December 15, 2023

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, December 21, 2023, 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, December 21, 2023, 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, December 21, 2023, 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
Michael Olmos, Secretary/Treasurer

Cindy Moccio

Cindy Moccio
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, December 21, 2023
5105 W. Cypress Avenue
Kaweah Health Lifestyle Fitness Center Conference Room

ATTENDING: Board Members; David Francis – Committee Chair, Michael Olmos; Gary Herbst, CEO; Keri Noeske, RN, BSW, DNP, 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 DNP, RN CLSSBB, Director of Quality and Patient Safety; Ben Cripps, Chief Compliance and Risk Management Officer; Evelyn McEntire, Director of Risk Management; and Michelle Adams, Recording.

OPEN MEETING – 7:30AM

1. **Call to order** – *David Francis, 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 (Cindy Moccio 559-624-2330) or cmoccio@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, OD, Vice Chief of Staff and Quality Committee Chair*
   - **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** – *David Francis, Committee Chair*

CLOSED MEETING – 7:31AM

1. **Call to order** – *David Francis, Committee Chair & Board Member*
2. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Julianne Randolph, OD, Vice Chief of Staff and Quality Committee Chair*

3. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Michelle Peterson, RN, Director of Emergency Services and Lori Winston, MD, Chief Medical Education Officer.*

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** – *David Francis, Committee Chair*

OPEN MEETING – 8:00AM

1. **Call to order** – *David Francis, 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. Infection Prevention Quarterly Dashboard
    - 3.2. Hand Hygiene Report
    - 3.3. Subacute
    - 3.4. Handoff Quality Focus Team
    - 3.5. Best Practice Teams – No update

4. **Renal Services -** A review of key performance indicators and actions associate with care of Dialysis services**.** *Amy Baker, MSN, RN, Director of Renal Services*

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** – *David Francis, 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.

KAWEAH DELTA HEALTH CARE DISTRICT

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Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2023							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
I. Environmental Surveillance							
A. **Sterilization and High Level Disinfection Quality Control**							
Goal <2% of Immediate Use Sterilization		**1.60%**	**1.28%**	**1.52%**			**1st QTR:** There were a total of 44 IUS events out of 2,724 cases performed. **2nd QTR:** There were 44 IUS events out of 3,427 cases performed. **3rd QTR:** There were 40 IUSS events out of 2,633 cases performed. Primarily ENT by Bien Air is device most reprocessed by IUSS. **4th QTR:**
B. Dialysis Water/Dialysate Quality Control (AAMI RD52:2004) (% of machines that did not exceed limits)							
Acute Dialysis (Inpatient) RO Water [Target: <200cfu] [Action: > or = 50cfu] Endotoxin [Target: <2EU] [Action: > or = 1EU]		**100%**	**100%**	**100%**			**1st QTR:** 51 Reverse Osmosis and 6 Dialysate samples tested all below maximum allowable limits - no action required. **2nd QTR:** 51 Reverse Osmosis and 6 Dialysate samples tested all below maximum allowable limits - no action required. **3rd QTR:** 56 Reverse Osmosis and 5 Dialysate samples tested all below maximum allowable limits - no action required. **4th QTR:**
Outpatient Dialysis RO Water [Target: <200cfu] [Action: > or = 50cfu] Endotoxin [Target: <2EU] [Action: > or = 1EU]		**100%**	**100%**	**100%**			**1st QTR** 8 Reverse Osmosis and 6 Dialysate samples tested all below maximum allowable limits - no action required. **2nd QTR:** 8 Reverse Osmosis and 6 Dialysate samples tested all below maximum allowable limits - no action required. **3rd QTR:** 6 Reverese Osmosis and 9 Dialysate samples tested all below maximum allowable limits - no action required. **4th QTR:**
C. Environmental Cleaning (ATP testing surfaces)							

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2023							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
Pass/Fail based on a threshold of ATP score of <200. Multiple high-touch surfaces tested each month.	Goal 100%	81%	81.9%	78.0%			**1st QTR:** A total of 223 first pass cleanings out of 275 opportunties. The devices with the highest first pass rate: Room sink; handrail, flush handle, counter. The devices with the lowest first pass rate: call button, rest room sink, telephone, bedrail. All fallouts result in room being re-cleaned. **2nd QTR:** A total of 240 first pass cleaning out of 293 opportunities. The devices with the highest first pass rate: Room sink, OR Bed Control, Flush Handle. The devices with the lowest first pass rate: Room Light Switch, Bedrail, Call Button, Telephone. All fallout results in room being re-cleaned. Areas with highest first pass rates: OB OR, Cath Lab. Areas with lowest first pass rates: ICU, CVICU. **3rd QTR:** A total of 338 first pass cleaning out of 433 opportunitiies. The devices with the highest first pass rate: Restroom sink, Restroom Doorknob, Flush handle. The devices with the lowest first pass rate: Bedside table, Room sink, Room Doorknob. All fallout results in room were re-cleaned. Locations that underwent ATP testing include all surgical operating room suites, CVICU, ICCU, and ICU. During this quarter a larger volume of ATP testing was performed (32% increase in test samples compared to 2nd QTR 2023). **4th QTR**
II. Antimicrobial Stewardship Measures							
# of antibiotic IV to PO conversion		112	148	137			**1st QTR:** The majority of IV-to-PO conversions over the past 3 months occurred in the ICU and CVICU, 19 and 21, respectively. **2nd QTR:** IV-to-PO conversions increased by 32% from previous quarter. The majority of IV-to-PO conversions occured in CVICU followed by ICU and 3W. **3rd QTR:** The greatest number of IV-to-PO interventions over the past 3 months occurred in the CVICU (33 events), followed by Broderick Pavilion (31 events), then 3 South with (21 events). There was a broader array of units with IV-to-PO impacts. IV-to-PO conversions helps with reducing the need for intravenous lines that could potentially predispose a patient to risk of sepsis if contamination occurs. **4th QTR:**
Average Days of Therapy per 1,000 patient days - Fluoroquinolones		NA					**1st QTR:** This information is unavailable at this time. **2nd QTR:** This informaiton is difficult to provide quarterly. This metric will no longer be reported on. The information is ultimately shared in the Antimicrobial Stewardship Committee. **3rd QTR: ----** **4th QTR: ----**

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2023							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
Average Days of Therapy per 1,000 patient days - Carbapenems		NA					**1st QTR:** This information is unavailable at this time. **2nd QTR:** This informaiton is difficult to provide quarterly. This metric will no longer be reported on. The information is ultimately shared in the Antimicrobial Stewardship Committee. **3rd QTR:** ---- **4th QTR:** -----
III. Employee Health							
A. Needlestick Injuries							
Number of sharps/needle stick reports		22	17	NA	NA		**1st QTR:** Majority (10) of needlestick injuries occur when engaging the needle safety mechanism. The majority of the sharps exposures involve RN's (9) followed by Residents (7). **2nd QTR:** Majorioty of needlestick injuries involve RN's (6), followed by, LVN's (4), Techs (4) GME Residents (2), and EVS (1). Most events associated with discarding needles (8), recapping (1), activating safety mechanism (1), lack of attention (3), surgery (2), needle disposed in trash and EVS worker poked (1). **3rd QTR:** No longer reported at IPC with IPC approval. Report available with EOC Committee. **4th QTR**: No longer reported at IPC with IPC approval. Report avaiable with EOC Committee.
IV. Healthcare Associated Infection Measures							
I. Overall Surgical Site Infections (SSI)	**IR/SIR**						**SSIs calculated internally though standard incidence rate and externally through Standardized Infection Ratio (SIR) from National Health and Safety Network (NHSN).**
A. #Total Procedure Count		448	1258	1276			**Cumulative Ct:** 2,982
B. Total Infection Count *[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]*		2	14	9			**1st QTR:** 2 **Predicted:** 7.991 **2nd QTR:** 14 **Predicted:** 16.348 **3rd QTR:** 9 **Predicted:** 17.123 **4th QTR:** **Predicted:**
D. SIR Confidence Interval (CI-KDHCD predicted range, based on risks)		0.042, 0.827	0.487, 1.403	0256, 0.965			**1st QTR:** Better than state average. **2nd QTR:** Better than state average. **3rd QTR:** Better than state average. **4th QTR:**
E. Standardized Infection Ratio (SIR) for all surgical procedures.	**<1.0**	**0.25**	**0.856**	**0.526**			**1st QTR:** There was 1 appendectomy and 1 colorectal surgical site infection. **2nd QTR:** There was 1 appendectomy, 1 small bowel, 1 gallbladder surgery, 1 heart bypass, 1 craniotomy, 1 spinal fusion, 1 total abdominal hysterectomy, 1 exploratory surgery, 3 colorectal surgeries, 3 cesarean section surgeries **3rd QTR:** There was 1 cholecystecomy, 2 craniotomy, 2 cesarean section, 2 spinal fusion, 1 abdominal hysterectomy, 1 small bowel surgery. **4th QTR:**

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2023							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
V. Specific Surgical Review	**SIR**						
A. Colon Surgery (COLO) CMS/VBP							
1. #Total Procedure Count		41	40	48			**Cumulative Ct:** 129
2. Total Infection Count		1 [1]	3 [3]	0 [0]			1st QTR: 1 Predicted: 2.945/CMS 1 Predicted: 1.358 2nd QTR: 3 Predicted: 2.274/CMS 3 Predicted: 1.107 3rd QTR: 0 Predicted: 2.888/CMS 0 Predicted: 1.35 4th QTR: Predicted: /CMS Predicted:
3. SIR CI (KDHCD predicted range, based on risks)		0.017, 1.675	0.336, 3.591	, 1.037			**1st QTR:** Better than national average. **2nd QTR:** Better than national average. **3rd QTR:** Better than national average. **4th QTR:**
4. SIR (Standardized Infection Ration) total Value Based Purchasing (VBP) SIR = [ ]	VBP Goal <0.717	0.34	1.319	0			**1st QTR:** One event in which clean closure was not performed. The surgical quality improvement committee is working on ensuring clean closure practice is performed for procedures it is indicated. **2nd QTR:** There were 3 colorectal SSI events reported. Opportunities to improve documentation to support PATOS criteria. All events occurred at the organ-space. **3rd QTR:** There were no COLO SSI events reported this quarter. **4th QTR:**
B. Gallbladder Surgery (CHOL)							
1. #Total Procedure Count		0	100	126			**Cumulative Ct:** 226
2. Total Infection Count		0	1	1			**1st QTR:** 0 **Predicted:** 0 **2nd QTR:** 1 **Predicted:** 0.157 **3rd QTR:** 1 **Predicted:** 0.855 **4th QTR:** **Predicted:**
3. SIR CI (KDHCD predicted range, based on risks)		0	0.00	0.00			**1st QTR:** No procedures performed. **2nd QTR:** Worse than national average. **3rd QTR:** Worse than national average. **4th QTR:**
4. SIR (Standardized Infection Ration) total	Goal SIR <1.00	0.00	6.37	1.17			**1st QTR:** No procedures performed. **2nd QTR:** 1 event in which patient developed a post-op seroma that eventually was identified to be an abscess with a possible bile leak from the surgical site. E. coli was identified by specimen culture. This was an organ-space SSI event. **3rd QTR:** 1 event, 6 days post-op, intra-abdominal abscess with CT guided drainage. Patient seen by outside primary care provider who suspected an SSI. **4th QTR:**
C. Spinal Fusion (FUSN)							
1. #Total Procedure Count		26	94	58			**Cumulative Ct:** 178
2. Total Infection Count		0	1	2			**1st QTR:** 0 **Predicted:** 0.468 **2nd QTR:** 1 **Predicted:** 1.391 **3rd QTR:** 2 **Predicted:** 1.068 **4th QTR:** **Predicted:**

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2023							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
3. SIR CI (KDHCD predicted range, based on risks)		0	0.036, 3.545	0.314, 6.188			**1st QTR:** Better than national average. **2nd QTR:** No different than national average. **3rd QTR:** Worse than national average. **4th QTR:**
4. SIR (Standardized Infection Ration) total	Goal SIR <1.00	**0.00**	**0.72**	**1.873**			**1st QTR:** No events. **2nd QTR:** No events. **3rd QTR:** 2 superficial incisional primary surgical site infection event. Different surgeons. **4th QTR:**
D. Knee Replacement (KPRO)							
1. #Total Procedure Count		24	84	77			**Cumulative Ct:** 185
2. Total Infection Count		**0**	**0**	**0**			**1st QTR:** 0 **Predicted:** 0.198 **2nd QTR:** 1 **Predicted:** 0.556 **3rd QTR:** 0 **Predicted:** 0.561 **4th QTR: Predicted:**
3. SIR CI (KDHCD predicted range, based on risks)		0	0	0			**1st QTR:** Better than national average. **2nd QTR:** Better than national average. **3rd QTR:** Better than national average. **4th QTR:**
4. SIR (Standardized Infection Ration) total	Goal SIR <1.00	**0.00**	**0.00**	**0**			**1st QTR:** No events. **2nd QTR:** No events. **3rd QTR:** No events. **4th QTR:**
E. Small Bowel (SB)							
1. #Total Procedure Count		12	27	27			**Cumulative Ct:** 66
2. Total Infection Count		0.00	**1**	**1**			**1st QTR:** 0 **Predicted:** 0.484 **2nd QTR:** 1 **Predicted:** 1.218 **3rd QTR:** 1 **Predicted:** 1.204 **4th QTR: Predicted:**
3. SIR CI (KDHCD predicted range, based on risks)		0	0.041, 4.049	0.042, 4.097			**1st QTR:** Better than national average. **2nd QTR:** No different than national average. **3rd QTR:** No different than national average. **4th QTR:**
4. SIR (Standardized Infection Ration) total	Goal SIR <1.00	**0.00**	**0.821**	**0.831**			**1st QTR:** No events. **2nd QTR:** 1 superficial incisional primary surgical site infection of the small bowel SSI event 9 days post-op. **3rd QTR:** 1 superficial incisional primary surgical site infection of the small bowel SSI event . **4th QTR:**
F. Hysterectomy (HYST) CMS/VBP							
1. #Total Procedure Count		6	30	28			**Cumulative Ct:** 64
2. Total Infection Count		**0** **[0]**	**1** **[1]**	**1** **[1]**			**1st QTR:** 6 **Predicted:** 0.096/**CMS** 0 **Predicted:** 0.042 **2nd QTR:** 1 **Predicted:** 0.536/**CMS** 1 **Predicted:** 0.253 **3rd QTR:** 1 **Predicted:** 0.559/**CMS** 1 **Predicted:** 0.244 **4th QTR: Predicted: /CMS Predicted:**

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2023							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
3. SIR CI (KDHCD predicted range, based on risks)		0	0	0			**1st QTR:** Better than national average. **2nd QTR:** Worse than national average. **3rd QTR:** Worse than national average. **4th QTR:**
4. SIR (Standardized Infection Ration) total Value Based Purchasing (VBP) SIR = [ ]	VBP Goal <0.738	**0.00**	**1.87**	**1.79**			**1st QTR:** No events. **2nd QTR:** 1 organ-space total abdominal hysterectomy surgical site infection event. **3rd QTR:** 1 total abdominal hysterectomy resulting in an intra-abdominal abscess that was drained in C.T. **4th QTR:**
G. Coronary Bypass Graft (CBGB)							
1. #Total Procedure Count		12	66	56			**Cumulative Ct:** 78
2. Total Infection Count		**0**	**1**	**0**			**1st QTR:** 0 **Predicted:** 0.260 **2nd QTR:** 1 **Predicted:** 1.294 **3rd QTR:** 0 **Predicted:** 1.051 **4th QTR:** **Predicted:**
3. SIR CI (KDHCD predicted range, based on risks)		0	0.039, 3.813	, 2.851			**1st QTR:** Better than national average. **2nd QTR:** No different than national average. **3rd QTR:** No different than national average. **4th QTR:**
4. SIR (Standardized Infection Ration) total Value Based Purchasing (VBP) SIR = [ ]	Goal SIR <1.00	**0.00**	**0.77**	**0.00**			**1st QTR:** No events. **2nd QTR:** 1 deep incisional primary surgical site infection event. **3rd QTR:** No events. **4th QTR:**
H. Fractures (FX)							
1. #Total Procedure Count		20	50	48			**Cumulative Ct:** 118
2. Total Infection Count		**0**	**0**	**0**			**1st QTR:** 0 **Predicted:** 0.194 **2nd QTR:** 0 **Predicted:** 0.550 **3rd QTR:** 0 **Predicted:** 0.481 **4th QTR:** **Predicted:**
3. SIR CI (KDHCD predicted range, based on risks)		0	0	**0**			**1st QTR:** Better than national average. **2nd QTR:** Better than national average. **3rd QTR:** Better than national average. **4th QTR:**
4. SIR (Standardized Infection Ration) total Value Based Purchasing (VBP) SIR = [ ]	Goal SIR <1.00	0.00	**0.00**	**0.00**			**1st QTR:** No events. **2nd QTR:** No events. **3rd QTR:** No events. **4th QTR:**
VI. Ventilator Associated Events (VAE)	**SIR**						
A. Ventilator Device Use SUR (standardized utilization ratio)		**1.76**	**1.99**	NA	NA		**1st QTR:** 811 **Predicted:** 459.943 **2nd QTR:** 810 **Predicted:** 407.023 **3rd QTR:** With approval of IPC this metric is reported to Critical Care Committee and no longer required at IPC. **4th QTR:** With approval of IPC this metric is reported to Critical Care Committee and no longer required at IPC.
B. Total VAEs ICU (NHSN Reportable)	Includes IVAC Plus						

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2023							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
1. SIR Total VAE CI (KDHCD predicted range, based on risks)		1.645, 1.888	, 1.261	NA	NA		**1st QTR:** Better than national average. **2nd QTR:** Better than national average. **3rd QTR:** With approval of IPC this metric is reported to Critical Care Committee and no longer required at IPC. **4th QTR:** With approval of IPC this metric is reported to Critical Care Committee and no longer required at IPC.
2. Total VAEs SIR	<1.0	**0.16**	**0**	NA	NA		**1st QTR:** 1 VAE event, 6.409 predicted. **2nd QTR:** No events. **3rd QTR:** With approval of IPC this metric is reported to Critical Care Committee and no longer required at IPC. **4th QTR:** With approval of IPC this metric is reported to Critical Care Committee and no longer required at IPC.
C. Total IVAC Plus -ICU		**1**	**0**	NA	NA		**1st QTR:** 1 IVAC event very likely due to aspiration pneumonia secondary to large cerebellar infarction. Patient nares colonized with MRSA and he developed MRSA pneumonia. Mupirocin ordered 3 days after admission after IVAC identified. **2nd QTR:** No events. **3rd QTR:** With approval of IPC this metric is reported to Critical Care Committee and no longer required at IPC. **4th QTR:** With approval of IPC this metric is reported to Critical Care Committee and no longer required at IPC.
1. Total IVAC Plus CI (KDHCD predicted range, based on risks)		0.021, 2.074	, 1.261	NA	NA		**1st QTR:** Better than national average. **2nd QTR:** Better than national average. **3rd QTR:** With approval of IPC this metric is reported to Critical Care Committee and no longer required at IPC. **4th QTR:** With approval of IPC this metric is reported to Critical Care Committee and no longer required at IPC.
2. Total IVAC *Plus* ICU SIR		**0.42**	**0**	NA	NA		**1st QTR:** 1. IVAC event, 2.378 predicted **2nd QTR:** No events. **3rd QTR:** With approval of IPC this metric is reported to Critical Care Committee and no longer required at IPC. **4th QTR:** With approval of IPC this metric is reported to Critical Care Committee and no longer required at IPC.
1. Process Measures							
% of patients with head of bed >30 dregrees per visual inspection.	**Goal = 100%**	NA	NA	NA	NA		**1st QTR:** Rounding not performed due to limited resources. **2nd QTR:** Rounding not performed due to limited resources. **3rd QTR:** With approval of IPC this metric is reported to Critical Care Committee and no longer required at IPC. **4th QTR:** With approval of IPC this metric is reported to Critical Care Committee and no longer required at IPC.
% Sedation Vacation	**Goal = 100%**	NA	NA	NA	NA		**1st QTR:** Rounding not performed due to limited resources. **2nd QTR:** Rounding not performed due to limited resources. **3rd QTR:** With approval of IPC this metric is reported to Critical Care Committee and no longer required at IPC. **4th QTR:** With approval of IPC this metric is reported to Critical Care Committee and no longer required at IPC.

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2023							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
% Oral Care Provided (per visual inspection)	**Goal = 100%**	NA	NA	NA	NA		**1st QTR:** Rounding not performed due to limited resources. **2nd QTR:** Rounding not performed due to limited resources. **3rd QTR:** With approval of IPC this metric is reported to Critical Care Committee and no longer required at IPC. **4th QTR:** With approval of IPC this metric is reported to Critical Care Committee and no longer required at IPC.
% CHG Bath within last 24 hours	**Goal = 100%**	NA	NA	NA	NA		**1st QTR:** Rounding not performed due to limited resources. **2nd QTR:** Rounding not performed due to limited resources. **3rd QTR:** With approval of IPC this metric is reported to Critical Care Committee and no longer required at IPC. **4th QTR:** With approval of IPC this metric is reported to Critical Care Committee and no longer required at IPC.
% Vent Tubing Position Appropriately (drain away from patient - visual inspection)	**Goal = 100%**	NA	NA	NA	NA		**1st QTR:** Rounding not performed due to limited resources. **2nd QTR:** Rounding not performed due to limited resources. **3rd QTR:** With approval of IPC this metric is reported to Critical Care Committee and no longer required at IPC. **4th QTR:** With approval of IPC this metric is reported to Critical Care Committee and no longer required at IPC.
VII. Central Line Associated Blood Stream Infections (CLABSI) CMS/VBP	**NHSN SIR**						
A. Total number of Central Line Days (CLD)		3,650	3,747	4,030			**Cumulative Ct:** 11,427
B. Central Line Device Use SUR (standardized utilization ratio)		**0.672**	**0.769**	**0.79**			**1st QTR:** 3,650 CLD **Predicted:** 5,429.792 **2nd QTR:** 3,747 CLD **Predicted:** 4,870.352 **3rd QTR:** 4,030 CLD **Predicted:** 5,103.727 **4th QTR:** CLD **Predicted:**
C. Total Infection Count Valule Based Purchasing (VBP) # events = [ ]		**3** **[3]**	**5** **[3]**	**6** **[4]**			**1st QTR:** 3 **Predicted:** 3.548 **/CMS:** 3 **Predicted:** 2.174 **2nd QTR:** 5 **Predicted:** 3.671/**CMS:** 3 **Predicted:** 2.204 **3rd QTR:** 6 **Predicted:** 3.929/**CMS:** 4 **Predicted:** 2.290 **4th QTR: Predicted: /CMS: Predicted:**
D. SIR Confidence Interval		0.215, 2.301	0.499, 3.019	0.619, 3.176			**1st QTR:** No different than national average. **2nd QTR:** Worse than national average. **3rd QTR:** No different than national average. **4th QTR:**

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2023							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
E. SIR (Standardized Infection Ratio) total Value Based Purchasing (VBP) SIR = [ ]	**≤ 0.589 excluding COVID population**	**0.845**	**1.362**	**1.527**			**1st QTR:** 1 CLABSI event with Candidemia, on TPN, Diabetic; 1 CLABSI event with Candidemia in patient with multiple femoral CVCs, on Steroids, and receiving TPN/Fat Emulsion, Diabetic. CLABSI QFT is working with CMO/CQO, Medical Director for Quality, Medical Director for Infection Prevention on pursuing a comprehensive approach to reducing CLABSI events. **2nd QTR:** 5 CLABSI events. Improvement opportunities: Hand hygiene compliance, culturing practices, extended femoral access, multiple peripheral IVs (just-in-case-culture), documentation and actions related to most likely primary source of bloodstream infection (e.g. endocarditis, osteomyelitis). **3rd QTR:** 6 CLABSI events. Units involved: 4S (1), 4T (1), 3W (1), 3S (1), ICU (2). Primary bacteria identified - E. coli. Primary fallout(s) identified: expired peripheral IV x 3 events, lack of daily bath x 3 events, blood cultures collected prior to comfort care x 2 - both patients expired within 3 days of specimen collection. **4th QTR:**
F. Process Measures							
% of patients with a bath within 24 hours	**Goal 100%**	**92.1%**	**87.2%**	**92.8%**			**1st QTR:** 2,655 responses out of 2,884 responses (total of 3,511 rounds) **2nd QTR:** 2,467 responses out of 2,829 responses (total of 3,190 rounds) **3rd QTR:** 2,326 responses out of 2,506 responses (otal of 3,478 rounds) **4th QTR:**
% of central lines inserted with a valid rationale	**Goal 100%**	**91.7%**	**97.3%**	**96.0%**			**1st QTR:** 1,568 responses out of 1,710 responses (total of 3,511 rounds). **2nd QTR:** 1,533 responses out of 1,575 responses (total of 3,190 rounds). **3rd QTR:** 1,712 responses out of 1,783 responses (total of 3.478 rounds) **4th QTR:**
% of central line dressings clean, dry and intact	**Goal 100%**	**98.1%**	**98.6%**	**98.5%**			**1st QTR:** 1,693 responses out of 1,725 responses (total of 3,511 rounds). **2nd QTR:** 1,558 responses out of 1,580 responses (total of 3,190 rounds). **3rd QTR:** 1,756 responses out of 1,782 responses (total of 3,478 rounds) **4th QTR:**
% of central line dressing changes no > than 7 days	**Goal 100%**	**98.3%**	**99.0%**	**98.2%**			**1st QTR:** 1,693 responses out of 1,723 responses (total of 3,511 rounds). **2nd QTR:** 1,570 responses out of 1,586 responses (total of 3,190 rounds). **3rd QTR:** 1,757 responses out of 1,789 responses (total of 3,190 rounds). **4th QTR:**

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2023							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
% of patients with properly placed CHG patch	Goal 100%	97.2%	97.9%	98.6%			**1st QTR:** 963 responses out of 991 responses (total of 3,511 rounds). **2nd QTR:** 870 responses out of 889 responses (total of 3,190 rounds). **3rd QTR:** 1,163 responses out of 1,180 responses (total of 3,190 rounds) **4th QTR:**
% of patients with appropriate & complete documentation	Goal 100%	96.2%	96.0%	95.6%			**1st QTR:** 1,660 responses out of 1,726 responses (total of 3,511 rounds). **2nd QTR:** 1,521 responses out of 1,585 responses (total of 3,190 rounds). **3rd QTR:** 1,701 responses out of 1,779 responses (total of 3,190 rounds). **4th QTR:**
# of central line days rounded on		1,661	1,586	1,787			**1st QTR:** Total of 1,661 central lines were rounded on in multiple patient care units. **2nd QTR**: Total of 1,586 central lines were rounded on in multiple patient care units. **3rd QTR**: Total of 1,787 central lines were rounded on in multiple patient care units. **4th QTR:**.
Skilled Nursing/Acute Rehab % of central dressing clean/dry/intact	Goal 100%	100.0%	100.0%	100.0%			**1st QTR:** Total of 93 responses out of 93 responses (total of 257 rounds). **2nd QTR:** Total of 128 resposes out of 128 responses (total of 325 rounds). **3rd QTR:** Total of 80 responses out of 80 responses (total of 286 rounds). **4th QTR:**
Skilled Nursing/Acute Rehab % of central line dressings changed no > 7 days	Goal 100%	100.0%	100.0%	100.0%			**1st QTR:** Total of 93 responses out of 93 responses (total of 257 rounds). **2nd QTR:** Total 129 responses out of 129 responses (total of 325 rounds). **3rd QTR:** Total of 81 responses out of 81 responses (Total of 286 rounds). **4th QTR:**
VIII. Catheter Associated Urinary Tract Infections (CAUTI) CMS/VBP	**NHSN SIR**						
A. Total number of Catheter Device Days (CDD)		4,247	4,013	3,991			**Cumulative Ct:** 12,251
B. Catheter Device Days SUR (Standardized Utilization Ratio)		0.933	0.973	0.945			**1st QTR:** 4,247 CDD **Predicted:** 4,550.281 CDD **2nd QTR**: 4,013 CDD **Predicted:** 4,122.823 CDD **3rd QTR:** 3,991 CDD **Predicted**: 4,233.154 CDD **4th QTR:** CDD **Predicted:** CDD
C. Total Infection Count Value Based Purchasing (VBP) # of events = [ ]		0	3	2			**1st QTR:** 0 **Predicted:** 5.505 /**CMS:** 0 **Predicted:** 3.091 **2nd QTR:** 3 **Predicted:** 5.234/**CMS:** 2 **Predicted:** 2.674 **3rd QTR:** 2 **Predicted:** 5.171/**CMS:** 1 **Predicted:** 2.860 **4th QTR: Predicted: /CMS: Predicted:**
D. SIR Confidence Interval		0	0.146, 1.560	0.065, 1.278			**1st QTR:** Better than national average. **2nd QTR:** Better than national average. **3rd QTR:** Better than national average. **4th QTR:**

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2023							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
E. SIR (Standardized Infection Ratio) total Value Based Purchasing (VBP) SIR = [ ]	≤ 0.650 excluding COVID population	0	0.573	0.387			**1st QTR:** No events. **2nd QTR:** 3 CAUTI events. Opportunities for improvement: Pursue an alternative to an indwelling urinary catheter, ordering cultures for patients on comfort care, stool management, hand hygiene compliance. **3rd QTR:** 2 CAUTI events. Opportunities exist with reducing indwelling urinary catheter use, seeking alternatives to indwelling urinary catheters. **4th QTR:**
F. Process Measures							
% of patients with appropriate cleanliness (a minimum of peri-care in the last 12 hours)	Goal 99%	95.9%	96.8%	97.5%			**1st QTR:** 1,862 responses out of 1,862 responses (total of 3,511 rounds). **2nd QTR:** 1,749 responses out of 1,806 responses (total 3,190 rounds). **3rd QTR:** 1,987 responses out of 2,038 responses (total of 3,478 rounds). **4th QTR:**
% of IUCs with order and valid rationale	Goal 100%	93.3%	93.0%	93.9%			**1st QTR:** 1,803 responses out of 1,932 responses (total of 3,511 rounds). **2nd QTR:** 1,676 responses out of 1,807 responses (total of 3,190 rounds). **3rd QTR:** 2,229 responses out of 2,375 responses (total of 4,019 rounds). **4th QTR:**
% of IUCs where removal was attempted		1.9%	11.4%	8.5%			**1st QTR:** 36 responses out of 1,945 responses (total of 3,511 rounds). **2nd QTR:** 130 responses out of 1,139 responses (total of 3,190 rounds). **3rd QTR:** 126 responses out of 1,479 responses (total of 4, 019 rounds) **4th QTR:**
% of patients where alternatives have been attempted		4.0%	8.0%	6.8%			**1st QTR:** 78 responses out of 1,192 responses (total of 3,511 rounds). **2nd QTR:** 103 responses out of 1,216 responses (total of 3,190 rounds). **3rd QTR:** 114 responses out of 1,670 responses (total of 3,190 rounds). **4th QTR:**
% of IUCs removed because of unit "GEMBA" rounds		2.2%	2.9%	1.5%			**1st QTR:** 42 responses out of 1,929 responses (total of 3,511 rounds). **2nd QTR:** 53 responses out of 1,799 responses (total of 3,190 rounds). **3rd QTR:** 36 responses out of 2,355 responses (total of 4,019 rounds). **4th QTR:**
# of IUCs removed because of unit "GEMBA" rounds		42	53	36			**1st QTR:** No additional comments. **2nd QTR:** No additional comments. **3rd QTR:** **4th QTR:**

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2023							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
# of Indwelling Urinary Catheter days rounded on		1,819	1,803	2,352			**1st QTR:** No additional comments. **2nd QTR:** Total of 1,803 responses (total of 3,190 rounds). **3rd QTR:** Total of 2,352 responses (total of 4,019 rounds). **4th QTR:**
Skilled Nursing/Acute Rehab % of completed baths performed within 48 hours for patients with central lines	**Goal 100%**	**100.0%**	**100.0%**	**99.6%**			**1st QTR:** 256 responses out of 256 responses (total of 257 rounds) **2nd QTR:** 323 responses out of 323 responses (total of 325 rounds). **3rd QTR:** 284 responses out of 285 responses (total of 286 rounds). **4th QTR:**
Skilled Nursing/Acute Rehab % of peri care performed within in a 12 hour shift	**Goal 100%**	**100.0%**	**100.0%**	**100.0%**			**1st QTR:** 176 responses out of 176 responses (total of 257 rounds). **2nd QTR:** 195 responses out of 195 responses (total of 325 rounds). **3rd QTR**: 204 responses out of 204 responses (total of 286 rounds). **4th QTR:**
IX. Catheter Associated Urinary Tract Infections Long Term Care/Rehabilitation	**Goal = 0**						
Short Stay (# of Infections/ Incidence Rate)		**0**	**1**	**1**			**1st QTR:** No cases, 151 catheter days (Cath utilization rate = 0.055) **2nd QTR:** 1 event, 31 catheter days (Cath utilization rate = 0.023) **3rd QTR:** 1 CA-SUTI case, 271 catheter days (Cath utilization rate = 0.099). **4th QTR:**
Subacute (# of Infections/ Incidence Rate)		**0**	**0**	**0**			**1st QTR:** No events. **2nd QTR:** No events. **3rd QTR:** No events. **4th QTR:**
Acute Rehabilitiation (# of Infections/ Incidence Rate)		**0**	**0**	**0**			**1st QTR:** No events. **2nd QTR:** No events. **3rd QTR:** No events. **4th QTR:**
X. LTC Symptomatic Urinary Tract Infections	**Goal = 0**						
Short Stay (# of Infections/ Incidence Rate)		**0**	**1**	**0**			**1st QTR:** No cases. There were 2,770 resident days, and 2,619 non-catheter days. There were 5 urine cultures ordered (urine culture rate = 1.805) and there were 5 antibiotic starts. **2nd QTR:** 1 event, SUTI rate = 0.775. There were 1,381 resident days, and 1,290 non-catheter days. **3rd QTR:** No events. **4th QTR:**
Subacute (# of Infections/ Incidence Rate)		**0**	**1**	**1**			**1st QTR:** No events. **2nd QTR:** 1 event, SUTI rate = 0.750. There were 1,364 resident days, and 1,333 non-catheter days. **3rd QTR:** 1 ABUTI event, SUTI rate = 0.407. There were 2,726 resident days, and 2,455 non-catheter days. **4th QTR:**

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2023							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
XI. Clostridium *difficile* Infection (CDI) CMS/VBP	**SIR**						
A. Total Infection Count	All units	11	8	6			**1st QTR:** 11 **Predicted:** 16.868 **2nd QTR:** 8 **Predicted:** 16.230 **3rd QTR:** 6 **Predicted:** 16.436 **4th QTR: Predicted:**
B. SIR CI (KDHCD predicted range, based on risks)		0.342, 1.133	0.229, 0.936	0.148, 0.759			**1st QTR:** No difference from national average. **2nd QTR:** Better than national average. **3rd QTR:** Better than national average. **4th QTR:**
C. SIR (Standardized Infection Ratio) total Value Based Purchasing (VBP) SIR = [ ]	VBP Goal <0.520	0.652	0.493	0.365			**1st QTR:** There is ongoing work to develop a pop-up in the EMR for providers reminding them not to order C. diff. testing for patients on a bowel program. Additionally, an automatic discontinuation of C. diff. orders that are not completed within 24 hours is being developed. **2nd QTR:** At the end of the second quarter the medical record pop-up reminder and auto-cancellation at 24 hours for C. difficile orders in which a specimen wasn't collected all went live. Continued education and just-in-time interventions to reduce inappropriate C. difficile testing performed throughout this quarter. **3rd QTR:** Number of HO C. difficile are trending downward. **4th QTR:**
XII. Hand Hygiene	**95%**						
A. Total Hand Hygiene Observations (combination of manual and electronic hand hygiene surveillance)		96.5%	96.09%	95.92%			**1st QTR:** 2,766,588 compliant out of 2,866,337 opportunities. **2nd QTR:** 2,663,467 compliant out of 2,771,846 oppportunities. **3rd QTR:** 2,568,546 compliant out of 2,677,800 opportunities. **4th QTR:**
B. All units Percentage of Hand Hygiene compliance based on observations/opportunities (>200 observations/ month/unit) *(note these are partially patient observations)*		82.9%	87.9%	93.4%			1st QTR: Mental Health 756 compliant out of 756 opportunities or 100% compliance rate. All Clinics (including KHMG) NRC patient observations of HCP HH activities = 4,376 out of 5,438 opportunities or 80.5% compliance rate. 2nd QTR: Mental Health 663 compliant out of 663 opportunities or 100% compliance rate. All Clinics NRC patient observations of HCP HH activities = 1,754 compliant out of 2,087 opportunities or 84% compliance rate. 3rd QTR: Mental Health 704 compliant out of 704 opportunities or 100% compliant rate. All clinics NRC patient observations of HCP HH activities = 1,942 compliant out of 2,234 opportunities or 86.9% compliance rate. 4th QTR:

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2023							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
C. Percentage of Hand Hygiene compliance performed during "Day Shift"		96.5%	96.1%	95.95%			**1st QTR:** 1,629,768 compliant out of 1,688,354 opportunities. **2nd QTR:** 1,517,880 compliant out of 1,579,480 opportunities. **3rd QTR:** 1,469,455 compliant out of 1,531,148 opportunities. **4th QTR:**
D. Percentage of Hand Hygiene compliance performed during "Night Shift"		96.7%	96.3%	95.92%			**1st QTR:** 899,013 compliant out of 929,981 opportunities. **2nd QTR:** 871,728 compliant out of 905,221 opportunities. **3rd QTR:** 1,765,730 compliant out of 1,840,836 opportunities. **4th QTR:**
XIII. VRE (HAI) Blood-Hospital Onset (HO)							
A. Total Infection Count		0	1	0			**1st QTR:** 0 **Predicted:** 0 **2nd QTR:** 1 **Predicted:** 5.345 **3rd QTR:** 0 **Predicted:** 0 **4th QTR: Predicted:**
B. Prevalence Rate (x100)		0	0.019	0			**1st QTR:** There were no cases of VRE BSI. **2nd QTR:** There was 1 case of hospital onset VRE BSI. **3rd QTR:** There were no cases of VRE BSI. **4th QTR:**
C. Number Admissions		6,074	5,345				**Cumulative Ct:** 11,419
XIV. MRSA (HAI) Blood CMS/VBP	**SIR**						
A. Total Infection Count (IP Facility-wide)		1	2	1			**1st QTR:** 1 **Predicted:** 2.201 **2nd QTR:** 2 **Predicted**: 1.937 **3rd QTR:** 1 **Predicted:** 2.043 **4th QTR: Predicted:**
B. SIR CI (KDHCD predicted range, based on risks)		0.023, 2.240	0.173, 3.411	0.024, 2.414			**1st QTR:** Better than national average. **2nd QTR:** Worse than national average. **3rd QTR:** No different than national average. **4th QTR:**
C. SIR (Standardized Infection Ration) total Value Based Purchasing (VBP) SIR = [ ]	**≤ 0.726 excluding COVID population**	0.454	1.032	0.489			**1st QTR:** 1 event likely related to aspiration pnuemonia with secondary MRSA bloodstream infection. **2nd QTR:** 2 events. 1 event involving paitent with complex pyscho/neuro disorder (history of IVDU/homelessness), developed aspiration pneumonia and tested positive for MRSA BSI. 1 event involving a patient who fell at home sustaining multiple fractures, deteriorated during 2nd day of admission requiring an RRT due to hypoxia. Developed aspiration pneumonia and bloodstream infection due to MRSA on day 3 of admission. (both patients expired) **3rd QTR:** 1 case of HO MRSA BSI. **4th QTR:**
XV. MDRO LABID - Long Term Care							
Short Stay (# of Infections/ Incidence Rate)		0	0	0			**1st QTR:** No events. **2nd QTR:** No events. **3rd QTR:** No events. **4th QTR:**

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2023							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
Transitional Care (# of Infections/ Incidence Rate)		0	0	0			**1st QTR:** No events. **2nd QTR:** No events. **3rd QTR:** No events. **4th QTR:**
Subacute (# of Infections/ Incidence Rate)		0	0	0			**1st QTR:** No events. **2nd QTR:** No events. **3rd QTR:** No events. **4th QTR:**
XVI. Influenza Rates (Year 2022-2023)	**NHSN**						
A. All Healthcare Workers	**>90%**		84%				**2nd QTR:** A total of 4,096 employees received flu vaccination either with Kaweah Health or elsewhere out of a total number of 4,888 employees who worked at least 1 day at Kaweah Health during the influenza season. Employee = 84% vaccinated (3,451/4,113) LIP = 88% vaccinated (456/517) Students = 73% vaccinated (189/258)

Approved IPC: 4/27/23
Approved IPC: 7/27/23
Approved IPC: 10/26/23
Approved IPC:

Prepared by: Shawn Elkin, Infection Prevention Manager

Biannual Hand Hygiene Report

Quality Council

12/2023

Hand Hygiene (HH) Monitoring

- 4th QTR 2019 - BioVigil electronic hand hygiene was initially piloted on 4N and ICU (total of 50 beds).
- 1st QTR 2021 – BioVigil added to total of 428 beds in all downtown patient care areas, excluding procedural areas and ED.
- 1st QTR 2022 - BioVigil added to total of 245 more beds to include, ED, ASC, Dialysis Clinic, Endoscopy, CVU, Infusion Center, Rehab, and TCS/Subacute.
- Once again during 1st QTR 2022 – BioVigil added to total of 25 beds – ED Zone 5 and 1 additional bed in Dialysis Clinic.
- 3rd QTR 2023 – Biovigil added 3 locations at Kaweah Health Mental Health Hospital.

Hand Hygiene Monitoring

- Only the Rural Clinics are not covered by the BioVigil electronic hand hygiene surveillance system.
- Rural Health Clinics uses NRC to monitor hand hygiene compliance through the eyes of the patient. Patients are asked by electronic survey if they observed their healthcare worker perform hand hygiene.

Hand Hygiene Monitoring

- Hand Hygiene data is analyzed by location, role and shift.

Hand Hygiene Outcome Measures

Hand hygiene compliance remains at ≥95%, however, there is a consistent gradual downward trend quarter-to-quarter.

All branches of leadership and staff receive scheduled hand hygiene compliance reports.

Units not achieving ≥95% hand hygiene compliance submit corrective action plans within their QAPI reports submitted to the Quality Improvement Committee (QIC)

During the September 2023, representatives from Biovigil did an onsite visit for several days. They answered staff and leadership questions, performed observations, and presented to all leaders in the district information about a new report tool in Biovigil that will help with performance evaluations and coaching.

Measure Description	Benchmark /Target	2020Q3	2020Q4	2021Q1	2021Q2	2021Q3	2021Q4	2022Q1	2022Q2	2022Q3	2022Q4	2023Q1	2023Q2	2023Q3
OUTCOME MEASURES														
HH Overall Compliance	95%	98.16	97.61	97.16	97.42	97.22	97.25	97.11	97.05	96.42	96.47	96.52	96.08	95.92
Number of HH Audits Performed	n/a	1,800,659	3,323,059	2,816,935	2,359,124	2,318,073	2,446,660	2,279,162	3,700,926	3,226,589	2,648,996	2,872,214	2,776,657	2,677,800
HH Overall Compliance - Patient Care Areas	95%	98.16	97.61	97.16	97.42	97.22	97.25	97.14	97.32	96.91	96.60	96.57	96.18	95.97
Number of HH Audits Performed - Patient Care Areas	n/a	1,800,659	3,323,059	2,816,935	2,359,124	2,318,073	2,446,660	2,222,112	3,105,912	2,816,731	2,422,678	2,623,609	2,488,916	2,441,458

Hand Hygiene Process Measures

There is very little difference in hand hygiene compliance observed between days, evenings, weekdays and weekends.

There are about twice the amount of HH observations during AM shift compared to PM shift. Both shifts have an average compliance rate of 95%.

Hand Hygiene observations during weekends account for less than 1/3 than amount that occur during weekdays. Yet, hand hygiene compliance consistently hovers around 95-96%.

Measure Description	Benchmark /Target	2019Q4	2020Q1	2020Q2	2020Q3	2020Q4	2021Q1	2021Q2	2021Q3	2021Q4	2022Q1	2022Q2	2022Q3	sparklines
PROCESS MEASURES - Patient Care Units Hand Hygiene By Day/time														
HH Overall Compliance - AM Shift	95%	98.14	97.47	97.24	97.32	97.10	97.16	97.19	97.40	96.84	96.56	96.52	96.12	95.95
Number of HH Audits Performed - AM Shift	n/a	1,114,081	2,048,761	1,739,305	1,441,663	1,441,715	1,523,929	1,407,765	1,987,968	1,788,791	1,537,477	1,692,071	1,581,236	1,531,148
HH Overall Compliance - PM Shift	95%	98.20	97.82	97.03	97.57	97.43	97.40	97.06	97.19	97.02	96.67	96.67	96.29	95.99
Number of HH Audits Performed - PM Shift	n/a	686,578	1,274,298	1,077,630	917,461	876,358	922,731	814,347	1,117,944	1,027,940	885,201	931,538	907,680	910,310
HH Overall Compliance - Weekdays	95%	98.17	97.64	97.21	97.39	97.21	97.21	97.10	97.35	96.90	96.53	96.52	96.14	95.92
Number of HH Audits Performed - Weekdays	n/a	1,356,125	2,511,844	2,144,621	1,799,976	1,773,803	1,856,630	1,684,577	2,364,996	2,161,631	1,831,097	2,036,012	1,896,628	1,840,836
HH Overall Compliance - Weekends	95%	98.13	97.48	97.02	97.52	97.26	97.39	97.27	97.23	96.94	96.82	96.77	96.33	96.10
Number of HH Audits Performed - Weekends	n/a	444,534	811,215	672,314	559,148	544,270	590,030	537,535	740,916	655,100	591,581	587,597	592,288	600,622

Hand Hygiene Process Measures

During 3rd quarter 2023, all but 6 units are performing at 95% or greater hand hygiene compliance with few exceptions. This number has grown by 2 units from last report.

Biovigil utilization has been made mandatory and added to the Progressive Discipline policy on 10/25/2023.

Increasing pairing time with a Biovigil badge/increasing active user ship, improving overall hand hygiene compliance rates, has been discussed during Safety Huddle and District-wide Leadership Meetings.

Measure Description	Benchmark /Target	2020Q1	2020Q2	2020Q3	2020Q4	2021Q1	2021Q2	2021Q3	2021Q4	2022Q1	2022Q2	2022Q3	2022Q4	2023Q1	sparklines
Hand Hygiene By Patient Care Unit Location (*biovgil data)															
2AcequiaCVC - HH Compliance	95%	88.00	99.00	100.00	100.00	100.00	100.00	97.65	96.72	95.10	95.52	94.88	95.95	94.64	v
2AcequiaCVC - HH Audits Performed	n/a	25	198	21	404	502	302	10,287	68,200	42,591	32,295	32,071	20,203	30,377	0.50
2EastLabor&Delivery - HH Compliance	95%	65.00	97.24	97.33	97.64	97.51	97.24	97.82	97.27	96.69	96.54	97.00	97.32	96.47	v
2EastLabor&Delivery - HH Audits Performed	n/a	46	70,276	148,020	129,732	131,498	149,119	129,564	127,280	103,004	97,575	83,086	80,939	105,127	0.30
2NorthMedTele - HH Compliance	95%	81.00	97.23	96.92	97.36	97.62	97.26	96.30	96.56	96.22	95.87	94.52	94.09	94.69	^
2NorthMedTele - HH Audits Performed	n/a	110	140,554	234,410	221,218	167,286	199,907	264,236	289,318	301,476	291,144	320,448	288,894	258,009	-0.11
2SouthObservation - HH Compliance	95%	83.00	98.43	98.08	98.02	98.51	97.82	98.16	98.05	97.11	96.90	96.48	96.24	96.22	v
2SouthObservation - HH Audits Performed	n/a	102	67,987	157,102	133,157	131,810	108,888	162,821	192,247	198,488	166,970	177,196	171,920	102,452	-0.40
2WestICU - HH Compliance	95%	97.12	96.90	97.34	96.33	97.37	96.93	97.98	97.51	97.21	97.10	97.00	97.36	96.78	^
2WestICU - HH Audits Performed	n/a	29,058	108,729	144,031	95,348	123,559	113,931	121,395	124,457	105,929	67,661	76,377	71,635	84,719	0.18
3AcequiaCVICU - HH Compliance	95%	NULL	97.69	97.43	96.91	96.07	93.35	95.69	94.94	95.01	93.00	92.71	92.48	94.34	v
3AcequiaCVICU - HH Audits Performed	n/a	NULL	91,774	157,004	120,389	131,750	136,066	100,504	145,970	124,275	102,607	103,172	92,508	115,743	0.25
3AcequiaMotherBaby - HH Compliance	95%	100.00	98.18	97.74	97.81	97.93	97.03	97.92	97.79	97.68	97.65	97.69	97.81	97.86	^
3AcequiaMotherBaby - HH Audits Performed	n/a	66	81,760	145,315	122,579	101,757	97,097	98,568	109,367	116,523	106,521	105,543	94,701	105,168	0.11
3EastPediatrics - HH Compliance	95%	100.00	98.76	98.30	98.13	98.17	98.00	97.36	97.67	97.57	96.73	97.47	97.97	98.12	^
3EastPediatrics - HH Audits Performed	n/a	18	5,498	21,187	14,734	22,950	24,640	21,887	24,025	22,493	22,872	17,139	10,637	11,742	0.10
3EastPostSurgery - HH Compliance	95%	NULL	97.85	98.21	98.18	98.46	99.04	98.80	99.10	98.98	98.97	99.08	99.06	98.30	v
3EastPostSurgery - HH Audits Performed	n/a	NULL	36,195	86,475	77,833	66,474	58,299	49,802	54,220	58,918	47,917	57,873	51,394	46,509	-0.10
3NorthMedSurg - HH Compliance	95%	75.00	98.69	98.38	98.23	98.25	98.32	98.20	97.90	97.92	98.00	97.87	98.09	97.53	v
3NorthMedSurg - HH Audits Performed	n/a	63	157,106	306,844	271,518	208,799	187,554	176,578	243,881	224,411	192,247	222,652	231,301	219,472	-0.05
3SouthOncology - HH Compliance	95%	85.00	98.59	97.98	97.76	97.66	96.82	96.72	95.74	95.25	95.40	95.44	95.35	94.12	v
3SouthOncology - HH Audits Performed	n/a	67	170,917	357,067	328,071	268,062	216,920	248,538	253,251	225,974	193,534	176,571	147,794	165,429	0.12
3WestICCU - HH Compliance	95%	100.00	96.99	97.02	95.59	96.72	96.33	95.53	96.24	96.31	96.09	96.08	95.87	96.09	v
3WestICCU - HH Audits Performed	n/a	61	84,081	157,893	131,983	114,691	124,755	135,314	149,991	148,644	110,365	125,766	125,183	148,272	0.18
4AcequiaMedicalTelemetry - HH Compliance	95%	100.00	98.60	97.91	97.40	97.80	97.30	97.24	97.75	97.32	97.68	97.57	95.71	95.58	v
4AcequiaMedicalTelemetry - HH Audits Performed	n/a	17	103,470	251,186	187,526	149,809	121,763	69,425	68,363	70,311	65,918	78,236	98,378	118,574	0.21
4NorthRenalMedSurg - HH Compliance	95%	99.10	98.77	98.17	98.06	98.01	97.67	97.16	97.52	97.13	96.79	96.61	96.67	96.51	v
4NorthRenalMedSurg - HH Audits Performed	n/a	283,147	335,897	379,797	348,343	316,657	330,358	262,742	335,695	316,114	291,368	345,759	316,693	317,508	0.00
4SouthOrthoNeuroMedSurg - HH Compliance	95%	31.00	98.84	98.03	97.43	97.18	98.28	96.97	97.09	96.64	97.30	96.83	94.14	92.80	v
4SouthOrthoNeuroMedSurg - HH Audits Performed	n/a	13	149,209	292,764	243,596	103,355	178,163	137,735	180,775	125,023	96,735	177,796	236,321	187,296	-0.21
5AcequiaCVICCU - HH Compliance	95%	NULL	97.30	95.25	93.47	93.84	95.38	94.84	94.65	92.56	92.45	94.81	93.77	93.72	v
5AcequiaCVICCU - HH Audits Performed	n/a	NULL	127,579	351,393	302,510	203,322	139,949	121,730	166,696	139,610	121,685	97,962	80,540	111,926	0.39
6AcequiaNICU - HH Compliance	95%	85.00	99.14	99.51	99.38	99.59	99.47	99.59	99.61	99.41	99.14	99.47	99.47	99.40	v

Hand Hygiene Process Measures

Majority of the locations listed here were recently added to the BioVigil electronic hand hygiene surveillance system during March 2022.

Emergency Department has improved hand hygiene over time. The layout and function of the ED presents challenges and there is a learning curve on how BioVigil is appropriately used in this environment. Hand hygiene compliance is hovering around 93-94%. With continued experience and training this rate of compliance will meet goal.

Measure Description	Benchmark /Target	2020Q1	2020Q2	2020Q3	2020Q4	2021Q1	2021Q2	2021Q3	2021Q4	2022Q1	2022Q2	2022Q3	2022Q4	2023Q1	sparklines
ASC - HH Compliance	95%	48.00	83.00	75.00	100.00	100.00	100.00	98.60	98.79	97.39	96.70	95.96	95.43	98.15	
ASC - HH Audits Performed	n/a	118	65	91	552	628	512	4,916	47,085	34,642	18,641	22,676	8,529	11,216	
Emergency Department - HH Compliance	95%	52.00	47.00	NULL	92.00	90.00	90.00	94.25	93.72	90.01	92.97	95.66	94.52	93.59	
Emergency Department - HH Audits Performed	n/a	140	155	NULL	636	207	647	30,530	316,991	213,753	78,550	69,926	153,415	75,474	
Endoscopy - HH Compliance	95%	100.00	100.00	100.00	100.00	0.00	0.00	99.42	99.00	97.44	97.27	97.09	96.89	97.38	
Endoscopy - HH Audits Performed	n/a	12	27	30	10	0	0	3,116	26,881	21,297	16,987	15,748	10,717	19,661	
Infusion - HH Compliance	95%	100.00	100.00	100.00	100.00	100.00	100.00	98.21	97.28	94.44	94.32	94.35	95.86	97.49	
Infusion - HH Audits Performed	n/a	20	30	30	30	40	30	2,293	15,139	12,958	11,152	9,014	10,678	12,809	
SouthCampusSubAcuteCare - HH Compliance	95%	100.00	100.00	100.00	97.00	0.00	100.00	98.55	99.05	98.15	97.38	97.81	97.42	97.41	
SouthCampusSubAcuteCare - HH Audits Performed	n/a	47	93	101	124	0	86	4,471	203,222	158,928	140,866	161,004	147,616	109,623	
SouthCampusTCS - HH Compliance	95%	100.00	100.00	97.00	100.00	100.00	0.00	99.42	99.35	99.40	99.21	99.03	99.09	97.68	
SouthCampusTCS - HH Audits Performed	n/a	42	88	66	90	60	0	4,495	119,381	93,993	27,367	1,132	766	560	
WestCampusAcuteCareRehab/ShortStay - HH Compliance	95%	88.00	93.00	NULL	93.00	94.00	94.00	97.04	98.27	97.99	97.20	97.54	97.49	96.99	
WestCampusAcuteCareRehab/ShortStay - HH Audits Perform	n/a	82	75	NULL	639	634	1,050	4,873	192,063	139,598	145,829	166,567	126,061	109,124	
WestCampusDialysis - HH Compliance	95%	100.00	100.00	100.00	100.00	100.00	96.00	97.33	97.86	96.77	96.37	96.29	96.33	96.39	
WestCampusDialysis - HH Audits Performed	n/a	90	102	82	90	130	142	5,250	106,554	75,022	60,539	92,153	79,316	80,737	
WestCampusWoundCare - HH Compliance	95%	NULL	NULL	NULL	NULL	NULL	NULL	95.8967	98.53	97.60	97.52	97.18	90.70	96.06	
WestCampusWoundCare - HH Audits Performed	n/a	NULL	NULL	NULL	NULL	NULL	NULL	658	14,164	9,595	8,154	7,017	4,883	6,068	
WestCampusMentalHealth - HH Audits Compliance	95%	93.80	76.10	96.00	99.00	100.00	100.00	NULL	100.00	100.00	100.00	100.00	100.00	100.00	
WestCampusMentalHealth - HH Audits Performed	n/a	435	427	555	588	781	379	NULL	844	568	721	756	663	704	

Hand Hygiene By Role

Physician/Resident and mid-level practitioner hand hygiene, is very low in volume.

Infection Prevention met with the hospitalists group during 3rd quarter 2022 and encouraged greater use of BioVigil. Providers are evaluating whether to use Biovigil. Discussion about Resident usage is ongoing. Mid-level practitioner use is being pursued.

Certified Nursing Assistants are being encouraged to improve compliance rates.

Measure Description	Benchmark /Target	2019Q4	2020Q1	2020Q2	2020Q3	2020Q4	2021Q1	2021Q2	2021Q3	2021Q4	2022Q1	2022Q2	2022Q3	sparklines
Hand Hygiene by Role (>10 observations in one quarter, does not inlcude biovigil)														
Aide - HH Compliance	95%	99.10	98.68	97.78	98.30	98.34	97.72	97.85	98.01	96.59	97.46	96.44	95.94	95.72
Aide - HH Audits Performed	n/a	8,451	19,202	15,794	15,254	15,415	16,515	17,855	34,884	32,989	24,288	22,916	26,422	14,670
C.N.A. - HH Compliance	95%	97.95	96.77	96.09	96.53	95.84	95.94	96.40	96.77	96.00	95.61	95.53	93.79	94.00
C.N.A. - HH Audits Performed	n/a	416,120	831,386	684,279	522,495	489,887	572,524	532,211	819,068	712,329	579,885	668,698	617,169	648,218
EVS - HH Compliance	95%	97.45	96.60	95.53	95.09	92.70	95.81	95.49	95.68	96.38	96.51	96.60	97.47	95.79
EVS - HH Audits Performed	n/a	90,866	138,281	106,399	79,822	40,426	34,340	81,413	143,234	140,698	140,719	223,114	276,807	280,703
LVN/Tech - HH Compliance	95%	98.80	98.04	98.50	97.33	97.70	97.80	97.34	97.19	96.46	96.79	96.92	95.76	95.28
LVN/Tech - HH Audits Performed	n/a	58,774	120,366	102,399	88,559	105,878	129,757	136,711	323,431	295,512	236,036	254,785	289,097	185,841
Nurse - HH Compliance	95%	98.15	97.85	97.40	97.61	97.64	97.56	97.26	96.86	96.17	96.31	96.44	96.33	96.47
Nurse - HH Audits Performed	n/a	1,010,487	1,799,550	1,409,149	1,186,345	1,279,644	1,322,875	1,154,162	1,837,379	1,601,691	1,264,992	1,261,264	1,133,843	1,289,203
Other - HH Compliance	95%	98.73	98.53	98.14	98.33	98.01	98.31	98.02	98.51	98.17	98.11	98.12	98.29	98.72
Other - HH Audits Performed	n/a	162,302	302,064	331,851	309,086	265,952	264,691	261,304	406,867	349,458	329,884	371,111	352,448	244,122
Physician - HH Compliance	95%	97.39	94.81	93.83	97.64	90.60	98.61	95.72	97.39	98.99	97.06	99.89	97.19	95.62
Physician - HH Audits Performed	n/a	920	12,344	13,703	4,114	234	72	187	766	693	953	909	1,672	2,398
Respiratory - HH Compliance	95%	98.45	98.17	97.86	98.37	97.61	97.14	97.80	98.34	97.90	97.29	96.94	97.15	97.18
Respiratory - HH Audits Performed	n/a	45,275	82,248	88,040	97,902	86,616	70,921	66,678	103,000	61,923	52,783	49,344	69,457	12,273
Student - HH Compliance	95%	99.41	99.11	98.57	98.28	97.78	98.27	97.57	96.44	96.32	97.15	97.19	95.74	97.58
Student - HH Audits Performed	n/a	7,464	17,618	65,321	55,547	34,021	34,965	28,641	32,297	31,296	19,456	20,073	9,742	372

Live with passion.

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

Kaweah Health

Sub Acute and Short Stay SNF Specific Data Collection Summarization

Professional Staff Quality Committee

Unit/Department: Sub Acute and Short Stay SNF **Report Date: October 2023**

Measure Objective/Goal:

1. Falls (internal data)
2. Pressure Injuries (internal data)
3. Psychoactive medication use (MDS/Casper)

Date range of data evaluated:

Data evaluated populated from internal data as well as CASPER report period: 1/01/2023 – 6/30/2023. Data compared with Casper Report and QTR 1 2023 through QTR 2 2023, internal data. TCS will no longer be reported as it is closed.

Nationally benchmarked quality data is collected through the MDS submissions process to CMS where data is populated into the CASPER report. CMS divides data between short-stay cases (<100 day length) and long-stay cases (>100 day length). The Skilled Nursing program client group is predominately in the short-stay category. Statistically this means that Long-Stay measures typically have a denominator of 33-34. Short-Stay measures typically have a denominator of 200+. Internal data is based on total units of service and does not differentiate based upon length of stay. There is no comparable national bench-marking of Short Stay cases for falls, and for HAPI prevalence overall. For these two indicators, we assess ourselves as related to internal performance goals.

FALLS

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

The rate of falls per 1000/pt. days in 1Q23 was 0.57 and 4Q22 totaling 0.88 falls per 1000 patient days. Facility observed percent for falls for long stay patients in the most current CASPER report is 6.3%, remaining well below national average of 43.7%, placing the program in the top 1 percentile nationally.

Falls per Unit per 1000 Pt Days per Quarter 2022-23

Unit	1Q22	2Q22	3Q22	4Q22	2022 Total	1Q23	**2Q23**	2023 Total
SAC	0.00	0.00	1.14	0.00	0.15	0.36	**0.70**	0.38
TC-W	3.06	1.83	0.91	5.00	0.62	1.70	**0.87**	0.38
TC-S	0.86	1.42	1.31	0.00	0.26	------	-----	------

Falls per Unit per Quarter 2023

Unit	1Q23	**2Q23**	TOTAL
SAC	1	**2**	3
TC-W	2	**1**	3

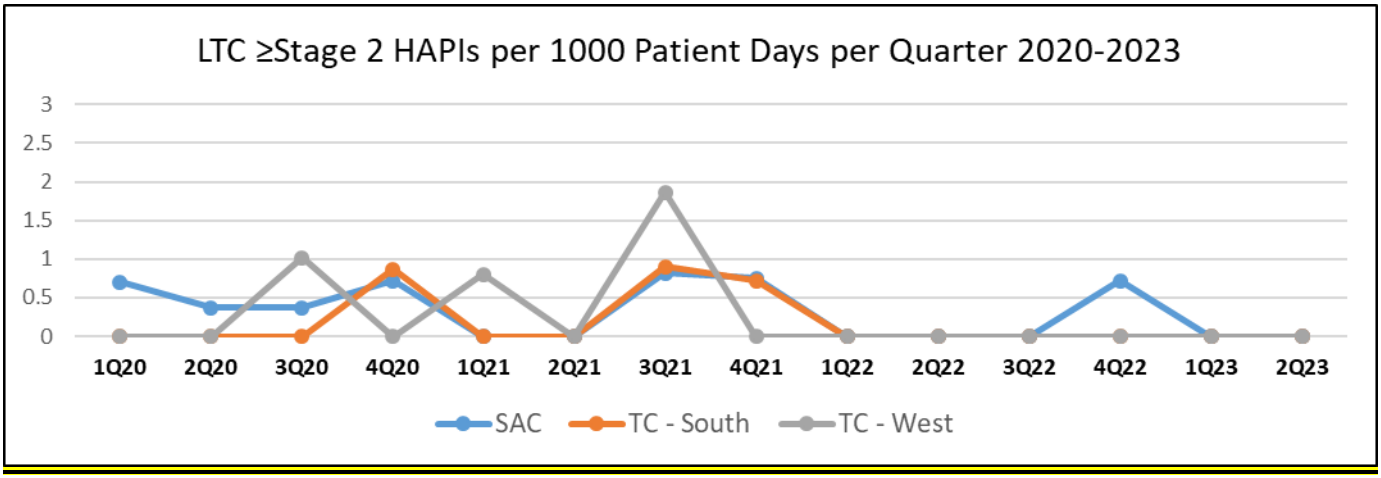
If improvement opportunities identified, provide action plan and expected resolution date:
Staff continues to participate in district-wide initiatives for fall prevention including Falls University to identify trends and communicate "take-aways". Falls occur most commonly with our short-stay population, this skilled nursing units has many patients who participate in physical and occupational therapy sessions with varying functional levels. Therapy sessions are designed to promote mobility and independence ultimately preparing the residents to discharge home. The Short Stay unit utilizes several interventions, such as adding fall review during staff meetings for educational purposes and increasing the availability of fall prevention equipment such as tele sitters and chair alarms.

PRESSURE INJURIES

Analysis of all measures/data: (Include key findings, improvements, opportunities)
Incidence of new or worsening pressure ulcers for short stay patients, which would include Sub Acute patients with a length of stay under 100 days, as reported on the Casper report is 0.4 %, below the national average of 2.7 %.

Patients at high risk for pressure ulcers (long stay residents, defined as high risk, who have > stage II pressure ulcers) is 16.1%. This is an increase from 12.9% in the last report; the national average is 8.8% and state at 8.4 %. This puts us at the 89th percentile, which is worse than the previous 78th percentile. The definition for this long stay quality measure asks if a wound is present, not if acquired in the facility. This is particularly challenging in a program that preferentially admits cases with pressure ulcers for ongoing treatment. The measure triggers a flag until the wound completely heals (and through the 6-month period). Very large wounds that have healed down to very small, chronic wounds will continue to trigger this measure. Thus, it is common to see a delay in improvement on the CASPER report, while seeing improvement more immediately in our internal data.

Overall, the total wound rate for the two SNF units per 1000/pt. days for Q1 and Q2 2023 was 0. This is an increase from last report of 0. All three SNF units participate in Kaweah health Clinical Skin Institute when pressure injuries are discovered on the unit, staff capture skin injuries during routine assessments and preventative measures are implemented early leading to better patient outcomes.



If improvement opportunities identified, provide action plan and expected resolution date:
We will continue to work within the high standards of the District, with close management of our fragile, chronic wound cases, collaborating closely with the Kaweah Health wound nurses and utilizing the standardized treatment sets available to us.

UBC teams for South Campus nursing are reviewing clinical cases using a Peer review methodology to assess for and remediate practice concerns.

During the first two weeks of admission meeting in south campus, patients at high risk for developing pressure ulcers are discussed with the IDT and treatment teams and preventative options are implemented.

Any wounds that are present and worsening wounds or pressure ulcer are discussed shift to shift during safety huddles for all SNF units. Weekly summaries are done for patients to identify high risk patients for developing pressure sores.

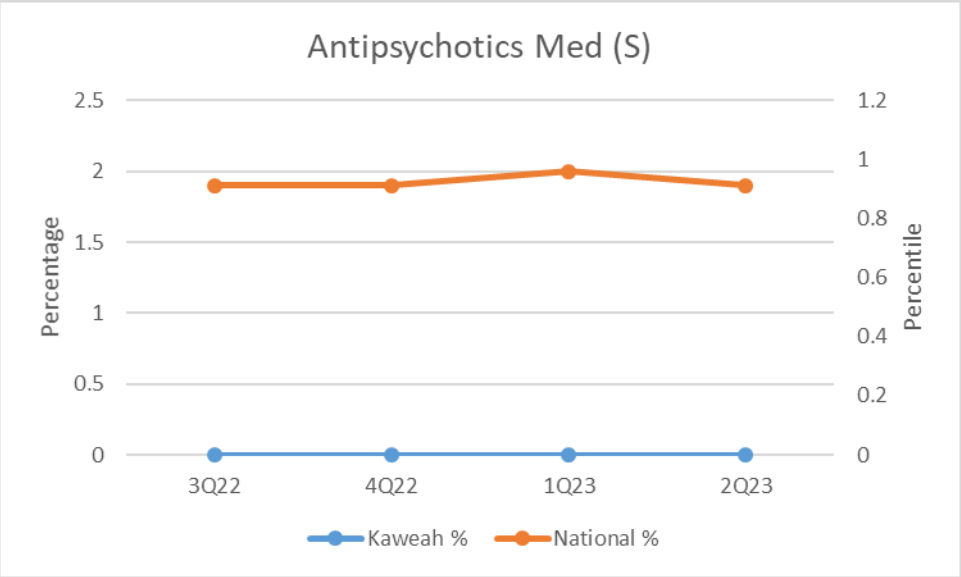
PSYCHOACTIVE MEDICATION USE

Definitions/Assumptions:
This measure is collected through the MDSs that are completed and submitted to CMS at the defined intervals by the program. The data includes only the information regarding prescribed medications by drug category (not by intended use or indication). Therefore, for instance, a practice change in the use of anxiolytics like lorazepam to antipsychotics like quetiapine for ventilator management would affect this data directly

Increased use of medications in the antipsychotic drug-class for management of depression is also moving our results in these measures. Antianxiety and hypnotic medication use is not reported as a quality measure for the short-stay population. The data is collected through the

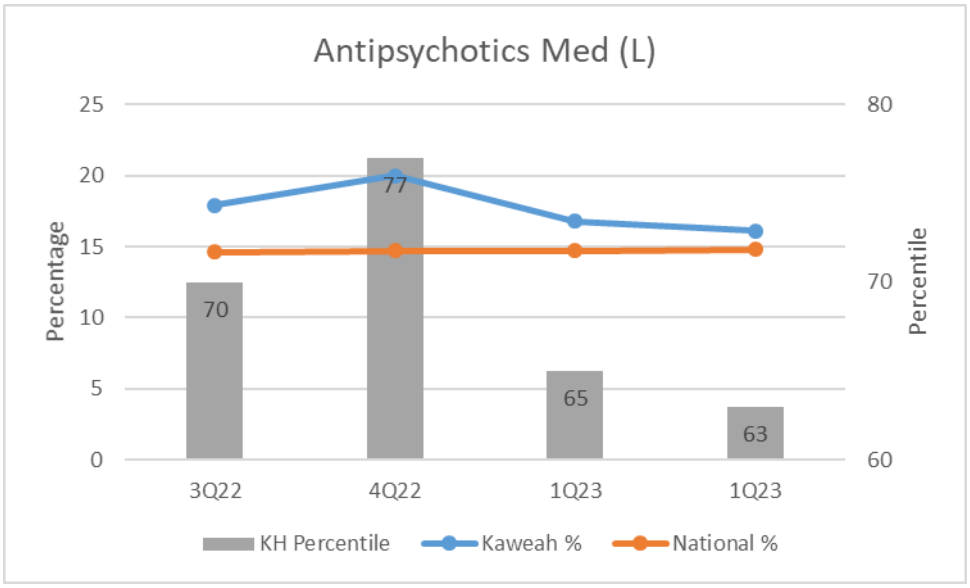
MDS, but is not included in the measures that make up our quality ranking. All values are expressed in percentile rankings.

Analysis of all measures/data: (Include key findings, improvements, opportunities)
Short Stay residents (<100 days) Antipsychotic medication use for short stay patients is below the national average, which measures only cases with newly prescribed antipsychotics. The short stay patients who begin a new anti-psychotic during their stay is 0% for both 1Q23 and 2Q23, compared to the national average of 1.9%



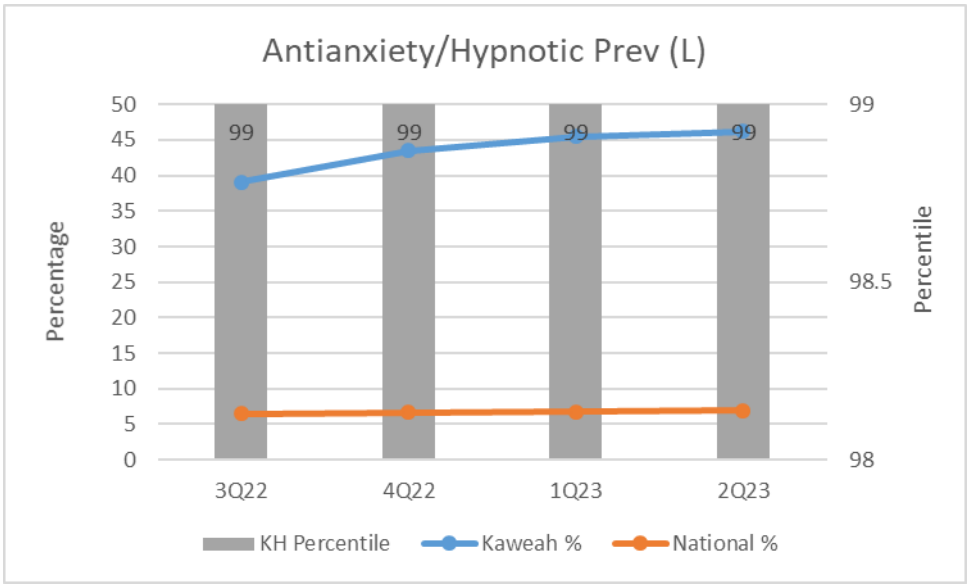
Long Stay residents.
The facility percent for antipsychotic use in long stay residents for 1Q23/2Q23 is 16.1% compared to the national average of 14.8% This puts us in the 63rd percentile respectively. Unlike the short stay measure, which only includes newly prescribed antipsychotics, the long stay measure includes all patients on the medication for any portion of the time(even if it was a home medication). Included in this measure are medications like quetiapine, used for depression or for ventilator management cases. There is another instance where our target client group for long-term care (Sub Acute program) is the primary driver of our performance.

SNF leadership has been working closely with the medical team and our MDS nurses to ensure that appropriate psychiatric diagnoses are captured in the medical record whenever possible. A small number of these diagnoses are excluded from this quality measure.



Long Stay residents.

Antianxiety/Hypnotic Medication use for long stay residents has remained high at the 99th percentile for 1Q23 and 2Q23, consistent throughout the year. This is reflective of the use of these meds for our ventilated patients in the subacute unit. There are no exclusions for medical diagnosis for this measure.



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

Psychotropic medications are under constant scrutiny by CMS. Concerns around these medications are primarily founded in two concepts:

1. Inappropriate or excessive medications
2. Using psychotropic medications to control behaviors (as a chemical restraint) or for more convenient management of difficult patients.

While the majority of our client group has clear and compelling indications for these agents, we continue to monitor the medications very closely. Our LTC pharmacist plays an important role in helping us ensure that we follow all of these medications closely during the transition process. Our primary focus is unnecessary medications, (like prn hypnotics). Hence, we also monitor for the potential to reduction when possible.

All residents receive a monthly medication regimen review and physician consultation by our LTC pharmacist. This close partnership has helped reduce psychoactive medication used generally, including dose reduction practices. We have seen a reduction in the use of hypnotic medication in our short term (<100 days) patients.

Although we struggle in this measure, in the past 3 years of CMS survey including the last survey in July 2022, there have been no findings around inappropriate use of psychotropic mediations in any of our programs.

Submitted by Name:
Molly Niederreiter

Date Submitted:
October 2023

Handoff

Date: 12/12/23

Project Leader: Franklin Martin

Situation

During Greeley mock survey (April 4-6, 2022) There were several instances in which staff were asked to discuss handoff communication for unit-to-unit transfers. Currently, there is no standardize SBAR process consistently used.

Background

1. A Sentinel Event Alert (SEA) was issued by The Joint Commission (TJC) September 2017. The gap analysis indicated that Kaweah Health at the time had several opportunities in adequately addressing TJCs recommendations and improving the handoff process.
2. As a result a Quality Focus Team (QFT) was established by our Executive Team and Quality Council (QC) in 2018 to address these gaps.

Assessment

1. The defective rate or the use of Cerner tools has not been remeasured broadly since 2018.
2. Midas event report data from 2019-1Q 2022 indicates decreasing events submitted in 2020 through 2Q 2021 compared to 2019. However increasing events starting 3Q21 through 1Q22. An overall decrease in event reports was noted overall during 2020 due to decrease volumes at the start of the pandemic. Also, several event reports were submitted for the 1E location in 1Q 22 once new leadership was established for that location as a way to measure/track & trend handoff events for awareness of the issue and to help direct future improvement efforts. 23/29 Handoff Midas events in 1Q 2022 were categorized under “no handoff received” event type.

Recommendation

Recommendation	Action item	Status	Action Responsibility

Audit	We continue to perform weekly audits for 1 floor. 16 floors have successfully completed 3 months of audits with a > 80% compliance and have now moved on to quarterly. On 8/25/23, Cindy from Quality did a handoff audit validation and surveyed 10 nurses. They all passed with 100% compliance based on our audit criteria for this project.	Ongoing	Frank/Kathy
Build	We have completed maternal child health and are working on Peri-op/Surgical areas (ETA early 2024).	Peri-op handoff tools were turned in, and we are waiting for the ISS build. ETA for completion first qtr. 2024.	Frank/ ISS team

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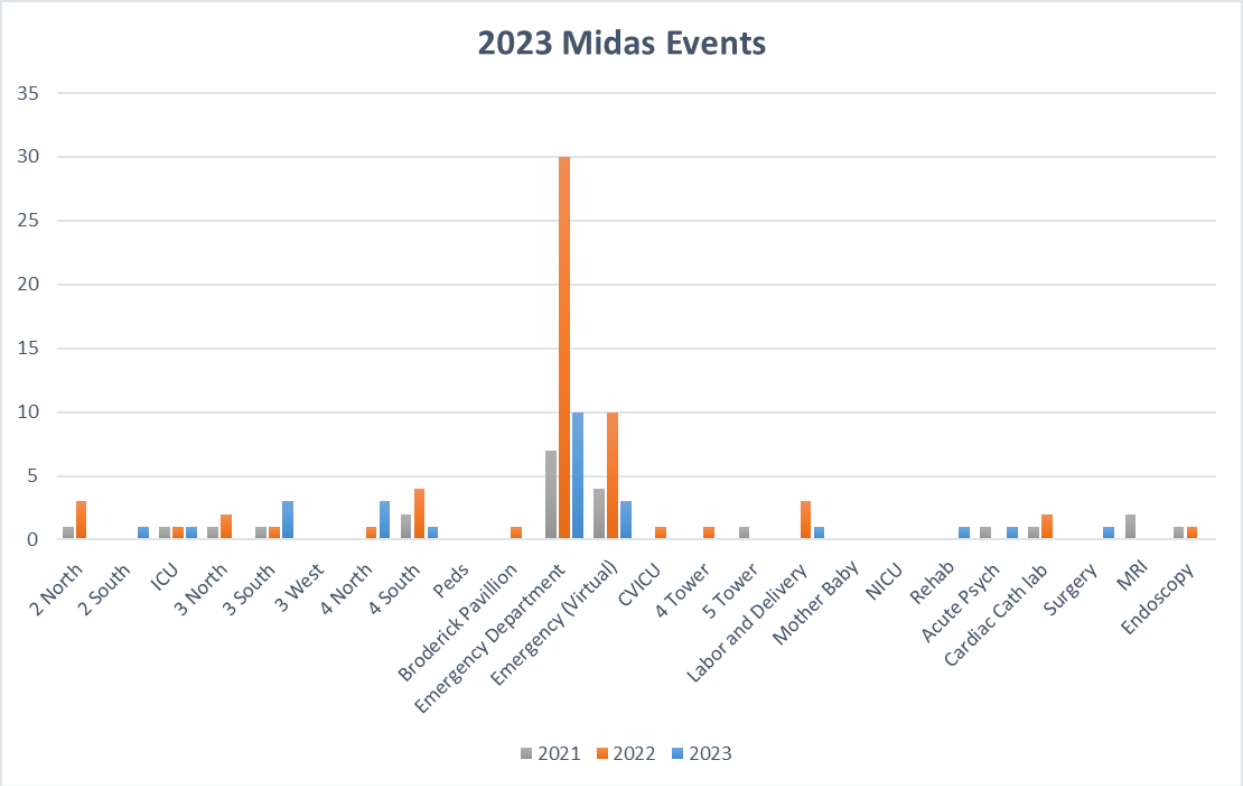
SBAR Handoff

SBAR handoff Tracking	Benchmark	Partial Month Feb - 23	Mar - 23	Apr - 23	May - 23	June - 23	July - 23	Aug - 23	Sept- 23	Oct - 23	Nov- 23
2 North	80%	93%	69%	68%	72%	100%	96%	100%	n/a	n/a	n/a
2 South	80%	94%	92%	96%	n/a	n/a	100%	n/a	n/a	n/a	
ICU	80%	85%	72%	81%	64%	98%	92%	94%	n/a	n/a	n/a
3 North	80%	48%	75%	97%	97%	100%	n/a	n/a	n/a	100%	n/a
3 South	80%	99%	97%	98%	n/a	n/a	n/a	96%	n/a	n/a	n/a
3 West	80%	92%	94%	91%	n/a	n/a	100%	n/a	n/a	n/a	100%
4 North	80%	88%	92%	98%	n/a	n/a	n/a	96%	n/a	n/a	n/a
4 South	80%	72%	49%	74%	84%	99%	100%	n/a	n/a	100%	n/a
Peds	80%	0%	75%	45%	98%	80%	90%	n/a	n/a	n/a	100%
Broderick Pavillion	80%	62%	80%	78%	77%	80%	80%	80%	n/a	n/a	100%
Emergency Department	80%	99%	90%	85%	n/a	n/a	n/a	100%	n/a	n/a	n/a
CVICU	80%	80%	100%	95%	n/a	n/a	n/a	100%	n/a	n/a	n/a
4 Tower	80%	60%	92%	92%	88%	n/a	n/a	n/a	100%	n/a	n/a
5 Tower	80%	100%	100%	100%	n/a	n/a	n/a	100%	n/a	n/a	100%
Labor and Delivery	80%	n/a	n/a	n/a	n/a	48%	97%	99%	99%	n/a	n/a
Mother Baby	80%	n/a	n/a	n/a	n/a	94%	99%	98%	n/a	n/a	100%
NICU	80%	n/a	n/a	n/a	n/a	98%	100%	100%	n/a	n/a	100%
Midas Event	0	5	3	1	5	3	2	2	0	1	1
Overall											
All Patients	80%	76%	78%	86%	83%	89%	94%	96%	99%	100.0%	100.0%

KEY	>10% below goal/benchmark	Within 10% of goal/benchmark	Outperforming/meeting goal/benchmark



Midas Events

Year to date, we currently have 26 Midas events related to handoff, which is less than half of of our 2022 totals (61 events).

Overall

Overall, we have made some amazing progress with this project. We are currently working on building the handoff page for the surgical services area. Every department is currently on quarterly audits, and we have a great response from all the leaders completing the audits.

Renal Services

Quality Board Report
December 21, 2023

Renal Services

Kaweah Health Dialysis Clinic and Inpatient Acute Dialysis

KAWEAH HEALTH DIALYSIS CLINIC

- 131 Hemodialysis Patients
- 16 Peritoneal Dialysis Patients
- 4 Kidney Transplants in 2022
- 3 Kidney Transplants in 2023
- 18,119 Hemodialysis Treatments in 2022
- 16,427 Hemodialysis Treatments in 2023 and still counting!
- 29 Dialysis Machines onsite
- 24 reclining chair stations and 2 isolation rooms
- 4 hospital beds for patients to use if medically indicated
- 2 private Peritoneal Dialysis treatment Rooms

INPATIENT ACUTE DIALYSIS

- 6 rooms located on 4 North where acute hemodialysis treatments are performed on medical surgical level of care patients
- Acute Dialysis Registered Nurses travel to critical care to perform hemodialysis treatments or set up and assist in maintaining Sustained Low Efficiency Dialysis (SLED)
- 8,254 Hemodialysis Treatments in 2022
- 6,667 Hemodialysis Treatment in 2023 and still counting!
- 17 Dialysis and Reverse Osmosis Machines

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Quality and Performance Data

Patient Satisfaction Scores

- 24 patients completed the Patient Satisfaction Survey in Spring 2023
- Staff scored higher than benchmark in "Staff behaved professionally and "Staffed cared"
- Out of 32 questions, 15 scored higher than benchmark
- Low scores were discussed during Unit Based Council (UBC)
- Plans were developed and implemented to address any low scores

Question Table Client Name: Kaweah Health
Time Period: Spring 2023

		Kaweah Health Dialysis Center	
Question Text	Benchmark	Positive Score	n-size
Center was clean	78.7%	79.2%	24
Connected to machine within 15 min	46.4%	52.2%	23
Doctors cared	66.7%	83.3%	24
Doctors explained things understandably	63.9%	82.6%	23
Doctors listened carefully	65.8%	87.5%	24
Doctors showed respect	71.9%	91.7%	24
Doctors spent enough time	53.5%	73.9%	23
Doctors up to date about care from other doctors	88.5%	91.3%	23
Doctors/staff talked about peritoneal dialysis	65.8%	70.8%	24
Doctors/staff talked about what treatment was right	85.8%	91.7%	24
Felt comfortable asking about dialysis care	94.5%	95.8%	24
Involved as much as wanted in choosing treatment	88.3%	95.8%	24
Know how to take care of dialysis connection method	94.3%	95.8%	24
Rate center	78.4%	91.7%	24
Rate kidney doctors	65.5%	83.3%	24
Rate staff	77.6%	95.8%	24
Staff behaved professionally	75.7%	91.7%	24
Staff cared	70.5%	91.3%	23
Staff checked on patient as closely as wanted	67.4%	79.2%	24
Staff discussed diet	91.9%	91.7%	24
Staff explained blood test results understandably	66.7%	83.3%	24
Staff explained things understandably	68.2%	87.5%	24
Staff explained what to do if problems at home	86.8%	87.5%	24

Quality and Performance Data

KT/V Scores

	Goal 2021	Actual 2021	Goal 2022	Actual 2022	Goal 2023	Actual 2023
%KT/V>1.2	97.61	95.66%	97.61%	96.43%	97.61%	97.66%

- KT/ V measures how well a patient is being dialyzed
- This is measured each month for each patient
- Our dialysis team monitor patients labs and work closely with nephrologists to adjust prescriptions to ensure treatments are adequate
- An interdisciplinary care team meets weekly to discuss patients who are not meeting their KT/V goals
- The interdisciplinary team consists of dietician, registered nurse and a social worker to ensure the best care is provided to our patients

Quality and Performance Data

Fistula and Catheter Rate

	Goal 2021	Actual 2021	Goal 2022	Actual 2022	Goal 2023	Actual 2023
Fistula Rate	62%	53.46%	62%	54.48%	62%	56.49%
Long term Catheter Rate (Greater than 90 days)	17%	24.39%	17%	23.83%	17%	22.32%

- We continue to struggle with meeting our fistula and long term catheter goals
- Reasons are
  - Vascular surgery availability
  - Patient preference
  - Nephrologist preference for patient

Quality and Performance Data

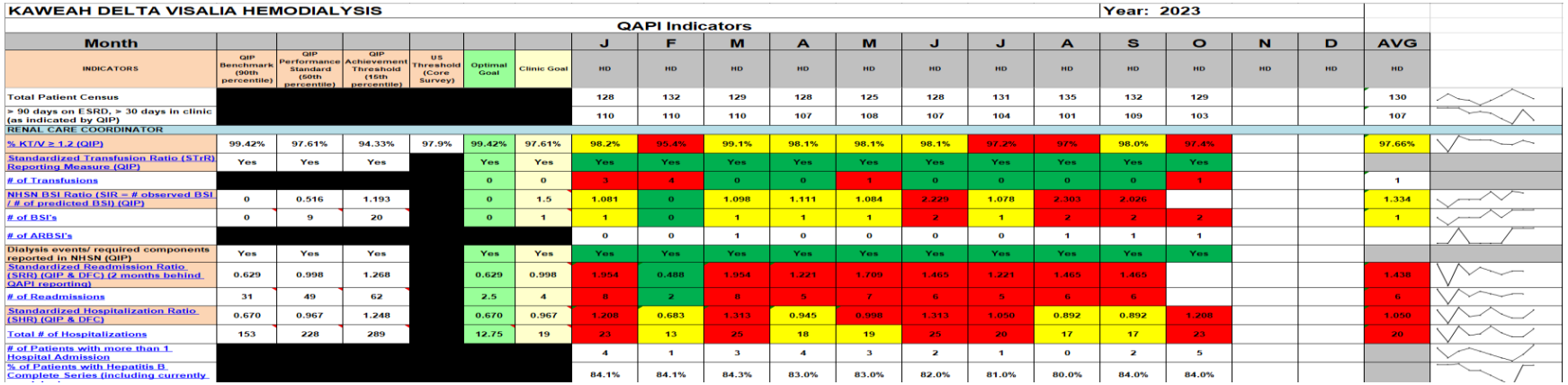
Bloodstream Infections

	Goal 2021	Actual 2021	Goal 2022	Actual 2022	Goal 2023	Actual 2023
BSI Ratio Standard Infection Ratio (SIR)	0	2.679	0	2.340	0	1.334

- Patients receiving dialysis are at a greater risk for blood stream infection than the general population
- To ensure our team is utilizing best practices the Nurse Manager completes audits each month
- The audits include observations of hand hygiene compliance, medication preparation and administration and central venous access site care
- Results are discussed during the monthly Quality Assessment and Performance Improvement (QAPI) meeting

Quality and Performance Data

QAPI Program



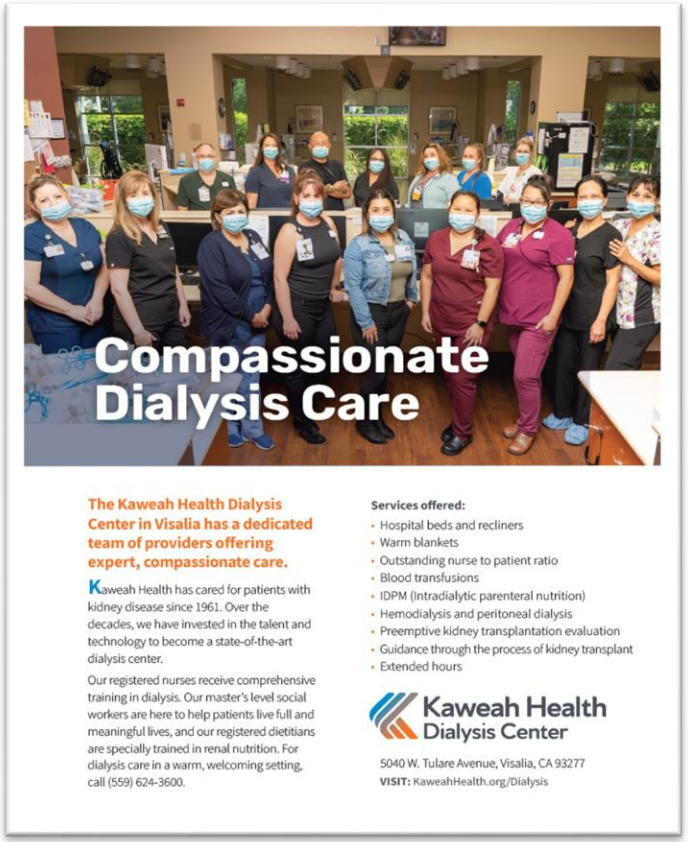
KAWEAH DELTA VISALIA HEMODIALYSIS							QAPI Indicators											Year: 2023	
Month							J	F	M	A	M	J	J	A	S	O	N	D	AVG
INDICATORS	QIP Benchmark (90th percentile)	QIP Performance Standard (60th percentile)	QIP Achievement Threshold (15th percentile)	US Threshold (Core Survey)	Optimal Goal	Clinic Goal	HD	HD	HD	HD	HD	HD	HD	HD	HD	HD	HD	HD	HD
Total Patient Census							128	132	129	128	125	128	131	135	132	129			130
> 90 days on ESRD, > 30 days in clinic (as indicated by QIP)							110	110	110	107	108	107	104	101	109	103			107
RENAL CARE COORDINATOR																			
% KT/V ≥ 1.2 (QIP)	99.42%	97.61%	94.33%	97.9%	99.42%	97.61%	98.2%	95.4%	99.1%	98.1%	98.1%	98.1%	97.2%	97%	98.0%	97.4%			97.66%
Standardized Transfusion Ratio (STrR) Reporting Measure (QIP)	Yes	Yes	Yes		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes			
# of Transfusions					0	0	3	4	0	0	1	0	0	0	0	1			1
NHSN BSI Ratio (SIR = # observed BSI / # of predicted BSI) (QIP)	0	0.516	1.193		0	1.5	1.081	0	1.098	1.111	1.084	2.229	1.078	2.303	2.026				1.334
# of BSI's	0	9	20		0	1	1	0	1	1	1	2	1	2	2	2			1
# of ARBSI's							0	0	1	0	0	0	0	1	1	1			
Dialysis events/ required components reported in NHSN (QIP)	Yes	Yes	Yes		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes			
Standardized Readmission Ratio (SRR) (QIP & DFC) (2 months behind QAPI reporting)	0.629	0.998	1.268		0.629	0.998	1.954	0.488	1.954	1.221	1.709	1.465	1.221	1.465	1.465				1.438
# of Readmissions	31	49	62		2.5	4	8	2	8	5	7	6	5	6	6				6
Standardized Hospitalization Ratio (SHR) (QIP & DFC)	0.670	0.967	1.248		0.670	0.967	1.208	0.683	1.313	0.945	0.998	1.313	1.050	0.892	0.892	1.208			1.050
Total # of Hospitalizations	153	228	289		12.75	19	23	13	25	18	19	25	20	17	17	23			20
# of Patients with more than 1 Hospital Admission							4	1	3	4	3	2	1	0	2	5			
% of Patients with Hepatitis B Complete Series (including currently							84.1%	84.1%	84.3%	83.0%	83.0%	82.0%	81.0%	80.0%	84.0%	84.0%			

- The Dialysis Clinic has it's own robust Quality Assessment and Performance Improvement (QAPI) Program
- Meets monthly at Dialysis Clinic
- 90 different quality data indicators are discussed for Hemodialysis
- 50 different quality data indicators are discussed for Peritoneal Dialysis
- If a goal is not met further evaluation is completed to see what needs to be done to correct the fall out

Policy, Strategic or Tactical Issues

Working to Increase Patient Census

- Partnered with Physician Recruitment and Relation Team to make office visits at our local nephrologist office
- Created a Kaweah Health Dialysis Clinic Patient Referral Form
- Peritoneal Dialysis Nurses evaluate all hemodialysis patients to see if Peritoneal Dialysis would be a option
- Created a flyer with marketing to post on 4 North and add to welcome folder for all patients on 4 North



Policy, Strategic or Tactical Issues

Clarity- Electronic Medical Record

- Clarity does not interface well with Soarian Financials
- Charges are incorrect or missing when they interface from Clarity to Soarian Financials
- Currently we are performing manual audits and manually entering in missing or incorrect charges
- Work group created with dialysis clinic team, revenue cycle and finance team members collaborating on fallout opportunities
- Requesting new electronic medical record

Policy, Strategic or Tactical Issues

Employee Engagement and Retention

- Celebrate Nephrology Nurses Week in September
- Celebrate Certified Hemodialysis Technician Week in October
- Focus on top opportunities from last Employee Engagement Pulse Survey
- Improve Employee Communication by Weekly Updates and Daily Safety Huddles

Conclusion

Plan for future…

- Strive for overall quality outcomes and set goals to continue to improve
- Increase peritoneal dialysis and hemodialysis patient volumes
- Monitor patient to nurse assignments to ensure productive ratios are maintained
- Evaluate and request new electronic medical record for dialysis clinic with third party billing to eliminate interface with Soarian Financials
- Evaluate hemodialysis standards in care to make appropriate pharmaceutical decisions for patients and clinic

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REPORT TO THE BOARD OF DIRECTORS

Renal Services

Amy Baker, MSN, RN
Director of Renal Services
(559) 624-5423
December 21, 2023

Summary Issue/Service Considered

- Continue to focus on building census after census drop with new dialysis clinic opening in Visalia in 2022 and patient loss due to Covid Pandemic.
- Consistent Nurse Manager leadership for Dialysis Clinic for one year.
- Improve internal processes to expedite care of patients at clinic. This includes optimizing patient treatment schedule and employee work schedule.
- Actively monitor all quality measures with a focused effort on treatment adequacy goals, our fistula rate and blood stream infections.
- Nursing remains focused on patient satisfaction scores and patient safety.
- Working to reduce costs per treatment.
- Collaborating with Finance Department to ensure optimal reimbursement is achieved and accurate charging and claims filed.

Quality/Performance Improvement Data

Patient Satisfaction Scores:

Question Table Client Name: Kaweah Health
Time Period: Spring 2023

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Staff explained things understandably	68.2%	87.5%	24
Staff explained what to do if problems at home	86.8%	87.5%	24

NRC Health completed our spring patient satisfaction survey. We had twenty four patients complete the survey for spring. Kaweah Health Dialysis Clinic scored statistically significantly greater than benchmark in the areas of “Staff behaved professionally”, “Doctors showed respect” and “Staff cared”. Out of the thirty two questions fifteen were higher than the benchmark. Scores below benchmark are discussed during our unit based council meetings. Unit Based Councils or UBC’s members include unit leadership, Registered Nurses and Certifed Hemodialysis Techicians. Plans were developed and implemented to address any low scores. Ideas for improving patient satisfacation that come from front line staff are very successful.

KT/V Scores:

	Goal 2021	Actual 2021	Goal 2022	Actual 2022	Goal 2023	Actual 2023
%KT/V>1.2	97.61	95.66%	97.61%	96.43%	97.61%	97.66%

A KT over V score measures how well a patient is being dialyzed. It measures the adequacy of the treatment or how well the treatment is cleaning the patients blood. We have improved from the previous years and have met goal for calandar year 2023. Our dialysis team continues to monitor patients labs and work closely with nephrologists to adjust treatments to ensure treatments are adequate. An interdisciplinary care team meets weekly to discuss patients who do not meet there KT/V goal. The interdisciplinary care team includes dieticians, registered nurses and a social worker to ensure the best care is delivered to our patients.

Fistula and Catheter Rates:

	Goal 2021	Actual 2021	Goal 2022	Actual 2022	Goal 2023	Actual 2023
Fistula Rate	62%	53.46%	62%	54.48%	62%	56.49%
Long term Catheter Rate (Greater than 90 days)	17%	24.39%	17%	23.83%	17%	22.32%

We continue to promote Fistula First to prevent complications associated with catheters. This is the industry standard. We have consolidated roles amongst back office staff and continue to provide a lot of patient education about fistula's. All participants of the interdisciplinary care team assist with stressing the importance of a fistula to the patient. Barriers to fistulas include patient preferences for a catheter and access to vascular surgeons to create the fistulas. When patients have fistulas, the fistulas get accessed with needles. Some patients prefer the catheters due to not getting poked by a needle each treatment. The Kaweah Health team continues to educate patients on the effectiveness of the fistula. Surgery team and surgeons are increasing operating room access to perform fistula procedures.

Bloodstream Infection Rates (BSI):

	Goal 2021	Actual 2021	Goal 2022	Actual 2022	Goal 2023	Actual 2023
BSI Ratio Standard Infection Ratio (SIR)	0	2.679	0	2.340	0	1.334

Bloodstream infections can occur when bacteria or fungus enter the blood stream. With patients receiving hemodialysis three times a week the chances of obtaining a blood stream infection is higher than the general population. At the Dialysis Clinic, we take every precaution to prevent blood stream infections. The number of actual infections divided by the number of expected infections gives us a standard infection ratio (SIR). To ensure best practice we have implemented employee audits by our Nurse Manager. These audits include observations of hand hygiene compliance, medication preparation and administration, and central venous access exit site care. We have provided education to our patients about the importance of washing their hands and fistula sites prior to initiating dialysis and the importance of using chlorhexidine. We review each bloodstream infection with our infection prevention registered nurse liaison. Learning opportunities are discussed at the monthly Quality Assessment and Performance Improvement (QAPI) meeting.

Policy, Strategic or Tactical Issues

- Review monthly, all quality data, in our Quality Assessment and Performance Improvement committee (QAPI) meeting to ensure we are meeting our goals. If a goal is not met then further evaluation is completed to see what needs to be done to correct fall out. In this meeting 90 different quality data indicators are discussed for hemodialysis and 50 different quality data indicators are and discussed for peritoneal dialysis.
- Work to recruit more patients to the clinic. This year we collaborated with Physician Recruitment and Relation team to make office visits at our local nephrologists' offices. Our clinic leadership was able to meet several local nephrologists' office staff to build relationships to help increase patient referrals. A new Kaweah Health Dialysis Clinic Patient Referral Form was created to help ease and streamline the

process of referrals. Leadership will monitor the volumes and continue with referring physician visits and relationship development.

- Reviewing current policies for clinic and updating order sets for admission. All policies and order sets reviewed for 2022 and ongoing process initiated to ensure this maintained moving forward. Next step is to update all protocols.
- *Clarity*, the electronic medical record, the dialysis clinic utilizes does not interface well with Soarian Financials. Each month, Clarity should send charges to Soarian Financials for each patient to generate the claim to submit to insurance. This has not been working correctly. Charges are being missed or charged incorrectly causing manual audits to ensure accuracy. Clarity is not sending all the information needed to submit claims appropriately. This is specific to missing drug coding and modifiers. Manual audits and manual charge entry into Soarian Financials is occurring to confirm accuracy. Work group with dialysis clinic, revenue cycle and finance team members collaborating on fallout opportunities.

Recommendations/Next Steps

- Educate and retain Registered Nurses and Certified Hemodialysis Technicians to decrease turn over and burn out.
- Focus on employee engagement by focusing on top opportunities from last Employee Engagement Pulse survey.
- Continue with employee weekly updates to facilitate information from leadership to employees. Also have daily Employee Safety Huddle at 10:30 to discuss safety concerns for staff and patients. This has helped address several clinic issues and increased overall moral.
- Focus on improving supply utilization by eliminating unnecessary items on supply list.
- Continue to work closely with pharmacy to monitor medication trends and evaluate cost versus benefit to patient.

Approvals/Conclusions

- Strive for overall quality outcomes and set goals to continue to improve.
- Increase peritoneal dialysis and hemodialysis patient volumes to improve financial strength of clinic.
- Monitor patient to nurse assignments to ensure productive ratios are maintained to improve financial strength of clinic.
- Evaluate and request new electronic medical record for dialysis clinic with third party billing to eliminate interface with Soarian Financials.
- Evaluate hemodialysis standards in care to make appropriate pharmaceutical decisions for patients and clinic.

Outstanding Health Outcomes Update

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

October 2023

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Outstanding Healthoutcomes (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%									75%
Sepsis and Related Conditions o/e mortality	≤0.78		1.12	0.75	0.82	0.78	0.84									0.80

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								9
CLABSI SIR	0.39	1.01 Ex COVID	0.93 Ex COVID	0.83	1.16	2.22	0.00	1.15								1.15
Central Line Utilization Rate (ICU)	0.68	1.02	0.88	0.749	0.791	0.828	0.774	0.685								0.77

Catheter Associated Blood Stream 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								4
CAUTI SIR	0.48	1.09 Ex COVID	0.55 Ex COVID	0.00	0.00	1.06	0	0.974								0.41
Indwelling Uninary Catheter (IUC) Utilization Rate (ICU)	0.70	1.18	1.22	0.869	0.925	1.040	1.080	1.10								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								1
MRSA SIR	0.55	1.11 Ex COVID	0.66 Ex COVID	0.00	0.00	1.47	0.00	1.32								0.57

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, expand to inpatient
- Re-identifying root causes of SEP-1 non-compliance to focus SEP-1 QI on the highest contributing factors

Healthcare Acquired Infections

- New 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 to start in January 2024 in high risk areas, addresses line necessity (less lines=less infections)
    - Decolonization rates
        - Improved from 32% (Jan-June 2023) to 89% (Sept – Nov 2023), November 94%. 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
    - Cleaning effectiveness in high risk areas
        - Additional training, including cleaning and testing processes
    - Hand Hygiene (use of BioVigil system for monitoring)
        - Increased use of system, improvement from 31% of active users achieving target badge hours in FY 2023, to 48% FYTD24. Next steps, additional tools provided to leaders and staff to support increase use, and evaluation of active users with the denominator

Questions?

The pursuit of healthiness