July 14, 2022

NOTICE

The Board of Directors of the Kaweah Delta Health Care District will meet in a Quality Council Committee meeting at 7:30AM on Thursday, July 21, 2022, in the Kaweah Health Lifestyle Fitness Center Conference Room, 5105 W. Cypress Avenue, Visalia, CA 93277.

The Board of Directors of the Kaweah Delta Health Care District will meet in a Closed Quality Council Committee at 7:31AM on Thursday, July 21, 2022, in the Kaweah Health Lifestyle Fitness Center Conference Room, 5105 W. Cypress Avenue, Visalia, CA 93277, pursuant to Health and Safety Code 32155 & 1461.

The Board of Directors of the Kaweah Delta Health Care District will meet in an open Quality Council Committee meeting at 8:00AM on Thursday, July 21, 2022, 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, July 21, 2022
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; Monica Manga, MD, Chief of Staff; Daniel Hightower, MD, Professional Staff Quality Committee Chair; Tom Gray, 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 Rita Pena, 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 – *Daniel Hightower, MD, and Professional Staff Quality Committee Chair; James McNulty, Sandy Volchko, RN, DNP, Director of Quality and Patient Safety.*
   - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 - *James McNulty, PharmD, Director of Pharmacy.*
   - **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 – *Daniel Hightower, MD, and Professional Staff Quality Committee Chair*
3. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 - *James McNulty, PharmD, Director of Pharmacy.*
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. Rapid Response Team (RRT) Quality Report
    - 3.2. Stroke Program Quality Report
    - 3.3. Catheter Associated Urinary Tract Infection (CAUTI) Quality Focus Team
    - 3.4. CMS Star Rating Report
    - 3.5. Clinical Quality Goals Update
4. **Infection Prevention Dashboard** – A review of key infection prevention measures and associated action plans. *Shawn Elkin, MPA, BSN, RN, PHN, CIC, Infection Prevention Manager*
5. **Nursing Workforce Study** - National Quality Forum Safe Practice #9: Nursing Workforce – An evaluation and analysis of nurse staffing, skill mix and adverse events. *Keri Noeske, DNP, Chief Nursing Officer*
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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THURSDAY JULY 21, 2022

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RRT/Code Blue ProStaff Report Q1 2022

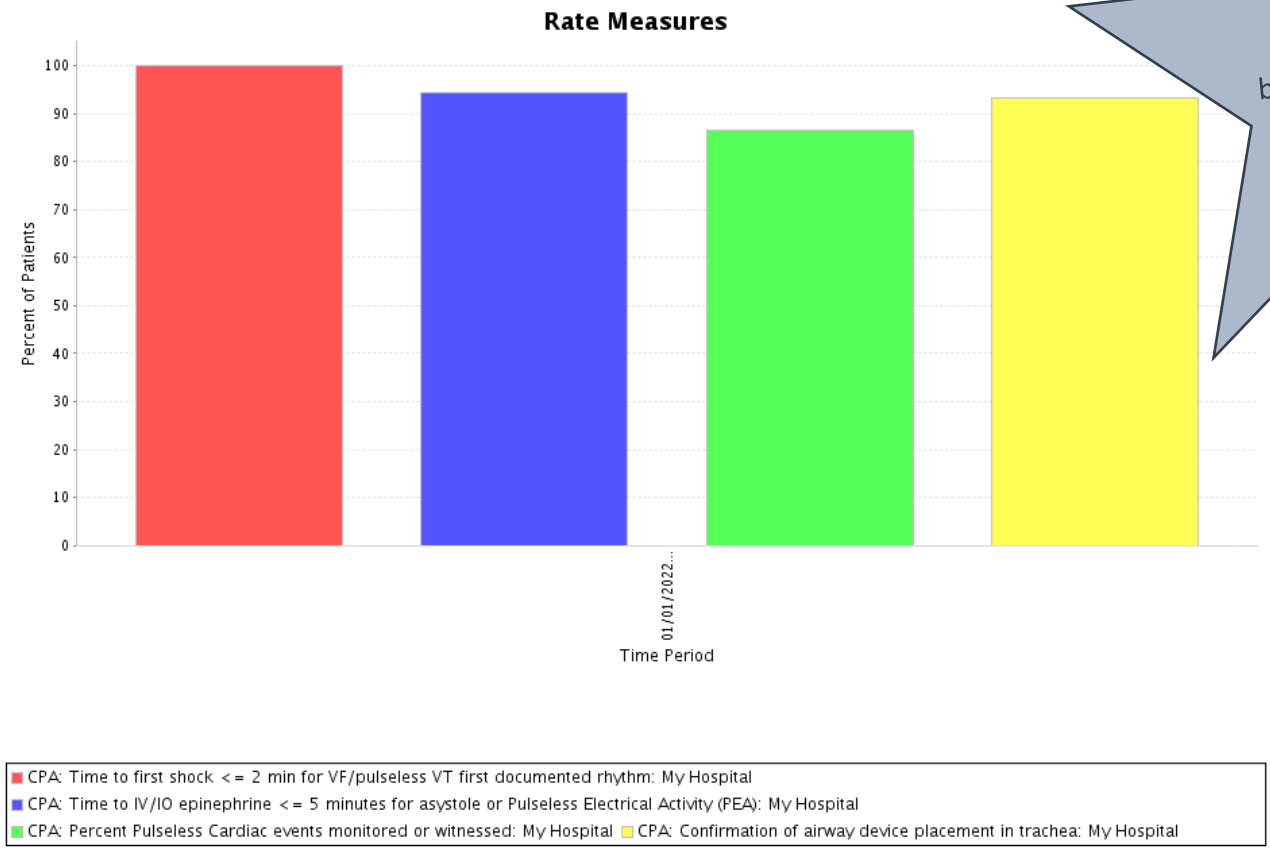
Shannon Cauthen and Stacey Cajimat

The Rapid Response Team Mission Statement

“To host opportunities that provide education while building relationships with patient care staff to foster a trust that encourages earlier activation of the RRT system.”

GWTG Metrics

Goal= 85% Compliance



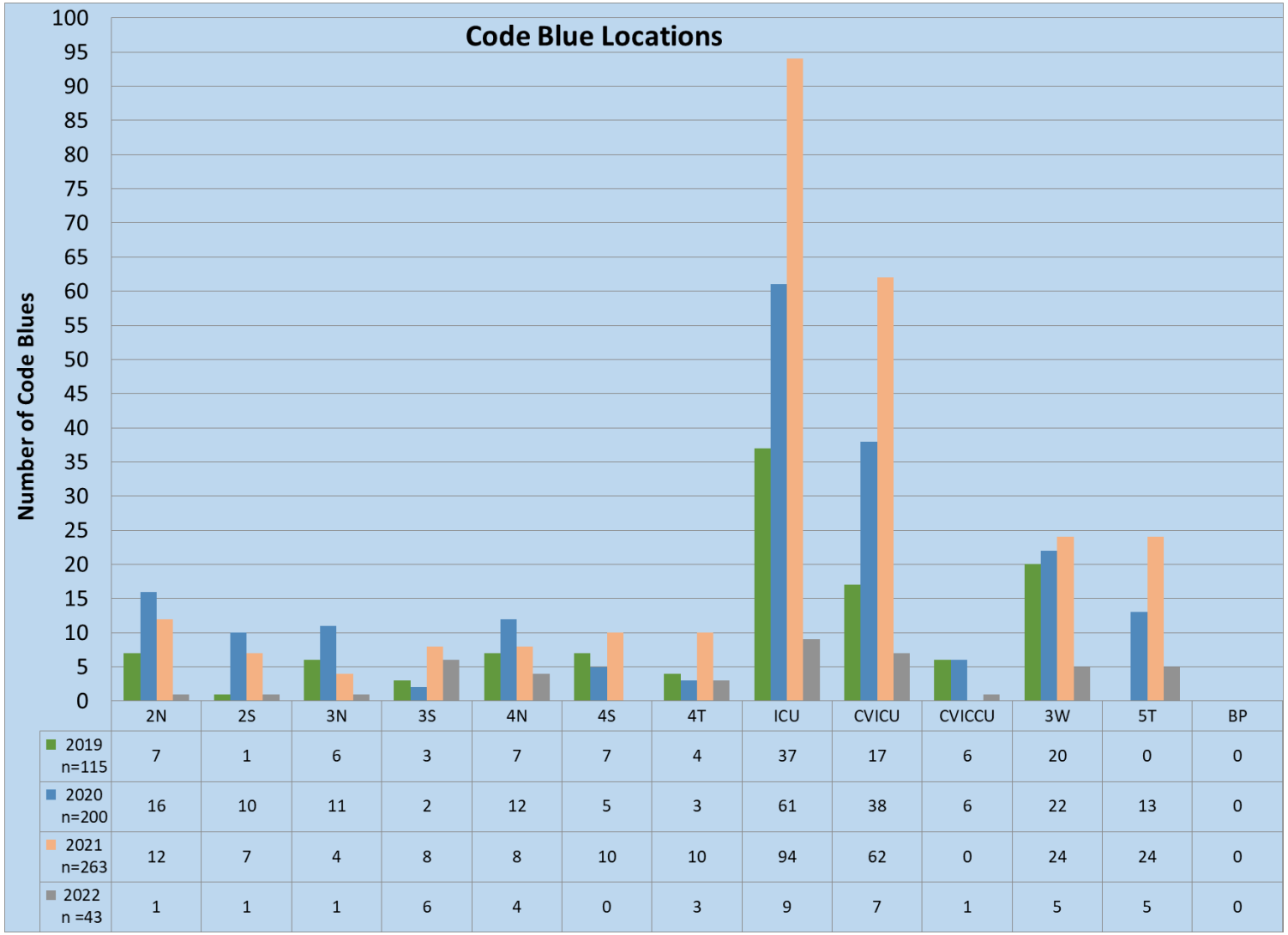
1st time meeting benchmark in all 4 categories!

RRT and Resuscitation- Quality Scorecard

Measure Description	All GWTG Hospitals External Benchmark	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Mean 2021-2022
Code Blue Data																
Total Code Blues		30	17	15	12	10	16	15	30	34	37	20	17	16	10	20
Total COVID-19 Positive Code Blues		14	0	0	0	0	1	9	13	15	16	8	8	4	2	6
Code Blues per 1000 Discharges Med		8	5	8	7	1	5	5	6	14	8	3	8	9	3	6
Code Blues per 1000 Discharges Critical Care		17	7	4	2	7	7	7	17	12	23	12	4	4	4	9
Percent of Codes in Critical Care	66% (↑ is better)	50%	59%	33%	25%	90%	56%	60%	73%	47%	73%	80%	35%	31%	50%	54%
Code Blue: Survival to Discharge	20% (↑ is better)	7%	18%	27%	25%	40%	19%	0%	7%	6%	3%	10%	0%	13%	20%	14%
Deaths from Cardiac Arrest		15	5	8	5	2	6	6	10	14	14	10	9	5	0	8
Overall Hospital Mortality per 1000 Patients		5.661	3.29	3.132	2.778	1.897	2.539	3.323	5.279	4.866	6.023	4.105	4.47	4.399	2.632	3.89
RRT Data																
Total RRTS		154	109	101	116	103	110	134	185	182	124	110	137	112	103	127
RRTs per 1000 Patient Discharge Days		129	81	76	87	75	82	106	145	139	104	85	102	93	77	99
RRT Mortality	21% (↓ is better)	31% n-47	20% n-22	22% n-22	17% n-20	16% n-16	20% n-22	27% n-36	33% n-62	39% n-54	50% n-51	30% n-29	26% n-36	21% n-24	13% n-13	26%
RRTs Within 24 hours of Arriving to Inpatient Unit	15% (↓ is better)	16% n-25	29% n-32	28% n-28	28% n-32	29% n-30	28% n-31	16% n-22	18% n-33	17% n-31	17% n-21	26% n-29	20% n-27	17% n-19	26% n-27	23%
RRT- Med-Surg to Intermediate Critical Care Transfers	9%												12% n-16	16% n-18	9% n-9	12%
RRT- Med-Surg to Critical Care Transfers	29%												8% n-14	9% n-10	11% n-11	6%
RRT-Intermediate Critical Care Transfers to Critical Care	32%												10% n-14	5% n-6	8% n-8	8%

Green	Better than Target
Yellow	Within 10% of Target
Red	Does not meet Target

Code Blues



	2N	2S	3N	3S	4N	4S	4T	ICU	CVICU	CVICCU	3W	5T	BP
2019 n=115	7	1	6	3	7	7	4	37	17	6	20	0	0
2020 n=200	16	10	11	2	12	5	3	61	38	6	22	13	0
2021 n=263	12	7	4	8	8	10	10	94	62	0	24	24	0
2022 n =43	1	1	1	6	4	0	3	9	7	1	5	5	0

-62% of our codes are occurring in our ICUs and the ICCUs- this is the goal!

-The second highest incidence of code blues occurred on 3S- 14%.

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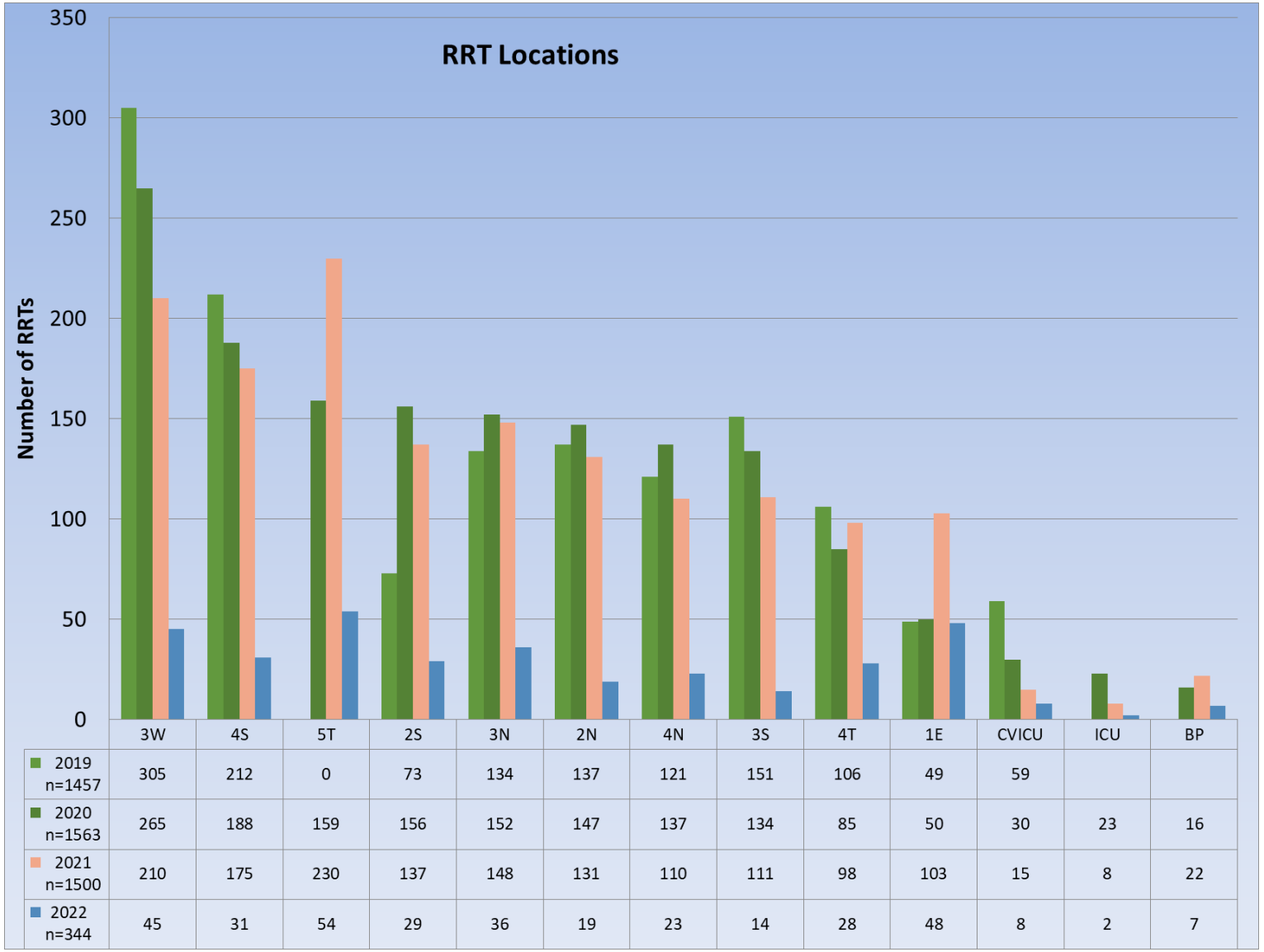
RRTs



	3W	4S	5T	2S	3N	2N	4N	3S	4T	1E	CVICU	ICU	BP
2019 n=1457	305	212	0	73	134	137	121	151	106	49	59		
2020 n=1563	265	188	159	156	152	147	137	134	85	50	30	23	16
2021 n=1500	210	175	230	137	148	131	110	111	98	103	15	8	22
2022 n=344	45	31	54	29	36	19	23	14	28	48	8	2	7

-At current time, on trend to have an average of 150 less RRTs than last three CYs.

-43% of our RRTs occur in 1E, 3W and 5T

-Remaining 57% of RRTs are divided amongst 10 units

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Next Steps: General

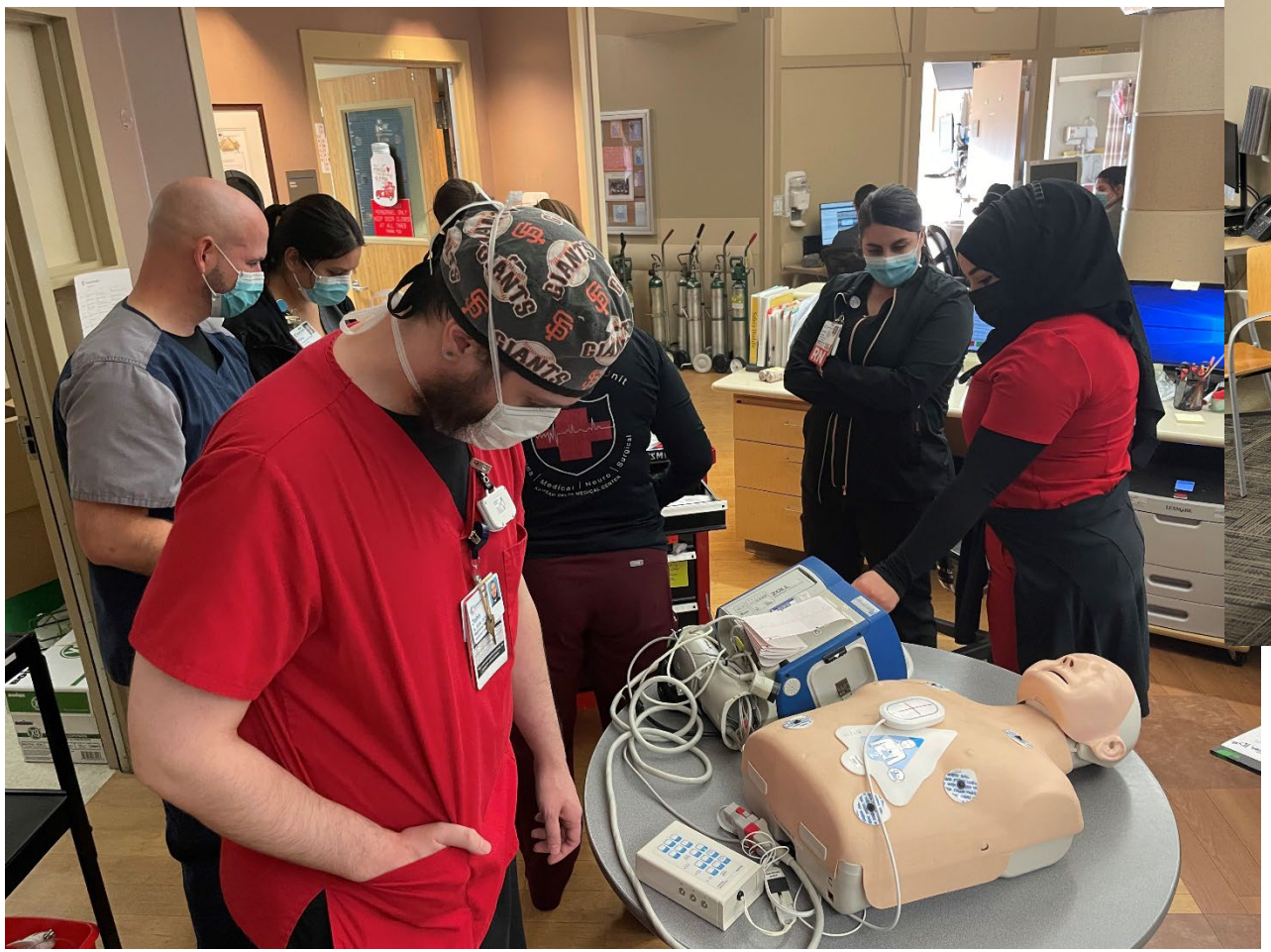
- Recruit and fill Medical Director Position- Vacant since December 2021. In-progress
- Revised code blue form to easily capture all code blue process elements to meet GWTG standards. Approved by Forms Committee and draft approved. Waiting for them to be printed and dispersed. Point person-Shannon. In progress. Go-live: Approx 5/23/22.
- Go-live with use of AED "Analyze" function in code blues. Point person- Shannon. In progress. Go-live: 5/23/22.
- Formalization of non-licensed staff and family activated RRT process. On hold.
- Re-instate Hi-Fidelity mock in-situ code blues. Point Person- Shannon. On hold.
- Review of Redivus Code Blue App for Consistent Documentation and Data collection. Point person- Evan. On hold.
- Advanced Training for TCAR, CALS, IABP, Impella. Complete
- RRT Partners (all RRT nurses have designated partner unit; attend one staff meeting/quarter to provide education and build rapport. Complete.

Education Details

- RRT nurses partnered with all in-house units to build relationships and attend staff meeting once per quarter. Q2 education will relate to AED Analyze Button on Zoll- decreasing time to first defibrillation in cardiac arrests.
  -Subsequent education topics to be standardized based on in-house needs to assure uniformity in educating staff.

- TBTU (Taco 'Bout Training Up) continues quarterly. Q2 topic will be another show on the road to continue to educate on Analyze Feature. Scheduled for June.

- First TCAR (Trauma Care After Resuscitation) Course was taught in-house on May 13th-14th. Next course coming in September! Our goal is to train all ICU and RRT staff.



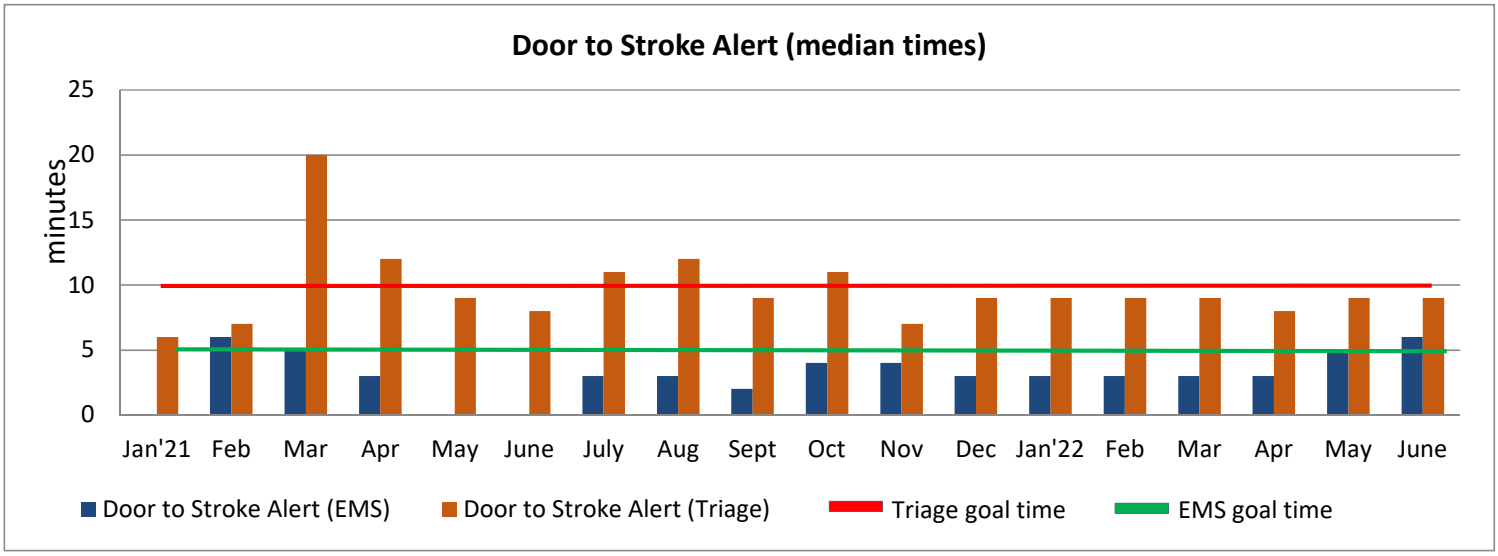
Kaweah Health

Live with passion.

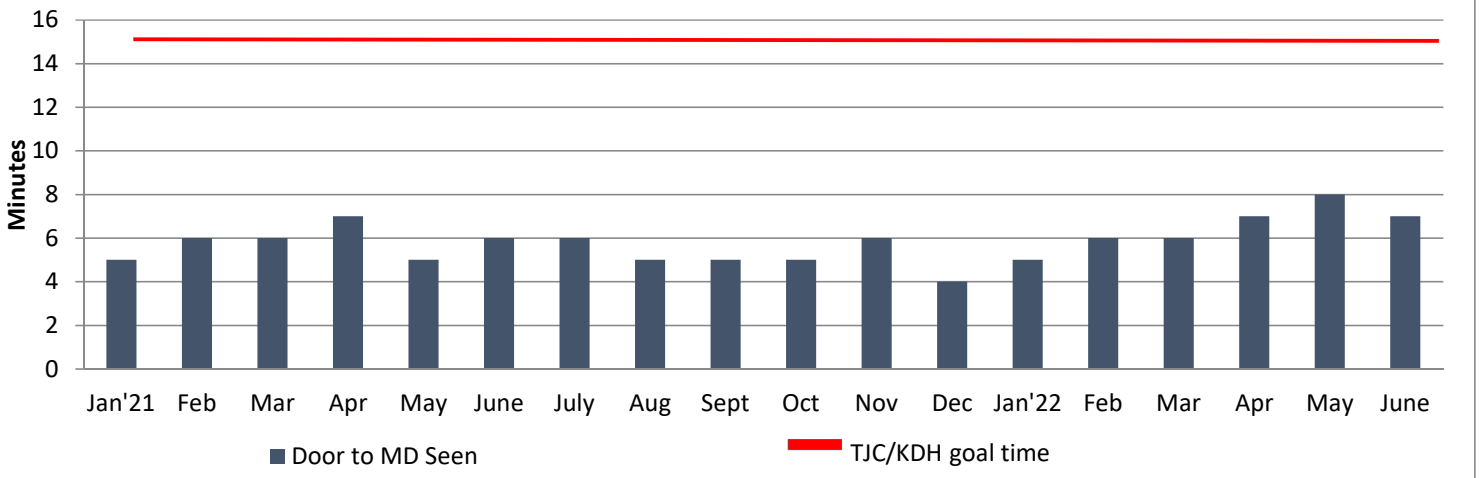
Health is our passion. Excellence is our focus. Compassion is our promise.

Kaweah Health

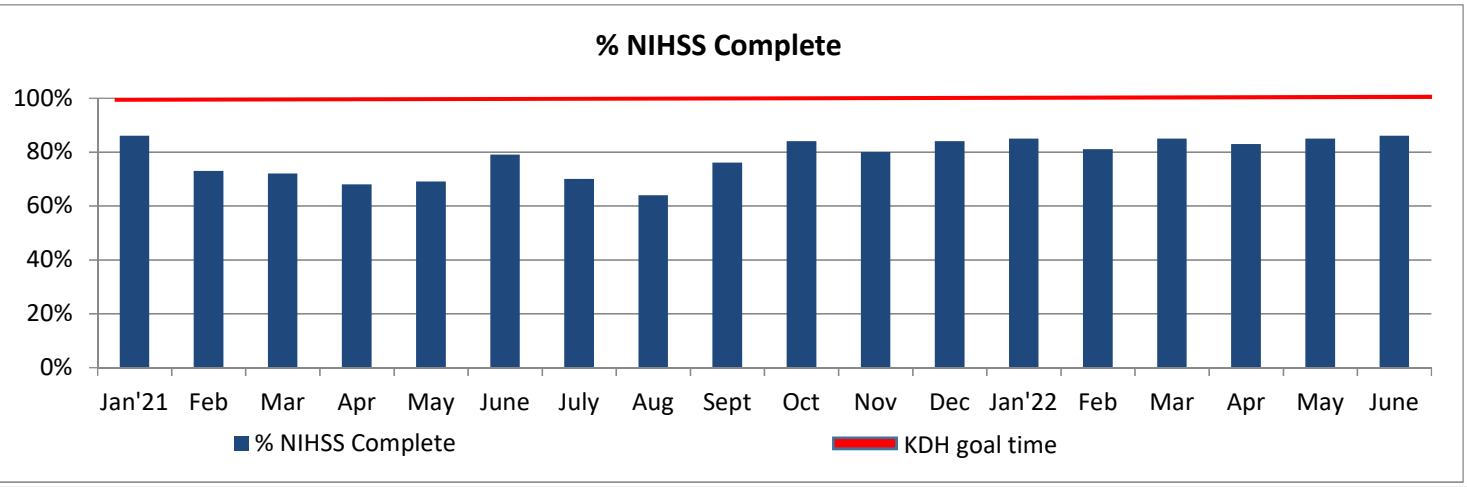
2020-2021 Stroke Alert Dashboard



Per KDH ED Stroke Alert process; stroke alerts to be called within 5 min for EMS and 10 min for Triage. ED Stroke Alert Triage task force convened to look for opportunities for improvement March 2020.

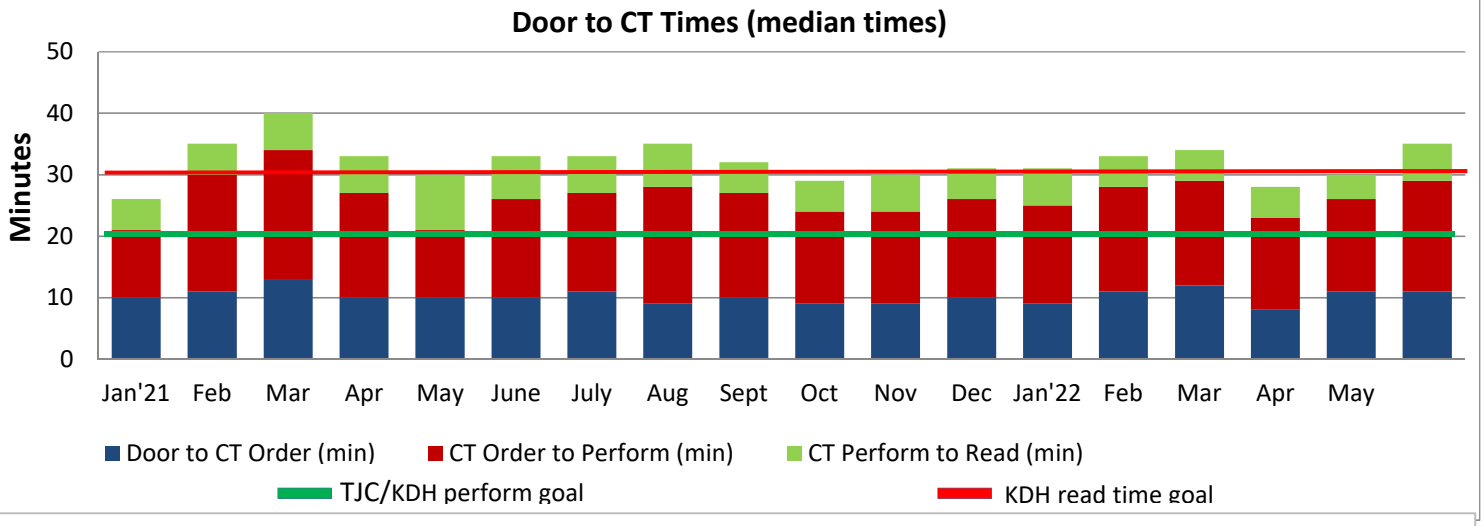


The expectation is that the physician will see the stroke alert patient within 15 minutes of arrival. Improvements made throughout the past year include: early notification from EMS, MD meets the pt at the door upon arrival, scribe documents first seen time in the record.

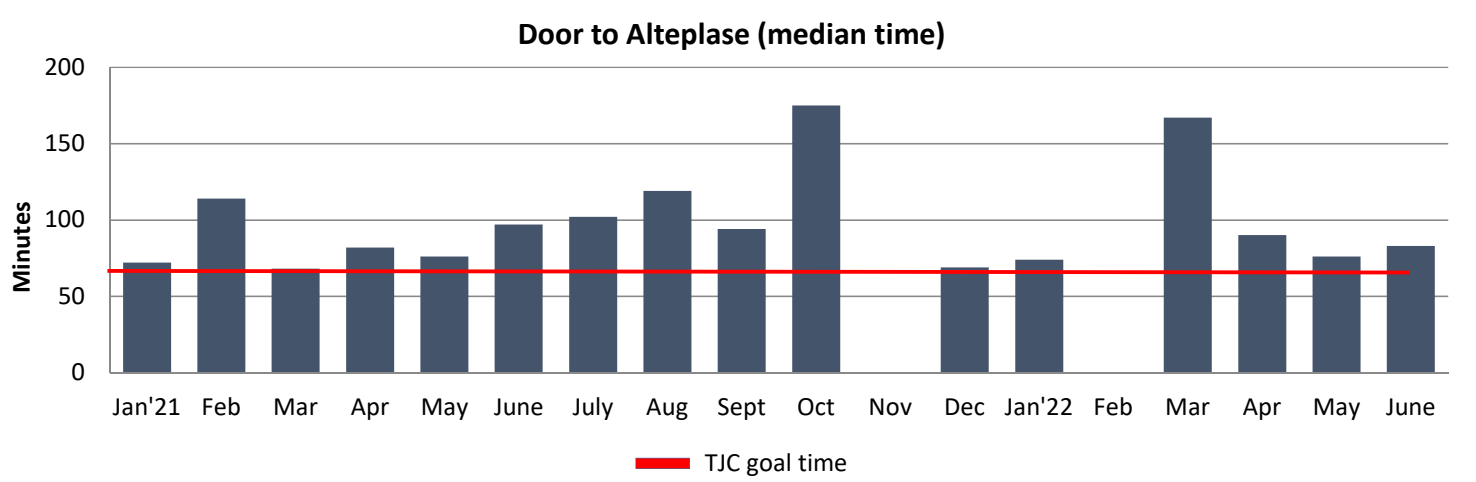


The expectation is that all stroke alert patients will have a NIHSS completed by a certified ED staff member and/or the attending physician; the primary responsible person is the attending/resident physician. This audit ONLY tracks if attending/resident physician have completed a full NIHSS in the ED record.

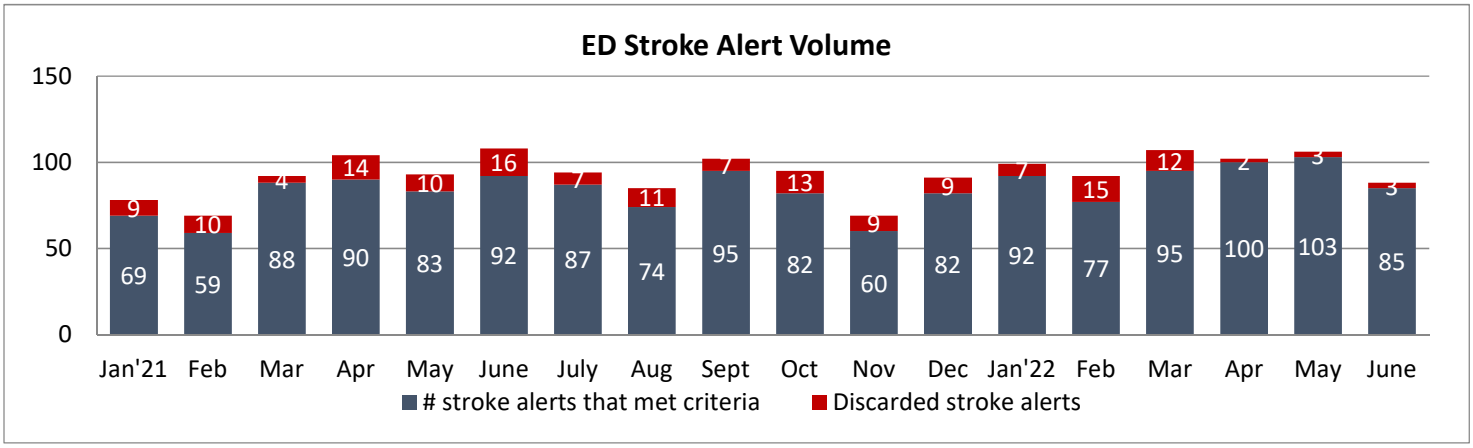
2020-2021 Stroke Alert Dashboard



CMS and TJC expectation is that the CT will be performed by 20 minutes and read by 45 minutes of arrival. KDH's CT read time goal is 30 minutes. Starting 2019; tracking of CT start times will be included in this measurement. start time is define by the first CT images in Synapse. **Feb 2021 removed CT start time metric.



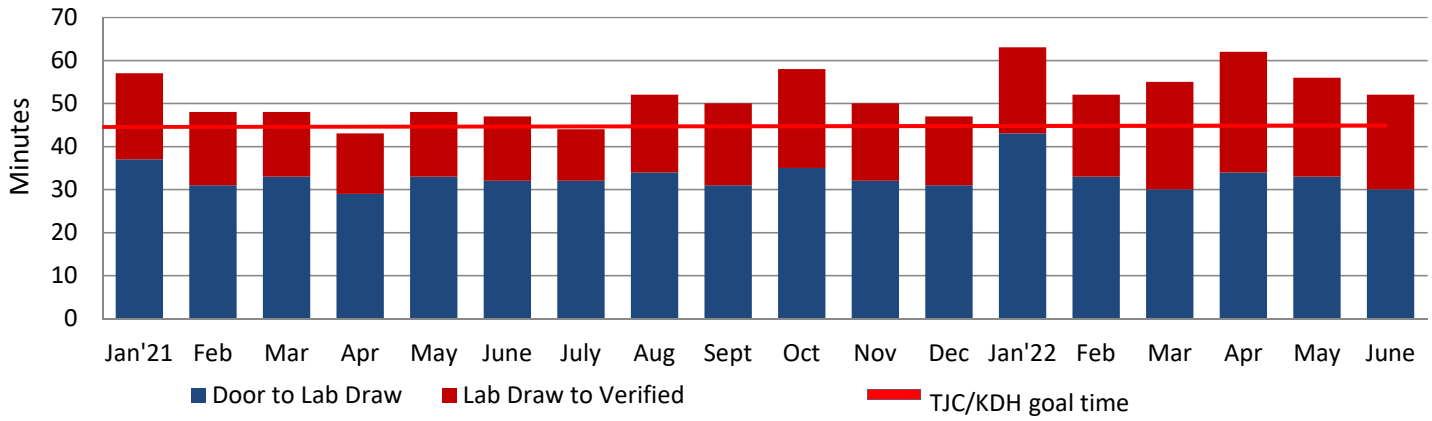
The data in this graph includes all Alteplase patients which differs from the TJC rate because exclusion criteria is not used. TJC expectation is that IV thrombolytics are given within 60 minutes to eligible patients who present for stroke care. AHA/ASA GWTG expectations were update in 2019 with new IV thrombolytic goal time to 45 minutes at least 75% of the time (when applicable). To meet this goal, continued changes to the stroke alert process have been made.



Stroke alert criteria includes: pt presenting with stroke like symptoms +FAST screen, stroke alerts called prior to arrival and up to 1 hour after arrival. Excluded cases: >1 after arrival or if stroke alert was cancelled.

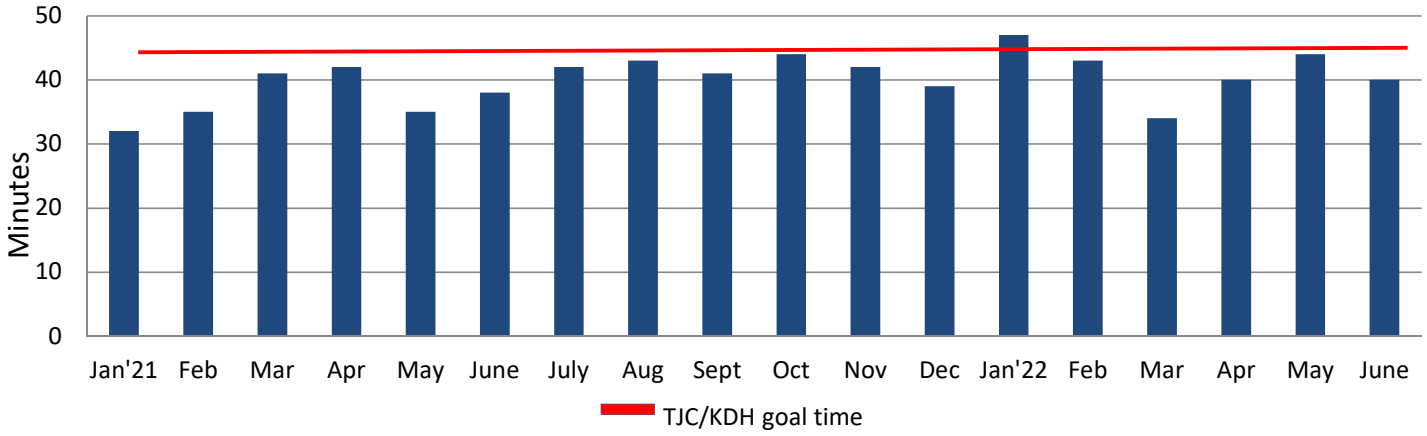
2020-2021 Stroke Alert Dashboard

Door to Lab Time (median times)



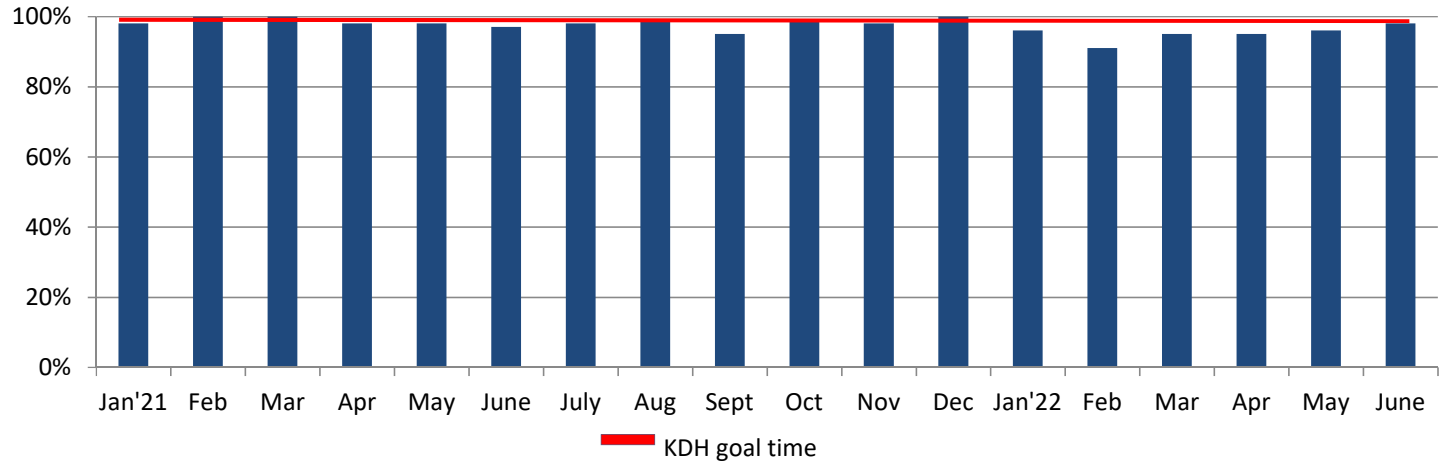
TJC expectation is that laboratory tests are completed within 45 minutes of arrival. Changes in stroke alert process has been made early 2019 to improve lab verified times. Action items taken: IV start kits in CT rooms with lab tubes, lab label makers in both CT rooms and specimens taken immediately down to lab.

Door to EKG Time (median time)



TJC expectation is that EKGs are completed within 45 minutes of arrival.

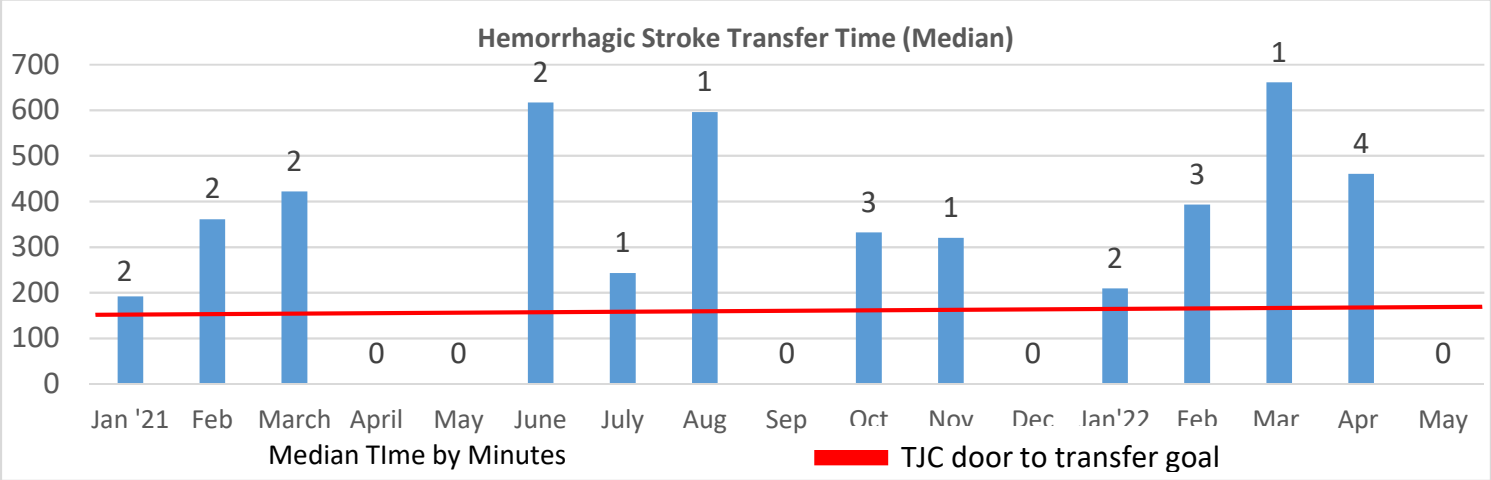
% Dysphagia screen completed when ordered



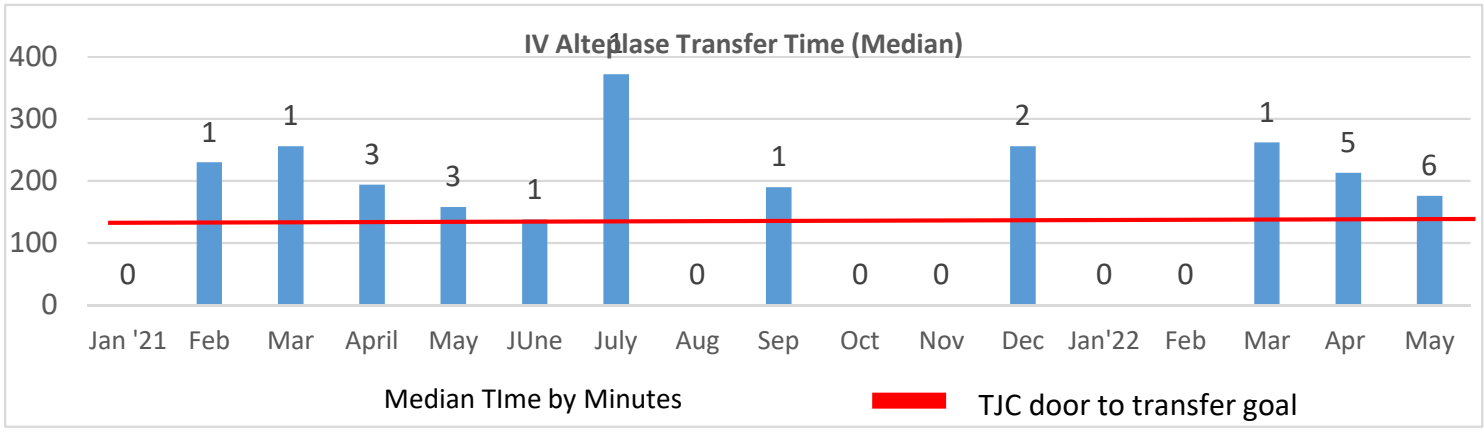
Dysphagia screening should be completed by the RN on all stroke alert patients prior to any po intake, including meds. Dysphagia screening is part of the ED stroke alert order sets. Goal is 100% compliance.

2021-2022 TRANSFERS FROM ED TO ANOTHER ACUTE CARE FACILITY

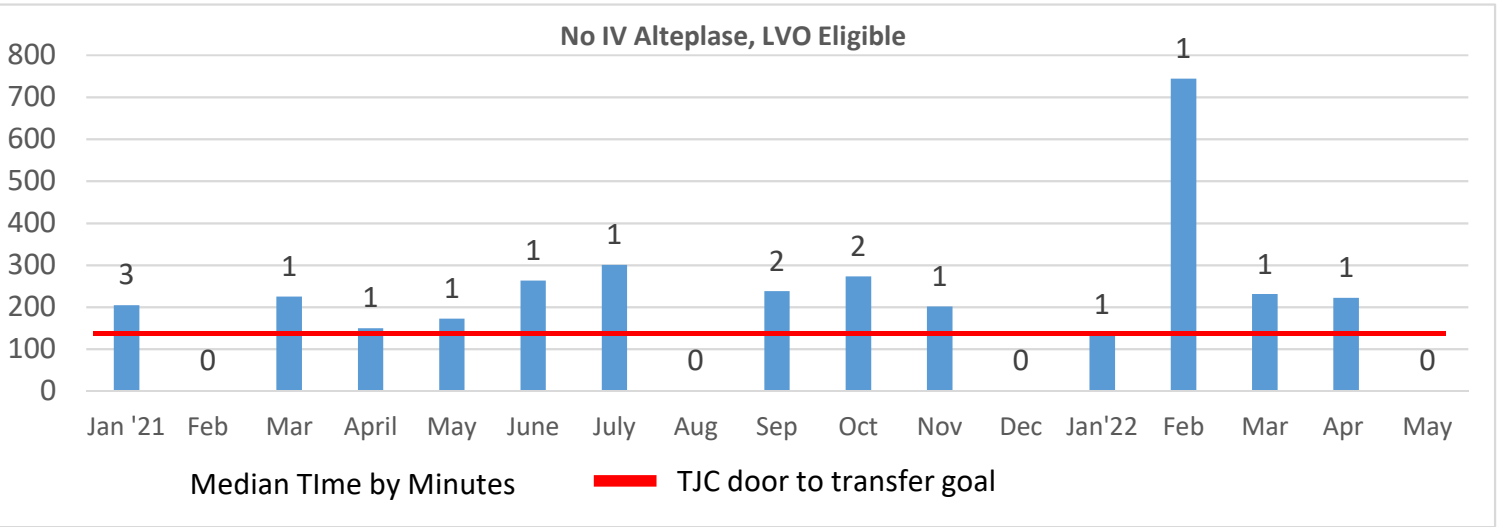
Median Time by Minutes - Goal 120 Minutes



Hemorrhagic patients are transferred out for other procedures not done at KDH, specifically coiling/clipping of aneurysms or bleeds. A task force has been set up to help streamline the process, all action items are captured in PDSA document. The Covid 19 pandemic has caused delays in transfer times due to the additional precautions, resources and screening needed.



Transfers for ischemic strokes occur primarily if a large vessel occlusion is noted and would be eligible for endovascular treatment. As a result of the efforts made by the ED Stroke Alert Committee and the Transfer Process Task Force door to transfer times have improved; however the Covid 19 pandemic has caused delays in transfer times due to the additional precautions, resources, and screening needed in the recent months.



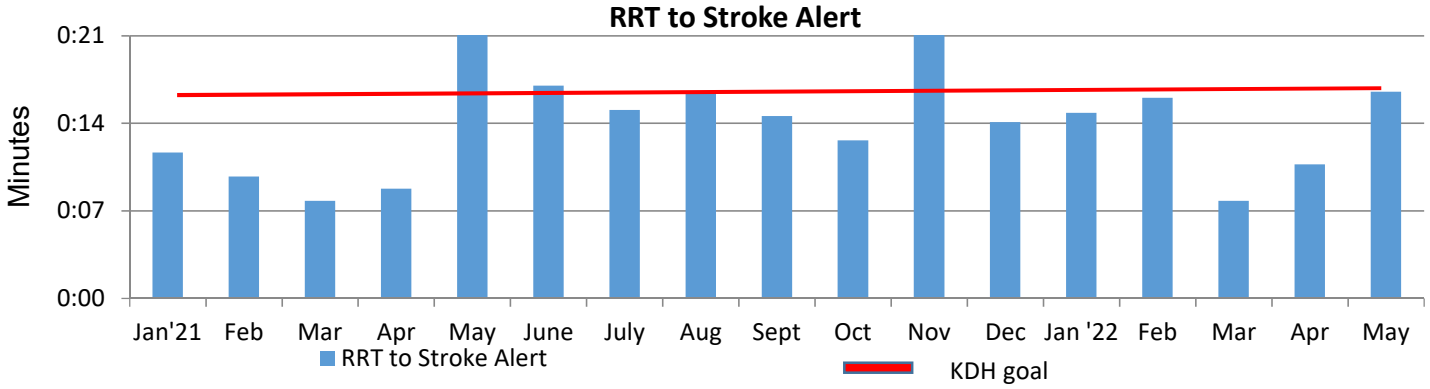
This cohort of patients have a large vessel occlusion that would be eligible for endovascular treatment and do not meet criteria for Alteplase administration. The Covid 19 pandemic has caused delays in transfer times due to the additional precautions, resources and screening needed in the recent months.

2021-2022
In-House Stroke Alert Dashboard

Stroke Alert Location

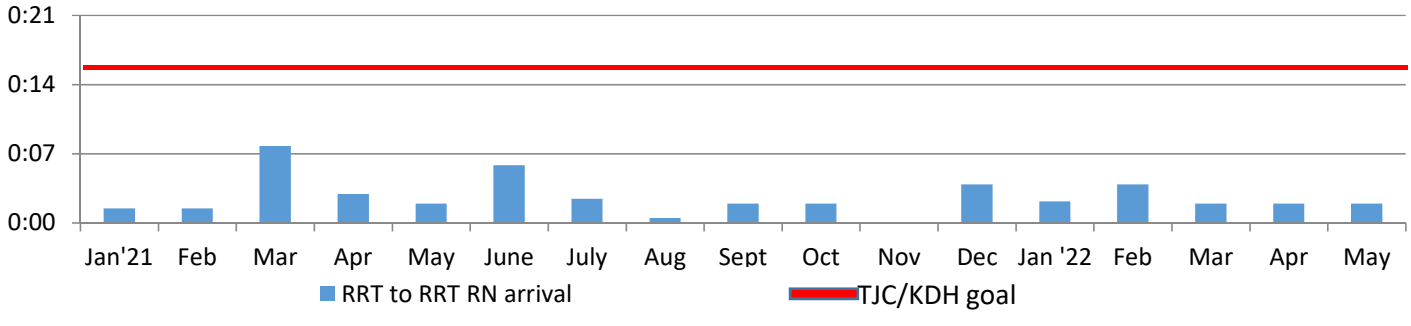
	Jan'21	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan'22	Feb	Mar	Apr	May
3W	4	1	1	3	2	2		1	1	1			1	1	1		
4S	6	2	4	4	1	3	3	2		3	2	2	2	1	4	1	5
2S	1			1	1	3		1			1	1	2		1	1	3
3S				1		1	1	1	1	1	2	1		1			
Cath Lab			1		1										1	1	
CVICU					1	1	1	1		1						2	1
ICU															1		2
4N	1	2		1			3	2	3	3		1		1	2		
3N						1		1	1		1	1	1		1		
4T		1			1	1	2	1						1		1	
PACU					1					1							
2N		1		1					1	2		1		2		1	2
5T	1		1	2	1	1	1	1	1	2	4	1		1	1		
BP																	
1E									1	1			4		1		
MB							1										
CT											1						
Endo										1							
Peds										1							

RRT to Stroke Alert



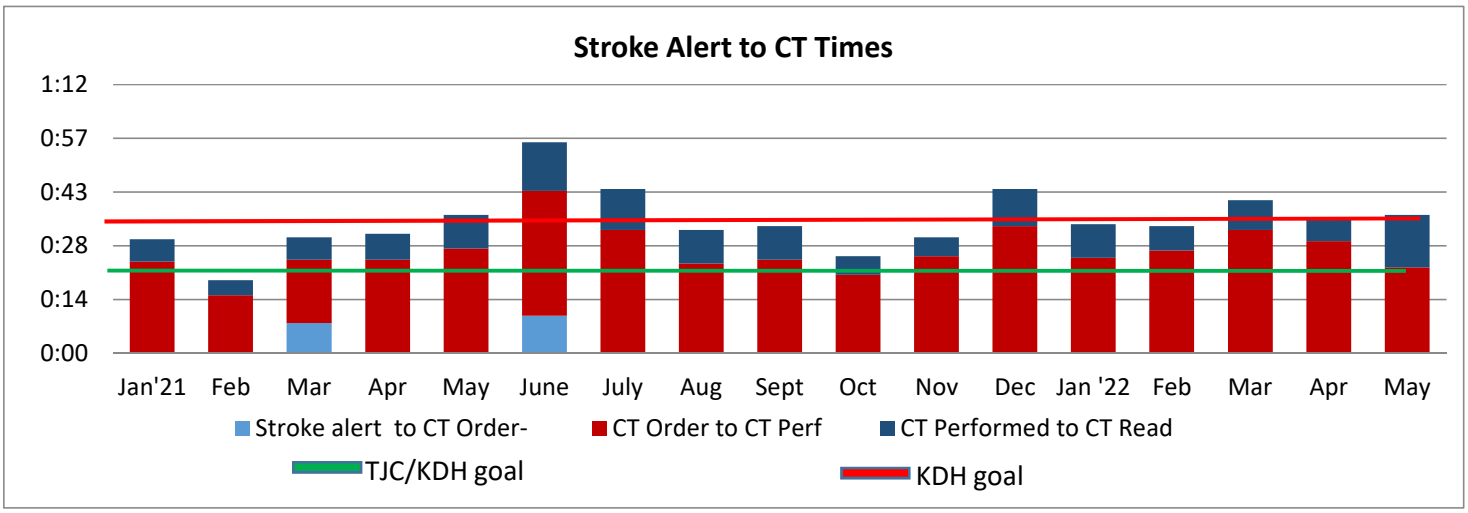
If patients exhibit any new or worsening neuro deficits while in the hospital; RNs are to call an RRT. The RRT RN will evaluate and determine if a stroke alert should be called. The goal from calling RRT to stroke alerts should be <15 minutes.

RRT to RRT RN arrival

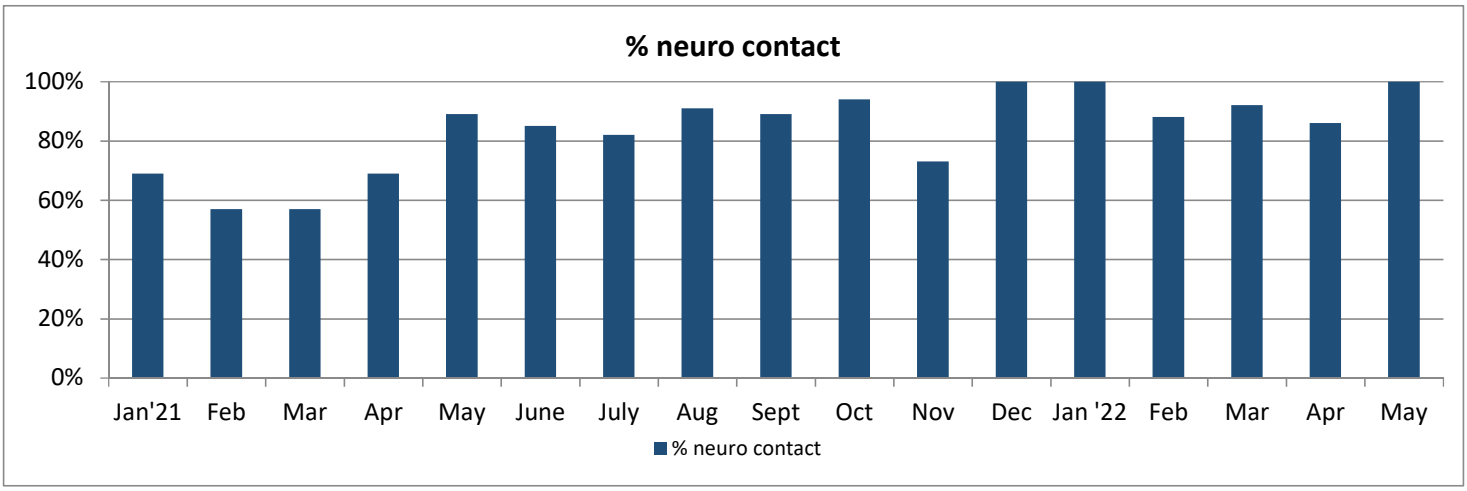


TJC expectation is that a designated provider is at the bedside within 15 minutes of stroke alert. KDH has designated the RRT RN as the provider for in-house stroke alerts.

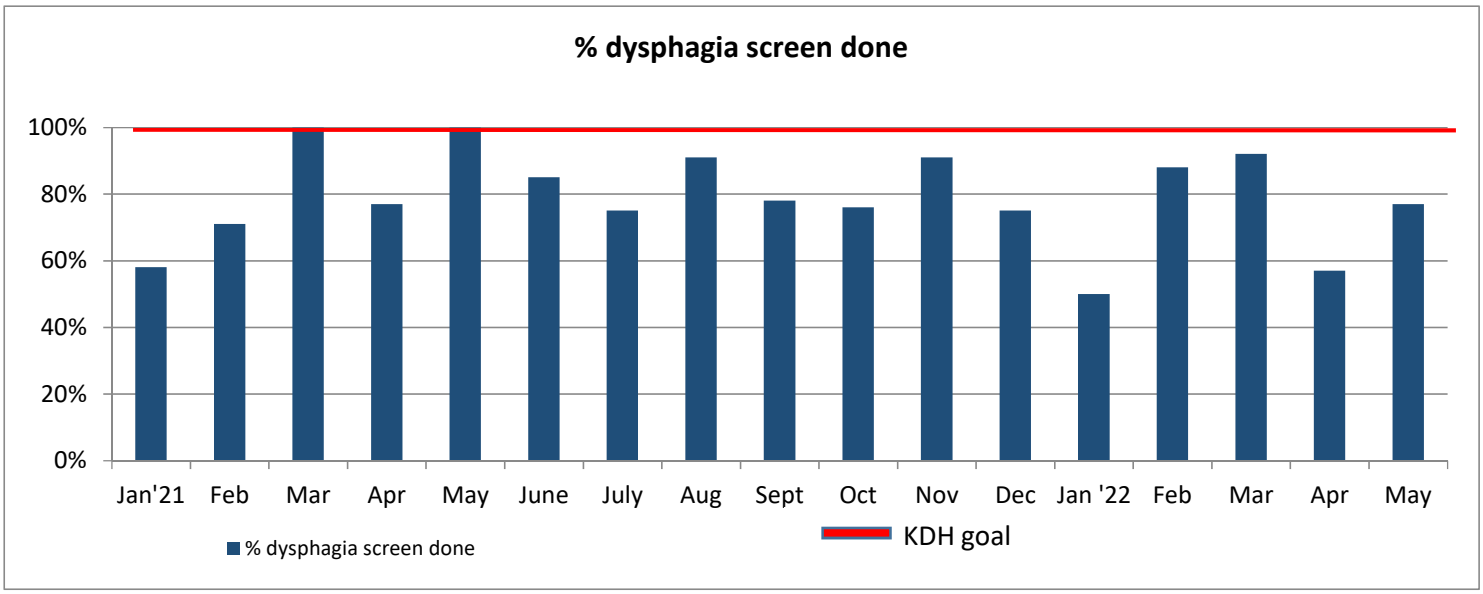
2021-2022
In-House Stroke Alert Dashboard



TJC expectation is that the CT will be read within 45 minutes of arrival. KDH's goal is 30 minutes **(red line).** TJC added a new metric in 2018; the expectation is that the CT will be performed within 20 minutes of alert **(green line).**



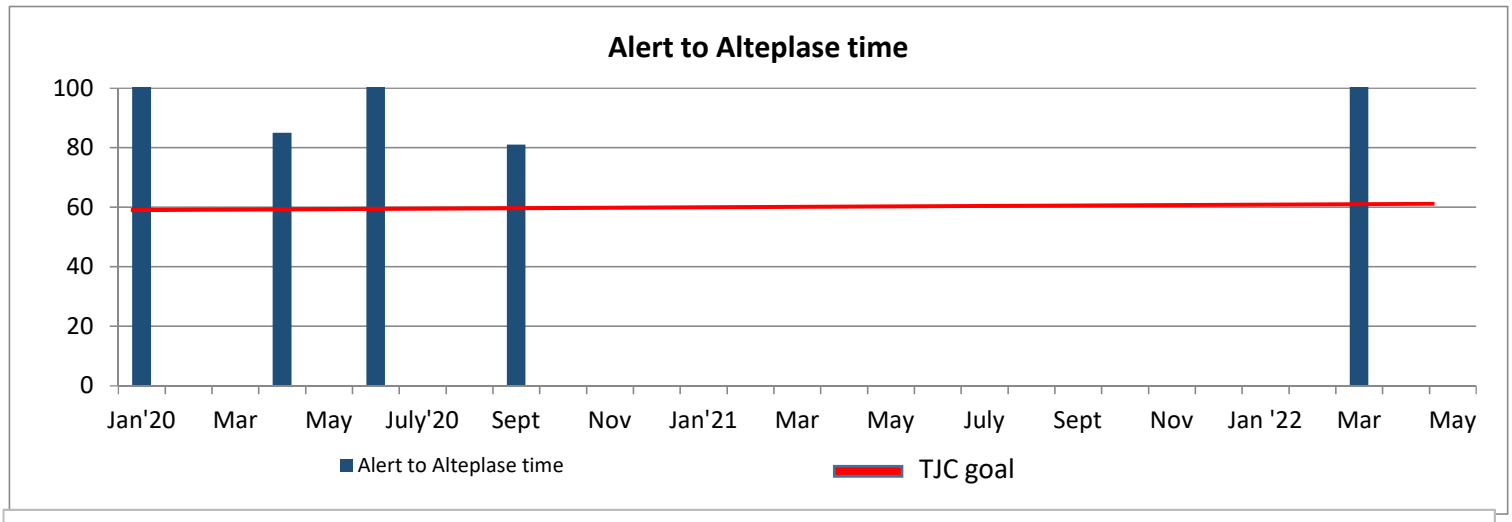
Neurology consultation should occur on all in-house stroke alerts.



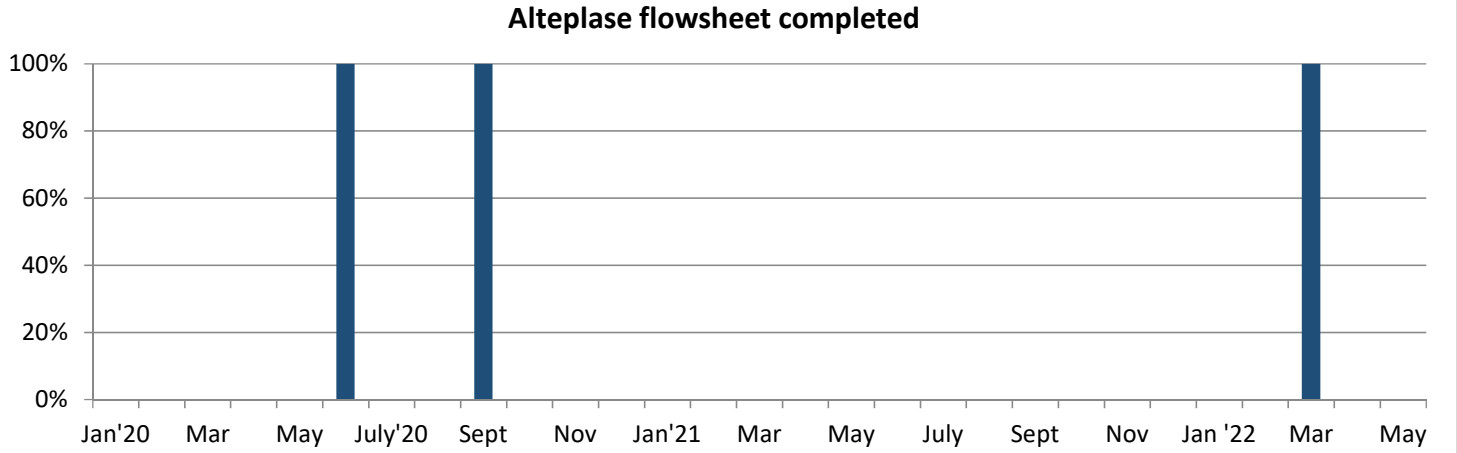
Whenever there are new or worsening neurological deficits ≥3 points, the RN should perform a dysphagia screen to evaluate the patient's ability to swallow.

2021-2022

In-House Stroke Alert Dashboard



ED Patients: TJC expectation is that IV thrombolytics are given within 60 minutes to eligible patients who present for stroke care at least 50% of the time. In-House Stroke alerts: KDH expectation is that IV thrombolytics are given within 60 minutes to eligible patients who have been identified with new or worsening stroke symptoms. In-house alteplase administration rarely occurs; however it is tracked to ensure compliance throughout the continuum of care.



KDH expectation is that post Alteplase monitoring is in compliance with our standardized protocol. All key elements must be completed to be determined as compliant.

Stroke Program Dashboard 2021-2022

	Bench-marks	2020 Total	Jan'21	Feb	Mar	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan'22	Feb	Mar	Apr
Grouping of Stroke Patients																		
Ischemic		381	34	33	32	36	39	37	33	38	37	35	22	33	36	25	33	43
Hemorrhagic		78	5	12	8	5	9	12	7	7	8	3	8	9	4	6	7	14
TIA (in-patient and observation)		281	18	18	26	19	20	16	19	14	17	19	18	17	13	15	26	20
Transfers to Higher Level of Care (Ischemic)		35	3	1	2	4	4	2	2	0	3	2	1	2	1	1	2	1
Transfers to Higher Level of Care (Hemorrhagic)		24	2	2	2	0	0	2	1	1	0	3	1	0	2	3	1	4
TOTAL NUMBER OF PATIENTS		795	62	66	70	64	72	69	62	60	65	62	50	61	56	50	69	82
Total # of Pts who rec'd Alteplase (Admitted/Transferred)		44	1	2	1	5	7	5	3	3	7	2	0	4	4	0	4	3
% of Alteplase - Inpatient & Transfers		10%	3%	6%	3%	13%	16%	13%	9%	8%	18%	5%	0%	11%	11%	0%	11%	9%
% Appropriate vital sign monitoring post Alteplase	90%	81%	100%	100%	100%	80%	100%	100%	100%	66%	63%	0%	NA	100%	100%	100%	25%	100%
Rate of hemorrhagic complications for Alteplase pts	0%	0%	0%	0%	0%	0%	14%	0%	33%	0%	29%	0%	NA	0%	0%	NA	0%	0%
Core Measure: OP-23 Head CT/MRI Results	72%	70%	NA	100%	100%	100%	67%	50%	67%	NA	100%	100%	50%	50%	100%	NA	67%	100%
% Appropriate stroke order set used (In-Patient)	90%	95%	93%	96%	95%	90%	88%	87%	97%	94%	92%	91%	89%	91%	96%	97%	96%	94%
% Appropriate stroke order set used (ED)	90%	90%	86%	88%	86%	91%	92%	88%	95%	83%	95%	78%	77%	84%	90%	80%	83%	91%
STK-1 VTE (GWTG, TJC)	85%	93%	89%	92%	91%	90%	95%	70%	83%	91%	88%	88%	95%	85%	79%	88%	100%	89%
STK-2 Discharged on Antithrombotic (GWTG, TJC)	85%	99%	100%	97%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
STK-3 Anticoag for afib/aflutter ordered at Dc (GWTG, TJC)	85%	95%	100%	100%	NA	50%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
STK-4 Alteplase Given within 60 min (GWTG, TJC)	75%	93%	NA	NA	NA	100%	100%	100%	NA	NA	67%	NA	NA	NA	100%	0%	NA	NA
STK-5 Early Antithrombotics by end of day 2 (GWTG, TJC)	85%	97%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
STK-6 Discharged on Statin (GWTG, TJC)	85%	99%	90%	94%	100%	100%	100%	100%	100%	97%	93%	96%	100%	100%	100%	100%	100%	100%
STK-8 Stroke Education (GWTG, TJC)	75%	95%	95%	97%	100%	100%	94%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
STK-10 Assessed for Rehab (GWTG, TJC)	75%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	96%	100%	100%	100%	100%	100%
% Dysphagia Screen prior to po intake (GWTG)	75%	87%	78%	90%	88%	71%	90%	88%	89%	94%	91%	77%	88%	83%	84%	83%	88%	87%
% Smoking Cessation (GWTG)	85%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
% LDL Documented (GWTG)	75%	93%	100%	100%	100%	100%	100%	100%	100%	100%	98%	94%	96%	100%	100%	100%	100%	100%
Intensive Statin Therapy (GWTG)	75%	92%	90%	94%	100%	100%	88%	100%	100%	97%	93%	94%	96%	100%	97%	96%	100%	97%
% tPA Arrive by 3.5 Hrs; Treat by 4.5 Hrs (GWTG)	75%	97%	100%	NA	100%	100%	100%	100%	100%	NA	100%	NA	NA	100%	100%	NA	100%	100%
% NIHSS Reported (GWTG)	75%	96%	100%	100%	90%	100%	100%	97%	95%	97%	97%	97%	96%	100%	97%	96%	97%	97%
Ischemic ALOS/GMLOS excess	<1.0	1.46	1.9	2.76	3.63	0.75	1.43	2.3	1.13	2.06	2.2	3.06	0.97	2.87	3.43	8.74	2.49	4.69
Hemorrhagic ALOS/GMLOS excess	<1.0	2.99	3.46	3.05	11.17	1.12	6.2	2.26	0.58	-1.26	3.33	2.1	0.77	11.84	3.43	23.45	8.39	5.61
Ischemic Mortality ACA O/E Ratio (Midas)	<1.0	0.88	1.4	1.6	0	1.4	1.3	1.4	2.4	1.6	0	3.1	0	0	1.3	0	0.8	0.5

Catheter Associated Urinary Tract Infection (CAUTI) Quality Focus Team Report July 2022

Kari Knudsen, Director of Post-Surgical Care (Chair)
Alisha Sandidge, Advanced Practice Nurse (Co-Chair)

CAUTI- FY22 Goals

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

Lower is Better	July 2021	Aug 2021	Sept 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	June 2022	Estimated Annual Number Not to Exceed to Achieve Goal*	FYTD SIR** (number of actual/ number expected)	FY22 Goal	FY21 FY20
CAUTI Catheter Associated Urinary Tract Infection COVID-19 PATIENTS	1 0	3 1	5 5	2 0	2 1	1 0	3 1	3 2	2 0	1 0			16 (12 predicted over 6 months)	1.66 0.66 Excluding COVID (Feb 2022)	≤0.676	0.54 1.12

*based on July-Dec 2021 NHSN predicted

**Standardized Infection Ratio is the number of patients who acquired one of these infections while in the hospital divided by the number of patients who were expected.

Kaizen Root Cause

Analysis:

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

1. Communication
2. Leadership Standard Work
3. Peri-care/Bathing
4. Prompt Catheter Removal
5. Culture Ordering
6. Retention Management
7. Staff Consistency with prevention bundle
8. Alternatives to Catheter Insertion

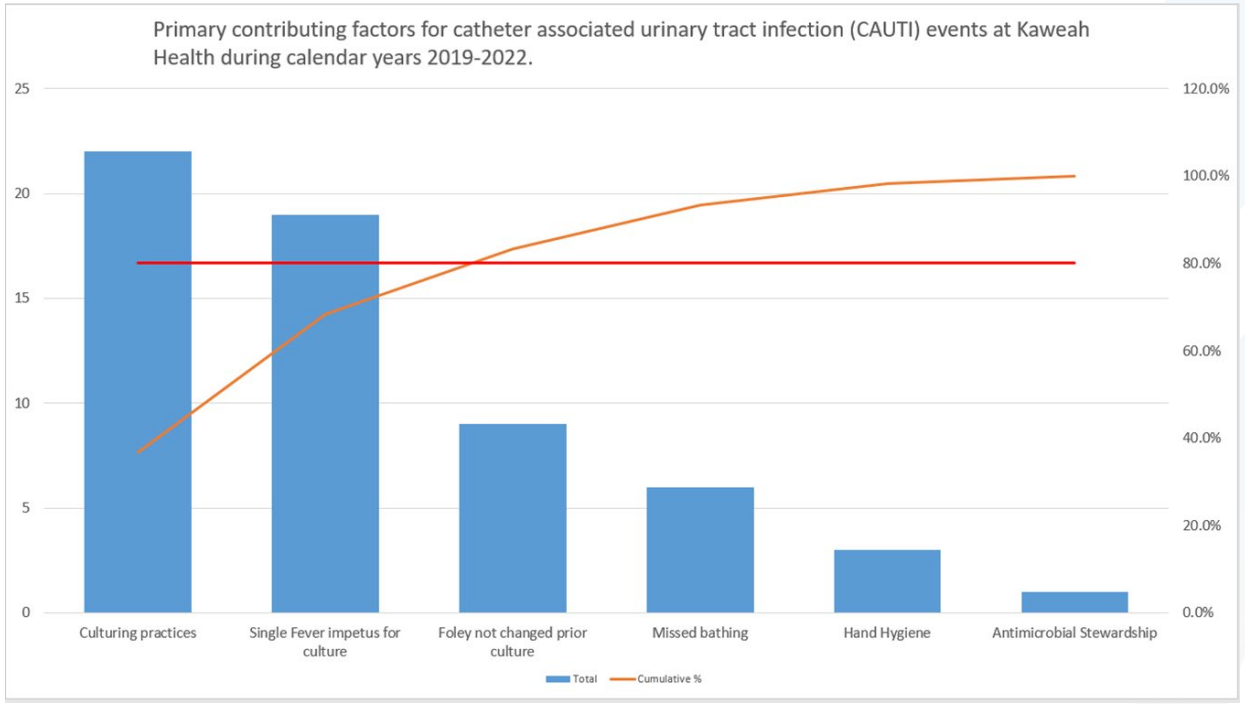
Kaizen improvement strategies focused on addressing the top 4 root causes

Initial KAIZEN initiatives focused on the top **4** root causes

Since April 2020 we have incorporated strategies to address **7** of the root causes, including:
Culture ordering
Retention Management
Alternatives to Catheter Insertion

Kaweah Health

Root Cause Pareto



Calendar years 19-22

- 22 CAUTI related to culturing practices
- 19 CAUTI with single fever impetus for culture
- 9 CAUTI related to IUC not changed prior to culture

- FY 22: 54% CAUTI events a second culture was ordered within 24 hours of urine culture = pan culturing

Kaweah Health

Post KAIZEN-Gemba Data

CAUTI Committee Dashboard																	
Measure Description	**Benchmark/ Target**	**Mar-20**	**Qtr 2 2020**	**Qtr 3 2020**	**Qtr 4 2020**	**Qtr 1 2021**	**Qtr 2 2021**	**Jul-21**	**Aug-21**	**Sep-21**	**Oct-21**	**Nov-21**	**Dec-21**	**Jan-22**	**Feb-22**	**Mar-22**	**Apr-22**
OUTCOME MEASURES																	
Number of CAUTI	0	0	4	2	3	1	3	1	3	5	2	2	1	3	3	2	1
FYTD SIR	≤0.676							0.569			1.436	1.319	1.177	1.22	1.24	1.22	1.17
PROCESS MEASURES IUC Gemba																	
% of pts with appropriate cleanliness	99%	98%	97%	97%	99%(e)	99%	99%(e)	98%			95%	100%	99%	99%	99%	N/A	99%
% of pts with order present with indication	100%	90%	93%	92%	95%(e)	93%	93%(e)	94%			96%	97%	95%	98%	96%	N/A	89%
% of IUCs where removal was attempted	n/a	8%	6%	6%	4%(e)	4%	4%(e)	6%			3%	3%	7%	27%	26%	N/A	4%
% of pts where alternatives have been attempted	n/a	15%	11%	11%	9%(e)	10%	10%(e)	15%			8%	7%	11%	19%	9%	N/A	10%
# of Pt Catheter days rounded on	n/a	616	2545	3280	2093	2757	1879	1045			1068	902	874	802	931	N/A	1169
% of IUCs removed because of Gemba Round	n/a	7%	4%	4%	5%(e)	6%	6%(e)	6%			4%	5%	7%	6%	4%	N/A	6%
# of IUCs removed because of Gemba Round	n/a	46	110	142	104	152	94	43			43	49	64	48	37	N/A	63
*volume reduced due to reduced Gemba on weekends **FYTD includes cases removed in Mar 2021 *e=estimated		Equal or Better than Target						Within 5% of Target				Does not meet Target					

FY22

Total Catheter days rounded on = **6791**

99% of patients with daily bath and peri-care each shift

89% have order and valid rationale

347 catheters removed as a result of the Gemba

Kaweah Health

CAUTI QFT – Key Strategies

- "Culture of Culturing"
  - "Pan Culture" rates
  - Quantify volume of cultures ordered when a previous culture was ordered within 48-72 hrs
  - Reviewed data set and results with hospitalists Jan 2022
  - Case review of all CAUTI since July were pan culturing suspected by resident MD and NP complete
- Final SonoSite Bladder scanners purchased- each unit has a state of the art ultrasound machine to scan the bladder ~ thank you Foundation!
- Versette (female external catheter) trial underway
- Men's Liberty Acute (male external catheter) product roll out underway

Live with passion.

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

Kaweah Health

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

Unit/Department: CAUTI QFT **ProStaff/QIC Report Date:** 7/12/2022

Measure Objective/Goal:

- Goal for FY22 ≤ 0.676 (CMS 50th percentile); **Current SIR = 1.66**
- Pre KAIZEN baseline SIR is 1.557
- SIR is as of April 2022; Actual CAUTI FY22 is 24

CAUTIs result in poor outcomes for patients, a negative public perception of care through publically reported safety scores and financially impact the organization through HAC and VBP programs as well as increased treatment costs and LOS.

Date range of data evaluated: FYTD SIR (7/2021 – 4/2022)

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

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

CAUTI Committee Dashboard

Measure Description	Benchmark/ Target	Mar-20	Qtr 2 2020	Qtr 3 2020	Qtr 4 2020	Qtr 1 2021	Qtr 2 2021	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
OUTCOME MEASURES																	
Number of CAUTI	0	0	4	2	3	1	3	1	3	5	2	2	1	3	3	2	1
FYTD SIR	≤0.676							0.569			1.436	1.319	1.177	1.22	1.24	1.22	1.17
PROCESS MEASURES IUC Gemba																	
% of pts with appropriate cleanliness	99%	98%	97%	97%	99%(e)	99%	99%(e)	98%			95%	100%	99%	99%	99%	N/A	99%
% of pts with order present with indication	100%	90%	93%	92%	95%(e)	93%	93%(e)	94%			96%	97%	95%	98%	96%	N/A	89%
% of IUCs where removal was attempted	n/a	8%	6%	6%	4%(e)	4%	4%(e)	6%			3%	3%	7%	27%	26%	N/A	4%
% of pts where alternatives have been attempted	n/a	15%	11%	11%	9%(e)	10%	10%(e)	15%			8%	7%	11%	19%	9%	N/A	10%
# of Pt Catheter days rounded on	n/a	616	2545	3280	2093	2757	1879	1045			1068	902	874	802	931	N/A	1169
% of IUCs removed because of Gemba Round	n/a	7%	4%	4%	5%(e)	6%	6%(e)	6%			4%	5%	7%	6%	4%	N/A	6%
# of IUCs removed because of Gemba Round	n/a	46	110	142	104	152	94	43			43	49	64	48	37	N/A	63
*volume reduced due to reduced Gemba on weekends **FYTD includes cases removed in Mar 2021 *e=estimated		Equal or Better than Target						Within 5% of Target				Does not meet Target					

FY 22 Total Catheter Days rounded on = 6791

99% of patients with daily bath and peri-care per shift

89% with order and valid rationale

347 catheters removed as a result of the Gemba

Opportunities:

- Accurate, timely and clinically indicated cultures; reduce pan-culturing practices
- Appropriate indications for IUC, reduction in IUC use; using alternatives to IUC
- Learning from Fallouts

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

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

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

CAUTI QUALITY IMPROVEMENT STRATEGIES	STATUS
1. Adding sticker to IUC GOAL: Visual reminder to replace IUC prior to specimen collection after 72 hours to reduce false positives from biofilm	Go live in May 2022
2. Fever Indication for Culture Task Force: CAUTI/CLABSI medical case review complete for all events this FY where pan culturing present, data synthesis pending; Data presentation for intensivist group	In progress
3. ICU Forum- follow up to action plan implementation	In progress
4. Create Gemba rounds, daily M-F on every patient with a urinary catheter	3/2020
5. Create change IUC task at 30 days following documented insertion GOAL- trigger nursing staff to change chronically retained IUC	12/23/20
6. Hide single Insert IUC orderable for downtown campus and Rehab GOAL: Improve bundle compliance by driving use of the insert IUC Powerplan which contains needed maintenance elements	10/27/20
7. Kaizen strategy: evaluate option for time clock for line info GOAL- Improve prompt removal, visual reminder of how long the line has been in place	11/24/2020
8. CAUTI Case Reviews Lessons Learned GOAL – Reduce CAUTI by ensuring identified opportunities are addressed globally	On-going
9. Bathing Prioritization (in collaboration with CLABSI Committee) GOAL – Improve bathing/peri-care of IUC patients	10/27/20
10. Add 'restricted use' to the urine culture only orderable GOAL- reduce use of culture only order in defined populations without accompanying UA	7/28/20
11. Develop insert IUC Powerplan to include important maintenance elements: straight cath option prior to IUC insertion, change IUC prior to specimen collection, change IUC at 30 days GOAL- Create and bundle essential orders for IUC maintenance	8/25/20
12. Develop provider update/education related to current CAUTI status and how to order IUC/Culturing awareness GOAL- create awareness	9/29/20
13. Changes to discontinue IUC orderable- alerts RN to dc the insert IUC Powerplan and related maintain order GOAL- assist with order clean up	8/25/20
14. Develop orders for Adult Urinary Retention management GOAL- orders for retention management currently exist as one off options, bundling them together for ease of ordering increases use	9/29/20
15. Place all IUC order resources on eCoach GOAL- Increase IUC appropriateness/ prompt removal, bundle compliance (improving ease of access for providers and nursing staff)	2/16/21
16. Develop Urine Culture only powerplan to replace single orderable. GOAL- Reduce CAUTI events related to culture ordering by guiding intentional use of this risky order	2/23/21
17. Add 3-way catheter as trigger to device list GOAL- accurate collection of device count	4/22/21
18. Safety Summit (CAUTI education for new hires) relaunch post-COVID GOAL – Improve/sustain RN bundle compliance	6/22/21
19. Changes to the discontinue order- alert will prompt the provider to order retention management order GOAL- provides orders for nursing to manage post IUC DC retention	5/25/21
20. Kari will discuss CN "review" of culture orders before obtaining specimen at PPC for input, bring back to QFT	3/22/21
21. Medline urology assessment	5/25/21
22. Powerchart changes- IUC dynamic group for POA include present on transfer from OR/procedure GOAL- capture device list for lines already in place	7/21/22
23. Embed IUC insert power plan in existing Powerplans where the insert IUC order exists	10/25/21

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

GOAL – Improve IUC order appropriateness and bundle compliance with increased use of Powerplan which contains needed IUC maintenance elements	
24. IUC inserted in OR/procedural areas- no insert order = no maintain order = no reason for insertion. Create maintain subphase and insert in existing appropriate powerplans. GOAL: Functional efficiencies to require rationale of IUC.	10/25/21
25. Resident Notifications of near misses and events GOAL: Resident request for awareness and learning opportunities.	11/23/21
26. Mandatory CBL Resident education On-going monitoring	5/25/21
27. Letter for providers on events (like CLABSI) GOAL: Provider awareness of HAI.	3/19/22
28. Rapid Cycle Post Gemba Rounds 29. GOAL – reduce IUC utilization, verify completion of follow up	11/23/21
30. Primofit & Medline External Male Catheter Product Trial GOAL: Reliable method for male external alternative to IUC	3/19/22
31. SonoSite Bladder Scanner conversion	3/19/22
32. On-going attempts to do in person Resident education	8/23/21
33. ICU Forum	1/24/22
34. Add number of attempts for IUC insertion, Policy no more than 2 attempts.	1/24/22
35. Medline Urology product line conversion	3/22/22

*QI strategies colored green indicate completed; yellow indicates in process strategies

Next Steps/Recommendations/Outcomes:

A. Continue to maintain Kaizen initiatives: Daily IUC Gemba rounds, data collection, and dissemination and QI strategy development.
B. Continue to monitor CAUTI events, reviewed with unit leadership at the HAI review meeting, unit leadership creates quality improvement plan and implements at the unit level. The QFT monitors QI opportunities for global implementation
C. Continue to address culturing practices in newly revised Fever as an Indication for Culture Taskforce with medical staff partnership

Submitted by Name: Kari Knudsen **Date Submitted:** 6/23/2022

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

Centers for Medicare & Medicaid Services (CMS) Star Ratings

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

Quality Council
July 2022

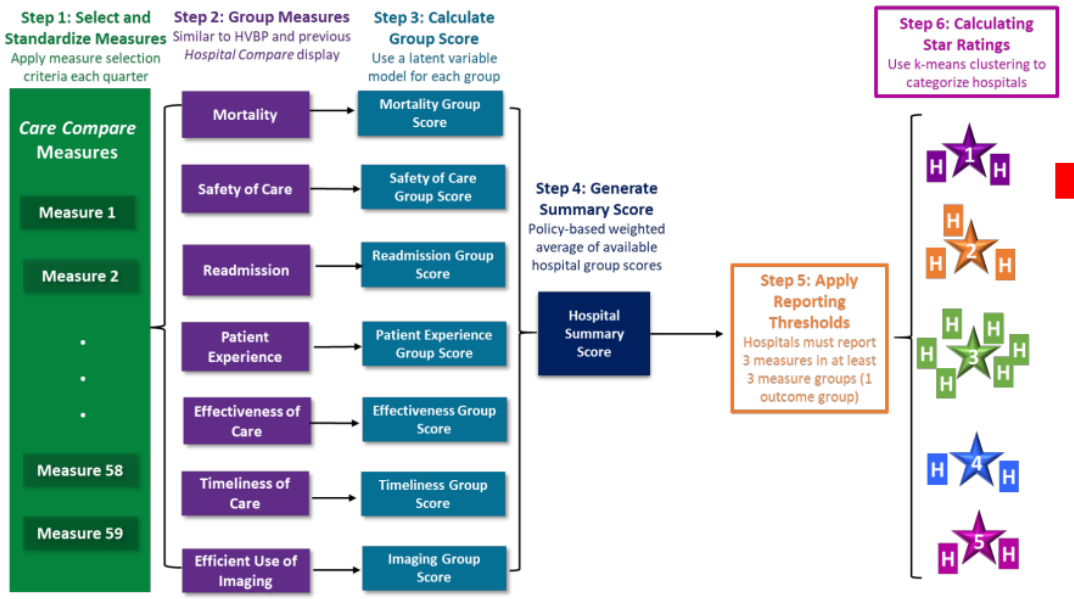
Acronyms

- AMI - Acute Myocardial Infarction
- CABG – Coronary Artery Bypass Graft (ie. open heart surgery)
- CMS - Centers for Medicare & Medicaid Services
- COPD - Chronic Obstructive Pulmonary Disease
- EDAC – Excess Days in Acute Care
- ED – Emergency Department
- EKG – electrocardiogram
- HAI – Healthcare Acquired Infection
- HCOMP - Hospital Consumer Assessment of Healthcare Providers and Systems (CMS survey of patient experience
- HF – Heart Failure
- MRSA - Methicillin-resistant Staphylococcus Aureus
- PC – Perinatal Care Core Measure
- PN – Pneumonia
- OP - Out Patient
- PSI – Patient Safety Indicator
- READM - Readmission
- SD – Standard Deviation
- V - Version

Methodology Changes

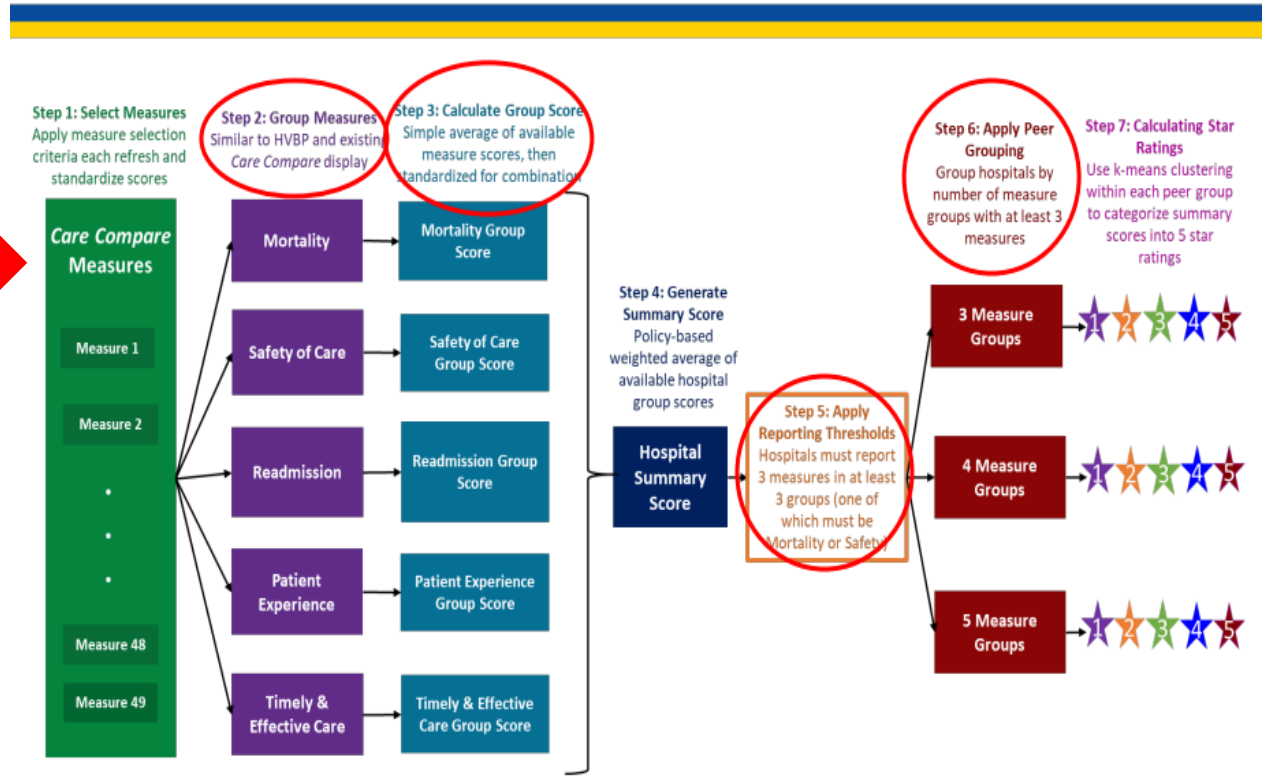
2020 and Previous Releases

Prior Overall Star Rating Methodology (v3.0)



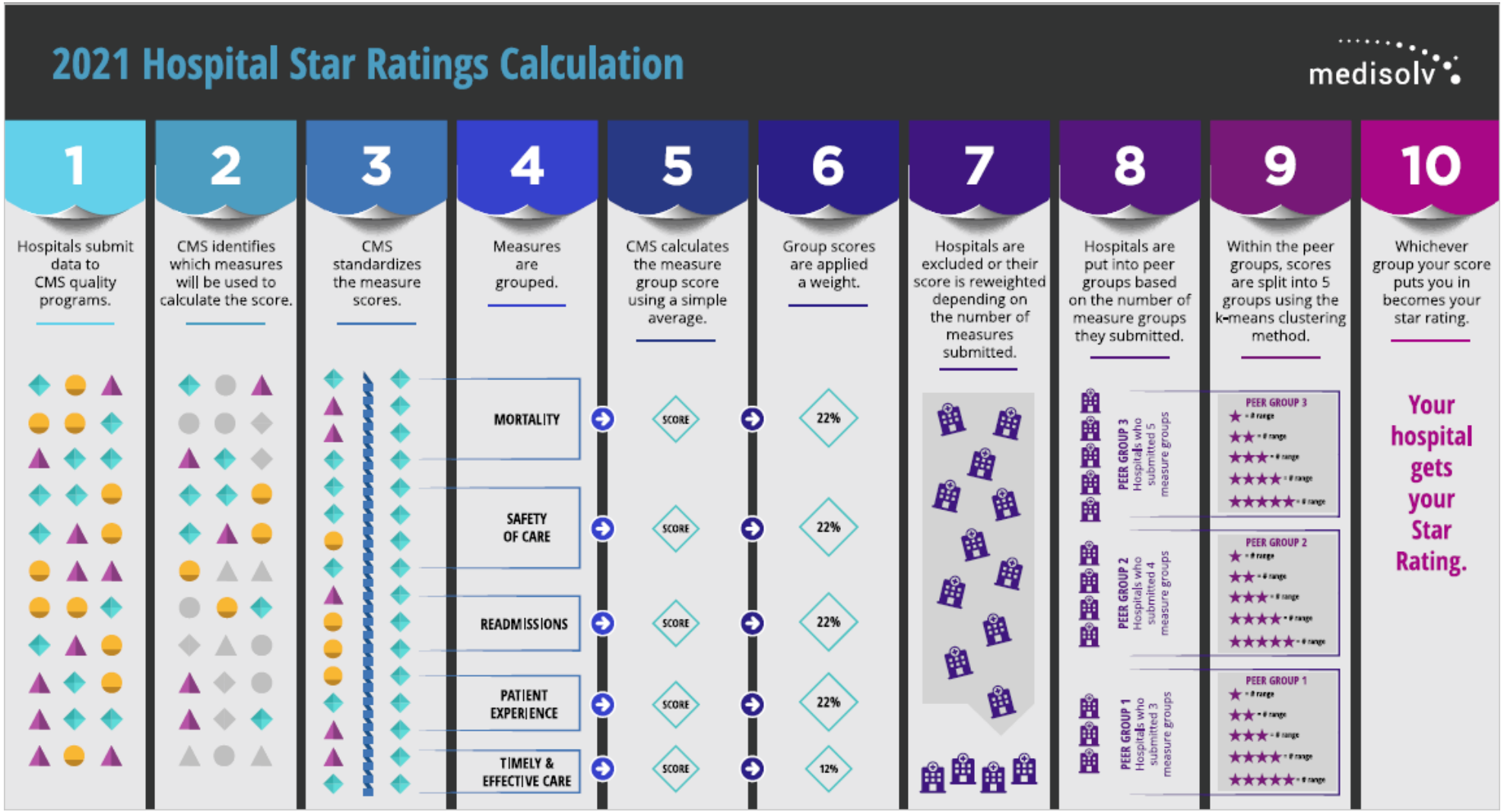
2021 & 2022 Release

New Star Rating Methodology (v4.0)



2022 Star Ratings

Kaweah Health is scored based on performance of 40 different measures



2022 CMS Star Ratings

KAWEAH DELTA MEDICAL CENTER

Overall Star Rating Results	Your Hospital's Results	National Average
Overall Star Rating [a]	*** (3 out of 5 stars)	*** (3 out of 5 stars)
Hospital Summary Score [b]	-0.21	-0.06
Peer Grouping [c]	5 Measure Groups	--

July 2021 Summary Score -0.56

Summary Score by Star Rating

Rating	5-measure group peer group (n=2,465)
1 Star	-2.21, -0.87
2 Star	-0.87, -0.41
3 Star	-0.41, -0.04
4 Star	-0.04, 0.34
5 Star	0.35, 1.39

Summary Score National Average: -0.06 across all groups

2022 CMS Star Ratings

KH is on par with the National Average of a 3 star rating. KH improved in 3/5 measure groups (readmission, safety and timeliness), unchanged in 1/5 (patient experience, no data update), and got worse in 1/5 (mortality).

KH Star Rating are based on 40 different measures in the 5 different categories. 21/40 measures improved from 2021 star rating, 10/41 got worse than the 2021 performance, the remaining stayed the same (no updated data). Details below as reference.

KAWEAH DELTA MEDICAL CENTER

*Color arrows indicate direction of performance compared to the 2021 Star Rating, yellow indicates no change

Measure Group	Number of Measures for Your Hospital [b]	Your Hospital's Measure Group Weight [c]	July 2022 Release Your Hospital's Standardized Measure Group Score [g]	July 2021 Release Your Hospital's Standardized Measure Group Score [g]2	National Group Score [h]
Mortality	7	22.0%	-0.10	0.02	-0.02
Readmission	9	22.0%	-0.35	-0.69	-0.02
Safety of Care	7	22.0%	0.06	-0.66	0.005
Patient Experience	8	22.0%	-0.68	-0.68	0.00
Timely & Effective Care	9	12.0%	0.17	-0.98	-0.03

The hospital's standardized measure group score is calculated using the following formula: (Your Hospital's Measure Group Result - Measure Group's National Mean of Scores)/ Measure Group's Standard Deviation Across Hospitals

2022 CMS Star Ratings

Measure Group	Performance Improved from 2021	Performance got Worse from 2021
Mortality *All measures perform as "same as national benchmark"	• Pneumonia & CABG 30-Day Mortality Rate • PSI 4 - Death Rate Among Surgical Inpatients with Serious Treatable Complications	• AMI, COPD, HF & Acute Ischemic Stroke30-Day Mortality Rate
Readmission *All measures perform as "same as national benchmark" with the exception of the 3 Excess Days in Acute care measures which are "worse than national benchmark"	• Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction & Heart failure • COPD & Elective Total Hip Arthroplasty (THA)/Total Knee Arthroplasty (TKA) 30-Day Readmission Rate • Facility Seven-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy • Hospital-Wide All-Cause Unplanned Readmission	• CABG 30-Day Readmission Rate • Excess Days in Acute Care after Hospitalization for Pneumonia (PN)
Safety *All measures perform "same as" the national average with exception of C. Difficile which performs "better" than	• CAUTI, CLABSI, MRSA, SSI Colon, • Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and Total Knee Arthroplasty (TKA) • PSI 90 Patient Safety and Adverse Events Composite	• Clostridium Difficile (C.difficile)
Patient Experience	• N/A - No changes (data not updated by CMS)	• N/A - No changes (data not updated by CMS)
Timely & Effective Care *category comparison data not provided by CMS	• MRI Lumbar Spine for Low Back Pain • Abdomen CT Use of Contrast Material • ED-Patient Left Without Being Seen • ED-Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke • Endoscopy/Polyp Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients • Severe Sepsis and Septic Shock	• Median Time from ED Arrival to ED Departure for Discharged ED Patients • Elective Delivery Prior to 39 Completed Weeks Gestation: Percentage of Babies Electively Delivered Prior to 39 Completed Weeks Gestation • Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac Low-Risk Surgery

Actions to Improve

Measure Group	Strategy
Safety of Care	• Continue with heightened focus through Quality Focus Teams (Gemba rounds, EMR enhancements, culture of culturing) • Continued use of Biovigil • MRSA targeted decolonization
Readmissions & Mortality	• Best-Practice Teams: COPD, HF, NSTEMI and Pneumonia – focused on operationalizing best practices to reduce mortality and readmissions
Patient Experience	• Installation of communication white boards in patient rooms • Scripting for providers when communicating with patients • Leader rounding program
Timeliness & Effectiveness of Care	• Chartis/Throughput Committee work

Questions?

Live with passion.

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

Kaweah Health

Reference Materials

Measure Date Ranges Used in the July 2022 Star Ratings

The July 2022 Overall Star Ratings were calculated using the measure data from the October 2021 update on Care Compare on Medicare.gov to allow hospitals more time to preview results prior to publicly releasing Overall Star Ratings.

Mortality * Denotes measure reporting periods that would have normally included 1Q and 2Q 2020

Measure	Dates
MORT-30-AMI	July 1, 2017 - December 1, 2019*
MORT-30-CABG	July 1, 2017 - December 1, 2019*
MORT-30-COPD	July 1, 2017 - December 1, 2019*
MORT-30-HF	July 1, 2017 - December 1, 2019*
MORT-30-PN	July 1, 2017 - December 1, 2019*
MORT-30-STK	July 1, 2017 - December 1, 2019*
PSI 04-SURG-COMP	July 1, 2018 - December 31, 2019*

Safety of Care * Denotes measure reporting periods that would have normally included 1Q and 2Q 2020

Measure	Dates
HAI-1	April 1, 2019 - December 31, 2019, July 1, 2020 - September 30, 2020*
HAI-2	April 1, 2019 - December 31, 2019, July 1, 2020 - September 30, 2020*

Measure	Dates
HAI-3	April 1, 2019 - December 31, 2019, July 1, 2020 - September 30, 2020*
HAI-4	April 1, 2019 - December 31, 2019, July 1, 2020 - September 30, 2020*
HAI-5	April 1, 2019 - December 31, 2019, July 1, 2020 - September 30, 2020*
HAI-6	April 1, 2019 - December 31, 2019, July 1, 2020 - September 30, 2020*
COMP-HIP-KNEE	April 1, 2017 - October 2, 2019*
PSI 90-Safety	July 1, 2018 - December 31, 2019*

Readmission * Denotes measure reporting periods that would have normally included 1Q and 2Q 2020

Measure	Dates
READM-30-CABG	July 1, 2017 - December 1, 2019*
READM-30-COPD	July 1, 2017 - December 1, 2019*
READM-30-Hip-Knee	July 1, 2017 - December 1, 2019*
READM-30-HOSP-WIDE	July 1, 2019 - December 1, 2019*
EDAC-30-AMI	July 1, 2017 - December 1, 2019*
EDAC-30-HF	July 1, 2017 - December 1, 2019*
EDAC-30-PN	July 1, 2017 - December 1, 2019*
OP-32	January 1, 2017 - December 24, 2019
OP-35 ADM	January 1, 2019 - December 1, 2019
OP-35 ED	January 1, 2019 - December 1, 2019
OP-36	January 1, 2019 - December 24, 2019

Patient Experience * Denotes measure reporting periods that would have normally included 1Q and 2Q 2020

Measure	Dates
H-COMP-1	January 1, 2019 - December 31, 2019
H-COMP-2	January 1, 2019 - December 31, 2019
H-COMP-3	January 1, 2019 - December 31, 2019
H-COMP-5	January 1, 2019 - December 31, 2019
H-COMP-6	January 1, 2019 - December 31, 2019
H-COMP-7	January 1, 2019 - December 31, 2019
H-CLEAN-HSP / H-QUIET-HSP	January 1, 2019 - December 31, 2019
H-HSP-RATING / H-RECMND	January 1, 2019 - December 31, 2019

Timely and Effective Care * Denotes measure reporting periods that would have normally included 1Q and 2Q 2020

Measure	Dates
IMM-3	October 1, 2019 - March 31, 2020
OP-10	July 1, 2019 - December 31, 2019*
OP-13	July 1, 2019 - December 31, 2019*
OP-18b	October 1, 2019 - December 31, 2019, July 1, 2020 - September 30, 2020*
OP-2	October 1, 2019 - December 31, 2019, July 1, 2020 - September 30, 2020*
OP-22	January 1, 2019 - December 31, 2019
OP-23	October 1, 2019 - December 31, 2019, July 1, 2020 - September 30, 2020*
OP-29	January 1, 2019 - December 31, 2019
OP-33	January 1, 2019 - December 31, 2019
OP-3b	October 1, 2019 - December 31, 2019, July 1, 2020 - September 30, 2020*
OP-8	July 1, 2019 - December 31, 2019*
PC-01	October 1, 2019 - December 31, 2019, July 1, 2020 - September 30, 2020*
SEP-1	October 1, 2019 - December 31, 2019, July 1, 2020 - September 30, 2020*

Chart Elements Used in the April 2021 Star Ratings

Column Name	Description
Measure Group [a]	Contains the measure group to which the measure was assigned.
Measure ID [b]	Contains the measure ID displayed on Care Compare on Medicare.gov.
Measure Name [c]	Contains the full measure name.
Your Hospital's Measure Result [d]	Contains your hospital's score for the measure that was publicly reported on Care Compare on Medicare.gov.
Measure Performance Category [e]	Your hospital's measure performance category that was publicly reported Care Compare on Medicare.gov.
Measure's National Mean of Scores [f]	Contains the national mean score for each measure.
Measure's Standard Deviation Across Hospitals [g]	Contains the standard deviation for each measure.
Your Hospital's Standardized Measure Score [h]	Contains your hospital's standardized score for the measure.
Measure Weight [i]	Measures weights within the Measure Group.

[a] The measure group to which this measure is assigned. [b] ID associated with each measure and corresponds with the measure ID on Care Compare on Medicare.gov. [c] Measure name to describe each measure.

[d] Your hospital's measure result that was publicly reported in October 2020.

[e] Your hospital's measure performance category that was publicly reported in October 2020. The measure performance category is based on your hospital's measure results compared to the publicly reported national-level measure results.

[f] The national mean score for each measure based on the distribution of measure scores across all Overall Star Rating eligible hospitals.

[g] The standard deviation for each measure based on the distribution of hospital results. The standard deviation is the same for all hospitals across the nation.

[h] Your hospital's standardized measure score. The standardized measure score may have been flipped so that a higher score means a better score. Your hospital's standardized measure score is calculated using the following formula: (Column D [Your Hospital's Measure Result] - Column F [Measure's National Mean of Scores]) / Column G [Measure's Standard Deviation Across Hospitals]. Please note that the standardized measure score is multiplied by -1 for measures where a lower rate is better. See the Comprehensive Methodology Report v.4.0 posted on QualityNet for more information on how your hospital's standardized measure score is calculated.

[i] Measure weights are equally weighted across all measures reported by a hospital within a given measure group. 0% is used when hospital does not report measure. For measure groups where hospitals may not report all measures within a measure group, measure weights will be proportionally redistributed for measures reported within the group. The average of the standardized measure scores a hospital reports within a given measure group will be used to calculate the measure group scores. See the Comprehensive Methodology Report (v4.0) for further information.

2022 vs 2021 Star Ratings – Mortality Measure Group

Measure Group [a]	Measure ID [b]	Measure Name [c]	Measure Performance Category [e]	July 2022 Release (colored arrow note changes from 2021 Star Ratings) Your Hospital's Standardized Measure Score [h]	July 2021 Release Your Hospital's Standardized Measure Score [h]2	Measure Weight [i]
Mortality	MORT-30-AMI	Acute Myocardial Infarction (AMI) 30-Day Mortality Rate	Same	↓ -0.32	-0.04	14.3%
Mortality	MORT-30-CABG	Coronary Artery Bypass Graft (CABG) 30-Day Mortality Rate	Same	↑ 1.43	1.47	14.3%
Mortality	MORT-30-COPD	Chronic Obstructive Pulmonary Disease (COPD) 30-Day Mortality Rate	Same	↓ -1.12	-0.65	14.3%
Mortality	MORT-30-HF	Heart Failure (HF) 30-Day Mortality Rate	Same	↓ 0.12	0.57	14.3%
Mortality	MORT-30-PN	Pneumonia (PN) 30-Day Mortality Rate	Same	↑ -0.14	-0.17	14.3%
Mortality	MORT-30-STK	Acute Ischemic Stroke (STK) 30-Day Mortality Rate	Same	↓ -0.62	-0.92	14.3%
Mortality	PSI-4-SURG-COMP	Death Rate Among Surgical Inpatients with Serious Treatable Complications	Same	↑ 0.23	-0.22	14.3%

2022 vs 2021 Star Ratings – Readmission Measure Group

Measure Group [a]	Measure ID [b]	Measure Name [c]	Measure Performance Category [e]	July 2022 Release (colored arrow note changes from 2021 Star Ratings) Your Hospital's Standardized Measure Score [h]	July 2021 Release Your Hospital's Standardized Measure Score [h]2	Measure Weight [i]
Readmission	EDAC-30-AMI	Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction	Worse	-0.61	-0.58	11.1%
Readmission	READM-30-CABG	Coronary Artery Bypass Graft (CABG) 30-Day Readmission Rate	Same	-0.40	0.31	11.1%
Readmission	READM-30-COPD	Chronic Obstructive Pulmonary Disease (COPD) 30-Day Readmission Rate	Same	-1.47	-1.91	11.1%
Readmission	EDAC-30-HF	Excess Days in Acute Care after Hospitalization for Heart Failure	Worse	-0.58	-1.06	11.1%
Readmission	READM-30-Hip-Knee	Hospital-Level 30-Day All-Cause Risk- Standardized Readmission Rate (RSRR) Following Elective Total Hip Arthroplasty (THA)/Total Knee Arthroplasty (TKA)	Same	0.84	-0.38	11.1%
Readmission	EDAC-30-PN	Excess Days in Acute Care after Hospitalization for Pneumonia (PN)	Worse	-0.81	-0.33	11.1%
Readmission	READM-30-HOSP-WIDE	HWR Hospital-Wide All-Cause Unplanned Readmission	Same	-0.53	-0.54	11.1%
Readmission	OP-32	Facility Seven-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy	Same	2.09	1.26	11.1%
Readmission	OP-35 ADM	Admissions for Patients Receiving Outpatient Chemotherapy	Too Few	N/A	N/A	0.0%
Readmission	OP-35 ED	Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy	Too Few	N/A	N/A	0.0%
Readmission	OP-36	Hospital Visits after Hospital Outpatient Surgery	Same	0.06	0.06	11.1%

2022 vs 2021 Star Ratings – Safety of Care Measure Group

Measure Group [a]	Measure ID [b]	Measure Name [c]	Measure Performance Category [e]	July 2022 Release (colored arrow note changes from 2021 Star Ratings) Your Hospital's Standardized Measure Score [h]	July 2021 Release Your Hospital's Standardized Measure Score [h]2	Measure Weight [i]
Safety of Care	HAI-1	Central-Line Associated Bloodstream Infection (CLABSI)	Same	-0.03	-0.72	14.3%
Safety of Care	HAI-2	Catheter-Associated Urinary Tract Infection (CAUTI)	Same	-1.29	-2.02	14.3%
Safety of Care	HAI-3	Surgical Site Infection from Colon Surgery (SSI-colon)	Same	0.59	0.47	14.3%
Safety of Care	HAI-4	Surgical Site Infection from Abdominal Hysterectomy (SSI-abdominal hysterectomy)	N/A	N/A	N/A	0.0%
Safety of Care	HAI-5	MRSA Bacteremia	Same	-0.74	-1.16	14.3%
Safety of Care	HAI-6	Clostridium Difficile (C.difficile)	Better	0.58	0.62	14.3%
Safety of Care	COMP-HIP-KNEE	Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and Total Knee Arthroplasty (TKA)	Same	0.44	0.11	14.3%

Estimated 2022 Standardized Group Score -0.60
Improved from April 2021

2021 Star Ratings – Patient Experience Measure Group

Data not updated for 2022 Star Ratings

Measure Group [a]	Measure ID [b]	Measure Name [c]	Measure Performance Category [e]	July 2022 Release (colored arrow note changes from 2021 Star Ratings) Your Hospital's Standardized Measure Score [h]	July 2021 Release Your Hospital's Standardized Measure Score [h]2	Measure Weight [i]
Patient Experience	H-COMP-1	Communication with Nurses	--	-0.54	-0.54	12.5%
Patient Experience	H-COMP-2	Communication with Doctors	--	-1.05	-1.05	12.5%
Patient Experience	H-COMP-3	Responsiveness of Hospital Staff	--	-0.27	-0.27	12.5%
Patient Experience	H-COMP-5	Communication About Medicines	--	-0.07	-0.07	12.5%
Patient Experience	H-COMP-6	Discharge Information	--	-0.25	-0.25	12.5%
Patient Experience	H-COMP-7	Care Transition	--	-1.06	-1.06	12.5%
Patient Experience	H-CLEAN-HSP / H-QUIET-HSP	Cleanliness and Quietness of Hospital Environment	--	-1.11	-1.11	12.5%
Patient Experience	H-HSP-RATING / H-RECMND	Overall Rating of Hospital	--	-0.25	-0.25	12.5%

2022 vs 2021 Star Ratings – Timely & Effective Care Measure Group

Measure Group [a]	Measure ID [b]	Measure Name [c]	Measure Performance Category [e]	July 2022 Release (colored arrow note changes from 2021 Star Ratings) Your Hospital's Standardized Measure Score [h]	July 2021 Release Your Hospital's Standardized Measure Score [h]2	Measure Weight [i]
Timely & Effective Care	OP-8	MRI Lumbar Spine for Low Back Pain	--	↑ 2.34	1.55	11.1%
Timely & Effective Care	OP-10	Abdomen CT Use of Contrast Material	--	↑ 0.23	0.21	11.1%
Timely & Effective Care	OP-13	Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac Low-Risk Surgery	--	↓ 0.81	1.23	11.1%
Timely & Effective Care	OP-2	Fibrinolytic Therapy Received Within 30 Minutes of Emergency Department Arrival	--	● TFH	TFH	0.0%
Timely & Effective Care	OP-3b	Median Time to Transfer to Another Facility for Acute Coronary Intervention	--	● N/A	N/A	0.0%
Timely & Effective Care	OP-18b	Median Time from ED Arrival to ED Departure for Discharged ED Patients	--	↓ -1.97	-1.91	11.1%
Timely & Effective Care	IMM-3	Healthcare Personnel Influenza Vaccination	--	● N/A	N/A	0.0%
Timely & Effective Care	OP-22	ED-Patient Left Without Being Seen	--	↑ -0.33	-1.61	11.1%
Timely & Effective Care	OP-23	ED-Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke who Received Head CT or MRI Scan Interpretation Within 45 Minutes of Arrival	--	↑ -0.42	-1.02	11.1%
Timely & Effective Care	OP-29	Endoscopy/Polyp Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients	--	↑ 0.25	-0.52	11.1%
Timely & Effective Care	OP-33	External Beam Radiotherapy for Bone Metastases	--	● N/A	N/A	0.0%
Timely & Effective Care	PC-01	Elective Delivery Prior to 39 Completed Weeks Gestation: Percentage of Babies Electively Delivered Prior to 39 Completed Weeks Gestation	--	↓ 0.00	0.20	11.1%
Timely & Effective Care	SEP-1	Severe Sepsis and Septic Shock	--	↑ 0.74	0.39	11.1%

Clinical Quality Goal Update

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

July 2022

FY22 Clinical Quality Goals

	July 21-Apr 22 Higher is Better	FY22 Goal	FY21	FY21 Goal
SEP-1 (% Bundle Compliance)	79%	≥ 75%	74%	≥ 70%

Percent of patients with this serious infection complication that received "perfect care". Perfect care is the right treatment at the right time for our sepsis patients.

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

Lower is Better	July 2021	Aug 2021	Sept 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	June 2022	Estimated Annual Number Not to Exceed to Achieve Goal*	FYTD SIR** (number of actual/ number expected)	FY22 Goal	FY21 FY20
CAUTI Catheter Associated Urinary Tract Infection COVID-19 PATIENTS	1 0	3 1	5 5	2 0	2 1	1 0	3 1	3 2	2 0	1 0	1 0		16 (12 predicted over 6 months)	1.13 0.67 Excluding COVID (Feb 2022)	≤0.676	0.54 1.12
CLABSI Central Line Associated Blood Stream Infection COVID-19 PATIENTS	0 0	4 3	3 3	3 0	1 1	1 0	1 0	0 0	2 0	2 0	1 0		11 (9.5 predicted over 6 months)	1.09 0.67 Excluding COVID	≤0.596	0.75 1.20
MRSA Methicillin-Resistant Staphylococcus Aureus COVID-19 PATIENTS	2 0	0 0	1 0	3 1	0 0	2 0	1 1	1 1	0 0	2 0	1 0		5 (3.6 predicted over 6 months	1.86 1.44 Excluding COVID	≤0.727	2.78 1.02

*based on July-Dec 2021 NHSN predicted

**Standardized Infection Ratio is the number of patients who acquired one of these infections while in the hospital divided by the number of patients who were expected.

Key Strategies

Sepsis, CAUTI, CLABSI & MRSA

1. Refining root cause analysis of Sepsis order set utilization
   - for committee review and QI action planning end of June
2. Provider notification of Sepsis Alert
   - Revising process so it's easier for RNs to document
3. Sepsis Simulation training (GME)
   - Emergency Management GME program sim program in March 2022; Family Medicine sim program simulation date tbd
3. Culturing Practices
   - Data analysis and follow up with provider groups
   - Alert for repeat cultures in place
4. Root Cause Analysis
   - Process & practice assessment from IV supply vendor
   - Equipment enhancements – conversion to medline products and new bladder scanners for each unit!
   - Review of current data & cases and quantifying contributing factors to target improvement strategies
5. MRSA Decolonization
   - 4N & ICU Pilot – 100% patients decolonized, expanded additional 3 months; evaluation for Aug 2022.
   - All other units – targeting those who should be decolonized, working on optimizing processes to achieve decolonization. Key element in process is identification of the at risk patient through medical record triggers and workflow

Questions?

Live with passion.

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

Kaweah Health

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2022							
		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		1.93					**1st QTR:** The quarter average was just below 2%. IUSS during the month of March was very high and related to Cardiac Surgery. The instruments involved in the increase of IUSS are retractors and forceps. There is work underway to address processing times to shore-up the IUSS activity. **2nd QTR:** **3rd QTR:** **4th QTR:**
B. Dialysis Water/Dialysate Quality Control (AAMI RD52:2004) (% of machines that did not exceed limits)							
RO Water [Target: <200cfu] [Action: > or = 50cfu]		0%					**1st QTR:** 51 Acute Dialysis and 6 Outpatient Visalia Dialysis Clinic Water RO samples were tested for bacterial & endotoxin counts and all results where within acceptable parameters. **2nd QTR:** **3rd QTR:** **4th QTR:**
Endotoxin [Target: <2EU] [Action: > or = 1EU]		0%					**1st QTR:** 6 Acute Dialysis Machine and 7 Outpatient Visalia Dialysis Machine samples were tested for bacterial & endotoxin counts and all results where within acceptable parameters. **2nd QTR:** **3rd QTR:** **4th QTR:**
C. Environmental Cleaning (ATP testing surfaces)							
Pass/Fail based on a threshold of ATP score of <200. Multiple high-touch surfaces tested each month.	Goal 100%	69%					**1st QTR:** A total of 589 samples were tested, 406 passed on first sweep, 182 failed. For all failed results the room was re-cleaned. **2nd QTR:** **3rd QTR:** **4th QTR**
II. Antimicrobial Stewardship Measures							
# of antibiotic IV to PO conversion		257					**1st QTR:** There were a total of 257 IV to PO conversion ABS interventions. The majority occurred CVICU and 3S. **2nd QTR:** **3rd QTR:** **4th QTR:**

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		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
Average Days of Therapy per 1,000 patient days - Fluoroquinolones		Not available					**1st QTR:** This information is unavailable for 1st QTR. It will be presented at next IP Committee meeting. **2nd QTR:** **3rd QTR:** **4th QTR:**
Average Days of Therapy per 1,000 patient days - Carbapenems		Not available					**1st QTR:** This information is unavailable for 1st QTR. It will be presented at next IP Committee meeting. **2nd QTR:** **3rd QTR:** **4th QTR:**
III. Employee Health							
A. Needlestick Injuries							
Number of sharps/needle stick reports		11					**1st QTR:** 6 events involved GME Residents. 5 RNs account for the remaining needlestick events. There were 5 events related to a needle with safety mechanism, 3 events related to an insulin syringe with safety mechanism, and 2 events involving sutures. **2nd QTR:** . **3rd QTR:** **4th QTR**:
B. Blood/Body Fluid Exposures							
Number of blood/body fluid exposures		3					**1st QTR:** 1 event with blood to eye from IV pigtail. 1 event blood to eye with drawing lab specimen. 1 event involving IV fluid/blood present during disconnecting the IV. **2nd QTR:** **3rd QTR:** **4th QTR:**
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		764					**Cumulative Ct: 764**
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]*		5					**1st QTR:** 5 **Predicted:** 11.627 **2nd QTR: Predicted:** **3rd QTR: Predicted:** **4th QTR: Predicted:**
C. Incidence Rate (IR) [# of total SSI infections/# total procedures x 100]	Internal 0.70 Goal	0.654					**1st QTR:** Better than State benchmark. **2nd QTR:** **3rd QTR:** **4th QTR:**

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2022							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
D. SIR Confidence Interval (CI-KDHCD predicted range, based on risks)		0.158, 0.953					**1st QTR:** With 95% confidence the SSI event incidence rate appropriately reflects the population. **2nd QTR:** **3rd QTR:** **4th QTR:**
E. Standardized Infection Ratio (SIR)	NHSN	**0.43**					**1st QTR:** There were 1 CSEC, 1 KPRO, 1 SB, 2 XLAP SSI events. All events were superficial incision primary events. Continuing to monitor SSI events for particular trends. **2nd QTR:** **3rd QTR:** **4th QTR:**
V. Specific Surgical Review	**SIR**						
A. Colon Surgery (COLO) CMS/VBP							
1. #Total Procedure Count		28					**Cumulative Ct: 28**
2. Total Infection Count		**0** **[0]**					**1st QTR:** 0 **Predicted:** 1.983/**CMS** 0 **Predicted:** 0.874 **2nd QTR: Predicted: /CMS Predicted:** **3rd QTR: Predicted: /CMS Predicted:** **4th QTR: Predicted: /CMS Predicted:**
3. SIR CI (KDHCD predicted range, based on risks)		, 1.511					**1st QTR:** With 95% confidence the absence of COLO SSI events appropriately reflects the population. **2nd QTR:** **3rd QTR:** **4th QTR:**
4. SIR (Standardized Infection Ration) total Value Based Purchasing (VBP) SIR = [ ]	VBP Goal <0.717	0.00					**1st QTR:** No COLO SSI events. **2nd QTR:** **3rd QTR:** **4th QTR:**
B. Cesarean Section (CSEC)							
1. #Total Procedure Count		230					**Cumulative Ct: 230**
2. Total Infection Count		**1**					**1st QTR:** 1 **Predicted:** 2.064 **2nd QTR: Predicted:** **3rd QTR: Predicted:** **4th QTR: Predicted:**
3. SIR CI (KDHCD predicted range, based on risks)		0.024, 2.390					**1st QTR:** With 95% confidence the 1 CSEC event is representative of the population of CSEC procedures performed. **2nd QTR:** **3rd QTR:** **4th QTR:**
4. SIR (Standardized Infection Ration) total	Goal SIR <1.00	**0.49**					**1st QTR:** There was 1 superficial Cesarean section SSI event 3 days post-op. Pre-op antibiotics not documented. **2nd QTR:** **3rd QTR:** **4th QTR:**
C. Spinal Fusion (FUSN)							

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		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
1. #Total Procedure Count		44					**Cumulative Ct: 44**
2. Total Infection Count		**0**					**1st QTR:** 0 **Predicted:** 0.792 **2nd QTR: Predicted:** **3rd QTR: Predicted:** **4th QTR: Predicted:**
3. SIR CI (KDHCD predicted range, based on risks)		NA					**1st QTR:** With 95% confidence the absence of FUSN SSI events appropriately reflects the population. **2nd QTR:** **3rd QTR:** **4th QTR:**
4. SIR (Standardized Infection Ration) total	Goal SIR <1.00	0.00					**1st QTR:** No Spinal Fusion surgical site infections reported. **2nd QTR:** **3rd QTR:** **4th QTR:**
D. Hysterectomy (HYST) CMS/VBP							
1. #Total Procedure Count		14					**Cumulative Ct: 14**
2. Total Infection Count		**0** **[0]**					**1st QTR:** 0 **Predicted:** 0.298/**CMS** 0 **Predicted:** 0.108 **2nd QTR: Predicted: /CMS Predicted:** **3rd QTR: Predicted: /CMS Predicted:** **4th QTR: Predicted: /CMS Predicted:**
3. SIR CI (KDHCD predicted range, based on risks)		NA					**1st QTR:** With 95% confidence the absence of HYST SSI events appropriately reflects the population. **2nd QTR:** **3rd QTR:** **4th QTR:**
4. SIR (Standardized Infection Ration) total Value Based Purchasing (VBP) SIR = [ ]	VBP Goal <0.738	0.00					**1st QTR:** There were no Abdominal Hysterectomy surgical site infection. **2nd QTR:** **3rd QTR:** **4th QTR:**
VI. Ventilator Associated Events (VAE)	**SIR**						
A. Ventilator Device Use SUR (standardized utilization ratio)		**1.83**					**1st QTR:** 1,080 **Predicted:** 591.467 **2ndt QTR: Predicted:** **3rd QTR: Predicted:** **4th QTR: Predicted:**
B. Total VAEs ICU (NHSN Reportable)	Includes IVAC Plus						
1. SIR Total VAE CI (KDHCD predicted range, based on risks)		0.006, 1.587					**1st QTR:** With 95% confidence the VAE event appropriately reflects the population of patients on a ventilator. **2nd QTR:** **3rd QTR:** **4th QTR:**

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		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
2. Total VAEs SIR	<1.0	**0.32**					**1st QTR:** Less than predicted number of events. **2nd QTR:** **3rd QTR:** **4th QTR:**
C. Total IVAC Plus -ICU		**1**					**1st QTR:** Patient had a IVAC event after 5 days of ventilation. **2nd QTR:** **3rd QTR:** **4th QTR:**
1. Total IVAC Plus CI (KDHCD predicted range, based on risks)		0.016, 1.557					**1st QTR:** With 95% confidence the VAE event appropriately reflects the population of patients on a ventilator. **2nd QTR:** **3rd QTR:** **4th QTR:**
2. Total IVAC *Plus* ICU SIR		**0.117**					**1st QTR:** Less than predicted number of events. **2nd QTR:** **3rd QTR:** **4th QTR:**
D. Total VAEs CVICU (NHSN Reportable)	Includes IVAC Plus						
1. SIR Total VAE CI (KDHCD predicted range, based on risks)		NA					**1st QTR:** Not applicable. **2nd QTR:** **3rd QTR:** **4th QTR:**
2. Total VAEs SIR		**0**					**1st QTR:** No events. **2nd QTR:** **3rd QTR:** **4th QTR:**
E. Total IVAC Plus CVICU SIR		**0**					**1st QTR:** No events. **2nd QTR:** **3rd QTR:** **4th QTR:**
1. Total IVAC Plus CI (KDHCD predicted range, based on risks)		NA					**1st QTR:** No events. **2nd QTR:** **3rd QTR:** **4th QTR:**
2. Total IVAC *Plus* CVICU SIR		**0**					**1st QTR:** No events. **2nd QTR:** **3rd QTR:** **4th QTR:**
F. Total VAEs-Both Units		**1**					**1st QTR:** 1 **Predicted:** 8.535 **2nd QTR: Predicted:** **3rd QTR: Predicted:** **4th QTR: Predicted:**
1. Process Measures							

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		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
% of patients with head of bed >30 dregrees per visual inspection.	**Goal = 100%**	**84.7%**					**1st QTR:** 50 of 59 rounds demonstrated a patient with the head of bed at or beyond 30 degrees elevation on visual inspection. **2nd QTR:** **3rd QTR:** **4th QTR:**
% Sedation Vacation	**Goal = 100%**	**92.3%**					**1st QTR:** 24 of 26 rounds demonstrated a patient who received a sedation vacation while on the ventilator. **2nd QTR:** **3rd QTR:** **4th QTR:**
% Oral Care Provided (per visual inspection)	**Goal = 100%**	**93.8%**					**1st QTR:** 60 of 64 rounds demontrated a patient who received oral care based on visual inspection of the mouth. **2nd QTR:** **3rd QTR:** **4th QTR:**
% CHG Bath within last 24 hours	**Goal = 100%**	**95.3%**					**1st QTR:** 61 or 64 rounds demonstrated a patient who received a CHG bath within the last 24 hours prior to the round. **2nd QTR:** **3rd QTR:** **4th QTR:**
% Vent Tubing Position Appropriately (drain away from patient - visual inspection)	**Goal = 100%**	**90.6%**					**1st QTR:** 58 or 64 rounds demonstrated a patient with ventilator tubing positioned appropriately (draining away from the patient's airway). **2nd QTR:** **3rd QTR:** **4th QTR:**
VII. Central Line Associated Blood Stream Infections (CLABSI) CMS/VBP	**NHSN SIR**						
A. Total number of Central Line Days (CLD)		4284					**Cumulative Ct: 4284**
B. Central Line Device Use SUR (standardized utilization ratio)		**0.736**					**1st QTR:** 4284 CLD **Predicted:** 5819.971 **2nd QTR:** CLD **Predicted:** **3rd QTR:** CLD **Predicted:** **4th QTR:** CLD **Predicted:**
C. Total Infection Count Valule Based Purchasing (VBP) # events = [ ]		**3** **[0]**					**1st QTR:** 3 **Predicted:** 4.213/**CMS:** 0 **Predicted:** 2.558 **2nd QTR: Predicted: /CMS: Predicted:** **3rd QTR: Predicted: /CMS: Predicted:** **4th QTR: Predicted: /CMS: Predicted:**
D. SIR Confidence Interval		0.181, 1.938					**1st QTR:** Worst than national benchmark. **2nd QTR:** **3rd QTR:** **4th QTR:**

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2022							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
E. SIR (Standardized Infection Ratio) total Value Based Purchasing (VBP) SIR = [ ]	**0.589**	**0.712**					**1st QTR:** January event due to limited patient bathing and pan-culture practices. February events due to extended Femoral access, limited patient bathing, poor assessment of surgical site; Another extended Femoral access, poor adherance to hand hygiene practice. **2nd QTR:** **3rd QTR:** **4th QTR:**
F. Process Measures							
% of patients with a bath within 24 hours	**Goal 100%**	**96.0%**					**1st QTR:** 1,642 responses out of 1,703 rounds. **2nd QTR:** **3rd QTR:** **4th QTR:**
% of central lines inserted with a valid rationale	**Goal 100%**	**97.0%**					**1st QTR:** 1,046 responses out of 1,703 rounds. **2nd QTR:** **3rd QTR:** **4th QTR:**
% of central line dressings clean, dry and intact	**Goal 100%**	**98.0%**					**1st QTR:** 1,042 responses out of 1,703 rounds. **2nd QTR:** **3rd QTR:** **4th QTR:**
% of central line dressing changes no > than 7 days	**Goal 100%**	**98.0%**					**1st QTR:** 1,048 responses out of 1,703 rounds. **2nd QTR:** **3rd QTR:** **4th QTR:**
% of patients with properly placed CHG patch	**Goal 100%**	**98.0%**					**1st QTR:** 541 responses out of 552 rounds. **2nd QTR:** **3rd QTR:** **4th QTR:**
% of patients with appropriate & complete documentation	**Goal 100%**	**95.0%**					**1st QTR:** 1,250 responses out of 1,333 rounds. **2nd QTR:** **3rd QTR:** **4th QTR:**
# of central line days rounded on		2,871					**1st QTR:** Approximately, 957 central lines rounds on a month. **2nd QTR:** **3rd QTR:** **4th QTR:**
Skilled Nursing/Acute Rehab % of central dressing clean/dry/intact	**Goal 100%**	**95.9%**					**1st QTR:** 47 of 49 central dressing were clean, dry and intact. **2nd QTR:** **3rd QTR:** **4th QTR:**

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		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
Skilled Nursing/Acute Rehab % of central line dressings changed no > 7 days	**Goal 100%**	**NA**					**1st QTR:** There were no reports provided for this metric. **2nd QTR:** **3rd QTR:** **4th QTR:**
VIII. Catheter Associated Urinary Tract Infections (CAUTI) CMS/VBP	**NHSN SIR**						
A. Total number of Catheter Device Days (CDD)		4713					**Cumulative Ct: 4713**
B. Catheter Device Days SUR (Standardized Utilization Ratio)		**0.915**					**1st QTR:** 4713 CDD **Predicted:** 5150.948 CDD **2nd QTR**: CDD **Predicted:** CDD **3rd QTR:** CDD **Predicted**: CDD **4th QTR:** CDD **Predicted:** CDD
C. Total Infection Count Value Based Purchasing (VBP) # of events = [ ]		**8** **[5]**					**1st QTR:** 8 **Predicted:** 6.115/**CMS:** 5 **Predicted:** 3.240 **2nd QTR: Predicted: /CMS: Predicted:** **3rd QTR: Predicted: /CMS: Predicted:** **4th QTR: Predicted: /CMS: Predicted:**
D. SIR Confidence Interval		0.608, 2.484					**1st QTR:** Worst than national benchmark. **2nd QTR:** **3rd QTR:** **4th QTR**:
E. SIR (Standardized Infection Ratio) total Value Based Purchasing (VBP) SIR = [ ]	**0.605**	**1.308**					**1st QTR:** January events: pan-culturing practices, poor hand hygiene compliance, specimen collection practices, minimal patient bathing. February events: one fever impetus for ordering cultures, pan-culturing practices, specimen collection practices, questionnable indication for indwelling urinary catheter, antimicrobial stewardship, minimal patient bathing. **2nd QTR:** **3rd QTR:** **4th QTR:**
F. Process Measures							
% of patients with appropriate cleanliness	**Goal 99%**	**99.0%**					**1st QTR:** 1,991 responses out of 2,126 rounds. **2nd QTR:** **3rd QTR:** **4th QTR:**
% of IUCs with order and valid rationale	**Goal 100%**	**96.0%**					**1st QTR:** 1,171 responses out of 1,240 rounds. **2nd QTR:** **3rd QTR:** **4th QTR:**
% of IUCs where removal was attempted		**6.3%**					**1st QTR:** 56 responses out of 890 rounds. **2nd QTR:** **3rd QTR:** **4th QTR:**
% of patients where alternatives have been attempted		**10.4%**					**1st QTR:** 129 respones out of 1,235 rounds. **2nd QTR:** **3rd QTR:** **4th QTR:**

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2022							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
% of IUCs removed because of unit "GEMBA" rounds		5.2%					**1st QTR:** 64 responses out of 1,237 rounds. However, this represents **2nd QTR:** **3rd QTR:** **4th QTR:**
# of IUCs removed because of unit "GEMBA" rounds		64					**1st QTR:** Approximately, 21 indwelling urinary catheters a month were removed as a results of Gemba rounds. **2nd QTR:** **3rd QTR:** **4th QTR:**
# of Indwelling Urinary Catheter days rounded on		2,607					**1st QTR:** Approximately, 869 rounds on indwelling urinary catheters a month. **2nd QTR:** **3rd QTR:** **4th QTR:**
Skilled Nursing/Acute Rehab % of complete baths performed within 24 hours *(Modification to this measure to start 2022 1st QTR - % of completed baths performed within 48 hours for patients with central lines)*	**Goal 100%**	95.6%					**1st QTR:** 87 of 91 complete baths were performed within 24 hours. **2nd QTR:** **3rd QTR:** **4th QTR:**
Skilled Nursing/Acute Rehab % of peri care performed within in a 12 hour shift	**Goal 100%**	98.1%					**1st QTR:** 53 of 54 pericare actions were completed and documented within the 12 hour shift. **2nd QTR:** **3rd QTR:** **4th QTR:**
IX. Catheter Associated Urinary Tract Infections Long Term Care/Rehabilitation	**Goal = 0**						
Short Stay (# of Infections/ Incidence Rate)		0					**1st QTR:** There were no CAUTI events. **2nd QTR:** **3rd QTR:** **4th QTR:**
Transitional Care (# of Infections/ Incidence Rate)		0					**1st QTR:** There were no CAUTI events. **2nd QTR:** **3rd QTR:** **4th QTR:**
Subacute (# of Infections/ Incidence Rate)		0					**1st QTR:** There were no CAUTI events. **2nd QTR:** **3rd QTR:** **4th QTR:**
Acute Rehabilitiation (# of Infections/ Incidence Rate)		0					**1st QTR:** There were no CAUTI events. **2nd QTR:** **3rd QTR:** **4th QTR:**
X. LTC Symptomatic Urinary Tract Infections	**Goal = 0**						

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		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
Short Stay (# of Infections/ Incidence Rate)		0					**1st QTR:** There were no SUTI events. **2nd QTR:** **3rd QTR:** **4th QTR:**
Transitional Care (# of Infections/ Incidence Rate)		2					**1st QTR:** There were 2 Symptomatic Urinary Tract Infection events without a foley catheter in place. 1 occurred during February the other during March. The SUTI rate = 0.464. **2nd QTR:** **3rd QTR:** **4th QTR:**
Subacute (# of Infections/ Incidence Rate)		0					**1st QTR:** There were no SUTI events. **2nd QTR:** **3rd QTR:** **4th QTR:**
XI. Clostridium *difficile* Infection (CDI) CMS/VBP	**SIR**						
A. Total Infection Count	All units	9					**1st QTR:** 9 **Predicted:** 18.253 **2nd QTR: Predicted:** **3rd QTR: Predicted:** **4th QTR: Predicted:**
B. SIR CI (KDHCD predicted range, based on risks)		0.240, 0.905					**1st QTR:** Better the National benchmark. **2nd QTR:** **3rd QTR:** **4th QTR:**
C. SIR (Standardized Infection Ratio) total Value Based Purchasing (VBP) SIR = [ ]	VBP Goal <0.520	0.493					**1st QTR:** Infection Prevention is reminding nursing and providers about the C-difficile algorithm. Stools are being collected later during the patient's stay when while receiving a bowel regimen or on Lactulose. **2nd QTR:** **3rd QTR:** **4th QTR:**
XII. Hand Hygiene	**95%**						
A. Total Hand Hygiene Observations (combination of manual and electronic hand hygiene surveillance)		2,277,368					**1st QTR:** BioVigil electronic hand hygiene surveillance system was installed at South and West campuses. Go-Live with nearly systemwide surviellance occurred on 3/26/2022. The only areas were manual hand hygiene compliance rates are gathered on clinics and Mental Health. **2nd QTR:** **3rd QTR:** **4th QTR:**

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		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
B. All units Percentage of Hand Hygiene compliance based on observations/opportunities (>200 observations/ month/unit)		97.1%					**1st QTR:** Overall hand hygiene compliance is remains above the 95% threashold. Work is underway to ensure there is compliance all healthcare workers using BioVigil where it is available. There are currently 3,656 users on the system. **2nd QTR:** **3rd QTR:** **4th QTR:**
C. Percentage of Hand Hygiene compliance performed during "Day Shift"		97.0%					**1st QTR:** Day shift and night shift have equal compliance rates. Will continue to encourage hand hygiene compliance. **2nd QTR:** **3rd QTR:** **4th QTR:**
D. Percentage of Hand Hygiene compliance performed during "Night Shift"		97.0%					**1st QTR:** Night shift and day shift have equal compliance rates. Will continue to encourage hand hygiene compliance. **2nd QTR:** **3rd QTR:** **4th QTR:**
XIII. VRE (HAI) Blood-Hospital Onset (HO)	**BM**						
A. Total Infection Count		0					**1st QTR:** 0 **Predicted:** 0 **2nd QTR: Predicted:** **3rd QTR: Predicted:** **4th QTR: Predicted:**
B. Prevalence Rate (x100)		0					**1st QTR:** Better than National benchmark. **2nd QTR:** **3rd QTR:** **4th QTR:**
C. Number Admissions		4,244					**Cumulative Ct: 4244**
XIV. MRSA (HAI) Blood CMS/VBP	**SIR**						
A. Total Infection Count (IP Facility-wide)		2					**1st QTR:** 2 **Predicted:** 1.247 **2nd QTR: Predicted**: **3rd QTR: Predicted:** **4th QTR: Predicted:**
B. SIR CI (KDHCD predicted range, based on risks)		0.269, 5.297					**1st QTR:** Worst than National benchmark. **2nd QTR:** **3rd QTR:** **4th QTR:**
C. SIR (Standardized Infection Ration) total Value Based Purchasing (VBP) SIR = [ ]	<0.726	1.603					**1st QTR:** 2 HO MRSA BSI events. **2nd QTR:** **3rd QTR:** **4th QTR:**
XV. MDRO LABID - Long Term Care							
Short Stay (# of Infections/ Incidence Rate)		0					**1st QTR:** There were no MDRO reported. **2nd QTR:** **3rd QTR:** **4th QTR:**

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		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
Transitional Care (# of Infections/ Incidence Rate)		1					**1st QTR:** There was 1 Clostridium difficile infection event involving a patient transferred from Kaweah Health downtown campus to Transitional Care. Patient received antimicrobial therapy for an extended period of time. **2nd QTR:** **3rd QTR:** **4th QTR:**
Subacute (# of Infections/ Incidence Rate)		0					**1st QTR:** There were no MDRO reported. **2nd QTR:** **3rd QTR:** **4th QTR:**
XVI. Influenza Rates (Year 2020-2021)	**NHSN**						
A. All Healthcare Workers							**1st QTR:** Pending report
XVII. COVID-19 Vaccination Rates (Year 2020-2021)							
A. All Healthcare Workers with a completed series of COVID-19 vaccinations.		4,805					**1st QTR:** There were 702 COVID-19 vaccines administered to employees. Of a total 5,907 employees, 4,805 employees are completed the series of COVID-19 vaccinations as of March 31st, 2022. This demonstrates an 81.3% complete vaccination rate. **2nd QTR:** **3rd QTR:** **4th QTR:**

Approved IPC:
Approved IPC:
Approved IPC:
Approved IPC:

Prepared by: Shawn Elkin, Infection Prevention Manager

Nursing Workforce: 2021

Emma Camarena, DNP, RN, ACCNS-AG
Director of Nursing Practice

Foundation for the Role of Nurses

Kaweah Health Nursing Vision

Professional nurses dedicated to providing patient-centered care with compassion.

Kaweah Health Nursing Philosophy

Nurses at Kaweah Delta are committed to:

1. Sustaining a culture of inquiry, professional excellence, continuous practice
improvement and lifelong learning.
2. Collaborating with the healthcare team to deliver high-quality care at all times
and promote outstanding clinical outcomes.
3. Creating a caring-healing environment by partnering with patients, families, and
each other to promote exceptional healthcare.

Kaweah Health

Nurse Work Environment

- Facilitate or constrain nursing practice
- Linked to patient outcomes
- Characterized by
  - Safe staffing
  - Communication & team work
  - Competent managers
  - Supportive senior leadership

(Carthon et al. 2019)

Kaweah Health

Adequate Nurse Staffing

- Contributes to improved patient outcomes
  - Surveillance
  - Time with patients
  - Early detection

(Carthon et al., 2019; Costa & Yakusheva, 2016)

Kaweah Health

High Patient Workloads

- Nurses report patient safety concerns
  - Information falling through the cracks
  - Missed communications
  - Delayed or missed care
  - Risk of adverse event

(Carthon et al., 2019)

Kaweah Health

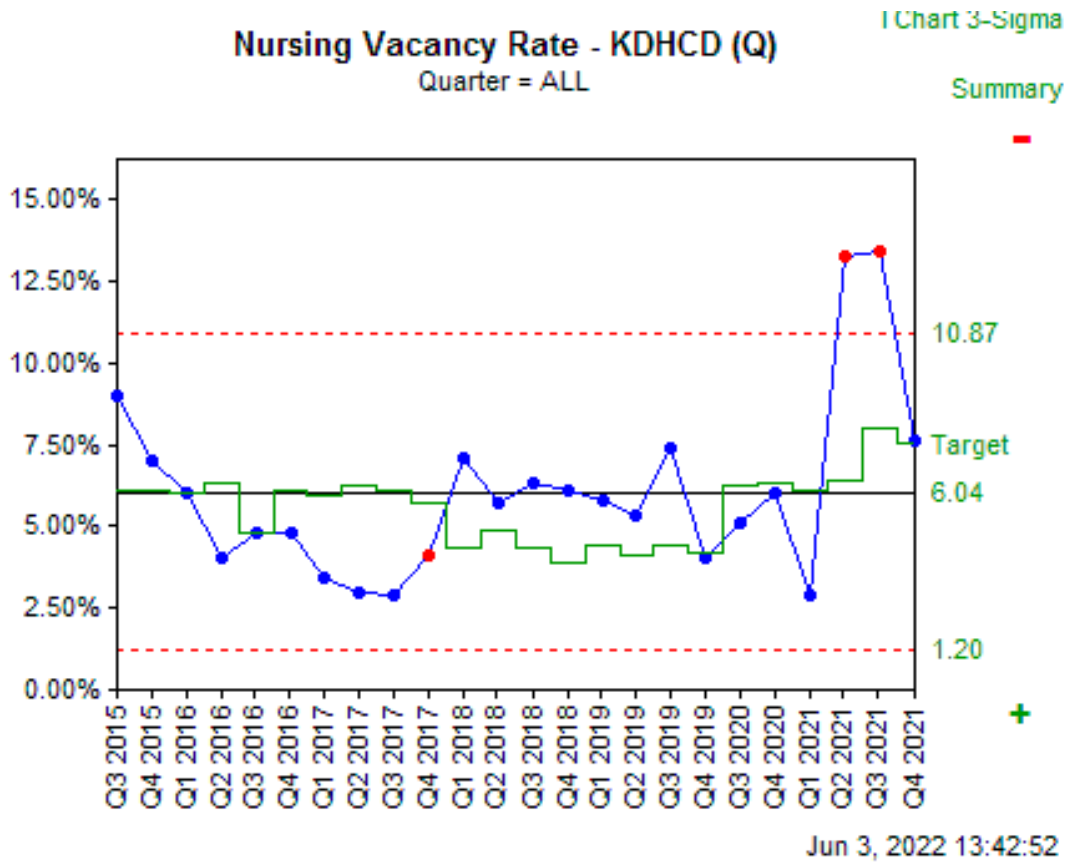
High Patient Workloads

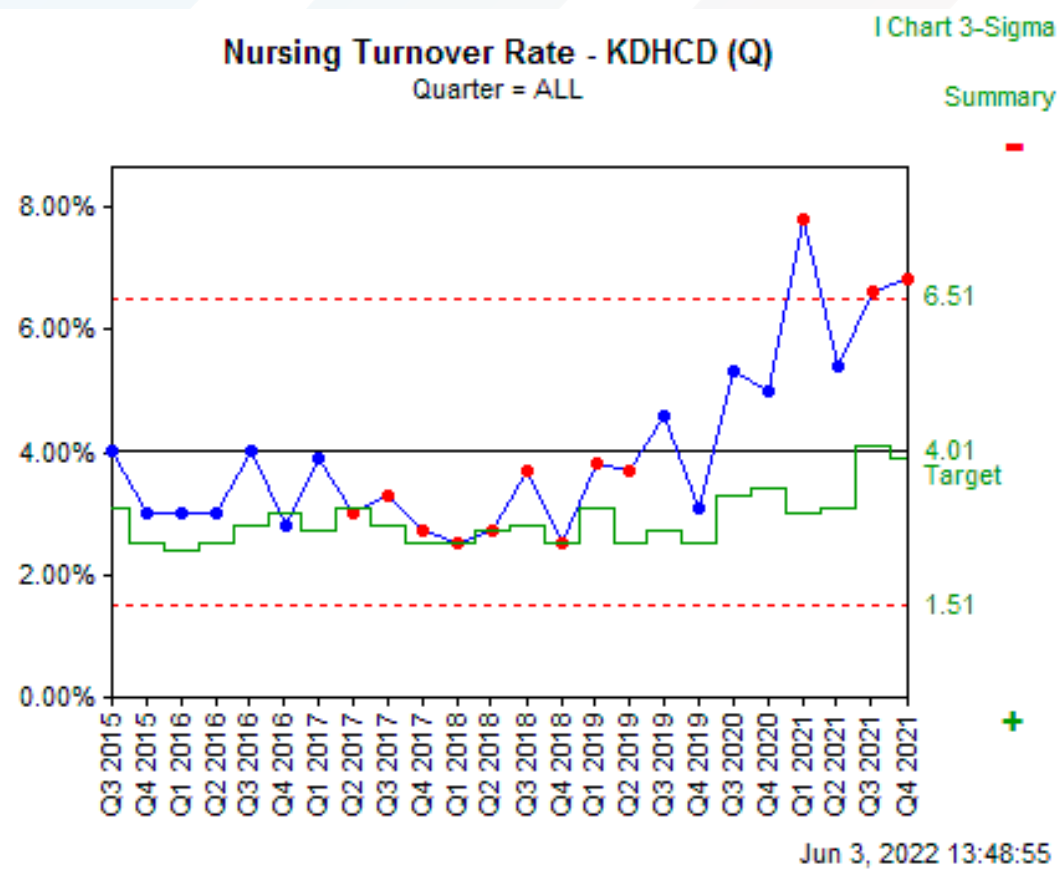
- Increased likelihood of adverse nurse outcomes
  - Burnout
  - Job dissatisfaction
  - Intent to leave

(Shin, Park, & Bae, 2018)

Kaweah Health

Kaweah Health Vacancy and Turnover Rate





Cost of Clinical Nurse Burnout

- 74% of nurses are concerned about stress
- 45% of nurses are tired of their jobs
- 34% of nurses suffer from “Burnout Syndrome”
- $65,000 average cost to replace one nurse
- RN turnover costs: ↑ 1% = $337,000 per year
- Brain drain – Lose the skills and knowledge base in the organization
- 2% decrease in patient satisfaction for every 10% of dissatisfied nurses
- Increase in Hospital Acquired Infections

Ruggiero, J. & Vanek, F. (2019). *Engaging Leaders by Prioritizing Their Wellbeing and Resillency.* Presentation at the annual AONE Conference, San Diego, California
Holm, C. (2019). *Attributes in Leaders Most Desired by Clinical Nurses. .* Presentation at the annual AONE Conference, San Diego, California

Kaweah Health

Impact of COVID-19 Pandemic in CA

Fear of RN shortages

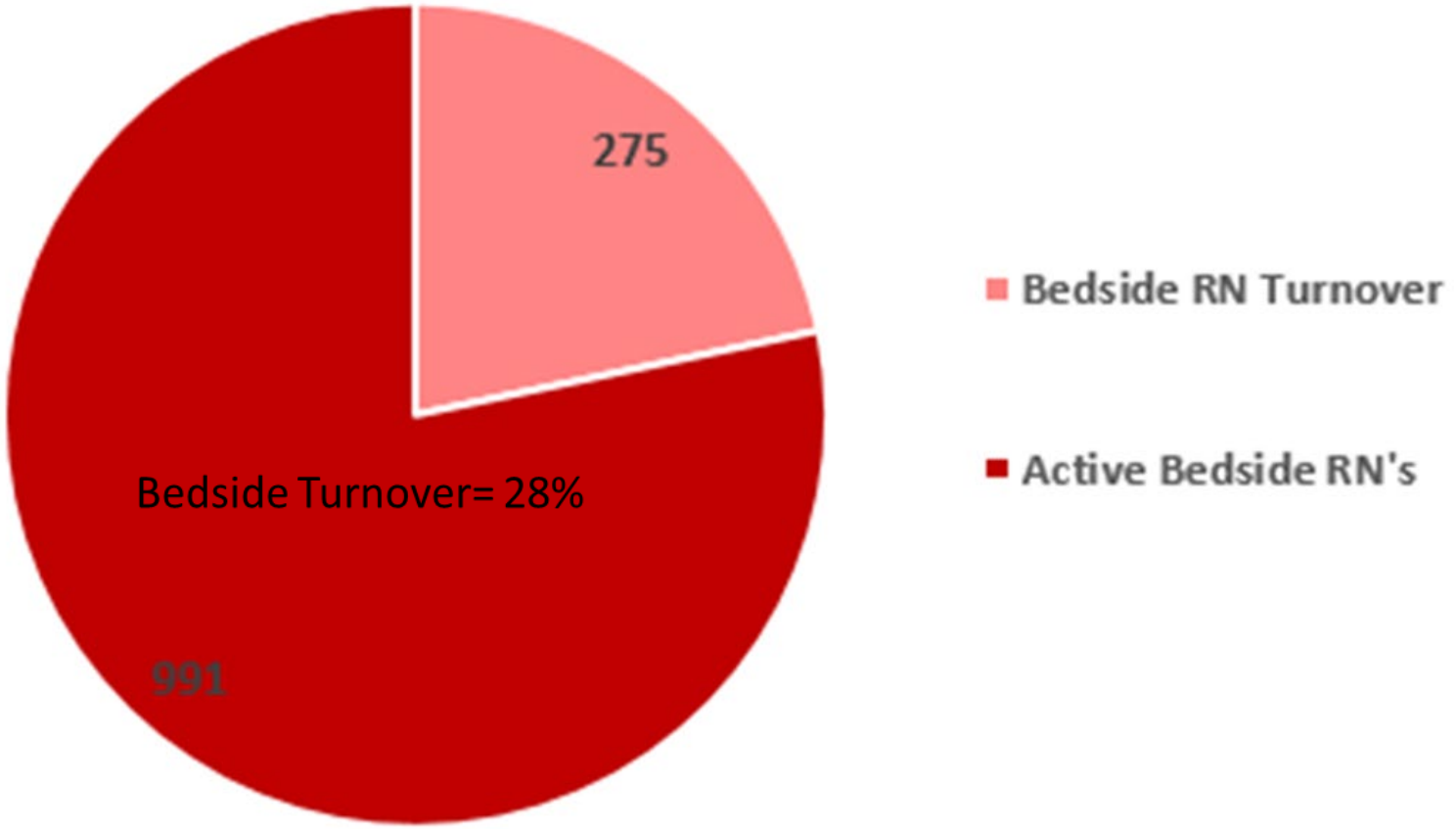
- Education programs:
  - Students unable to continue
  - Education programs: unable to modify programs
  - Students unwilling to engage in remote education
- RNs quit:
  - Fear of COVID
  - High stress
- RNs retiring:
  - 2018: 11.4%
  - 2020: 25.2%

(2021. The Regents of the University of California https://healthworkforce.ucsf.edu)

Kaweah Health

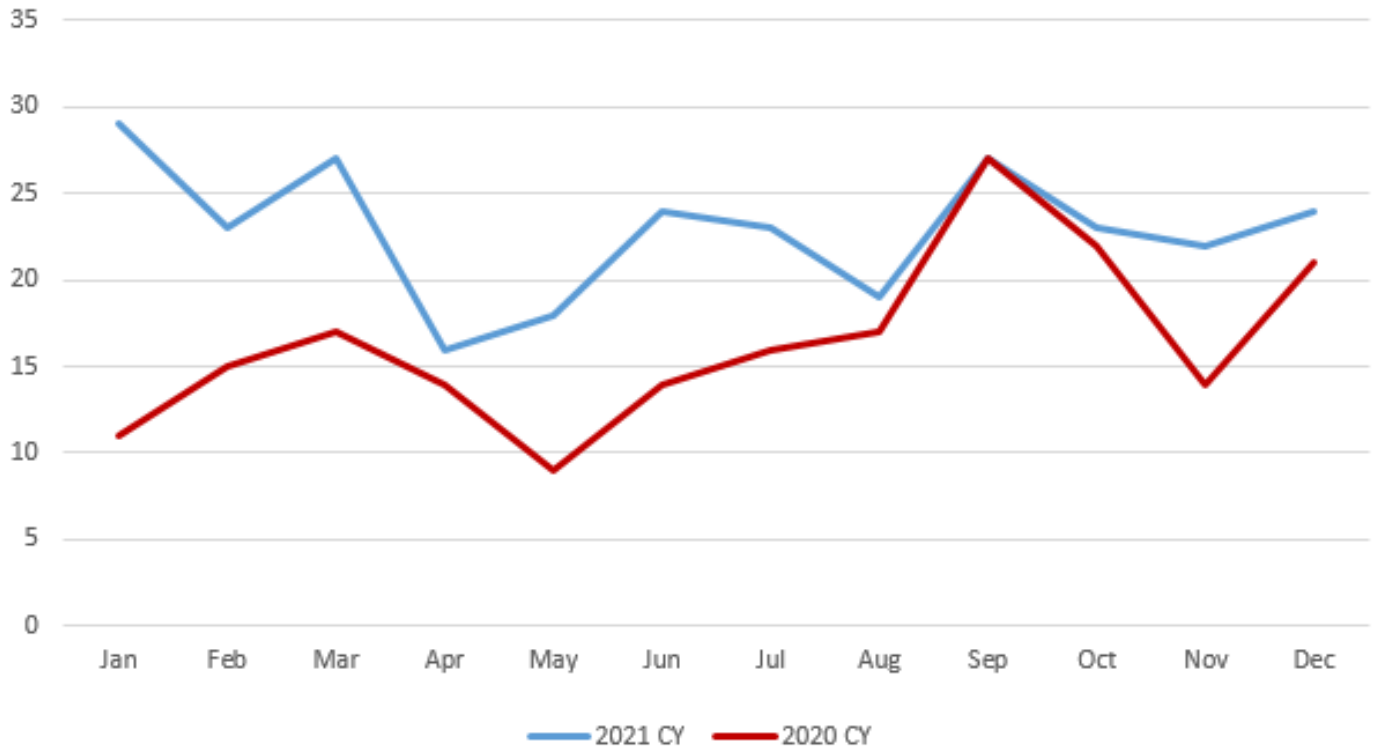
Kaweah Health Bedside RN Turnover January 2021– December 2021

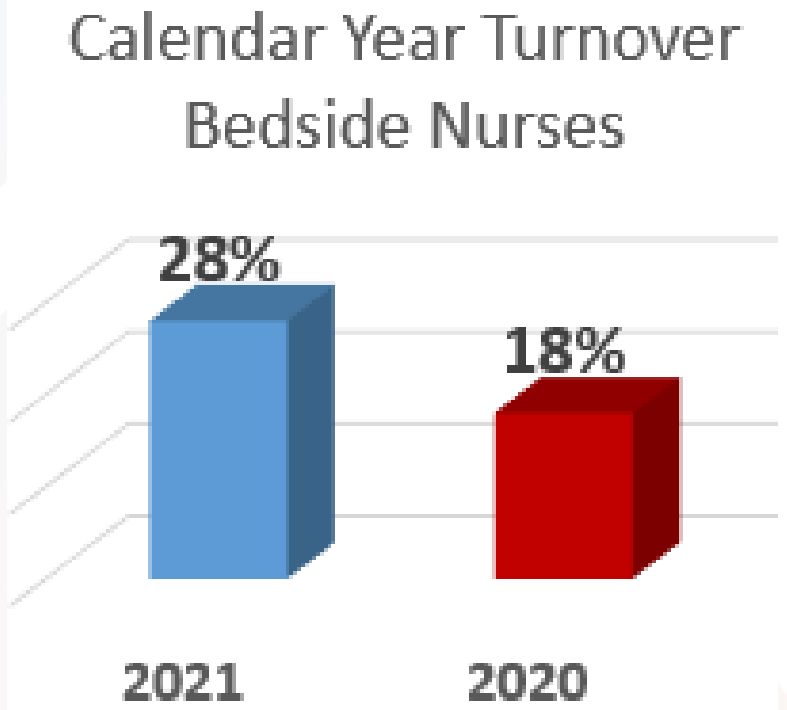
Includes FT/PT Bedside RNs



Kaweah Health

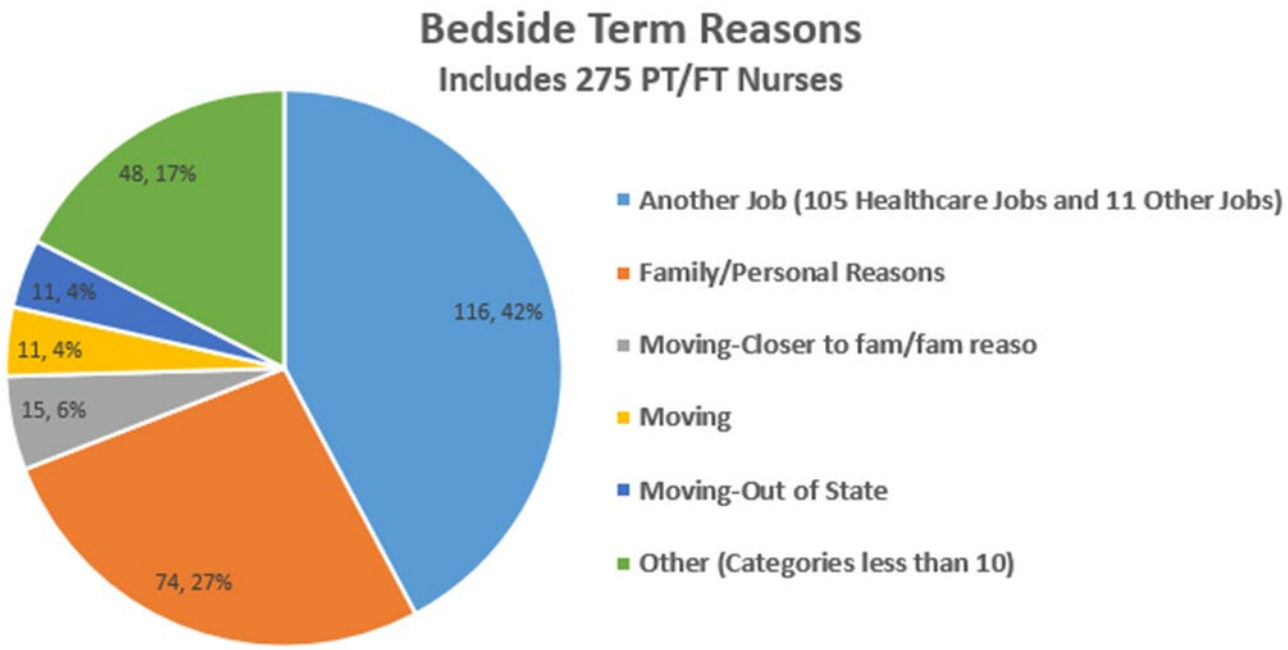
Bedside RN Terms by Month
January 2021– December 2021
Includes FT/PT Bedside RNs

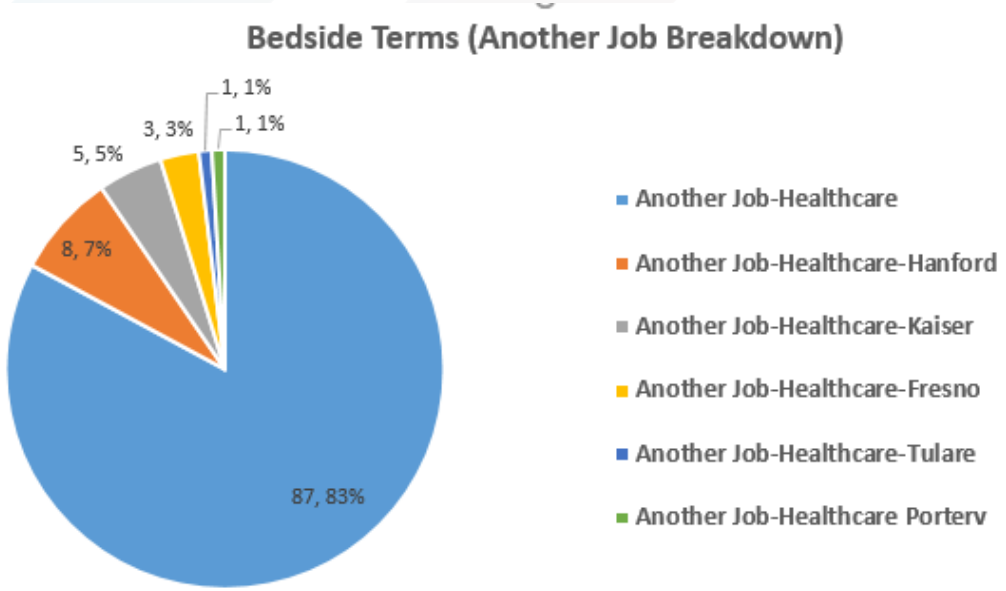




Kaweah Health

Reasons Direct Care RNs Left
CY 2021

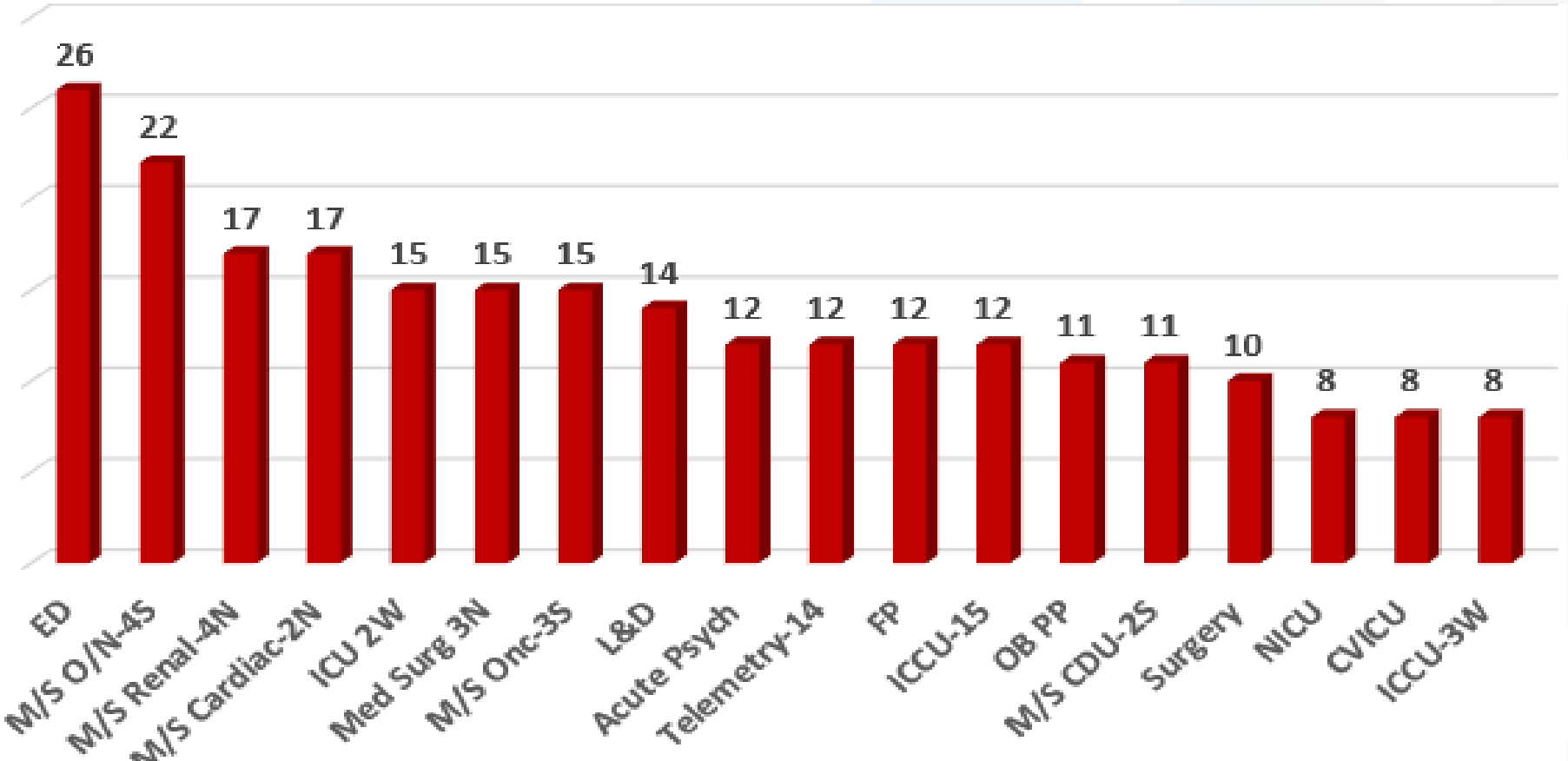




Kaweah Health

Departments with 5+ Bedside RN Terms January 2021– December 2021

Includes FT/PT Bedside RNs



Kaweah Health

Adverse Events and Staffing at Kaweah Health

- In 2021, a total of 21 Focus Reviews/Root Cause Analyses were conducted

Root Cause	Action Plan
Staffing Related (57%)	Enhanced Orientation, Residency Programs, Student Nurse Intern Program
	Active recruitment – permanent and travel nurse positions Participation in Job Fairs Partnership with Nursing Programs – Increase Seats
Communication Related (61%)	Communication tool training – on hire and annually
	Quality Focus Team – Patient HandOff
	Just Culture- Encourage safety concern reporting
	Safety checklists – pre/post procedure care areas
	Additional timeout at procedure completion
	Standardized documentation of legal hold status across all areas

KHMC Staff Assignment Guidelines

- ***Level of overall nursing experience*** (i.e., novice to expert)
  - Consider the experience level of the RNs at all times, all shifts
  - Consider reassigning/redistributing pts in an effort to balance workload
- ***Resources for mentoring, precepting, addressing skill development needs of nurses***
  - New hires assigned to Mentor RN as resource in addition to Charge RN
  - RN's who are orienting another RN should not be given a more difficult assignment because there are "2" of them
  - Preceptors will successfully completed a preceptor training class
- ***Specific needs of population served***
  - Reassess assignments throughout the day
  - Modify assignments as driven by unit activity & patient acuity
  - Attempt to keep RN room assignments approximated
  - PC. 205 Staffing & Scheduling
  - PC.180 Patient Placement Guidelines, Critical Care/Telemetry Units admission guidelines

https://www.nursingworld.org/~4a51bc/globalassets/practiceandpolicy/nurse-staffing/staffing-principles-infographic.pdf

Kaweah Health

Kaweah Health Applies Principles for Nurse Staffing to Mitigate Adverse Events

1. Staffing decisions based on census *and* acuity
2. RNs lead/partner in collaborative health care teams
   - Gemba rounds
   - Quality Focus Teams
3. Protected time to participate in safety culture initiatives
   - Kaizen
   - Comprehensive Unit-Based Safety Program
   - Shared Decision Making
4. Recruitment strategies:
   - Social media
   - Priority acceptance to nursing programs
   - Student nurse interns-Student nurse aides

https://www.nursingworld.org/~4a51bc/globalassets/practiceandpolicy/nurse-staffing/staffing-principles-infographic.pdf

KD Applies Principles for Nurse Staffing to Mitigate Adverse Events

5. Flex resources at all levels to meet rapidly changing patient/community needs
   - Staff training & competency, technology, personal protective equipment, environment
6. Ongoing efforts to improve data reporting and technology to support unit-level review of nurse-sensitive outcome indicators
   - Bar Code Medication Administration (BCMA)
   - Midas prompts include staff role in event
   - GEMBA rounds - data collection

https://www.nursingworld.org/~4a51bc/globalassets/practiceandpolicy/nurse-staffing/staffing-principles-infographic.pdf