July 11, 2024

NOTICE

The Board of Directors of the Kaweah Delta Health Care District will meet in a Quality Council Committee meeting at 7:30AM on Thursday, July 18, 2024, in the Kaweah Health Lifestyle Fitness Center Conference Room, 5105 W. Cypress Avenue, Visalia, CA 93277.

The Board of Directors of the Kaweah Delta Health Care District will meet in a Closed Quality Council Committee at 7:31AM on Thursday, July 18, 2024, in the Kaweah Health Lifestyle Fitness Center Conference Room, 5105 W. Cypress Avenue, Visalia, CA 93277, pursuant to Health and Safety Code 32155 & 1461.

The Board of Directors of the Kaweah Delta Health Care District will meet in an open Quality Council Committee meeting at 8:00AM on Thursday, July 18, 2024, in the Kaweah Health Lifestyle Fitness Center Conference Room, 5105 W. Cypress Avenue, Visalia, CA 93277.

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 Health Medical Center, Mineral King Wing entry corridor between the Mineral King lobby and the Emergency Department waiting room.

The disclosable public records related to agendas are available for public inspection at Kaweah Health Medical Center – Acequia Wing, Executive Offices (Administration Department) {1st floor}, 400 West Mineral King Avenue, Visalia, CA and on the Kaweah Delta Health Care District web page https://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
http://www.kaweahhealth.org

KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS
QUALITY COUNCIL

Thursday, July 18, 2024
5105 W. Cypress Avenue
Kaweah Health Lifestyle Fitness Center Conference Room

ATTENDING: Board Members: Michael Olmos (Chair), Dean Levitan, MD; Gary Herbst, CEO; Keri Noeske, Chief Nursing Officer; Tom Gray CMO/CQO; Julianne Randolph, OD, 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; and Kyndra Licon, Recording.

OPEN MEETING – 7:30AM

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 jurisdiction 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. **Approval of Quality Council Closed Meeting Agenda** – 7:31AM
   - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Julianne Randolph, DO, Vice Chief of Staff and Quality Committee Chair; Mara Miller, PharmD BCPS, Medication Safety Coordinator*
   - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Evelyn McEntire, RN, BSN, Director of Risk Management and Ben Cripps, Chief of Compliance and Risk Officer.*
4. **Adjourn Open Meeting** – *Mike Olmos, Committee Chair*

CLOSED MEETING – 7:31AM

1. **Call to order** – *Mike Olmos, Committee Chair*

2. **Approval of June 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 – *Julianne Randolph, DO, Vice Chief of Staff and Quality Committee Chair; Mara Miller, PharmD BCPS, Medication Safety Coordinator*

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

5. **Adjourn Closed Meeting** – *Mike Olmos, Committee Chair*

OPEN MEETING – 8:00AM

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. **Approval of June Quality Council Open Session Minutes –** Mike Olmos, Committee Chair; Dean Levitan, Board Member

4. **Sepsis Quality Focus Team Report -** A review of key quality measures and action plans focused on the care of sepsis patient population. *Erika Pineda, BSN, RN, PHN, CPHQ, Quality Improvement Manager; LaMar Mack, MD, MHA, Medical Director of Quality and Patient Safety.*

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

6. **Adjourn Open Meeting** – *Mike Olmos, 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.

Agenda item intentionally omitted

OPEN Quality Council Committee
Thursday, June 20, 2024
The Lifestyle Center Conference Room

Attending: Board Members: Mike Olmos (Chair) & Dr. Dean Levitan; Gary Herbst, Chief Executive Officer; Dr. Paul Stefanacci, CMO/CQO; Mark Mertz, Chief Strategy Officer; Sandy Volchko, Director of Quality & Patient Safety; Jag Batth, Chief Operating Officer; Ryan Gates, Chief Population Health Officer; Erika Pineda, Quality Improvement Manager; Shawn Elkin, Infection Prevention Manager; Kyndra Licon, Program Coordinator – Recording.

Mike Olmos called to order at 7:30 am.

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

Mike Olmos adjourned the meeting at 7:31 am.

Mike Olmos called to order at 8:00 am.

3. **Approval of April Quality Council Open Session Minutes –** Mike Olmos, Committee Chair; Dean Levitan, Board Member.
    - Approval of April Quality Council Open Session Minutes by Dean Levitan and Mike Olmos.

4. **Written Quality Reports –** A review of key quality metrics and actions associated with the following improvement initiatives: discussion on 4.1 Leapfrog Fall 2024 Safety Score Review Report.

    4.1 Leapfrog Fall 2024 Safety Score Review Report

    Detailed discussion on Leapfrog measures, grade and outcome in Spring 2024. The color coding reflects our Spring 2024 score results compared to the national mean. Red indicates it is under preforming under the mean. The majority of the measures come from CMS and the Leapfrog Survey. Leapfrog is an independent entity and is considered"a watch dog" group consisting of members from Fortune 500 companies. Mike "We simply have to tough this thing out. The one thing that struck me is we were knocked on hand hygiene". A lot of work done by Shawn and other individuals to meet Leapfrog measures. One of them is making sure we have manual hand hygiene observations on top of our electronic system, which is where we missed. We also have to have patient family education, and includes the report that Shawn completes for our oversight committees reporting to community. We will be up 40 to 70 points in the next cycle. Who is deemed trained and competent in observing staff preform hand hygiene? We have trained individuals who perform this task, right now we have IP team. A factor in collecting accurate hand hygiene compliance data is the Hawthorne effect - when an individual modifies their behavior if they know they are being observed. The plan is to have clinical leaders of areas that have Biovigil assign 5 hand hygiene audit each month to staff who can complete observations on nights and weekends. The Hand Hygiene report is on the agenda today to show some of the data. It's a robust chapter. There is nothing we can do about this score; it doesn't mean that we should be accepting of it. We need to formulate an approach to not be a grade "C" again and be better. Top 7 measures are done through Leapfrog survey, the remaining measures come from CMS.

4.2 Renal Services – Network 18 Quality Report
4.3 Subacute Quality Report
4.4 Trauma Services Quality Report
4.5 Health Equity Quality Report

5. **Hand Hygiene –** A review of current performance and actions focused on the clinical goal for Hand Hygiene*. Shawn Elkin, Infection Prevention Manager.*

Increased users of Biovigil has led to a drop in compliance, this is related to a learning curve for staff in system functionality and is expected. Upward trend for number of hand hygiene (HH) observations being performed. Overall compliance and in patient care areas, we are meeting HH compliance goal of 95%. We monitor percentage of active Biovigil users and set a goal of 50%; this measures individuals who have access to Biovigil are pairing themselves to a badge with pair time of >80hrs for the month. There ahs been a positive increase over the months. There has been discussion of increasing the goal as the current goal has been surpassed. Leapfrog wants to know all the elements of hand hygiene. This includes quarterly audits and trending hand hygiene supply processes (refill soap, paper towels, sanitizer) by EVS. They want to know you are monitoring and analyzing data, educating, it's a robust chapter to check all the boxes. 95% is an internal goal that Kaweah Health set for our organization for HH compliance. There were two requirements that we could not answer Leapfrog last year. This time we were able to answer with a yes to voume of observations, and there is a plan in place to ensure we are compliant with the direct/manual observations for next year. We have to complete 20 observations per patient care location per quarter. It's a bit frustrating we have this elaborate device that provides electronic data but Leapfrog wants us to do manual observation to confirm the accuracy. The requirement is to review all shift at all hours (weekdays, weekends, day and nights) and we did not do that so we did not achieve full point in the hand hygiene section of the survey. Discussed all who wear the Biovigil badge. Recognized Food Services as the department month after month with the highest compliance. Night shift has a slight better hand hygiene compliance rate compared to day shift while using the Biovigil hand hygiene monitoring system. Day shift has an overall larger volume of hand hygiene opportunities compared with night shift. Weekend hand hygiene opportunities account for only 32% of the volume that occurs during weekdays. Locations with ≥5 quarter of performance below 95% hand hygiene compliance are: 2N, CVICU, 5T, CVICCU, ED. Job categories with consistent performance below 95% hand hygiene compliance are: Certified Nurse's Assistant. Job categories with low number of hand hygiene opportunities (reflection of low Biovigil usage) are: Respiratory Therapy, and physicians/residents/advance practitioners (nurse practitioners/physician Assistants). Are there any medical benefits to Biovigil? Is there a demonstrated Biovigil correlation to hand hygiene that supports patient safety care? Do we believe that as a presence? History shows that hand hygiene contributes to safer care. Our staff and physicians had poor hand hygiene and high infection rates. Kaweah Health acquired Biovigil because of this and Biovigil helps remind individuals to wash hands. We hear complaints of hands being dry because they wash hands all the time

now. Our exit rates are higher than our entrance rate. It should be ideally both. If someone does not comply is it subject to discipline? It is part of the evaluation process. Hand Hygiene and Biovigil importance is discussed in our new hire orientation.
Have we started to pilot Biovigil to our physicians? MEC was supportive to mandate employees but not our medical staff. Committee gave approval to pilot Biovigil on ICU floor for physicians. There is an example benefit to encourage those clinical staff to use hand hygiene. Staff is frustrated that we express hand hygiene to our employees and not mandate to our physicians. Physicians are leaders who come in the room and I hope they would take that as part of the leadership role.
It's going to be difficult for physicians to use Biovigil, we have to show data to them now without Biovigil and with the use of Biovigil there is a significant change for the better. We only have one shot to pull off this pilot with physicians.
Jag asked for the respiratory therapist's hand hygiene report to discuss with his team and Wendy.

6. **Value Based Purchasing –** A review of completed and planned initiatives to identify and address Value Based Purchasing. *Erika Pineda, Quality Improvement Manager*.
    - Reviewed and explained the quick overview of Value Based Purchasing. FY 2024 is based on domains and measures from CY 2022: Clinical Outcomes, Efficiency and Cost Reduction, Person and Community Engagement, and Safety. CHA FY 2024 estimated cost for Kaweah Health at 2%; 1.7 million dollars. Areas we outperformed (earned points) Elective THA/TKA Complication Rate, HAIs and Medicare spending per beneficiary (MSPB = the hardest area to receive points). Areas of opportunity (earned 0 points) Mortality (AMI, COPD, CABG, HF, & PN) HAIs; C Diff and Patient Experience (2 categories earn in threshold or achievement). You can earn up to ten points through achievement as you are improving and if you are outperforming 50th percentile compared to national benchmark. Further discussion on earning points for Medicare Spending Per Beneficiary. Detailed discussion on missed opportunities for HAIs: C.Diff. Residents are involved in ordering lab tests and are a factor in improving.
      Discussed future conversation on how to have some dedicated time to connect with our residents and discuss areas we need improvement on: Hand Hygiene, Leapfrog and Value Based Purchasing. The hospital has a reputation to uphold and when residents need volumes to graduate they need to remember that patients look for a place of service, and their practices affect that. Sandy will add leapfrog into the resident orientation slides. Performance period for FY 2026 timeline. High level overview of leadership touching all the areas. Mike and Dean stated, we are leaving money on the table every year. We work so hard and reach achievements it seems like the hospital has done some very good things.

7. **Clinical Quality Goals Update-** A review of current performance and actions focused on the clinical quality goals for Sepsis, and Healthcare Acquired Infections. *Sandy Volchko, RN, DNP, Director of Quality and Patient Safety.*
    - Reviewed the outstanding health outcomes dashboard. Sepsis 1 FYTD 24 is 75% goal is to be at 85%. Sepsis and related conditions o/e mortality is .96 FYTD 24, our goal is ≤ .78.
    - We have had 17 CLABSI for FYTD 24. CLABSI SIR target is .39 our FYTD 24 is 1.14. No CLABSI events in May.
    - Central line utilization rate goal is .68, our FYTD 24 is .77.
    - CAUTI FYTD 24 total of 8events. No CAUTI events in May. CAUTI SIR goal is .40, we are in the green FYTD is .38.
    - Utilization rate is 1.00 FYTD 24 and goal is .70. infection rate is low and utilization is high.
    - MRSA 7 events FYTD 24.
    - MRSA SIR goal .55 FYTD24 .80. not meeting the 30th percentile.

8. Adjourn Open Meeting – *Mike Olmos, Committee Chair*

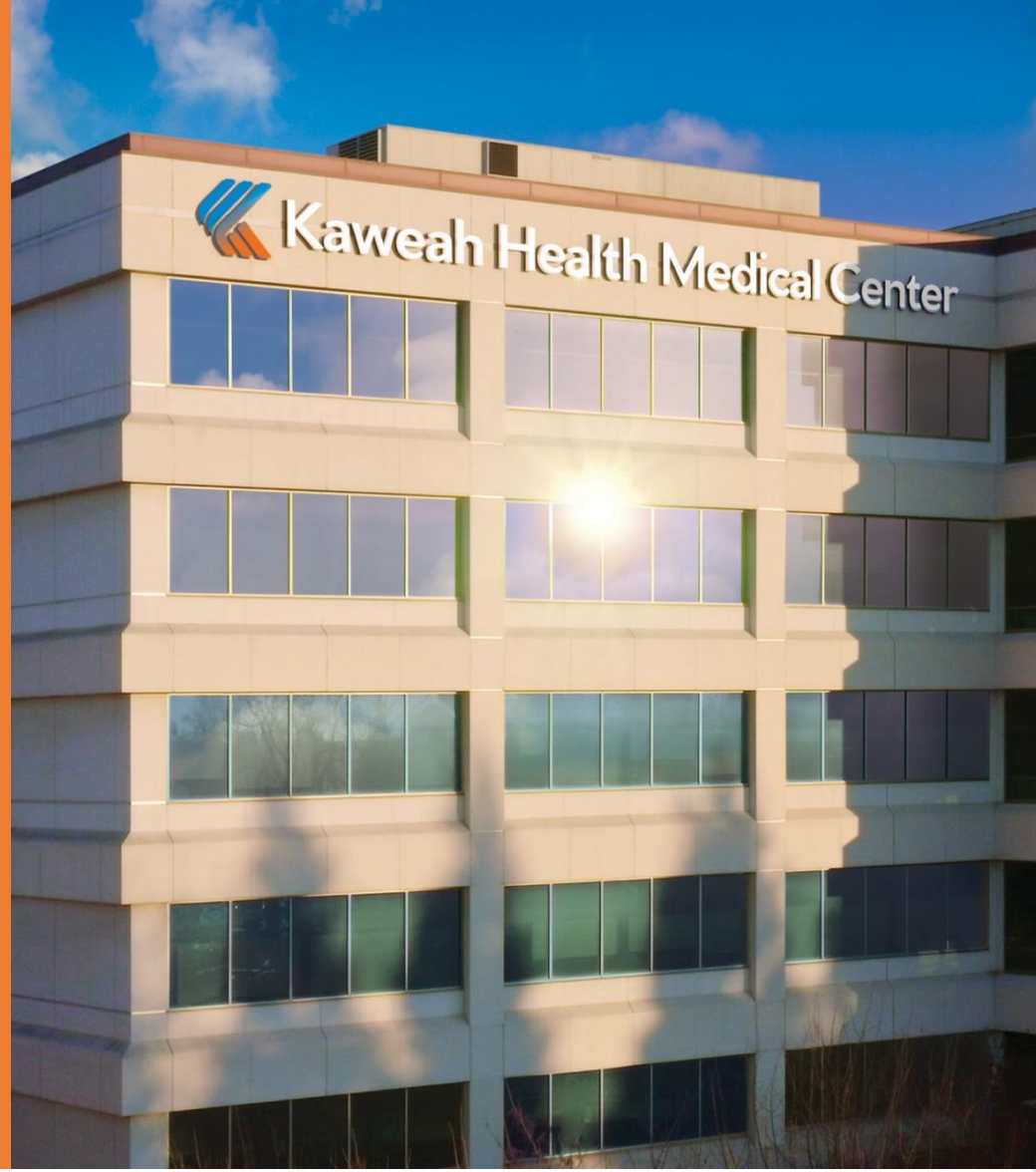
Mike Olmos adjourned the meeting at 9:23 am.

Committee minutes were approved for distribution to the Board by the Committee Chair on

Sepsis Quality Focus Team Report

Quality Council Report
July, 2024

Erika Pineda BSN, RN, CPHQ Quality Improvement Manager
Dr. Lamar Mack, M.D. MHA Medical Director of Quality & Patient Safety



Current Quality Priorities

What are we working on to improve quality?

- Enhancements to Electronic Medical Record (EMR) to help care team identify patients that need Sepsis work up and treatment within the first hour
- Resident Project: Establishing “time zero” through documentation in Sepsis.
- Completed the expansion of the Sepsis 1-Hour bundle to Inpatient setting on 7/2/24
- Upcoming Sepsis Continuing Medical Education for Medical Staff & Care Team
- Sepsis education to incoming KH Residents
- Sepsis Team Partnership with ED Chief Residents

Why are we working on this?

- Enhancing EMR Provides tools to care team that help remember evidence based practice
- Mentioning of infection/Sepsis in the ED differential diagnosis will automatically trigger “time zero” to when the note was open/started if other Sepsis clinical indicators are present per CMS. Timestamping Sepsis ED Differential Diagnosis will allow time zero to start when Sepsis 1-Hour order-set is initiated.
- ED, Medical Surgical including step down & ICU units have Sepsis 1- Hour power plan aids in Provider documentation requirements & includes order options to assist in compliance with CMS Sepsis requirements
- Provider education and strong partnerships with care team increases Sepsis awareness and promotes clear communication

Why is it important to Kaweah Health/community?

Sepsis is a life threatening emergency. Employing evidence based guidelines promotes best practices and timely care to the population we serve.

Current Performance

Kaweah Health

SEP-1 Early Management Bundle Compliance

CMS SEP-1 Bundle Compliance

SEP-1 CMS % bundle compliance

SEP-1 Bundle Elements

3 hr SEP-1 Bundle % Compliance

6 hr bundle % Compliance

	Goal	FY2020	FY2021	FY2022	FY2023	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	YTD
	85%	66.9%	74.6%	75.0%	73.0%	68%	77%	76%	76%	82%	69%	71%	85%	71%	67%			74%
	95%	76.0%	78.6%	88.0%	79.0%	79%	82%	81%	79%	86%	77%	74%	88%	71%	81%			80%
	95%	85.4%	93.5%	90.0%	91.0%	83%	94%	91%	95%	83%	88%	96%	94%	100%	77%			90%

KEY: >10% away from goal | Within 10% of goal | Within 5% of goal | Outperforming/meeting goal

CA State Compliance 65% ~ National Compliance 60% ~ Top Performing Hospitals 81%

FY 2024: 6 Lives Saved

Sepsis Any Diagnosis – Observed/Expected Mortality

Kaweah Health

Sepsis Any Diagnosis - Observed/Expected (o/e) Ratio

Number of Observed Mortality (N)

Total number Expected Mortality (D)

FY24 Goal	FY2023	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	YTD
≤0.78	1.12	0.76	0.82	0.78	0.84	1.38	1.02	0.92	1.07	0.93	0.82			0.95
n/a	140	5	8	5	9	12	19	19	15	15	8			115
n/a	125	6.62	9.77	6.42	10.78	8.71	18.71	20.59	14.03	16.13	9.72			121.47

KEY: >10% away from goal | Within 10% of goal | Within 5% of goal | Outperforming/meeting goal

Midas Risk Adjusted National 50th Percentile (Median) o/e ratio: 0.74

Opportunities for Improvement

Opportunities

- Differential diagnoses of infections are not being treated with Sepsis intervention or are not being refuted when infectious process is no longer entertained.
- It is not customary to treat every differential diagnosis (ddx) & to time a ddx documented in the ED record

Action Plan

- Continue education to providers during concurrent review of cases
- Resident Project: Establishing “time zero” through documentation in Sepsis.
- Sepsis brief updates to ED Chief Resident & Provider education during Sepsis meetings or other educational events

Opportunities for Improvement

Opportunities

- Blood Culture not ordered or drawn timely
- Provider does not order Blood Culture (order set not used) and/or Staff has competing priorities & miss collecting Blood Culture prior to administration of antibiotics

Action Plan

- Enhancements to Electronic Medical Record (EMR) to help care team identify patients that need Sepsis work up and treatment within the first hour
  - ✓ Sepsis reference checklist to be added to order set
  - ✓ Color coded alert or flag to alert staff who needs blood culture drawn first
- Advocate for Sepsis champions in units
- Campaign to ensure Residents have added Sepsis order set to their favorites

Accomplishments

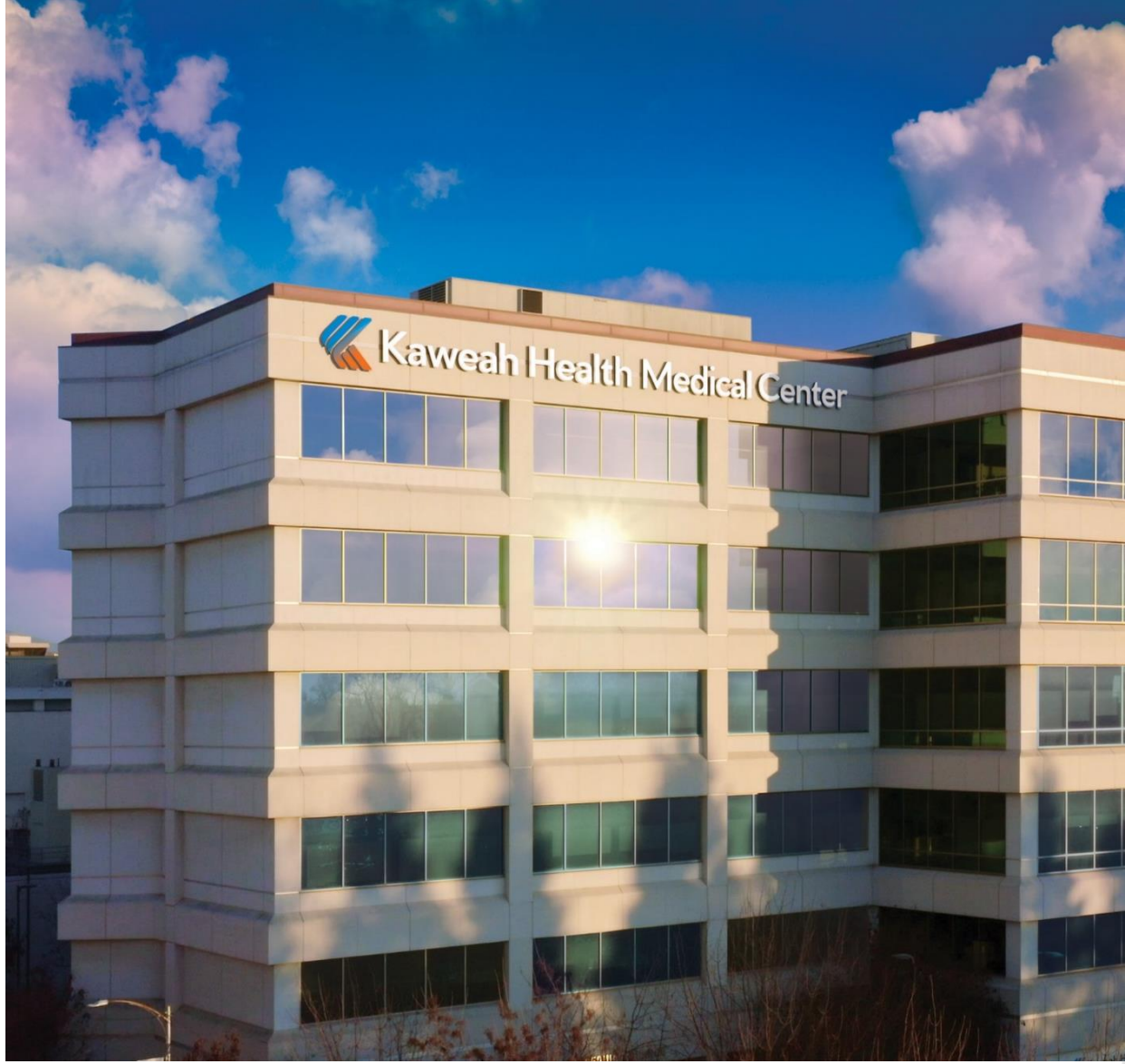
What have you achieved so far?

- 6 Sepsis lives saved for FYTD 2024 (FY 2023 o/e: 1.12 [140/125] vs FYTD 24 o/e 0.95 [115/121.47])
- Completed Implementation of Sepsis 1-Hour bundle to all inpatient units
- 1-Hour Bundle Healthy Analytics dashboard to identify and drill down in opportunities for improvement
- More fluids being ordered/administered then our historical performance or appropriately documented reasons for lesser fluid order in medical record (FY 23 compliance 84% vs FYTD 24 92%)
- ED Physician collaboration with ED Pharmacy team to document appropriate verbiage when making Ideal Body Weight adjustments to fluid bolus orders for patients with Body Mass Index over 30
- Length of Stay: Average Opportunity Days in FY24: 1.68 (0.11 decrease in FY24 vs. FY23)

How has this been achieved?

Multidisciplinary team awareness & engagement
Ongoing collegial discussion of fall out events in monthly Sepsis committee
Sepsis Mortality Initiative ongoing since June 2023
Modified Kaizen event in spring 2024

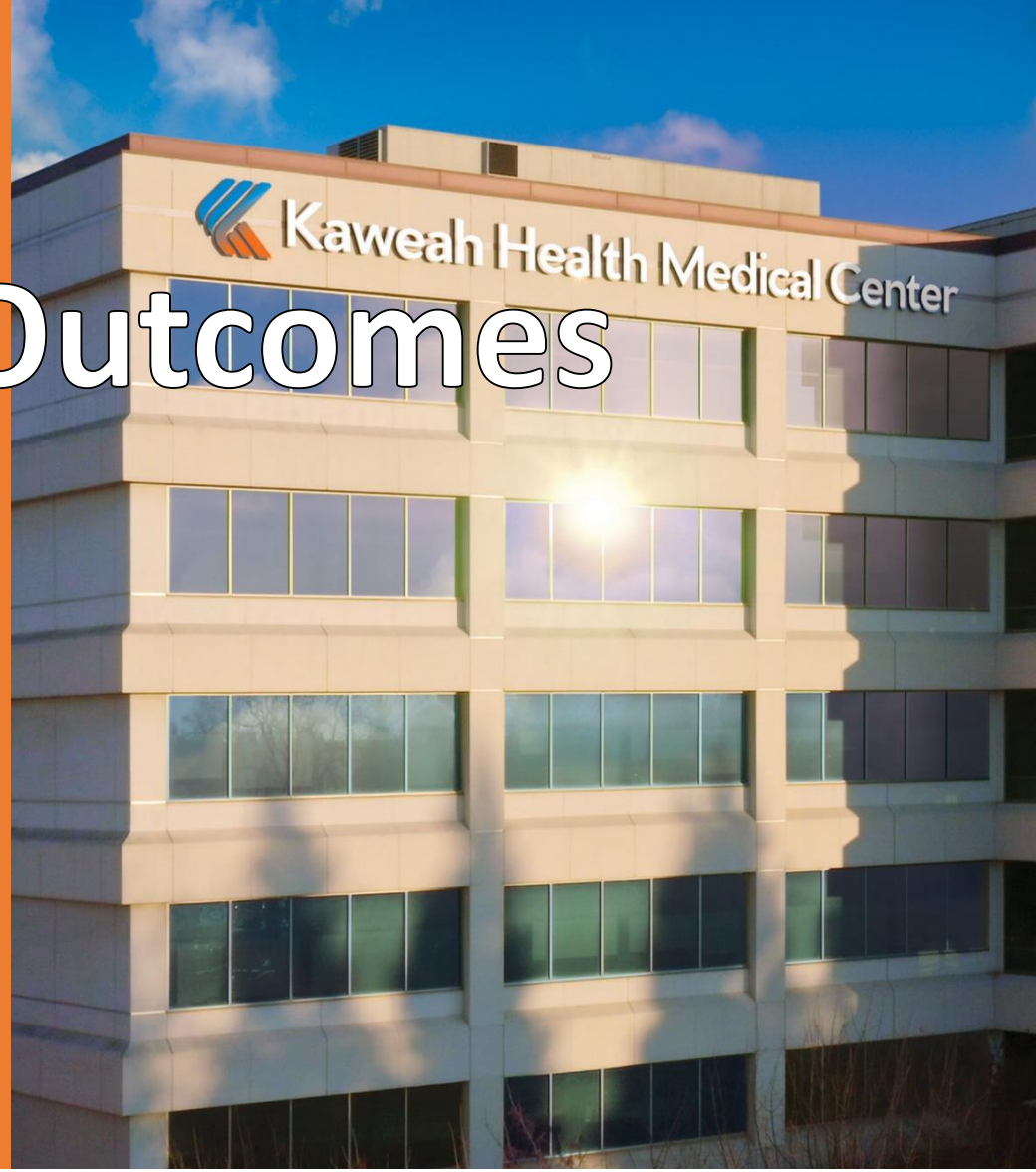
Questions?



Outstanding Health Outcomes Update

Sandy Volchko DNP, RN, CPHQ, CLSSBB
Director Quality & Patient Safety

July 2024



Kaweah Health
MORE THAN MEDICINE. LIFE.

Outstanding Health Outcomes (OHO) Dashboard

Sepsis (SEP)	FY 2024 Target	FY 2022	FY 2023	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	FYTD 24
SEP-1 CMS % bundle compliance	85%	75%	73%	68%	77%	76%	76%	82%	69%	71%	85%	71%	67%			74%
Sepsis and Related Conditions o/e mortality	≤0.78		1.12	0.75	0.82	0.78	0.84	1.38	1.02	0.92	0.93	0.93	0.82			0.95

Central Line Associated Blood Stream Infection (CLABSI)	FY 2024 Target	FY 2022	FY 2023	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	FYTD 24
CLABSI Events		18 Ex COVID	14 Ex COVID	1	2	3	0	3	0	2	3	1	2	0		17
CLABSI SIR	0.39	1.01 Ex COVID	0.93 Ex COVID	0.83	1.16	2.22	0.00	1.15	0.00	1.29	2.31	0.86	1.50	0.00		1.14
Central Line Utilization Rate	0.68	1.02	0.88	0.749	0.791	0.828	0.774	0.685	0.876	0.822	0.799	0.66	0.79	0.749		0.77

Catheter Associated Urinary Tract Infection (CAUTI)	FY 2024 Target	FY 2022	FY 2023	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	FYTD 24
CAUTI Events		23 Ex COVID	12 Ex COVID	0	0	2	0	2	1	1	0	0	2	0		8
CAUTI SIR	0.40	1.09 Ex COVID	0.55 Ex COVID	0.00	0.00	1.06	0.00	0.97	0.46	0.46	0.00	0.00	0.07	0.00		0.38
Indwelling Uninary Catheter (IUC) Utilization Rate (ICU)	0.70	1.18	1.22	0.869	0.925	1.040	1.080	1.10	1.077	1.025	1.07	0.98	1.00	0.82		1.00

Methicillin-Resistant Staphylococcus Aureus (MRSA)	FY 2024 Target	FY 2022	FY 2023	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	FYTD 24
MRSA Events		10 Ex COVID	6 Ex COVID	0	0	1	0	1	3	2	0	0	0	0		7
MRSA SIR	0.55	1.11 Ex COVID	0.66 Ex COVID	0.00	0.00	1.47	0.00	1.32	3.00	2.26	0.00	0.00	0.00	0.00		0.80

KEY	Does not meet goal/benchmark	Within 10% of goal/benchmark	Outperforming/ meeting goal/benchmark

Action Plan Summary

Our Mission

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

Our Vision

To be your world-class healthcare choice, for life

Sepsis

- Focus on 1 hr bundle and expanding to inpatient areas, new order sets/power plans in process with physician stakeholders
- Six Sigma improvement work in process to re-identifying root causes of SEP-1 non-compliance to focus improvement work on the highest contributing factors

Healthcare Acquired Infections

- Super "HAI Brain Trust" Quality Focus Team established, approved by Quality Improvement Committee
- Combine and focus efforts on process metrics that affect the SIRs for CAUTI, CLABSI & MRSA and includes:
    - Line utilization (both central lines and indwelling urinary catheters
        - Multidisciplinary Rounds (MDR) started January 2024 in ICU, addresses line necessity (less lines=less infections), monitoring line utilization rates to evaluate effectiveness; ICU central line and ICU utilization rates for last 2 months (March & April 2024) have been lower that FY23 SUR. Plan to spread MDRs to DCVICU and Step Down units following Intensivist-Hospitalist transitions.
        - Reinvigorate the Standardized Procedure – medical staff approved criteria for nurses to remove urinary catheters, procedure approved, pending education
    - Decolonization rates
        - Nasal Decolonization– Significantly improved from 32% (Jan-June 2023) to 84% (July – Jan 2024). Includes patients who are screened and test positive for MRSA upon admission and not discharged within 24 hours of Mupirocin order (decolonization agent). Next Steps – determining and addressing root causes of patients missed screening, and review of workflow of Mupirocin order to administration processes
        - Skin Decolonization – developing process for skin decolonization through CHG bathing
    - Cleaning effectiveness in high risk areas
        - Quantifying the effectiveness of cleaning during EVS onboarding and annual review with ATP testing; continue to measure cleaning effectiveness through ATP testing in high risk areas (ie. OR's, ICUs) – last 2 reported months of cleaning effectiveness (Feb & March 2024) 92% an increase from 66% in FY23.
    - Hand Hygiene (use of BioVigil system for monitoring)
        - Increase use of BioVigil system, improvement from 31% of active users achieving target badge hours in FY 2023, to 56% (July 23' to May 24'). Next steps, additional tools provided to leaders and staff to support increase use, and evaluation of active users with the denominator
        - Started March 2024 – RECOGNITION PROGRAMS for units/departments that have achieve highest % of staff meeting 80hrs active time (paired) per month!

Questions?

The pursuit of healthiness