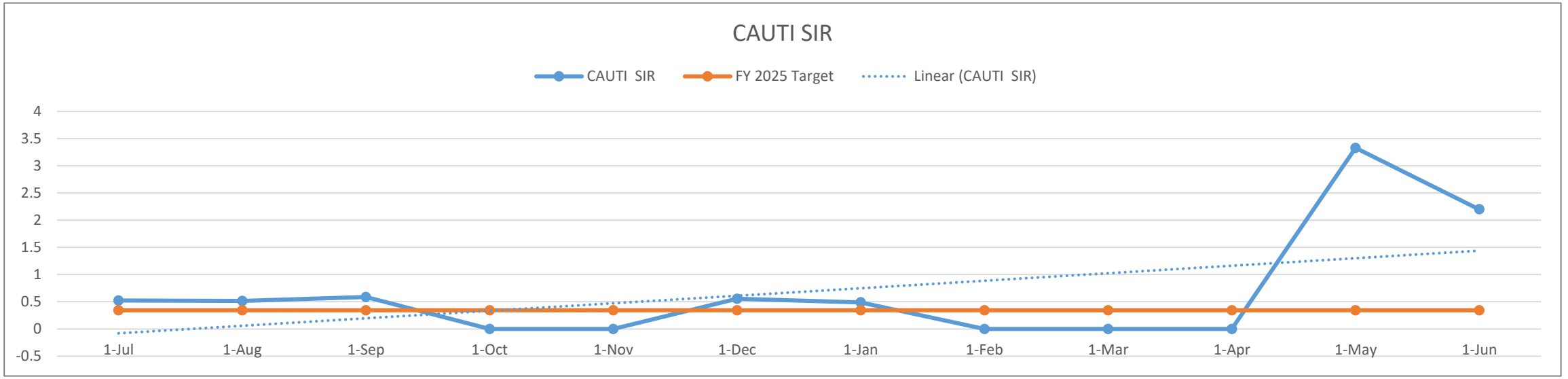
OHO FY25 Plan: HAI Reduction of Standardized Infection Ratio (SIR)
(number of actual infections/number of predicted infections by CMS)



	FY 2025 Target	FY 2024	24-Jul	24-Aug	24-Sep	24-Oct	24-Nov	24-Dec	25-Jan	25-Feb	25-Mar	25-Apr	25-May	25-Jun	FYTD 25
CLABSI Events		17	2	0	0	1	1	1	2	0	0	1	0	0	9
CLABSI Predicted Events		16.06	1.051	1.117	0.121	1.008	1.072	1.262	1.323	0.848	0.989	0.682	0.656	0.713	9.331
CLABSI SIR	<0.486	1.06	1.903	0	0	0.992	1.865	0.792	1.512	0	0	1.446	0	0	0.96

*note predicted values updated mid-FY25

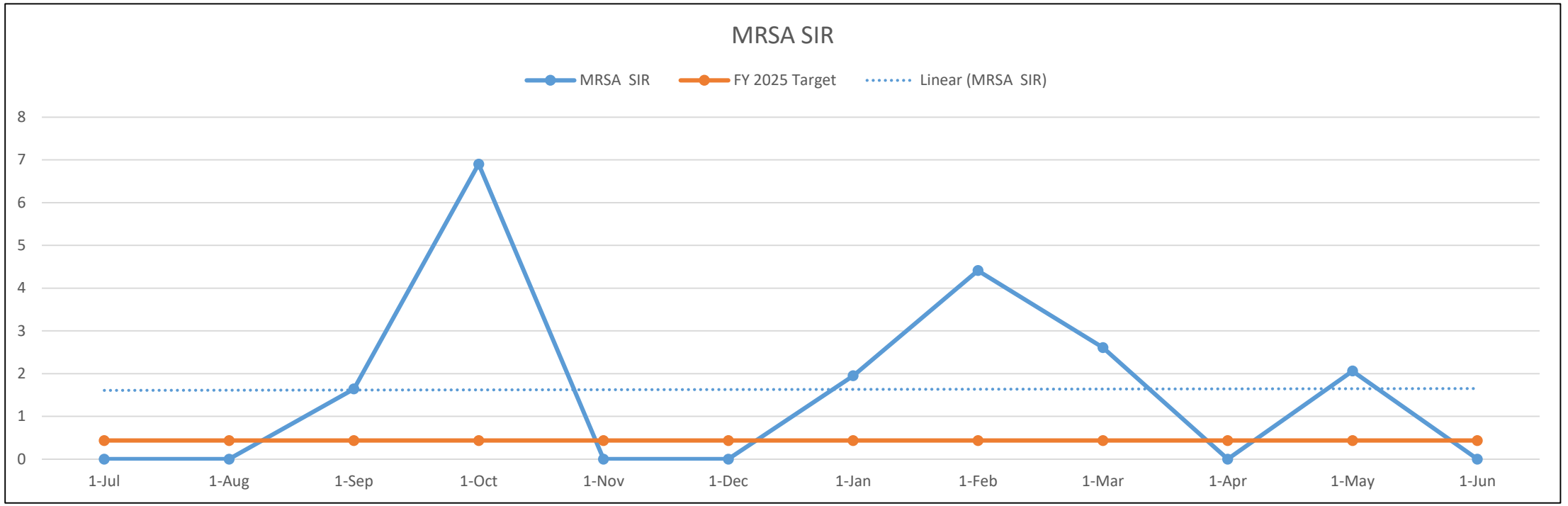
OHO FY25 Plan: HAI Reduction of Standardized Infection Ratio (SIR)
(number of actual infections/number of predicted infections by CMS)



	FY 2025 Target	FY 2024	24-Jul	24-Aug	24-Sep	24-Oct	24-Nov	24-Dec	25-Jan	25-Feb	25-Mar	25-Apr	25-May	25-Jun	FYTD 25
CAUTI Events		9	1	1	1	0	0	1	1	0	0	0	3	2	10
CAUTI Predicted Events		22.58	1.917	1.94	1.707	1.577	1.54	1.801	2.05	1.404	1.716	1.053	0.9	0.909	14.3
CAUTI SIR	<0.342	0.4	0.522	0.515	0.586	0.00	0	0.555	0.488	0	0	0	3.33	2.2	0.70

*note predicted values updated mid-FY25

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



	FY 2025 Target	FY 2024	24-Jul	24-Aug	24-Sep	24-Oct	24-Nov	24-Dec	25-Jan	25-Feb	25-Mar	25-Apr	25-May	25-Jun	FYTD 25
MRSA Events		7	0	0	1	2	0	0	1	2	1	0	1	0	8
MRSA Predicted Events		9.62	0.501	0.482	0.485	0.290	0.451	4.74	0.512	0.454	0.383	0.465	0.485	0.48	5.597
MRSA SIR	<0.435	0.73	0	0	1.64	6.9	0	0	1.95	4.41	2.61	0	2.06	0	1.43

*note predicted values updated mid-FY25

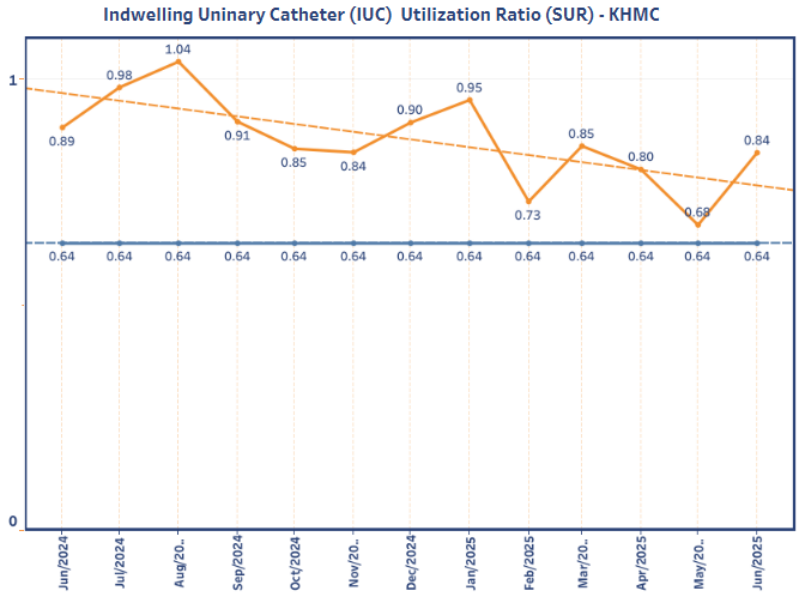
OHO FY25 Plan: HAI Reduction of Standardized Infection Ratio (SIR)

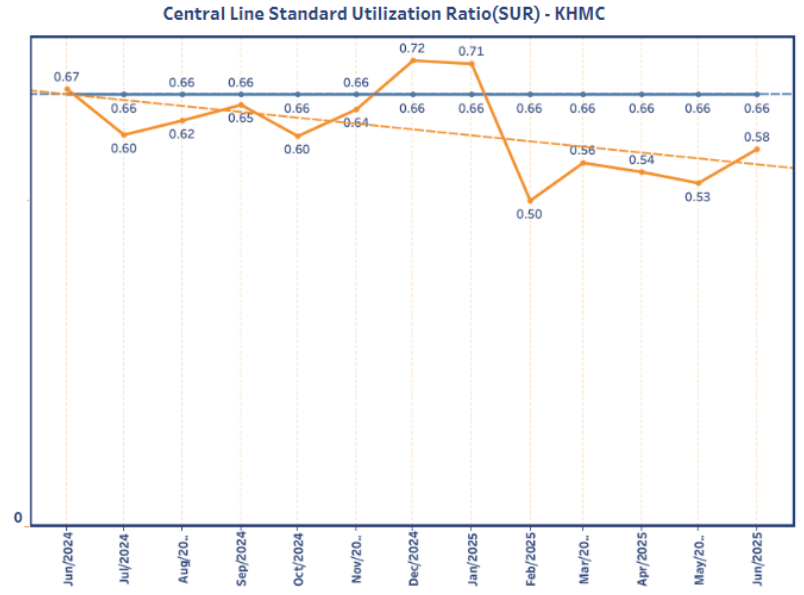
The last data point did not meet goal because:

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

Targeted Opportunities

- Reduce line utilization; less lines, less opportunity for infections to occur
  - Goal: reduce central line utilization ratio to <0.663
  - July 2024 - June 2025 0.60 (April – June 2025 0.550)
  - Goal: reduce urinary catheter ratio to <0.64
  - July 2024 - Jun 2025 0.87 (April – June 2025 0.71)
- MRSA nasal and skin decolonization for patients with lines.
  - Goal: 100% of at risk patients nasally decolonized
  - Jul 2024 - Feb 2025 100% of screen patients nasally decolonized
  - Data under evaluation, case reviews indicated that all SNF patients are being screened upon admission (Mar- Jun 2025)
  - Jul 2024 - Goal: 100% of line patients have CHG bathing
- Improve hand hygiene (HH) through increased use of BioVigil electronic HH monitoring system
  - Goal: 60% of staff are active users of BioVigil
  - Jul 2024- June 2025 56% of staff are active users (Jan-June 2025 increased to **60%**)
  - HH Compliance rate overall 94% July 2024- June 2025 (goal 95%) – decreasing trend noted over 3 quarters
- 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)
  - July 2024 – May 2025 Pass cleanliness effectiveness testing **90%** of the time in high risk areas





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

CURRENT IMPROVEMENT ACTIVITIES	EXPECTED COMPLETION DATE	BARRIERS
Expand Multidisciplinary rounds to include other stakeholders to reduce line use; NEW device rounds with Charge RN and Infection Prevention started May 1, 2025 on all inpatient units	5/1/25	Buy in from physician stakeholders
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
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 (increase 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	None
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

Thank you

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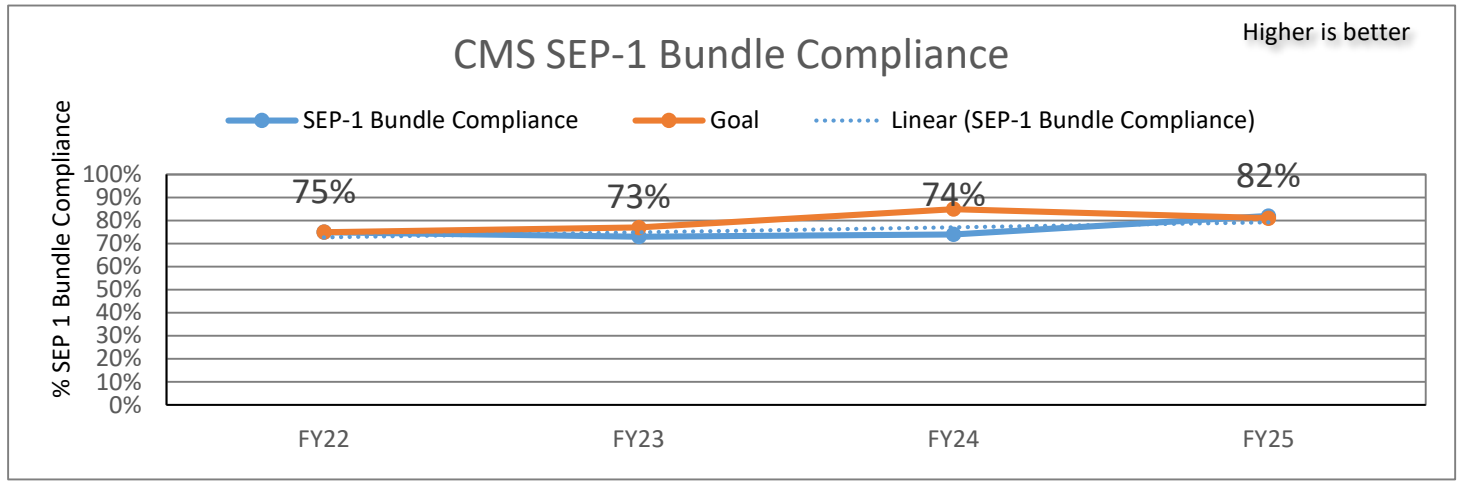
SEPSIS COMMITTEE REPORT
QUALITY & PATIENT SAFETY

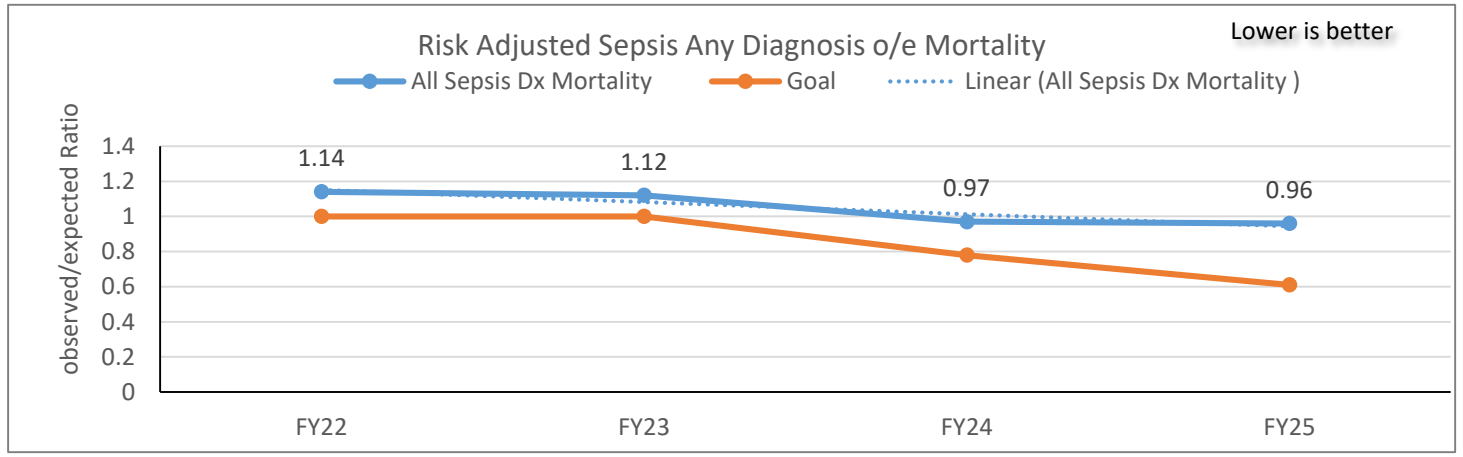
Sepsis CMS SEP-1 & Sepsis Mortality

August 2025

OHO FY25 Plan: CMS SEP 1 and Mortality (observed/expected)

Historical Baseline





FY25 PLAN – CMS SEP-1

High Level Action Plan

- Provide Early Goal Directed Therapy (Sepsis work up and Treatment)

  % of Patients provided top 3 most frequently missed Sepsis bundle elements

  Goal FY 25 95%

  - IV Fluid Resuscitation
  - Antibiotic Administered
  - Blood Cultures Drawn
- Provide Early Goal Directed Therapy (Sepsis Treatment)

  Goal FY 25 = 30%

  - Pts with Sepsis that Received Abx within 60 Minutes of Pt 1st Seen
  - Pts Met 1- Hr Bundle

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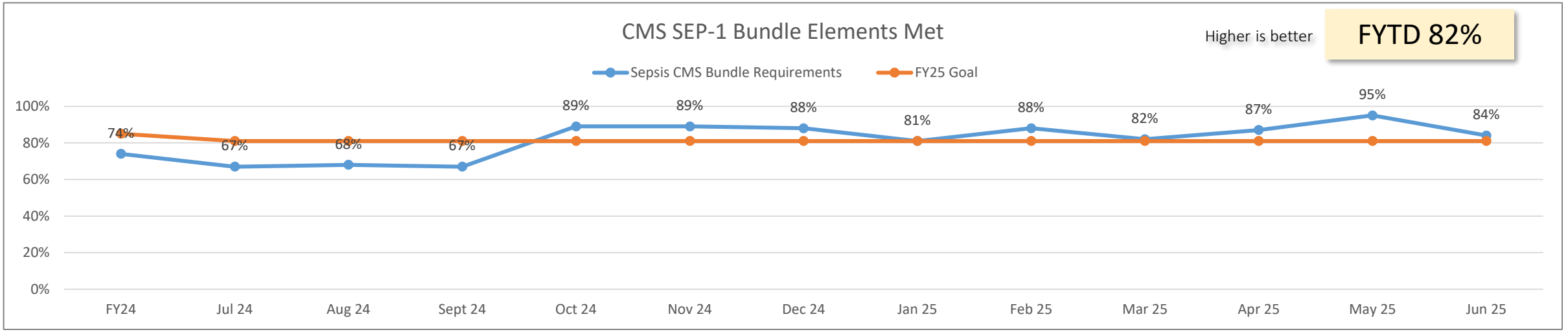
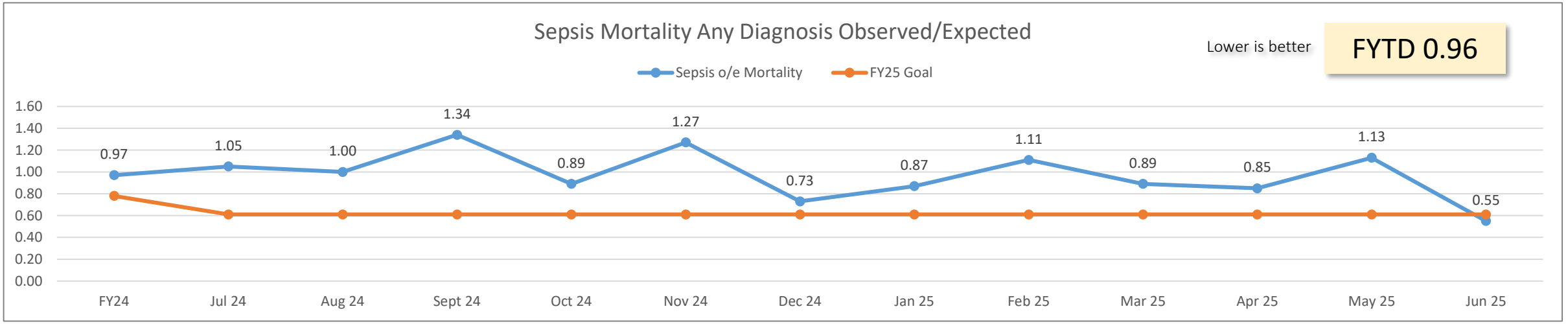
OHO FY25 Monthly Update: CMS SEP-1 & Mortality





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OHO FY25 Monthly Update: CMS SEP-1 & Mortality

The last data point did not meet goal because (Goal has been met for FY 2025 publicly reportable SEP 1):

- Diagnosis of infections are not being treated with Sepsis interventions or are not being refuted when Sepsis is no longer entertained
- Sepsis bundle ordered but not as intended (i.e. fluids ordered outside of the bundle which does not contain the required CMS verbiage for lesser fluid documentation)
- One (1) fall out only for May; Abx, Lactic acid, BC not ordered within 3 hours of Sepsis Time Zero
- One (1) abx order delayed subsequently causing it to be administered 6minutes after 3 hour window & BC drawn after abx administered (counts as 1 fall out), One (1) BC documented to be drawn 3 minutes after antibiotic administered (count as 1 fall out), One (1) abx ordered as a schedule medication, not ordered/administered timely
- Deep Dive into Sepsis mortality revealed opportunity in fluid resuscitation & linking organism to specify Sepsis documentation (workgroup ongoing)

Targeted Opportunities

- Provide Early Goal Directed Therapy (Sepsis work up and Treatment)

  FY25

  - % of Patients provided top 3 most frequently missed Sepsis bundle elements at KH (Higher performance = Better care)
  - IV Fluid Resuscitation 95%
  - Antibiotic Administered 93%
  - Blood Cultures collection 95%

  Goal = 95%

- Provide Early Goal Directed Therapy (Sepsis Treatment)

  FY25

  - Pts with Sepsis that Received Abx within 60 Minutes of Pt 1st Seen by ED Provider 30%
  - Pts Met 1- Hr Bundle 27.4%

  Goal = 30%

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OHO FY25 Monthly Update: CMS SEP-1 & Mortality

CURRENT IMPROVEMENT ACTIVITIES	EXPECTED COMPLETION DATE	BARRIERS
1. GME Resident engagement and ongoing education throughout the year, not just during yearly orientation ○ Ongoing Strong collaboration with Chief ED Residents (FY26) (Currently transitioning to new ED chiefs) ✓ Ongoing education during weekly didactic ○ 2 Resident project focus on Sepsis power plan utilization awareness & ED Provider pop-up to declare or refute sepsis prior to inpatient transfer ○ *Engaged with Surgery (ACTS), Family Medicine (FM) team for ongoing Sepsis education* ○ Incrementally engage Transitional Year & Psych Residents ○ Educational letters sent to providers (Resident & Attending) involved in opportunity case from Sepsis committee	Surgery 7/15/25 FM 6/4/25 GME yearly orientation 6/25	
2. Code Sepsis in ED (workgroup in progress) Ongoing support from Executive and ED leadership to support this enhancement	Ongoing discussions	

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OHO FY25 Monthly Update: CMS SEP-1 & Mortality

CURRENT IMPROVEMENT ACTIVITIES	EXPECTED COMPLETION DATE	BARRIERS
3. Mortality summary reviews presented to Sepsis committee workgroup for Sepsis 1-hour bundle success review, analysis & improvement strategies (Intensivist, Hospitalist group engaged) o Deep dive ongoing with multidisciplinary collaboration and engagement	Ongoing	
4. Improve Severe Sepsis Alert Specificity (EMR optimization) o Collaborate with ISS team and Cerner EMR resources to optimize Sepsis alert o Decrease lookback window (for labs and vital signs) from Cerner 36 hours to 8 hrs. for more meaningful alerts o Explore use of AI tool (s) for Sepsis alert	TBD	Limitations within Cerner cloud Concerns with disrupting existing algorithm Cerner has not yet released Sepsis AI tool, no ETA
5. Sepsis documentation improvement project o Reviewing Sepsis cases for appropriateness of Physician documentation & coding to ensure clinical picture is reflected on the medical record (including Physician linking organism & procedures performed to Sepsis population for a more descriptive clinical picture of the patient) o CDI/Coding team optimizing coding opportunities to ensure pt acuity is reflected in ICD 10 codes	Ongoing	

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OHO FY25 Monthly Update: CMS SEP-1 & Mortality

CURRENT IMPROVEMENT ACTIVITIES	EXPECTED COMPLETION DATE	BARRIERS
6. RN Sepsis Coordinator position posted ○ New Interim RN Sepsis Coordinator live 7/14/25 ○ Transitioning back of previous Sepsis coordinator 8/4/25	Ongoing	
7. Dr. Tu Educational Sepsis event to existing and incoming providers	7/15	
8. 1:1 ED Staff coaching for individual ED Sepsis fall outs	Ongoing	
9. Continue to focus on increase of order set usage	Ongoing	
10. ED leadership team shift huddle education to ED staff	Ongoing	
11. Sepsis team Sepsis refresher to ED staff during staff meetings	Ongoing	
12. Partnership with HIM/ISS/Medical Staff leaders to further enhance EMR tools to streamline Sepsis documentation ○ Goal to automate or ease of use for provider sepsis documentation	TBD	
13. Sepsis awareness months educational activities planned for 2025	9/2025	
14. CMS Sepsis chart validation/audit preparation	2025/2026	

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