

September 9, 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, September 17, 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/206244725> or call (571) 317-3122 - Access Code: 206-244-725.

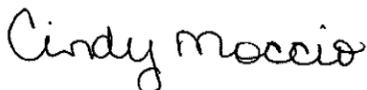
The Board of Directors of the Kaweah Delta Health Care District will meet in a Closed Quality Council Committee at 7:01Am on Thursday, September 17, 2020, in the Kaweah Delta Lifestyle Center, Conference Room A, 5105 W. Cypress Avenue, pursuant to Health and Safety code 32155 & 1461. Board members and 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 September 17, 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/206244725> or call (571) 317-3122- Access Code: 206-244-725.

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, September 17th, 2020

5105 W. Cypress Avenue

The Lifestyle Center; Conference Room A

Call in option: 1-571-317-3122 Access Code: 206-244-725

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. [Value Based Purchasing](#)
 - 3.2. [Patient Experience](#)
 - 3.3. [Emergency Department Dashboard](#)
 - 3.4. [Maternal Child Health Service Line Quality Report](#)
 - 3.5. [Infection Prevention Quarterly Quality Report](#)
 - 3.6. [Handoff Communication Quality Focus Team Report](#)
- 4. [COVID-19 Clinical Quality Outcomes](#) –** A review of clinical quality outcomes for the COVID-19 patient population. *Sandy Volchko, RN, DNP, Director of Quality and Patient Safety*
- 5. [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*
- 6. Adjourn – 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.

Value Base Purchasing (VBP) Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

Unit/Department: Quality & Patient Safety

ProStaff/QIC Report Date: July 10, 2020

Measure Objective/Goal:

Goal is to earn at least 2% back of annual contribution with zero balance. This goal was not met.

Date range of data evaluated: CY 2019

Analysis of all measures/data: (Include key findings, improvements, opportunities)

Value base purchasing total performance *estimated* score calculated by the California Hospital Association for CY 2019 is 21.8%.

All hospitals contribute 2% per Medicare beneficiary. For FY 2021, it is *estimated* that Kaweah will contribute 3.40%. This will be an annual loss of \$491,900 (less than previous years). We have worsened in HCAHPS and HAIs, and improved in Clinical Outcomes.

Final annual VBP report from CMS will come out July or August 2020. California Hospital Association provides a highlight report with estimated numbers.

If improvement opportunities identified, provide action plan and expected resolution date:

Areas that received zero points (more points are better):

- All patient experience domains (includes 8 measures)
- CLABSI
- CAUTI

Areas awarded points:

- AMI mortality (5 points)
- Heart Failure mortality (1 point)
- Pneumonia mortality (2 points)
- COPD mortality (2 points)
- Total Knee and Hip Post-Operative Complication (7 points)
- MRSA (1 point)
- C. diff (7 points)
- SSI – colon surgery (1 point)
- Medicare spending per beneficiary (2 points)

Please submit your data along with the summary to your PI liaison 2 weeks prior to the scheduled report date.

Value Base Purchasing (VBP) Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

Next Steps/Recommendations/Outcomes:

- Patient Experience continues to facilitate “Operation Always” with department specific action plans and increased leader patient rounding. Physician leaders are also engaged in improvement efforts via individual physician performance, scripting for “physicians explaining care provided,” and rounding focused on physician communication. A Patient Experience Board Committee is being created and will be chaired by 2 members of the Board of Directors who will have oversight of survey details, data review, and leader rounding.
- Infection Prevention has teams in each area working on improvements. In 2020, Kaizen projects focusing on CLABSI and CAUTI were conducted with nursing and physician leaders specific. Action items were identified and many have been completed. We have seen a reduction in the number of CLABSI and CAUTI events. Also, several strategies were implemented to enhance hand hygiene: D.U.D.E. campaign, a pilot program for BioVigil (highly successful and now being rolled out at the medical center), and required hand hygiene demonstrations to validate competency of all staff who touch patients or touch items that are used by patients. The new Purell sanitizer stations are also being re-validated for appropriate volume dispensed and dry time.
- Mortality Committee meets every month with the largest improvement opportunity in earlier palliative care and implementing General Inpatient Hospice beds. A new process of real-time mortality case review has been implemented to ensure documentation and coding of the care provided to these patients is captured as accurately as possible. Trends and high-risk events are also identified in real-time and escalated as needed. Disease-specific teams are also working on best practices.

Submitted by: Evelyn McEntire, Manager of Quality & Patient Safety

Date Submitted: July 10, 2020

Please submit your data along with the summary to your PI liaison 2 weeks prior to the scheduled report date.

**Patient Experience (HCAHPS) Performance: World-Class Service
Oct 2020**

Time Period	1Q19 -4Q19		July – June 2020	
HCAHPS Measure	Full Adj (Mode Adj + Pt Mix Adj)	CMS 50 th percentile National	Mode Adj Only	Comments/Improvement Efforts
# of surveys 22% response rate	2026	-	2466	-
Communication with Nurses	77% ↑ Below CMS	81%	79%	Nursing Care Bundle 1) Welcome Letter 2) Communication white board 3) Patient Guide 4) Medicine Guide 5) Discharge Thank you Card
Communication with Doctors	76% ↑ Below CMS	82%	79%	1) Greet patients/companions with smile 2) Listening “What questions do you have for me?” 3) Explaining plan in simple language 4) Conclude with “Is there anything else I can do for you?”
Responsiveness of Staff	67% ↑ Below CMS	70%	69%	1) Hourly Rounding 2) Proactive toileting
Communication about Meds	60% ↑ Below CMS	66%	66%	Medicine Guide
Cleanliness of Environment	68% ↑ Below CMS	76%	72%	Increased surveillance
Quietness of Environment	49% Below CMS	62%	55%	<i>No new interventions</i>
Discharge Information (Yes)	87% ↑ Below CMS	87%	89%	1) NRC Discharge Phone Calls 2) Discharge needs addressed via discharge rounds 3) Medicine Guide 4) Patient Guide
Care Transition (Strongly Agree)	47% ↑ Below CMS	54%	49%	<i>Same as above</i>
Overall Rating of Hospital (0 = worst; 10 = best)	71% (9 or 10) Below CMS	73%	74%	OPERATION ALWAYS <i>Purpose: Consistently provide world-class service</i> →Leader Rounding →Patient Experience Board Committee →Kaweah Care Experience 1) Warm Introductions 2) With our colleagues 3) Over the phone 4) Caring closures
Willingness to Recommend (Definitely Recommend)	70% Below CMS	72%	73%	<i>Same as above</i>

EMERGENCY DEPARTMENT DASHBOARD

GENERAL METRICS

	Bench- mark	Feb 2020 KDHCD	Mar 2020 KDHCD	Apr 2020 KDHCD	May 2020 KDHCD	June 2020 KDHCD	July 2020 KDHCD
ED Volume		7446	5955	4174	5033	5964	6672
% pts Left without being seen	1.5%	1.8%	1.2%	0.3%	0.5%	0.5%	0.5%
% of Pts Admitted		24%	25%	29%	29%	27%	25%
% of Pts Discharged		69%	67%	64%	63%	64%	67%

ED THROUGHPUT METRICS

Median Length of Stay (LOS) for Admitted Pts (hrs)	407 (6.8)	507 (8.5)	445 (7.4)	376 (6.3)	410 (6.8)	487 (8.1)	513 (8.6)
Median LOS in Min for discharged Pts (hrs)	186 (3.1)	208 (3.5)	200 (3.3)	191 (3.2)	209 (3.5)	234 (3.9)	214 (3.6)
Median LOS in Min for Admit decision to ED Depart	197 (3.3)	294 (4.9)	244 (4.1)	206 (3.4)	222 (3.7)	258 (4.3)	280 (4.7)
Average LOS in minutes for Admitted Mental Health Pts		792 (13.2)	657 (10.9)	810 (13.5)	791 (13.2)	918 (15.3)	993 (16.6)

PATIENT EXPERIENCE

ED Overall Care Percent 9s & 10s	62%*	63.59%	64.36%	72.77%	62.86%	69.23%	71.00%
Would Recommend Percent Definitely YES	76%*	80.41%	77.42%	87.56%	79.25%	76.39%	77.66%

CENSUS TOTALS BY DISPOSITION

Number of Patients Arriving by Ambulance	1992	1793	1501	1622	1782	1874
Number of Trauma Patients	136	162	141	163	155	178
Number of Patients Admitted	1821	1504	1222	1465	1589	1675
Number of Patients Discharged	5048	4006	2672	3183	3829	4442
Number of Mental Health Patients Admitted	91	70	90	108	120	92

KEY

>10% above goal/benchmark

Within 10% of goal/benchmark

Outperforming/meeting
goal/benchmark

* benchmark Press Ganey 50th Percentile

o

GENERAL METRICS

ED Volume

% pts Left without being seen

% of Pts Admitted

% of Pts Discharged

ED THROUGHPUT METRICS

Median Length of Stay (LOS) for Admitted Pts (hrs)

Median LOS in Min for discharged Pts (hrs)

Median LOS in Min for Admit decision to ED Depart

Average LOS in minutes for Admitted Mental Health Pts

PATIENT EXPERIENCE

***90TH PERCENTILE - ED Overall Care Percent 9s & 10s**

Would Recommend Percent Definitely YES

CENSUS TOTALS BY DISPOSITION

Number of Patients Arriving by Ambulance

Number of Trauma Patients

Number of Patients Admitted

Number of Patients Discharged

Number of Mental Health Patients Admitted

Discern report used: 1_KDHD_ED_VISIT_LOG_EXPANDED_June-V2

DATA DEFINITION

Total volume of all patients who enter ED

Numerator: # of pts with d/c disposition as LWBS

Denominator: # of total patients who enter ED

Numerator: # of pts with d/c disposition as Admitted to this hospital as inpatient**

Denominator: # of total patients who enter ED

Numerator: # of pts with d/c disposition as Discharged home (routine), discharged home with HH, discharge Hospice (home), and discharged to assisted living/Board and care

Denominator: # of total patients who enter ED

DATA DEFINITION

Median time of ED arrival to ED depart for pts with d/c disposition as Admitted to this hospital as inpatient**

Median time of ED arrival to ED depart for pts with d/c disposition as Discharge home (routine)discharged home with HH, discharge Hospice (home), and discharged to assisted living/Board and care

inpatient

Mean time of ED arrival to ED depart for pts with d/c disposition as D/T to Psych Hosp or Unit who only admit to KDMHH* See note below

DATA DEFINITION

As defined by press ganey - data obtained through Roxanne Mendez in Q&P/S

As defined by press ganey - data obtained through Roxanne Mendez in Q&P/S

DATA DEFINITION

of patients who have "ambulance" or "ACLS Transport" documented in their arrival mode

Total number of Trauma pts as noted at bottom of report received from Amber Woods/Kathy M

of pts with d/c disposition as Admitted to this hospital as inpatient**

of pts with d/c disposition as Discharge home (routine)discharged home with HH, discharge Hospice (home), and discharged to assisted living/Board and care

pts with d/c disposition as D/T to Psych Hosp or Unit who only admit to KDMHH* See note below

*NOTE - Soarian financials must discharge patients from ED to admit them to our KDMHH. Patients with a discharge disposition in our EMR as D/T to Psych Hosp or Unit have both KDMHH patients and patients who transfer to another non-KD psych facility. All medical records of these patients with this discharge disposition have to be reviewed to separate the KDMHH pt's from the non so that only KDMHH patients are included in the
 ** NOTE - At times staff document the wrong d/c disposition for 2-emergent 5150 acuity patients (see data cleaning instructions); the medical record of these pts has to be reviewed to ensure accurate d/c dispo to

1. Column L has to be reformatted first to remove LOS text and reformat cells so that they calculate
2. filter for Admitted, discharged and discharge to psych (per data definitions) and place on their own tab

3. Admitted patients:

- a) Filter column I (Acuity) for "2 – Emergent 5150 Risk". Review EMR to verify that those patient were admitted to medical center vs psych facility. To find this review the ED Disposition note (hoping the nurse marked disposition location and report called information), and also look at PFS notes to see who they have been contact with and where there is confirmed disposition location. If patients are found that were admitted to KDMHH remove those patients and place in the "discharge to psych" tab. If pt's were tx to outside psych facility, remove from admitted population and place on their own tab (no data is calculated for non-KDMHH pt's). If they were admitted to medical center, leave in the admitted population tab
- b) Filter column M "ADMIT_DEC_TO_DEPART" for blanks. Chart review to verify the pt was admitted. If they were admitted, find and enter the time admit decision to depart in minutes. If they were not admitted (discharged, etc) move to the appropriate population tab (ie. discharged pt's to dishcharge tab)

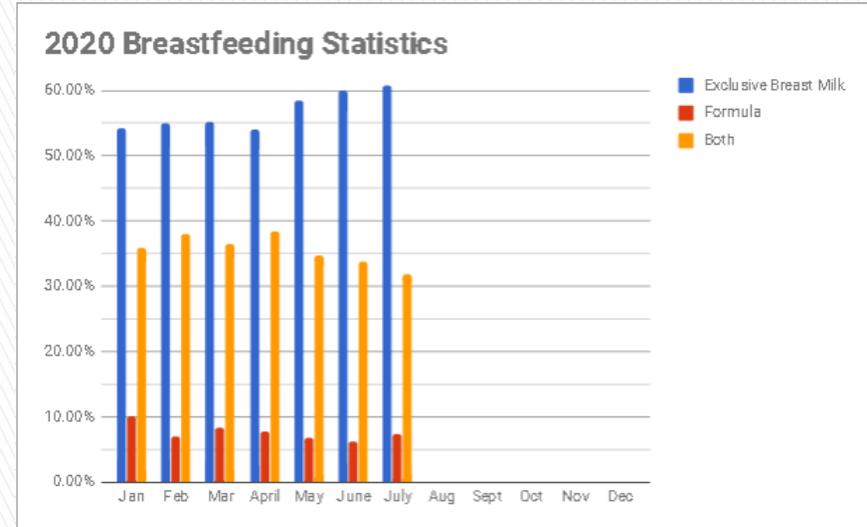
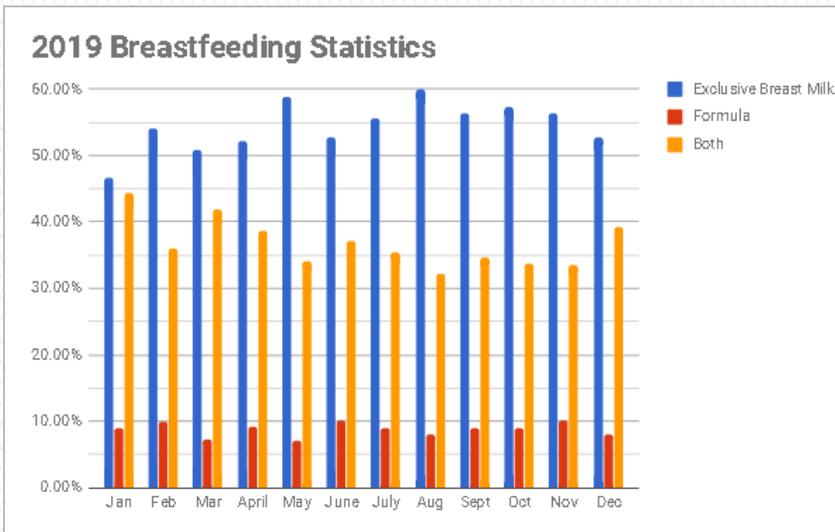
4. d/c to psych:

Review each chart to determine which patients were admitted to KDMHH vs another outside psych facility. Remove the non-KDMHH pt's and put on a separate tab (no data is calculated for non-KDMHH pt's)

Mother / Baby Quality Data

January – June 2020

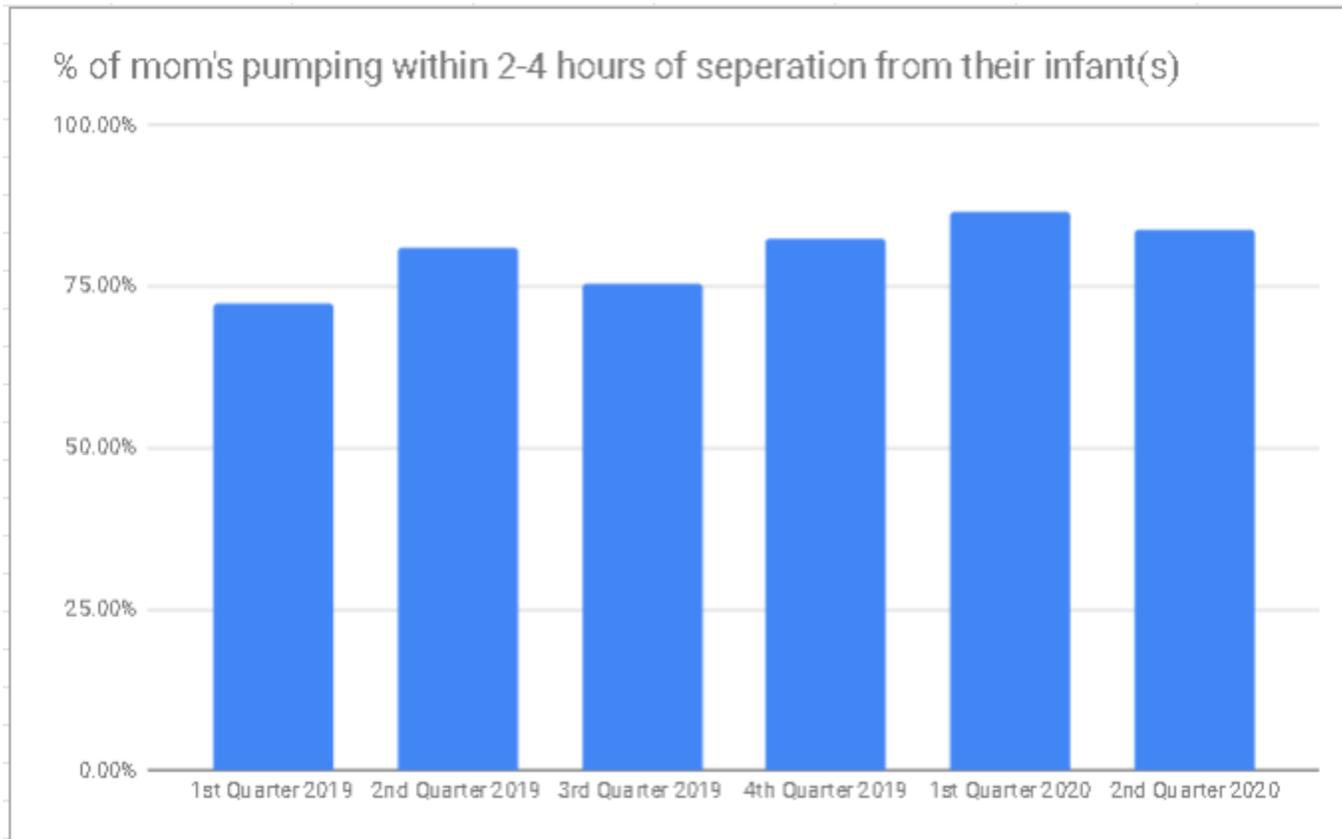
Breastfeeding Stats



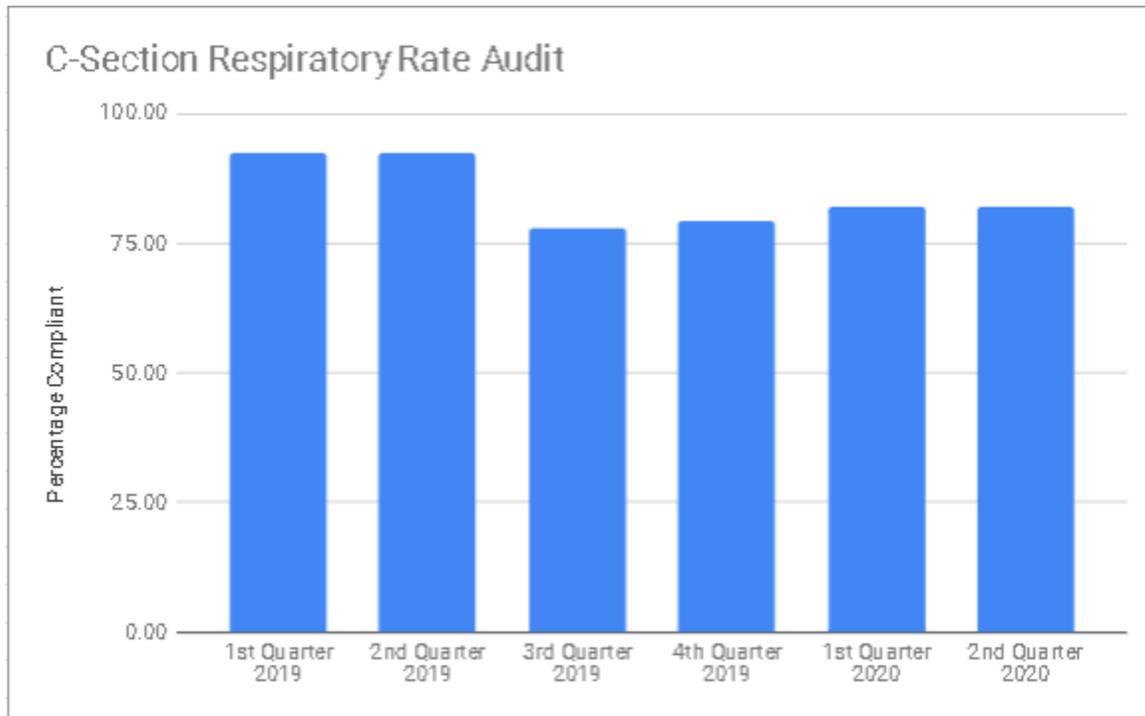
2019

2020

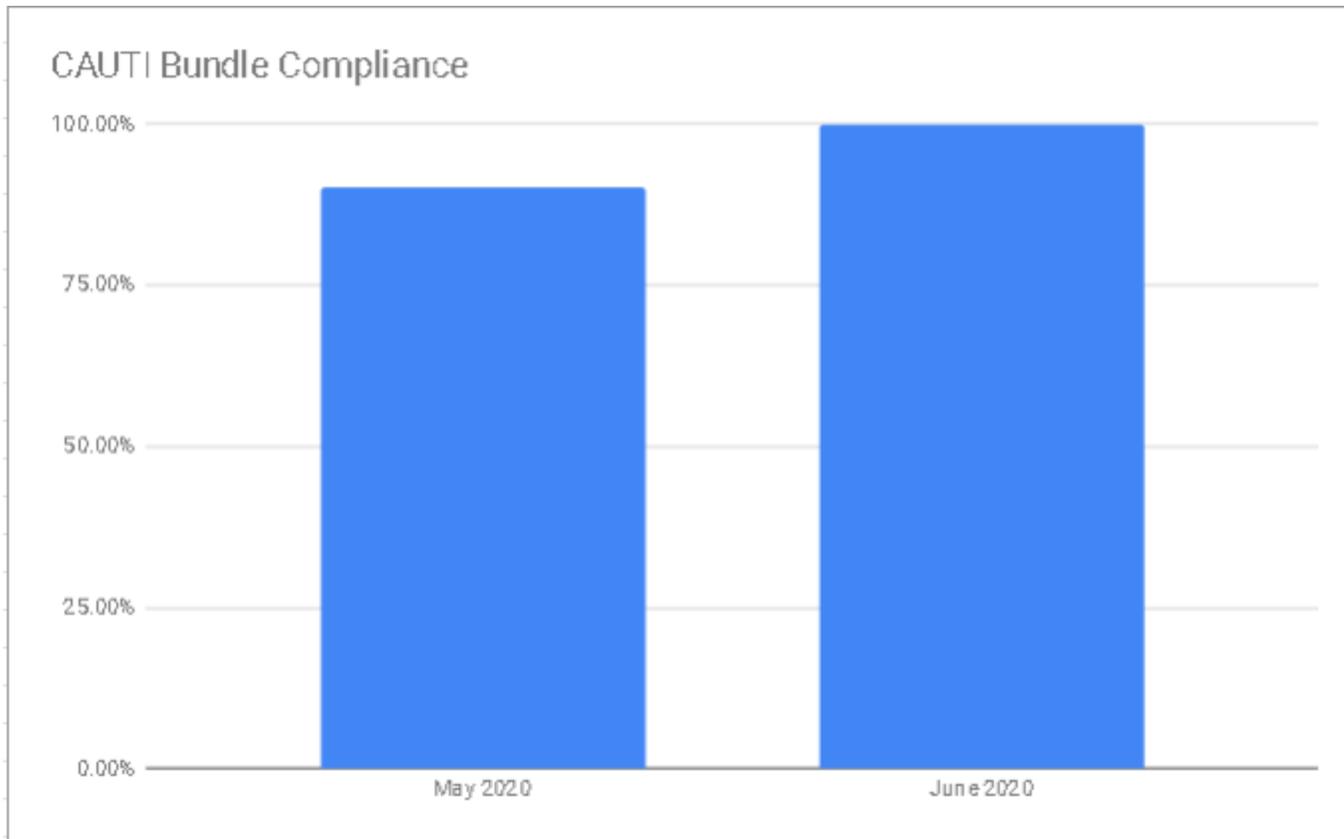
NICU MOM'S PUMPING



C-SECTION RESPIRATORY RATE AUDIT



CAUTI Bundle Compliance



Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

Unit/Department: *NICU*

ProStaff/QIC Report Date: *July, 2020*

Measure Objective/Goal:

1. *CLABSI per 1000 device days: Goal-Meet or exceed benchmark*
2. *VAP per 1000 ventilator device days: Goal-Meet or exceeds benchmark*
3. *Monthly hand hygiene compliance: Goal-Meet or exceeds benchmark*

Date range of data evaluated:

January 2020 through June 2020

Analysis of all measures/data: (Include key findings, improvements, opportunities)

(If this is not a new measure please include data from your previous reports through your current report):

1. *KD NICU 0/1000 central line days. No CLABSI since May 2019. 267 Central line days since Jan 2020. Goal met.*
 - a. *Improvements & Opportunities: Continue to follow central line bundle-Gemba round daily*
2. *KD NICU VAP- No VAP. Goal Met*
3. *Monthly hand hygiene- **Goal not met***

If improvement opportunities identified, provide action plan and expected resolution date:

1. *Continue to participate in CLABSI collaborative. Maintain central line bundle. Report findings to CPQCC.*
2. *NICU VAP policy and bundle in place.*
3. *Soap and water as well as hand sanitizer available in every patient room. Continue to monitor compliance beyond reporting requirements. Include NICU parents in hand hygiene monitoring. Goal of 95% or higher every month.*

HAND HYGIENE COMPLIANCE DATA & ANALYSIS

	Benchmark/ Target	4Q19	1Q20	Apr/May20
NICU Hand Hygiene Compliance	95%	89%	74%	87%

- Hand Hygiene compliance is below target for each time period

ACTION PLAN:

Please submit your data along with the summary to your PI liaison 2 weeks prior to the scheduled report date.

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

- Mandatory training completed for all staff regarding HH (completed July 3, 2020) includes content on: the importance of HH, when to do HH, and some examples of missed HH opportunities such as after removal of gloves, before/after patient care and cross-contamination
- Review of overall hand hygiene results, analysis and trends to focus improvement efforts (completed PCL meeting July 8, 2020)
- (CCU, ED, MH) Unit/dept hand hygiene observations increased and monitored
- In the moment observations and coaching of staff
- Observation and check off on new hire employees hand hygiene demonstrations (included in mandatory 48 hr new hire checklist)
- Biovigil implementation, enhanced monitoring and in the moment staff & patient feedback, and enhance patient/visitor awareness that they are encouraged to ask care providers to wash hands.

NEXT STEPS:

- Monitor data for effectiveness
- Review tools/resources in new manager library and determine best fit strategies to enhance hand hygiene unit/dept QI strategy

Submitted by: Felicia Vaughn

Next Steps/Recommendations/Outcomes:

1. *Continue with current standardized insertion practice and care of all central lines.*
2. *No VAP. Benchmark met; continue to support current P&P.*
3. *Observe greater than 30 opportunities, involve parents in monitoring staff.*

UPDATE September 8, 2020: Kaweah Delta went live with Biovigil on August 25, 2020. As of today, Sept 8, 2020 the NICU Hand Hygiene compliance is 99.8%.

Submitted by Name:

Felicia Vaughn

Date Submitted:

July 1st, 2020

Please submit your data along with the summary to your PI liaison 2 weeks prior to the scheduled report date.

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee

Unit/Department: Pediatrics

ProStaff Report Date: July 2020

Measure Objective/Goal:

Total Patient Falls per 1000 patient days

Goal: 1.68

Goal not met.

Date range of data evaluated:

January-June 2020

Analysis of all measures/data: (Include key findings, improvements, opportunities)

Pediatrics has had 3 patient falls during this data range. Two falls were same patient, back to back days. Patients parents are licensed health care workers in the hospital, were instructed on asking for help prior to any patient transfers but did not follow those instructions. Both falls were assisted falls to the ground by parents. 3rd patient fall was a 13-month old toddler who had a safe toddler bed in the room which would allow for safe play with instructions to use. Parents were given instructions at admission, and throughout stay of safe sleep practices as well as safe patient play. Patient's parent instead chose to allow toddler to crawl on adult bed, with all side rails up. Pt slipped between rails onto the floor while mom was distracted on phone.

If improvement opportunities identified, provide action plan and expected resolution date:

Continue to provide education to parents and/or supervising family members regarding patient safety in the room. Additional education given to parents on admission, and throughout stay. Additional action plan to be tailored to patient and completed after initial fall, and with each subsequent readmission, or new admission.

Next Steps/Recommendations/Outcomes:

We will continue to implement fall risk precautions and educate families on safe sleep as well as monitored activities within room by caregiver. We will continue to have parents acknowledge that education was provided and sign waivers when they decline Safe Sleep and safe practices. We will trial using soft play mats on the floor next to the bedside of active toddlers to provide for increased level of safety when patients do fall due to lack of vigilance by parent or when children have developmental falls.

Submitted by Name:

Date Submitted:

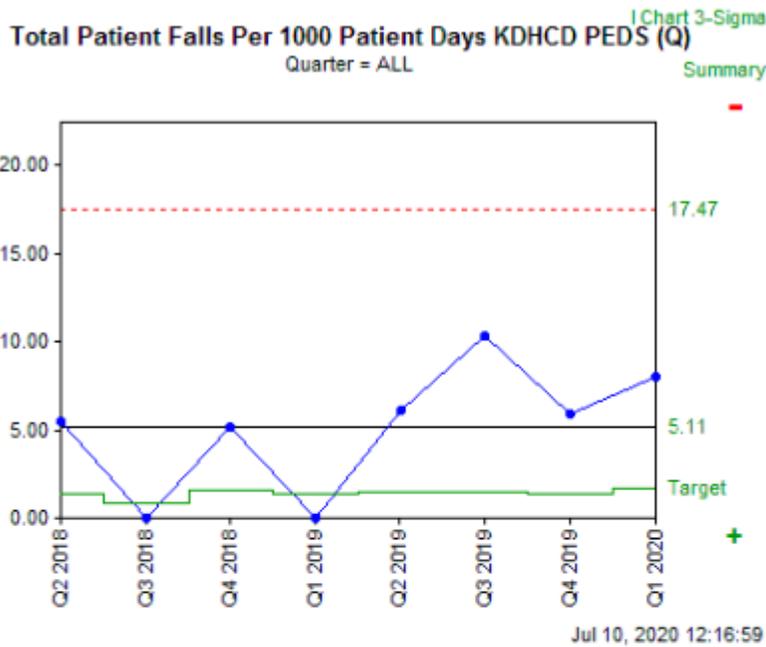
Please submit your data along with the summary to your PI liaison 2 weeks prior to the scheduled report date.

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee

Danielle Grimaldi, RN, BSN, CPN

07/10/20



Date	KDHCD	Target
Q1 2020	8.02	1.68
Q4 2019	5.92	1.34
Q3 2019	10.31	1.47
Q2 2019	6.06	1.46
Q1 2019	0.00	1.35
Q4 2018	5.13	1.60
Q3 2018	0.00	0.83
Q2 2018	5.46	1.41

UPDATE September 8, 2020: Pediatrics has had no falls since March, 2020.

Please submit your data along with the summary to your PI liaison 2 weeks prior to the scheduled report date.

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee

Unit/Department: Pediatrics

ProStaff Report Date: July 2020

Measure Objective/Goal:

Catheter Associated Urinary Tract Infection

Goal: 0.00

Date range of data evaluated:

January- June 2020

Analysis of all measures/data: (Include key findings, improvements, opportunities)

We had 0 CAUTIs for this quarter. We are performing equal to the benchmark.

If improvement opportunities identified, provide action plan and expected resolution date:

Next Steps/Recommendations/Outcomes:

We will continue to use aseptic technique to insert urinary catheters, and we will continue to provide perineal care every shift. We will also continue to evaluate need for urinary catheter on a daily basis.

Submitted by Name:

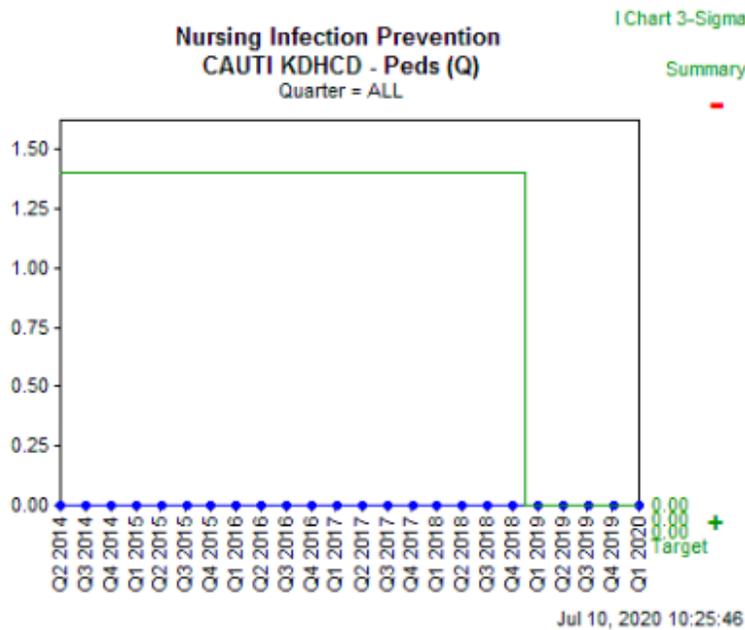
Danielle Grimaldi, RN, BSN, CPN

Date Submitted:

07/10/20

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee



Date	KDHCD	Target
Q1 2020	0.00	0.00
Q4 2019	0.00	0.00
Q3 2019	0.00	0.00
Q2 2019	0.00	0.00
Q1 2019	0.00	0.00
Q4 2018	0.00	1.40
Q3 2018	0.00	1.40
Q2 2018	0.00	1.40
Q1 2018	0.00	1.40
Q4 2017	0.00	1.40
Q3 2017	0.00	1.40
Q2 2017	0.00	1.40
Q1 2017	0.00	1.40
Q4 2016	0.00	1.40
Q3 2016	0.00	1.40
Q2 2016	0.00	1.40
Q1 2016	0.00	1.40
Q4 2015	0.00	1.40
Q3 2015	0.00	1.40
Q2 2015	0.00	1.40
Q1 2015	0.00	1.40
Q4 2014	0.00	1.40
Q3 2014	0.00	1.40
Q2 2014	0.00	1.40

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee

Unit/Department: Pediatrics

ProStaff Report Date: July 2020

Measure Objective/Goal:

Central Line Associated Blood Infections

Goal: 0.00

Date range of data evaluated:

January-June 2020

Analysis of all measures/data: (Include key findings, improvements, opportunities)

We had 0 CLABSIs for this quarter. We are performing equal with the benchmark.

If improvement opportunities identified, provide action plan and expected resolution date:

Next Steps/Recommendations/Outcomes:

We will continue to use aseptic technique to perform scheduled dressing and cap changes. We will also continue to evaluate need for central line on a daily basis.

Submitted by Name:

Danielle Grimaldi, RN, BSN, CPN

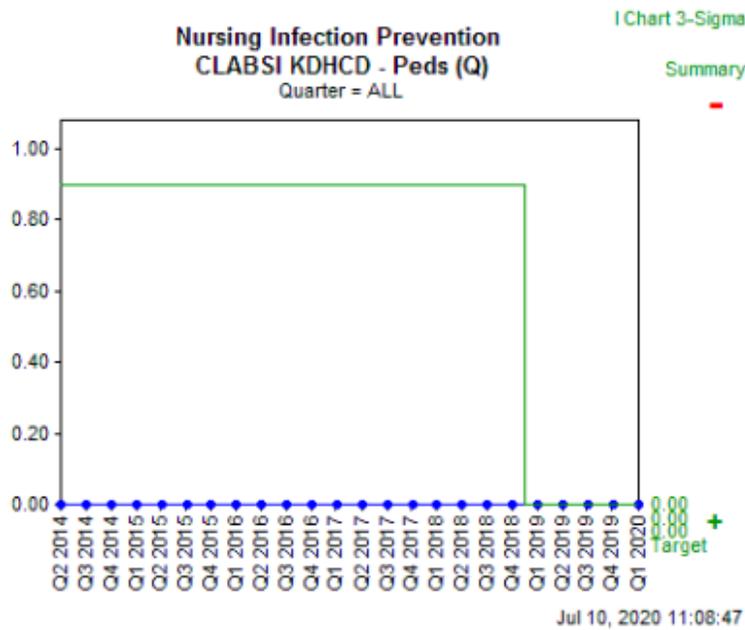
Date Submitted:

7/10/20

Please submit your data along with the summary to your PI liaison 2 weeks prior to the scheduled report date.

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee



Date	KDHCD	Target
Q1 2020	0.00	0.00
Q4 2019	0.00	0.00
Q3 2019	0.00	0.00
Q2 2019	0.00	0.00
Q1 2019	0.00	0.00
Q4 2018	0.00	0.90
Q3 2018	0.00	0.90
Q2 2018	0.00	0.90
Q1 2018	0.00	0.90
Q4 2017	0.00	0.90
Q3 2017	0.00	0.90
Q2 2017	0.00	0.90
Q1 2017	0.00	0.90
Q4 2016	0.00	0.90
Q3 2016	0.00	0.90
Q2 2016	0.00	0.90
Q1 2016	0.00	0.90
Q4 2015	0.00	0.90
Q3 2015	0.00	0.90
Q2 2015	0.00	0.90
Q1 2015	0.00	0.90
Q4 2014	0.00	0.90
Q3 2014	0.00	0.90
Q2 2014	0.00	0.90

weeks prior to the scheduled report date.

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee

Unit/Department: Pediatrics

ProStaff Report Date: July 2020

Measure Objective/Goal:

Percent of patients with stage 2 or greater HAPI: 0.00

Goal: 0.51

Date range of data evaluated:

January-June 2020

Analysis of all measures/data: (Include key findings, improvements, opportunities)

We had 0 HAPIs stage 2 or greater for this quarter. This is better than the benchmark.

If improvement opportunities identified, provide action plan and expected resolution date:

Next Steps/Recommendations/Outcomes:

We will continue identifying patients at risk for skin breakdown and implement appropriate preventative measures.

Submitted by Name:

Danielle Grimaldi, RN, BSN, CPN

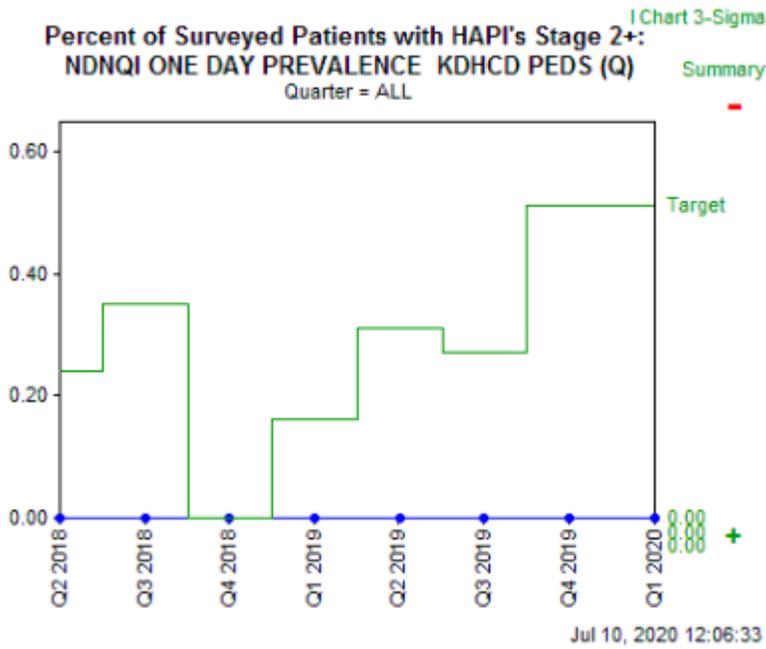
Date Submitted:

07/10/20

Please submit your data along with the summary to your PI liaison 2 weeks prior to the scheduled report date.

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee



Date	KDHCD	Target
Q1 2020	0.00	0.51
Q4 2019	0.00	0.51
Q3 2019	0.00	0.27
Q2 2019	0.00	0.31
Q1 2019	0.00	0.16
Q4 2018	0.00	0.00
Q3 2018	0.00	0.35
Q2 2018	0.00	0.24

Please submit your data along with the summary to your PI liaison 2 weeks prior to the scheduled report date.

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee

Unit/Department: Pediatrics

ProStaff Report Date: July 2020

Measure Objective/Goal:

Percent of PEWS fallouts-PEWS score charted every 4 hours on every patient.

Goal: 90% or greater no fallouts.

Date range of data evaluated:

June-January 2020

Analysis of all measures/data: (Include key findings, improvements, opportunities)

Using data received within the last 180 days, we have had a 96% success rate in PEWS score being charted every 4 hours. Results are better than benchmark for PEWS score.

If improvement opportunities identified, provide action plan and expected resolution date

Next Steps/Recommendations/Outcomes:

Continue to maintain PEWS scoring greater than 90% expected with next report date.

Submitted by Name:

Danielle Grimaldi, RN, BSN, CPN

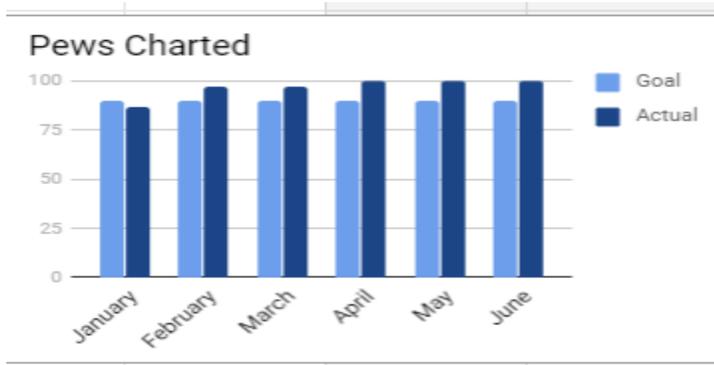
Date Submitted:

07/10/20

Please submit your data along with the summary to your PI liaison 2 weeks prior to the scheduled report date.

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee



Please submit your data along with the summary to your PI liaison 2 weeks prior to the scheduled report date.

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee

Unit/Department: Pediatrics

ProStaff Report Date: July 2020

Measure Objective/Goal:

Injury Falls per 1000 patient days

Goal: 0.51

Goal Met

Date range of data evaluated:

January-June 2020

Analysis of all measures/data: (Include key findings, improvements, opportunities)

We had met benchmark for Injury Falls per 1000 patient days during this data range.

If improvement opportunities identified, provide action plan and expected resolution date:

Next Steps/Recommendations/Outcomes:

We will continue to implement fall risk precautions and educate families on safe sleep as well as monitored activities within room by caregiver. We will continue to have parents sign waivers when they decline Safe Sleep. We will trial using soft play mats on the floor next to the bedside of active toddlers.

Submitted by Name:

Danielle Grimaldi, RN, BSN, CPN

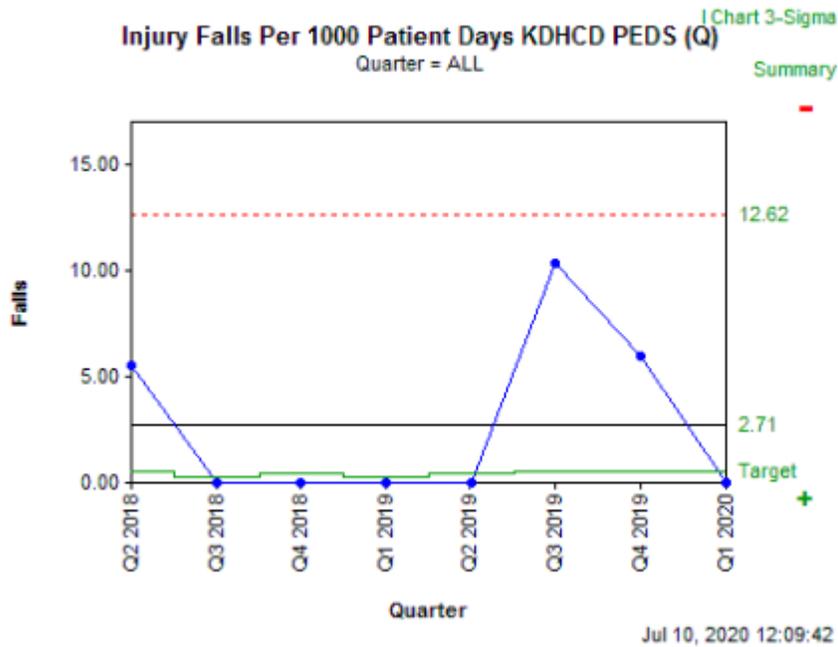
Date Submitted:

07/10/20

Please submit your data along with the summary to your PI liaison 2 weeks prior to the scheduled report date.

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee



Quarter	Falls	Target
Q1 2020	0.00	0.51
Q4 2019	5.92	0.51
Q3 2019	10.31	0.53
Q2 2019	0.00	0.42
Q1 2019	0.00	0.26
Q4 2018	0.00	0.42
Q3 2018	0.00	0.26
Q2 2018	5.46	0.55

UPDATE September 8, 2020: Pediatrics has had no falls since March, 2020.

Please submit your data along with the summary to your PI liaison 2 weeks prior to the scheduled report date.

Unit/Department Specific Data Collection Summarization
Professional Staff Quality Committee/Quality Improvement Committee

Unit/Department: 2E Labor and Delivery

ProStaff/QIC Report Date: January 2020 to June 2020

Measure Objective/Goal:

Hand Hygiene: Goal is 95%.
Goal Not Met: compliance rate was 63%

Date range of data evaluated:

January 2020 to June 2020

Analysis of all measures/data: (Include key findings, improvements, opportunities)
(If this is not a new measure please include data from your previous reports through your current report):

HAND HYGIENE COMPLIANCE DATA & ANALYSIS				
L&D	Benchmark/ Target	4Q19	1Q20	Apr/May20
	95%	86%	80%	63%
<ul style="list-style-type: none">• Hand Hygiene compliance is below target for each time period				
ACTION PLAN: <ul style="list-style-type: none">• Mandatory training completed for all staff regarding HH (completed July 3, 2020) includes content on: the importance of HH, when to do HH, and some examples of missed HH opportunities such as after removal of gloves, before/after patient care and cross-contamination• Review of overall hand hygiene results, analysis and trends to focus improvement efforts (completed PCL meeting July 8, 2020)• In the moment observations and coaching of staff• Observation and check off on new hire employees hand hygiene demonstrations (included in mandatory 48 hr new hire checklist)• Biovigil implementation, enhanced monitoring and in the moment staff & patient feedback, and enhance patient/visitor awareness that they are encouraged to ask care providers to wash hands.				
NEXT STEPS: <ul style="list-style-type: none">• Monitor data for effectiveness• Review tools/resources in new manager library and determine best fit strategies to enhance hand hygiene unit/dept QI strategy				
Submitted by: Roberta DeCosta				

Please submit your data along with the summary to your PI liaison 2 weeks prior to the scheduled report date.

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

Over the past 6 months the observer was not consistent in reporting to the required observations resulting in lower percentages as well as physician and other providers are not consistently use appropriate hand hygiene despite reminder by staff thus resulting in lower percentages.

If improvement opportunities identified, provide action plan and expected resolution data

Next Steps/Recommendations/Outcomes:

In an effort to improve percentages the following action plan will be in place as of 7/8/20.

1. Designation of 2 new observers with 1 representing each shift for consistent reporting
2. re-Education to staff by manager, educator and charge RN on DUDE program and set the example.
3. Manager to check with staff mid-month to check on observations to ensure the minimum of 30 will be completed.

Submitted by Name: Roberta DeCosta Date Submitted: 7/10/20

UPDATE September 8, 2020: Kaweah Delta went live with Biovigil on August 25, 2020. As of today, L&D is 96.6% compliant with Hand Hygiene. This technology helps not only monitor compliance but also number of observations. Tracking the number of observations was a barrier to demonstrating compliance in the past.

Please submit your data along with the summary to your PI liaison 2 weeks prior to the scheduled report date.

Unit/Department Specific Data Collection Summarization
Professional Staff Quality Committee/Quality Improvement Committee

Unit/Department: 2 East Labor and Delivery

ProStaff/QIC Report Date: January 2020 to June 2020

Measure Objective/Goal:

Early Elective Deliveries is defined as deliveries at 37-38 6/7 weeks with a goal of 0%.

Date range of data evaluated:

JANUARY 2020 – JUNE 2020

Analysis of all measures/data: (Include key findings, improvements, opportunities)

(If this is not a new measure please include data from your previous reports through your current report):

2020 reporting

This goal continues to be met with 0% or no failures of Early Elective Deliveries.

If improvement opportunities identified, provide action plan and expected resolution data

This goal continues to be met and monitored daily.

Next Steps/Recommendations/Outcomes:

Will Continue to monitor on a daily basis for scheduled inductions and c-sections

Submitted by Name: Roberta DeCosta

Date Submitted: 7/10/2020

Please submit your data along with the summary to your PI liaison 2 weeks prior to the scheduled report date.

Unit/Department Specific Data Collection Summarization
Professional Staff Quality Committee/Quality Improvement Committee

Unit/Department: **2E Labor and Delivery**

ProStaff/QIC Report Date: **January 2020 to June 2020**

Measure Objective/Goal:

MD notification of new onset of preeclampsia/severe hypertension is defined as greater than or equal to 160 systolic or greater than or equal to 110 diastolic on two consecutive occasions at least 15 minutes apart.

Goal is 90%

Goal Met at 93% compliance

Date range of data evaluated:

January 2020 to June 2020

Analysis of all measures/data: (Include key findings, improvements, opportunities)

(If this is not a new measure please include data from your previous reports through your current report):

Goal met at 93%

If improvement opportunities identified, provide action plan and expected resolution data
Next Steps/Recommendations/Outcomes:

Action Plan:

1. Continue to audit and report monthly and maintain at or better than the benchmark.

Submitted by Name: **Roberta DeCosta**

Date Submitted: **7/10/2020**

Please submit your data along with the summary to your PI liaison 2 weeks prior to the scheduled report date.

Unit/Department Specific Data Collection Summarization
Professional Staff Quality Committee/Quality Improvement Committee

Unit/Department: 2E Labor and Delivery

ProStaff/QIC Report Date: January 2020 to June 2020

Measure Objective/Goal:

Catheter Associated Urinary Tract Infections: Organizational Goal: SIR of <0.828
Goal Met: Zero CAUTI's during this time period...

Date range of data evaluated:

May 2020 to June 2020

Analysis of all measures/data: (Include key findings, improvements, opportunities)

(If this is not a new measure please include data from your previous reports through your current report):

Labor and Delivery, in collaboration with the Mother Baby Unit, have has zero CAUTI's. The role of the L&D RN is to place a securement device and perform pericare every 2 hours PRN but at least every shift until delivery. GEMBA Rounds completed daily on the Mother Baby Unit.

If improvement opportunities identified, provide action plan and expected resolution data
Next Steps/Recommendations/Outcomes:

In collaboration with ISS, we are in the process of adding pericare to the labor and delivery band in the EMR documentation will be much simpler to locate and document.

Will continue to monitor and audit to maintain above the benchmark

Submitted by Name: Roberta DeCosta **Date Submitted:** 7/10/2020

Please submit your data along with the summary to your PI liaison 2 weeks prior to the scheduled report date.

Unit/Department Specific Data Collection Summarization

Quality Improvement Committee

Unit/Department: Mother Baby

QIC Report Date: July 2020

Measure Objective/Goal:

To initiate NICU mom's pumping within 2-4 hours of separation from their baby 85.17% (Internal benchmark of 75%).

Date range of data evaluated:

January – June 2020

Analysis of all measures/data: (Include key findings, improvements, opportunities)

We currently are performing above the benchmark of 75%.

If improvement opportunities identified, provide action plan and expected resolution date:

Education provided to staff on the importance of pumping for both mother and babies well-being. We have been auditing the charts of NICU moms and providing one on one education to staff so that they are charting in the correct location within the EHR.

Next Steps/Recommendations/Outcomes:

We continue to audit, monitor and support the mother's choice of pumping.

Submitted by Name:

Melissa Filiponi, RNC-MNN, BSN

Date Submitted:

07/08/2020

Please submit your data along with the summary to your PI liaison 2 weeks prior to the scheduled report date.

Unit/Department Specific Data Collection Summarization

Quality Improvement Committee

Unit/Department: Mother Baby

QIC Report Date: July 2020

Measure Objective/Goal:

Monitoring c-section respiratory rates to ensure they are performed and documented as ordered within the first 24 hours post c-section. For this reporting period we are at 82.08% compliance. (Internal benchmark 80.0%)

Date range of data evaluated:

January – June 2020

Analysis of all measures/data: (Include key findings, improvements, opportunities)

We currently are performing above the benchmark of 80.0%.

If improvement opportunities identified, provide action plan and expected resolution date:

We recently experienced changes in these orders as ordered by our anesthesia team. Education has been provided to the staff and respiratory rate charting is being audited during bedside report.

Next Steps/Recommendations/Outcomes:

We will continue to monitor this measure until we achieve and sustain 80% compliance rate.

Submitted by Name:

Melissa Filiponi, RNC-MNN, BSN

Date Submitted:

07/08/2020

Please submit your data along with the summary to your PI liaison 2 weeks prior to the scheduled report date.

Unit/Department Specific Data Collection Summarization

Quality Improvement Committee

Unit/Department: Mother Baby

QIC Report Date: July 2020

Measure Objective/Goal:

Babies receiving exclusive breast milk while in the hospital 56.14% (TJC PC-05 Benchmark 52.2%)

Date range of data evaluated:

January – June 2020

Analysis of all measures/data: (Include key findings, improvements, opportunities)

We currently are performing above the benchmark of 52.2%.

If improvement opportunities identified, provide action plan and expected resolution date:

We are currently fully staffed with 7 day a week coverage spanning an average of 21 hours a day. We implemented coverage on Labor/Delivery to see our new mom's prior to delivery providing them with education so they can make an informed decision on how they want to feed their baby while in the hospital. We have implemented our breastfeeding bundle which included the following: change in lactation scheduling, mandatory breastfeeding education for RN's, breastfeeding education provided to our pediatricians, selection preference form to be collected on admission to Labor and Delivery and an investigative form for nursing to complete when formula is given. In addition to the above bundle, our lactation team has now changed their focus to include assisting with the first feed post-delivery and following the mothers who choose to do both breast and formula encouraging only breastfeeding while in the hospital.

Next Steps/Recommendations/Outcomes:

We continue to support our mother's choice of exclusive breastfeeding.

UPDATE September 8, 2020: August finished at 65%!!

Submitted by Name:

Melissa Filiponi, RNC-MNN, BSN

Date Submitted:

07/08/2020

Please submit your data along with the summary to your PI liaison 2 weeks prior to the scheduled report date.

Unit/Department Specific Data Collection Summarization

Quality Improvement Committee

Unit/Department: Mother Baby

QIC Report Date: July 2020

Measure Objective/Goal:

Babies receiving any breast milk while in the hospital 92.34% (CDPH 2018 benchmark of 93.8%)

Date range of data evaluated:

January – June 2020

Analysis of all measures/data: (Include key findings, improvements, opportunities)

We currently are performing below the benchmark of 93.9%.

If improvement opportunities identified, provide action plan and expected resolution date:

We are currently fully staffed with 7 day a week coverage spanning an average of 21 hours a day. We implemented coverage on Labor/Delivery to see our new mom's prior to delivery providing them with education so they can make an informed decision on how they want to feed their baby while in the hospital. We have implemented our breastfeeding bundle which included the following: change in lactation scheduling, mandatory breastfeeding education for RN's, breastfeeding education provided to our pediatricians, selection preference form to be collected on admission to Labor and Delivery and an investigative form for nursing to complete when formula is given. In addition to the above bundle, our lactation team has now changed their focus to include assisting with the first feed post-delivery and following the mothers who choose to do both breast and formula encouraging only breastfeeding while in the hospital.

Next Steps/Recommendations/Outcomes:

We continue to support our mother's choice for feeding her baby(ies).

Submitted by Name:

Melissa Filiponi, RNC-MNN, BSN

Date Submitted:

07/08/2020

Please submit your data along with the summary to your PI liaison 2 weeks prior to the scheduled report date.

Unit/Department Specific Data Collection Summarization

Quality Improvement Committee

Unit/Department: Mother Baby

QIC Report Date: July 2020

Measure Objective/Goal:

District wide CAUTI bundle was implemented on May 1, 2020. In collaboration with Labor and Delivery we ensure that all aspects of the bundle are met. The aspects include daily GEMBA patient rounding to check for securement device, foley care provided, and timely discontinuance. The data collection began on May 1, 2020. The district's goal SIR <0.828.

Goal Met: Zero CAUTI's during the reporting period.

Date range of data evaluated:

May – June 2020

Analysis of all measures/data: (Include key findings, improvements, opportunities)

Our current bundle compliance rate for interventions associated with the GEMBA rounds for 2nd Quarter 2020 is 95.15%. The initial issue when started in May was identifying one place in Cerner to document these cares.

If improvement opportunities identified, provide action plan and expected resolution date:

Education was implemented. Staff is ensuring that upon arrival to the unit the patient has a securement device in place as well as providing foley care at minimum of once per shift. Daily rounding occurs with unit leadership, clinical educator and bedside staff to ensure compliance.

Next Steps/Recommendations/Outcomes:

We continue to round daily to monitor for compliance.

Submitted by Name:

Melissa Filiponi, RNC-MNN, BSN

Date Submitted:

07/08/2020

Please submit your data along with the summary to your PI liaison 2 weeks prior to the scheduled report date.

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2020														
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION							
I. Overall Surgical Site Infections (SSI)	IR/SIR						SSIs calculated internally through standard incidence rate and externally through Standardized Infection Ratio (SIR) from National Health and Safety Network (NHSN).							
A. #Total Procedure Count		1381	442				Annual running total: 1,823							
B. Total Infection Count <i>[note: SSI events can be identified up to 90 days from the last day of the month in each quarter and only DIP and Organ Spc SSI are reported in NSHN]</i>		6	8				1st QTR: 6 Predicted: not available 2nd QTR: 8 Predicted: not available							
C. Incidence Rate (IR) [# of total SSI infections/# total procedures x 100]	Internal 0.70 Goal	0.43	1.8				1st QTR: Total number of SSI events fell well below the threshold of 0.70 this is better than Statewide averages. 2nd QTR: Total number of SSI event exceeded the threshold of 0.70 this is worse than Statewide averages. However, the number of total surgeries performed dropped by 939 procedures. This occurred as a result of restrictions associated with the ongoing COVID-19 pandemic.							
D. SIR Confidence Interval (CI-KDHCDC predicted range, based on risks)		not available	not available				1st QTR: not available 2nd QTR: not available							
E. Standardized Infection Ratio (SIR)	NHSN	not available	not available				1st QTR: not available 2nd QTR: not available							
F. Action Plan for Improvement							1st QTR: Ongoing action plans to improve on administration timing of pre-op antibiotics; antibiotic selection; antibiotic dosing. Reduction of staff entering/exiting O.R. suite during surgery. 2nd QTR: A new SSI prevention gap analysis performed using newer literature from 2017 to current. Comparisons made between current practice (implemented based on 2015 action plan) to current SSI prevention literature. Two interventions identified and being considered for adoption to the surgical services line - irrigation/lavage with dilute iodophor solution, intraoperative hyperoxygenation.							

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2020							
	SIR	Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
II. Specific Surgical Review							
A. Colon Surgery (COLO) CMS/VBP							
1. #Total Procedure Count		32	41				Annual running total: 73
2. Total Infection Count		0	2				1st QTR: 0 Predicted: not available 2nd QTR: 2 Predicted: not available
3. SIR CI (KDHCD predicted range, based on risks)		not available	not available				1st QTR: not available 2nd QTR: not available
4. SIR (Standardized Infection Ratio) total Value Based Purchasing (VBP) SIR = []		not available	not available				1st QTR: No COLO SSI events reported. Clean Closure is routinely being performed. 2nd QTR: 2 COLO SSI events reported. One in which evidence of infection was present at the time of surgery (PATOS); the second case in which bowel anastomosis leaked feculent content into the peritoneum resulting in an intraabdominal abscess.
B. Cesarean Section (CSEC)							
1. #Total Procedure Count		368	357				Annual running total: 368
2. Total Infection Count		1	0				1st QTR: 1 Predicted: not available 2nd QTR: 0 Predicted: not available
3. SIR CI (KDHCD predicted range, based on risks)		not available	not available				1st QTR: Although an SIR is not available the CSEC incident rate = 0.27 which is very low. 2nd QTR: No events.
4. SIR (Standardized Infection Ratio) total		not available	not available				1st QTR: Working on addressing "splash & dash" skin prep technique for emergency CSEC procedures. Also, recommending limiting number of staff in entering/exiting the O.R. suite during surgery. 2nd QTR: It appears some of the actions initiated to reduce CSEC SSI events at the end of 1st QTR 2020 have helped prevent new events in the 2nd QTR.
C. Spinal Fusion (FUSN)							
1. #Total Procedure Count		39	49				Annual running total: 88
2. Total Infection Count		1	2				1st QTR: 1 Predicted: not available 2nd QTR: 2 Predicted: not available
3. SIR CI (KDHCD predicted range, based on risks)		not available	not available				1st QTR: Although an SIR is not available the FUSN incident rate = 2.56 which is high for the volume of this type of procedure being performed. 2nd QTR: Although an SIR is not available the FUSN incident rate = 4 which continues to be high for the volume of this type of procedure being performed.
4. SIR (Standardized Infection Ratio) total		not available	not available				1st QTR: Action plan includes recommendations to provide nares and skin decolonization for MRSA/MSSA. Recommendation to clip, not shave the surgery site. Recommend providing ample instructions on what to do post-operatively if evidence of infection is apparent. 2nd QTR: First case caused by skin flora and likely pressure caused by the cages placed during surgery. Second case appears to be associated with incontinent bowel episode and exposure of stool to the spinal incision site. Education provided about both these findings.
D. Hysterectomy (HYST) CMS/VBP							
1. #Total Procedure Count		48	13				Annual running total: 61
2. Total Infection Count		0	0				1st QTR: 0 Predicted: not available 2nd QTR: 0 Predicted: not available
3. SIR CI (KDHCD predicted range, based on risks)		not available	not available				1st QTR: not available 2nd QTR: not available
4. SIR (Standardized Infection Ratio) total Value Based Purchasing (VBP) SIR = []		not available	not available				1st QTR: No HYST events reported. Clean Closure is routinely being performed. 2nd QTR: No HYST events reported.

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2020																	
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION										
II. Ventilator Associated Events (VAE)		SIR															
A. Ventilator Device Use SUR (standardized utilization ratio)		not available	not available				1st QTR: 891 vd Predicted: not available 2nd QTR: not available Predicted: not available										
B. Total VAEs ICU (NHSN Reportable)	Includes IVAC Plus	2	6				1st QTR: 2 Predicted: not available 2nd QTR: 6 Predicted: not available										
1. SIR Total VAE CI (KDHCD predicted range, based on risks)		not available	not available				This is an internal quality driven metric. A State or National benchmark has not been made available.										
2. Total VAEs SIR		not available	not available				1st QTR: not available 2nd QTR: not available										
C. Total IVAC Plus -ICU		0	4				1st QTR: 0 Predicted: not available 2nd QTR: 4 Predicted: not available										
1. Total IVAC Plus CI (KDHCD predicted range, based on risks)		not available	not available				This is an internal quality driven metric. A State or National benchmark has not been made available.										
2. Total IVAC Plus ICU SIR		0	not available				1st QTR: No IVAC or PVAPs reported. 2nd QTR: No SIR available.										
D. CVICU/KDHCD Total VAEs (not NHSN/Internal)		0	0				1st QTR: CVICU had no VAEs. 2nd QTR: CVICU had no VAEs.										
E. Total VAEs-Both Units		2	6				1st QTR: There were 2 VAC events both in ICU. 2nd QTR: There were 3 VAC, 3 IVAC, 1 PVAP events identified in ICU. This quarter has been exceptionally difficult due to the COVID-19 pandemic. COVID-19 patients have extensive lengths-of-stay and remain on the ventilator several weeks at a time. Secondary pneumonia is quite common in COVID-19 patients.										
III. Central Line Associated Blood Stream Infections (CLABSI) CMS/VBP		NHSN SIR															
A. Total number of Central Line Days (CLD)		3917	3283				Annual running total: 7,200										
B. Central Line Device Use SUR (standardized utilization ratio)		0.74	not available				1st QTR: 3917 Predicted: 5261.50 2nd QTR: 3283 Predicted: unavailable										
C. Total Infection Count Value Based Purchasing (VBP) # events = []		2	6				1st QTR: 2 Predicted: 3.86 2nd QTR: 5 Predicted: 5.95 (1 event = LCBI MBI not counted toward VBP)										
D. SIR Confidence Interval		0.087, 1.713	not available				1st QTR: No different than National benchmark. 2nd QTR: No confidence-interval provided.										
E. SIR (Standardized Infection Ratio) total Value Based Purchasing (VBP) SIR = []		0.519	0.84				1st QTR: Implementation of action plans approved through the CLABSI Kaizen Project. Performing daily nursing unit "Gemba" rounds. Emphasizing methods to reduce the "culture-of-culturing" and "just-in-case" culture of peripheral and CVC line utilization. 2nd QTR: Daily Gemba rounds, provider education related to CLABSI distributed in physician lounges. Letters submitted to providers for a line they inserted identified as in a CLABSI event. Blood culture electronic alert reduced approximately 50% of unnecessary serial blood culture orders. Elimination of the IV Safety Team. COVID-19 Pandemic heavily impacting operations at the hospital. With approval of ECE offered by CMS, HAI data for 4th QTR 2019 through 2nd QTR 2020 not reported via NHSN, as result predicted values and SIR have been calculated manually.										

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2020														
	NHSN SIR	Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION							
IV. Catheter Associated Urinary Tract Infections (CAUTI) CMS/VBP														
A. Total number of Catheter Device Days (CDD)		3549	2865				Annual running total: 6,414							
B. Catheter Device Days SUR (Standardized Utilization Ratio)		0.767	not available				1st QTR: 3549 Predicted: 4624.70							
C. Total Infection Count Value Based Purchasing (VBP) # of events = []		3	5				1st QTR: 3 Predicted: 4.553 2nd QTR: 5 Predicted: 3.69							
D. SIR Confidence Interval		0.168, 1.793	not available				1st QTR: No different than National benchmark. 2nd QTR: No confidence-interval provided.							
E. SIR (Standardized Infection Ratio) total Value Based Purchasing (VBP) SIR = []		0.66	1.36				1st QTR: Implementation of action plans approved through the CAUTI Kaizen Project. Performing daily nursing unit "Gemba" rounds. Emphasizing methods to reduce the "culture-of-culturing" and "just-in-case" culture of inserting indwelling urinary catheters when not indicated. Emphasizing alternatives to an indwelling urinary catheter and straight catheterization. Guiding providers away from ordering cultures based on urine color/sediment. 2nd QTR: Work underway to establish a physician PowerPlan built in Cerner to guide the provider to appropriately order urine cultures based on urine culture algorithm (developed from review of evidence-based literature). Gemba rounds have reduced indwelling urinary catheter days by 684 days. Peri care improving. Still have culture-of-culture issues. Also, need to address urinary retention/neurogenic bladder as an indication for an indwelling urinary catheter (diagnosis may be being overly used). With approval of ECE offered by CMS, HAI data for 4th QTR 2019 through 2nd QTR 2020 not reported via NHSN, as result predicted values and SIR have been calculated manually.							
V. Clostridium difficile Infection (CDI) CMS/VBP														
A. Total Infection Count	All units	3	8				1st QTR: 3 Predicted: 15.297 2nd QTR: 8 Predicted: Unavailable							
B. SIR CI (KDHCD predicted range, based on risks)		0.050, 0.534	not available				1st QTR: No different than national benchmark. 2nd QTR: unavailable							
C. SIR (Standardized Infection Ratio) total Value Based Purchasing (VBP) SIR = []		0.196	not available				1st QTR: Closely monitoring C. difficile rates. Occasionally reminding providers and nurses to look for alternative reasons for diarrhea (i.e. stool regimen) in advance of testing for C. difficile. 2nd QTR: Based historical predicted values the approximated SIR for 2nd QTR would be 0.52, which is still well below the national benchmark.							

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2020							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
VI. Hand Hygiene	95%						
A. All units Percentage of correct Hand Hygiene observations/opportunities (30 observations/month/unit)		88%	87%				<p>1st QTR: ICU and 4N Renal Unit are trialing Biovigil electronic hand hygiene surveillance system. Hand hygiene compliance rates remain above 97% with thousands of observations occurring weekly.</p> <p>The remaining nursing units perform unit based hand hygiene observations and the IP Liaison and Infection Prevention perform hand hygiene audits in these locations. The 88% HH compliance rate is composite of these observations. The Do You Disinfect Everytime (D.U.D.E.) Campaign continues with videos posted on KDCentral.</p> <p>2nd QTR: 87% compliance for all units/departments (excluding 4N and ICU) a total of 2,663 observations with 2,317 compliant. Biovigil trial still ongoing. Very high hand hygiene compliance rates in 4N a little less so in ICU (4N 99.1% & ICU 96.4%). New Leapfrog hand hygiene criteria achieved (increased hand hygiene observation volume per month/education/validation testing/marketing, etc.)</p>
VII. VRE (HAI) Blood-Hospital Onset (HO)	BM						
A. Total Infection Count		0	1				<p>1st QTR: 0 Predicted: 2nd QTR: 1 Predicted: not available</p>
B. Prevalence Rate (x100)		0	1.45				<p>1st QTR: No VRE BSI events reported. 2nd QTR: This is the first event of VRE BSI reported in a very long time at KDCHD.</p>
C. Number Admissions		6591	6881				13,472
VIII. MRSA (HAI) Blood CMS/VP	SIR						
A. Total Infection Count (IP Facility-wide)		2	1				<p>1st QTR: 2 Predicted: not available 2nd QTR: 1 Predicted: not available</p>
B. SIR CI (KDHC predicted range, based on risks)		0.212, 4.180	not available				<p>1st QTR: not available 2nd QTR: not available</p>
C. SIR (Standardized Infection Ratio) total Value Based Purchasing (VBP) SIR = []		1.265	not available				<p>1st QTR: Both cases involved patients who had blood cultures later than 3 days into their admission. Both patients demonstrated elevation in WBCs which initiated blood culture orders. However, findings for one patient demonstrated evidence of pneumonia, this patient never had respiratory secretion cultures performed. The second patient had a liver abscess that was drained, but blood cultures were performed a day in advance of the drainage procedure and MRSA was found.</p> <p>2nd QTR: MRSA BSI infection identified was a joint MRSA BSI and CLABSI event. The blood culture was collected on day 4 which results in the event being healthcare onset related instead of present-on-admission.</p>
IX. Influenza Rates (Year 2019-2020)	NHSN						
A. All Healthcare Workers		97.8%					<p>Season 2020-2021: 3,947 out of 4,034 healthcare personnel received influenza vaccination during the influenza season. This is down by 0.2% from the 2019-2020 Influenza Season vaccination rate. A total of 84 healthcare personnel declined influenza vaccine and 3 healthcare personnel had a medical contraindication to receiving influenza vaccination.</p> <p>Action: Early preparation for a potentially challenging year with a combined influenza season and COVID-19 pandemic.</p>
Approved IPC: Approved IPC: Approved IPC: Approved IPC:							
Prepared by Shawn Elkin, MPA, BSN, RN, PHN, CIC Infection Prevention Manager							
Note: Procedural DFP for Feb/March pending							
Note: Many variables are unavailable as a result of removing data from NHSN for 4th QTR 2019 and 1st/2nd QTR 2020							





Handoff Quality Focus Team

**Kassie Waters, Director of Cardiac Critical Care Services
& Tom Siminski, Director of Emergency Services**

Handoff Team

Team Leader: (3)

Kassie Waters, Director of Cardiac Critical Care Services, & Tom Siminski, Director of Emergency Services

Champion: (4)

Keri Noeske, VP Chief Nursing Officer

Team Members: (17)

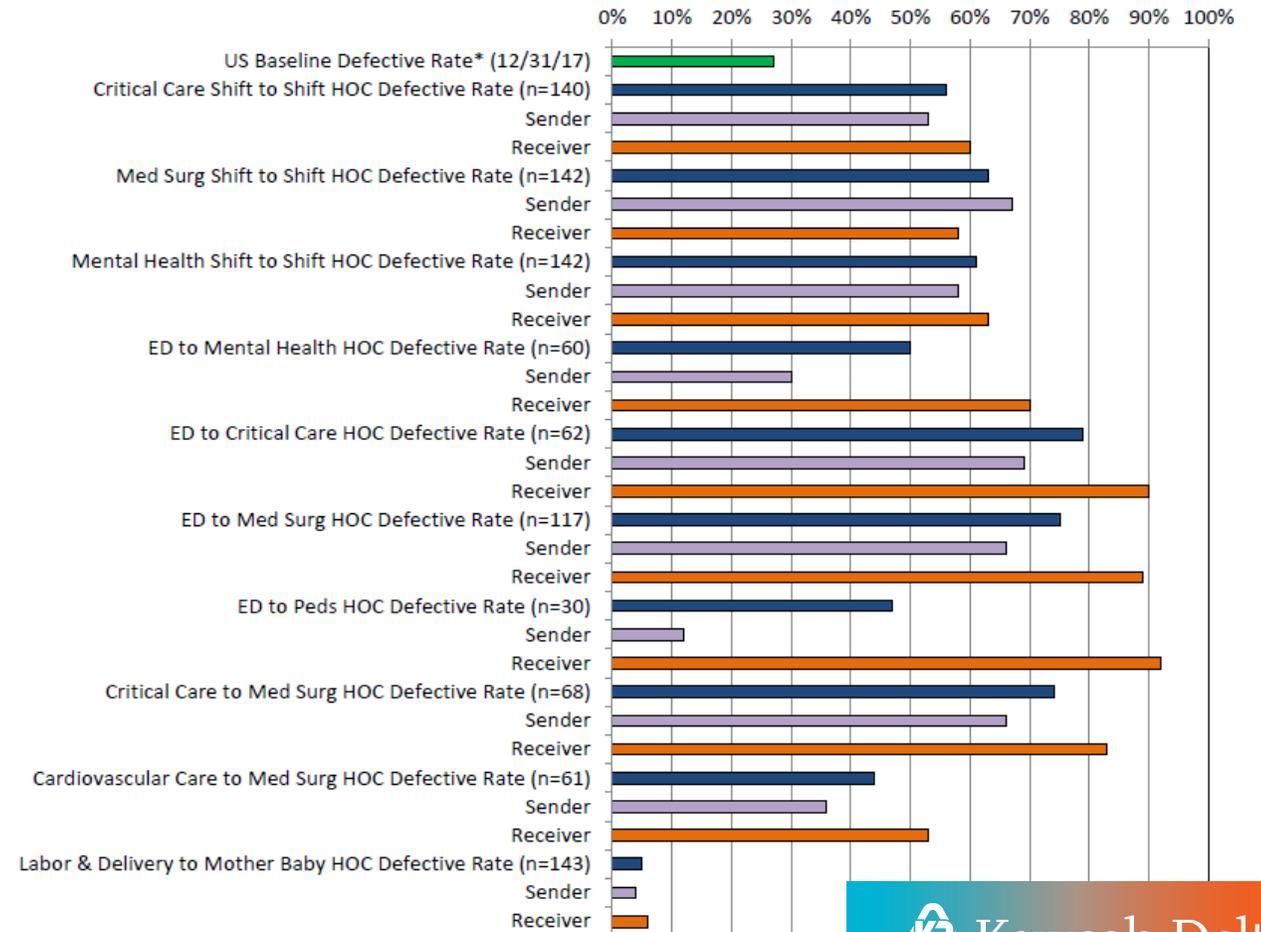
Keri Cochran, 4T Team Lead, Kristin Olson, Clinical Educator, Cindy Vander Schuur, RN Clinical Analyst, Janessa Dean, 4T Nurse Manager, Lacey Jensen, Director of Clinical Informatics, Erin Marquez, Clinical Educator, Billy Walker, ED Nurse Manager, Craig Dixon, Advance Practice Nurse, Rudy Gonzales, ED RN, Rick Brown, Clinical Informaticist, Sarah Brown, Clinical Informaticist, Dee Vernon, Case Management Coordinator, Kathy Milanesio, Administrative Assistant

Handoff Historical Data

Joint Commission Handoff Targeted Solutions Tool (TST) Baseline Data Completed in 2018

- Identified ED handoff with the highest defect rate between sender and receiver.
- Top Contributing Factors Included:
 - Sender unable to contact receiver
 - Inaccurate or incomplete information
 - Repeat or resend information
 - Interruptions

**Hand-off Communication (HOC) Baseline Defective Rate
April 2018**



Problem Statement & Data Continued

Problem Statement

No standardize handoff process utilized between the ED and in-patient departments which leads to miscommunication between the sender and receiver, increase patient safety errors, and ineffective use time by unavailability of the handoff receiver.

TST Data

- Receivers of handoff information stated 70-85% of the information was inaccurate or incomplete.
- 66-69% of Emergency RN senders needs are not met with the current handoff due to:
 - Interruptions (41-19%)
 - Repeated information (28-24%)
 - Unable to contact receiver (21-31%).
 - June 2020 - 7% of beds ready to occupied occur in 30 min (this time includes providing handoff). *Teletracking Data

Problem Statement & Data Continued

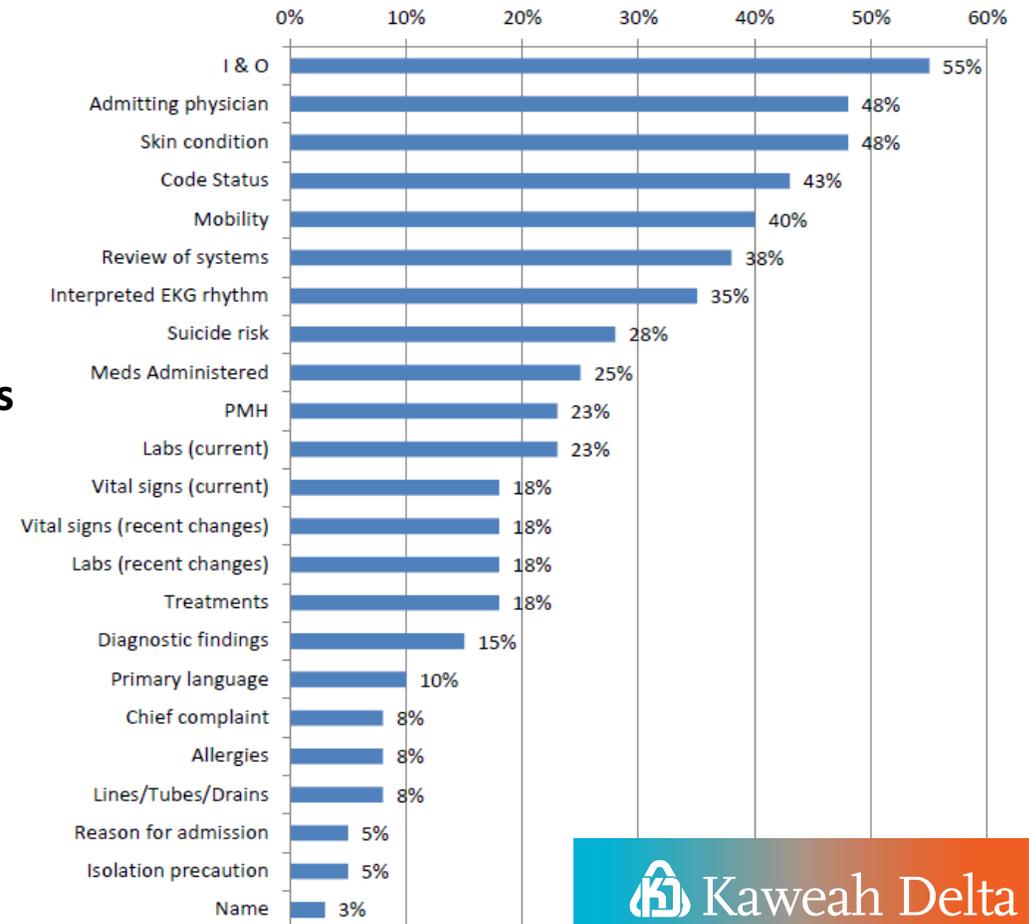
Time & Delay Issues - ED Sender Comments

- *No staff came to room to greet/help/lay eyes on patient.*
- *No bed in room caused 30-45 min delay.*
- *The floors do not want to take report at change of shift. This causes delays for movement of patients.*
- *I had to call the floor 4 times. Floor RN finally called me back after 4th call.*
- *ER RN was able to reach floor RN but she was at lunch. Charge Nurse was also at lunch. ER RN was asked to call back in 30 minutes when floor RN was finished with lunch.*
- *I called multiple times and was on hold for a total of 10 minutes. It seemed like they were all at lunch. Someone else had to take report.*

Handoff Defects

Emergency RN to Med Surg RN *Defects of individualized critical elements

(n=40) Note: each receiver can choose multiple defect elements



Team Mission

Implement standardize structure for nurse to nurse handoff when admitting a patient from the Emergency Department to in-patient departments.

Standardize structure will:

- Include critical content to eliminate communication errors.**
- Provide accurate and complete information to the receiver.**
- Meet the needs of the sender and receiver to handoff and receive care.**
- Accomplish a timely handoff (transfer) of the patient to the admitting department by removing barriers.**



Team Deliverables & Goals

Deliverables

1. Establish standard process
2. Standardize critical content elements
3. Build standard handoff tool utilizing EMR
4. Standardize training & education

Goals

Quality of Handoff Measurement

1. ED nurse "sender" provided accurate and complete information with 80% of handoffs (Current state is 15%)

Timeliness Measurement

2. Handoff completed and bed occupied with in 30 minutes of the bed being ready. (Current state is 1hour 18 minutes)

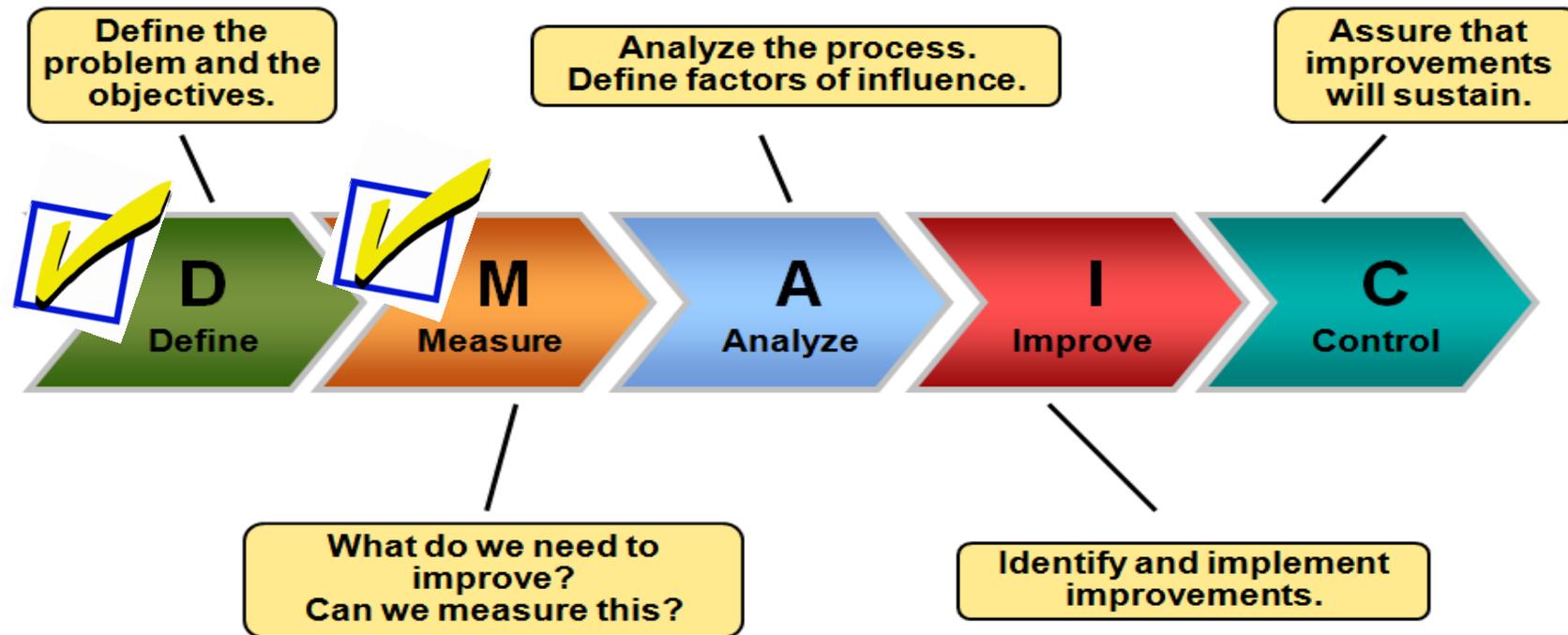
Safety Measurement

3. Reduce the number of handoff safety events from the ED to In-patient departments by 20%.(Current state data-pending)



DMAIC

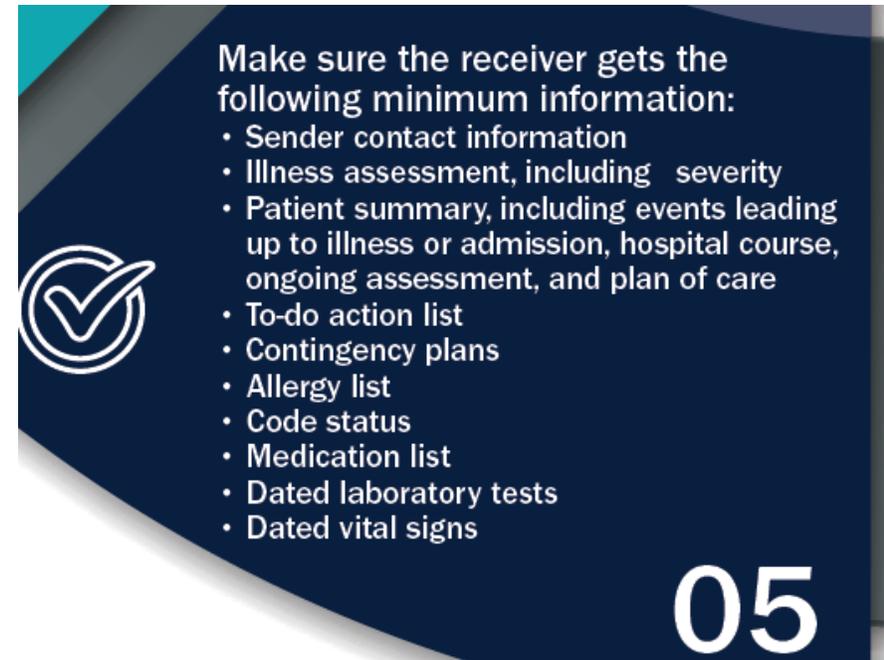
DMAIC Roadmap



Next Steps → Analyze

- Outline current work flow, barriers, and gaps (flow map)
- Maternal Child Health – Share current EMR handoff process (best practice identified by ISS)
- Review Cleveland Clinic process & EMR tools
- Review UC Davis Health System process & EMR tools
- List critical content to be included in the handoff
- What is high risk information
 - Insulin, antibiotics, anticoagulants, & blood product

Joint Commission Handoff List

A dark blue graphic with a white checkmark icon on the left. The text on the right lists the minimum information to be included in a handoff.

Make sure the receiver gets the following minimum information:

- Sender contact information
- Illness assessment, including severity
- Patient summary, including events leading up to illness or admission, hospital course, ongoing assessment, and plan of care
- To-do action list
- Contingency plans
- Allergy list
- Code status
- Medication list
- Dated laboratory tests
- Dated vital signs

05

Questions



COVID-19 Clinical Quality Review August 2020

COVID-19 Clinical Quality Summary

Who is in the denominator?

- Data date range April – July 2020 of discharged pts (1 case Feb & Mar 2020, excluded)
- **Inpatients with primary or secondary diagnosis of COVID-19** (n=474)
- Data source: Administrative data set (billing & ADT) from Midas
- *There are well over 100 COVID pt's admitted who are not included in this report because:
 - 68% had been discharged but not coded yet
 - 27% have not been discharged
 - 6% have been discharged, initially had an admitting Covid Dx, which was later removed and not included as a Final Dx.
- The sample size in this report does not represent ALL COVID-19 patients, but is a significant sample size to determine trends in outcomes.

COVID-19 Clinical Quality Summary

Data Summary

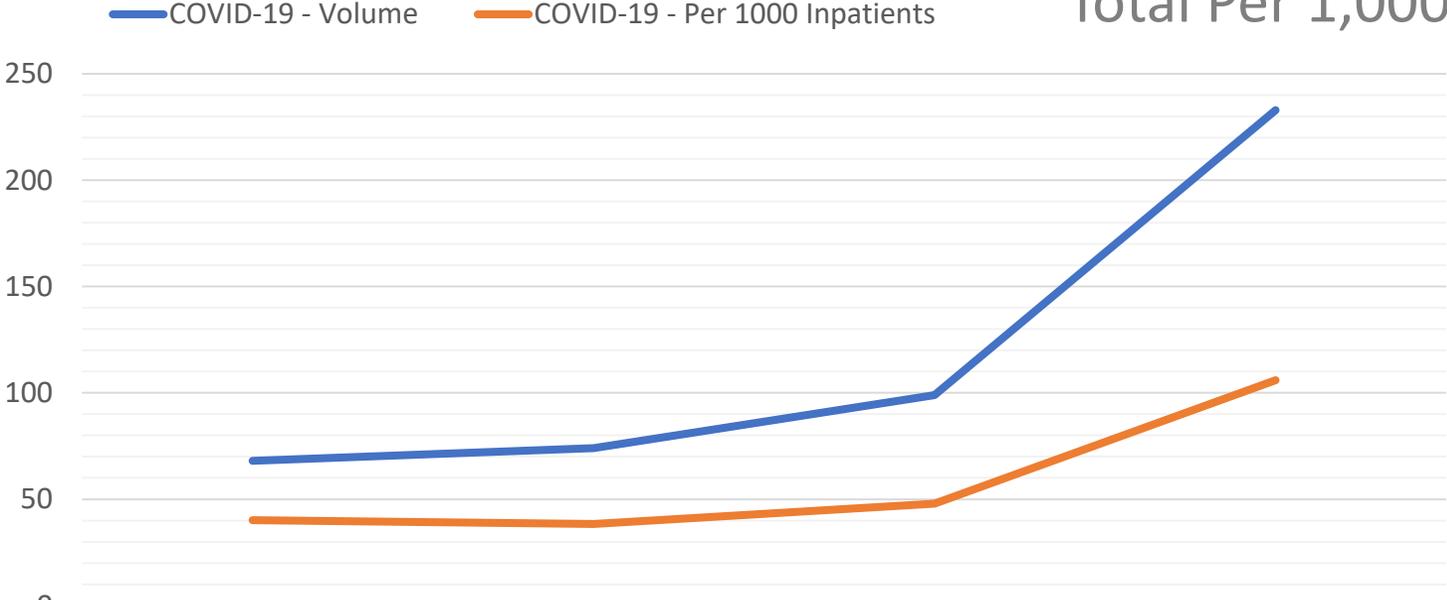
- ALOS decreasing over 3 months from >11 days May-June, 8.46 July
- Diabetes and Hypertension most prevalent comorbidities
- Proportion of high severity cases has decreased since May: proportion of ventilated patients has decreased from May 14.9%, June 12.1%, July 10.3%
- Mortality rate decreasing each month, April 33.8% - July 14.6%
- Readmission rates decreasing from 11.1% April, 5% May/June to 4% in July
- 31% have a major complication not present on admission, most prevalent: Sepsis, pneumonia, acute renal and respiratory failure

COVID-19 Clinical Quality Summary

Volume Primary and Secondary Dx

COVID Volume

Total Volume: 474
Total Per 1,000 Inpt: 60.0

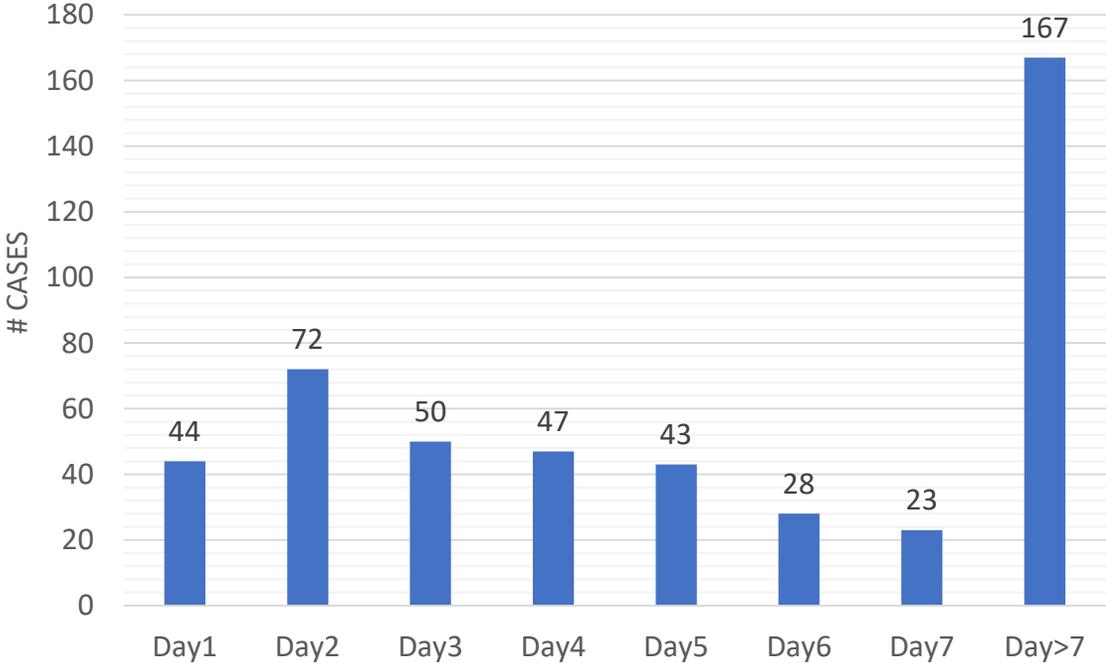


	Apr 2020	May 2020	Jun 2020	Jul 2020
COVID-19 - Volume	68	74	99	233
COVID-19 - Per 1000 Inpatients	40.2	38.3	47.9	106.0

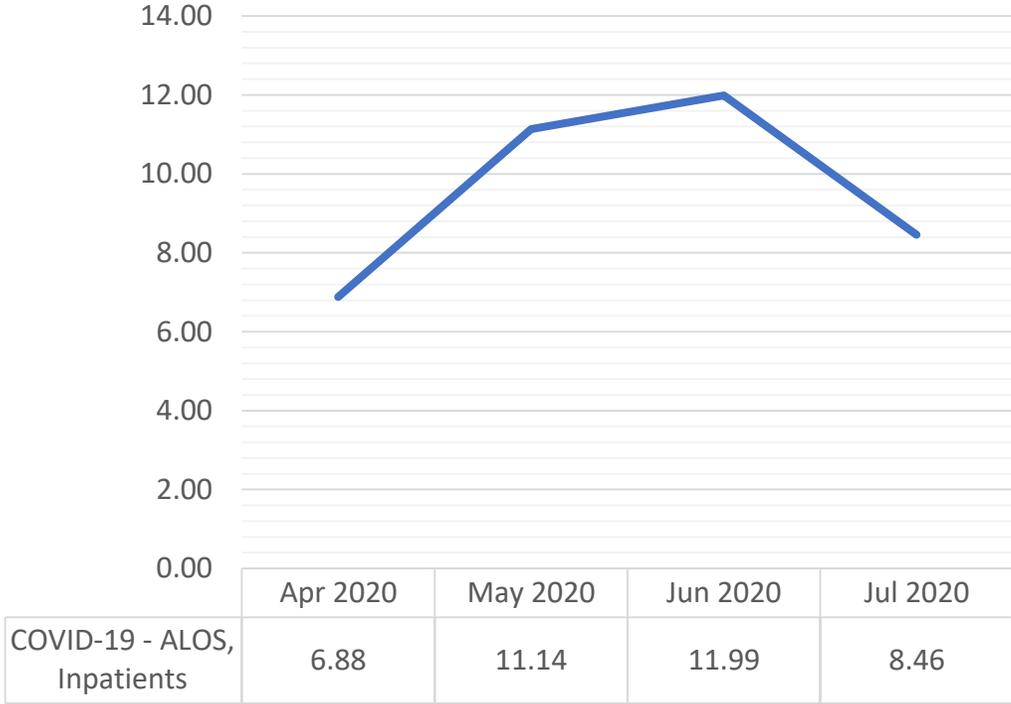
COVID-19 Clinical Quality Summary

Length of Stay (LOS)

Discharge Distribution by LOS



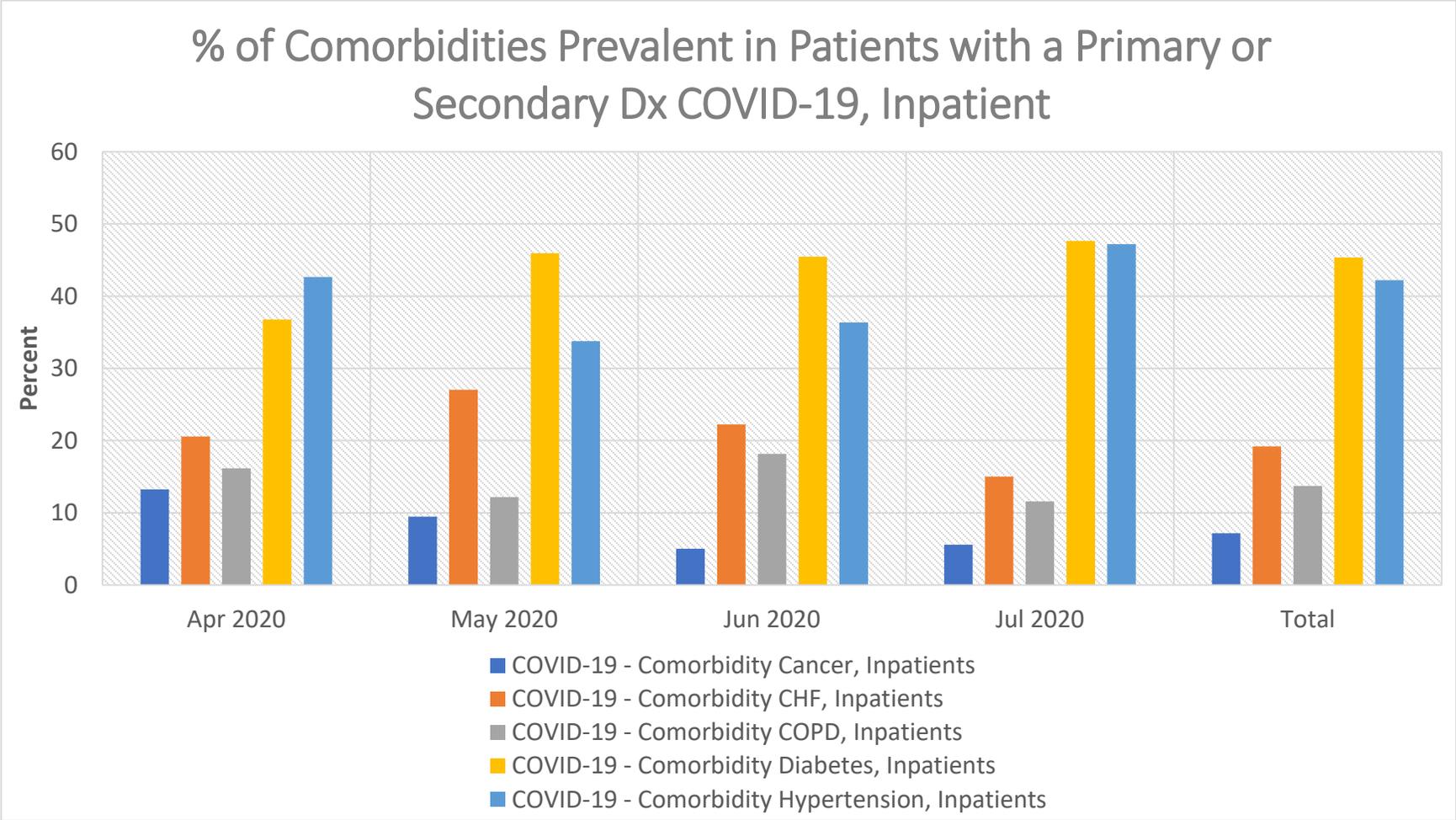
COVID-19 - ALOS, Inpatients



Total ALOS: 9.39

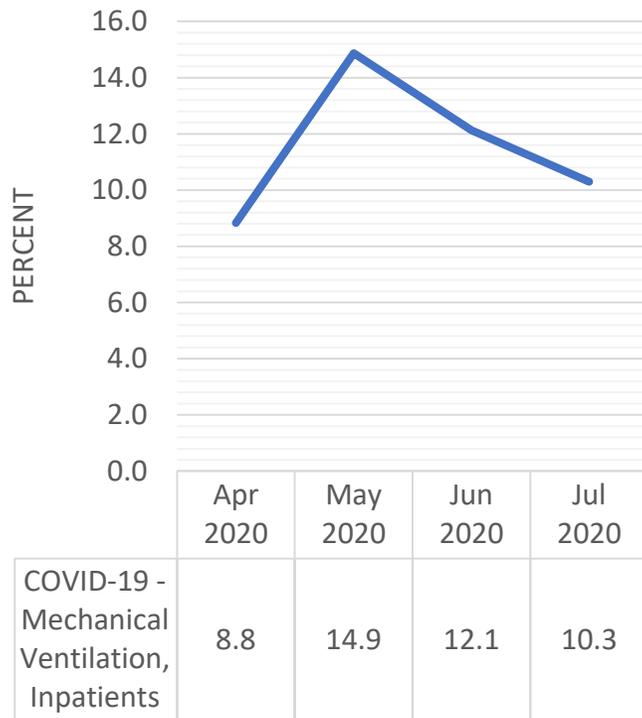
COVID-19 Clinical Quality Summary

Comorbid Conditions



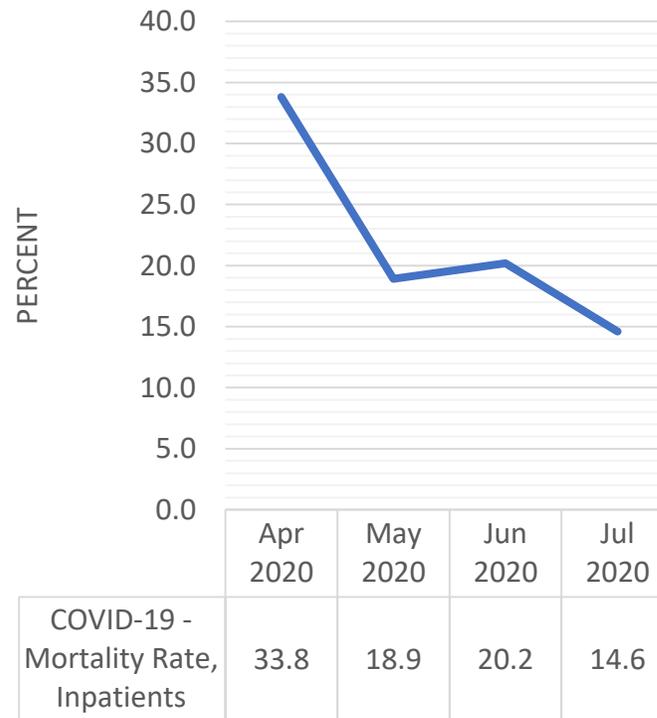
COVID-19 Clinical Quality Summary

COVID-19 - Mechanical Ventilation, Inpatients



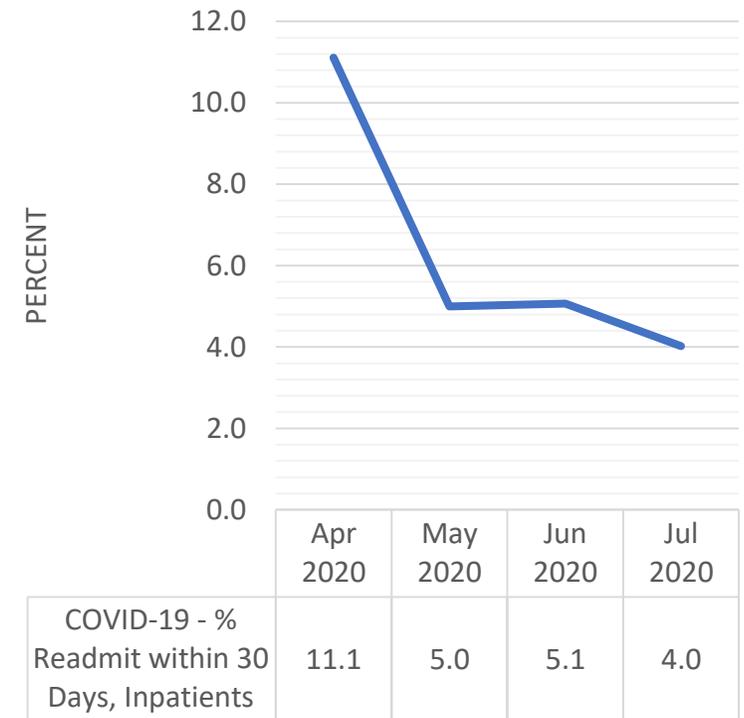
Total ALOS: 11.2%

COVID-19 - Mortality Rate, Inpatients



Total Mortality: 19.2%

COVID-19 - % Readmit within 30 Days, Inpatients



Total Readmission: 5.2%

COVID-19 Clinical Quality Summary

Admission Principal Diagnosis

Top Principal Diagnoses	Total
COVID-19	263
Other specified sepsis	86
Sepsis, unspecified organism	15
Other viral diseases complicating childbirth	9
Encounter for palliative care	7
Sepsis due to Escherichia coli [E. coli]	4
Oth coronavirus as the cause of diseases classd elswhr	3
Matern care for low transverse scar from prev cesarean del	3
Sepsis due to Methicillin susceptible Staphylococcus aureus	2
Chronic atrial fibrillation, unspecified	2
Cerebral infarction, unspecified	2
Atrioventricular block, complete	2
Dehydration	2
Breakdown of surgically created AV fistula, init	2
Calculus of gallbladder w acute cholecyst w/o obstruction	2
Non-ST elevation (NSTEMI) myocardial infarction	2

COVID-19 Clinical Quality Summary

Complications

Total Cases	474
# Cases with all Dx present on admission	250
# Cases with one or more Dx Not Present on Admission	224
<hr/>	
Major Complications Not Present On Admission	
Acute Myocardial Infarction	3
Acute Renal Failure	22
Acute Respiratory Failure and Edema	26
Acute Venous Embolism and Thrombosis	0
Cardiac or Respiratory Arrest	10
Cerebral Anoxia or Brain Death	5
Heart Failure	0
Ischemic Stroke	5
Pneumonia	29
Pulmonary Embolus	1
Sepsis	14
Septic Shock	17
Other Shock	13
Ventilator-Associated Pneumonia	1

146/474 (31%) have a major complication NPOA

Most prevalent: Sepsis, Pneumonia, Acute Renal & respiratory failure, respiratory edema



Clinical Quality Goal Update September 2020

Sepsis

July 2020
Higher is Better

	FYTD %	FY21 Goal	FY20	Last 6 Months FY20
SEP-1 (% Bundle Compliance)	tbd	≥ 70%	67%	69%

Top Initiatives (six sigma teamwork):

- Sepsis alert notification of providers, revision of electronic form and mandatory follow up
- Sepsis handoff, electronic version to ensure flow from ED to inpatient

Provider-level Initiatives

- Sepsis Coordinators using secure messaging with ED providers in real time
- Meeting with Hospitalist group in September; ongoing guidance for providers
- Resident education

Sepsis Heroes

Case Summary

- Fall at home likely to do septic shock (weakness)
- Came to ED, systolic blood pressure 70's
- Aggressive fluid strategy normalized BP with in 1.5 hrs
- Entire Sepsis Bundle (6 hr max) completed within 4 hrs entirely in the ED
- Patient discharged home within 3 days of admission
- National Mortality Rate of Septic Shock is 30%, early diagnosis and treatment drastically changes a septic patients outcome*



*Sepsis 2019 : Rio de Janerio, Brazil. 09 - 10 May 2019. Intensive Care Med Exp. 2019;7(Suppl 2):33. Published 2019 Jun 27. doi:10.1186/s40635-019-0254-1

Sepsis Awareness

Month

Kaweah Sepsis Coordinators

- New email: SepsisCoordinators@kdhcd.org
- Use this for any questions, concerns or follow up (sepsis cases), our Coordinators are here to help!



Jared Cauthen, RN

Ryan Smith, RN

SEND US YOUR 6 AND WIN!

SEPSIS AWARENESS MONTH - SEPTEMBER 2020

We want YOUR picture of a Set of 6 of ANYTHING

6 is the amount of HOURS we have to provide all the best practices for our sepsis patients so they have the BEST OUTCOMES

SEND US YOUR PICTURE OF A SET OF 6 OF ANYTHING TO PatientSafetyContest@kdhcd.org BY 11:59 SEPTEMBER 30TH AND BE ENTERED INTO AN OPPORTUNITY DRAWING FOR A "6 THEMED" GIFT BASKET

Send us a picture of 6 paper clips, 6 cards, do you have 6 grandchildren? Send us a picture of them together! Do you have 6 toes? That'll work too!



TIME ZERO

- SIRS + Infection=Sepsis
- Sepsis + Organ Dysfunction = Severe Sepsis
- Respond to the sepsis alert and initiate the bundle when indicated

HOURS 1 - 3

- Draw Lactate Level
- Blood culture prior to antibiotics
- Administer broad spectrum antibiotics
- Administer 30 ml/kg crystalloid fluids for hypotension or lactate ≥ 4 mmol/l

HOURS 3- 6

- Draw 2ND lactate if the first was ≥ 2 mmol/l
- Apply vasopressor (for hypotension that does not respond to initial fluid resuscitation) to maintain a MAP ≥ 65 mm Hg
- Physician reassessment - any one of: CVP, SvO₂, bedside cardiovascular US, passive leg raise or fluid challenge

Winner announced Oct 1, 2020

In the 2 minutes it took you to read this someone in the US was diagnosed with sepsis

CAUTI, CLABSI,

	Current													FYTD		Baseline	SIR GOAL	VBP 2022
	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	1.85	0.63	0.98	0.98	1.557 ↓37%	≤0.828 or 14	50 perc ≤0.727	
numerator (actual)	1	5	4	1	0	0	0	2	0	1	3	1	18	18				
denominator (predicted)	1.53	1.81	1.71	1.47	1.46	1.03	1.7	1.61	1.24									
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													FYTD		Baseline	SIR GOAL	VBP 2022
	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	0.81	4.07	1.09	1.09	1.253 ↓13%	<0.784 or 12	50 perc ≤0.633	
numerator (actual)	0	0	3	4	2	0	0	0	0	1	1	5	16	16				
denominator (predicted)	1.19	1.23	1.11	1.09	1.8	1.13	1.02	1.27	1.22									
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	SIR GOAL	VBP 2022
	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	1.410 ↓29%	<0.815 or 7	50 perc ≤0.748	
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				

FY21 CAUTI, CLABSI, MRSA

July 2020
Lower is Better

	July 2020 Lower is Better	Estimated Annual Number Not to Exceed to Achieve Goal*	FYTD SIR** (number of actual divided by number expected)	FY21 Goal	FY20	Last 6 Months FY20
CAUTI Catheter Associated Urinary Tract Infection	3	13	tbd	≤0.727	1.03	0.85
CLABSI Central Line Associated Blood Stream Infection	2	9	tbd	≤0.633	1.02	0.83
MRSA Methicillin-Resistant Staphylococcus Aureus	1	5-6	tbd	≤0.748	1.00	0.55

*based on FY20 NHSN predicted values

**Standardized Infection Ratio – Number of actual infections Kaweah had divided by the number of infections CMS expects Kaweah should have

CAUTI, CLABSI, MRSA

Case Review Summary

CAUTI – July

- Opportunities: Appropriate indications for IUC (neurogenic bladder), using alternatives to IUC
- Staffing Ratios: 14/22 shifts short initially, but balanced with other staff of equal or higher skill staff (source: Clarvia). Short shifts could be RN manager, CRN, RNs, CNA, or HUC

CLABSI/MRSA – June, July, August

- Opportunities: Avoiding multiple-lines when not indicated, use of midlines and PICC as alternatives, removal/replacement of femoral lines timely, evaluate timing of TPN initiation
- Staffing Ratios: 47/62 shifts short initially; all but 4 shifts balanced with equal or higher skilled staff. (source: Clarvia). Short shifts could be RN manager, CRN, RNs, CNA, or HUC. 4 short shifts could have contributed to event

CAUTI, CLABSI, MRSA

Action Plans

Biovigil installed in all inpatient units!

CAUTI

- 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