

August 13, 2020

NOTICE

The Board of Directors of the Kaweah Delta Health Care District will meet in a Quality Council Committee meeting at 7:00AM on Thursday, August 20, 2020, in the Kaweah Delta Lifestyle Center, Conference Room A, 5105 W. Cypress Avenue, or via GoTo Meeting from your computer, tablet or smartphone. <https://global.gotomeeting.com/join/677631437> or call (312) 757-3121 - Access Code: 677-631-437.

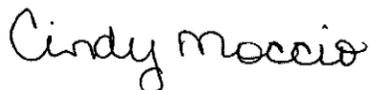
The Board of Directors of the Kaweah Delta Health Care District will meet in a Closed Quality Council Committee at 7:01Am on Thursday, August 20, 2020, in the Kaweah Delta Lifestyle Center, Conference Room A, 5105 W. Cypress Avenue, pursuant to Health and Safety code 32155 & 1461. Board members and Quality Council closed session participants will access closed meeting via Confidential GoTo Meeting phone number provided to them.

The Board of Directors of the Kaweah Delta Health Care District will meet in an open Quality Council Committee meeting immediately following the 7:01AM Closed meeting on Thursday August 13, 2020, in the Kaweah Delta Lifestyle Center, Conference Room A, 5105 Cypress Avenue, or via GoTo Meeting via computer, tablet or smartphone. <https://global.gotomeeting.com/join/677631437> or call (312) 757-3121 - Access Code: 677-631-437.

All Kaweah Delta Health Care District regular board meeting and committee meeting notices and agendas are posted 72 hours prior to meetings in the Kaweah Delta Medical Center, Mineral King Wing entry corridor between the Mineral King lobby and the Emergency Department waiting room.

Due to COVID 19 visitor restrictions to the Medical Center - the disclosable public records related to agendas can be obtained by contacting the Board Clerk at Kaweah Delta Medical Center – Acequia Wing, Executive Offices (Administration Department) {1st floor}, 400 West Mineral King Avenue, Visalia, CA via email: cmoccio@kdhcd.org, via phone: 559-624-2330 or on the Kaweah Delta Health Care District web page <http://www.kawahdelta.org>.

KAWEAH DELTA HEALTH CARE DISTRICT
David Francis, Secretary/Treasurer



Cindy Moccio
Board Clerk, Executive Assistant to CEO

DISTRIBUTION:
Governing Board, Legal Counsel, Executive Team, Chief of Staff
<http://www.kawahdelta.org>

**KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS
QUALITY COUNCIL**

Thursday, August 20th, 2020

5105 W. Cypress Avenue
The Lifestyle Center; Conference Room A

GoTo Meeting from your computer, tablet or smartphone. <https://global.gotomeeting.com/join/677631437>

Call in option: 1-312-757-3121 Access Code: 677-631-437

ATTENDING: Board Members; Herb Hawkins – Committee Chair, David Francis; Gary Herbst, CEO; Keri Noeske, RN, BSW, DNP, Interim CNO; Anu Banerjee, PhD, VP & Chief Quality Officer, Byron Mendenhall, MD, Chief of Staff; Monica Manga, MD, Professional Staff Quality Committee Chair; Daniel Hightower, MD, Secretary/Treasurer; Harry Lively, MD, Past Chief of Staff; Lori Winston, MD, DIO & VP of Medical Education; Tom Gray, MD, Quality and Patient Safety Medical Director; Sandy Volchko, Director of Quality and Patient Safety; Ben Cripps, Chief Compliance Officer, and Michelle Adams, Recording.

OPEN MEETING – 7:00AM

- 1. Call to order** – *Herb Hawkins, 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. Approval of Quality Council Closed Meeting Agenda – 7:01AM**
 - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Monica Manga, MD, and Professional Staff Quality Committee Chair;*
 - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Anu Banerjee, PhD, VP & Chief Quality Officer*
- 4. Adjourn Open Meeting** – *Herb Hawkins, Committee Chair*

CLOSED MEETING – 7:01AM

- 1. Call to order** – *Herb Hawkins, Committee Chair & Board Member*
- 2. [Quality Assurance pursuant to Health and Safety Code 32155 and 1461](#)** – *Monica Manga, MD, and Professional Staff Quality Committee Chair*

3. [Quality Assurance pursuant to Health and Safety Code 32155 and 1461](#) — *Anu Banerjee, PhD, VP & Chief Quality Officer*
4. **Adjourn Closed Meeting** – *Herb Hawkins, Committee Chair*

OPEN MEETING – Immediately following the 7:01AM Closed Meeting

1. **Call to order** – *Herb Hawkins, Committee Chair*
2. **Public / Medical Staff participation** – Members of the public wishing to address the Committee concerning items not on the agenda and within the subject matter jurisdiction of the Committee may step forward and are requested to identify themselves at this time. Members of the public or the medical staff may comment on agenda items after the item has been discussed by the Committee but before a Committee recommendation is decided. In either case, each speaker will be allowed five minutes.
3. **Written Quality Reports** – A review of key quality metrics and actions associated with the following improvement initiatives:
 - 3.1. [Cardiac Surgery Quality Report](#)
 - 3.2. [Cardiology Service Line Quality Report](#)
4. [Central Line Associated Blood Stream Infection \(CLABSI\) Quality Focus Team Report](#) – An evaluation of current outcome and process measures and action plans associated with reducing CLABSI. *Amy Baker, MSN, RN, Director of Renal Services.*
5. [Biovigil Electronic Hand Hygiene Monitoring Update](#) – A review of the results of the Biovigil pilot study on 4N and ICU and plans for broad spread implementation. *Jon Knudsen, FNP, Director of Critical Care Services.*
6. [Safety Culture Update](#) – A review of safety culture survey scores, and updates on quality improvement initiatives. *Sandy Volchko, RN, DNP, Director of Quality and Patient Safety.*
7. [Update: Fiscal Year \(FY\) 2020 Clinical Quality Goals](#) - A review of current performance and actions focused on the FY 2020 clinical quality goals. *Sandy Volchko, RN, DNP, Director of Quality and Patient Safety*
8. **Adjourn Closed Meeting** – *Herb Hawkins, Committee Chair*

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

Cardiac Surgery Data

2019 Q1-Q3



DATA ANALYSES BY THE SOCIETY OF THORACIC SURGEONS
NATIONAL ADULT CARDIAC SURGERY DATABASE

***Comparison STS reporting period 01/01/2019 through 9/30/2019**

Star Ratings 2018

Isolated CABG - (3 stars possible)



STS CABG Composite Quality Rating

Duke Clinical Research Institute

Participant 30045
STS Period Ending 12/31/2018

Quality Domain	Participant Score (98% CI)	STS Mean Participant Score	Participant Rating ¹	Distribution of Participant Scores ● = STS Mean
Jan 2018 - Dec 2018 Overall	96.6% (95.1, 97.8)	96.7%	★ ★	
Jan 2018 - Dec 2018 Absence of Mortality	97.8% (95.9, 99.0)	97.6%	★ ★	
Jan 2018 - Dec 2018 Absence of Morbidity ²	86.6% (81.6, 90.7)	88.8%	★ ★	
Jan 2018 - Dec 2018 Use of IMA ²	98.7% (96.4, 99.8)	99.0%	★ ★	
Jan 2018 - Dec 2018 Medications ²	97.7% (94.6, 99.4)	92.5%	★ ★ ★	

¹* = Participant performance is significantly lower than the STS mean based on 99% Bayesian probability
¹** = Participant performance is not significantly different than the STS mean based on 99% Bayesian probability
¹*** = Participant performance is significantly higher than the STS mean based on 99% Bayesian probability
²Please refer to Report Overview - STS Composite Quality Rating and NQF-Endorsed Measures for full details



AVR

STS AVR Composite Quality Rating



Participant 30045
STS Period Ending 12/31/2018

Quality Domain	Participant Score (95% CI)	STS Mean Participant Score	Participant Rating ¹	Distribution of Participant Scores ● = STS Mean
Jan 2016 - Dec 2018 Overall	96.7% (95.0, 98.0)	95.5%	★★	
Jan 2016 - Dec 2018 Absence of Mortality	98.3% (96.6, 99.3)	97.8%	★★	
Jan 2016 - Dec 2018 Absence of Morbidity ²	91.4% (87.5, 94.5)	89.6%	★★	



AVR+CAB

STS AVR + CABG Composite Quality Rating



Participant 30045
STS Period Ending 12/31/2018

Quality Domain	Participant Score (95% CI)	STS Mean Participant Score	Participant Rating ¹	Distribution of Participant Scores ● = STS Mean
Jan 2016 - Dec 2018 Overall	90.3% (86.3, 93.5)	92.3%	★★	
Jan 2016 - Dec 2018 Absence of Mortality	95.4% (91.9, 97.8)	96.2%	★★	
Jan 2016 - Dec 2018 Absence of Morbidity ²	79.7% (71.7, 86.3)	82.8%	★★	

Healthgrades

Specialty Clinical Quality Awards & Ratings



America's 50 Best Hospitals for Cardiac Surgery Award™ (2019, 2018)

Superior clinical outcomes in heart bypass surgery and heart valve surgery



America's 100 Best Hospitals for Cardiac Care Award™ (2019, 2018)

Superior clinical outcomes in heart bypass surgery, coronary interventional procedures, heart attack treatment, heart failure treatment, and heart valve surgery



Cardiac Surgery Excellence Award™ (2017)

Superior clinical outcomes in heart bypass surgery and heart valve surgery

Mortality Based Ratings

Procedure/Condition

Mortality In-Hospital

Mortality within 30 days

Coronary Artery Bypass Graft
(CABG) Surgery

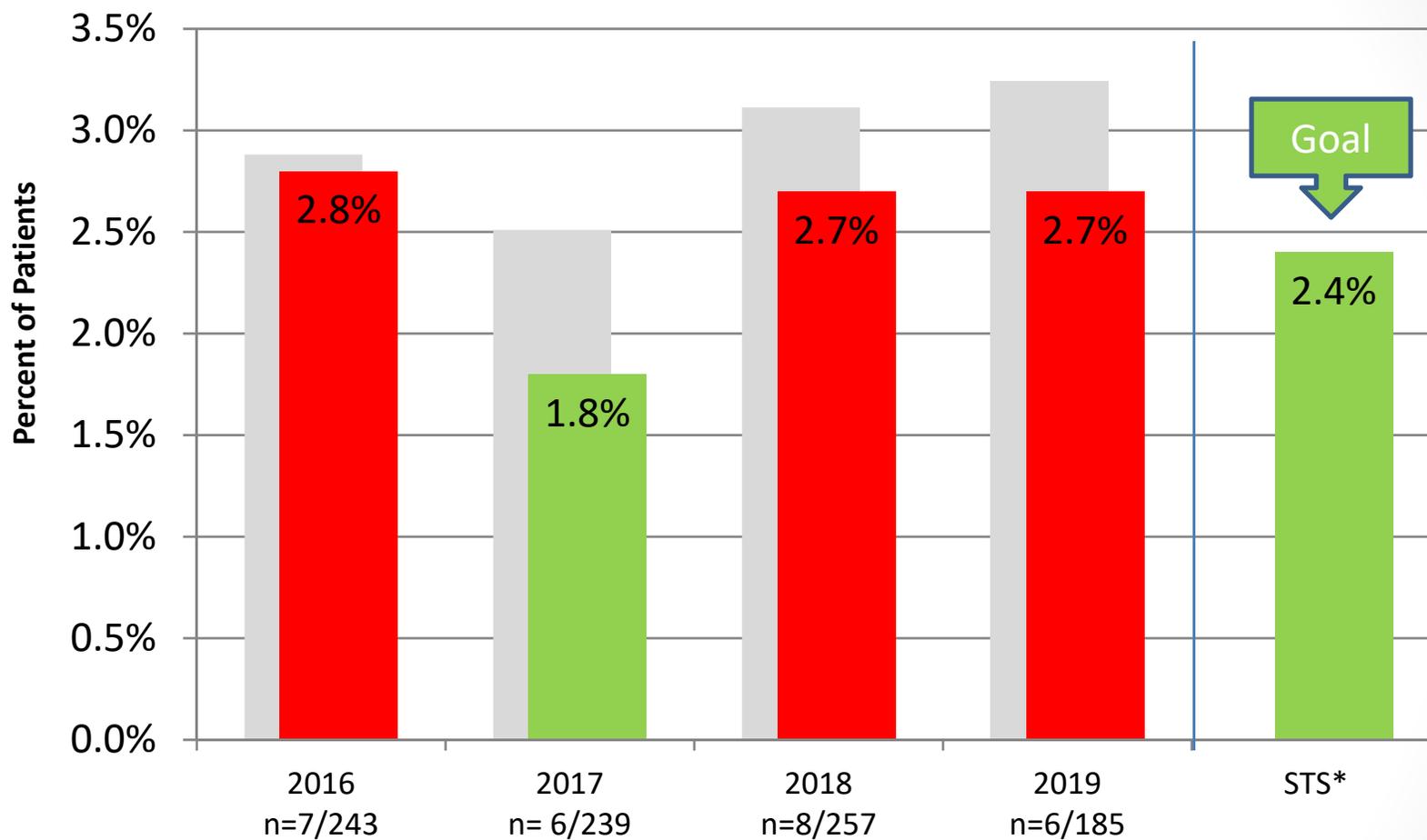


Better than Expected



Better than Expected

All Operative Mortality¹ Risk Adjusted in Color



Kaweah Delta Medical Center

2019 Risk-Adjusted O/E = 1.1

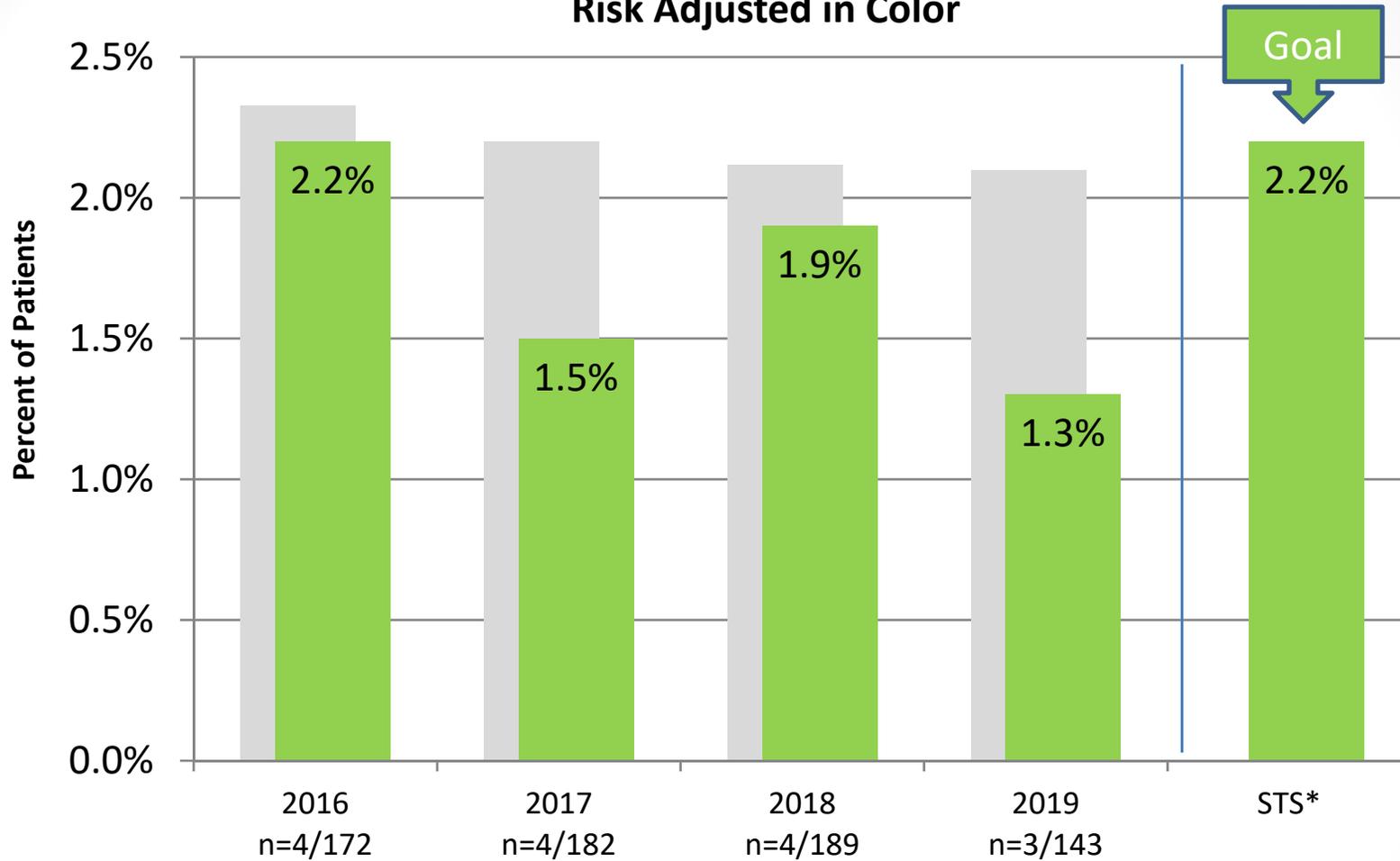
***Comparison reporting period 1/1/2019 through 9/30/2019**

1- Includes all 7 Major Procedure Categories (CABG, AVR, AVR+CABG, MVR, MVR+CABG, MVP, MVP+CABG)

Excludes Other category procedures

CABG Operative Mortality

Risk Adjusted in Color

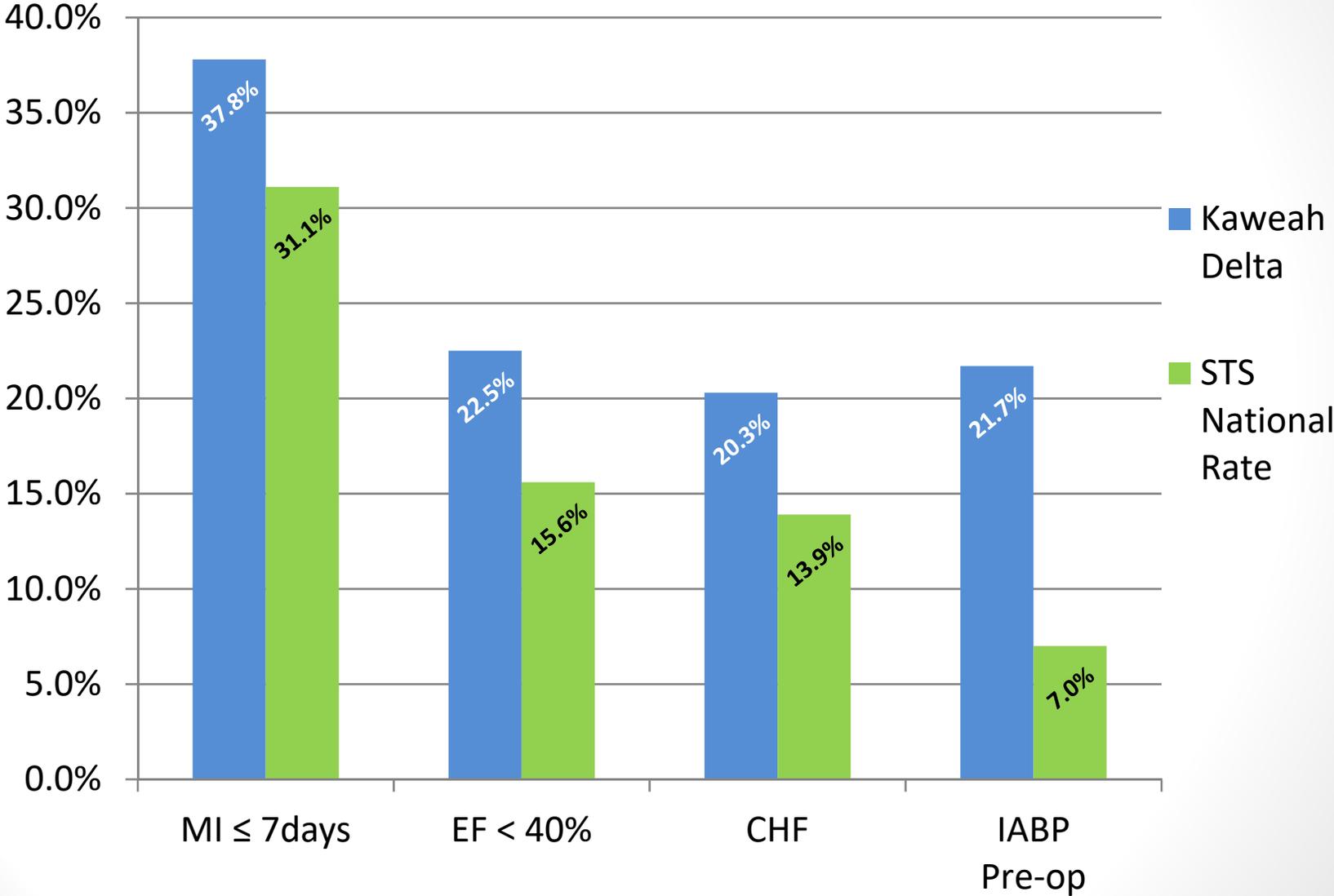


Kaweah Delta Medical Center

2019 Risk-Adjusted O/E = 0.7

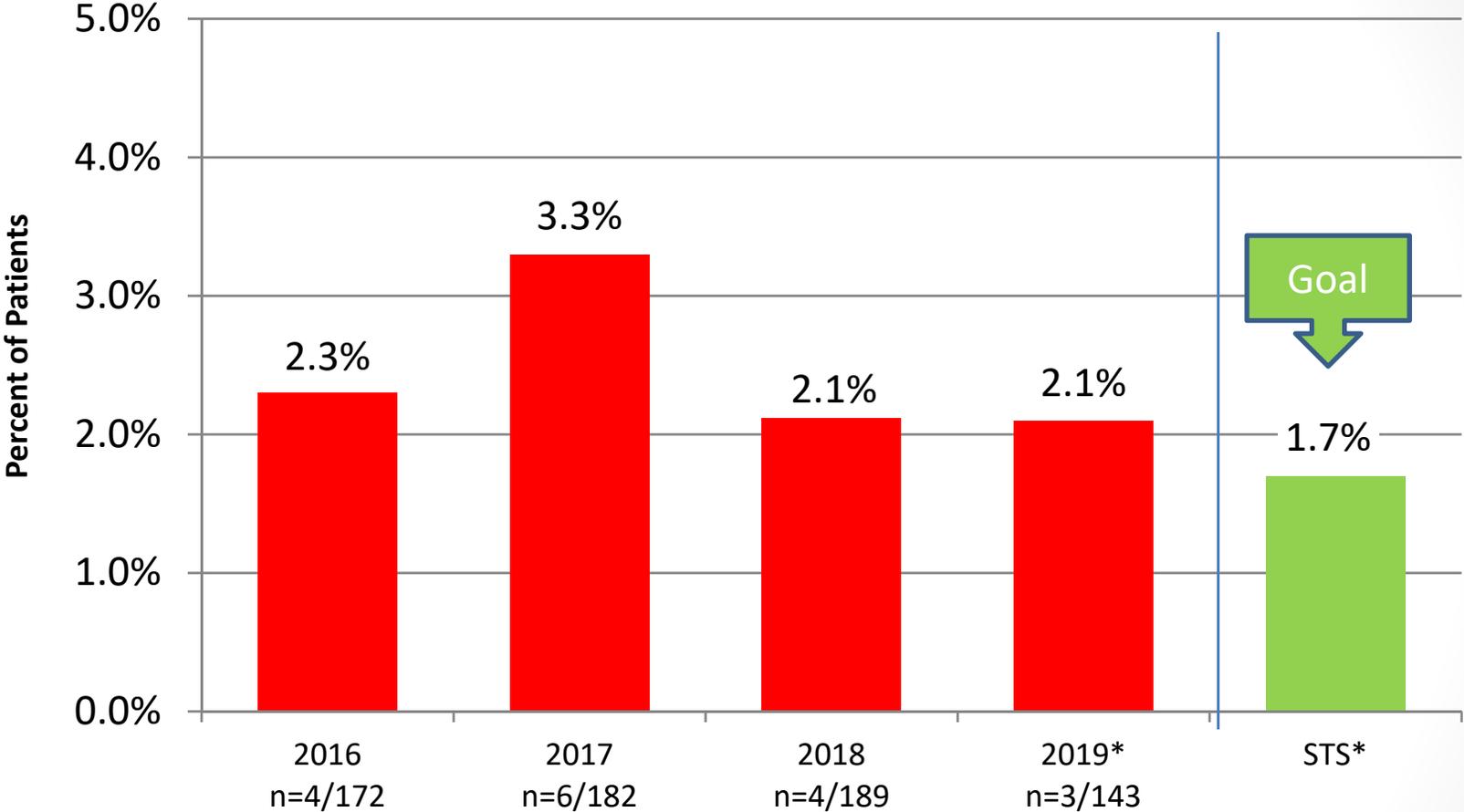
*Comparison reporting period 1/1/2019 through 9/30/2019

Kaweah Delta Pt. Populations



*Comparison reporting period 1/1/2019 through 9/30/2019 – Isolated CABG cases ONLY

CABG Re-Op Bleed or Tamponade



Kaweah Delta Medical Center

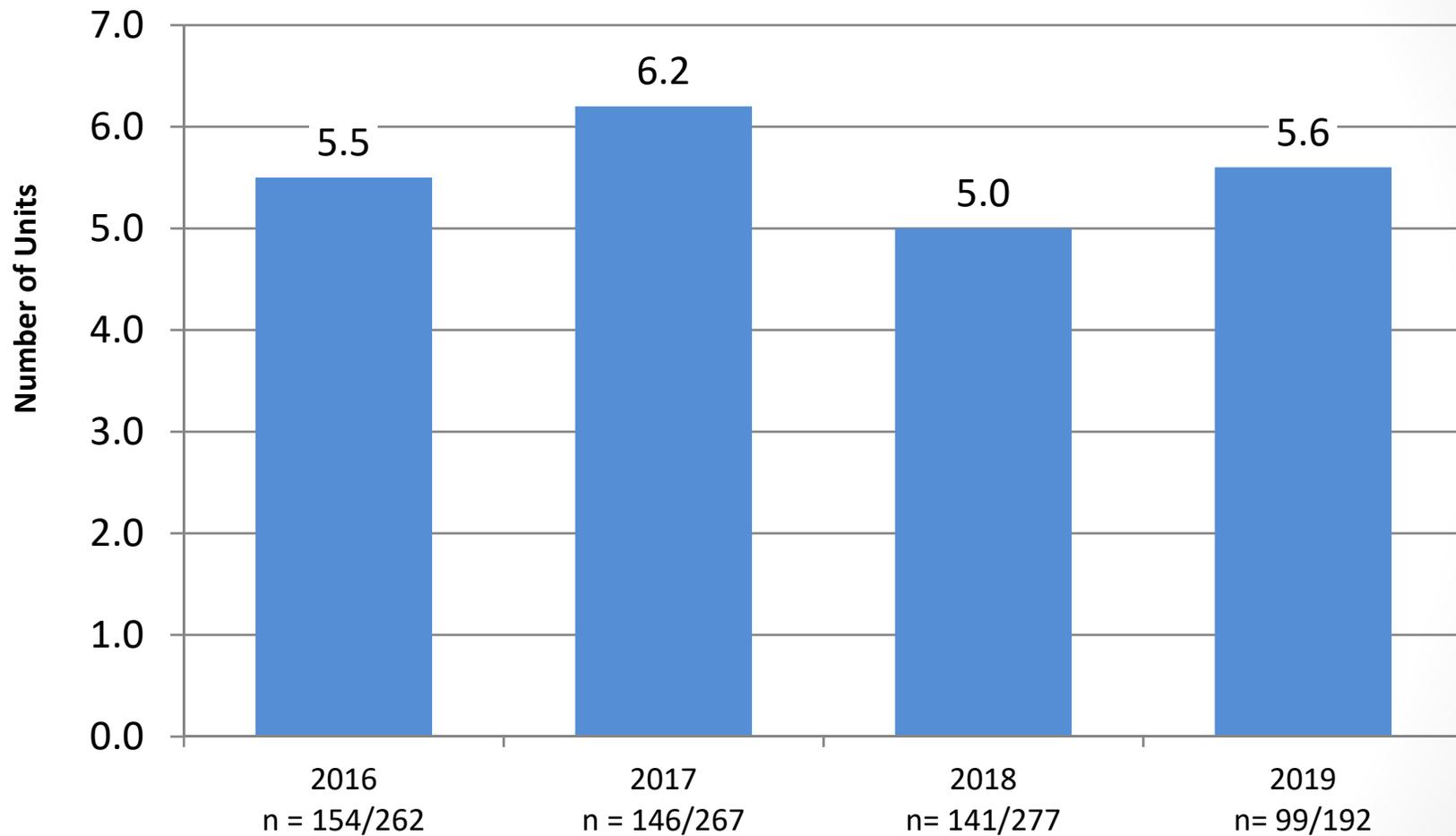
2019 O/E = 1.2

*Comparison reporting period 1/1/2019 through 9/30/2019

Quality Initiative: Intra-operative Patient Safety

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

Blood Usage - Average Units / Pt. receiving products¹ (No National Comparison Data)

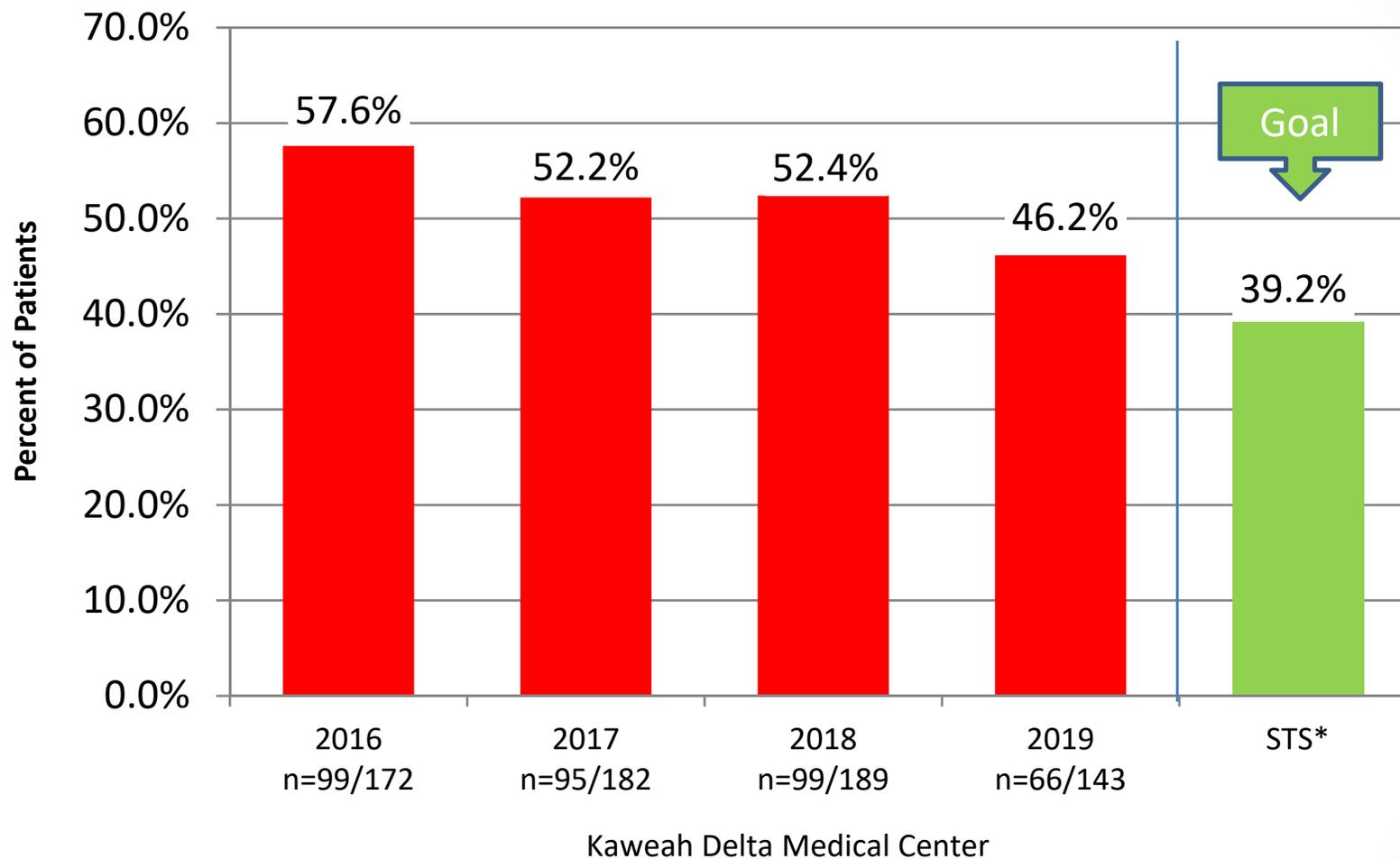


Kaweah Delta Medical Center

¹ All STS surgeries – Includes any blood products given Intra-op and Post-op (Excludes patients that did not receive any blood products; excludes pre-op Hgb<8 and Emergent/Salvage)

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

CABG Intra & Post-Op Blood Product Usage¹



2019 O/E = 1.2

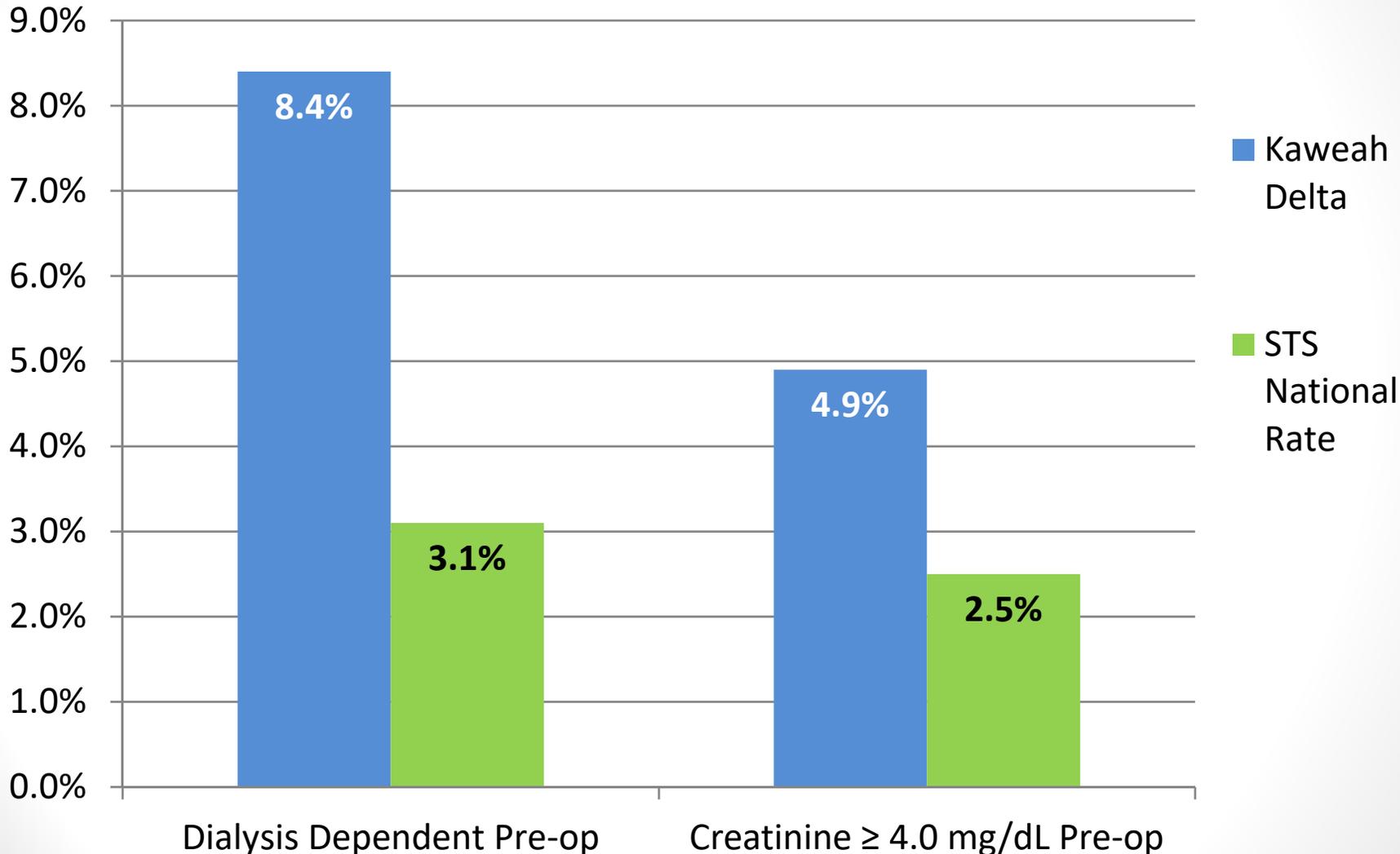
***Comparison reporting period 1/1/2019 through 9/30/2019**

¹Surgeries where at least one unit of blood product (RBC, Plasma, Platelet) was given Intra-and/or Post-operatively.

Quality Initiative: Bleeding, blood usage

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

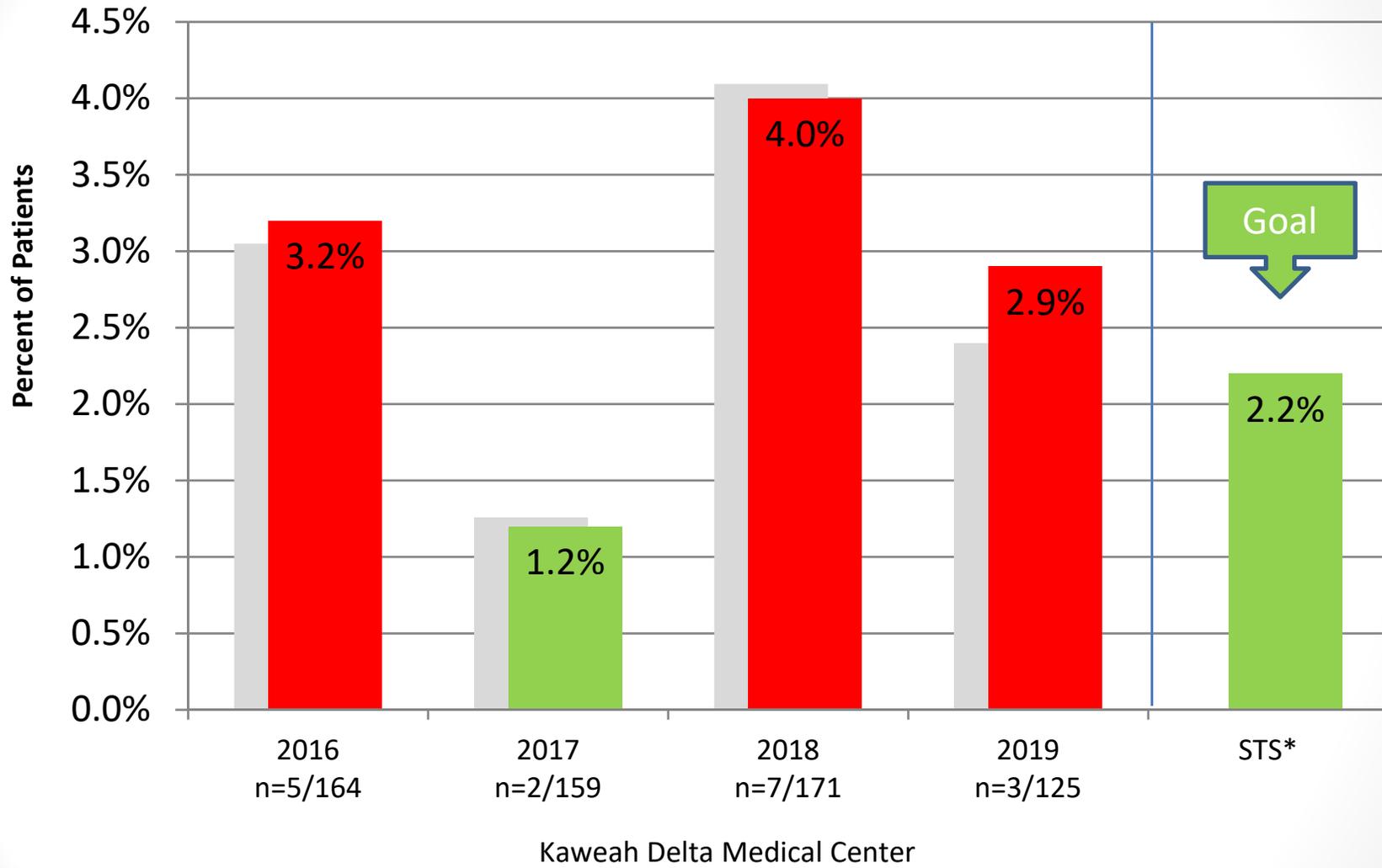
Kaweah Delta Pt. Populations



*Comparison reporting period 1/1/2019 through 9/30/2019 – Isolated CABG cases ONLY

CABG Post-Op Renal Failure¹

Risk Adjusted in Color



2019 Risk Adjusted O/E = 1.3

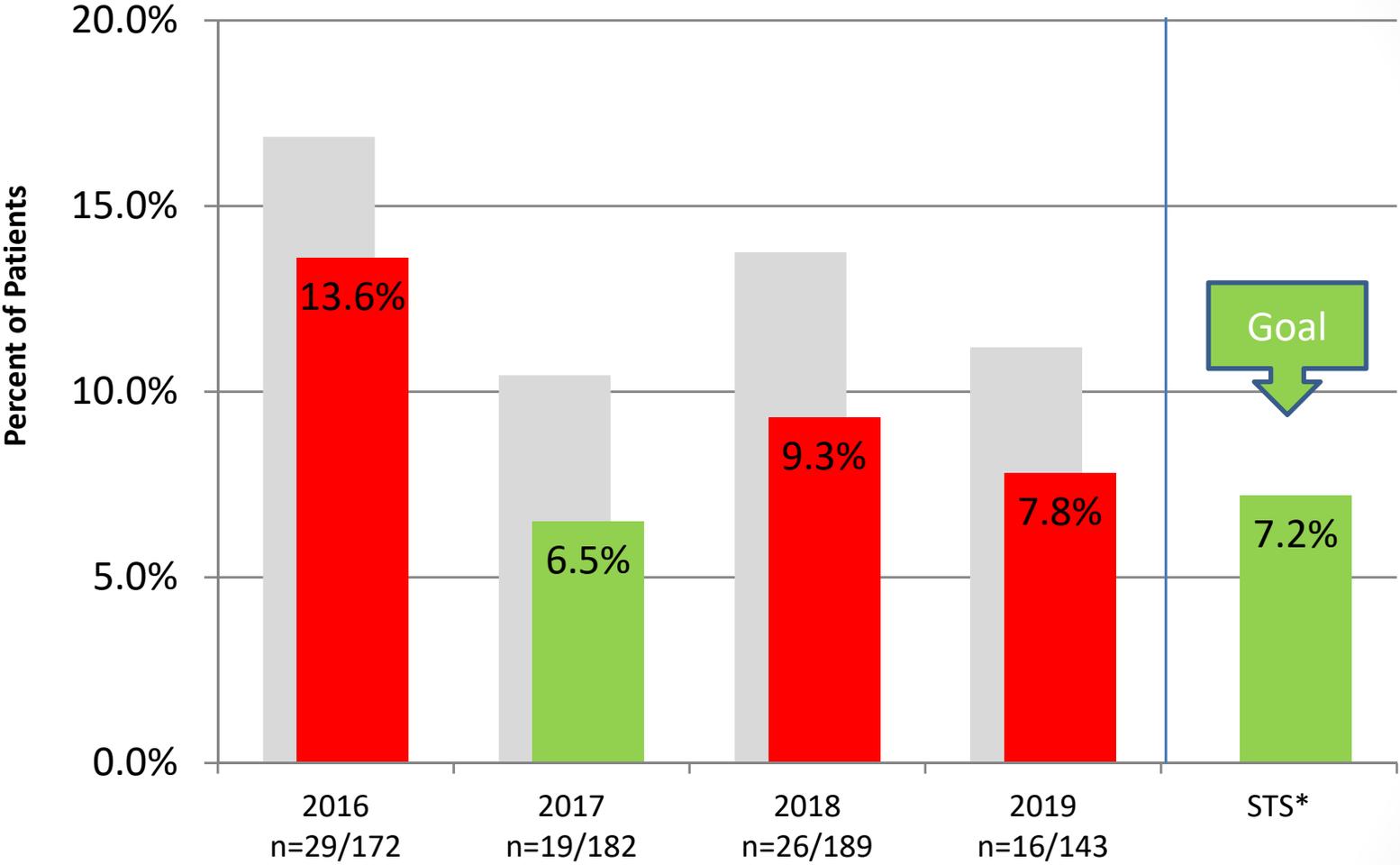
***Comparison reporting period 1/1/2019 through 9/30/2019**

1 – Excludes patients with preoperative dialysis or preoperative Creatinine ≥ 4

Quality Initiative: Renal failure prevention

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

CABG Prolonged Ventilation Risk Adjusted in Color



Kaweah Delta Medical Center

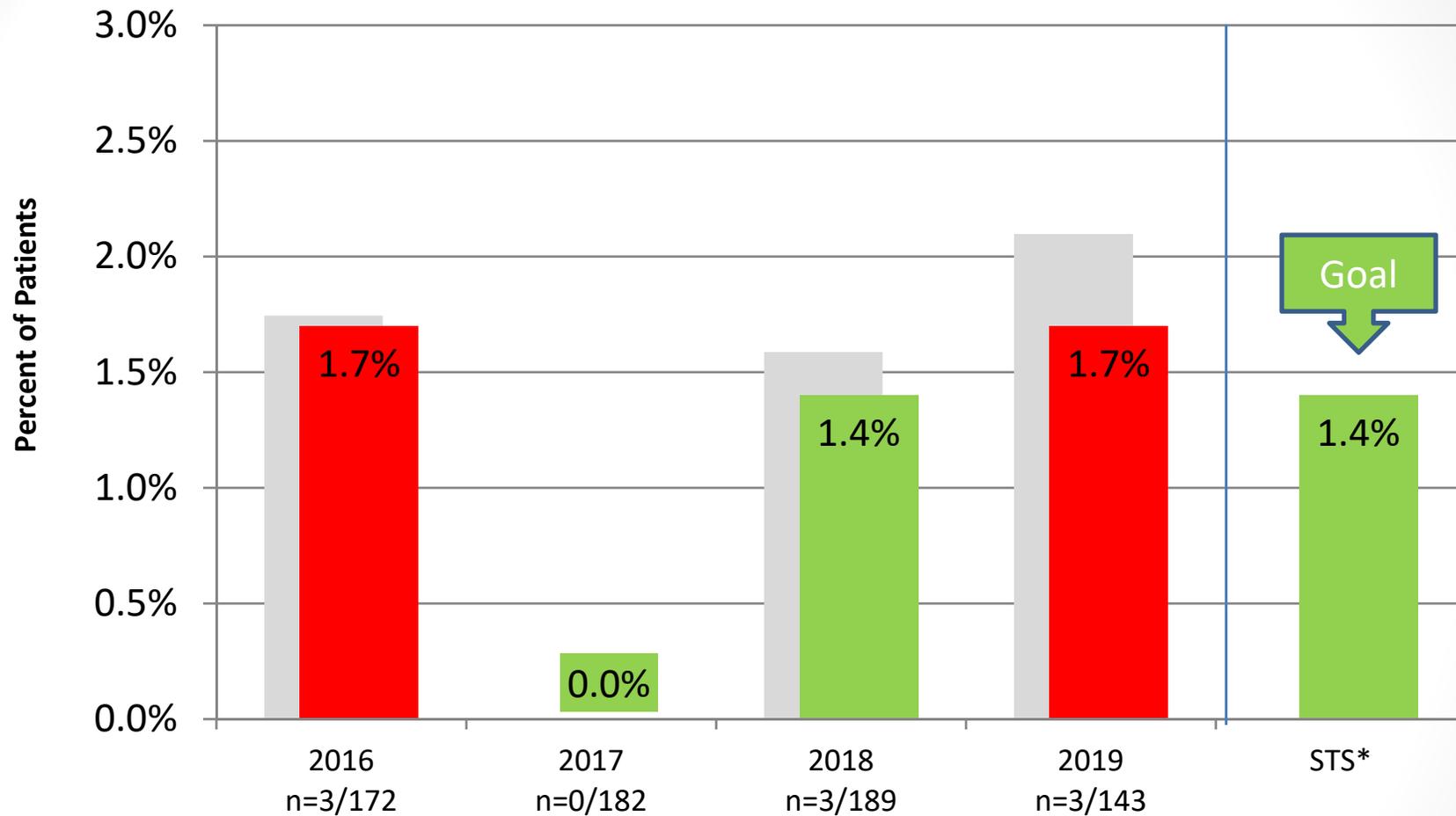
2019 Risk Adjusted O/E = 1.1

*Comparison reporting period 1/1/2019 through 9/30/2019

Quality Initiative: Prolonged Ventilation

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

CABG Post Op Permanent Stroke Risk Adjusted in Color



Kaweah Delta Medical Center

2019 Risk Adjusted O/E = 1.3

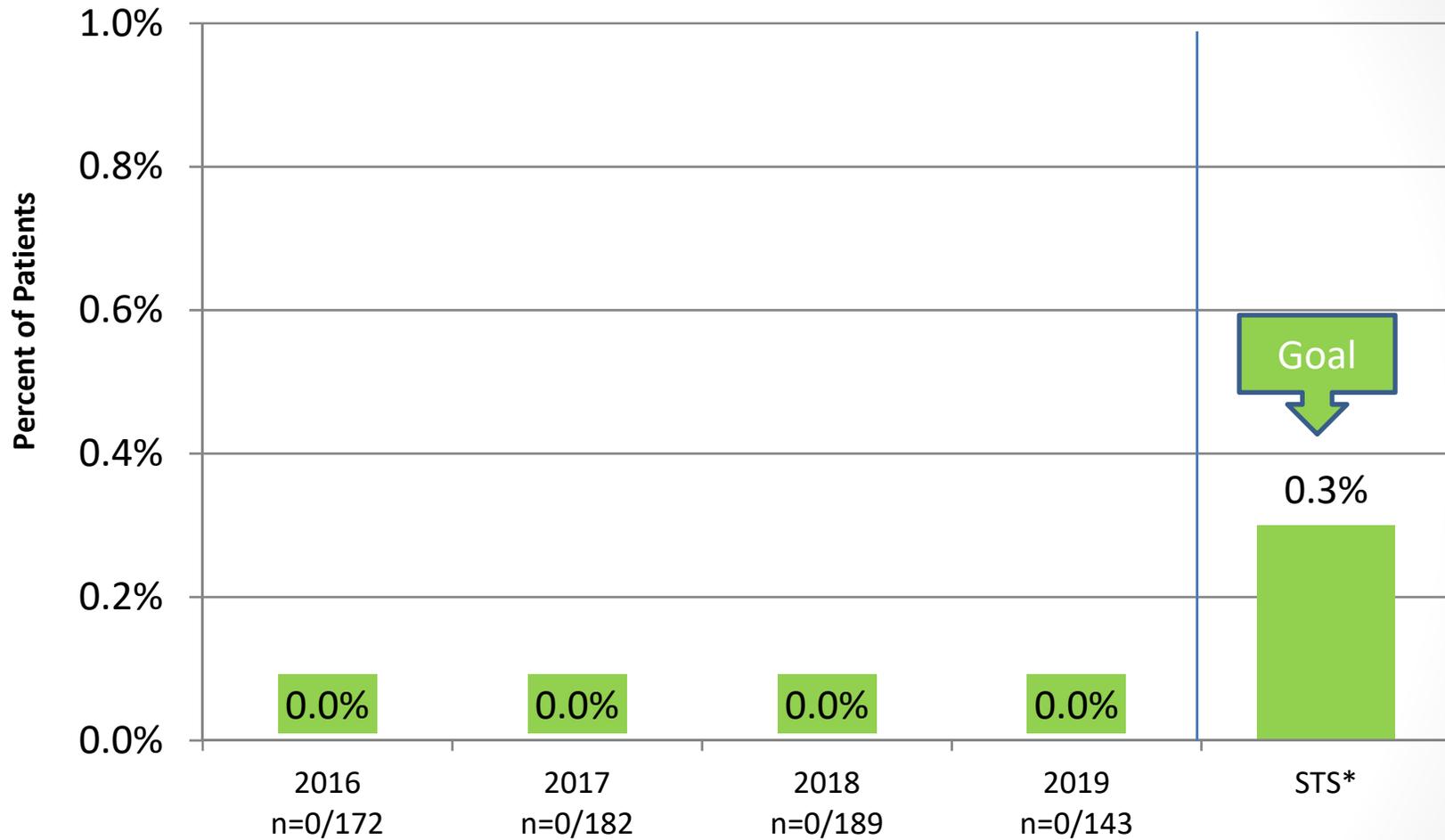
*Comparison reporting period 1/1/2019 through 9/30/2019

Quality Initiative: Stroke prevention

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

CABG Post Op Deep Sternal Wound Infection

Risk Adjusted in Color



Kaweah Delta Medical Center

2019 Risk Adjusted O/E = ~

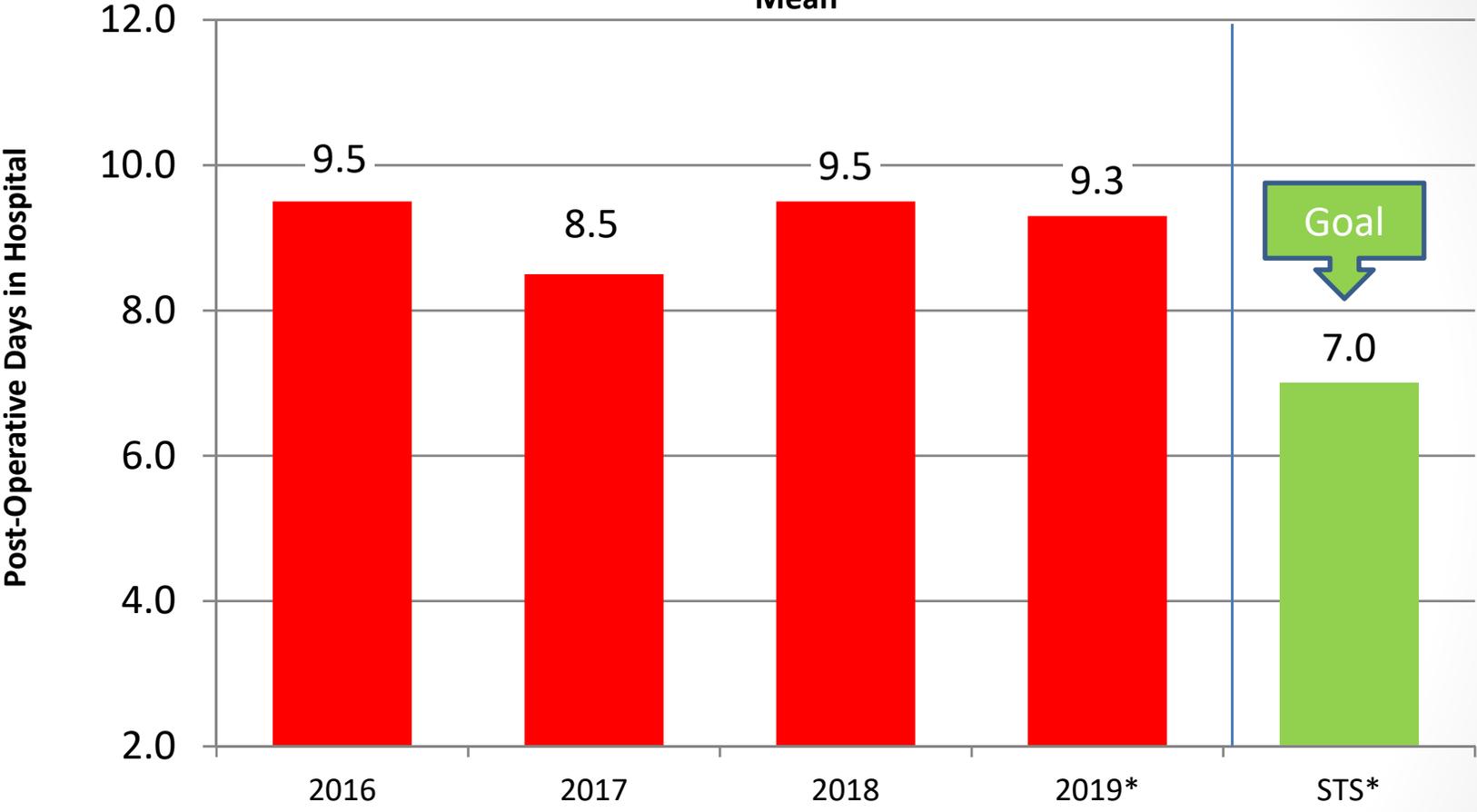
*Comparison reporting period 1/1/2019 through 9/30/2019

Quality Initiative: Infection Prevention

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

CABG Post Op Length of Stay

Mean

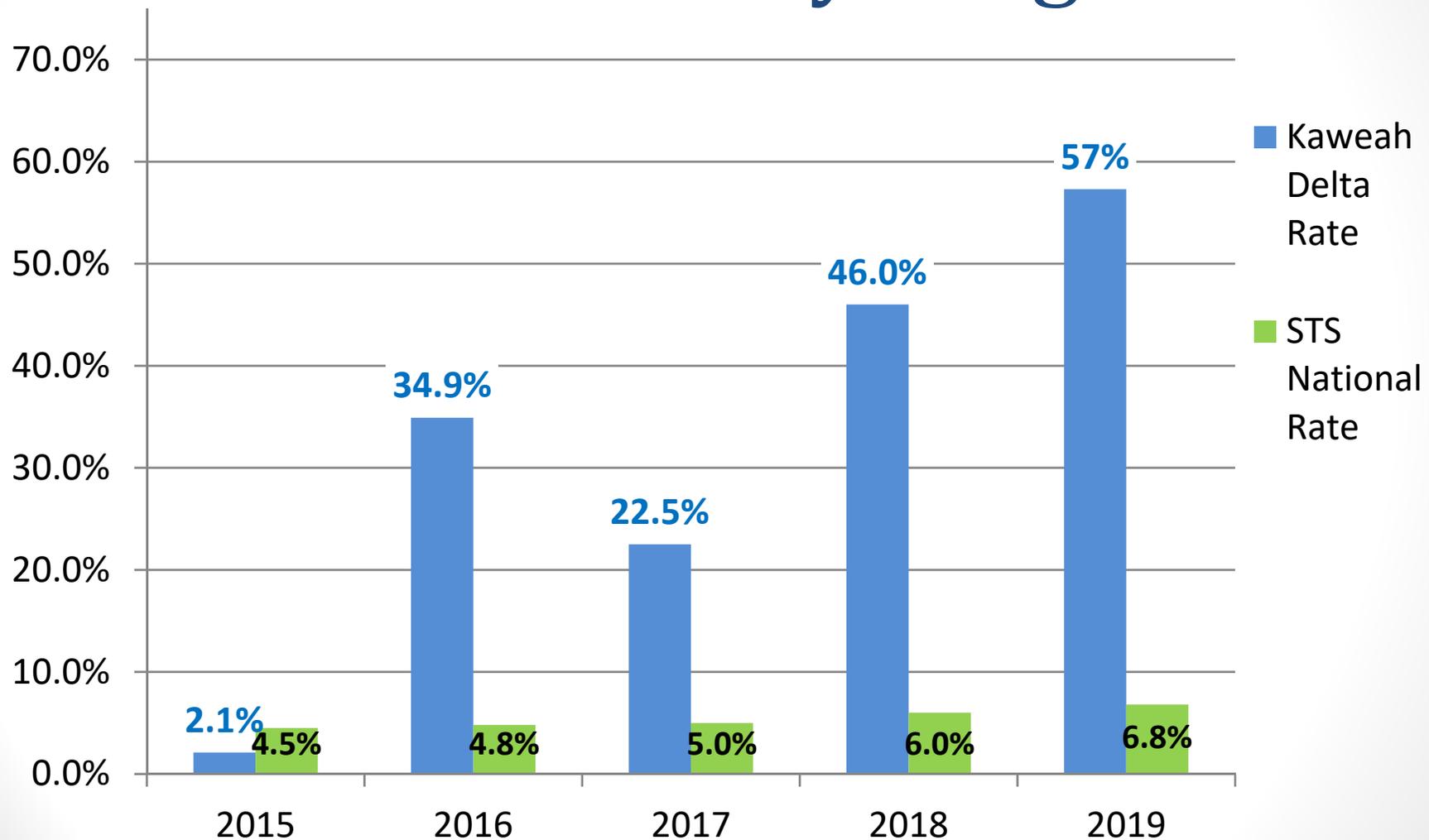


Kaweah Delta Medical Center

2019 O/E = 1.3

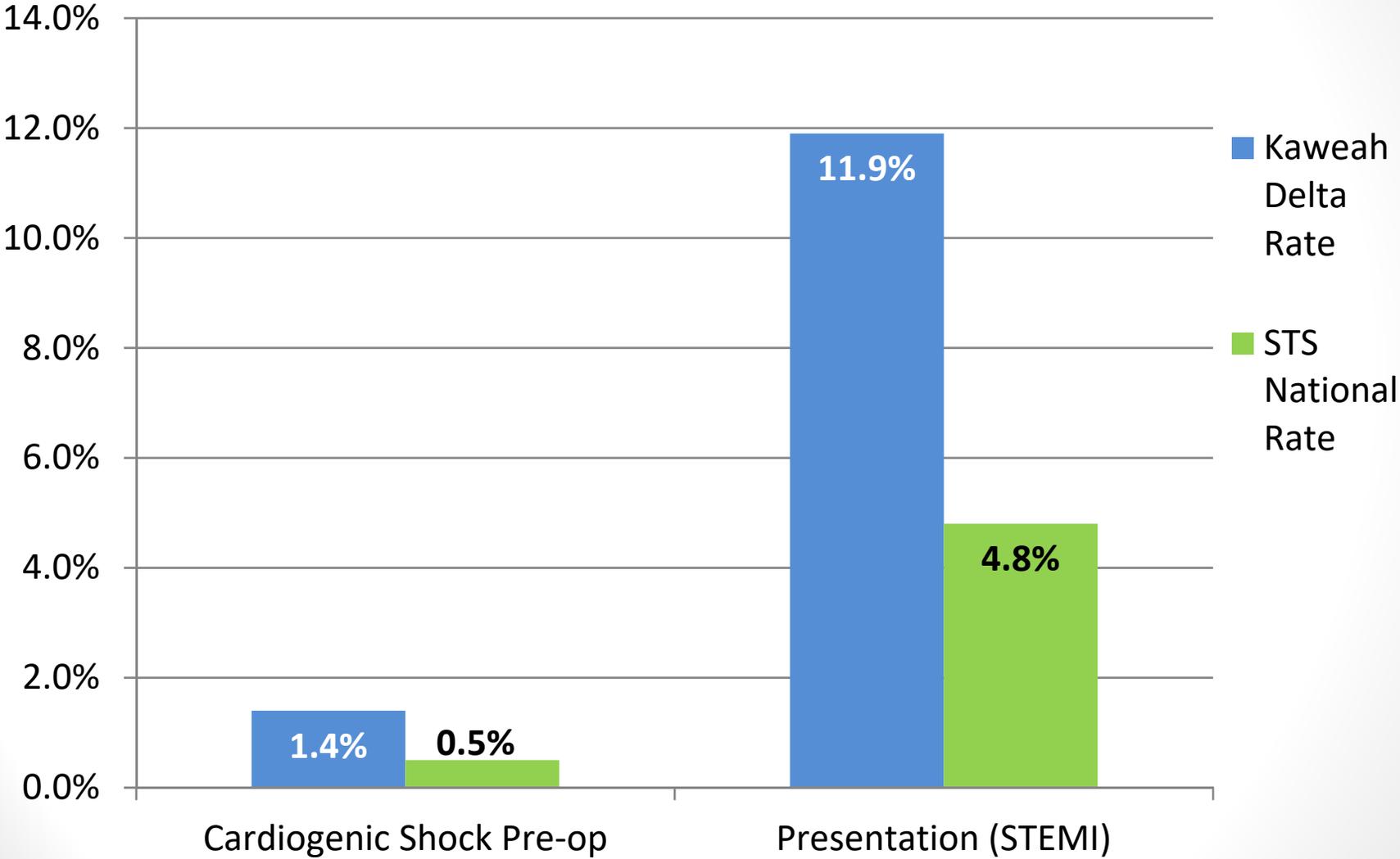
*Comparison reporting period 1/1/2019 through 9/30/2019

Kaweah Delta Radial Artery Usage



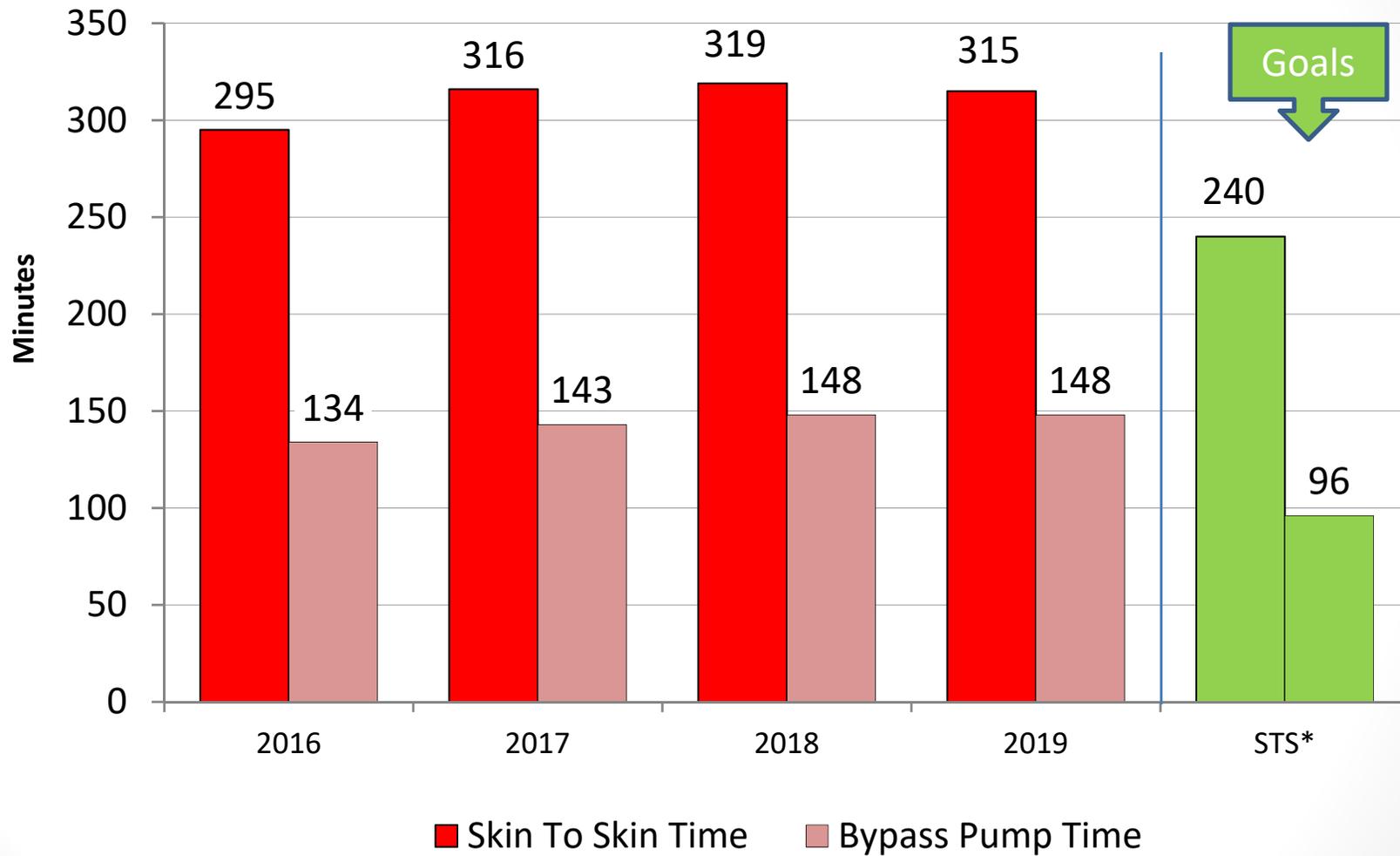
*Comparison reporting period 1/1/2019 through 9/30/2019 – Isolated CABG cases ONLY

Kaweah Delta Pt. Populations



*Comparison reporting period 1/1/2019 through 9/30/2019 – Isolated CABG cases ONLY

CABG Skin-to-Skin and Bypass Pump Durations ¹

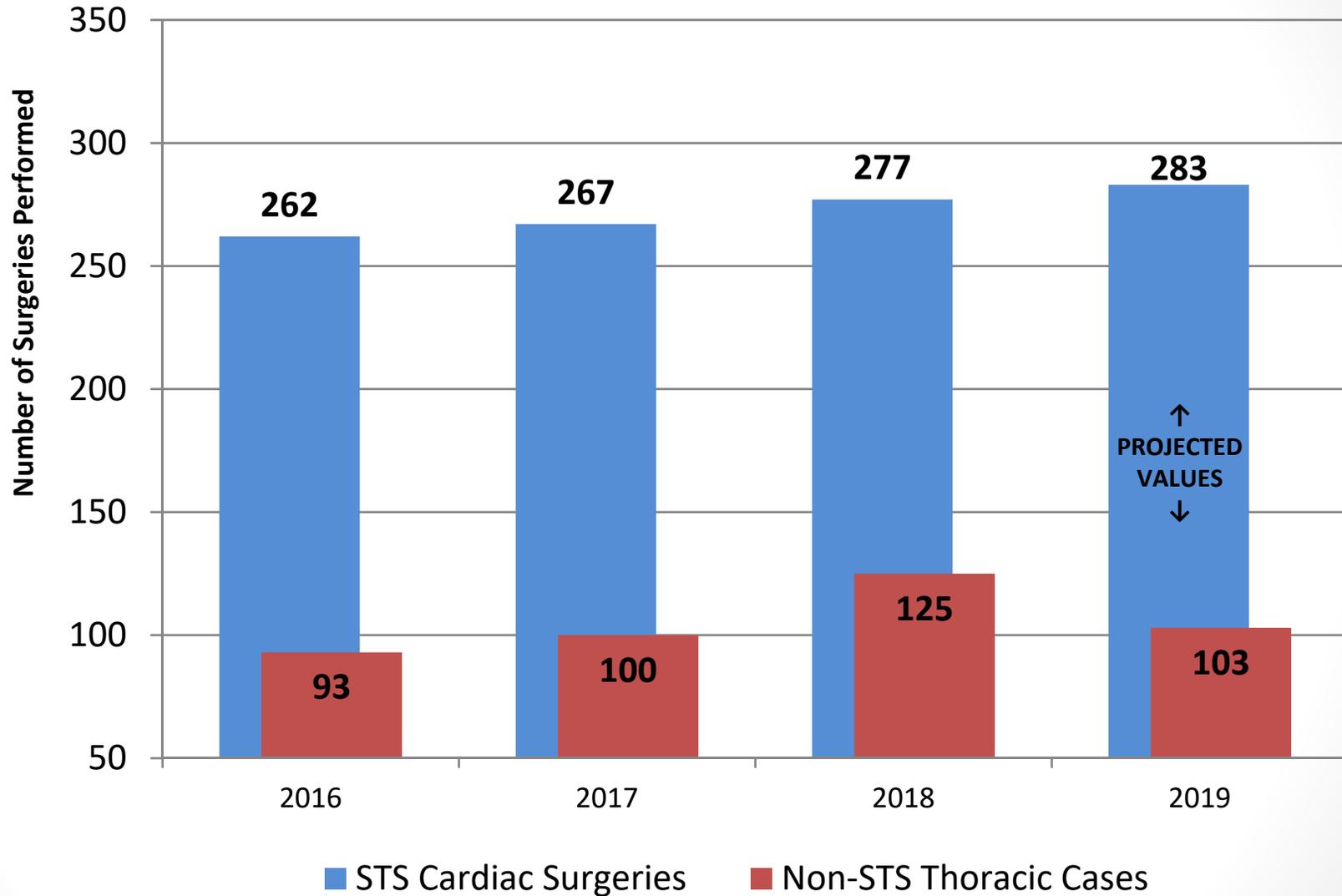


2019 O/E Skin Times = 1.3

2019 O/E Pump Times = 1.5

*Comparison reporting period 1/1/2019 through 9/30/2019

Cardiothoracic Surgery Volumes ¹



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

U.S. News & World Report



- Kaweah Delta Medical Center was one of only two Hospitals Recognized for *Cardiology & Heart Surgery* amongst All Central Valley Hospitals
- Kaweah Delta Medical Center rated Highest among the 46 Central Valley Hospitals and Clinics reviewed by U.S. News & World Report



Quality Improvement
for Institutions



AMERICAN
COLLEGE of
CARDIOLOGY

Kaweah Delta Medical Center PCI Data Quality Analysis

2019 Q2 – 2020 Q1

Green = In the Top 10% of the Nation

Yellow = Better or Equal to the National Average

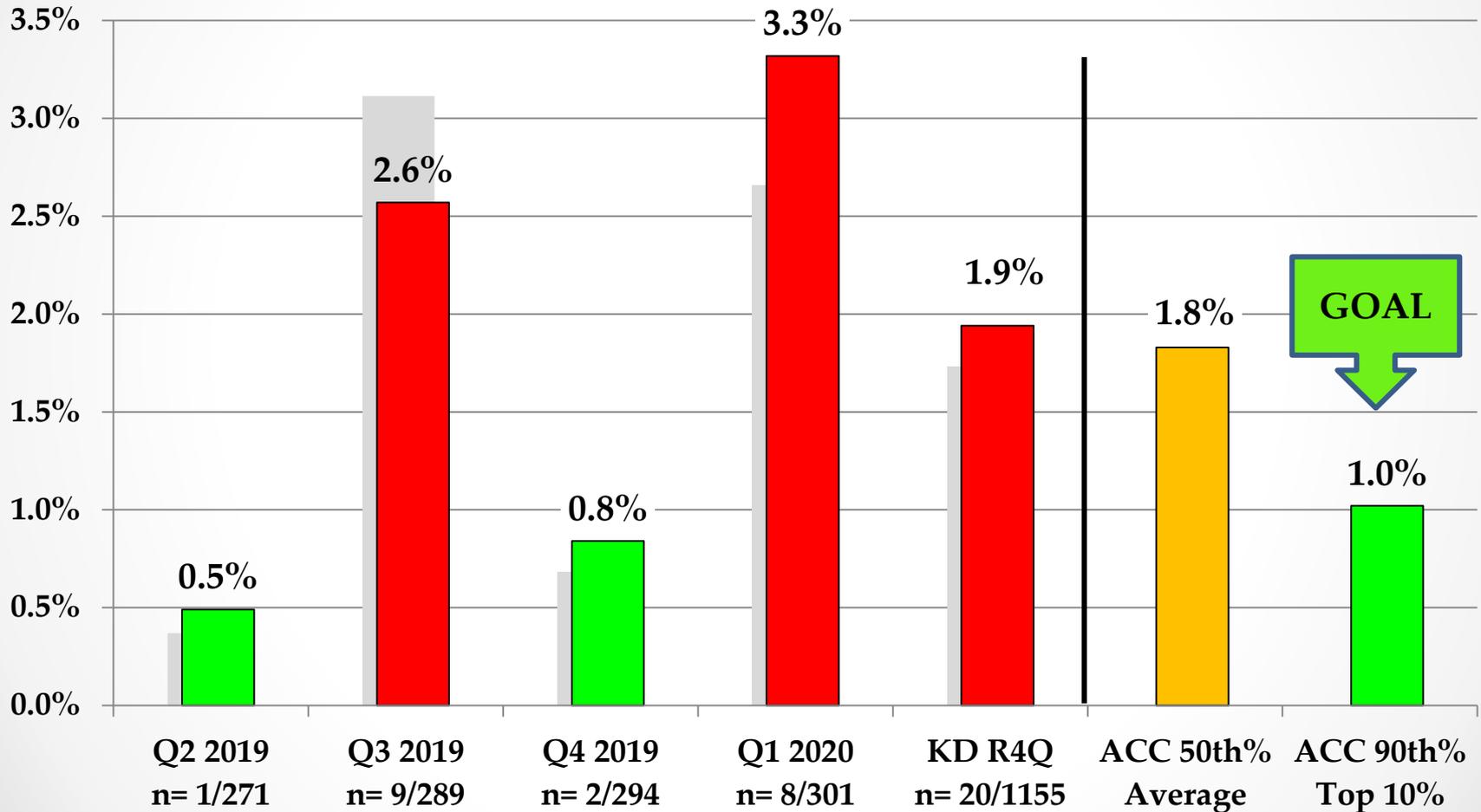
Red = Worse than National Average

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

*Comparison reporting period 04/01/19 through 03/31/20

PCI In-Hospital Mortality Rate¹

Risk Adjusted^{InColor} (All patients)



R4Q O/E = 1.03

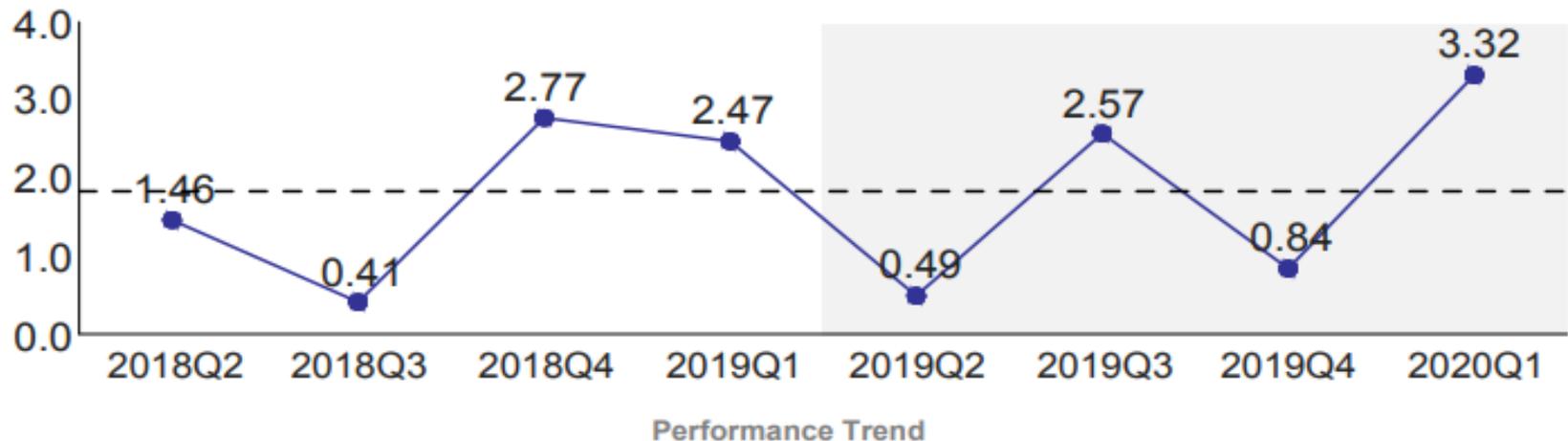
¹ PCI in-hospital mortality rate for all patients, risk adjusted. Exclusions include patients with a discharge location of "other acute care hospital." (ref: 4739)

*Comparison reporting period is 04/01/19 through 03/31/20

99/173

PCI In-Hospital Mortality Rate¹ Risk Adjusted (All patients)

- TWO-YEAR TRENDING

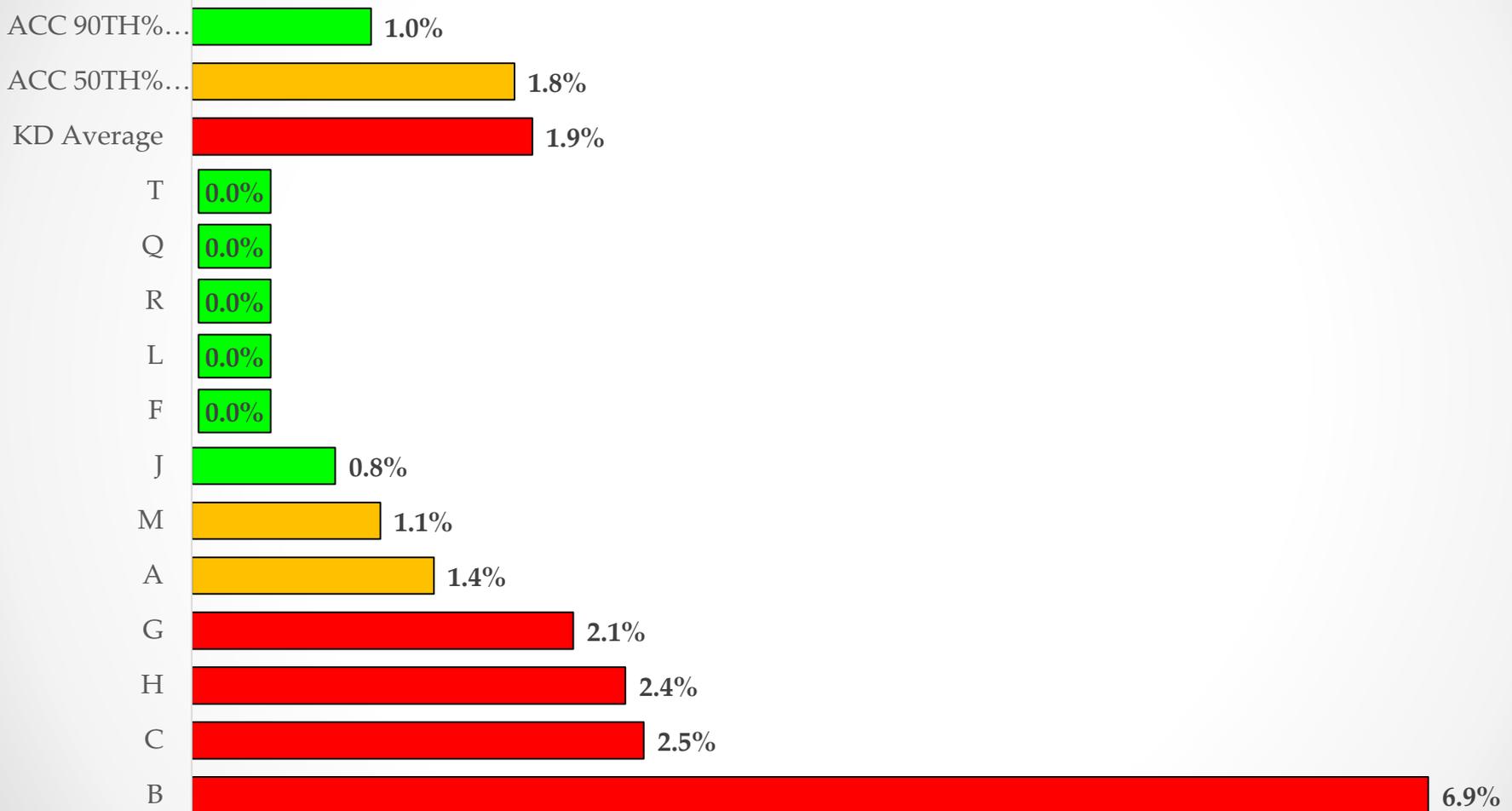


R4Q O/E = 1.03

¹ PCI in-hospital mortality rate for all patients, risk adjusted. Exclusions include patients with a discharge location of "other acute care hospital." (O/E ref: 4748)

PCI Mortality¹ Rate by Physician

ALL PATIENTS - ROLLING 4 QUARTERS (Q2 2019 – Q1 2020*)

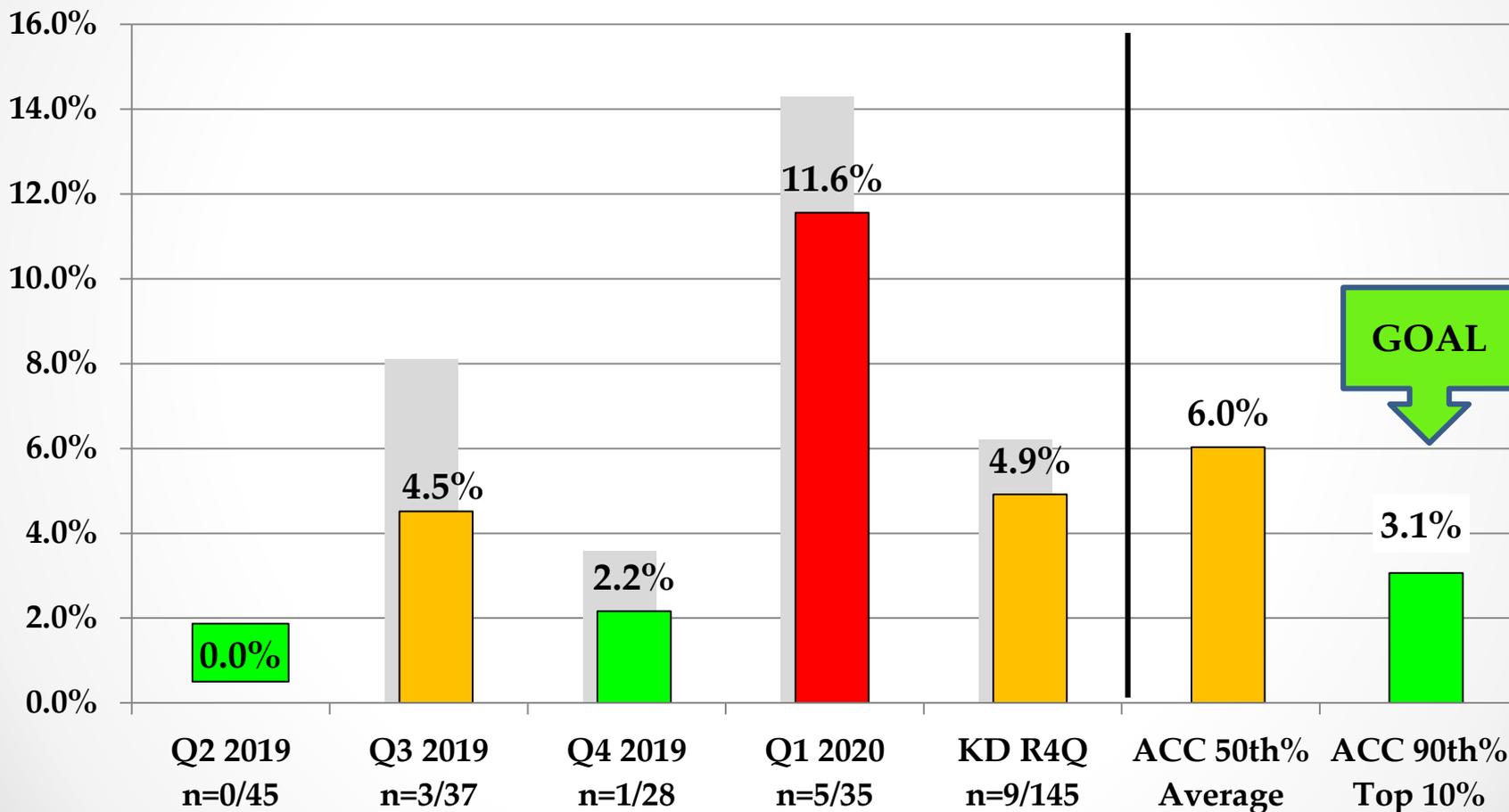


¹ PCI in-hospital mortality rate for all patients for that MD. Exclusions include patients with a discharge location of "other acute care hospital." (ref: NCDR/ACC Physician Dashboard)

*Comparison reporting period is 04/01/19 through 03/31/20. Raw DATA all Quarters

PCI In-Hospital Mortality Rate¹

Risk Adjusted In Color (STEMI patients)



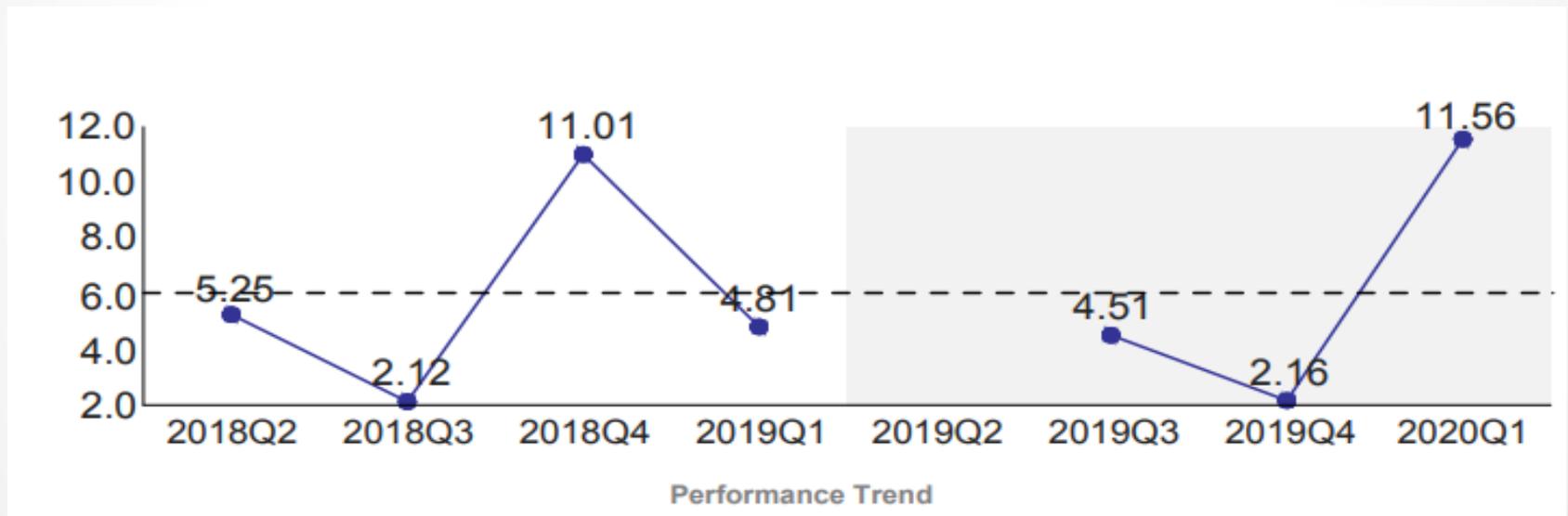
R4Q O/E = 0.78

¹ PCI in-hospital mortality rate for STEMI Pt.'s. (ref: 4740)

*Comparison reporting period 04/01/19 through 03/31/20 102/173

PCI In-Hospital Mortality Rate¹ Risk Adjusted (STEMI patients)

- TWO-YEAR TRENDING

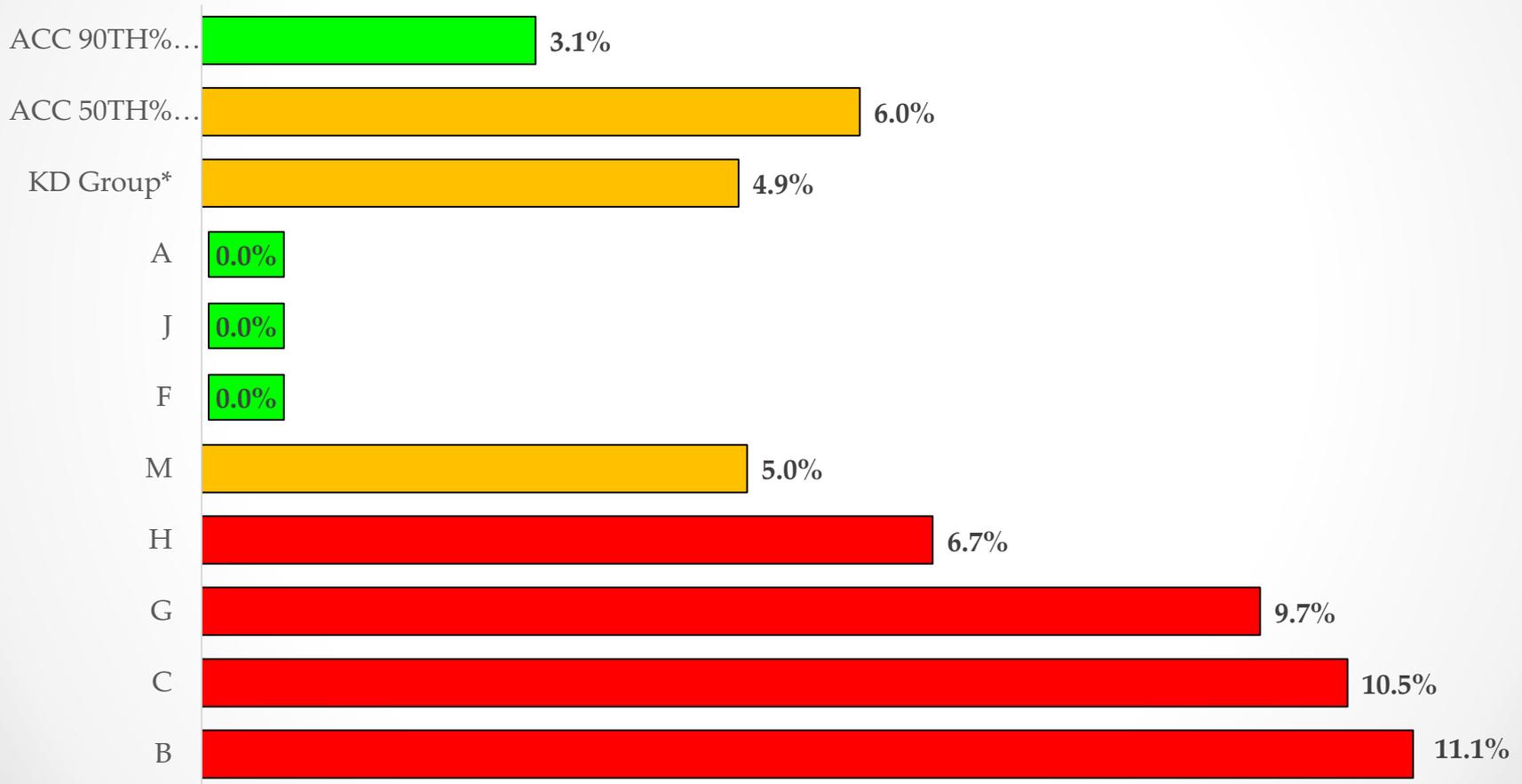


R4Q O/E = 0.78

¹ PCI in-hospital mortality rate for STEMI Pt.'s. (O/E ref: 4749)

PCI Mortality¹ Rate by Physician

STEMI PATIENTS - ROLLING 4 QUARTERS (Q2 2019 – Q1 2020*)

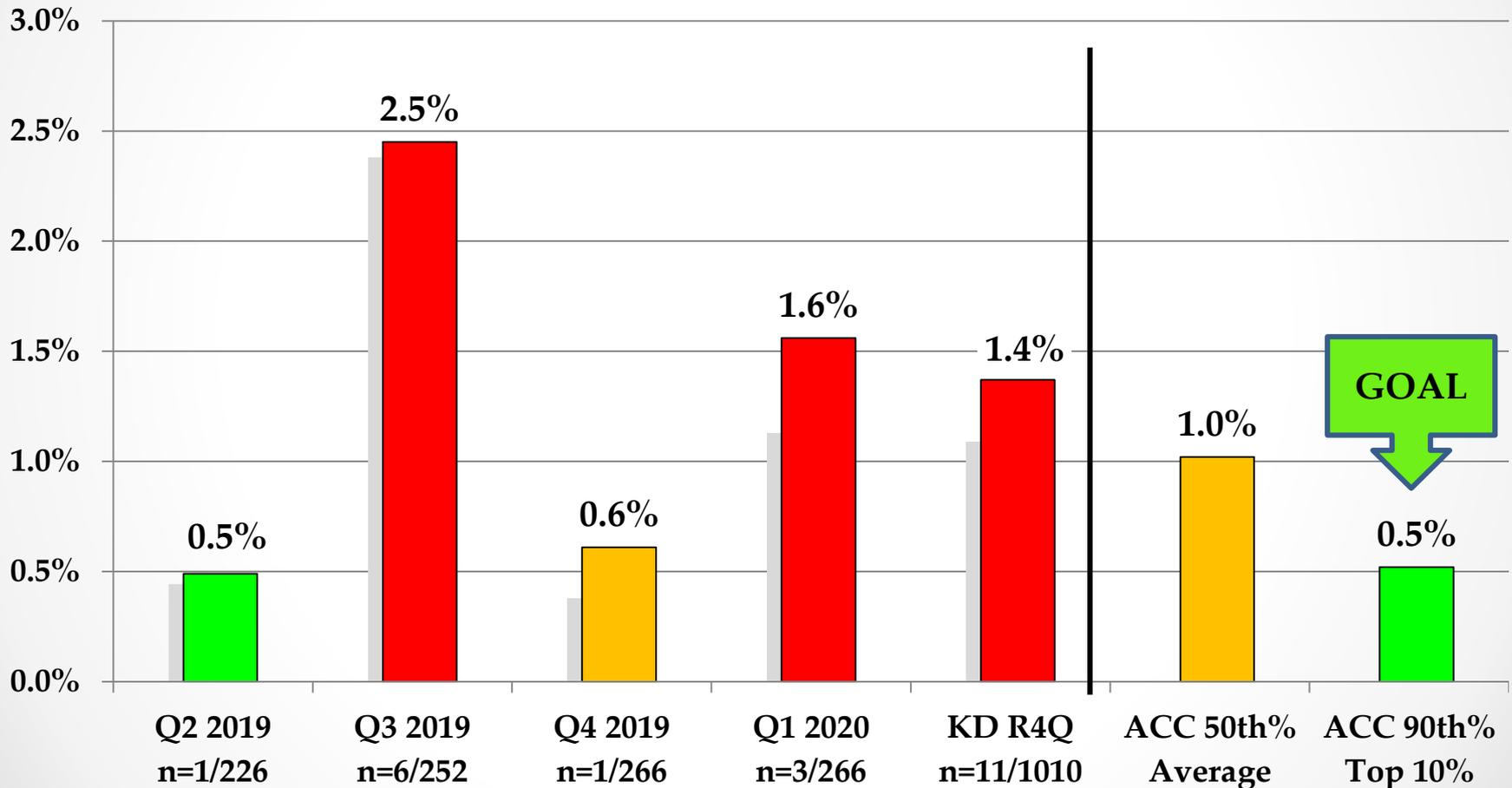


¹ PCI in-hospital mortality rate for STEMI patients for that MD. Exclusions include patients with a discharge location of "other acute care hospital." (ref: NCDR/ACC Physician Dashboard)

*Comparison reporting period is 04/01/19 through 03/31/20. Raw DATA all Quarters

PCI In-Hospital Mortality Rate¹

Risk Adjusted^{InColor} (NSTEMI, unstable angina, electives)



R4Q O/E = 1.39

¹ PCI in-hospital mortality rate for all patients Excluding STEMI. Exclusions include patients with a discharge location of "other acute care hospital." (ref: 4741)

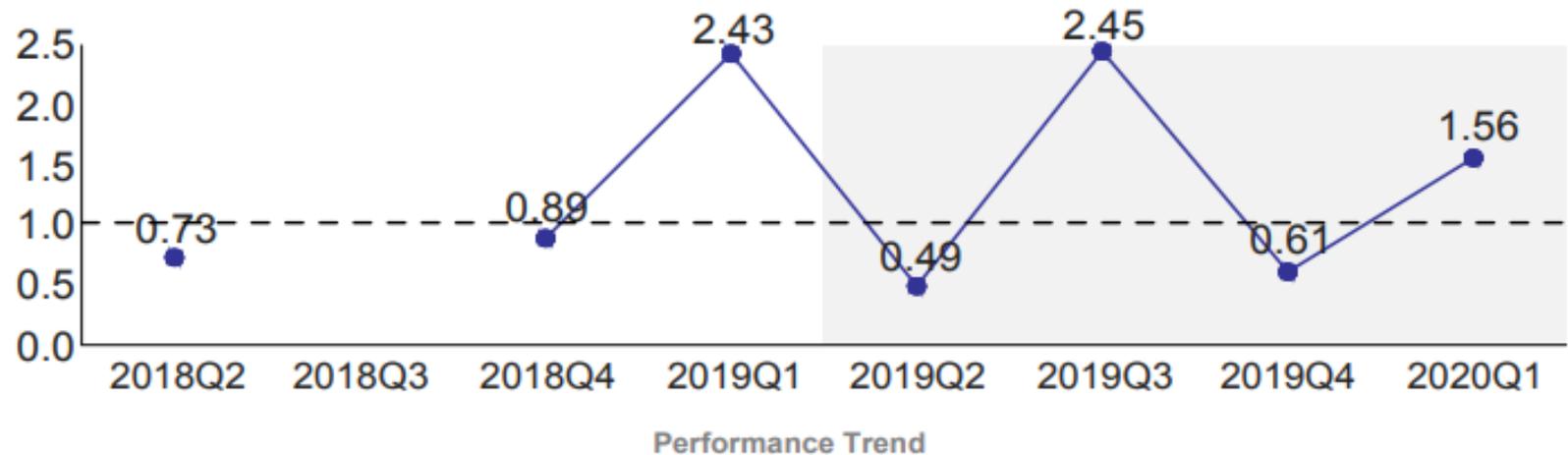
*Comparison reporting period is 04/01/19 through 03/31/20

105/173

PCI In-Hospital Mortality Rate¹

Risk Adjusted (NSTEMI, unstable angina, electives)

- TWO-YEAR TRENDING

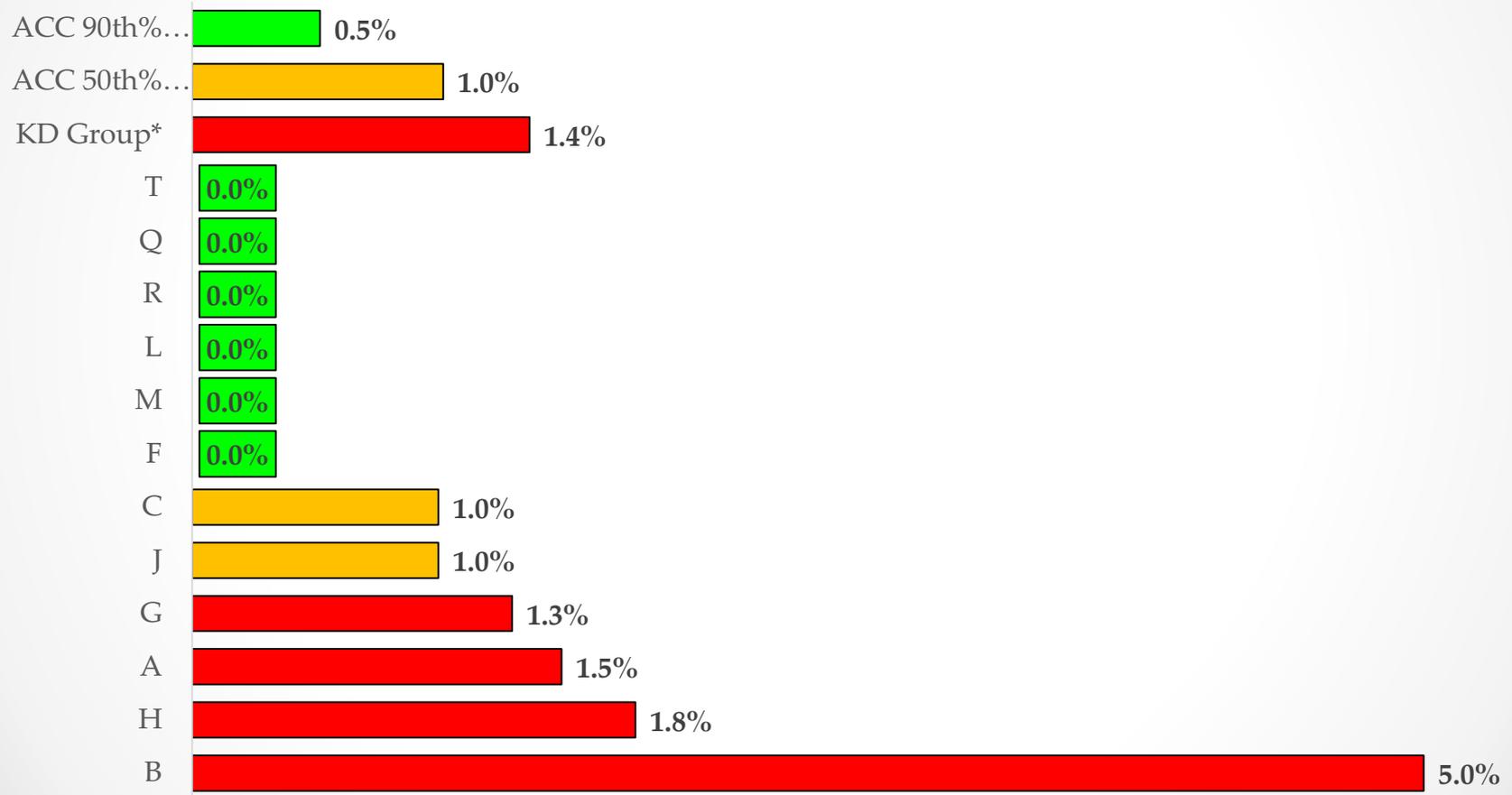


R4Q O/E = 1.39

¹ PCI in-hospital mortality rate for all patients Excluding STEMI. Exclusions include patients with a discharge location of "other acute care hospital." (O/E ref: 4750)

PCI Mortality¹ Rate by Physician

N-STEMI, USA, ELECTIVE PATIENTS - ROLLING 4 QUARTERS (Q2 2019 – Q1 2020*)



¹ PCI in-hospital mortality rate for N-STEMI, USA, Elective patients for that MD. Exclusions include patients with a discharge location of "other acute care hospital." (ref: NCDR/ACC Physician Dashboard)

*Comparison reporting period is 04/01/19 through 03/31/20. Raw DATA all Quarters

STEMI Triage Guidelines

Thoughtful Pause

- Should go to CVICU First, not the Cath Lab
 - Cardiac Arrest with CPR \geq 20 minutes and un/minimally responsive
 - Cardiogenic Shock, age \geq 80
 - STEMI \geq 24 hours without Chest Pain
 - Excess risk of bleeding (e.g. active internal bleed, ICH < 3 mos, Hct < 22, PLT < 30K)
 - Altered Mental Status
 - Apparent sepsis or other conditions (other than pure cardiogenic shock) that would markedly increase the risk of dying within 30 days
 - Pre-existing DNR / No Code Status
- ❖ Consider lytic agents for symptoms < 3 hours, anticipated DTB time > 120 minutes and low risk of bleeding
- ❖ These are intended as guidelines, not to supersede clinical judgement

Adopted from The Cleveland Clinic Heart Institute: Triage Guidelines for STEMI patients.

Predicted Mortality Risk Factors

- STEMI
- Age >70
- BMI
- Cerebral Vasc. Disease
- Peripheral Vasc. Disease
- Chronic Lung Disease
- Previous PCI
- NIDDM
- IDDM
- GFR
- Renal Failure / Dialysis
- Ejection Fraction
- Cardiogenic Shock
- NYHA Class I/II/III
- NYHA Class IV
- Cardiac Arrest
- Thrombosis w/in 1 month
- PCI of Prox LAD
- PCI of LM
- ≥ 2 VD
- Total Chronic Occlusion

*Risk Factors taken from the American College of Cardiology inclusion list for their Risk Model for Predicted Mortality: version 4.4

Quality Initiative:

Treatment Algorithm for Invasive Cardiac Procedures

- Targeted Temperature Management
 - Immediate hypothermia measures to be implemented on cardiac arrest patients
- 12-Lead ECG must be done within 10 minutes of arrival to hospital
- ACT initiated – (Do not delay cooling measures)
 - Assessment for unfavorable resuscitation features
 - Consultation between ED, Critical Care and Cardiology physicians
 - Transport to CathLab urgently when consensus reached

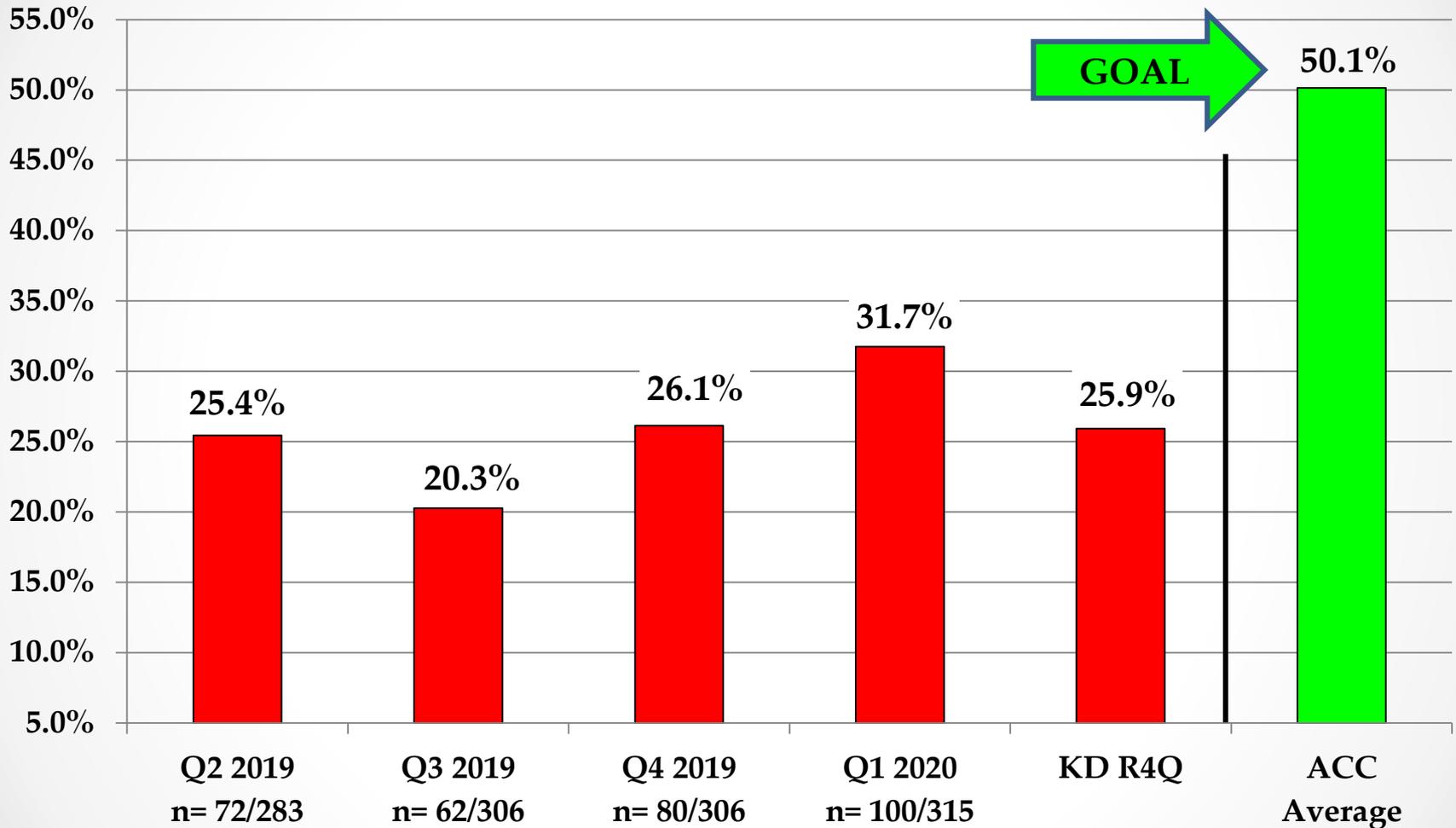
Quality Initiative: Vitaly Important Steps

- Physician collaboration & coordination between departments is required
- Cardiologist must participate in all thoughtful pause discussions
- ED physician and Cardiologist will consult with an Intensivist as needed for difficult cases
- Intensivist will respond to the ED for thoughtful pauses as requested
- Thoughtful pause must be documented in patient's EMR by a physician
- Families must be given aggressive treatment options with their corresponding prognosis or futility
- Honest communication between all parties required to maintain transparency and trust

Ethical Issues pertinent to care

- Ethical issues are unavoidable in the care of critically ill patients but we must maximize the ethical decision-making regarding angiography and PCI in these patient populations
 - Clinical judgments of the multidisciplinary physicians must be observed whenever possible
 - Diagnostic tools and data must be readily available for discussion in real time so that decisions can be made
 - Additional research into emerging data on this topic and diagnostic tools to keep our patients receiving state of the art care
 - Transparent discussions at the practice and policy making levels about what characterizes appropriate or futile care
 - Assessing patient wishes, respecting DNR and advanced directives even in times of family crisis and proxy decision makers
 - ***Lastly and importantly, a frank and honest discussion with families as to what is futile care***

PCI Radial Artery Access



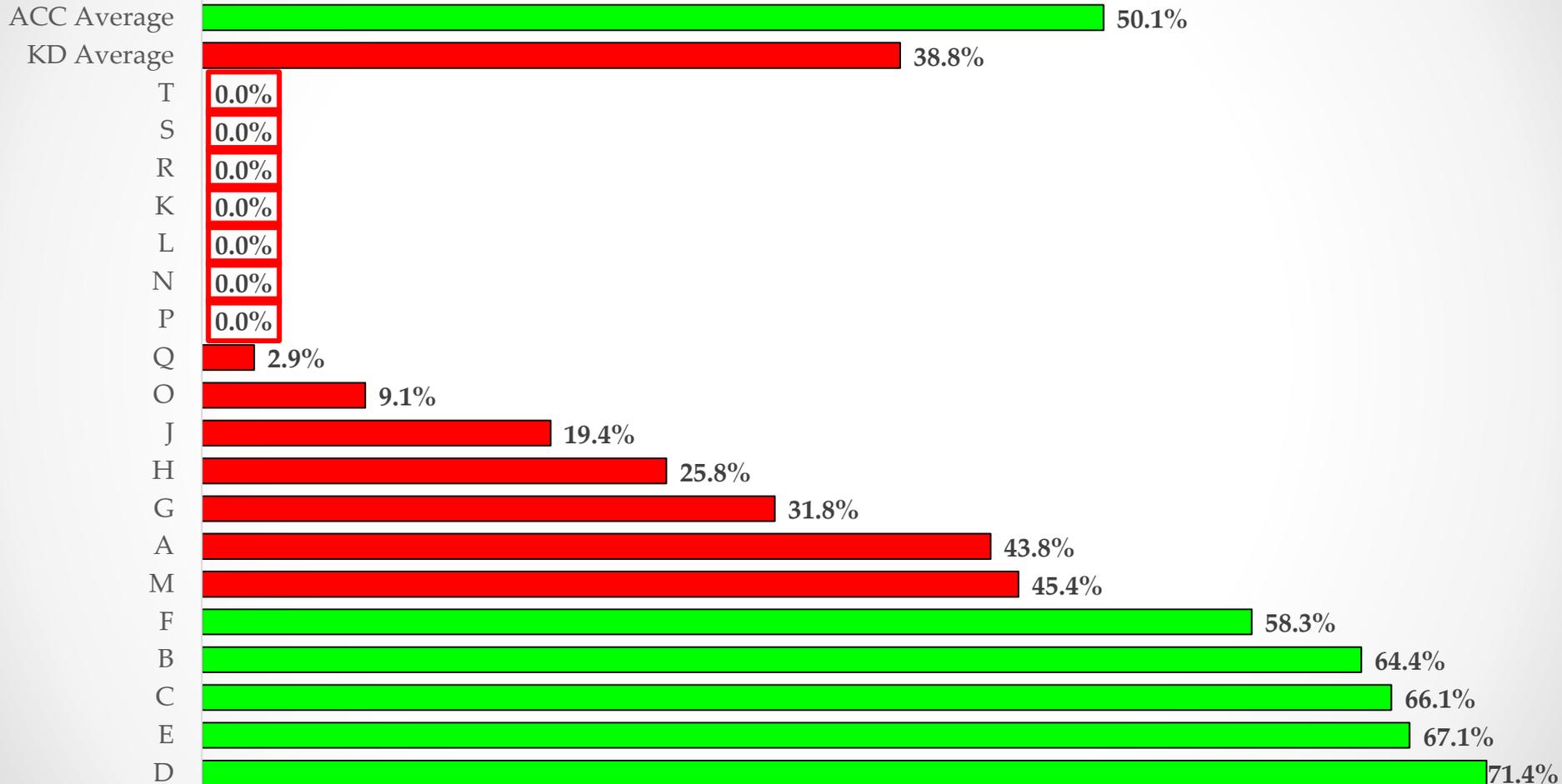
R4Q O/E = 0.5

PCI Procedures - Arterial Access Site equaling "Radial", no exclusions (ref: 4163)

*Comparison (ACC Average) reporting period is 04/01/19 through 03/31/20

All Caths Radial Artery Use¹ by Physician

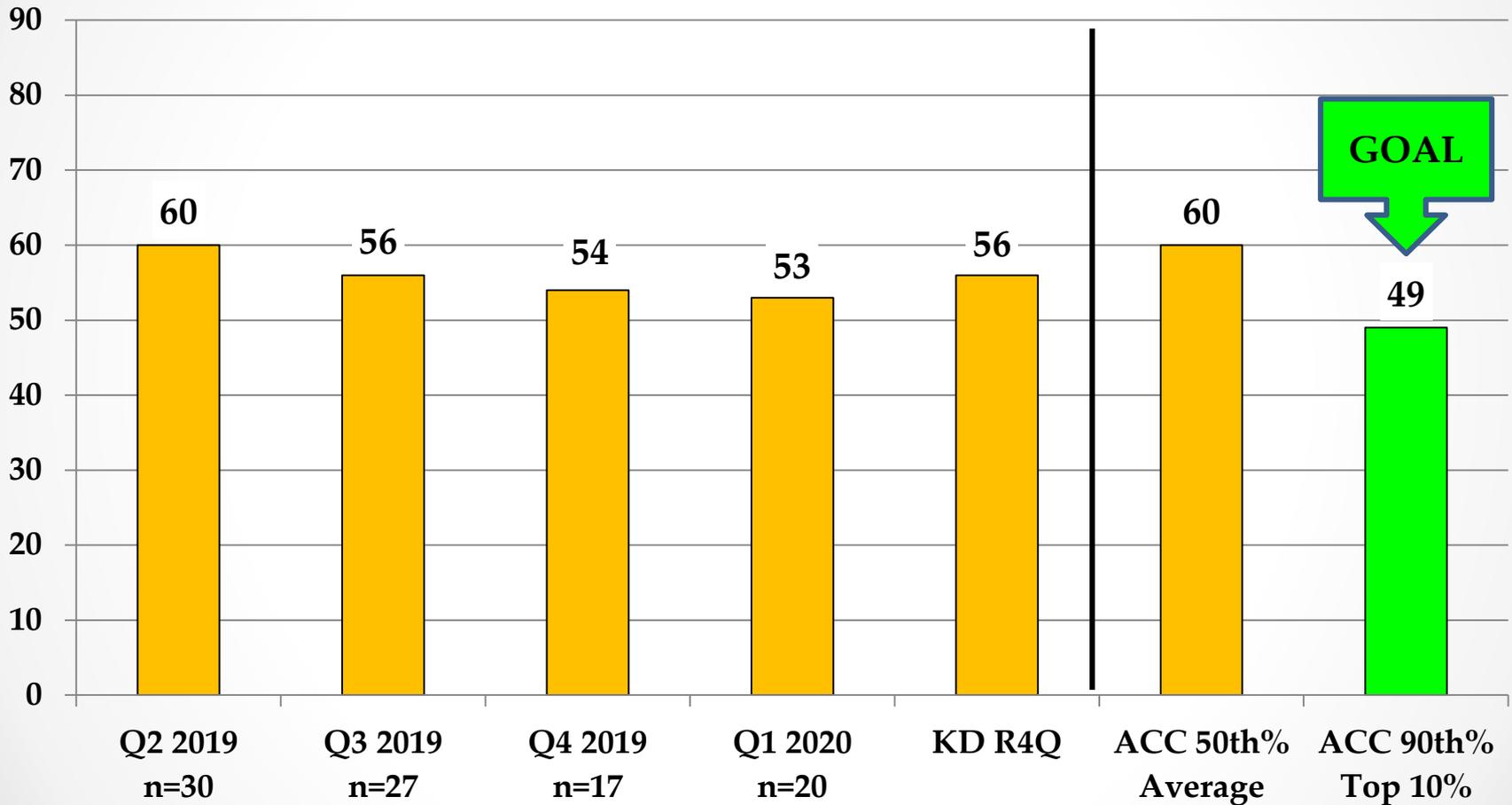
ROLLING 4 QUARTERS (Q2 2019 – Q1 2020*)



¹ PCI & Diagnostic Cardiac Catheterization Procedures - Arterial Access Site equaling "Radial" for all patients for that MD. No Exclusions; Pt.'s with an aborted Radial attempt included in denominator (ref: SENSIS Statistical Manager)

*Comparison (ACC Average) reporting period is 04/01/19 through 03/31/20 –RAW DATA all quarters

Immediate PCI for STEMI (in minutes)¹

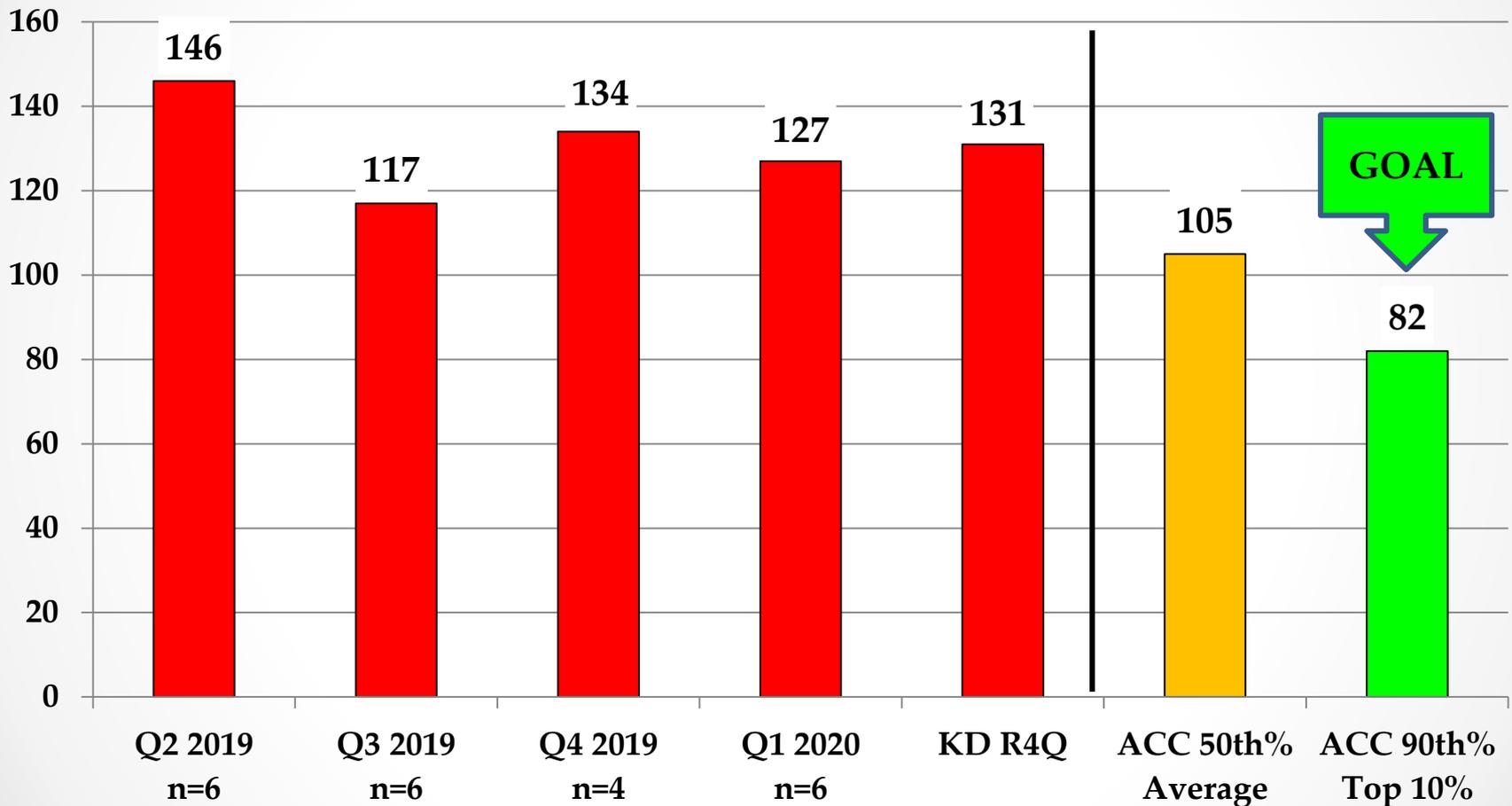


R4Q O/E = 0.9

¹ Median time frame from hospital arrival to immediate PCI for STEMI pts in minutes. Exclusions: Patients transferred in from another acute care facility; Reasons for delay does not equal none. (ref:4448)

*Comparison reporting period is 04/01/19 through 03/31/20 115/173

Immediate PCI for STEMI Transfers (in minutes)¹



R4Q O/E = 1.2

¹ Median time from ED arrival at STEMI transferring facility to immediate PCI at STEMI receiving facility among transferred patients (excluding reason for delays); Reasons for delay does not equal none. (ref:4452)

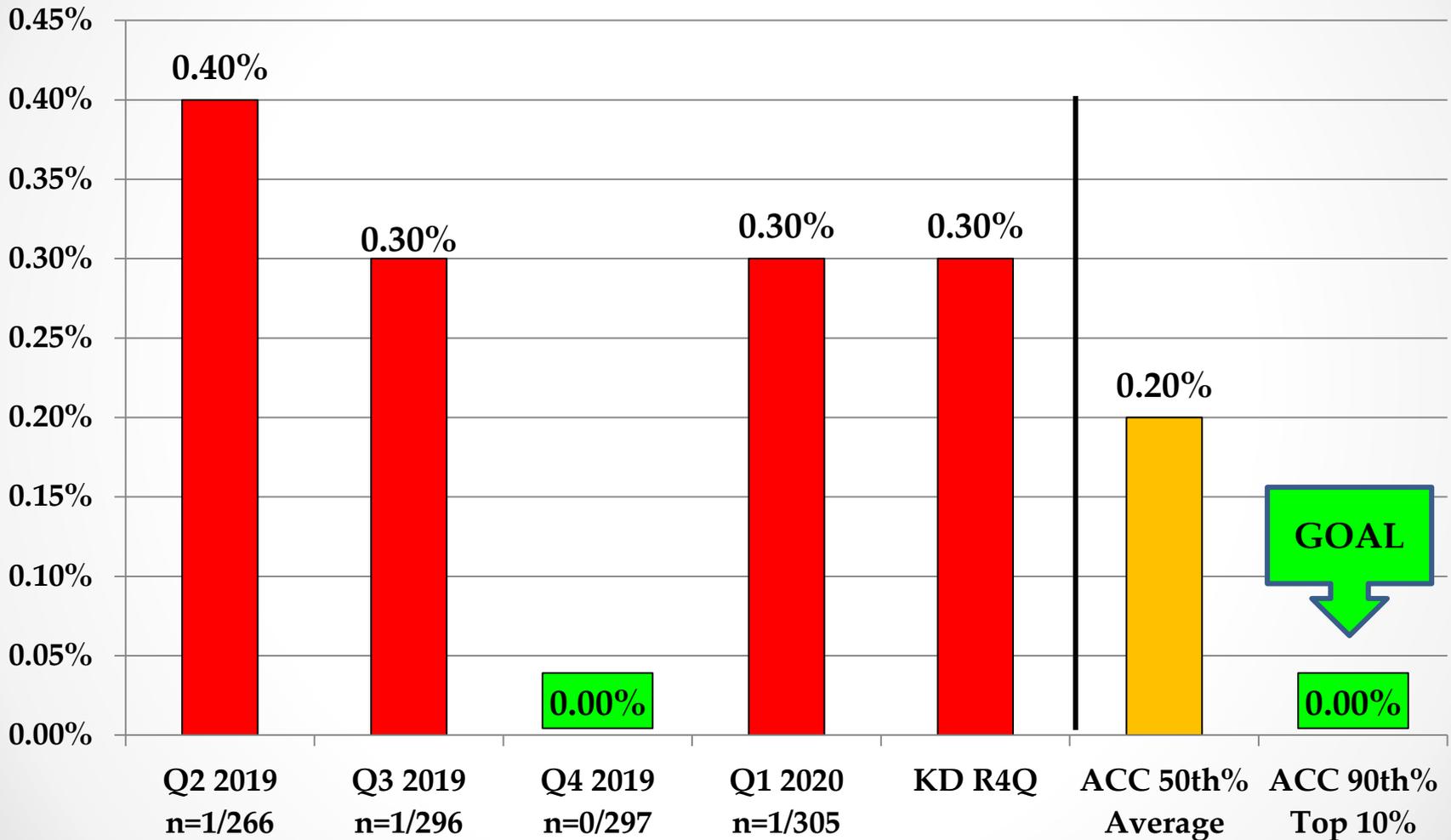
*Comparison reporting period is 04/01/19 through 03/31/20 116/173

Quality Initiative:

Best Practice in Door to Balloon

- Cardiac Alerts to be called at the time of leaving transferring hospitals
- STEMI Protocol cards to be sent to referring hospitals with education to follow.
- ED EKG to be placed in EMR or Tracemaster
- Cath Lab on call crew response time of 20 minutes
- Fallouts are reviewed promptly and in every case
- Cardiac Alerts called within 10 minutes of ED arrival unless Thoughtful Pause is documented in the EMR
- Additional RN added to call team to facilitate efficiency

Stroke Post PCI¹



R4Q O/E = 1.3

¹ Exclusions: Patients with an Intervention this admission (Surgery, EP, Other); Pt's discharged to *Other Acute Care Facility*
 (ref: 4235) *Comparison reporting period is 04/01/19 through 09/31/20

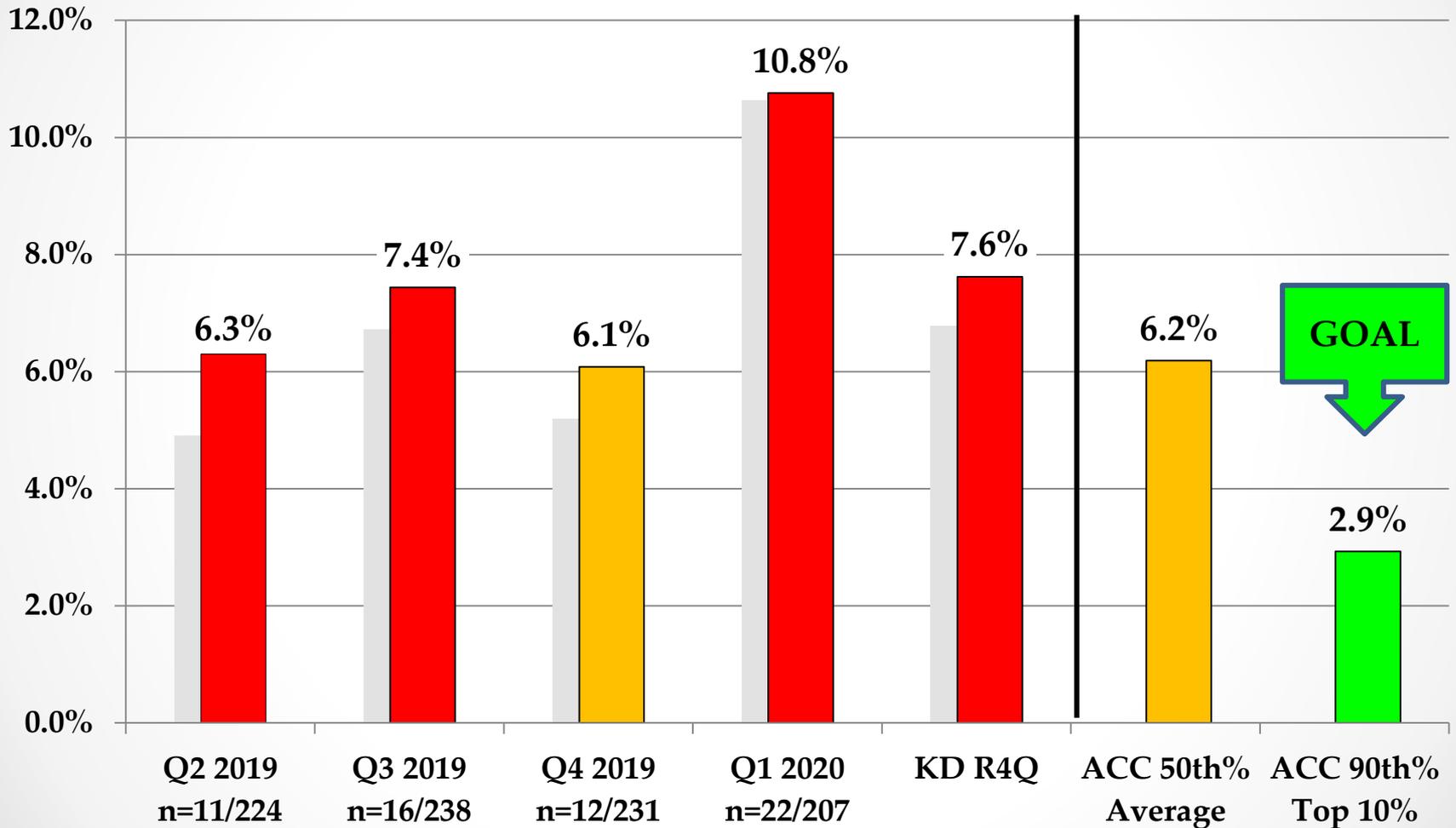
Quality Initiative:

Stroke Recognition and Treatment

- Assess Stroke Risk factors in PCI for each patient
 - Age, gender, history of CVA, End Stage Renal Disease, Diabetes, Hypertension, Peripheral Vascular Disease, Smoking, Congestive Heart Failure, Atrial Fibrillation, CABG surgery or emergent PCI
- Rapid recognition of stroke symptoms in Cath Lab
- Use of the clear protocol for recognition and interventions will facilitate efficient care in the unlikely event of a stroke in Cath Lab

Acute Kidney Injury¹ Post PCI

Risk Adjusted^{InColor}



R4Q O/E = 1.11

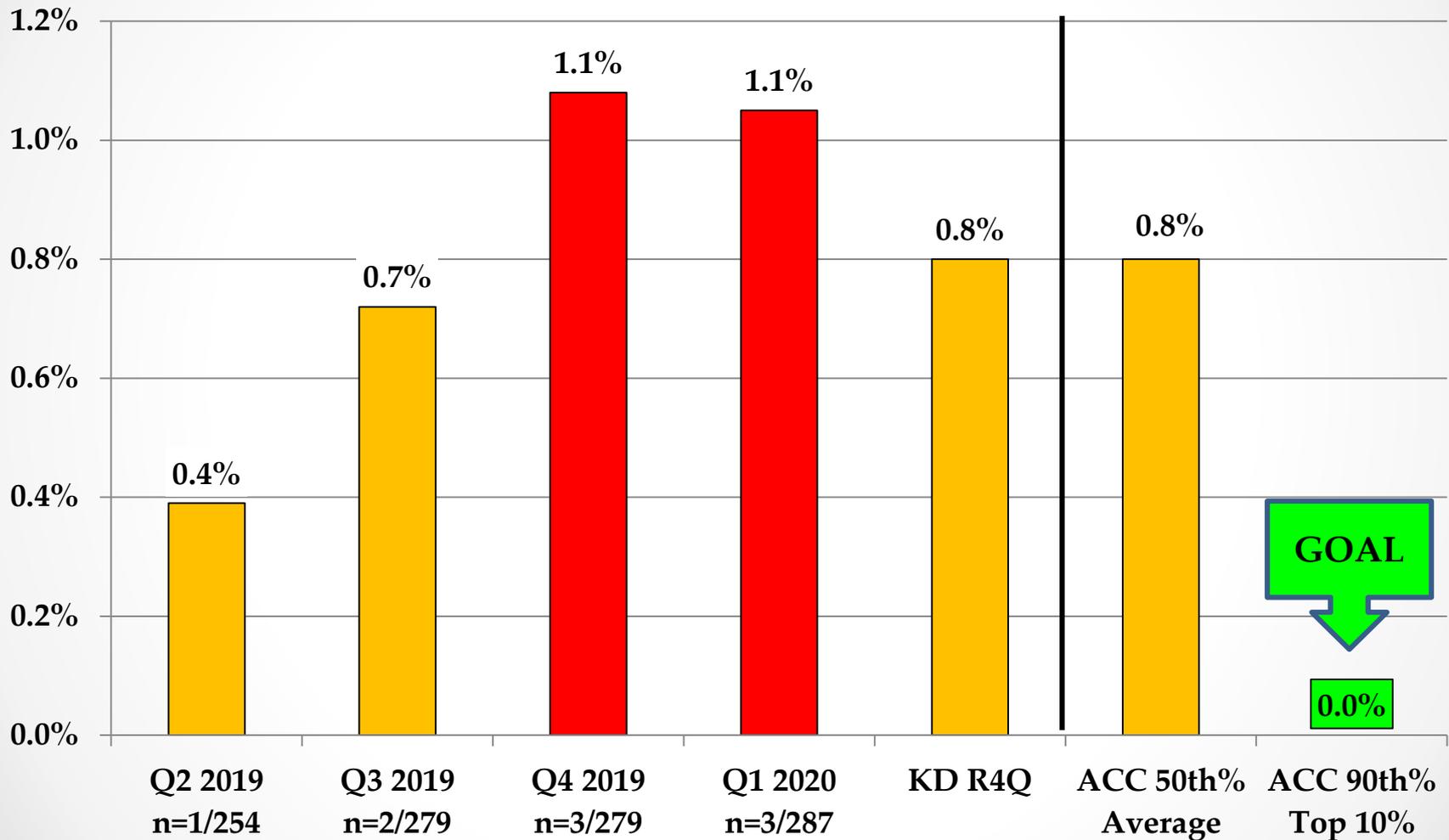
¹ Proportion of pt's with a rise of serum creatinine of > 50% or ≥ 0.3 mg/dL over the pre-procedure baseline; all pt's w/ New Requirement for Dialysis. Exclusions: pt's on dialysis pre-procedure; pt's second PCI within this episode of care; same day discharges. (ref: 4882; O/E ref: 4881) *Comparison reporting period is 04/01/19 through 03/31/20

Quality Initiative:

Contrast Induced Nephropathy

- Renal impairment = estimated glomerular filtration rate \leq 60mL/min
- Pre-arrival: Oral hydration encouraged the day before arrival. Patients instructed to drink clear liquids up to 2 hours prior to arrival. Intravenous hydration to be started upon admission, and continued post cath,
 - Pre procedure: IV fluids at 200 ml/hr.
 - Intra procedure:
 - LVEDP $<$ 18 \rightarrow NS 500 mL/hr for 4 hours
 - LVEDP $>$ 19 \rightarrow NS 250 mL/hr for 4 hours
 - Post procedure: Normal Saline 100 ml/hr for 6-24 hours. Oral hydration encouraged.
- Post procedure labs must be ordered
- Metabolic panel ordered one day post procedure
- Track and Report contrast utilization for Diagnostic and Interventional procedures

Transfusion Post-PCI of RBCs¹



R4Q O/E = 1.1

¹ Proportion of 9 who receive a transfusion of whole blood or RBCs during or after, but within 72 hours of PCI procedure.

Exclusions: Patients on dialysis; EP study or CABG or other major surgery during the same admission; Pt.'s with a pre-procedure hemoglobin <8g/dL or no value. (ref: 4288) *Comparison reporting period is 04/01/19 through 03/31/20

APPROPRIATE USE OF RED BLOOD CELLS

- A. Pre-transfusion hematocrit of less than 24% or hemoglobin less than 8 grams/dl.

- B. Transfusion may be administered when hemoglobin levels are 8-10 grams/dl in the following circumstances:
 - 1. Acute Blood Loss/Active Bleed
 - 2. Presence of Symptomatic Anemia
 - 3. HGB <9 w/ Chemotherapy
 - 4. HGB <10 w/ Radiation Treatment

Quality Initiative:

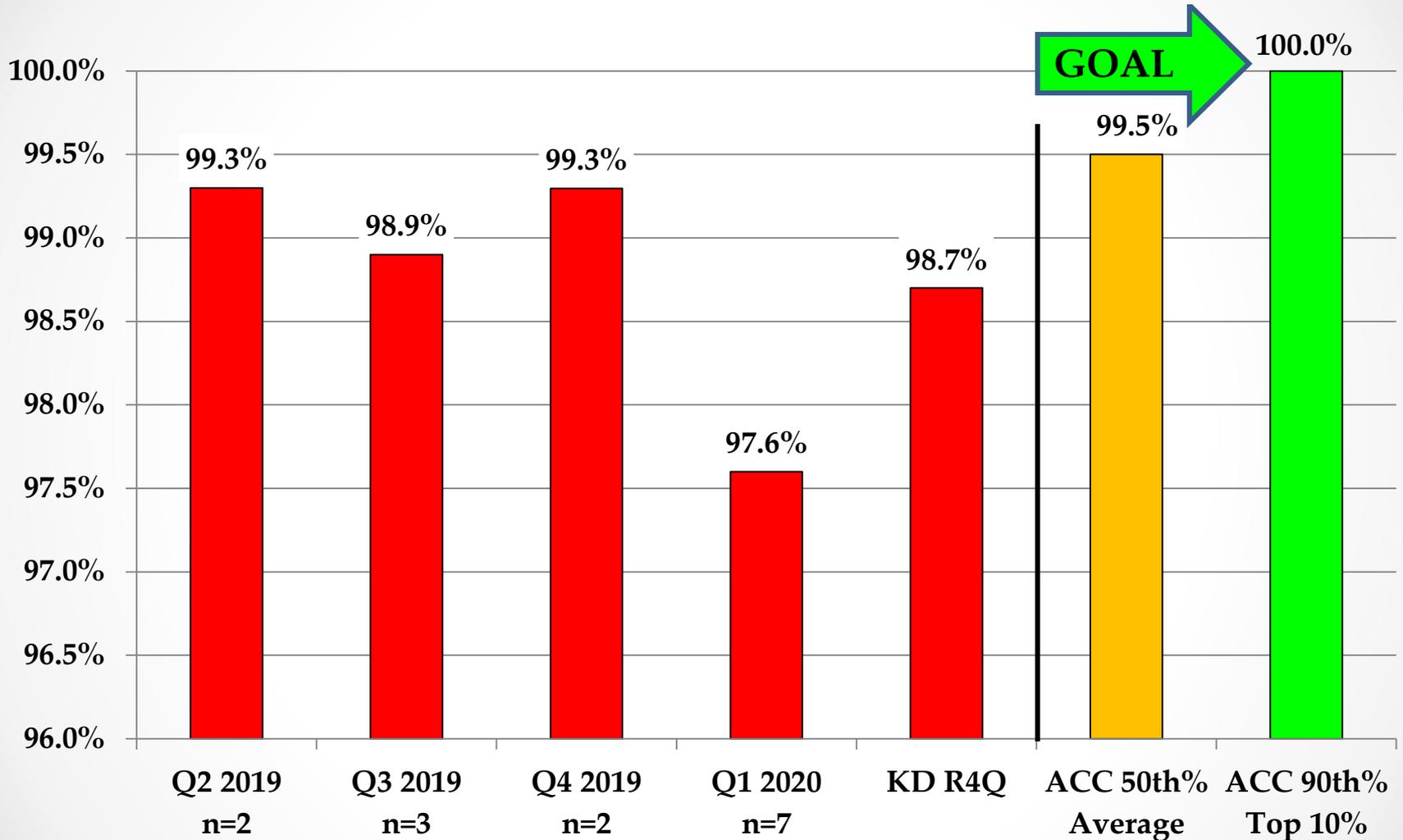
Bleeding Protocol

- Bleeding Avoidance Strategies (Risk Stratification)
 - Cath lab patients are now risk stratified
 - Low Risk Total Score of ≤ 7 points,
 - Medium Risk Total Score between 8-17 points
 - High Risk Total Score of ≥ 18 points
- Once score is known if patient is (High Risk)
 - Evaluate for short acting anticoagulant (Angiomax)
 - Evaluate quality of stick for sealant device deployment
 - High stick or Low stick, No sealant device
 - Admit patient to appropriate level of care (ICCU)

- Implemented best practice hemostasis management strategies standardized for Post Procedure Bleeding and Sheath Removal
 - Hemostasis management education program for early recognition of post procedure bleeds
 - Includes recognition of signs and symptoms of bleeding
 - Standardized communication
 - Communication between the procedure team and physician with emphasis on the quality of the groin stick and whether the use of sealant is used.
 - Bedside reporting between procedure team through the admitting nurse with emphasis on the vascular access site assessment
 - Manual sheath removal
 - Hold manual pressure minimum of 20 minutes
 - Frequent vital signs and distal pulse monitoring
 - Diligent vascular access site assessment
 - Assess Patient for pain
 - Vascular sealant device
 - Hold manual pressure minimum of 5 minutes
 - Frequent vital signs and distal pulse monitoring
 - Diligent vascular access site assessment
 - Assess patient for pain

- Implementation of mandatory hemostasis management education
 - Mandatory self study educational presentation using pre and post test evaluation testing. (Must be completed and passed)
 - Added to Nursing Unit Annual Competency
 - Added to core curriculum nursing education (Cardiac and CV ICU units)
 - 4 Tower, 2 North, 3 West, CVICU and ICU, CV ICCU.
 - Mock simulation of a post procedure bleeding patient is being done twice a year. Once in the skills lab and the other on the nurses home unit
- Utilize hemostat, with fluoroscopy to visualize location of femoral head, picture to be saved.
- Increase utilization of Radial Access to ACC average
- Utilize Ultrasound for vascular access

ASA Prescribed at DC¹

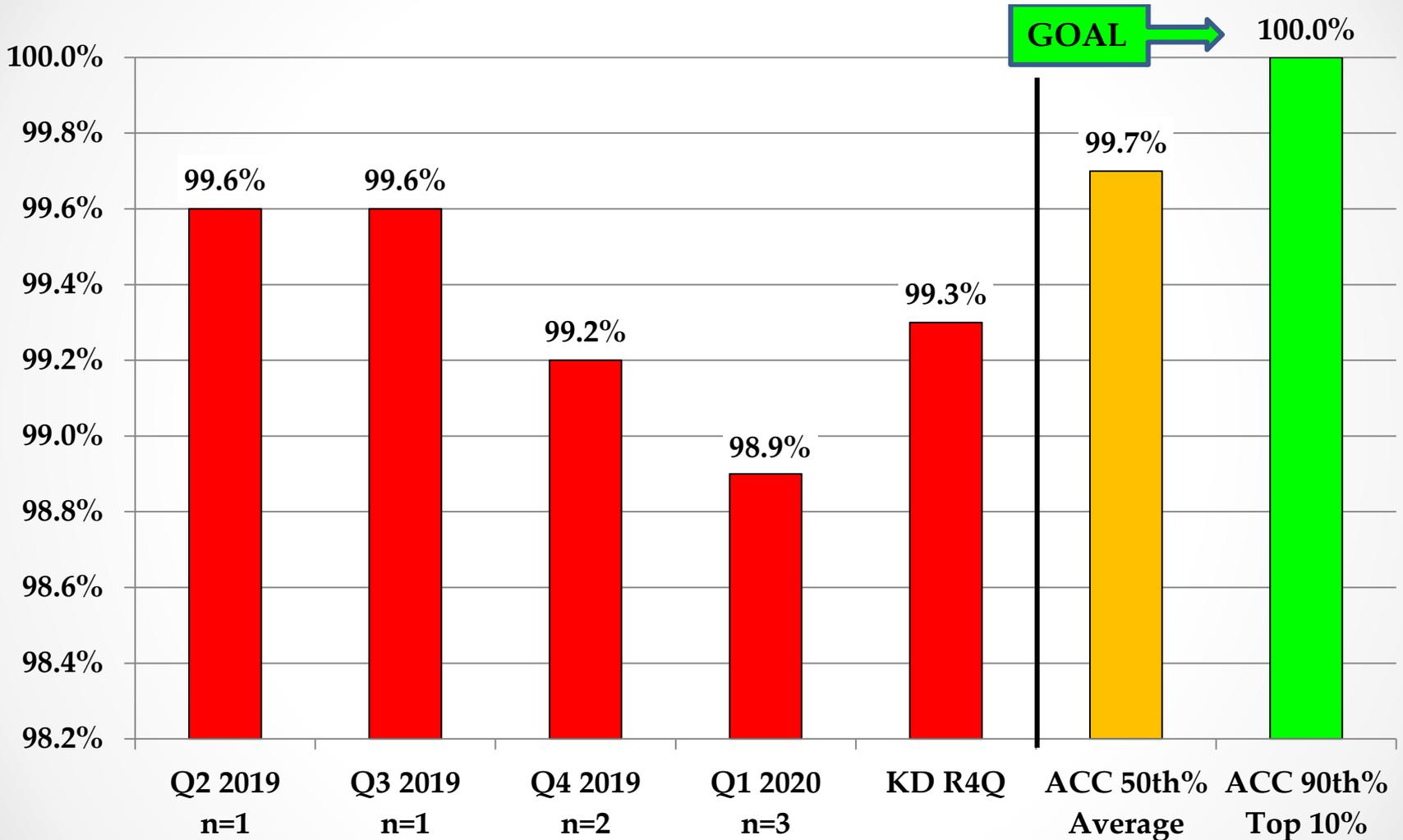


R4Q O/E = 1.0

¹ Proportion of pt.'s (without a documented contraindication) with a PCI attempted or performed that were prescribed aspirin at discharge. Exclusions: pt.'s that were discharged on Comfort Measures only; discharged to "Other acute care hospital", "Hospice", "Left against medical advice (AMA)" or deaths. (ref: 4702)

*Comparison reporting period is 04/01/19 through 03/31/20 127/173

P2Y12 Inhibitor Prescribed at DC¹



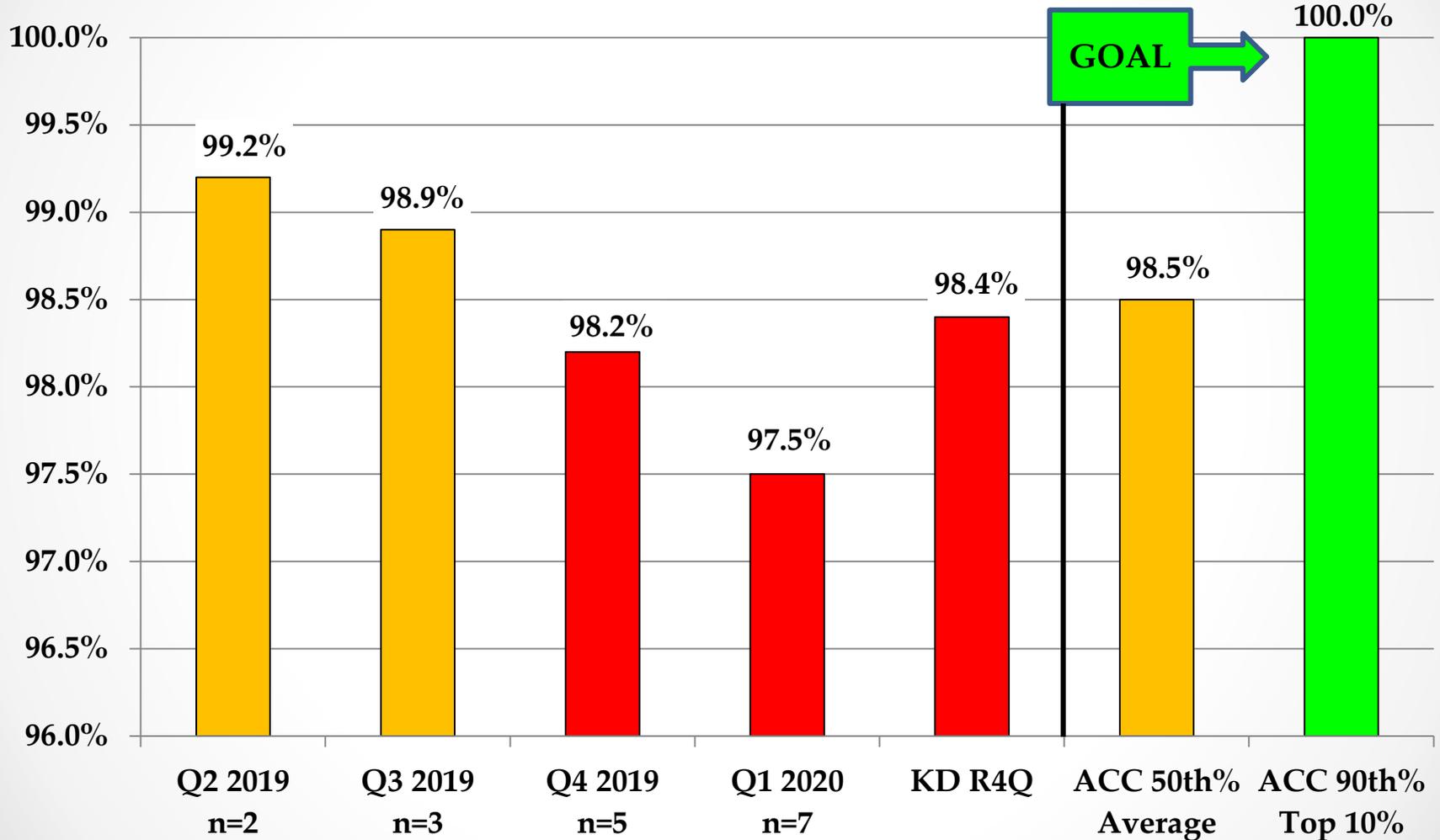
R4Q O/E = 1.0

¹ Proportion of pt.'s (without a documented contraindication) with a cardiac stent placed that were prescribed a thienopyridine/P2Y12 inhibitor at discharge. Exclusions: pt.'s that were discharged on Comfort Measures only; discharged to "Other acute care hospital", "Hospice", "Left against medical advice (AMA)" or deaths (ref: 1714)

*Comparison reporting period is 04/01/19 through 03/31/20

128/173

Statins Prescribed at DC¹



R4Q O/E = 1.0

¹ Proportion of pt.'s (without a documented contraindication) with a PCI attempted or performed that were prescribed a statin at

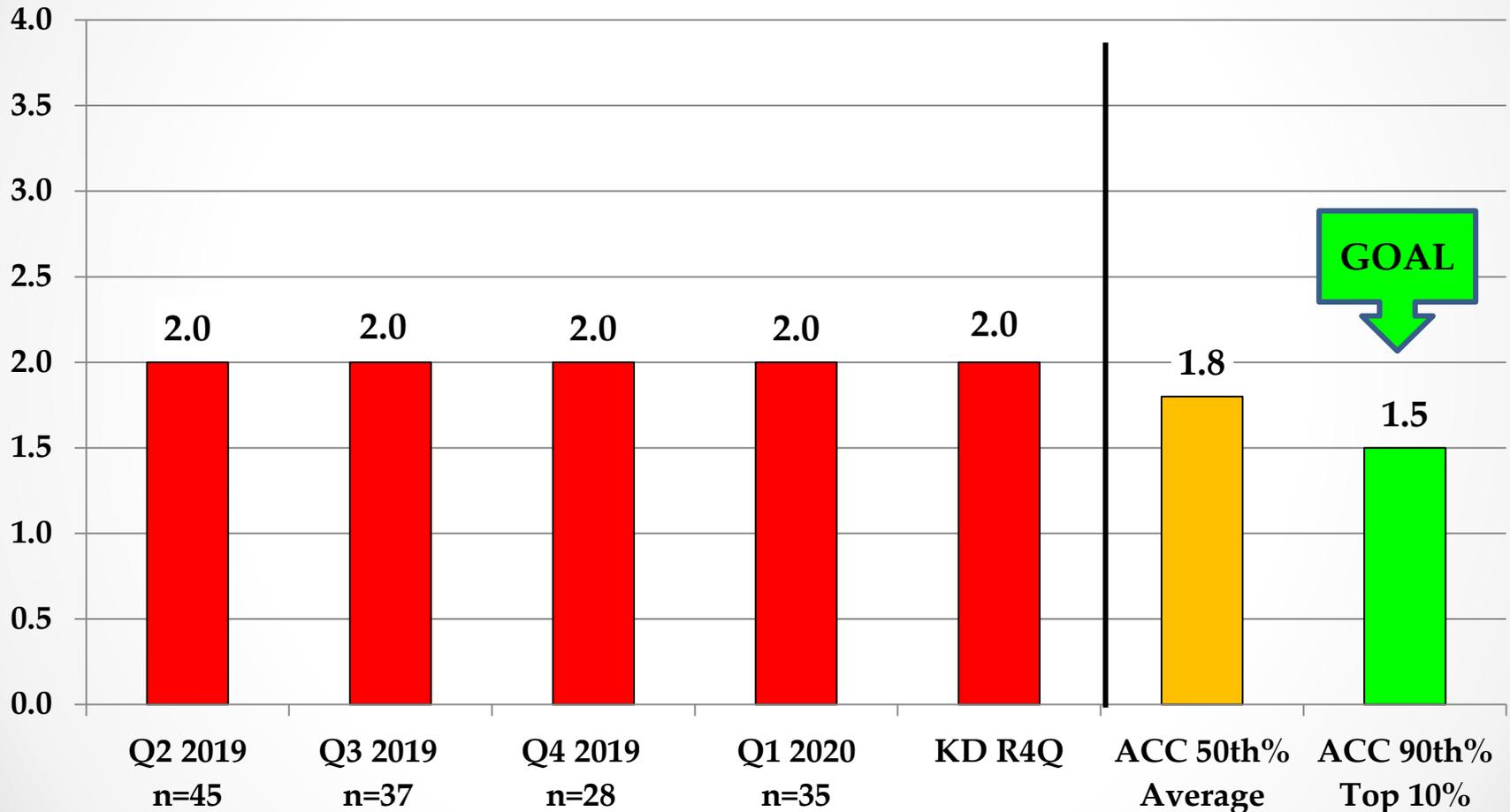
discharge. Exclusions: pt.'s that were discharged on Comfort Measures only; discharged to "Other acute care hospital", "Hospice", "Left against medical advice (AMA)" or deaths. (ref: 4707) *Comparison reporting period is 04/01/19 through 03/31/20

Quality Initiative:

Discharge Medications

- Developed and implemented PCI specific discharge order set
- Developed and implemented post PCI Med Recon process for Cardiologist to complete with post PCI Orders.
- Re-educate Hospitalists and Nurse Practitioners on importance of specific discharge medications in this patient population and utilization of new Order Set.
- Track utilization of order set
- Contact Lead Hospitalist or Nurse Practitioner with all fallouts and track
- Improving Clinical documentation in the Discharge Summary of any contraindications
- Improving Clinical documentation in the Discharge Summary clarifying any pending diagnosis (i.e. possible NSTEMI, possible MI)

Post-PCI Length of Stay¹ – STEMI

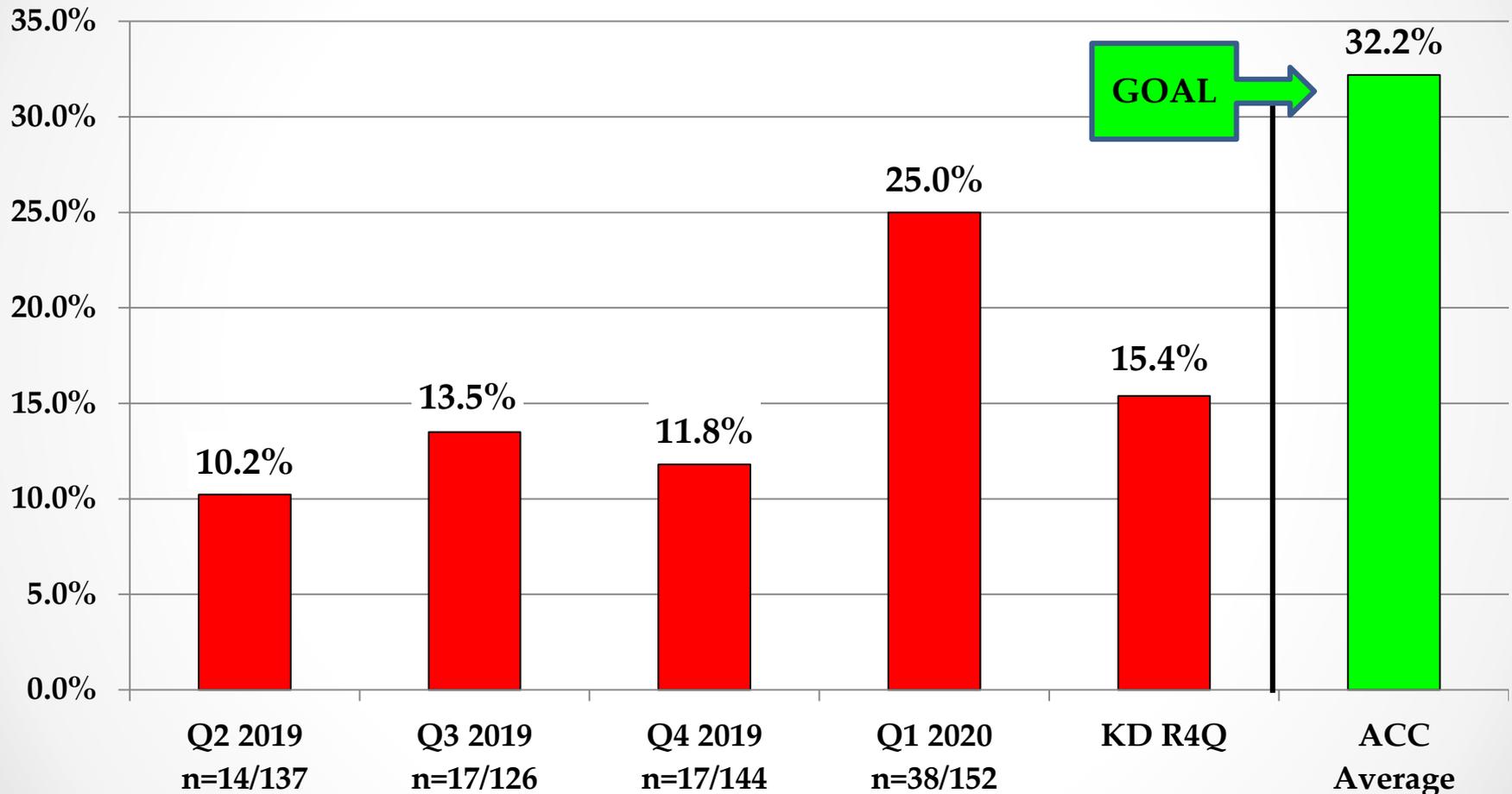


R4Q O/E = 1.1

¹ Median Post-procedure length of stay in STEMI patients. Exclusions: pt.'s discharged to Another Acute Care Facility; pt.'s who die during procedure (ref:4340)

*Comparison reporting period is 04/01/19 through 03/31/20 131/173

Post-PCI Same Day Discharge - Electives



R4Q O/E = 0.5

¹ Patients discharged on the same day as procedure. Exclusions: mortalities and pt.'s discharged to Another Acute Care Facility or AMA (ref:4971)

*Comparison reporting period is 04/01/19 through 03/31/20 132/173



Central Line Blood Stream Infection (CLABSI) Quality Focus Team Report August 11, 2020

Amy Baker, Director of Renal Services (Chair)

Emma Camarena, Advanced Practice Nurse (Co-Chair)

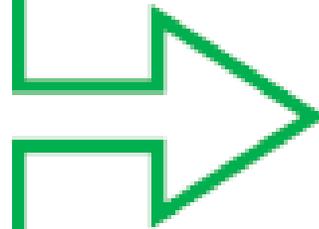
Shawn Elkin, Infection Prevention Manager (IP Liaison)

Kaizen Analysis

Analysis:

Identified Root Causes (in order from most significant to least):

1. Line Necessity
2. Bundle Practice
3. Education
4. Cultures
5. Central Line Insertion
6. Bathing
7. Leadership Standard Work
8. Documentation
9. Human Factors



Kaizen
improvement
strategies
focused on
addressing
the top 4 root
causes

Action Plan

Improvement Strategy	Who?	When?
<u>Line Necessity</u> –Implementation of interventions delayed due to COVID-19 pandemic	Emma C. Joetta D.	March 31, 2020 (TPN orders 7/2020)
<u>Bundle Practice</u> –Implementation of interventions delayed due to COVID-19 pandemic	Amy Baker	March 31, 2020
<u>Education</u> –Implementation of interventions delayed due to COVID-19 pandemic priorities	Eileen P. Enri S.	March 31, 2020 (Comp Fair 6/20)
<u>Blood Cultures: The Culture of Culturing</u>	Dr. Gray & Shawn Elkin	
<u>Leadership Standard Work</u>	Mary Laufer	
Improve location and par of central line supplies <ul style="list-style-type: none"> • Include in manager communication plan; • Include in RN & CNA education that they need to follow up with CN or manager that PAR level needs to be adjusted; also talk to manager & central distribution 	Kaizen Team Education Team	
Email Take-Always after CLABSI committee review of events	Amy Baker	
Insertion: New site = New kit to be included with MD/resident education with Dr. LeDonne— Conference cancelled due to COVID-19 pandemic.	Dr. Gray Shawn Elkin	

*Covid -19 Pandemic impacted resources 3 Weeks after Clabsi Kaizen E

Post Kaizen- Gemba Data

CLABSI Committee Dashboard

Measure Description	Benchmark/ Target	Mar-20	Apr-20	May-20	Jun-20
OUTCOME MEASURES					
Number of CLABSI	0	0	1	0	
Days Between Events (from Nov 2019) (from last CLABSI to end of reporting month OR next CLABSI) BASELINE(4/1208 to 10/2019) = 12.78	>30	143	26 (4/4/20)	57	
Quarterly SIR (all payor)	≤ 0.784	0.248			
FYTD SIR (all payor) BASELINE (FY19) =1.557	≤ 0.784	0.9	0.81	0.74	
PROCESS MEASURES					
CL Gemba Rounds					
% of Gemba Rounds Completed	100%	n/a	n/a	n/a	n/a
% of pts with bath within 24 hrs	100%	n/a	81%	75%	80%
% of CL with valid rationale	100%	n/a	93%	98%	97%
% of CL dressings clean, dry and intact	100%	n/a	92%	92%	95%
% of CL that had drsg change no > than 7 days	100%	n/a	97%	87%	90%
% of patients with proper placed gardiva patch	100%	n/a	83%	81%	93%
% of CL pts with app & complete documentation	100%	n/a	81%	81%	86%
# of Pt Central Line days rounded on	n/a	n/a	426	1052	1315

Total Number of Patient Central Line Days Rounded on = 2,793

97% of Central Lines had a valid reason for the month of June

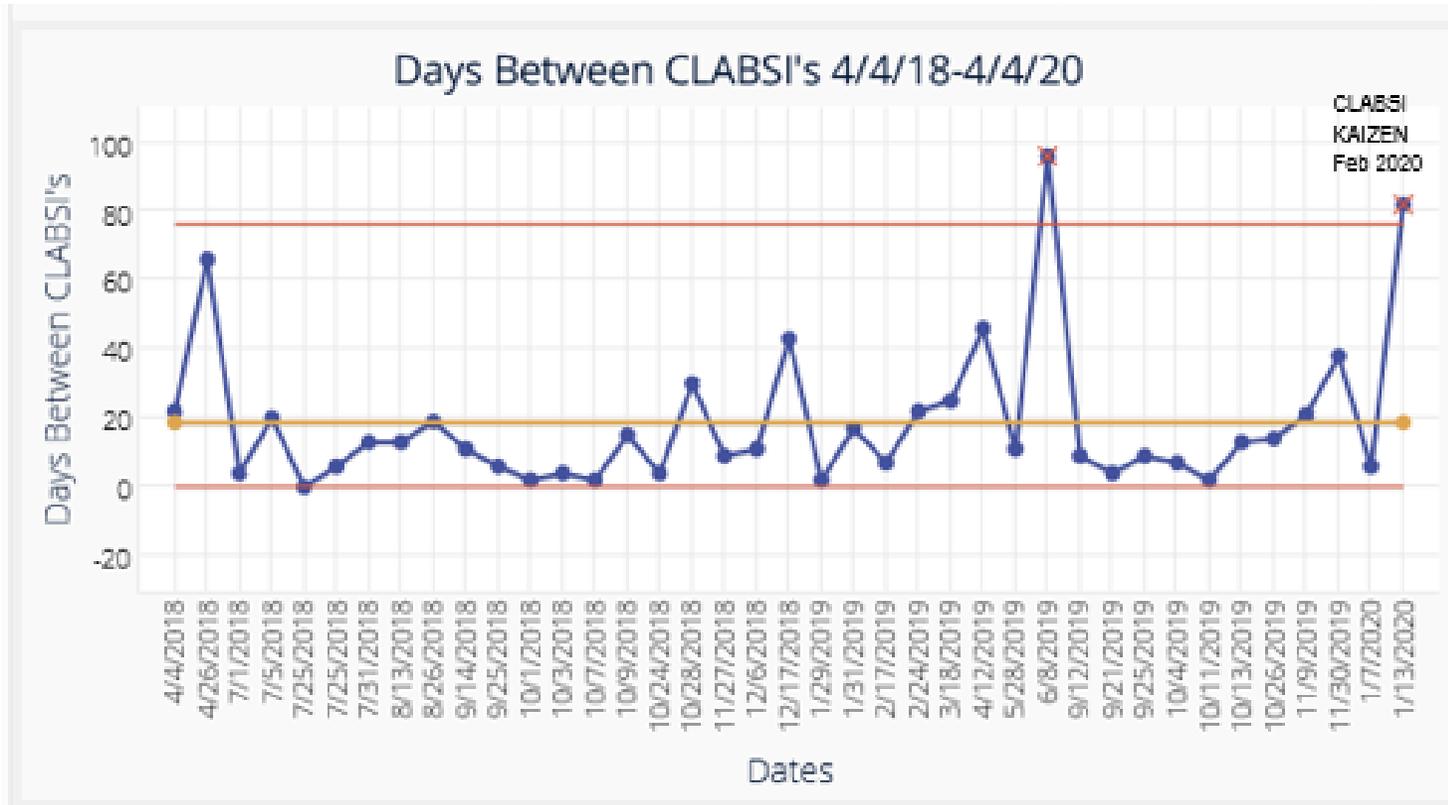
95% of Central Lines had a clean dry and intact dressing for the month of June

93% of Central Lines had a Gardiva patch placed appropriately

CLABSI Kaizen Next Steps

- IUC/ Central Line Gemba form revised for ease of use
- Data collection process simplified
- Continue to monitor when appropriate to re initiate some Kaizen initiatives that are put on hold due to COVID- 19 Pandemic

Days Between Clabsi's



Results Report

BASELINE DATA

July-Dec 2019
 SIR = 1.47
 Goal = ≤ 0.784

Mean days between
 CLABSI's 4/2018 to
 1/2020 = 17
 Goal > 40.5

Update: April 2020

Oct 2019-April 2020
 SIR = 1.02

Mean days between
 CLABSI 4/2018 to
 4/2020 = 18.74

Clabsi QFT- Plans for Improvement

- Sending out potential Clabsi's to each unit to increase awareness as soon as a potential Clabsi is detected
- Continuing to make advancements to Power Plan to increase awareness of appropriate line placement
 - For example: new pop up alert when MD is ordering a Central Line to validate reason and that other methods (PICC or Midline) have been explored
- Culture of Culturing Subcommittee meeting to prevent unnecessary testing
- Evaluating the need to bring back the IV Safety Team (IV Safety Team was terminated due to budget and staffing)
- New Central Line Dressing kit coming soon due to All Points no longer supplying current kits
- Continue to push out educational topics in our Clabsi Takeaway emails

Reply Reply All Forward
Tue 7/21/2020 5:02 PM
Baker, Amy
Learning from your Central Line Experiences- CLABSI QFT Takeaways
To *RN Group; *Nurse Manager

I WALK THE LINE
Learning From Your Central Line Experiences

June 2020
5 CLABSI Events
Days between Clabsi's?
(The higher the number of days between Clabsi's the better!)

Total Clabsi's
2019-17
2020-7

Walk the Line- learning from your Central Line Experiences
Because your mine- I'll do that Central Line dressing NOW!!
CLABSI stands for Central Line Associated Blood Stream Infection
Definition of a CLABSI- a blood stream infection that occurs when a central line has been in for greater than 2 days

Hello RN's,

It's with a heavy heart, I report that we had **five** CLABSI events for **June**. These cases have not been confirmed yet and are still in review but it looks like they will count. Because they are not confirmed CLABSI's I do not have the dates. In next month's takeaway we will have an updated number of days between CLABSI's. This is just a temporary setback. I know we will recover and continue to reduce Clabsi's for our patients. We must move forward and provide world class central line care to each and every patient. Please carefully review the takeaways below.

Some Important takeaways:

- If you see a central line dressing that is not clean, dry, or intact you must stop what you are doing and change the dressing. It's the right thing to do!
- If your patient has a central line do they really need additional peripheral IV's too? Each of the CLABSI's above had additional peripheral IV's and a central line. Sometimes this is necessary but if it's not we must remove the peripheral IV's or see if the central line is no longer needed. The more lines and tubes in a patient the greater the risk for infection. Keeping a peripheral IV for "just in case" is not an appropriate reason to keep the IV.
- Did your patient with a central line just have blood cultures ordered? If so, you should immediately start thinking this could be a

Future State Predications

Organizational Clinical Quality Goals FY20

	Current									Future State Scenario			FYTD	Baseline 1.253 ↓28%	SIR GOAL <0.784 or 12	
	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020	April 2020	May 2020	June 2020	Total			Total
CLABSI (SIR)	0.00	0.00	2.70	3.67	1.11	0.00	0.98	0.00	0.00	0.79	0.00	0.00	0.73	0.90		
numerator (actual)	0	0	3	4	2	0	1	0	0	1	0	0	11	10		
denominator (predicted)	1.19	1.23	1.11	1.09	1.8	1.13	1.02	1.27	1.22	1.26	1.26	1.26	15.12	11.06		

QUESTIONS?



Hand Hygiene

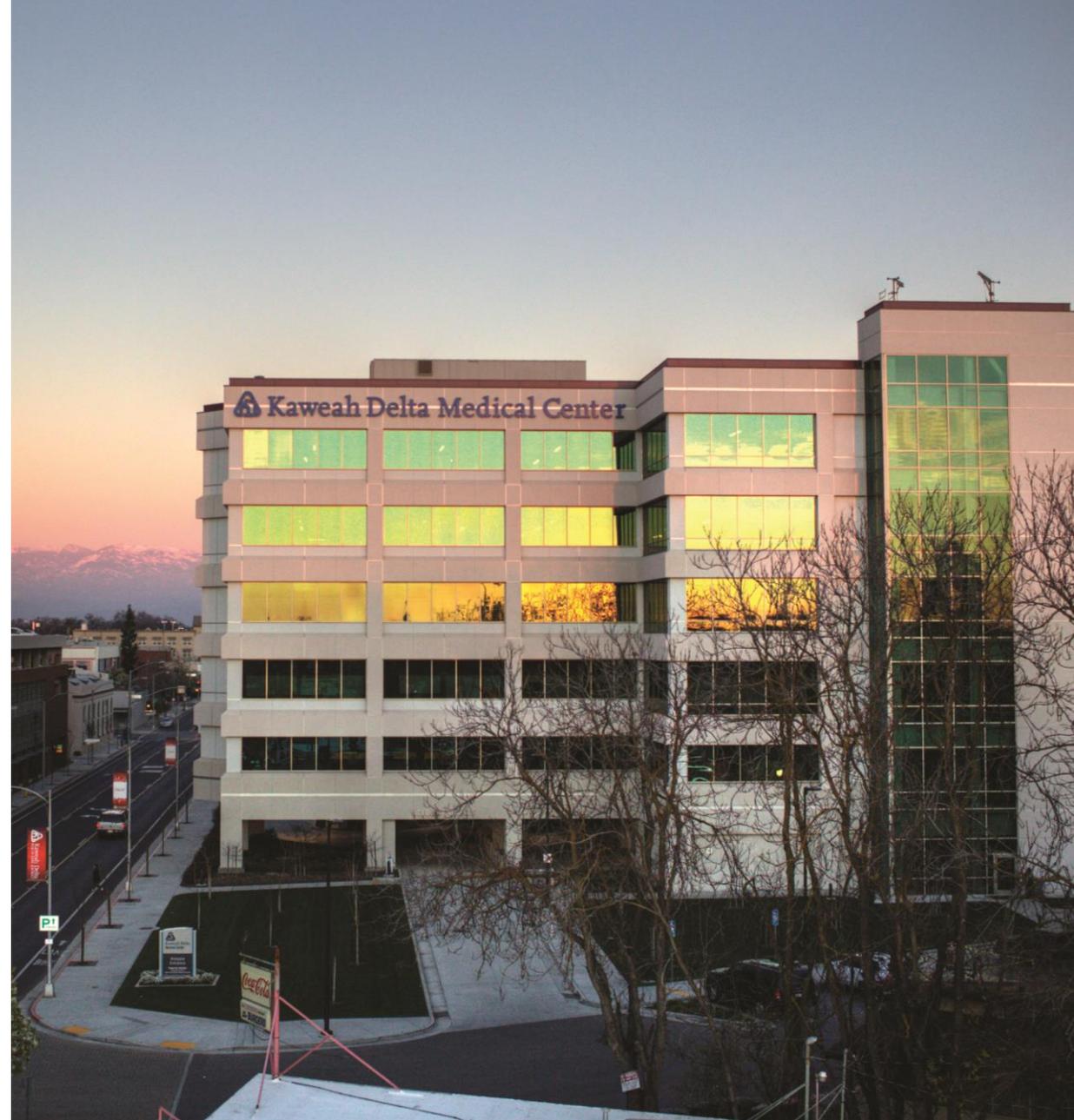
Why Monitor?

- It's the right thing to do
- Regulatory requirement, Joint Commission, Leap Frog
- Published articles:
 - Achieving over 90% compliance has shown to reduce Hospital Acquired Infections
 - Recent Journal of Infection Prevention showed reduction in sick time by 38% in an Emergency Department

ER Article: <https://doi.org/10.1016/j.ajic.2019.11.023>

Hand Hygiene Compliance

- 2016: 62%
- 2017: 58.8%
- 2019: 64%
- 12,000 opportunities observed throughout the district annually



Biovigil Trial

- Began December 18, 2019
- 4North, Acute Dialysis, ICU
- Participants:
 - Nurse, Nurses aides, unit secretaries, rapid response nurses, attending/resident physicians, environmental services, managers and directors of the units

First 2 quarters 2020



Performance Summary Dashboard

From: 1/1/2020 1:00:00 AM (-07:00); To: 6/30/2020 8:55:00 AM (-07:00)

Department

All Departments

Total HHOs

864,265

Total Compliance

99.0%

864,265 observations with 99.0% compliance

Previous: 12,000 manual observations with ~60% compliance

=Roughly 72 years of data

Sample report

<i>Job Category</i>	<i>Total Compliant (HHO)</i>	<i>Total (HHO)</i>	<i>Entry Compliance</i>	<i>Exit Compliance</i>	<i>Total Compliance</i>	<i>Entries Cross-Contaminated Non-Compliant</i>
Assistant Nurse Manager	107	107	100.0%	100.0%	100.0%	0.00%
Attending	509	525	96.5%	97.4%	97.0%	0.00%
Certified Hemodialysis Tech	4,428	4,434	99.9%	99.9%	99.9%	0.05%
Certified Nursing Assistant	37,636	37,841	99.4%	99.5%	99.5%	0.09%
Charge Nurse	15,108	15,292	98.6%	99.0%	98.8%	0.13%
Director	53	53	100.0%	100.0%	100.0%	0.00%
Environmental Services	4,252	4,343	97.7%	98.1%	97.9%	0.41%
Health Unit Coordinator	2,140	2,179	97.5%	98.9%	98.2%	0.19%
LVN	857	859	99.5%	100.0%	99.8%	0.00%
Nurse Manager	92	93	97.8%	100.0%	98.9%	0.00%
Per Diem CNA	1,337	1,339	99.7%	100.0%	99.9%	0.00%
Registered Nurse	143,610	145,052	98.8%	99.2%	99.0%	0.17%
Resident	208	216	95.1%	97.4%	96.3%	0.98%
RN-Rapid Response Nurse	5,505	5,550	98.8%	99.6%	99.2%	0.04%
RN-Renal Coordinator	105	105	100.0%	100.0%	100.0%	0.00%

<i>Non-Compliant (<= 85.0%)</i>	<i>OFI (Opportunity for Improvement) (<= 95.0%)</i>	<i>Compliant (> 95.0%)</i>
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Sample report

<i>Nursing Unit</i>	<i>Room</i>	<i>Total Compliance (HHO)</i>	<i>Total (HHO)</i>	<i>Entry Compliance</i>	<i>Exit Compliance</i>	<i>Total Compliance</i>	<i>Entries Cross-Contaminated Non-Compliant</i>
4North	Room 4North 4N1	2,648	2,672	99.0%	99.2%	99.1%	0.15%
4North	Room 4North 4N10	2,483	2,497	99.3%	99.6%	99.4%	0.00%
4North	Room 4North 4N11	3,294	3,319	99.2%	99.3%	99.2%	0.25%
4North	Room 4North 4N12	2,716	2,735	99.2%	99.4%	99.3%	0.30%
4North	Room 4North 4N13	4,090	4,122	99.0%	99.4%	99.2%	0.15%
4North	Room 4North 4N14	3,121	3,145	99.2%	99.3%	99.2%	0.13%
4North	Room 4North 4N15	3,201	3,213	99.6%	99.7%	99.6%	0.19%
4North	Room 4North 4N16	3,520	3,541	99.1%	99.7%	99.4%	0.23%
4North	Room 4North 4N17	3,555	3,567	99.8%	99.6%	99.7%	0.00%
4North	Room 4North 4N18	2,946	2,956	99.4%	99.9%	99.7%	0.07%
4North	Room 4North 4N19	3,054	3,086	98.7%	99.2%	99.0%	0.26%
4North	Room 4North 4N2	3,204	3,224	99.2%	99.6%	99.4%	0.06%
4North	Room 4North 4N20	3,484	3,497	99.6%	99.7%	99.6%	0.18%
4North	Room 4North 4N21	3,059	3,097	98.5%	99.1%	98.8%	0.20%
4North	Room 4North 4N22	2,110	2,127	99.1%	99.3%	99.2%	0.19%
4North	Room 4North 4N23	2,006	2,023	98.9%	99.4%	99.2%	0.61%
4North	Room 4North 4N24	2,098	2,128	98.6%	98.6%	98.6%	0.48%
4North	Room 4North 4N25	2,848	2,858	99.5%	99.8%	99.7%	0.00%
4North	Room 4North 4N26	2,712	2,721	99.5%	99.0%	99.7%	0.15%

Sample report

	Entries Total	Entries Cross-Contaminated	Entries Cross-Contaminated	Entries Cross-Contaminated Non-Compliant	Entries Cross-Contaminated Non-Compliant
	153	21	13.73%	9	5.88%
	26	2	7.69%	1	3.85%
	242	25	10.33%	9	3.72%
3	77	6	7.79%	2	2.60%
7	271	29	10.70%	5	1.85%
3	1,023	63	6.16%	18	1.76%

Next stage of implementation:

- 2N/S
- 3N/S
- 4N/S
- BP
- ICU
- 3W
- CVICU
- 4T
- 5T
- L&D
- Labor Triage
- NICU
- MB
- Peds

423 rooms

Other areas will be considered for monitoring after these units are fully implemented and evaluated.

Questions...

Safety Culture Update

May 2020



Safety Culture Update

1. Safety Culture reporting requirements
2. SAQ 2018 results review & current org strategies
3. Just Culture Steering Committee Update
4. TeamSTEPPS training Evaluation
 - Broad dissemination of “Say it again, Sam” (aka 2-Challenge Rule)
5. Event Reporting QI
6. Safety Attitudes Questionnaire Update

Safety Culture Measurement and QI

Entities/Initiatives with Requirements:

- Leapfrog National Quality Forum Safe Practice, included in Leapfrog Safety Score/Grade
 - Teamwork training is a NQF safe practice QI strategy
- The Joint Commission – Patient Safety Chapter requirements
- Kaweah Strategic Plan (under Kaweah Culture pillar)
 - Teamwork and Safety Climate

2018 KDHC SAQ Domain Scores & Organizational Initiatives

JOB SATISFACTION

70%

-1%
Score Change

71%
Industry Med.

[View Dashboard](#)

Below Median

ORG INITIATIVE

- Employee engagement initiatives
- Unit-Level SAQ action plans

- 5 categories below the 50th percentile, 1 above and 1 equal
- 3 domains have improved from 2016, 2 have decreased and 2 are unchanged

Score change is % change from KDHC's 2016 SAQ survey

TEAMWORK CLIMATE

63%

0%
Score Change

66%
Industry Med.

Below Median

- TeamSTEPPS
- CUSP Program

SAFETY CLIMATE

69%

-2%
Score Change

73%
Industry Med.

Below Median

ORG INITIATIVE

- Just Culture
- Midas system revisions
- Good catch/Hero
- CUSP/IP Liaison
- CUS mandatory new hire module

STRESS RECOGNITION

55%

6%
Score Change

47%
Industry Med.

Above Median

- Stress Recognition modules for all new hires and ad hoc

PERCEPTIONS OF LOCAL MANAGEMENT

62%

3%
Score Change

67%
Industry Med.

Below Median

- CUSP
- Leader rounding
- Just Culture

PERCEPTIONS OF SENIOR MANAGEMENT

41%

1%
Score Change

46%
Industry Med.

Below Median

- CUSP ET Sponsors
- Leader rounding
- Just Culture

WORKING CONDITIONS

55%

0%
Score Change

55%
Industry Med.

Equal to Median

- Employee engagement initiatives
- Unit-Level SAQ action plans

Just Culture Steering Committee Update

- Plan for Just Culture staff awareness campaign tentatively fall 2020
- Evaluating additions of Just Culture questions to event follow up in Midas
- Including the Just Culture focused questions in the 2020 SAQ (compare to 2018 baseline)
- Ongoing manager training to Just Culture and the Marx Algorithm

TeamSTEPPS Training Evaluation

March 3&4, 2020

Mean response on 1-5 Likert Scale (1=poor, 5=excellent)	n=30
The objectives of this course were met	4.87
Course content is relevant to my work	4.93
My understanding of the topic prior to the course (n=15)	3.20
My understanding of the topic after the course	4.77
Change pre/post training	1.57
Percent improvement	49%
Would recommend this course to others	97%

- Summary: The training did what it was supposed to, participants felt it was useful to their role/work, and learning occurred: 49% improvement in the understanding of TeamSTEPPS

TeamSTEPPS Training Evaluation

- 15 TeamSTEPPS Tools
- Implemented, or plan to be implemented in 11 different units/depts at Kaweah Delta
- TeamSTEPPS takes us:
 - **To a new environment**
 - **Using a new language**
 - **That builds teams**
 - **Brings more joy and meaning to the workplace**
 - ***and Saves Lives***

The TeamSTEPPS Tool Box

BARRIERS

- Inconsistency in Team Membership
- Lack of Time
- Lack of Information Sharing
- Hierarchy
- Defensiveness
- Conventional Thinking
- Complacency
- Varying Communication Styles
- Conflict
- Lack of Coordination and Followup With Coworkers
- Distractions
- Fatigue
- Workload
- Misinterpretation of Cues
- Lack of Role Clarity

TOOLS and STRATEGIES

Communication

- SBAR
- Call-Out
- Check-Back
- Handoff

Leading Teams

- Brief
- Huddle
- Debrief

Situation Monitoring

- STEP
- I'M SAFE

Mutual Support

- Task Assistance
- Feedback
- Assertive Statement
- Two-Challenge Rule
- CUS
- DESC Script

OUTCOMES

- Shared Mental Model
- Adaptability
- Team Orientation
- Mutual Trust
- Team Performance
- Patient Safety

Say it again, Sam

Get your concern addressed! Say it twice for patient safety!

Say it again, Sam is used to speak up to a care team member if you have a patient safety concern or need clarification on an issue. **It's all about saying it twice!** Use this with or without your "CUS" words (I am Concerned, Uncomfortable, it's a Safety Situation).

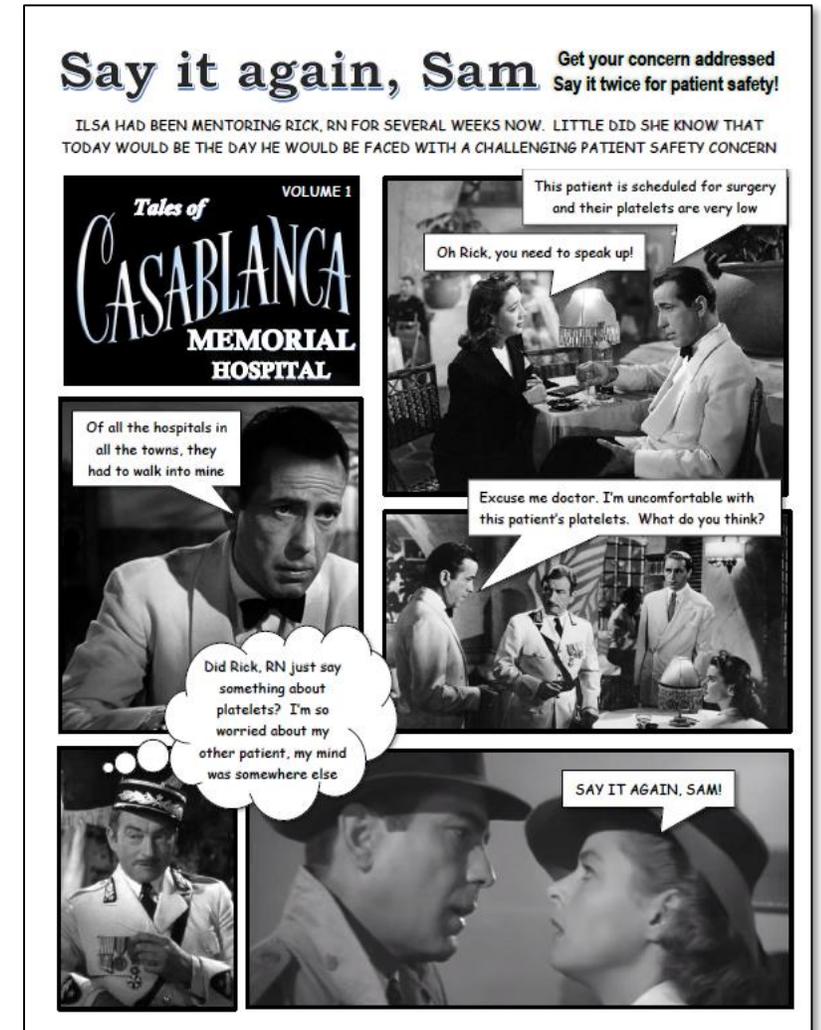
1. Speak up about your patient safety concern
2. If your concern is ignored or dismissed, Say it Again – **add more detail about your concern.**
3. If your concern is not addressed after 2 attempts, **use chain of command.**

Say it again, Sam is all about advocating for patients. It ensures that your concern has been:

- heard
- understood
- acknowledged

If a patient care concern is stated to you twice **stop, listen**, and respond; this is a very real concern that needs attention!

This communication is key to patient safety and helps us provide quality care to our patients.



Next Steps for TeamSTEPPS

- Leader coach tool implementation
- Evaluating a staff level voluntary TeamSTEPPS option (recommended by leader coaches)
- Broad awareness of “Say it again, Sam”
- Cohort #3 planned for next FY

Event Reporting QI

Based on careful evaluation and staff feedback the event reporting system was revised to be easier for staff and providers to enter event reports

The Journey to Improving Safety Culture: Reducing Entry Time for Patient Safety Events

Evelyn McEntire, BSN, RN, Sandy Volchko, DNP, RN, CLSSBB, Jennifer Halsey, BS, Eduardo Castro, BIS, Mary Rogers
Kaweah Delta Risk Management and Quality & Patient Safety Departments

Background

Encouraging patient safety reporting empowers an organization's most valuable assets - its people - to always be vigilant for hazards in the face of varying system conditions.

Reporting close calls is an important step toward developing the ability to respond to "weak signals" or poorly detected risks. Close calls are defined as unsafe acts or conditions - errors, procedure violations or hazards - that could have seriously harmed a patient but did not because they were identified, reported, and addressed or eliminated (The Joint Commission [TJC], 2018).

Reporting close calls is important for the following reasons:

- They provide valuable information on active and potential weaknesses in health care systems.
- They are more frequent than events causing harm and provide information about errors from the perspective of health care workers in different positions.
- Analysis of high-frequency or high-potential-severity near miss reports makes it possible to identify system weaknesses and learn from them in the context of daily workflow or systems use (TJC, 2018).

To enhance the value of event reporting systems, industry experts Cuong Pham, Girard, & Pronovost (2013) recommend making reporting easier. "Rather than making adverse event reporting systems more complex, we should move to making reporting exceedingly easy and less burdensome. Healthcare providers should have quick and ready access (electronic, web-based) to these systems. These systems should be so simple that staff can use them with minimal or without training. Given the infrequent nature by which most staff members report adverse events, any training will likely have been forgotten at the time of reporting."

These systems should ask for a minimal amount of information about the event. And instead of asking the healthcare provider to categorize the event, rate the event, and attribute causes, a free text description and some identifying information may be all that is required. The ease of event reporting is key in increasing the amount of events reported, the identification of close calls, and in an organization's journey of just culture.

Introduction

In 2018 a custom question was added to the organization's safety culture survey to assess the user perceptions of the ease of event reporting. Based on a Likert scale of 1-5, over 2,000 health care providers answered the question: "The event reporting system is easy to use." 59% of respondents answered favorably (agree [4] or strongly agree [5]). It was evident from these results that changes needed to occur to move forward in the safety culture journey.

Beginning in 2013, the organization has administered the Safety Attitudes Questionnaire (SAQ) every two years to assess safety culture and focus improvement efforts. In 2018 seven custom questions focused on elements of just culture were added to obtain a baseline measure of staff's perceptions of just culture in the organization; the ease of event reporting was one of those questions.

Methodology

Between 2018 and early 2019 feedback on how to make the event reporting system and process easier was solicited from staff and providers using formal and informal methods. This input was used in evaluating components of event reporting forms and workflow by patient safety leadership, and resulted in several significant system modifications:

1. The 16 existing forms were reviewed and evaluated for necessity and 12 were consolidated into 1 form titled "general event." Reducing the number of forms to select from 16 to 5 made reporting easier by limiting the number of options for end-users to select from.



2. The need for end-users to categorize the event was removed. Previous to the system modifications, end-users were required to select categories such as "Unexpected Return to the OR" and "Wrong Type of Test/Treatment/Procedure" to submit an event. There were over 170 categories in total to choose from, often confusing and time consuming for the end-user. Workflow changes led to Risk Management Department taking on the responsibility of this function, which took the onus off the end-user and resulted patient safety experts categorizing events accurately upon initial review.



3. Several mandatory fields were eliminated. More importantly, five (5) tabs/pages of questions were eliminated including over two (2) dozen fields. As a result end-users complete one short form instead of multiple tabs and fields to click through. Examples of mandatory fields:



- "What type of safety event is being reported?"
- "Did the event reach the patient?"
- "Was the level of harm severe (or is it anticipated to be severe)?"
- "Was the event caught as part of the normal checks in the process?"

Results

The mean amount of time required to submit an event report decreased following the system modifications:

- Mean time to submit a general event 10.7 minutes from July 2018 - June 2019
- Mean time to submit a general event 9.09 minutes from July 2019 - December 2019
- There was a significant difference in the time before system modifications (M=10.70, SD=0.462) and after (M=9.09, SD=0.721); t(16)=5.796, p = 0.001
- Estimated time savings per event entry 1:37
- There are on average 171 general events submitted per month
- Estimated time savings in event entry: 4 hrs 34 min per month; >55 hrs per year



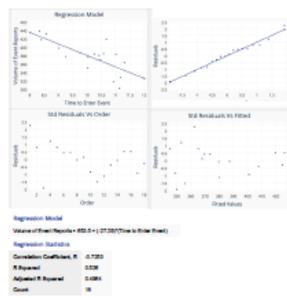
The mean volume of patient safety events submitted increased after system modifications were completed.

- Mean volume of event reports submitted monthly January 2017 to May 2019 (before system revisions) 357
- Mean volume of event reports submitted monthly June 2019 to January 2020 (after system revisions) 405
- There was a significant difference in the volume of events before system changes (M=1357, SD=41.15) and after (M=405.38, SD=34.71); t(35)=2.03, p = 0.0045



Simple linear regression was carried out to investigate the relationship between number of event reports and time to enter events (minutes). The scatterplot showed that there was a strong negative linear relationship between the two, which was confirmed with a Pearson's correlation coefficient of -0.725. Simple linear regression showed a significant relationship between time to enter an event and number of events (p < 0.001). The slope coefficient for volume of events was -27.29 so the volume of event reports increases by 27 (95% CI [-39.98, -14.59]) when the time to enter decreases by 1 minute. The R2 value was 0.526 so 52.6% of the variation in volume of event reports can be explained by the model containing only time to enter events.

Results Cont'd



Regression Model

Value of (Event Reports) = 405.38 + (27.29)(Time to Enter Event)

Regression Statistics

Correlation Coefficient, R: 0.7253

R Squared: 0.526

Adjusted R Squared: 0.4984

Count: 35

Coefficient Table

Intercept	Volume	Std. Error	t-value	p-value	95% CI (Lower)	95% CI (Upper)
405.38	-27.29	41.15	-1.27	0.2027	323.8	486.9

ANOVA

Source	Sum Sq	Mean Sq	F-value	p-value
Regression	111.9833603	11.19833603	17.296	0.0007
Residuals	16.10268191	0.40268191	NA	NA
Total	128.0860522	NA	NA	NA

Conclusion

The system modifications for event entry resulted in significant reduction in the time to enter events. Following the system modifications the volume of events increased significantly. Considering no other strategies targeted at increasing event reporting were implemented parallel to the system modifications it is reasonable to assume that "reporting complexity" was a significant root cause of under reporting. Simplification was the countermeasure and this resulted in less time to report and more reporting.

Next Steps

In April 2020 the organization will administer the Safety Attitudes Questionnaire (safety culture survey) to approximately 3,000 staff. The just culture focused questions from the administered 2018 SAQ survey will be included in the 2020 survey as a means to measure the change of the end-users' perceptions of the ease of event reporting. Further evaluation will continue to identify additional opportunities to reduce reporting burden.

References

Julius Cuong Pham, Thierry Girard, Peter J. Pronovost (2013). What to do with healthcare Incident Reporting Systems. Journal of Public Health Research, volume 2:227. The Joint Commission (2018). Sentinel Event Alert #60: Developing a reporting culture: Learning from close calls and hazardous conditions. Retrieved from : jointcommission.org

RESULTS

- The mean amount of time required to submit an event report decreased following the system modifications
- Mean time to submit a general event 10 7 minutes from July 2018 June 2019
- Mean time to submit a general event 9 09 minutes from July 2019 December 2019
- There was a significant difference in the time before system modifications (10 70 SD= 0 462 and after M= 9 09 SD= 0 721 t(16 5 796 p 0 001
- Estimated time savings per event entry 1 37
- There are on average 171 general events submitted per month
- Estimated time savings in event entry 4 hrs 34 min per month, 55 hrs per year

- The mean volume of patient safety events submitted increased after system modifications were completed

- Mean volume of event reports submitted monthly January 2017 to May 2019 (before system revisions) 357
- Mean volume of event reports submitted monthly June 2019 to January 2020 (after system revisions) 405

- There was a significant difference in the volume of events before system changes M= 1357 SD= 41 15 and after M= 405 38 SD= 34 71 t(35 2 03 p 0 0045

Safety Culture Measurement

- SAQ tentatively for Nov/Dec 2020
- Includes the 7 custom Just Culture Questions plus an additional new question for 2020
 1. When I see others doing something unsafe for patients, I speak up.
 2. My manager supports and leads a culture of patient safety in my work setting.
 3. When staff make clinical errors, we focus on learning rather than blaming.
 4. I enter reports about events in which I was involved.
 5. I make the hospital a safer place for patients by entering event reports.
 6. My Director supports and leads a culture of patient safety in my work setting.
 7. The event reporting system is easy to use.
 8. Physicians support a culture of patient safety in this work setting. NEW!

Questions? Comments?

Clinical Quality Goal Update August 2020

Sepsis

Kaweah Clinical Quality Goal Calculator - FY20

	Current												FYTD	Baseline 67%	Goal 70%	Top 10% = 81% (Q3 2018 - Q2 2019)
	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020	April 2020	May 2020	June 2020	Total			
SEP-1 Early Management Bundle	68%	67%	58%	67%	61%	74%	54%	75%	61%	88%	56%	85%	67%	67%		
numerator	13	16	14	20	17	17	14	18	14	22	18	17	200	200		
denominator	19	24	24	30	28	23	26	24	23	25	32	20	298	298		

June 2020 Case Summary

- 3 sepsis fallouts
 - Patient had second hypotensive episode after coordinator left
 - Patient needed repeat lactic acid, ED “Catch Up” order set used, omitted the LA

Sepsis Heroes

Case Summary

- Renal and cardiac disease, high blood pressure(BP), diabetes, gout, obesity, ejection fraction 30% with implantable defibrillator, and possible aspiration pneumonia.
- Low BP at Visalia Dialysis
- ED to 4N, code blue with PEA (pulseless electrical activity)
- Resuscitated, transferred to CVICU
- Sepsis Alert fired, coordinator at bedside ensuring bundle requirements met, sepsis treat empirically, but low on the differential (CHF exasperation/fluid overload thought to be primary cause)
- Fever spiked as coordinator left bedside, Sepsis diagnosis
- Sepsis identified and treated EARLY
- Patient recovered, tx back to med/surg, and is now HOME!



CAUTI, CLABSI,

	Current												FYTD	Baseline 1.557 ↓34%	SIR GOAL ≤0.828 or 14	VBP 2022 50 perc ≤0.727	
	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020	April 2020	May 2020	June 2020	Total				Total
CAUTI (SIR)	0.65	2.76	2.34	0.68	0.00	0.00	0.00	1.24	0.00	0.59	2.47	0.63	1.03	1.03			
numerator (actual)	1	5	4	1	0	0	0	2	0	1	4	1	19	19			
Denominator (Actual 9 months + Predicted Apr - Jun) Linear Regression	1.53	1.81	1.71	1.47	1.46	1.03	1.7	1.61	1.24	1.69	1.62	1.58	18.45	18.45			

	Current												Future State Scenario	FYTD	Baseline 1.253 ↓41%	SIR GOAL <0.784 or 12	VBP 2022 50 perc ≤0.633
	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020	April 2020	May 2020	June 2020	Total *	Total			
CLABSI (SIR)	0.00	0.00	2.70	3.67	1.11	0.00	0.00	0.00	0.00	0.82	0.00	4.07	0.68	0.74			
numerator (actual)	0	0	3	4	2	0	0	0	0	1	0	0	0	15			
Denominator (Actual 9 months + Predicted Apr - Jun) Linear Regression	1.19	1.23	1.11	1.09	1.8	1.13	1.02	1.27	1.22	1.22	1.23	1.23	14.74	14.74			

	Current												FYTD	Baseline 1.410 ↓29%	SIR GOAL <0.815 or 7	VBP 2022 50 perc ≤0.748	
	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020	April 2020	May 2020	June 2020	Total				Total
MRSA (SIR)	2.67	1.33	1.33	0.00	0.00	2.78	0.00	1.89	1.89	0.00	0.00	0.00	1.00	1.00			
numerator (actual)	2	1	1	0	0	2	0	1	1	0	0	0	8	8			
denominator (predicted)	0.75	0.75	0.75	0.72	0.72	0.72	0.53	0.53	0.53	0.68	0.68	0.68	8.04	8.04			

CLABSI/MRSA

CLABSI Committee Dashboard						
Measure Description	Benchmark/ Target	Mar-20	Apr-20	May-20	Jun-20	Jul-20
OUTCOME MEASURES						
Number of CLABSI	0	0	1	0		
Days Between Events (from Nov 2019) (from last CLABSI to end of reporting month OR next CLABSI) BASELINE(4/1208 to 10/2019) = 12.78	>30	143	26 (4/4/20)	57		
Quarterly SIR (all payor)	≤ 0.784	0.248				
FYTD SIR (all payor) BASELINE (FY19) =1.557	≤ 0.784	0.9	0.81	0.74		
PROCESS MEASURES						
CL Gemba Rounds						
% of Gemba Rounds Completed	100%	n/a	n/a	n/a	n/a	
% of pts with bath within 24 hrs	100%	n/a	81%	78%	80%	
% of CL with valid rationale	100%	n/a	93%	93%	97%	
% of CL dressings clean, dry and intact	100%	n/a	92%	92%	95%	
% of CL that had drsg change no > than 7 days	100%	n/a	97%	90%	90%	
% of patients with proper placed gardiva patch	100%	n/a	83%	81%	93%	
% of CL pts with app & complete documentation	100%	n/a	81%	81%	86%	
# of Pt Central Line days rounded on	n/a	n/a	426	1050	1315	
					Better than	

Summary:

- 4/6 of our best practices are now performing >90% great work! The larger sized Gardiva patches are in place
- Opportunity in getting the bathing done daily – 1 of every 5 pt's with a central line has not had a bath within 24 hrs (80%)
- Volume in pt CL days gemba'd increased from May (1052) to June (1315)
- Blood Culture (BC) within 24 Hrs - 6/17/20 through 7/31/20 the alert fired 474 times and 252 times the provider didn't go through with the order (53%).

CAUTI

CAUTI Committee Dashboard							
Measure Description	Benchmark/Target	Mar-20	Apr-20	May-20	Jun-20	Jul-20	A
OUTCOME MEASURES							
Number of CAUTI	0	0	1	4	1		
Days Between Events (from last CAUTI to end of reporting month OR next CAUTI) BASELINE (4/1208 to 10/2019) = 12.78	>30	49	2 (4/28/20)	1 (5/30/20)	3 (6/2/20)		
Quarterly SIR (all payor)	≤ 0.838	0.52			1.23		
FYTD SIR (all payor) BASELINE (FY19) =1.557	≤ 0.838	0.96	0.93	1.09	1.03		
PROCESS MEASURES							
IUC Shift Huddles							
% Huddles Accurately Completed	100%	74%	89%	93%	88%		
% insertion missed	0%	19%	40%	46%	50%		
% cleanliness missed	0%	81%	60%	54%	50%		
IUC Gemba Rounds							
% of pts with appropriate cleanliness	100%	98%	99%	98%	95%		
% of IUCs with order & valid rationale	100%	90%	93%	92%	93%		
% of IUCs where removal was attempted	n/a	8%	5%	6%	7%		
% of pts where alternatives have been attempted	n/a	15%	12%	12%	10%		
# of Pt Catheter days rounded on	n/a	616	720	948	877		
% of IUCs removed because of Gemba Round	n/a	7%	6%	3%	4%		
# of IUCs removed because of Gemba Round	n/a	46	42	33	35		
					Better than Targ		

Summary:

- 877 patient catheter days Gemba'd, wow!
- >90% ensuring best practices of cleanliness (bath or peri-care) and appropriate use of IUC! Great work!
- 35 Catheters removed because of the Gemba! That's 35 Patients who didn't get a CAUTI or UTI/Sepsis!
- Opportunity in getting huddles completed that include both elements, important for continuity of care!
- Note the proportion of patients where alternatives to the IUC is attempted is consistently decreasing. We have more patient days with catheters in May and June, and less proportion of those patients where alternatives to an IUC are being attempted.

CAUTI, CLABSI,

CAUTI MIRSA

Bi-vision installation currently in progress!

- New! CAUTI reduction email group and all near misses go out to this group for awareness/follow patient in gembas
- CAUTI QFT summary provided monthly with updates, data and next steps
- Changes to the UA orders are live! the UA and UA with reflex culture have mandatory criteria for testing included in the order, the culture only order has the 'restricted use' language
- The IUC insert powerplan goes live mid-August, plan for this powerplan to be embedded in existing powerplans (coming soon), as well as task to change the IUC at 30 days if chronically retained coming soon

CLABSI/MRSA

- Sending out potential Clabsi's to each unit to increase awareness as soon as a potential Clabsi is detected
- Continuing to make advancements to Power Plan to increase awareness of appropriate line placement
 - For example: new pop up alert when MD is ordering a Central Line to validate reason and that other methods (PICC or Midline) have been explored
- Culture of Culturing Subcommittee meeting to prevent unnecessary testing
- Evaluating the need to bring back the IV Safety Team (IV Safety Team was terminated due to budget and staffing)
- New Central Line Dressing kit coming soon due to All Points no longer supplying current kits
- Continue to push out educational topics in our Clabsi Takeaway emails

Questions?