December 8, 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, December 15, 2022, in the Kaweah Health Lifestyle Fitness Center Conference Room, 5105 W. Cypress Avenue, Visalia, CA 93277.
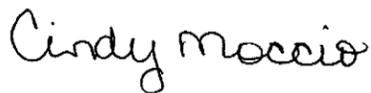
The Board of Directors of the Kaweah Delta Health Care District will meet in a Closed Quality Council Committee at 7:31AM on Thursday, December 15, 2022, in the Kaweah Health Lifestyle Fitness Center Conference Room, 5105 W. Cypress Avenue, Visalia, CA 93277, pursuant to Health and Safety Code 32155 & 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, December 15, 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, December 15, 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
   o **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.*
   o **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 – *Evelyn McEntire, RN, BSN, Director of Risk Management, and Ben Cripps, Chief Compliance and Risk Officer.*

4. **Adjourn Closed Meeting** – *David Francis, Committee Chair*

OPEN MEETING – 8:00AM

1. **Call to order** – *David Francis, Committee Chair*

2. **Public / Medical Staff participation –** Members of the public wishing to address the Committee concerning items not on the agenda and within the subject matter jurisdiction of the Committee may step forward and are requested to identify themselves at this time. Members of the public or the medical staff may comment on agenda items after the item has been discussed by the Committee but before a Committee recommendation is decided. In either case, each speaker will be allowed five minutes.

3. **Written Quality Reports –** A review of key quality metrics and actions associated with the following improvement initiatives:
   3.1. Infection Prevention Quality Dashboard
   3.2. Hand Hygiene Quality Report
   3.3. Renal Services Quality Report
   3.4. Subacute and Transitional Care Unit Quality Report
   3.5. Hospital Aquired Pressure Injuries (HAPI) Quality Focus Team
   3.6. Diversion Prevention Committee Quality Report

4. **2022 Annual Review of Quality and Patient Safety Plans -** A review of the Quality Improvement and Patient Safety Program Plans including scope, structure, function and priorities. Sandy Volchko, RN, DNP, Director of Quality and Patient Safety.

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

6. **Adjourn Open Meeting** – *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.

Thursday, December 15, 2022 – Quality Council   *Page 2 of 2*

| *David Francis* | *Lynn Havard Mirviss* | *Garth Gipson* | *Mike Olmos* | *Ambar Rodriguez* |
| *President* | *Vice President* | *Board Member* | *Secretary/Treasurer* | *Board Member* |

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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%**	**2.49%**	**2.07%**			**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:** IUSS activity continues to be higher than goal. **3rd QTR:** IUSS activity is improving, almost meeting goal. 7 events are due to instrument turnaround time; 8 events are due to instruments not being available; 2 events due to a contaminated instrument during surgery ; and 1 event in which the instrument was not available due to turnaround time. **4th QTR:**
B. Dialysis Water/Dialysate Quality Control (AAMI RD52:2004) (% of machines that did not exceed limits)							
Acute Dialysis (Inpatient) RO Water [Target: <200cfu] [Action: > or = 50cfu] Endotoxin [Target: <2EU] [Action: > or = 1EU]		**0%**	**0%**	**0%**			**1st QTR:** 51 Acute Dialysis RO Outlet samples and 6 Dialysis Machine samples were tested for bacterial & endotoxin counts and all results were within acceptable parameters. **2nd QTR:** 51 Acute Dialysis RO outlet samples and 6 Dialysis Machine samples were tested for bacterial & endotoxin counts and all results were within acceptable parameters. **3rd QTR:** 51 Acute Dialysis RO outlet samples and 5 Dialysis Machine samples were tested for bacterial & endotoxin counts and all results were within acceptable parameters. **4th QTR:**
Outpatient Dialysis RO Water [Target: <200cfu] [Action: > or = 50cfu] Endotoxin [Target: <2EU] [Action: > or = 1EU]		**0%**	**0%**	**0%**			**1st QTR:** 6 Outpatient Dialysis RO Outlet samples and 7 Dialysis Machine samples were tested for bacterial & endotoxin counts and all results were within acceptable parameters. **2nd QTR:** 7 Outpatient Dialysis RO Outlet samples and 8 Dialysis Machine samples were tested for bacterial endotoxin counts and all results were within acceptable parameters. **3rd QTR:** 6 Outpatient Dialysis RO Outlet samples and 6 Dialysate samples were tested for bacterial endotoxin counts and all results were within acceptable parameters. **4th QTR:**
C. Environmental Cleaning (ATP testing surfaces)							

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2022							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
Pass/Fail based on a threshold of ATP score of <200. Multiple high-touch surfaces tested each month.	Goal 100%	**69%**	**83.4%**	**80.3%**			**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:** A total of 339 samples were tested with 283 passing on first sweep, 59 failed. For all failed results the room was re-cleaned. Areas tested include (CVICU, MB, ICU, 4N, 5T, 3S, CVOR, OR, Main OR, OBOR, Cath Lab, 2E, 2N, 3N, 4S, BP, and PEDS.). Surfaces with greatest fallout are: Room sink, Rest Room sink, OR Table, Bedside Telephone. **3rd QTR:** A total of 418 samples were tested (79 or 23% increase from 2nd QTR), and 336 samples passed on first sweep, 82 failed. For all failed results the room was re-cleaned. Areas tested include (4T, 4S, ICU, 3N, 3S, 2E, 5T, 2S, 3W, Peds, Cath Lab, CVOR, CVICU, Main OR, 4N, BP, MB, OR). Sufaces with greatest fallout are: Overbed table, Calllight Button, Room Doorknob, Room Chair. EVS Leadership is working on streamlining and standardizing ATP testing to 30 specimens for each location.
II. Antimicrobial Stewardship Measures							
# of antibiotic IV to PO conversion		257	271	182			**1st QTR:** There were a total of 257 IV to PO conversion ABS interventions. The majority occurred CVICU and 3S. **2nd QTR:** There were a total of 271 IV to PO conversion ABS interventions. The majority occurred CVICU and ICU. The least occured in the ED. **3rd QTR:** There were a total of 182 IV to PO conversion ABS intervention. The majority occurred in CVICU, 3W and 1E/ED. **4th QTR:**
Average Days of Therapy per 1,000 patient days - Fluoroquinolones		Not available	Not available	Not available			**1st QTR:** This information is unavailable for 1st QTR. It will be presented at next IP Committee meeting. **2nd QTR:** This information is unavailable for 2nd QTR. It will be presented at next IP Committee meeting. **3rd QTR:** This information is unavailable for 3 QTR. A new ID Pharmacist has started and 2nd/3rd QTR information should be available by 4th QTR. **4th QTR:**
Average Days of Therapy per 1,000 patient days - Carbapenems		Not available	Not available	Not available			**1st QTR:** This information is unavailable for 1st QTR. It will be presented at next IP Committee meeting. **2nd QTR:** This information is unavailable for 2nd QTR. It will be presented at next IP Committee meeting. **3rd QTR:** This information is unavailable for 3 QTR. A new ID Pharmacist has started and 2nd/3rd QTR information should be available by 4th QTR. **4th QTR:**
III. Employee Health							
A. Needlestick Injuries							

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2022							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
Number of sharps/needle stick reports		11	15	NA			**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:** 8 events with the majority involving RNs (5) followed by LVNs (1) and Aides (1). Most needle sticks occur when engaging the needle safety mechanism with 3 of the devices involved in events being insuling syringes with a safety mechanism. There were additional events reported for 2nd QTR (3rd QTR data not yet available). An additional 7 sharps exposures occurred involving primarily needles with a safety mechanism, insulin syringes and sutures. This events are chiefly distributed among nurses and GME Residents. GME Residents account for the greatest number of sharps exposure during 2nd QTR. **3rd QTR:** Date not available yet.
B. Blood/Body Fluid Exposures							
Number of blood/body fluid exposures		3	0	NA			**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:** No splash events reported. **3rd QTR:** Date not available yet. **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	918	999			Cumulative Ct: 2,681
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	5	10			**1st QTR:** 5 **Predicted:** 11.627 **2nd QTR:** 5 **Predicted:** 12.993 **3rd QTR:** 10 **Predicted:** 12.933 **4th QTR:** **Predicted:**
C. Incidence Rate (IR) [# of total SSI infections/# total procedures x 100]	Internal 0.70 Goal	0.654	0.54	1			**1st QTR:** Better than State benchmark. **2nd QTR:** Better than State benchmark. **3rd QTR:** No different than State benchmark. **4th QTR:**
D. SIR Confidence Interval (CI-KDHCD predicted range, based on risks)		0.158, 0.953	0.141, 0.853	0.393, 1.378			**1st QTR:** With 95% confidence the SSI event incidence rate appropriately reflects the population. **2nd QTR:** With 95% confidence the SSI event incidence rate appropriately reflects the population. **3rd QTR:** With 95% confidence the SSI event incidence rate appropriately reflects the population. **4th QTR:**
E. Standardized Infection Ratio (SIR)	NHSN	0.43	0.385	0.773			**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:** There were 2 APPY, 2 COLO, 2 CSEC, 1 GAST, 2 KPRO, 1 SB SSI events in total. There 5 events of deep SSI events, amongst the total the following were deep SSI events 2 APPY, 2 CSEC, 1 KPRO. Findings for deep SSI events include: excessive entry/exit during surgery, clean closure procedure not performed, pre-op antibiotic administration not documented (uncertain if it occured), documentation to support PATOS or infection present at start of surgery. **3rd QTR:** There were 2 COLO, 1 CBGB, 1 CSEC, 1 KPRO, 1 HYST, 2 HER, 1 FX, 1 SB **4th QTR:**

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2022							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
V. Specific Surgical Review	SIR						
A. Colon Surgery (COLO) CMS/VBP							
1. #Total Procedure Count		28	37	28			Cumulative Ct: 93
2. Total Infection Count		0 [0]	0 [0]	2 [0]			**1st QTR:** 0 **Predicted:** 1.983/**CMS** 0 **Predicted:** 0.874 **2nd QTR:** 0 **Predicted:** 2.186/**CMS** 0 **Predicted:** 1.206 **3rd QTR:** 2 **Predicted:** 1.797 /**CMS** 0 **Predicted:** 0.909 **4th QTR:** **Predicted:** /**CMS** **Predicted:**
3. SIR CI (KDHCD predicted range, based on risks)		, 1.511	, 1.370	0.187, 3.678			**1st QTR:** With 95% confidence the absence of COLO SSI events appropriately reflects the population. **2nd QTR:** With 95% confidence the absence of COLO SSI events appropriately reflects the population. **3rd QTR:** With 95% confidence that absence of COLO SSI events appropriately reflects the population. **4th QTR:**
4. SIR (Standardized Infection Ration) total Value Based Purchasing (VBP) SIR = [ ]	VBP Goal <0.717	0.00	0	1.113			**1st QTR:** No COLO SSI events. **2nd QTR:** No COLO SSI events. **3rd QTR:** 2 COLO SSI events, both involve substitution of Cefotetan to Cefoxitan pre-op prophylactic antibiotic treatment. Hair removal in the O.R. was true for one case. Surgeon left 50 minutes prior to closure in the second case - patient had many comorbidities. **4th QTR:**
B. Cesarean Section (CSEC)							
1. #Total Procedure Count		230	220	279			Cumulative Ct: 729
2. Total Infection Count		1	2	1			**1st QTR:** 1 **Predicted:** 2.064 **2nd QTR:** 2 **Predicted:** 2.022 **3rd QTR:** 1 **Predicted:** 2.433 **4th QTR:** **Predicted:**
3. SIR CI (KDHCD predicted range, based on risks)		0.024, 2.390	0.166, 3.268	0.021, 2.027			**1st QTR:** With 95% confidence the 1 CSEC event is representative of the population of CSEC procedures performed. **2nd QTR:** With 95% confidence the 1 CSEC event is representative of the population of CSEC procedures performed. **3rd QTR:** With 95% confidence the 1 CSEC event is representative of the population of CSEC procedures performed. **4th QTR:**
4. SIR (Standardized Infection Ration) total	Goal SIR <1.00	0.49	0.989	0.411			**1st QTR:** There was 1 superficial Cesarean section SSI event 3 days post-op. Pre-op antibiotics not documented. **2nd QTR:** Both CSEC events were deep. One involved a patient with peripartum fever and infection 14 days post-op. The second event involved a procedure in which pre-op antibiotics were not documented making difficult to ascertain whether antibiotics were administered. **3rd QTR:** There was 1 superficial Cesarean section SSI event 9 days post-op involving a patient with a large pannus. Opsite was placed over incision site. Patient would have likely benefited from a Provena dressing over incision site instead. **4th QTR:**
C. Spinal Fusion (FUSN)							
1. #Total Procedure Count		44	62	67			Cumulative Ct: 173
2. Total Infection Count		0	0	0			**1st QTR:** 0 **Predicted:** 0.792 **2nd QTR:** 0 **Predicted:** 1.133 **3rd QTR:** 0 **Predicted:** 0.917 **4th QTR:** **Predicted:**

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2022							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
3. SIR CI (KDHCD predicted range, based on risks)		NA	NA	NA			**1st QTR:** With 95% confidence the absence of FUSN SSI events appropriately reflects the population. **2nd QTR:** NA **3rd QTR:** NA **4th QTR:**
4. SIR (Standardized Infection Ration) total	Goal SIR <1.00	0.00	0	0			**1st QTR:** No Spinal Fusion surgical site infections reported. **2nd QTR:** No Spinal Fusion surgical site infections reported. **3rd QTR:** No Spinal Fusion surgical site infections reported. **4th QTR:**
D. Hysterectomy (HYST) CMS/VBP							
1. #Total Procedure Count		14	15	15			**Cumulative Ct: 44**
2. Total Infection Count		0 [0]	0 [0]	1 [1]			**1st QTR:** 0 **Predicted:** 0.298/**CMS** 0 **Predicted:** 0.108 **2nd QTR:** 0 **Predicted:** 0.275 /**CMS** 0**Predicted:** 0.126 **3rd QTR:** 1 **Predicted:** 0.298/**CMS** 1 **Predicted:** 0.136 **4th QTR:** **Predicted:** /**CMS** **Predicted:**
3. SIR CI (KDHCD predicted range, based on risks)		NA	NA	NA			**1st QTR:** With 95% confidence the absence of HYST SSI events appropriately reflects the population. **2nd QTR:** NA **3rd QTR:** NA **4th QTR:**
4. SIR (Standardized Infection Ration) total Value Based Purchasing (VBP) SIR = [ ]	VBP Goal <0.738	0.00	0	3.36			**1st QTR:** There were no Abdominal Hysterectomy surgical site infection. **2nd QTR:** There were no Abdominal Hysterectomy surgical site infection. **3rd QTR:** There was one deep Abdominal Hysterectomy surgical site infection 5 days post-op. Very minimal operative documentation. Uncertain whether clean-closure performed. **4th QTR:**
VI. Ventilator Associated Events (VAE)	**SIR**						
A. Ventilator Device Use SUR (standardized utilization ratio)		1.83	1.221	0.823			**1st QTR:** 1,080 **Predicted:** 591.467 **2nd QTR:** 901 **Predicted:** 350.600 **3rd QTR:** 3,052 **Predicted:** 3,707.978 **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	, 0.886	0.300, 2.278			**1st QTR:** With 95% confidence the VAE event appropriately reflects the population of patients on a ventilator. **2nd QTR:** With 95% confidence the VAE event appropriately reflects the population of patients on a ventilator. **3rd QTR:** With 95% confidence the VAE event appropriately reflects the population of patients on a ventilator. **4th QTR:**
2. Total VAEs SIR	<1.0	0.32	0	0.944			**1st QTR:** Less than predicted number of events. **2nd QTR:** Less than predicted number of events. **3rd QTR:** Slightly less than predicted number of events. **4th QTR:**
C. Total IVAC Plus -ICU		1	0	3			**1st QTR:** Patient had a IVAC event after 5 days of ventilation. **2nd QTR:** No IVAC events. **3rd QTR:** There were 3 IVAC(+) events. **4th QTR:**

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2022							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
1. Total IVAC Plus CI (KDHCD predicted range, based on risks)		0.016, 1.557	, 2.387	0.486, 5.195			**1st QTR:** With 95% confidence the VAE event appropriately reflects the population of patients on a ventilator. **2nd QTR:** Less than predicted number of events. **3rd QTR:** With 95% confidence the VAE event appropriately reflects the population of patients on a ventilator. **4th QTR:**
2. Total IVAC *Plus* ICU SIR		0.117	0	1.909			**1st QTR:** Less than predicted number of events. **2nd QTR:** Less than predicted number of events. **3rd QTR:** Greater than predicted number of events. **4th QTR:**
1. Process Measures							
% of patients with head of bed >30 dregrees per visual inspection.	Goal = 100%	84.7%	79.5%	93.8%			**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:** 35 responses out of 44 responses. VAE prevention committee is meeting with Respiratory to determine ways in which to increase auditing and compliance. **3rd QTR:** 15 of 16 rounds demonstrated a patient whose head of bed was at >30 degrees. (low sample) **4th QTR:**
% Sedation Vacation	Goal = 100%	92.3%	38.6%	100.0%			**1st QTR:** 24 of 26 rounds demonstrated a patient who received a sedation vacation while on the ventilator. **2nd QTR:** 17 responses out of 44 responses. VAE prevention committee is meeting with Respiratory to determine ways in which to increase auditing and improve sedation vacation and mobility efforts. **3rd QTR:** 5 of 5 rounds demonstrated a patient who received a sedation vacation. (very low sample) **4th QTR:**
% Oral Care Provided (per visual inspection)	Goal = 100%	93.8%	100.0%	100.0%			**1st QTR:** 60 of 64 rounds demontrated a patient who received oral care based on visual inspection of the mouth. **2nd QTR:** 44 responses out of 44 responses. **3rd QTR:** 17 of 17 rounds demonstrated a patient who received oral care based on visual inspection of the mouth. (low sample) **4th QTR:**
% CHG Bath within last 24 hours	Goal = 100%	95.3%	100.0%	NA			**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:** 43 responses out of 43 responses. **3rd QTR:** CHG bathing information no longer monitored as part of the VAP prevention bundle. **4th QTR:**
% Vent Tubing Position Appropriately (drain away from patient - visual inspection)	Goal = 100%	90.6%	95.5%	100.0%			**1st QTR:** 58 or 64 rounds demonstrated a patient with ventilator tubing positioned appropriately (draining away from the patient's airway). **2nd QTR:** 42 responses out of 44 responses. **3rd QTR:** 17 of 17 rounds demonstrated a patient with ventilator tubing positioned appropriately (draining away from the patient's airway). (low sample) **4th QTR:**
VII. Central Line Associated Blood Stream Infections (CLABSI) CMS/VBP	NHSN SIR						
A. Total number of Central Line Days (CLD)		4284	3795	2,848			**Cumulative Ct:** 10,927
B. Central Line Device Use SUR (standardized utilization ratio)		0.736	0.718	0.668			**1st QTR:** 4284 CLD **Predicted:** 5819.971 **2nd QTR:** 3795 CLD **Predicted:** 5,284.516 **3rd QTR:** 2,848 CLD **Predicted:** 4,265.645 **4th QTR:** CLD **Predicted:**

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2022							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
C. Total Infection Count Value Based Purchasing (VBP) # events = [ ]		3 [0]	5 [3]	3 [2]			**1st QTR:** 3 **Predicted:** 4.213/**CMS:** 0 **Predicted:** 2.558 **2nd QTR:** 5 **Predicted:** 3.726/**CMS:** 3 **Predicted:** 2.257 **3rd QTR:** 3 **Predicted:** 2.816/**CMS:** 2 **Predicted:** 2.502 **4th QTR: Predicted: /CMS: Predicted:**
D. SIR Confidence Interval		0.181, 1.938	0.492, 2.974	0.271, 2.899			**1st QTR:** Worst than national benchmark. **2nd QTR:** Worst than national benchmark. **3rd QTR:** Worst than national benchmark. **4th QTR:**
E. SIR (Standardized Infection Ratio) total Value Based Purchasing (VBP) SIR = [ ]	≤ 0.589 excluding COVID population	0.712	1.342	1.065			**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 adherence to hand hygiene practice. **2nd QTR:** Events related to source control (i.e. osteomyelitis and endocarditis), family manipulating the patient's vascular line, patient scratching and pinching skin at vascular line insertion site, femoral line access in a patient that it was inappropriate for, and poor hand hygiene practice amongst healthcare workers. **3rd QTR:** First event involved a dislodged port and late orders for cultures. Second event was likely due to respiratory secretions contaminating the insertion site. Last case would have benefited from prophylactic Diflucan to avoid Candidemia. **4th QTR:**
F. Process Measures							
% of patients with a bath within 24 hours	Goal 100%	96.0%	89.5%	87.1%			**1st QTR:** 1,642 responses out of 1,703 rounds. **2nd QTR:** 1,281 responses out 1,432 responses. **3rd QTR:** 2,596 responses out of 2,979 rounds. **4th QTR:**
% of central lines inserted with a valid rationale	Goal 100%	97.0%	96.8%	95.8%			**1st QTR:** 1,046 responses out of 1,703 rounds. **2nd QTR:** 822 responses out of 849 responses. **3rd QTR:** 1,517 responses out of 1,584 rounds. **4th QTR:**
% of central line dressings clean, dry and intact	Goal 100%	98.0%	98.5%	97.1%			**1st QTR:** 1,042 responses out of 1,703 rounds. **2nd QTR:** 836 responses out of 849 responses. **3rd QTR:** 1,542 responses out of 1,588 rounds. **4th QTR:**
% of central line dressing changes no > than 7 days	Goal 100%	98.0%	91.6%	97.2%			**1st QTR:** 1,048 responses out of 1,703 rounds. **2nd QTR:** 772 responses out of 843 responses. **3rd QTR:** 1,543 responses out of 1,588 rounds. **4th QTR:**
% of patients with properly placed CHG patch	Goal 100%	98.0%	90.4%	51.9%			**1st QTR:** 541 responses out of 552 rounds. **2nd QTR:** 481 responses out 532 responses. **3rd QTR:** 824 responses out of 1,588 rounds. **4th QTR:**
% of patients with appropriate & complete documentation	Goal 100%	95.0%	90.9%	95.0%			**1st QTR:** 1,250 responses out of 1,333 rounds. **2nd QTR:** 768 responses out of 845 responses. **3rd QTR:** 1,507 responses out of 1,587 rounds. **4th QTR:**
# of central line days rounded on		2,871	844	1,584			**1st QTR:** Approximately, 957 central lines rounds a month. **2nd QTR:** Approximately, 488 central lines rounds a month. **3rd QTR:** Approximately 528 central line rounds a month. **4th QTR:**
Skilled Nursing/Acute Rehab % of central dressing clean/dry/intact	Goal 100%	95.9%	99.0%	98.3%			**1st QTR:** 47 of 49 central dressing were clean, dry and intact. **2nd QTR:** 190 respones out of 192 responses. **3rd QTR:** 119 responses out of 121 rpunds. **4th QTR:**

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2022							
		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	98.2%	98.3%			**1st QTR:** There were no reports provided for this metric. **2nd QTR:** 167 responses out of 170 responses. **3rd QTR:** 119 reposes out of 121 rounds. **4th QTR:**
VIII. Catheter Associated Urinary Tract Infections (CAUTI) CMS/VBP	NHSN SIR						
A. Total number of Catheter Device Days (CDD)		4713	3494	3052			**Cumulative Ct:** 11,259
B. Catheter Device Days SUR (Standardized Utilization Ratio)		0.915	0.751	0.823			**1st QTR:** 4713 CDD **Predicted:** 5150.948 CDD **2nd QTR:** 3494 CDD **Predicted:** 4650.527 CDD **3rd QTR:** 3052 CDD **Predicted:** 5,943.111 CDD **4th QTR:** CDD **Predicted:** CDD
C. Total Infection Count Value Based Purchasing (VBP) # of events = [ ]		8 [5]	3 [3]	4 [4]			**1st QTR:** 8 **Predicted:** 6.115/**CMS:** 5 **Predicted:** 3.240 **2nd QTR:** 3 **Predicted:** 4.549/**CMS:** 3 **Predicted:** 2.089 **3rd QTR:** 4 **Predicted:** 3.970/**CMS:** 4 **Predicted:** 3.216 **4th QTR:** **Predicted:** /**CMS:** **Predicted:**
D. SIR Confidence Interval		0.608, 2.484	0.168, 1.795	0.395, 3.00			**1st QTR:** Worst than national benchmark. **2nd QTR:** Worst than national benchmark. **3rd QTR:** Worst than national benchmark. **4th QTR:**
E. SIR (Standardized Infection Ratio) total Value Based Purchasing (VBP) SIR = [ ]	≤ 0.650 excluding COVID population	1.308	0.66	1.244			**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:** Events related to: single fever as an impetus to culture, peri-care not provided, culture-of-culturing, pan-culturing, and unnecessary cultures. **3rd QTR:** First event may be due to catheter insertion practices. Second event could have been prevented with better hand hygiene compliance, also uncertain why Q1hr. I&Os (rationale for catheter) really was needed considering the patient was on a Med/Surg unit. Third event due to inappropriate culturing practices and inappropriate rationale for indwelling urinary catheter. Fourth case due to insufficient patient bathing and patient pulling on his catheter. **4th QTR:**
F. Process Measures							
% of patients with appropriate cleanliness (a minimum of peri-care in the last 12 hours)	Goal 99%	99.0%	96.9%	96.3%			**1st QTR:** 1,991 responses out of 2,126 rounds. **2nd QTR:** 751 responses out of 775 responses. **3rd QTR:** 1735 responses out of 1803 rounds. **4th QTR:**
% of IUCs with order and valid rationale	Goal 100%	96.0%	95.8%	94.9%			**1st QTR:** 1,171 responses out of 1,240 rounds. **2nd QTR:** 738 responses out 770 responses. **3rd QTR:** 1,714 responses out of 1,807 rounds. **4th QTR:**
% of IUCs where removal was attempted		6.3%	1.8%	4.4%			**1st QTR:** 56 responses out of 890 rounds. **2nd QTR:** 14 responses out 770 responses. **3rd QTR:** 80 responses out of 1,804 rounds. **4th QTR:**
% of patients where alternatives have been attempted		10.4%	6.7%	7.6%			**1st QTR:** 129 responses out of 1,235 rounds. **2nd QTR:** 52 responses out 773 responses. **3rd QTR:** 137 responses out of 1,799 rounds. **4th QTR:**
% of IUCs removed because of unit "GEMBA" rounds		5.2%	4.4%	3.0%			**1st QTR:** 64 responses out of 1,237 rounds. **2nd QTR:** 28 responses out of 770 responses. **3rd QTR:** 76 responses out 1,782 rounds. **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		64	28	76			**1st QTR:** Approximately, 21 indwelling urinary catheters a month were removed as a results of Gemba rounds. **2nd QTR:** Approximately, 9 indwelling urinary catheters a month were removed as a result of Gemba rounds. **3rd QTR:** Approximately, 25 indwelling urinary catheters a month were removed as a result of Gemba rounds. **4th QTR:**
# of Indwelling Urinary Catheter days rounded on		2,607	764	1,803			**1st QTR:** Approximately, 869 rounds on indwelling urinary catheters a month. **2nd QTR:** Approximately, 255 rounds on indwelling urinary catheters a month. **3rd QTR:** Approximately, 601 rounds on indwelling urinary catheters a month. **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%	98.1%	98.7%			**1st QTR:** 87 of 91 complete baths were performed within 24 hours. **2nd QTR:** 305 responses out of 311 responses. **3rd QTR:** 77 responses out of 78 rounds. **4th QTR:**
Skilled Nursing/Acute Rehab % of peri care performed within in a 12 hour shift	Goal 100%	98.1%	97.9%	94.9%			**1st QTR:** 53 of 54 pericare actions were completed and documented within the 12 hour shift. **2nd QTR:** 185 responses out of 189 responses. **3rd QTR:** 74 responses out of 78 rounds. **4th QTR:**
IX. Catheter Associated Urinary Tract Infections Long Term Care/Rehabilitation	Goal = 0						
Short Stay (# of Infections/ Incidence Rate)		0	0	0			**1st QTR:** There were no CAUTI events. **2nd QTR:** There were no CAUTI events. **3rd QTR:** There were no CAUTI events. **4th QTR:**
Transitional Care (# of Infections/ Incidence Rate)		0	1	0			**1st QTR:** There were no CAUTI events. **2nd QTR:** There was 1 Symptomatic Catheter Associated Urinary Tract Infection events with a foley catheter in place. The CAUTI rate = 2.571 **3rd QTR:** There were no CAUTI events. **4th QTR:**
Subacute (# of Infections/ Incidence Rate)		0	0	0			**1st QTR:** There were no CAUTI events. **2nd QTR:** There were no CAUTI events. **3rd QTR:** There were no CAUTI events. **4th QTR:**
Acute Rehabilitiation (# of Infections/ Incidence Rate)		0	0	0			**1st QTR:** There were no CAUTI events. **2nd QTR:** There were no CAUTI events. **3rd QTR:** There were no CAUTI events. **4th QTR:**
X. LTC Symptomatic Urinary Tract Infections	Goal = 0						
Short Stay (# of Infections/ Incidence Rate)		2	1	1			**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:** There was 1 Symptomatic Urinary Tract Infection event without a foley catheter in place. The SUTI rate = 0.241 **3rd QTR:** There was 1 Symptomatic Urinary Tract Infection event without a foley catheter in place. SUTI rate = 0.58 **4th QTR:**
Transitional Care (# of Infections/ Incidence Rate)		0	0	2			**1st QTR:** There were no SUTI events. **2nd QTR:** There were no SUTI events. **3rd QTR:** There were 2 SUTI events. SUTI rate = 2.03. **4th QTR:**

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		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
Subacute (# of Infections/ Incidence Rate)		0	0	0			**1st QTR:** There were no SUTI events. **2nd QTR:** There were no SUTI events. **3rd QTR:** There were no SUTI events. **4th QTR:**
XI. Clostridium *difficile* **Infection (CDI) CMS/VBP**	SIR						
A. Total Infection Count	All units	9	8	10			**1st QTR:** 9 **Predicted:** 18.253 **2nd QTR:** 8 **Predicted:** 17.250 **3rd QTR:** 10 **Predicted:** 18.158 **4th QTR:** **Predicted:**
B. SIR CI (KDHCD predicted range, based on risks)		0.240, 0.905	0.215, 0.881	0.280, 0.982			**1st QTR:** Better than National benchmark. **2nd QTR:** Better than National benchmark. **3rd QTR:** Better than National benchmark. **4th QTR:**
C. SIR (Standardized Infection Ratio) total Value Based Purchasing (VBP) SIR = [ ]	VBP Goal <0.520	0.493	0.464	0.551			**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:** Infection Prevention continues to remind nursing and providers about the C-difficile algorithm. Information was also shared at GME orientation with new Residents. **3rd QTR:** Infection Prevention is closely monitoring the upward trend in the HO CDIFF rate. There has been a couple of months without an Antimicrobial Stewardship Pharmacist. A new hire has been approved and waiting for this Antimicrobial Stewardship Pharmacist to start - history demonstrates this position has been integral in reducing and sustaining a reduction in C. difficile rates. **4th QTR:**
XII. Hand Hygiene	95%						
A. Total Hand Hygiene Observations (combination of manual and electronic hand hygiene surveillance)		2,277,368	2,535,346	3,223,855			**1st QTR:** BioVigil electronic hand hygiene surveillance system was installed at South and West campuses. Go-Live with nearly systemwide surveillance occurred on 3/26/2022. The only areas were manual hand hygiene compliance rates are gathered on clinics and Mental Health. **2nd QTR:** BioVigil electronic hand hygiene surveillance system is gathering information throughout the majority of Kaweah Health. **3rd QTR:** **4th QTR:**
B. All units Percentage of Hand Hygiene compliance based on observations/opportunities (>200 observations/ month/unit)		97.1%	97.3%	96.4%			**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:** Now there are 4,147 registered users on BioVigil. A total of 2,466,892 hand hygiene opportunities were performed appropriately. **3rd QTR:** **4th QTR:**
C. Percentage of Hand Hygiene compliance performed during "Day Shift"		97.0%	97.6%	Not available			**1st QTR:** Day shift and night shift have equal compliance rates. Will continue to encourage hand hygiene compliance. **2nd QTR:** 1,330,634 HHOs performed appropriately out of 1,363,355 opportunities. **3rd QTR:** Not available. **4th QTR:**

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2022							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
D. Percentage of Hand Hygiene compliance performed during "Night Shift"		97.0%	97.3%	Not available			**1st QTR:** Night shift and day shift have equal compliance rates. Will continue to encourage hand hygiene compliance. **2nd QTR:** 745,837 HHOs performed out of 766,533 opportunities. **3rd QTR:** Not available. **4th QTR:**
XIII. VRE (HAI) Blood-Hospital Onset (HO)							
A. Total Infection Count		0	1	0			**1st QTR:** 0 **Predicted:** 0 **2nd QTR:** 1 **Predicted:** 0 **3rd QTR:** 0 **Predicted:** 0 **4th QTR:** **Predicted:**
B. Prevalence Rate (x100)		0	0.024	0			**1st QTR:** Better than National benchmark. **2nd QTR:** Better than National benchmark **3rd QTR:** Better than National benchmark **4th QTR:**
C. Number Admissions		4,244	4,158	6,464			**Cumulative Ct:** 14,866
XIV. MRSA (HAI) Blood CMS/VBP	**SIR**						
A. Total Infection Count (IP Facility-wide)		2	2	2			**1st QTR:** 2 **Predicted:** 1.247 **2nd QTR:** 2 **Predicted:**1.123 **3rd QTR:** 2 **Predicted:** 1.187 **4th QTR:** **Predicted:**
B. SIR CI (KDHCD predicted range, based on risks)		0.269, 5.297	0.679, 7.268	0.282, 5.565			**1st QTR:** Worse than National benchmark. **2nd QTR:** Worse than National benchmark. **3rd QTR:** Worse than National benchmark. **4th QTR:**
C. SIR (Standardized Infection Ration) total Value Based Purchasing (VBP) SIR = [ ]	≤ 0.726 excluding COVID population	1.603	1.78	1.684			**1st QTR:** 2 HO MRSA BSI events. **2nd QTR:** 2 HO MRSA BSI events. Related to source control (osteomyelitis/endocarditis) and positive test results that exceed 14 days post admission. Note, there was 1 additional HO MRSA reported during May 2022, but this was not actually an event the case involved MSSA and not MRSA (Lab corrected this information). **3rd QTR:** 2 HO MRSA BSI events. Both events were related to serial blood cultures obtained across different nursing units. Both events involve patients with MRSA in bloodstream present-on-admission. Per NHSN criteria these events shouldn't impact the hospital SIR as positive cultures didn't exceed 14 days repeat-infection-period. IP Manager is contacting the State CDPH HAI Program to determine why hospital SIR is being effected when it should not.
XV. MDRO LABID - Long Term Care							
Short Stay (# of Infections/ Incidence Rate)		0	0	0			**1st QTR:** There were no MDRO reported. **2nd QTR:** Gap analysis performed and risk assessment updated. Contact isolation fallouts noted with patients requiring isolation. In response, staff were inserviced and audits performed specifically for: isolation order, signage, caddie on door, PPE utilization and shift handoff. Improvements noted with audits for: signage, caddies, and PPE. Still working on orders and shift handoff. **3rd QTR:** There were no MDRO reported. **4th QTR:**

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2022						
		Q1	**Q2**	**Q3**	**Q4**	**AVG. or TOTAL YTD**	**SUMMARY / ACTION**
Transitional Care (# of Infections/ Incidence Rate)		1	0	0			**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:** There were no MDRO reported. Enhanced Standard Precautions staff education completed and new Powerform due for go-live during August. **3rd QTR:** There were no MDRO reported. **4th QTR:**
Subacute (# of Infections/ Incidence Rate)		0	0	0			**1st QTR:** There were no MDRO reported. **2nd QTR:** There were no MDRO reported. Enhanced Standard Precautions staff education completed and new Powerform due for go-live during August. **3rd QTR:** There were no MDRO reported. **4th QTR:**
XVI. Influenza Rates (Year 2020-2021)	NHSN						
A. All Healthcare Workers		87.0%					**1st QTR:** Total number of healthcare personnel having worked at least 1 day at Kaweah Health during Oct. 1, 2021 through March 30, 2022 = 5,142 with 4,470 receiving influenza vaccine rate. LIP =87% (475), Employees-only = 86% (3,434), Students/Volunteers = 96% (561)
XVII. COVID-19 Vaccination Rates (Year 2020-2021)							
A. All Healthcare Workers with a completed series of COVID-19 vaccinations.		4,805	4,875	3,951			**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:** Of 5,979 employees 4,875 have completed their series of COVID-19 vaccinations as of June 30, 2022. This demonstrates an 81.5% complete vaccination rate. **3rd QTR:** Of a total 4,727 employees 3,951 employees were vaccinated for COVID-19 (last week of 3rd QTR), accounting for 83.6% vaccination rate. Of the 3,951 employee vaccinated there were 2,662 "Up-To-Date" with vaccinations accounting for 56.3% of employees being "Up-to-Date". **4th QTR:**
Approved IPC: 4/28/2022 Approved IPC: 7/28/2022 Approved IPC: 10/27/2022 Approved IPC: Prepared by: Shawn Elkin, Infection Prevention Manager							

Biannual Hand Hygiene Report

Quality Council

12/15/2022

kaweahhealth.org

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Hand Hygiene (HH) Monitoring

- 4th QTR 2019 - BioVigil electronic hand hygiene was initially piloted on 4N and ICU (total of 50 beds).

- 1st QTR 2021 – BioVigil added to total of 428 beds in all downtown patient care areas, excluding procedural areas and ED.

- 1st QTR 2022 - BioVigil added to total of 245 more beds to include, ED, ASC, Dialysis Clinic, Endoscopy, CVU, Infusion Center, Rehab, and TCS/Subacute.

- Once again during 1st QTR 2022 – BioVigil added to total of 25 beds – ED Zone 5 and 1 additional bed in Dialysis Clinic.

Kaweah Health.

Hand Hygiene Monitoring

- Only Mental Health and the Rural Clinics are not covered by the BioVigil electronic hand hygiene surveillance system.

- Rural Health Clinics uses NRC to monitor hand hygiene compliance through the eyes of the patient. Patients are asked by electronic survey if they observed their healthcare worker perform hand hygiene.

- Mental Health performs its own hand hygiene audits monthly, a minimum of 200 observations a month.

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Hand Hygiene Monitoring

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

Kaweah Health.

Hand Hygiene Outcome Measures

Hand hygiene compliance is trending toward almost all units but achieving goal of ≥95% .

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

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

Measure Description	Benchmark /Target	2019Q4	2020Q1	2020Q2	2020Q3	2020Q4	2021Q1	2021Q2	2021Q3	2021Q4	2022Q1	2022Q2	2022Q3	sparklines
OUTCOME MEASURES														
HH Overall Compliance	95%	98.97	98.98	98.91	98.16	97.61	97.17	97.42	97.23	97.25	97.11	97.28	96.43	
Number of HH Audits Performed	n/a	86,487	552,670	312,205	1,798,574	3,320,010	2,794,940	2,343,324	2,317,980	2,446,234	2,277,805	2,535,346	3,224,539	
HH Overall Compliance - Patient Care Areas	95%	98.97	98.98	98.91	98.16	97.61	97.17	97.42	97.23	97.25	97.14	97.45	96.91	
Number of HH Audits Performed - Patient Care Areas	n/a	86,487	552,670	312,205	1,798,574	3,320,010	2,794,940	2,343,324	2,317,980	2,446,234	2,220,755	2,129,888	2,814,903	

Hand Hygiene Process Measures

There is very little difference observed between days, evenings, weekdays and weekends.

There are 39% more HH observations during AM shift compared to PM shift. Both shifts have an average compliance rate of 97%.

There are 28% more HH observations during weekdays compared to weekends. Weekends demonstrate .01% greater HH compliance compared to weekdays on average, 97.78% versus 97.77%.

Measure Description	Benchmark /Target	2019Q4	2020Q1	2020Q2	2020Q3	2020Q4	2021Q1	2021Q2	2021Q3	2021Q4	2022Q1	2022Q2	2022Q3	sparklines
Hand Hygiene By Day/time														
HH Overall Compliance - AM Shift	95%	99.17	99.16	98.83	98.14	97.48	97.24	97.33	97.10	97.16	97.19	97.57	96.85	
Number of HH Audits Performed - AM Shift	n/a	49,649	320,577	182,697	1,112,948	2,045,788	1,724,773	1,430,330	1,441,623	1,523,544	1,406,447	1,363,355	1,787,095	
HH Overall Compliance - PM Shift	95%	98.69	98.72	99.03	98.20	97.82	97.05	97.58	97.43	97.40	97.06	97.25	97.02	
Number of HH Audits Performed - PM Shift	n/a	36,838	232,093	129,508	685,626	1,274,222	1,070,167	912,994	876,357	922,690	814,308	766,533	1,027,808	
HH Overall Compliance - Weekdays	95%	98.94	98.99	98.90	98.17	97.65	97.21	97.39	97.22	97.21	97.10	97.47	96.94	
Number of HH Audits Performed - Weekdays	n/a	61,728	417,725	239,942	1,354,547	2,509,237	2,129,002	1,790,145	1,773,710	1,856,204	1,683,359	1,605,552	2,159,895	
HH Overall Compliance - Weekends	95%	99.05	98.94	98.96	98.13	97.49	97.03	97.53	97.26	97.39	97.27	97.39	96.94	
Number of HH Audits Performed - Weekends	n/a	24,759	134,945	72,263	444,027	810,773	665,938	553,179	544,270	590,030	537,396	524,336	655,008	

Hand Hygiene Process Measures

During 3rd quarter 2022, all units are performing at 95% or greater hand hygiene compliance with few exceptions.

CVICU and CVICCU have undergone recent leadership changes. Expectations related to hand hygiene compliance is being shared. It is projected that 4th quarter rates will show improvement.

Measure Description	Benchmark /Target	2019Q4	2020Q1	2020Q2	2020Q3	2020Q4	2021Q1	2021Q2	2021Q3	2021Q4	2022Q1	2022Q2	2022Q3	sparklines
Hand Hygiene By Patient Care Unit Location (*biovgil data)														
2AcequiaCVC - HH Compliance	95%	88.00	94.00	88.00	99.00	100.00	100.00	100.00	100.00	93.00	95.00	96.70	95.09	
2AcequiaCVC - HH Audits Performed	n/a	41	52	25	198	21	404	502	302	530	10,844	53,371	42,565	
2EastLabor&Delivery - HH Compliance	95%	86.00	80.00	65.00	97.24	97.33	97.64	97.51	97.24	97.97	97.82	97.55	96.69	
2EastLabor&Delivery - HH Audits Performed	n/a	80	76	46	70,276	148,020	129,732	131,498	149,119	145,080	129,564	88,627	103,004	
2NorthMedTele - HH Compliance	95%	79.00	61.00	81.00	97.23	96.92	97.36	97.62	97.26	97.09	96.29	96.57	96.22	
2NorthMedTele - HH Audits Performed	n/a	82	127	110	140,554	234,410	221,218	167,286	199,907	269,698	264,047	189,213	301,432	
2SouthObservation - HH Compliance	95%	89.00	50.00	83.00	98.43	98.08	98.02	98.51	97.82	98.31	98.16	98.29	97.13	
2SouthObservation - HH Audits Performed	n/a	28	90	102	67,987	157,102	133,157	131,810	108,888	138,197	162,681	131,994	198,290	
2WestICU - HH Compliance	95%	98.50	98.44	97.12	96.90	97.34	96.33	97.37	96.93	97.45	97.98	97.47	97.21	
2WestICU - HH Audits Performed	n/a	33,348	203,637	29,058	108,729	144,031	95,348	123,559	113,931	138,509	121,395	86,007	105,906	
3AcequiaCVICU - HH Compliance	95%	100.00	90.40	NULL	97.69	97.43	96.91	96.07	93.35	95.40	95.68	94.91	94.94	
3AcequiaCVICU - HH Audits Performed	n/a	122	63	NULL	91,774	157,004	120,389	131,750	136,066	119,300	100,240	99,668	124,011	
3AcequiaMotherBaby - HH Compliance	95%	99.00	99.00	100.00	98.18	97.74	97.81	97.93	97.03	97.79	97.92	97.84	97.68	
3AcequiaMotherBaby - HH Audits Performed	n/a	152	152	66	81,760	145,315	122,579	101,757	97,097	103,873	98,568	73,338	116,440	
3EastPediatrics - HH Compliance	95%	96.00	90.90	100.00	98.76	98.30	98.13	98.17	98.00	97.35	97.35	97.75	97.57	
3EastPediatrics - HH Audits Performed	n/a	51	33	18	5,498	21,187	14,734	22,950	24,640	25,754	21,844	15,880	22,493	
3EastPostSurgery - HH Compliance	95%	98.00	NULL	NULL	97.85	98.21	98.18	98.46	99.04	98.93	98.79	99.19	98.98	
3EastPostSurgery - HH Audits Performed	n/a	40	NULL	NULL	36,195	86,475	77,833	66,474	58,299	53,267	49,782	37,488	58,909	
3NorthMedSurg - HH Compliance	95%	84.00	80.00	75.00	98.69	98.38	98.23	98.25	98.32	98.31	98.19	97.96	97.92	
3NorthMedSurg - HH Audits Performed	n/a	64	105	63	157,106	306,844	271,518	208,799	187,554	201,745	176,546	169,860	224,382	
3SouthOncology - HH Compliance	95%	76.00	81.00	85.00	98.59	97.98	97.76	97.66	96.82	96.86	96.72	96.22	95.25	
3SouthOncology - HH Audits Performed	n/a	71	84	67	170,917	357,067	328,071	268,062	216,920	238,207	248,334	170,462	225,962	
3WestICCU - HH Compliance	95%	98.00	89.00	100.00	96.99	97.02	95.59	96.72	96.33	94.34	95.52	96.23	96.31	
3WestICCU - HH Audits Performed	n/a	63	71	61	84,081	157,893	131,983	114,691	124,755	131,411	135,100	100,603	148,535	
4AcequiaMedicalTelemetry - HH Compliance	95%	97.00	100.00	100.00	98.60	97.91	97.40	97.80	97.30	97.14	97.24	97.47	97.32	
4AcequiaMedicalTelemetry - HH Audits Performed	n/a	32	70	17	103,470	251,186	187,526	149,809	121,763	91,726	69,421	47,450	70,296	
4NorthRenalMedSurg - HH Compliance	95%	99.26	99.29	99.10	98.77	98.17	98.06	98.01	97.67	97.58	97.16	97.63	97.15	
4NorthRenalMedSurg - HH Audits Performed	n/a	53,139	349,033	283,147	335,897	379,797	348,343	316,657	330,358	302,329	262,742	232,306	315,661	
4SouthOrthoNeuroMedSurg - HH Compliance	95%	97.00	66.00	31.00	98.84	98.03	97.43	97.18	98.28	98.02	96.97	97.30	96.64	
4SouthOrthoNeuroMedSurg - HH Audits Performed	n/a	113	32	13	149,209	292,764	243,596	103,355	178,163	194,597	137,594	127,900	124,886	
5AcequiaCVICCU - HH Compliance	95%	NULL	NULL	NULL	97.30	95.25	93.47	93.84	95.38	94.19	94.83	94.90	92.55	
5AcequiaCVICCU - HH Audits Performed	n/a	NULL	NULL	NULL	127,579	351,393	302,510	203,322	139,949	148,872	121,624	116,897	139,306	

Hand Hygiene Process Measures

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

Infusion had some logistical issues related to use of BioVigil that the vendor addressed during late 3rd quarter 2022.

Emergency Department has improved hand hygiene over time. The layout and function of the ED presents challenges and there is a learning curve on how BioVigil is appropriately used in this environment. Hand hygiene compliance is hovering around 90%. With continued experience and training this rate of compliance will meet goal.

Measure Description	Benchmark/Target	2019Q4	2020Q1	2020Q2	2020Q3	2020Q4	2021Q1	2021Q2	2021Q3	2021Q4	2022Q1	2022Q2	2022Q3	sparklines
Hand Hygiene By Patient Care Unit Location (*biovgil data)														
6AcequiaNICU - HH Compliance	95%	89.00	74.00	85.00	99.14	99.51	99.38	99.59	99.47	99.47	99.59	99.63	99.41	
6AcequiaNICU - HH Audits Performed	n/a	90	90	89	67,542	129,522	66,403	101,545	130,571	143,669	107,434	82,183	143,019	
ASC - HH Compliance	95%	98.00	100.00	48.00	83.00	75.00	100.00	100.00	100.00	77.00	98.60	98.82	97.40	
ASC - HH Audits Performed	n/a	114	131	118	65	91	552	628	512	60	5,358	35,699	34,630	
Emergency Department - HH Compliance	95%	61.00	72.00	52.00	47.00	NULL	92.00	90.00	90.00	63.00	88.00	94.74	90.01	
Emergency Department - HH Audits Performed	n/a	66	68	140	155	NULL	636	207	647	252	31,244	200,632	213,664	
Endoscopy - HH Compliance	95%	100.00	92.00	100.00	100.00	100.00	100.00	0.00	0.00	0.00	99.42	99.19	97.44	
Endoscopy - HH Audits Performed	n/a	29	24	12	27	30	10	0	0	0	3,116	19,680	21,279	
Infusion - HH Compliance	95%	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	98.21	97.87	94.44	
Infusion - HH Audits Performed	n/a	30	36	20	30	30	30	40	30	20	2,293	10,399	12,958	
SouthCampusSubAcuteCare - HH Compliance	95%	100.00	71.40	100.00	100.00	100.00	97.00	0.00	100.00	100.00	98.55	99.19	98.15	
SouthCampusSubAcuteCare - HH Audits Performed	n/a	102	84	47	93	101	124	0	86	64	4,471	143,717	158,928	
SouthCampusTCS - HH Compliance	95%	100.00	50.00	100.00	100.00	97.00	100.00	100.00	0.00	0.00	99.42	99.47	99.40	
SouthCampusTCS - HH Audits Performed	n/a	30	10	42	88	66	90	60	0	0	4,495	82,780	93,993	
WestCampusAcuteCareRehab/ShortStay - HH Compliance	95%	100.00	89.00	88.00	93.00	NULL	93.00	94.00	94.00	94.00	97.04	98.43	97.99	
WestCampusAcuteCareRehab/ShortStay - HH Audits Performed	n/a	30	71	82	75	NULL	639	634	1,050	659	5,074	133,515	139,450	
WestCampusDialysis - HH Compliance	95%	100.00	97.00	100.00	100.00	100.00	100.00	100.00	96.00	95.00	97.33	97.98	96.77	
WestCampusDialysis - HH Audits Performed	n/a	93	87	90	102	82	90	130	142	40	5,250	75,823	74,945	
WestCampusWoundCare - HH Compliance	95%	NULL	NULL	NULL	NULL	NULL	NULL	NULL	NULL	NULL	95.90	98.50	97.60	
WestCampusWoundCare - HH Audits Performed	n/a	NULL	NULL	NULL	NULL	NULL	NULL	NULL	NULL	NULL	658	9,854	9,595	

Hand Hygiene By Role

Physician hand hygiene, although very low in volume, is improving for those that use BioVigil. Infection Prevention met with the hospitalists group during 3rd quarter 2022 and encouraged greater use of BioVigil, there was a lot of interest expressed.

The shear volume of hand hygiene opportunities is shared between CNAs and RNs followed by all others excluding (MDs, RTs, Students, LVNs, EVS, and Aides).

Hand Hygiene by Role (>10 observations in one quarter, does not inlcude biovigil)														
Aide - HH Compliance	95%	94.00	NULL	85.00	98.50	98.68	97.78	98.30	98.34	97.72	97.85	98.16	96.59	
Aide - HH Audits Performed	n/a	678	NULL	542	9,201	19,202	15,794	15,254	15,415	16,515	17,855	24,146	32,951	
C.N.A. - HH Compliance	95%	99.53	99.19	99.44	97.95	96.77	96.09	96.53	95.84	95.94	96.40	96.84	96.00	
C.N.A. - HH Audits Performed	n/a	15,486	102,302	69,129	415,866	831,386	684,279	522,495	489,887	572,524	532,047	558,962	711,701	
EVS - HH Compliance	95%	97.58	97.41	82.00	97.45	96.60	95.53	95.09	92.70	95.81	95.49	95.86	96.38	
EVS - HH Audits Performed	n/a	1,732	6,613	562	90,866	138,281	106,399	79,822	40,426	34,340	81,413	105,847	140,698	
LVN/Tech - HH Compliance	95%	91.00	99.62	99.49	98.80	98.04	98.50	97.33	97.70	97.80	97.34	97.57	96.46	
LVN/Tech - HH Audits Performed	n/a	161	11,837	17,672	58,774	120,366	102,193	88,326	105,878	129,757	136,711	215,381	295,512	
Nurse - HH Compliance	95%	98.86	98.92	98.60	98.10	97.85	97.41	97.61	97.64	97.56	97.26	97.15	96.17	
Nurse - HH Audits Performed	n/a	65,915	414,014	217,313	1,011,075	1,797,130	1,399,290	1,176,981	1,279,551	1,322,449	1,153,755	1,254,547	1,600,737	
Other - HH Compliance	95%	99.22	99.36	99.82	98.75	98.53	98.13	98.36	98.01	98.31	98.02	98.58	98.17	
Other - HH Audits Performed	n/a	3,217	16,689	8,528	162,090	302,052	322,758	303,172	265,952	264,691	260,518	280,419	349,028	
Physician - HH Compliance	95%	98.54	97.53	92.80	92.00	95.22	94.88	97.78	90.60	98.61	95.72	98.35	98.99	
Physician - HH Audits Performed	n/a	137	1,215	780	1,256	11,727	10,866	3,825	234	72	187	363	693	
Respiratory - HH Compliance	95%	90.00	NULL	91.00	98.30	98.17	97.86	98.37	97.61	97.14	97.80	98.45	97.90	
Respiratory - HH Audits Performed	n/a	396	NULL	282	45,719	82,248	88,040	97,902	86,616	70,921	66,678	72,302	61,923	
Student - HH Compliance	95%	91.00	NULL	100.00	99.41	99.11	98.57	98.28	97.78	98.27	97.57	97.79	96.13	
Student - HH Audits Performed	n/a	32	NULL	11	7,464	17,618	65,321	55,547	34,021	34,965	28,641	23,379	31,296	

Kaweah Health

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

Unit/Department: **ProStaff/QIC Report Date:**
Outpatient Renal: Kaweah Health Dialysis Clinic   December 2022
Measure Objective/Goal:
Outperform the national mean and/or benchmark in reported quality measures
1. Central Venous Access Management:
    a. Increase number of patients with arteriovenous fistula - Goal: 70% by end of year 2022
    b. Decrease number of patients with central venous catheter greater than 90 days- Goal: 10.7% by end of year 2022
2. Bloodstream Infection Reduction – Goal: Zero bloodstream infections

Date range of data evaluated:
May 2022 – August 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):

Month	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct
Pt Census	131	129	134	134	128	127	128	136	135	
Vascular Access										
AVF	61%	60.3%	62.4%	58.2%	57.4%	60.3%	60.3%	60.9%	62%	
AVG	8.4%	8.7%	8.3%	8.2%	8.5%	9.2%	9.9%	9.0%	9.1%	
Central Venous Catheter										
Total CVC	30.5%	31%	29.3%	33.6%	34.2%	31%	31.8%	28.4%	28.9%	
CVC w/AVF Maturing	5.3%	4.0%	1.5%	4.5%	3.9%	3.2%	4.8%	1.6%	0.8%	
CVC w/AVG Maturing	0%	0%	0%	0.7%	0.8%	0%	0%	0%	0%	
CVC <90 day	6.9%	5.6%	6.8%	8.9%	7.8%	4%	4%	2.4%	5.0%	
CVC >90 day	23.7%	25.4%	22.5%	24.6%	21.7%	23.8%	23%	24.4%	23.10%	

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

Standardized Fistula Rate (% AVF Using 2 Needles) (QIP & DFC)

	J	F	M	A	M	J	J	A	S	O	N	D
Standardized Fistula Rate (SFR) (% AVF using 2 needles) (QIP & DFC) (higher is better)	61.00%	60.30%	62.40%	58.20%	57.40%	59.50%	58.70%	61.80%				
% AVG	8.4%	8.7%	8.3%	8.2%	8.5%	9.5%	9.5%	9.8%				
AVF Clinic Goal	62%	62%	62%	62%	62%	62%	62%	62%	62%	62%	62%	62%
AVF Optimal Goal	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%
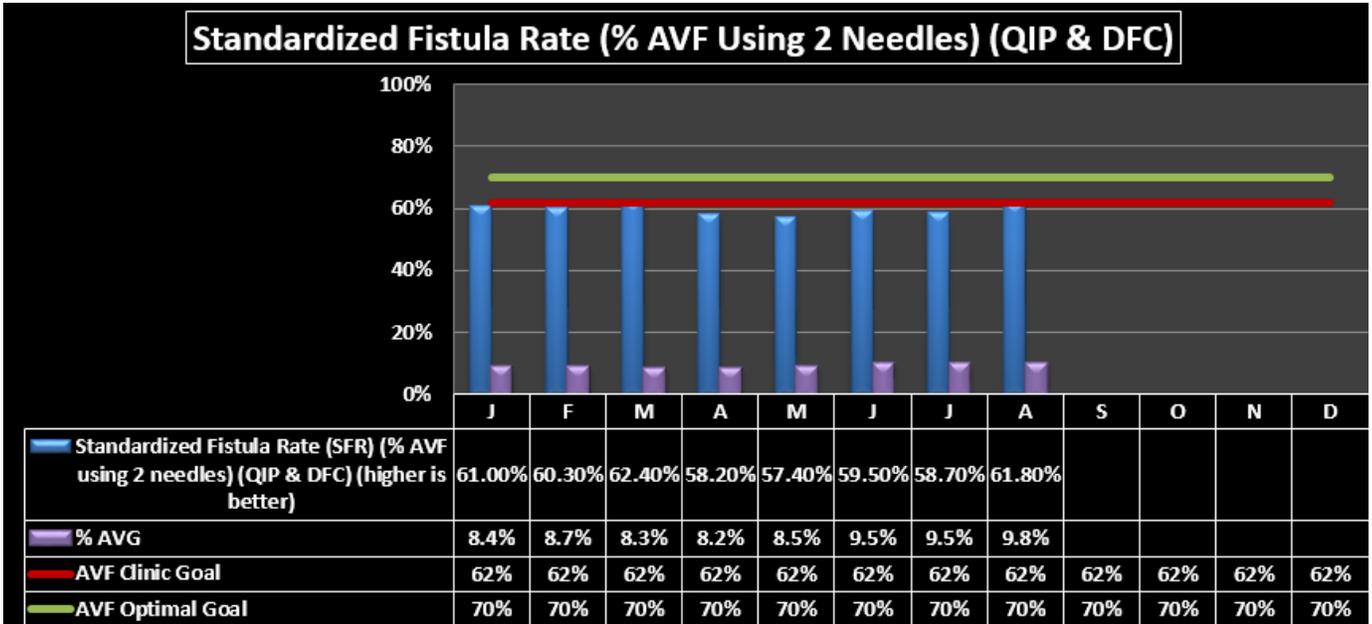
1. Vascular access management is below our clinic goal and optimal goal. The CMS QIP PY2022 benchmark (90th percentile of performance rates nationally for AVF (arteriovenous fistula) is 70%. Working with the clinical coordinator to establish a workflow to speed up referral process. We are utilizing clinic secretaries to schedule appointments for fistula placement. In addition, the secretaries are providing reminders to patients. These reminders include appointment reminders and procedure reminders to ensure compliance to increase the number of patients with fistulas at our dialysis clinic.
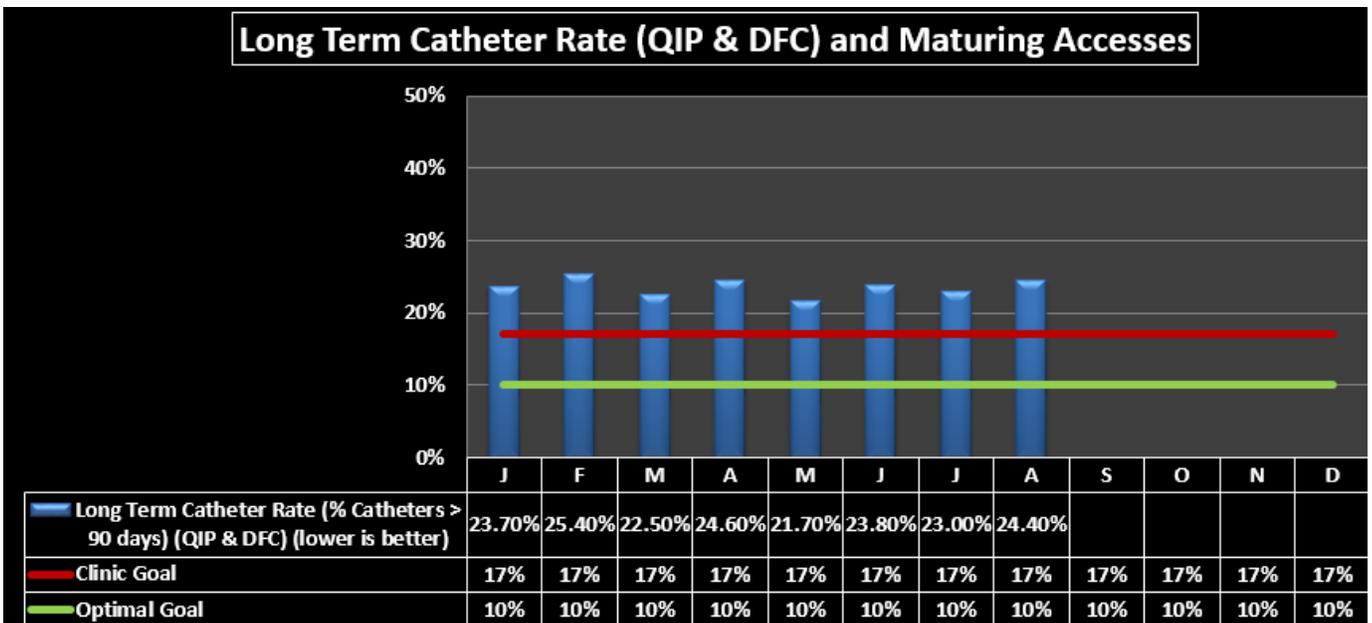
Long Term Catheter Rate (QIP & DFC) and Maturing Accesses

	J	F	M	A	M	J	J	A	S	O	N	D
Long Term Catheter Rate (% Catheters > 90 days) (QIP & DFC) (lower is better)	23.70%	25.40%	22.50%	24.60%	21.70%	23.80%	23.00%	24.40%				
Clinic Goal	17%	17%	17%	17%	17%	17%	17%	17%	17%	17%	17%	17%
Optimal Goal	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%

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

2. The CMS QIP PY 2022 benchmark (90th percentile of performance rates nationally) for CVC >90 days is 5.07%. The optimal goal is to be at the Network 18 goal of 10% CVC >90 days by year end 2022. Our clinic goal is to reach 17% by the end of year 2022. Currently, our central venous catheters in for longer than 90 days is 24.40%. We continue to have new patients accepted into the dialysis clinic with catheters. Immediately upon admission to our clinic with a catheter, we began to schedule appointments to get a fistula created for patient. This process takes longer than 90 days due to high volume of patients seeing vascular surgeons. Will continue to work on throughput for this measure.

	J	F	M	A	M	J	J	A	S	O	N	D
# of ARBSI's	0	0	1	0	0	1	0	0				
NHSN SIR	2.239	0	1.978	0	0	2.035	1.147	0				
Clinic Goal	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	0.0
Optimal Goal	0	0	0	0	0	0	0	0	0	0	0	0
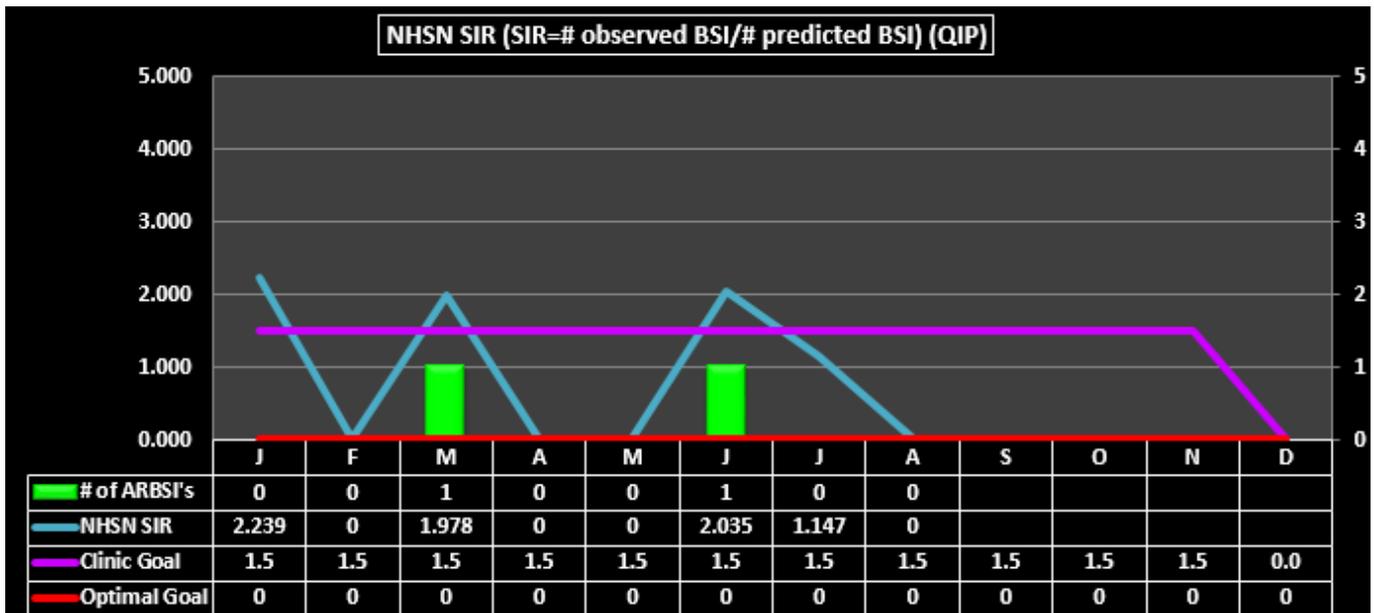
1. Bloodstream reduction management has had some areas of notable improvement but continues to be an area for improvement. The CMS QIP PY2022 benchmark (90th percentile of performance rates nationally) for Standardized (SIR) (# of observed infections/# of predicted infections) is 0.000 and an Achievement Threshold (15th percentile of performance rates nationally) of 1.365. The clinic monthly goal is zero infections. Our NHSN SIR is 0 for August 2022.

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

1. The state dialysis network advocates a central venous catheter rate of less than 10% for patients in treatment greater than 90 days. The vascular access management process has been overseen by clinical coordinator, who has taken over the access manager role. The education process has become a team approach, involving all disciplines. Each new patient that is admitted to the dialysis clinic is scheduled for vein mapping to start the process of receiving a fistula. The clinical coordinator meets with the patient shortly after

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

admission to review the steps to receive a fistula and to provide education. Some barriers include access to vascular surgeons. We do have some patients refuse to receive a fistula. A challenge we have faced is the refusal by patients to be referred for a fistula.

2. Though our required participation in Network 18 (Medicare's geographical name for California) projects has concluded, Clinic Educator is completing scheduled employee audits. These audits include observations of hand hygiene compliance, medication preparation and administration, and central venous access exit site care. With our spikes in blood stream infections, this year we have provided education to patients about importance of washing their hands and fistula sites prior to initiating dialysis. We have provided patient and employee education on importance of chlorhexidine. Additionally, since implementing the BioVigil hand hygiene monitoring system to ensure appropriate hand hygiene, there has been an immediate decline in BSI access infections in clinic.

Next Steps/Recommendations/Outcomes:

1. With our clinical coordinator overseeing access, we have seen an increase in referrals and catheter being taken out. Renal Director and Clinical Access Coordinator continue to meet every week to discuss developments and work on improvement plans as needed.
2. New clinical educator working on education to prevent bloodstream infections.

Submitted by Name: **Date Submitted:**

Amy Baker, MSN, RN- Director of Renal Services   December 2022

Acronym Key:
AVF- arteriovenous fistula
AVG- arteriovenous graft
CVC- central venous catheter
QIP-quality incentive program
DFC- dialysis facility compare
ESRD- End Stage Renal Disease
CMS- Centers for Medicare and Medicaid Services
PY2022- plan year 2022
NHSN- National Healthcare Safety Network
SIR- standard infection ratio
BSI- bloodstream infection
ARBSI- access related bloodstream infection

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

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Unit/Department: Sub Acute, TCS, and SS Rehab   **Report Date:** October 2022

Measure Objective/Goal:

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

Date range of data evaluated:
All categories are from the Report Period: 10/01/2021 – 3/31/2022. Comparison group: Casper Report from 4/25/2022 for period 08/01/2021-1/31/2022, and 1st quarter 2022 through 2nd quarter 2022, internal data.

Nationally benchmarked quality data is collected through the MDS submissions process. CMS divides data between short-stay cases (<100 day length) and long-stay cases (>100 day length). The Skilled Nursing program client group is predominately in the short-stay category. Statistically this means that Long-Stay measures typically have a denominator of 33-34. Short-Stay measures typically have a denominator of 275+. Internal data is based on total units of service and does not differentiate based upon length of stay. There is no comparable national bench-marking of Short Stay cases for falls, and for HAPI prevalence overall. For these two indicators, we assess ourselves as related to internal performance.

Analysis of all measures/data: (Include key findings, improvements, opportunities)
Measure Objective/Goal: Falls
The rate of falls per 1000/pt. days in Q1 and Q2 of 2022 is 0.83, lower than 2021 at 1.22. Facility observed percent for falls for long stay patients in the most current CASPER report is 0%, remaining well below national average of 44%, placing the program in the top 1 percentile nationally.
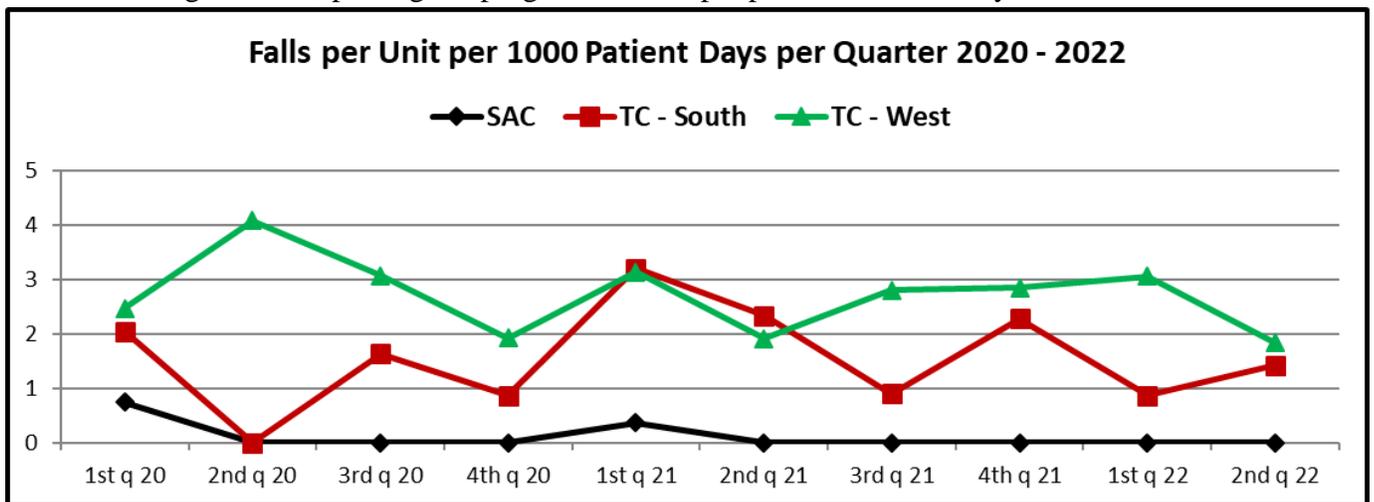
If improvement opportunities identified, provide action plan and expected resolution date:

Staff continues to participate in, and has a high rate of compliance with, district-wide initiatives for fall prevention. The skilled nursing units have many mobile patients and a "no restraint" environment. Falls occur most commonly with our short-stay population, all of whom are involved with therapy programs to enhance functional mobility. We will continue fully participation in the Kaweah Health prevention protocols. The recent increase in falls on the units prompted several interventions, these include increased orientation transfer competency for new staff.

Measure Objective/Goal: Pressure Injuries

     a. Incidence of new or worsening pressure ulcers for short stay patients (which would also include Sub Acute patients with a length of stay under 100 days) as reported on the Casper report is 0.8%, well below the national average of 2.8%.

     b. Patients at High risk for Pressure Ulcers (Long Stay residents, defined as high risk, who have Stage II-IV pressure ulcers) is 11.1%. This is a increase from 7.4% in the last report, with a national average of 9.3% and a state average of 9.1%. This puts us at the 67th percentile, worse than previous 46th percentile. The definition for this long-stay quality measure asks if a wound is present, not if acquired in the facility. This is particularly challenging in a program that <u>preferentially admits cases with pressure ulcers for ongoing treatment.</u> The measure triggers a flag until the wound completely heals (and through the 6 month report period). Very large wounds that have healed down to very small, chronic wounds will continue to trigger this measure. Thus, it is common to see a delay in improvement on the CASPER report, while seeing improvement more immediately in our internal data.

     c. Overall, the total wound rate for the three SNF units rate per 1000/pt. days for Q1 and Q2 2022 was 0. This is an increase from last year 2020 at 0.46. All three SNF units participate in Kaweah Health Clinical Skin Institute when pressure injuries are discovered on the unit. Staff capture skin injuries during routine assessments and preventative measures are implemented early leading to better patient outcomes.

LTC ≥Stage 2 HAPIs per 1000 Patient Days per Quarter 2020-2022
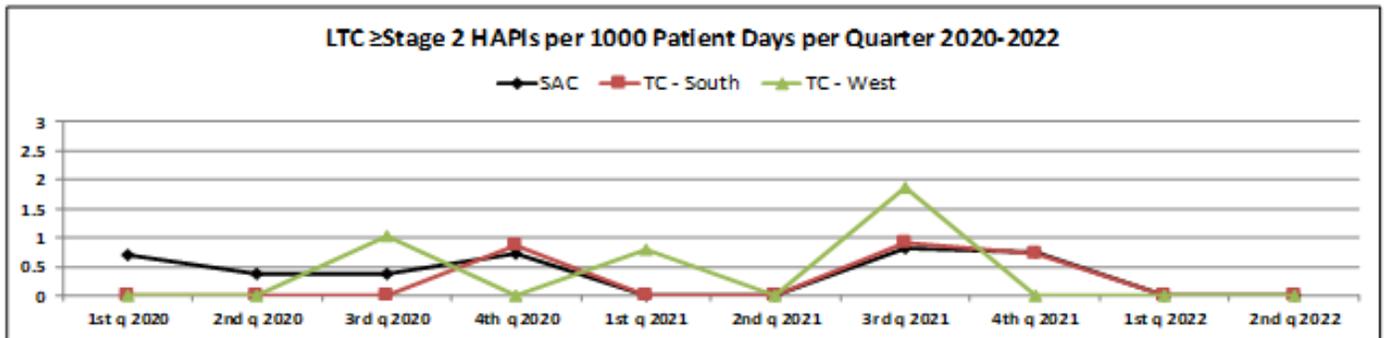
2. **If improvement opportunities identified, provide action plan and expected resolution date:**
    a. We will continue to work within the high standards of the District, with close management of our fragile, chronic wound cases, collaborating closely with the Kaweah Health wound nurses and utilizing the standardized treatment sets available to us.

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

Measure Objective/Goal: Psychoactive medication use:

Definitions/Assumptions:

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

Increased use of medications in the antipsychotic drug-class for management of depression is also moving our results in these measures. Antianxiety and hypnotic medication use is not reported as a quality measure for the short-stay population. The data is collected through the MDS, but is not included in the measures that make up our quality ranking. All values are expressed in percentile rankings.

Short Stay residents (<100 days). Antipsychotic medication use for short stay patients is below national average, which measures only cases with newly prescribed antipsychotics. The facility four quarter percent for short stay patients who begin a new anti-psychotic during their stay is 0.7%, putting us at the 57th percentile (lower is better). The comparison national average is 1.9%.

Antipsychotics Med (S)
Percentile Ranking

Period Ending	Value
2/29/20	0
7/31/20	0
9/30/20	59
3/31/21	56
1/31/22	0
3/31/22	57
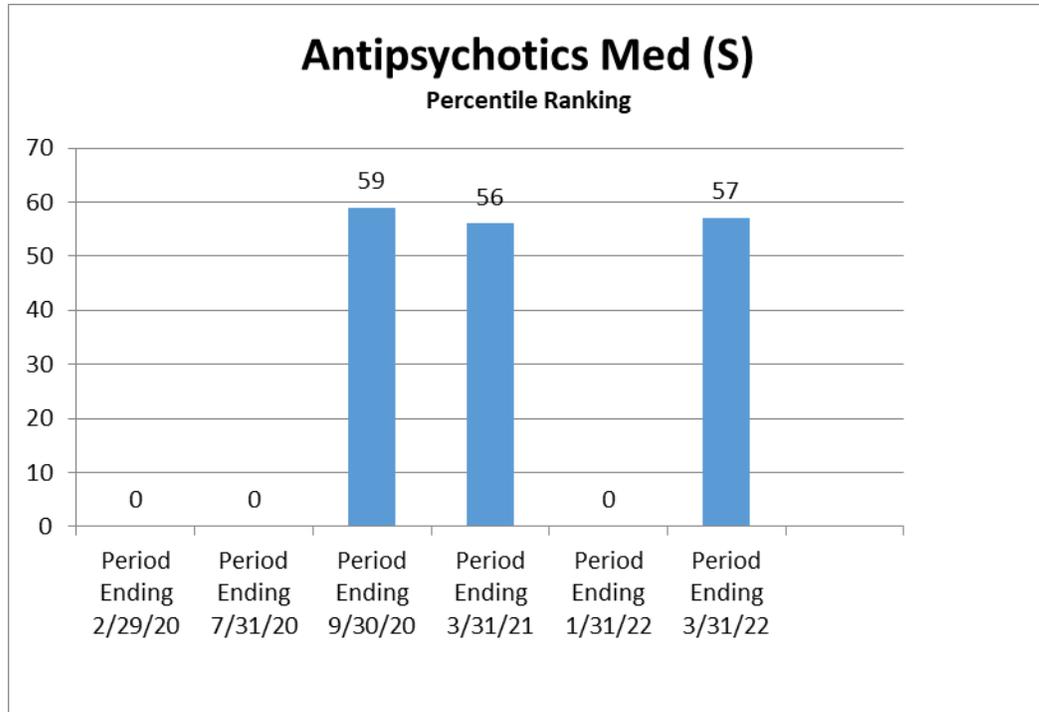
Long Stay residents. The facility percent for antipsychotic use in long stay residents is 29.6%. This puts us at the 93rd percentile (lower is better). The national average is 14.6%. Unlike the short stay measure, which only includes newly prescribed antipsychotics, the long-stay measure includes all patients on the medication for any portion of the time (even if it was a home medication). Included in this measure are medications like quetiapine, used for depression or for ventilator management cases. This is another instance where our target client group for long-term care (our Sub Acute program) is the primary driver of our performance.

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

Antipsychotics Med (L)
Percentile Ranking

Period Ending	Value
2/29/20	90
7/31/20	89
9/30/20	88
3/31/21	70
1/31/22	86
3/31/22	93
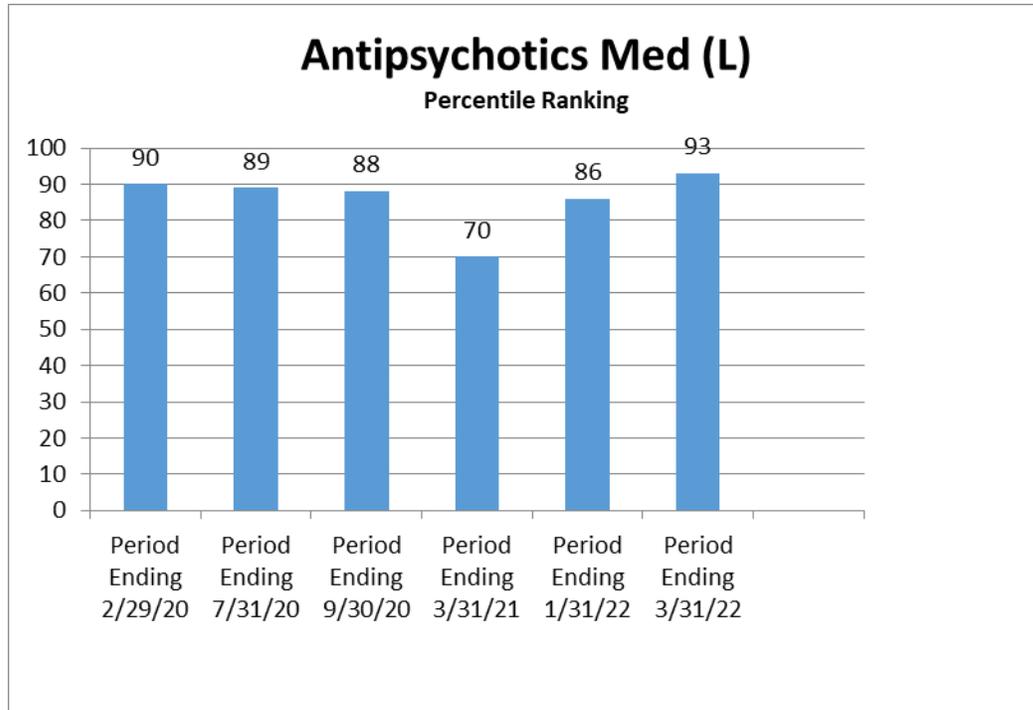
Long Stay residents. Antianxiety/Hypnotic Medication use for long stay residents has remained high at the 98th percentile same as the percentile the previous year. Our utilization rate is 50%, but national rates remain at 19.5%. There are no exclusions for medical diagnosis for this measure.
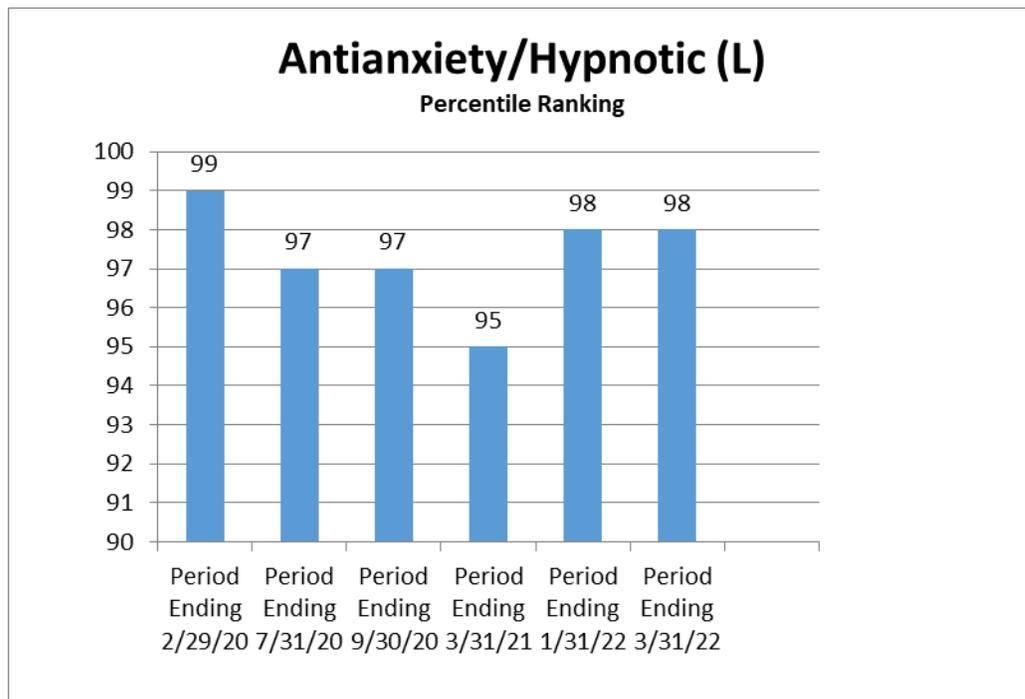
Antianxiety/Hypnotic (L)
Percentile Ranking

Period Ending	Value
2/29/20	99
7/31/20	97
9/30/20	97
3/31/21	95
1/31/22	98
3/31/22	98

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

Psychotropic medications are under constant scrutiny by CMS. Concerns around these medications are primarily founded in two concepts: 1: inappropriate or excessive medications and 2: using psychotropic medications to control behaviors (as a chemical restraint) or for more "convenient" management of "difficult" patients. While the majority of our client group has clear and compelling indications for these agents, we continue to monitor the medications very closely. Our LTC pharmacist plays an important role in helping us ensure that we follow all of these medications closely during the transition process. Our primary focus is on unnecessary medications, (like prn hypnotics). Hence, we also monitor for the potential for dose reductions when possible.

All residents receive a monthly medication regimen review and physician consultation by our LTC pharmacist. This close partnership has helped reduce psychoactive medication use generally, including reducing doses through gradual dose reduction practices. We have seen a reduction in the use of hypnotic medications in our short-term (under100 days) patients, in particular.

Although we struggle in this measure, in the past three years of CMS surveys (including the last annual survey in July 2022) there have been no findings around inappropriate use of psychotropic medications in any of our programs.

Submitted by Name:
Molly Niederreiter

Date Submitted:
October 2022

Unit/Department Specific Data Collection Summarization
Quality Improvement Committee

Unit/Department: HAPI QFT & Inpatient Wound Prevention   **Report Date:** October 2022

Measure Objective / Goal:

Hospital Acquired Pressure Injuries (HAPI), Total and Device-Related
Incidence data compiled from staff/unit-level self-report, with and without prompting from wound nurse consultant. Includes Stage 1-4, unstageable, suspected deep tissue pressure injury (DTPI).

Indicator #1 HAPI Stage 2+ per 1000 Patient Days

Goal   1.13 (-10% from 2021)

Date Range June 2022 – Sept 2022
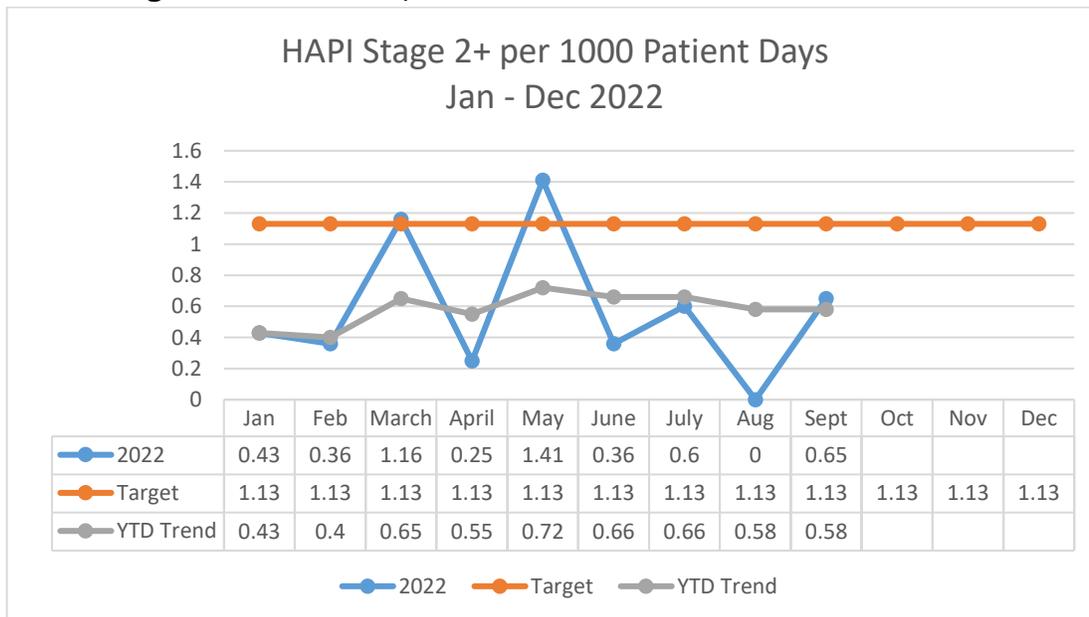
HAPI Stage 2+ per 1000 Patient Days
Jan - Dec 2022

	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
2022	0.43	0.36	1.16	0.25	1.41	0.36	0.6	0	0.65			
Target	1.13	1.13	1.13	1.13	1.13	1.13	1.13	1.13	1.13	1.13	1.13	1.13
YTD Trend	0.43	0.4	0.65	0.55	0.72	0.66	0.66	0.58	0.58			

Analysis of Measures / Data: (include key findings, improvements, opportunities)

- ✓ **Goal #1** Met: Met for Months of June (.36), and July (.6), Aug (.0) and Sept (.65)
- ✓   Met: Cumulative YTD below target (.58)

Continued education sent to the bedside care from our CSI takeaways. The wound care team is attending NPC meetings quarterly and sharing the latest and greatest wound care and common issues the team might encounter. Changes to the competency fair did not allow for the wound care team to have a booth, but we continue to arrange and set up monthly inservices with our wound care vendors and include times and dates to allow for all shift teams to be able to attend.

Indicator #2 Device Associated HAPI per 1000 Patient Days

Goal 0.55 (-10% from 2021)

Date Range June 2022 – Sept 2022
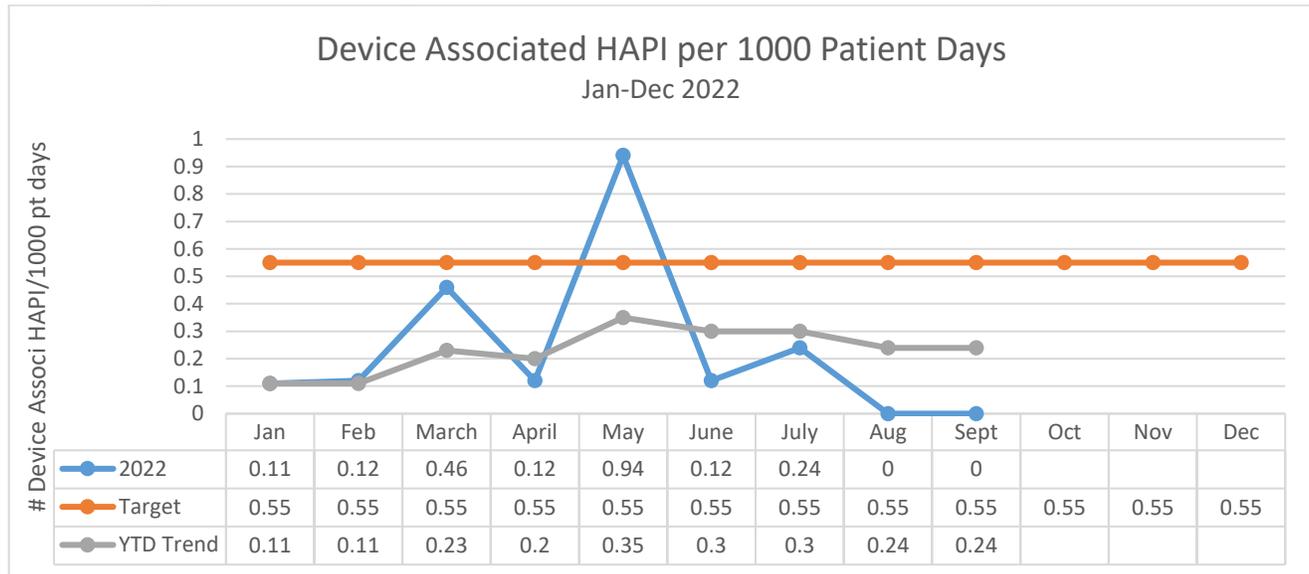
Device Associated HAPI per 1000 Patient Days
Jan-Dec 2022

	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
2022	0.11	0.12	0.46	0.12	0.94	0.12	0.24	0	0			
Target	0.55	0.55	0.55	0.55	0.55	0.55	0.55	0.55	0.55	0.55	0.55	0.55
YTD Trend	0.11	0.11	0.23	0.2	0.35	0.3	0.3	0.24	0.24			

Analysis of Measures / Data: (include key findings, improvements, opportunities)
- ✓ **Goal #1** Met: Met for Months of June (.12), July (.24), Aug (0), and Sept (0)
- ✓ Met: Cumulative YTD below target (0.24)

Device related HAPIs are also trending in the same fashion as HAPIs. See notes above about similar interventions for device related HAPIs. ICU has designed a Skin/Wound resource RN for both AM and PM shifts. GEMBA rounds continue to discuss wound care issues for each patient with lines on all critical care floors.

Unit/Department Specific Data Collection Summarization
Quality Improvement Committee

2022 Stage 2+ HAPI QFT Dashboard

Measure Description Outcome Measures	2022 Benchmark/ Target	2019 Baseline	2020 Baseline	2021 Baseline	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	YTD 2022
HAPI Stage 2+ per 1,000 pt days (all HAPIs)	1.13 (-10% from 2021)	1.64	1.61	1.26	0.43	0.36	1.16	0.25	1.41	0.36	0.60	0.00	0.65				0.58
Device Associated HAPI per 1,000 pt days	0.55 (-10% from 2021)	0.74	0.72	0.61	0.11	0.12	0.46	0.12	0.94	0.12	0.24	0.00	0.00				0.24
PSI 3 - Claims-based HAPI Stage 3, 4, and Unstageable per 1,000 discharges	0.6 - Hospital Compare (Q3 2017-Q2 2019) 0.35 - Midas 50th Percentile (2019)	0.79	0.95	1.42	0.00	0.00	0.00	1.16	0.00	0.00	0.00	0.00	1.25				0.25
Process Measures	(-10% from 2021)	**2019**	**2020**	**2021**	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	YTD 2022
Respiratory Device associated HAPI per 1,000 pt days	0.36		0.44	0.40	0.11	0.00	0.00	0.00	0.24	0.00	0.12	0.00	0.00				0.05
% of Respiratory Device associated HAPI's (out of all of the device associated HAPI's)	58%		61%	65%	100%	0%	0%	0%	25%	0%	50%	0%	0%				22%
Unit Level	(-10% from 2021)	**2019**	**2020**	**2021**	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	YTD 2022
4N - HAPI 2+ per 1,000 pt days	1.09	1.34	2.02	1.22	0.00	1.28	0.00	0.00	0.00	0.00	0.00	0.00	0.00				0.14
3W - HAPI 2+ per 1,000 pt days	2.29	2.26	3.2	2.55	0.00	0.00	0.00	0.00	0.00	0.00	3.85	0.00	0.00				0.42
ICU - HAPI 2+ per 1,000 pt days	3.72	7.1	7.44	4.14	0.00	0.00	3.98	0.00	0.00	0.00	0.00	0.00	6.44				1.19
CVICU - HAPI 2+ per 1,000 pt days	3.87	5.2	6.23	4.31	5.68	0.00	2.78	3.55	0.00	0.00	3.88	0.00	0.00				1.90
2N - HAPI 2+ per 1,000 pt days	0.63	0.1	0.22	0.71	0.00	0.00	1.15	0.00	0.00	0.00	0.00	0.00	0.00				0.14
2S - HAPI 2+ per 1,000 pt days	0.81	0.7	1.51	0.90	0.00	0.00	0.00	0.00	0.00	3.52	0.00	0.00	0.00				0.35
3N - HAPI 2+ per 1,000 pt days	0.99	0.86	0.72	1.11	0.00	0.00	0.00	0.00	6.92	1.00	0.00	0.00	0.00				0.91
3S - HAPI 2+ per 1,000 pt days	0.08	0.46	0.5	0.09	0.00	0.00	0.00	0.00	0.00	0.00	1.10	0.00	0.00				0.13
4S - HAPI 2+ per 1,000 pt days	1.03	1.37	0.66	1.15	1.96	0.00	2.02	0.00	3.33	0.00	0.00	0.00	1.16				0.97
4T - HAPI 2+ per 1,000 pt days	0.25	1.23	0.45	0.28	0.00	1.65	0.00	0.00	3.38	0.00	0.00	0.00	0.00				0.56
BP - HAPI 2+ per 1,000 pt days	0	0	0.62	0	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00				0.00
Rehab - HAPI 2+ per 1,000 pt days	0.14	0.75	0	0.16	0.00	2.38	0.00	2.11	0.00	0.00	0.00	0.00	0.00				0.43
5T - HAPI 2+ per 1,000 pt days	1.31		0.4	1.46	0.00	0.00	5.35	0.00	0.00	0.00	1.27	0.00	1.39				0.89
Other Units	2022 Benchmark/ Target	**2019**	**2020**	**2021**	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	YTD 2022
ED	n/a	4	3	0	0	0	0	0	0	0	0	0	0				0
Sub-Acute	n/a	5	6	5	0	0	0	0	0	0	0	0	0				0
Surgery	n/a	6	0	0	0	0	0	0	0	0	0	0	0				0
Cath Lab	n/a	1	0	0	0	0	0	0	0	0	0	0	0				0
Pediatrics	n/a	0	0	2	0	0	0	0	0	0	0	0	0				0
Mother Baby	n/a	1	0	0	0	0	0	0	0	0	0	0	0				0
Transitional Care (South Campus)	n/a	1	1	1	0	0	0	0	0	0	0	0	0				0
Short Stay (Rehab)	n/a	0	0	3	0	0	0	0	0	0	0	0	0				0
Lab	n/a				0	0	0	0	0	0	0	0	1	0			1

Meeting or Better than Target

Within 10% of Target

Does not meet Target

PSI 03: Pressure Ulcer Rate

Pressure ulcers have been associated with an extended length of hospitalization, sepsis, and mortality. The Agency for Healthcare Research an Quality (AHRQ) developed measures that health providers use to identify potential in-hospital patient safety problems for targeted institution-level quality improvement efforts. Patient Safety Indicator (PSI) 03 includes stage 3 or 4 pressure ulcers or unstageable (secondary diagnosis) per 1000 discharges among surgical or medical patients ages 18 years and older. *Exclusions: stays less than 3 days; cases with principal stage 3 or 4 (or unstageable) pressure ulcer diagnosis; cases with a secondary diagnosis of stage 3 or 4 pressure ulcer (or unstageable) that is present on admission; obstetric cases; severe burns; exfoliative skin disorders.*

Indicator #3 PSI-03 Claim-based HAPI Stage 3, 4, Unstageable per 1000 discharges

Goal 0.26 (Hospital Compare)

Date Range Q3 2022
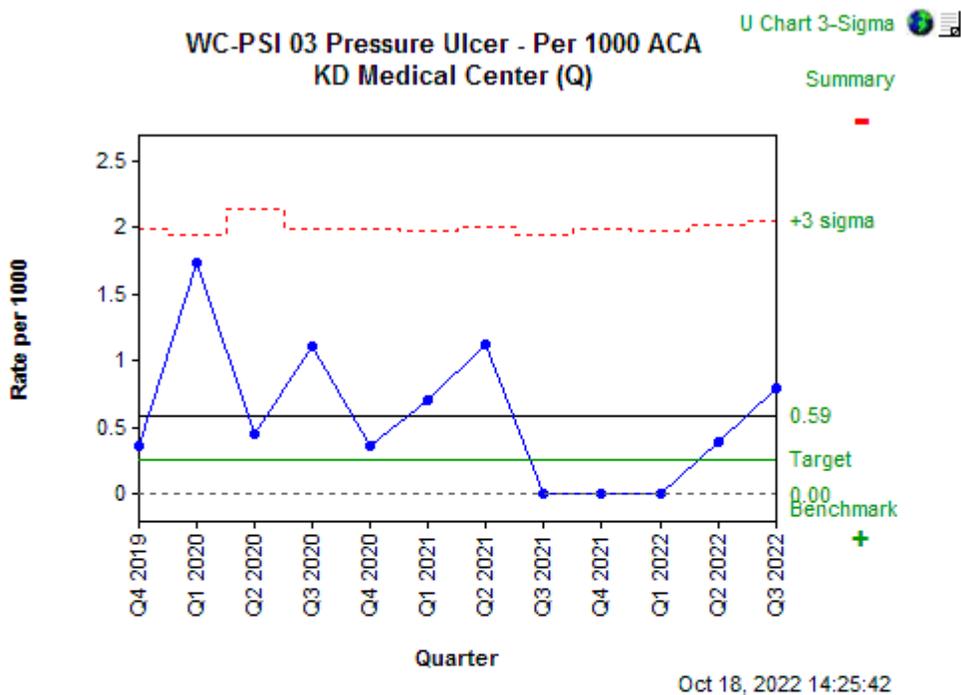
Quarter	Numerator	Denominator	Rate per 1000	Benchmark
Q3 2022	2	2501.00	0.80	0
Q2 2022	1	2576.00	0.39	0

Analysis of Measures / Data: (include key findings, improvements, opportunities)
- ✓ **Goal #3 Not** Met for Quarter 2 2022 (1)

We one possible PSI 3 this quarter in September 2022. PI has not had a chance to review the data so we will investigate and report on the next report.

Improvement Opportunities Identified, Action Plan and Expected Resolution Date / Next Steps, Recommendations, Outcomes:

Ongoing
- ✓ CSI reconvened in March 2022. Floors have continued to complete Root Cause Analysis audits for each identified wound and encouraged to bring their staff. Managers continue to prioritize these evaluations and participation is good.

- ✓ Quarterly education at NPC for bedside staff. Rotating topics shared with latest supplies and wound techniques to share with their units.

- ✓ Monthly inservices scheduled with vendors for wound vacs, waffle boots and mattresses, turn academy, etc. Multiple dates/times scheduled to accommodate both day and night shift staff.

Parking Lot
- ☐ It was determined by the HAPI QFT committee that we will hold the 5-day Kaizen until our traveler numbers decrease across the hospital due to rapid turnover of staff.

Submitted By: **Date Submitted:** October 18, 2022
Rebekah Foster, Director of Care Management and Specialty Care

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

Unit/Department: Kaweah Health – Diversion Prevention Committee

ProStaff/QIC Report Date: 8/22/2022

Measure Objective/Goal:
The Diversion Prevention Committee Goals include:

- Develop an organizational program to build awareness of and response to behaviors suspicious for drug diversion.
- Build a culture within the organization of attention to drug diversion prevention.
- Implement education with orientation and annual training related to awareness of and response to drug diversion for all staff and providers.
- Ensure continued awareness and knowledge of diversion prevention strategies at all levels of the healthcare team including non-patient care areas.
- Develop a Leadership training program to provide enhanced skills for detecting and preventing diversion activities.
- Ensure accountability for action items related to routine audits and medication related reports by department leaders.
- Use of technology and automation to ensure audits and reporting are routine and applicable.
- Communicate noted trends identified through Pharmacy audits such as Bluesight, Pyxis overrides, etc. or the occurrence reporting system to department leaders.
- Monitor all active audits outlined in the CMS diversion plan of correction until compliance is met and audits are closed.

The Diversion Prevention Committees Measures of Success include:

- All existing District staff will complete the appropriate MAT training module regarding diversion prevention topics with at least 90% compliance each quarter.
- All new hire District staff will complete orientation education regarding diversion prevention topics with at least 90% compliance each quarter.
- Committee members to verify efficacy of ongoing diversion prevention education by conducting 15 or more interviews each of varied District staff, residents, and medical staff each quarter with at least 90% answering 4/4 questions correctly.
- Provide education to the Leadership group at least once per quarter to provide enhanced knowledge and skills for detecting and preventing diversion activities.
- Monthly review of audit dashboard reveals improvements in audit outcomes.

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

Date range of data evaluated: Mar - Jul 2022

The Diversion Prevention Committee was formed in April 2021 in response to a recognized need for education and monitoring after two unrelated diversion events were identified within the organization. The initial goals are to increase awareness of the risk of diversion in the health care setting and increase knowledge of the signs and symptoms of diversion.

From March - July 2022 the following goals were achieved:

Diversion Prevention Awareness Mandatory Education (Ongoing):
- Diversion Prevention Strategies Education (ongoing) – All Employees:
  - **Goal Met** - April 2022: 99.81% of existing District staff completed the appropriate MAT I training module.
    Goal: At least 90% compliance this quarter.
  - **Goal Met** - April 2022: 99.75 % of new hire District staff completed the appropriate MAT I training module on diversion awareness, prevention, signs and symptoms of abuse and diversion and expectations of all team members diversion prevention topics. *Goal: At least 90% compliance this quarter.*
  - **Goal Met** - April - June 2022: 92% of existing District staff and providers (varied roles of District staff, residents, and medical staff) answered 4/4 questions correctly during 148 interviews conducted by DPC members.
    Goal: At least 90% compliance this quarter.
- Leadership Awareness Education (ongoing):
  - **Goal Met** - July 2022: District Leadership was provided ongoing education of diversion recognition via educational memes.
  - **Goal Met** - Beginning August 2022 - 1:1 education with each KHMC clinical manager and director of Bluesight data and IRIS score analytics provided by Medication Safety Specialist RN and Controlled Medication Coordinator.

Pharmacy-Related Monitoring:
- Pharmacy continues to monitor on a monthly basis the following with reduced sample size and bring to DPC should new trends arise. None noted for this time period.
  - Diversion 6 - Monitoring of Diluted Controlled Substance and Fentanyl Waste
  - Diversion 11 – Short Case Reviews

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):

All goals met this quarter. No new Pharmacy-related trends or concerns noted this quarter.

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

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

The purpose of the Diversion Prevention Committee is to identify opportunities and create action items on an ongoing basis.

At this time, the improvement opportunity continues to be to raise awareness and increase knowledge of the identification and risks of diversion for all staff and providers at KDHCD using creative and varied methods in addition to computer-based learning. Interviews of staff and leaders by Committee members will continue on a quarterly basis to monitor learning retention and effectiveness of ongoing education. This will allow the Committee to identify existing gaps and associated actions. Education will be changed or reinforced based on those findings.

Review of Pharmacy-related internal audits such as Bluesight analytics and IRIS score review as well as monitoring of occurrence reports and employee behavior concerns will also steer the Committee's continued efforts to educate, inform and monitor diversion-related activities to prevent the diversion of medications in the health care setting.

Next Steps/Recommendations/Outcomes:

Continue to monitor the effectiveness of the education through staff, provider and leader interviews by Committee members.

Create additional education as needed based on interviews, audits and occurrence reports.

Continue to monitor potential diversion-related events and increase surveillance by organizational staff and providers.

Modify existing goals within the Diversion Prevention Committee to meet the identified needs and opportunities for growth within the organization.

Incorporate Substance Abuse awareness and actions into the scope of the committee to support our teams.

Submitted by:
Shannon Cauthen, Co-Chair – Director of Critical Care Services
Evelyn McEntire, Co-Chair – Director of Risk Management

Date Submitted:
August 22, 2022

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

2022 Annual Review
Quality & Patient Safety Plans

Quality Council
Kaweah Health Board of Directors
December 2022

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

kaweahDelta.org

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2022 Annual Review Quality & Patient Safety Plans
Acronyms

CAUTI - Catheter-associated Urinary Tract Infections

CLABSI - Central Line-associated Bloodstream Infection

CC – Medicare billing code for Complication of Care

CMS - Centers for Medicare & Medicaid Services

DMAIC – Define, Measure, Analyze, Improve, Control – Lean Six Sigma model for improvement

EP – Element of Performance (part of a Joint Commission Standard)

G.I. – Gastrointestinal

LD – Leadership Joint Commission Standard

MCC – Medicare billing code for Major Complication

MRSA - Methicillin-resistant Staphylococcus aureus

MV – Medicare billing code term for mechanical ventilation

PDCA – Plan, Do, Check, Act – model for improvement

PI – Performance Improvement Joint Commission Standards

QIC – Quality Improvement Committee

TJC – The Joint Commission

w/o - Without

2022 Annual Review Quality & Patient Safety Plans

The Joint Commission/CMS Requirements

Leadership Patient Safety Regulatory Standards

LD.03.09.01

- Have an organization wide, integrated patient safety program within their performance improvement activities
- Summary of EP 1-11:
  - All departments, programs and services participate
  - must include all levels of harm (ie. near misses)
  - leaders create procedures for responding to system/process failures
  - leaders encourage the use of systems for blame-free internal reporting
  - conducts systematic analysis on sentinel events
  - provide support for staff involved in an adverse event
  - conducts a pro-active risk assessment every 18 months
  - disseminate lessons learned
  - provide written reports to governance related to sentinel events; report events externally as required

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2022 Annual Review Quality & Patient Safety Plans
The Joint Commission/CMS Requirements

Leadership Patient Safety Regulatory Standards

LD.03.01.01

- Leaders create and maintain a culture of safety and quality throughout the hospital.
    - EP1 Leaders regularly evaluate the culture of safety and quality using valid and reliable tools.
    - EP2 Leaders prioritize and implement changes identified by the evaluation.
    - EP4 Leaders develop a code of conduct that defines acceptable behavior and behaviors that undermine a culture of safety.
    - EP5 Leaders create and implement a process for managing behaviors that undermine a culture of safety.
    - EP9 The hospital has a workplace violence prevention program led by a designated individual and developed by a multidisciplinary team

2022 Annual Review Quality & Patient Safety Plans

The Joint Commission/CMS Requirements

Leadership Quality and Patient Safety Standards

LD.01.03.01 (§482.21)

- EP 21 The governing body is responsible for making sure that performance improvement activities reflect the complexity of the hospital's organization and services, involve all departments and services, and include services provided under contract. (For more information on contracted services, see Standard LD.04.03.09)

LD.03.07.01 (§482.21)

- EP 1   Performance improvement occurs hospital wide.
- EP 2   As part of performance improvement, leaders (including the governing body) do the following:
  - o   Set priorities for performance improvement activities and patient health outcomes
  - o   Give priority to high-volume, high-risk, or problem-prone processes for performance improvement activities
  - o   Identify the frequency of data collection for performance improvement activities
  - o   Reprioritize performance improvement activities in response to changes in the internal or external environment

LD.03.09.01

- Have an organization wide, integrated patient safety program within their performance improvement activities

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2022 Annual Review Quality & Patient Safety Plans
The Joint Commission/CMS Requirements

Performance Improvement Quality and Patient Safety Standards

- PI.01.01.01 The hospital collects data to monitor it's performance
- PI.02.01.01 – The hospital has a performance improvement plan
  - EP 1 Performance improvement priorities established by hospital leaders are described in a written plan that includes the following:

    -The defined process(es) needing improvement, along with any stakeholder (for example, patient, staff, regulatory) requirements, project goals, and improvement activities

    - Method(s) for measuring performance of the process(es) identified for improvement

    - Analysis method(s) for identifying causes of variation and poor performance in the process(es)

    - Methods implemented to address process deficiencies and improve performance

    - Methods for monitoring and sustaining the improved process(es) (See also LD.03.07.01, EP 2

  - EP 2 Leadership reviews the plan for addressing performance improvement priorities at least annually and updates it to reflect any changes in strategic priorities and in response to changes in the internal or external environment.
- PI.02.01.01 – The hospital compiles and analyzes data
- PI.04.01.01 – The hospital improves performance (LD.03.02.01 The hospital uses data and information to guide decisions and to understand variation in the performance of processes supporting safety and quality).

2022 Annual Review Quality & Patient Safety Plans
The Joint Commission/CMS Requirements

1 Collect Data hospital wide that reflects:
1) the scope of services provided and
2) high risk, high volume & problem prone issues

2 Quality & Patient Safety Plans
(how we approach improvement)

3 Compile & Analyze Date

4 Improve

5 Review & Reprioritize

1

Collect Data hospital wide that reflects:
1) the scope of services provided and
2) high risk, high volume & problem prone issues

How do Health Systems know what to focus on?
- External entities (ie. CMS, TJC) new requirements, new metrics, national sentinel event alerts
- Internal data monitoring
- Scope of services and volumes from internal data
- Event reporting
- Safety culture data

MSDRG Number	Medical or Surgical	MSDRG Description	Total Patient Cases
177	M	Respiratory infections & inflammations w MCC	1,303
871	M	Septicemia w/o MV 96+ hours w MCC	738
291	M	Heart failure & shock w MCC	719
193	M	Simple pneumonia & pleurisy w MCC	256
638	M	Diabetes w CC	217
603	M	Cellulitis w/o MCC	213
65	M	Intracranial hemorrhage or cerebral infarction w CC	198
392	M	Esophagitis, gastroent & misc digest disorders w/o MCC	194
378	M	G.I. hemorrhage w CC	193
682	M	Renal failure w MCC	188
683	M	Renal failure w CC	182
690	M	Kidney & urinary tract infections w/o MCC	175
640	M	Nutritional & misc metabolic disorders w MCC	174
64	M	Intracranial hemorrhage or cerebral infarction w MCC	174
280	M	Acute myocardial infarction, discharged alive w MCC	172
897	M	Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC	171
872	M	Septicemia w/o MV 96+ hours w/o MCC	162
207	M	Respiratory system diagnosis w ventilator support 96+ hours	158
853	S	Infectious & parasitic diseases w O.R. procedure w MCC	152
247	S	Perc cardiovasc proc w drug-eluting stent w/o MCC	151

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Kaweah Health

Annual Review - Clinical Quality Improvement Committees & Teams 2022-23 (Reporting structure noted in QIC/Prostaff schedules)

Board of Directors

Quality Council | **Medical Staff Executive Committee (MEC)**

Quality Improvement Committee (QIC)/Professional Staff Quality Committee (Prostaff)

Department Quality Reports
- Patient Care Operational Medical Staff - Service Line

Organizational Quality Committees
- Falls Prevention — Falls University
- Diabetes
- Trauma
- Stroke Committee — ED Stroke Alert
- Health Equity
- Patient Safety Indicator (PSI)
- Pain Committee
- Medication Safety — Adverse Drug Event Cmte / Patient Care Medication Safety
- Rapid Response/ Code Blue
- Mortality
- Infection Prevention Committee — Surgical Site Infection
- CAUTI
- Accreditation Regulatory Committee
- Environment of Care — WPV Case Review
- Diversion Prevention
- NSTEMI Best Practice Team
- COPD Best Practice Team
- Pneumonia Best Practice Team
- Heart Failure Best Practice Team
- Population Health Steering (QIP) — Population Health Quality
- Surgical Quality Improvement (SQIP)

Quality Focus Teams
- Sepsis
- Skin/Wound
- Handoff Communication
- CLABSI
- MRSA

Patient Throughput
- Throughput & Patient Progression
  - Care Mgmt roles & responsibilities
  - Discharge planning & timely discharge
  - Multidisciplinary huddles
- Throughput & Patient Progression
  - Long Stay Committee
- Demand Mgmt
  - ED to Inpatient admission process
- Capacity Mgmt
  - Patient Placement Infrastructure

Patient Safety Committee
- Root Cause Analysis/Focus Review Teams
- Quality-Risk Committee
- Just Culture/Safety Culture Steering Committee
- FMEA Team Proactive Risk Assessment
- METER

56/92

2022 Annual Review Quality & Patient Safety Plans

2

PI Plan (5W's and how we approach PI)
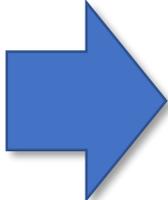
The Quality Improvement/ Performance Improvement and Patient Safety Plans (AP.41 and AP.175) outlines how Kaweah Health approaches QI, who oversees the program, where is that done, what is focused on and why.

HOW?
Models for Improvement

WHO?
WHAT?
WHERE?
WHEN? WHY?

Kaweah Health

3
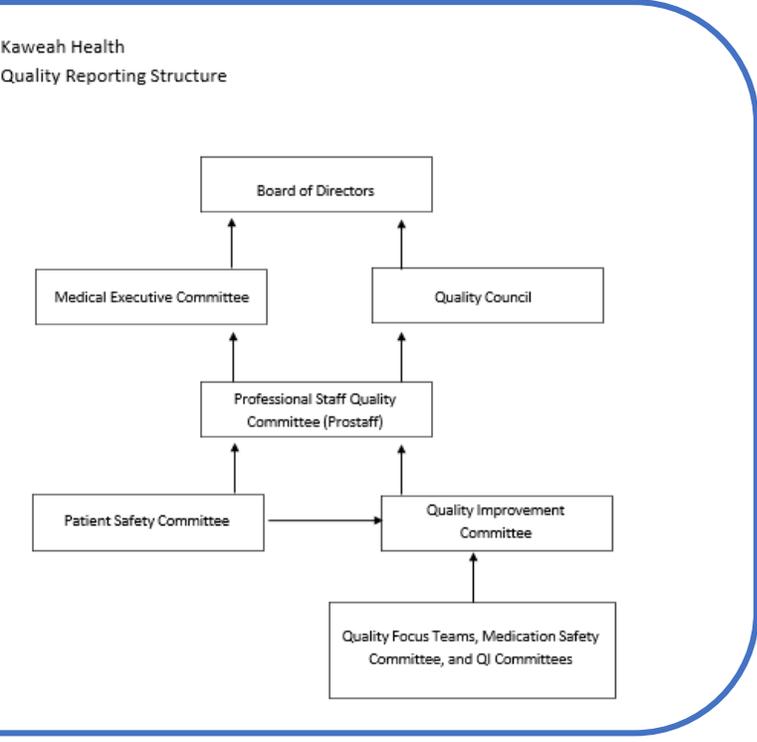
Compile & Analyze Date (make is useful)

LD.03.02.01 The hospital uses data and information to guide decisions and understand variation in the performance of process supporting safety and quality

Failure Modes Effects Analysis

Sepsis Quality Focus Team DASHBOARD

Pareto Chart Root Cause of CAUTI Events Jan 2022-Oct 2022

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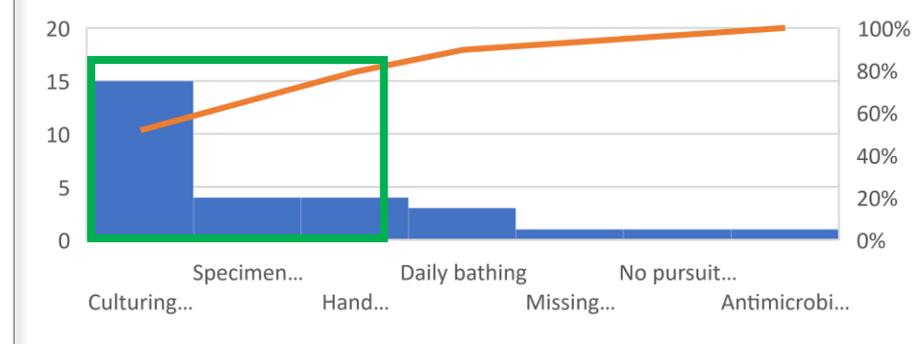
2022 Annual Review Quality & Patient Safety Plans

4

Improve (action if goals not achieved)

PDCA/DMAIC Report

What is being measured?

What is the goal?

Has it been achieved?

No

Yes

Is there an appropriate action plan?

Yes

Monitor for goal attainment/sustainment

Sustain

Determine new QI Opportunities

Are there any barriers?

Follow up requested

2022 Annual Review Quality & Patient Safety Plans

5
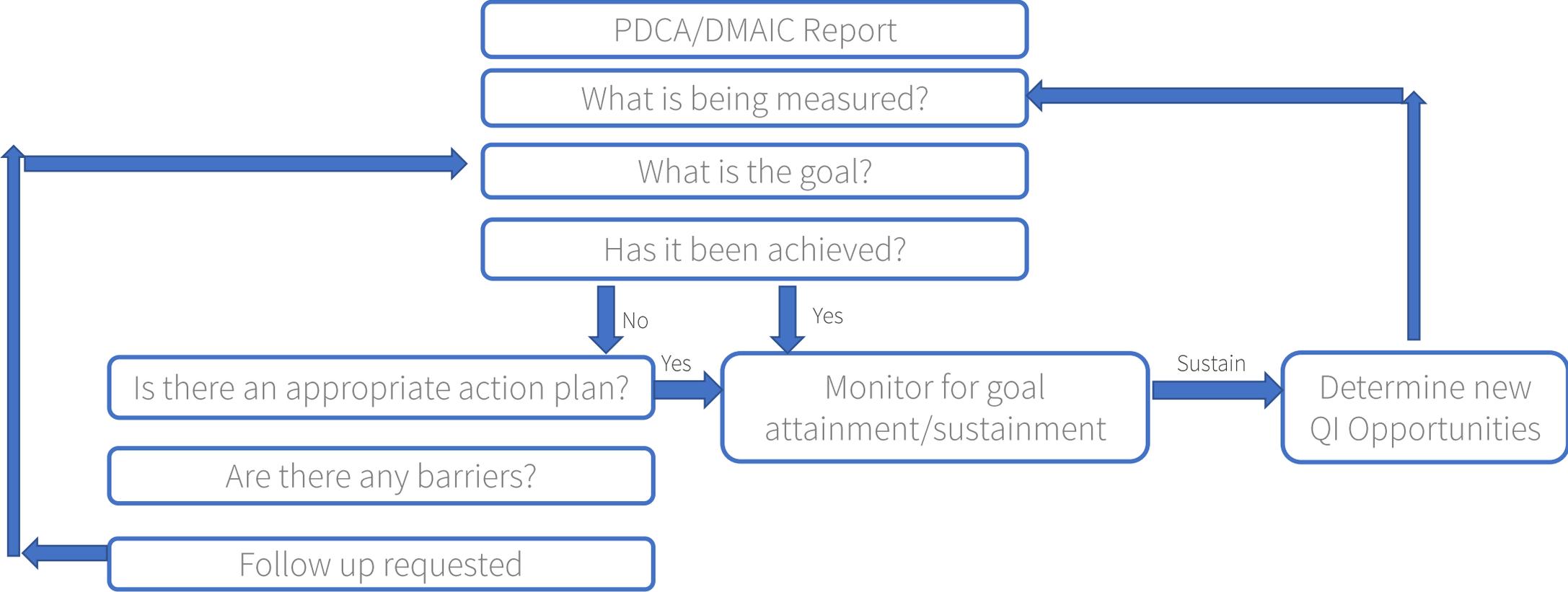
Review & Reprioritize

How do Health Systems know what to focus on?
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- Event reporting

MSDRG Number	Medical or Surgical	MSDRG Description	Total Patient Cases
177	M	Respiratory infections & inflammations w MCC	1,303
871	M	Septicemia w/o MV 96+ hours w MCC	738
291	M	Heart failure & shock w MCC	719
193	M	Simple pneumonia & pleurisy w MCC	256
638	M	Diabetes w CC	217
603	M	Cellulitis w/o MCC	213
65	M	Intracranial hemorrhage or cerebral infarction w CC	198
392	M	Esophagitis, gastroent & misc digest disorders w/o MCC	194
378	M	G.I. hemorrhage w CC	193
682	M	Renal failure w MCC	188
683	M	Renal failure w CC	182
690	M	Kidney & urinary tract infections w/o MCC	175
640	M	Nutritional & misc metabolic disorders w MCC	174
64	M	Intracranial hemorrhage or cerebral infarction w MCC	174
280	M	Acute myocardial infarction, discharged alive w MCC	172
897	M	Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC	171
872	M	Septicemia w/o MV 96+ hours w/o MCC	162
207	M	Respiratory system diagnosis w ventilator support 96+ hours	158
853	S	Infectious & parasitic diseases w O.R. procedure w MCC	152
247	S	Perc cardiovasc proc w drug-eluting stent w/o MCC	151

Kaweah Health

Hot Topics in the Healthcare Quality & Patient Safety Industry

Enhancing & Accelerating Patient Safety Program at Kaweah Health

- Under development for 2023 "Burden Scores"
- New ways of quantifying Midas event data that leads to enhanced trend identification and action (burden score = volume of event type X severity)
- System infrastructure work during 2022 with team of Cal Poly Industrial Engineers (Senior Project Sponsors)
- 2023 continued development on workflow plans with Quality Improvement committee and Kaweah Health Leadership

Use Bubble Charts to Compare Burden / Impact of Categories

Kaweah Health
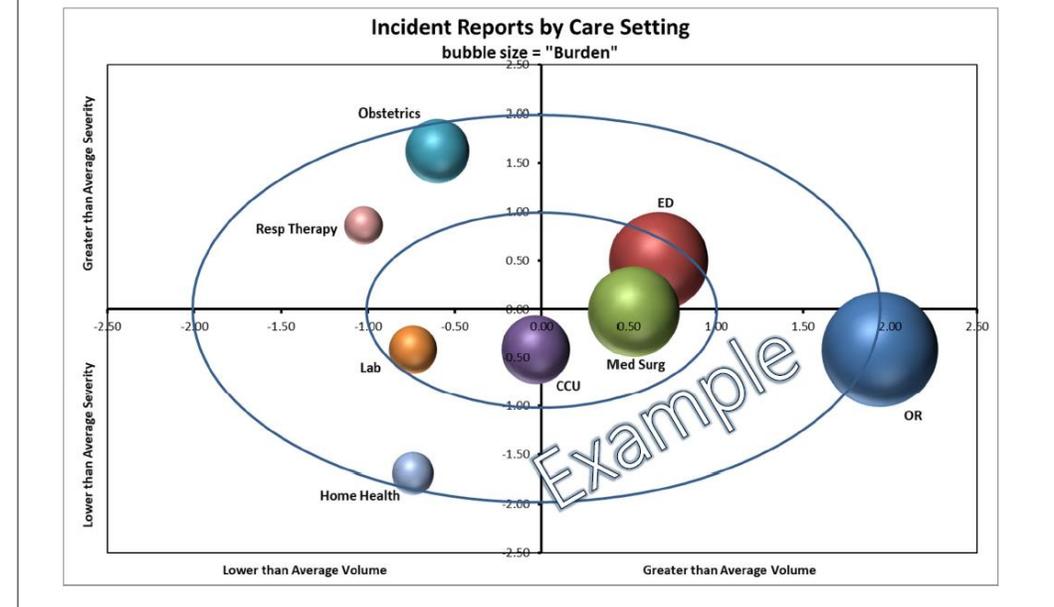
Hot Topics in the Healthcare Quality & Patient Safety Industry

Health Equity/Health Care Disparities

- New TJC Leadership Standards
- New CMS core measures 2023 forward

Cycles of:
- Identifying & addressing disparities
- Awareness, training and,
- Finding better ways to identify them

More than medicine. Life.

Kaweah Health

Hot Topics in the Healthcare Quality & Patient Safety Industry

National Action Plan to Advance Patient Safety

Safer Together: A National Action Plan to Advance Patient Safety, illuminates the collective insights of the 27 organizations represented on the National Steering Committee for Patient Safety (NSC), united in their efforts to achieve safer care and reduce harm to patients and those who care for them. The National Action Plan centers on four foundational and interdependent areas, which the NSC prioritized as essential to create total systems safety.

- Culture, Leadership, and Governance: The imperative for leaders, governance bodies, and policymakers to demonstrate and foster our deeply held professional commitments to safety as a core value and promote the development of cultures of safety.

- Patient and Family Engagement: The spread of authentic patient and family engagement; the practice of co-designing and co-producing care with patients, families, and care partners to ensure their meaningful partnership in all aspects of care design, delivery, and operations.

- Workforce Safety: Ensuring the safety and resiliency of the organization and the workforce is a necessary precondition to advancing patient safety; we need to work toward a unified, total systems-based perspective and approach to eliminate harm to both patients and the workforce.

- Learning System: Establishing networked and continuous learning; forging learning systems within and across health care organizations at the local, regional, and national levels to encourage widespread sharing, learning, and improvement.
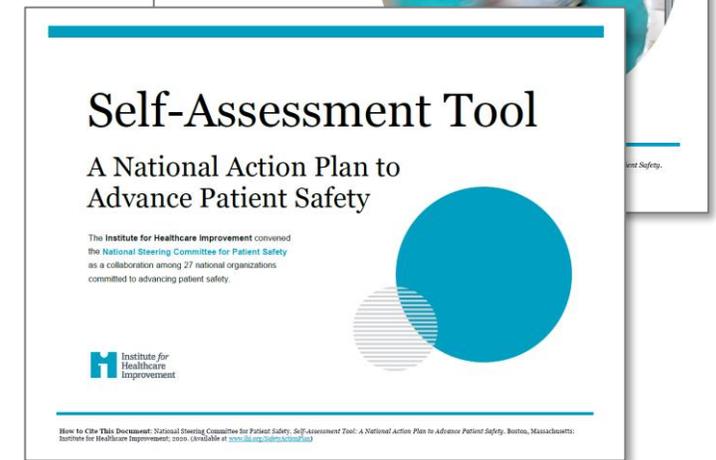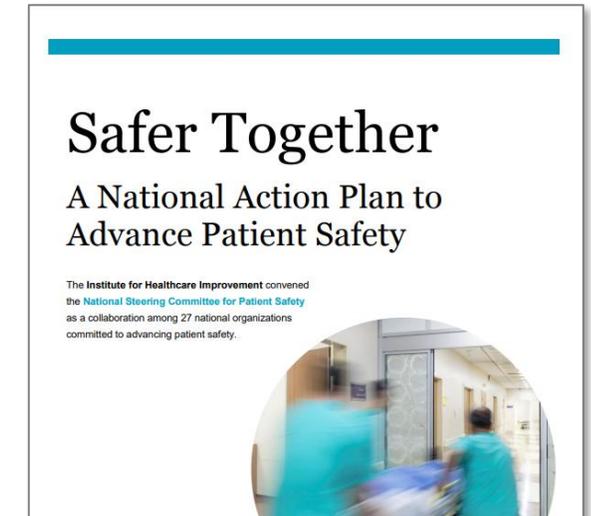
Hot Topics in the Healthcare Quality & Patient Safety Industry

Opioid Safety/Opioid Epidemic

Hot Topics in the Healthcare Quality & Patient Safety Industry

Introduction of H.R.9377 - National Patient Safety Board Act of 2022
December 8, 2022

- legislation to establish an independent federal agency dedicated to preventing and reducing healthcare-related harms.
- This landmark legislation is a critical step to improve safety for patients and healthcare providers by coordinating existing efforts within a single independent agency solely focused on addressing safety in health care through data-driven solutions.
- The National Patient Safety Board Act would create a National Patient Safety Board (NPSB), a nonpunitive, collaborative, independent agency modeled in part after the National Transportation Safety Board (NTSB) and the Commercial Aviation Safety Team (CAST) to address safety in health care. The aviation industry has had a stellar safety record thanks to the work of the NTSB and CAST, which together have been improving and promoting transportation safety in the United States for more than 25 years. The NPSB would guarantee a data-driven, scalable approach to preventing and reducing patient safety events in healthcare settings.

Questions?

Annual Review of Quality (AP.41) and Patient Safety Plan (AP.175)
2023 Quality and Patient Safety Initiatives & Quality Focus Team (QFT) Review

Quality Initiative	Type	Priority Category	Key Considerations	Measures of Success	Assigned Leader(s)
Patient Safety Committee	Org Oversight Committee	☒ High Risk ☒ Problem Prone ☒ High Volume	• Responsible per AP.175 Patient Safety Plan • Oversees Midas Event Triage and Ranking Committee (METER) and Quality-Risk Committee (QRC) • Oversees all action plans related to Root Cause Analysis and Focus Review teams • Oversees safety culture improvement action plan including Just Culture	• As determined by individual action plans • Reportable never events • Measure reports by subcommittee listed below	Director of Quality and Patient Safety
Midas Event Triage & Ranking Committee (METER)	Patient Safety Subcommittee	☒ High Risk ☒ Problem Prone ☒ High Volume	• Objective: Rank and Triage Events through a multidisciplinary team daily so that immediate notification of high risk events can be made to Medical Staff Leadership and Hospital Leadership • Events are reviewed daily Monday through Friday (weekend events reviewed Monday with RM notification processes in place on weekends) • Events are triaged using a criticality matrix in which members of the committee would come to consensus on event scoring	• Volume and severity of events; events escalated	• Director of Risk Management
Quality-Risk Committee	Patient Safety Subcommittee	☒ High Risk ☒ Problem Prone ☒ High Volume	• Reviews Midas event reports weekly to identify trends • High Risk Process Review (HiPR) which targets regular standardized review of seven high risk processes (proposal includes ability to revise list of targeted processes by Patient Safety Committee (PSC)). High risk processes include those identified by regulatory entities (The Joint Commission (TJC)), and/or identified as high risk by current Quality and Risk processes.	• Volume and significance of events, reports submitted anonymously • Specific event types trended and reported to the committee as identified; plan for 2023 includes trends identified by "Burden Scores" (volume x severity) HiPR process includes: • Event reports/ analysis, root cause analysis (RCA) and Focused Review (FR) data • Other quality data utilized specific to the topic (ie.	• Directors of Risk Management and Quality & Patient Safety

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				restraint use as documented in Cerner)	
Just Culture Steering	Patient Safety Subcommittee, Org Committee	☒ High Risk ☒ Problem Prone ☒ High Volume	• Key strategy in organization safety culture improvement action plan • National Quality Forum (NQF) safe practice included in Leapfrog Safety Grade	• Just Culture measures included in the Safety Culture Survey	Director of Organizational Development
Medication Safety	Org Oversight Committee	☒ High Risk ☒ Problem Prone ☒ High Volume	• Oversees the Medication Error Reduction Program (MERP) per CA state requirements • Oversees Nursing Medication Safety Task Force QI work • Oversight of medication elements of high risk processes such as anticoagulation, medication reconciliation and procedural sedation safety which are Joint Commission National Patient Safety Goals.	• Several measures monitored as determined annually by the committee through the MERP and Adverse Drug Event (ADE) committee work. Examples include antidote administration rates, bar code medication administration rates, reducing ADEs. • Medication Reconciliation measures include: Home medication list review of high risk patients; Complete initial home medication review within 24 hrs of admission	Director of Pharmacy
Adverse Drug Event (ADE) Committee	Org Sub-Committee Medication Safety	☒ High Risk ☒ Problem Prone ☒ High Volume	• Reviews, tracks and trends and resolves (or escalates) adverse drug event Midas reports	• ADE volume and tracked trends as reported to Medication Safety Committee	Medication Safety Coordinator
Sepsis QFT	OHO Strategic Initiative Quality Focus Team (QFT)	☒ High Risk ☒ Problem Prone ☒ High Volume	• Established QFT since 2016 • High volume diagnosis, high mortality rates nationally (problem prone) • Centers for Medicare and Medicaid Services (CMS) SEP-1 bundle compliance publically reported on CMS care compare website	• SEP-1 Bundle compliance • LOS • Mortality	Medical Director of Quality & Patient Safety; Director of Quality and Patient Safety

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Annual Review of Quality (AP.41) and Patient Safety Plan (AP.175)
2023 Quality and Patient Safety Initiatives & Quality Focus Team (QFT) Review

Handoff Communication QFT	Quality Focus Team (QFT)	☒ High Risk ☒ Problem Prone ☒ High Volume	• QFT established in 2018; QI work recommended by TJC in a Sentinel Event Alert issued in September 2017. • Several sources indicate need for improvement work (ie. trended event reports, sentinel event data, and external literature) ○ Midas Event volume – Handoff category: 2019 = 65, 2020 = 30, 2021 = 27, 0 harm	• Defective rate through TJC's survey tool • Midas event "Handoff" category volume & significance	Director of Trauma Program
Hospital Acquired Pressure Injury (HAPI) QFT	Quality Focus Team (QFT)	☒ High Risk ☒ Problem Prone ☐ High Volume	• PSI3 (HAPI) is a component of Leapfrog Safety Score & CMS public report • Mandated reporting to California Department of Public Health (CDPH)	• Percent of patients with stage 2+ • Proportion of HAPIs that are device related	Director of Throughput and Specialty Care
Central Line Associated Blood Stream Infection (CLABSI) QFT	OHO Strategic Initiative, QFT	☒ High Risk ☒ Problem Prone ☐ High Volume	• CMS Value-Based Purchasing (VBP) and star rating Measure • Leapfrog safety grade metric • TJC National Patient Safety Goal	• Standardized Infection Ratio (SIR) • Bundle compliance measures	Director of Renal Services
Catheter Associated Urinary Tract Infection (CAUTI) Committee	Org Committee	☒ High Risk ☒ Problem Prone ☐ High Volume	• CMS VBP and star rating Measure • Leapfrog safety grade metric •	• Standardized Infection Ratio (SIR) • Bundle compliance measures	Director of Post-Surgical Care
Methicillin-Resistant Staphylococcus Aureus (MRSA) QFT	OHO Strategic Initiative, QFT	☒ High Risk ☒ Problem Prone ☐ High Volume	• CMS VBP and star rating Measure • Leapfrog safety grade metric • TJC National Patient Safety Goal	• Standardized Infection Ratio (SIR) • Decolonization process measures, ATP testing	Director of Environmental Services
Heart Failure - Best Practice Team	OHO Strategic Initiative, Org Committee	☒ High Risk ☒ Problem Prone ☒ High Volume	• CMS VBP and star rating Measure • High volume medical diagnosis • CMS Readmission Reduction Program population	• Observed/expected (o/e) mortality and risk adjusted readmission rates • examples of key performance indicators (KPI) include discharge medication, and inpatient medication management	Director of Medical Surgical Services; Medical Director of Best Practice Teams

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Pneumonia - Best Practice Team	OHO Strategic Initiative, Org Committee	☒ High Risk ☒ Problem Prone ☒ High Volume	• CMS VBP and star rating Measure • High volume medical diagnosis • CMS Readmission Reduction Program population	• o/e mortality and risk adjusted readmission rates • examples of key performance indicators (KPI) Antibiotic medication timing and route, and power plan usage	Director of Rehabilitation; Medical Director of Best Practice Teams
NSTEMI - Best Practice Team	OHO Strategic Initiative, Org Committee	☒ High Risk ☒ Problem Prone ☒ High Volume	• CMS VBP and star rating Measure • High volume medical diagnosis • CMS Readmission Reduction Program population	• o/e mortality and risk adjusted readmission rates • examples of key performance indicators (KPI) include medication management and diagnostic testing	Director of Cardiovascular Services; Medical Director of Best Practice Teams
COPD - Best Practice Team	OHO Strategic Initiative, Org Committee	☒ High Risk ☒ Problem Prone ☐ High Volume	• CMS VBP and star rating Measure • CMS Readmission Reduction Program population	• o/e mortality and risk adjusted readmission rates • examples of key performance indicators (KPI) include diagnostic studies, immunization, and discharge education	Director of Respiratory Services; Medical Director of Best Practice Teams
Falls University	Org Committee	☒ High Risk ☒ Problem Prone ☐ High Volume	• Nursing sensitive quality indicator • Case reviews of fall events and collection an dissemination of contribution factors data	• Total falls and injury falls; contributing factors	Director of Nursing Practice
Diabetes	OHO Strategic Initiative, Org Committee	☒ High Risk ☒ Problem Prone ☒ High Volume	• High volume, high risk volume patient population	• Hypo and Hyperglycemia rates	Director of Nursing Practice, Medical Director of Quality & Patient Safety
Trauma Quality Program	Org Committee	☒ High Risk ☒ Problem Prone ☒ High Volume	• Trauma program oversight and QI work related to ACS trauma designation	• Various measures through data registry including documentation of assessment findings, airway management, timeliness of diagnostic studies, timeliness of	Director of Trauma Program, Medical Director of Trauma

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				surgical intervention, mortality rates	
Stroke Quality Program	Org Committee	☒ High Risk ☒ Problem Prone ☒ High Volume	• The Joint Commission (TJC) certified program • High risk population • Oversees work of the ED Stroke Alert sub task force	• Various measure through American Heart/Stroke Association including medication management, discharge indicators, timeliness of diagnostics studies and assessments	Manager of Stroke Program and Medical Director of Stroke Program
Health Equity	Org Committee	☒ High Risk ☒ Problem Prone ☒ High Volume	• National and ACGME initiative • TJC Sentinel Event issued January 2022	• Measures to identify disparities in care in key population • Uses REaL data (Race, Ethnicity and Language) in data analysis on population incidence, readmissions and mortality	COO
Patient Safety Indicator (PSI) Committee	Org Committee	☒ High Risk ☒ Problem Prone ☐ High Volume	• Review of coded complications of the surgical population • Reported on CMS Care Compare website • Component of CMS star rating, VBP program	• PSI rates	Medical Director of Surgical Quality, Director of Quality and Patient Safety
Surgical Quality Committee (SQIP)	Org Committee	☒ High Risk ☒ Problem Prone ☒ High Volume	• Oversees implementation of Enhanced Recovery After Surgery (ERAS) program (evidenced based care targeted at the surgical population • Oversees PSI (coded complications of care)	• ERAS measures • PSI measures	Director of Surgical Services, Medical Director of Surgical Quality
Pain Committee	Org Committee	☒ High Risk ☒ Problem Prone ☒ High Volume	• TJC Standards for organization leadership oversight and data requirements	• Measures of pain assessment, effectiveness and safety • Opioid prescribing	Director of Quality & Patient Safety, Medical Director of Quality and Patient Safety
Population Health Steering Committee	Org Oversight Committee; Medication Reconciliation OHO Initiative	☒ High Risk ☒ Problem Prone ☒ High Volume	• Quality Incentives Program (QIP) previously Public Hospital Redesign & Incentives Program (PRIME) • Oversees Population Health Quality Committee work	• A total of 20 measures primary care reported for the QIP program, of which 50% must be selected	Director of Population Health

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			• Medication Reconciliation a TJC National Patient Safety Goal (NPSG)	from the Priority Measures Set per DHCS • OHO measure -Outpatient medication reconciliation within 30 days post discharge from acute care	
Rapid Response/Code Blue	Org Committee	☒ High Risk ☒ Problem Prone ☒ High Volume	• TJC data monitoring requirements	• Several measures as submitted to American Heart Association registry including volume, location and outcome	Director of Critical Care Services
Mortality	Org Committee	☒ High Risk ☒ Problem Prone ☐ High Volume	• Review of unexpected deaths for follow up with quality of care concerns, coding or documentation	• Rates of cases with quality of care concerns, coding or documentation	Medical Director of Quality and Patient Safety
Infection Prevention Committee	Org Oversight Committee	☒ High Risk ☒ Problem Prone ☐ High Volume	• Oversees the Infection Prevention Plan • Oversees Surgical Site Infection task force • Oversees regulatory compliance with IP standards	• Several measures monitored through quarterly dashboard including surgical site infection rates, ventilator associated events, line infection rates, MRSA.	Manager of Infection Prevention, Medical Director of Infection Prevention
Accreditation Regulatory Committee	Org Oversight Committee	☒ High Risk ☒ Problem Prone ☒ High Volume	• Oversees compliance with regulatory standards and plans of correction	• Various measures determined by plans of correction • Regular tracer data for compliance with regulatory standards	Director of Quality & Patient Safety
Environment of Care Committee	Org Oversight Committee	☒ High Risk ☒ Problem Prone ☒ High Volume	• Oversees the EOC Plan and Workplace Violence Program (CA state mandate) • Oversees compliance with EOC regulatory standards	• Various measures including preventive maintenance completion rates, workplace violence, and employee injury rates.	Safety Officer
Diversion Prevention Committee	Org Committee	☒ High Risk ☒ Problem Prone ☐ High Volume	• Oversees plan of correction and improvement work related to prevention of opioids and propofol	• Several measures determined by plan of correction including chain	Director of Risk Management and Director of Critical Care Services

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			• Oversees knowledge and education initiatives related to diversion prevention	of custody, rendering propofol useless. • Staff knowledge on diversion prevention survey results	

Patient Throughput	Org Committee	☒ High Risk
		☒ Problem Prone
		☒ High Volume
			• Steering committee that oversees work of 5 sub-groups:
			• Throughput & Patient Progression
			  o Care Mgmt roles & responsibilities
			  o Discharge planning & timely discharge
			  o Multidisciplinary huddles
			• Throughput & Patient Progression
			  o Long Stay Committee
			• Demand Mgmt
			  o ED to Inpatient admission process
			• Capacity Mgmt
			  o Patient Placement Infrastructure
			• Project work will include a proactive risk assessment (FMEA) to be reviewed by Patient Safety Committee
			• Team Rounding
			  o Identified by Strategic planning group as a contributing factor to increased LOS, and decreased teamwork climate
				• Various throughput measures included time to provider, time from door to admit, time from admit to arrival on unit.
				• Several processes measures reported through each sub-group
					Executive Team

*All committees report to Quality Improvement Committee/Prostaff per AP.41

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Policy Number: AP41	Date Created: Not Set
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	Date Approved: 01/26/2022
Approvers: Board of Directors (Administration)	
Quality Improvement Plan	

I.   Purpose

The purpose of Kaweah Delta Health Care District's (KDHCD) Quality Improvement Plan is to have an effective, data-driven Quality Assessment Performance Improvement program that delivers high-quality, excellent clinical services and enhances patient safety.

II.   Scope

All KDHCD facilities, departments, patient care delivery units and/or service areas fall within the scope of the quality improvement plan requirements.

III.   Structure and Accountability

Board of Directors

The Board of Directors retain overall responsibility for the quality of patient care. The Board approves the annual Quality Improvement Plan and assures that appropriate allocation of resources is available to carry out that plan.

The Board receives reports from the Medical Staff and Quality Council. The Board shall act as appropriate on the recommendations of these bodies and assure that efforts undertaken are effective and appropriately prioritized.

Quality Council

The Quality Council is responsible for establishing and maintaining the organization's Quality Improvement Plan and is chaired by a Board member. The Quality Council shall consist of the Chief Executive Officer, representatives of the Medical Staff and other key hospital leaders. It shall hold primary responsibility for the functioning of the Quality Assessment and Performance Improvement program. Because District quality improvement activities may involve both the Medical Staff and other representatives of the District, membership is multidisciplinary. The Quality Council requires the Medical Staff and the organization's staff to implement and report on the activities for identifying and evaluating opportunities to improve patient care and services throughout the organization. The effectiveness of the quality

improvement and patient safety activities will be evaluated and reported to theQuality Council.

Medical Staff

The Medical Staff, in accordance with currently approved medical staff bylaws, shall be accountable for the quality of patient care. The Board delegates authority and responsibility for the monitoring, evaluation and improvement of medical care to the Professional Staff Quality Committee "Prostaff", chaired by the Vice Chief of Staff. The Chief of Staff delegates accountability for monitoring individual performance to the Clinical Department Chiefs. Prostaff shall receive reports from and assure the appropriate functioning of the Medical Staff committees. "Prostaff" provides oversight for medical staff quality functions including peer review.

Quality Improvement Committee (QIC)

QIC has responsibility for oversight of organizational performance improvement. Membership includes key organizational leaders including the Medical Director of Quality and Patient Safety or Chief Quality Officer, Chief Operating Officer, Chief Nursing Officer, Assistant Chief Nursing Officer, Directors of Quality and Patient Safety, Nursing Practice, Pharmacy Health System, Accreditation, and Risk Management; Manager of Quality and Patient Safety and Manager of Infection Prevention. This committee reports to Prostaff and the Quality Council.

The QIC shall have primary responsibility for the following functions:

1. **Health Outcomes:** The QIC shall assure that there is measureable improvement in indicators with a demonstrated link to improved health outcomes. Such indicators include but are not limited to measures reported to the Centers for Medicare and Medicaid Services (CMS) and The Joint Commission (TJC), and other quality indicators, as appropriate.

2. **Quality Indicators:**
   a. The QIC shall oversee measurement, and shall analyze and track quality indicators and other aspects of performance. These indicators shall measure the effectiveness and safety of services and quality of care.
   b. The QIC shall approve the specific indicators used for these purposes along with the frequency and detail of data collection.
   c. The Board shall ratify the indicators and the frequency and detail of data collection used by the program.

3. **Prioritization:** The QIC shall prioritize quality improvement activities to assure that they are focused on high- risk, high- volume, or problem-prone areas. It shall focus on issues of known frequency, prevalence or severity and shall give precedence to issues that affect health

outcomes, quality of care and patient safety. The QIC is responsible to establish organizational Quality Focus Teams who:
  a.   Are focused on enterprise-wide high priority, high risk, problem prone QI issues
  b.   May require elevation, escalation and focus from senior leadership
  c.   Have an executive team sponsor
  d.   Are chaired by a Director or Vice President
  e.   May have higher frequency of meetings as necessary to focus work and create sense of urgency.
  f.   Report quarterly into the QAPI program

4.   **Improvement:** The QIC shall use the analysis of the data to identify opportunities for improvement and changes that will lead to improvement. The QIC will also oversee implementation of actions aimed at improving performance.

5.   **Follow- Up:** The QIC shall assure that steps are taken to improve performance and enhance safety are appropriately implemented, measured and tracked to determine that the steps have achieved and sustained the intended effect.

6.   **Performance Improvement Projects:** The QIC shall oversee quality improvement projects, the number and scope of which shall be proportional to the scope and complexity of the hospital's services and operations. The QIC must also ensure there is documentation of what quality improvement projects are being conducted, the reasons for conducting those projects, and the measureable progress achieved on the projects.

Medical Executive Committee

The Medical Executive Committee (MEC) receives, analyzes and acts on performance improvement and patient safety findings from committees and is accountable to the Board of Directors for the overall quality of care.

Nursing Practice Improvement Council

The Nursing Practice Improvement Council is designed to ensure quality assessment and continuous quality improvement and to oversee the quality of patient care (with focus on systems improvements related to nursing practices and care outcomes).

The Nursing Practice Improvement Council is chaired by the Director of Nursing Practice and facilitated by a member of the Quality and Patient Safety department. This Council has staff nurse representation from a broad scope of inpatient and out-patient nursing units, and procedural nursing units. The Council will report to Patient Care Leadership, Professional Practice Council (PPC) and the Professional Staff Quality Committee.

Graduate Medical Education

Graduate Medical Education (Designated Institutional Official (DIO), faculty and residents, are involved in achieving quality and patient safety goals and improving patient care through several venues including but not limited to:

a) Collaboration between Quality and Patient Safety Department, Risk Management, and GME Quality Subcommittee
b) GME participation in Quality Improvement Committee and Patient Safety Committee
c) GME participation in KDHCD quality committees and root cause analysis (including organizational dissemination of lessons learned)

Methodologies:

Quality improvement (QI) models present a systematic, formal framework for establishing QI processes within an organization. QI models used include the following:

- [Model for Improvement (FOCUS Plan-Do-Study-Act [PDSA] cycles)](#)
- [Six Sigma](#): Six Sigma is a method of improvement that strives to decrease variation and defects with the use of the DMAIC roadmap.
- [Lean](#): is an approach that drives out waste and improves efficiency in work processes so that all work adds value with the use of the DMAIC roadmap.

1. The **FOCUS-Plan, Do, Check, Act (PDCA)** methodology is utilized to plan, design, measure, assess and improve functions and processes related to patient care and safety throughout the organization.

   - **F**—**Find** a process to improve
   - **O**—**Organize** effort to work on improvement
   - **C**—**Clarify** knowledge of current process
   - **U**---**Understand** process variation
   - **S**—**Select** improvement

   - <u>**Plan:**</u>

     - Objective and statistically valid performance measures are identified for monitoring and assessing processes and outcomes of care including those affecting a large percentage of patients, and/or place patients at serious risk if not performed well, or performed when not indicated, or not performed when indicated; and/or have been or likely to be problem prone.

     - Performance measures are based on current knowledge and clinical experience and are structured to represent cross-departmental, interdisciplinary processes, as appropriate.

- **Do:**

  - Data is collected to determine:
    - ◆ Whether design specifications for new processes were met
    - ◆ The level of performance and stability of existing processes
    - ◆ Priorities for possible improvement of existing processes

- **Check:**

  - Assess care when benchmarks or thresholds are reached in order to identify opportunities to improve performance or resolve problem areas

- **Act:**

  - Take actions to correct identified problem areas or improve performance
  - Evaluate the effectiveness of the actions taken and document the improvement in care
  - Communicate the results of the monitoring, assessment and evaluation process to relevant individuals, departments or services

3. DMAIC (Lean Six Sigma): DMAIC is an acronym that stands for Define, Measure, Analyze, Improve, and Control. It represents the five phases that make up the road map for Lean Six Sigma QI initiatives.

   - **Define** the problem, improvement activity, opportunity for improvement, the project goals, and customer (internal and external) requirements. QI tools that may be used in this step include:
     - o Project charter to define the focus, scope, direction, and motivation for the improvement team
     - o Process mapping to provide an overview of an entire process, starting and finishing at the customer, and analyzing what is required to meet customer needs
   - **Measure** process performance.
     - o Run/trend charts, histograms, control charts
     - o Pareto chart to analyze the frequency of problems or causes
   - **Analyze** the process to determine root causes of variation and poor performance (defects).
     - o Root cause analysis (RCA) to uncover causes
     - o Failure mode and effects analysis (FMEA) for identifying possible product, service, and process failures

- **Improve** process performance by addressing and eliminating the root causes.
  - o Pilot improvements and small tests of change to solve problems from complex processes or systems where there are many factors influencing the outcome
  - o Kaizen event to introduce rapid change by focusing on a narrow project and using the ideas and motivation of the people who do the work
- **Control** the improved process and future process performance.
  - o Quality control plan to document what is needed to keep an improved process at its current level. Statistical process control (SPC) for monitoring process behavior
  - o Mistake proofing (poka-yoke) to make errors impossible or immediately detectable

IV. Confidentiality

All quality assurance and performance improvement activities and data are protected under the Health Care Quality Improvement Act of 1986, as stated in the Bylaws, Rules and Regulations of the Medical Staff, and protected from discovery pursuant to California Evidence Code §1157.

V. Annual Evaluation

Organization and Medical Staff leaders shall review the effectiveness of the Quality Improvement Plan at least annually to insure that the collective effort is comprehensive and improving patient care and patient safety. An annual evaluation is completed to identify components of the plan that require development, revision or deletion. Organization and Medical Staff leaders also evaluate annually their contributions to the Quality Improvement Program and to the efforts in improving patient safety.

VI. Attachments

Components of the Quality Improvement and Patient Safety Plan:

Attachment 1: Quality Improvement Committee Structure
Attachment 2: KDHCD- Prostaff Reporting Documents
Attachment 3: Quality and Patient Safety Priorities, Outstanding Health Outcomes Strategic Plan

Kaweah Health
Quality Reporting Structure

Attachment 2

Kaweah Health - QUALITY IMPROVEMENT COMMITTEE REPORTING DEPARTMENTS

Departments within Kaweah Health participate in the Quality Improvement plan by prioritizing performance improvement activities based on high-risk, high-volume, or problem-prone areas. Department level indicators shall focus on issues of known frequency, prevalence or severity and shall give precedence to issues that affect health outcomes, quality of care and patient safety. Departments include, but are not limited to:

PROFESSIONAL and PATIENT CARE SERVICES
Laboratory
Nursing Quality Dashboard
Advanced Nursing Practice
Wound Care, Inpatient (Skin and Wound Committee)
Patient Access
Community Outreach
Patient & Family Services
Case Management/Utiliz Mgt & Bed Alloc
Interpreter Services
EOC (Security, facilities, Clinical Engineering, EVS)
Chaplain Services
Exeter Health Clinic (includes Lindsay, Woodlake, Dinuba)
Inpatient Pharmacy
Conscious Sedation (ED) Annual
Organ Donation (Annual)
Maternal Child Health
Labor & Delivery
Mother Baby
Neonatal Intensive Care Unit
Pediatrics
Mental Health Services
Mental Health
Episodic Care
Emergency
Trauma Service
Urgent Care
Cardiovascular Services
Dept of Cardiovascular Services (ACC/STS/) - Cath lab, IR, CVCU and Cardiac Surgery
CVICU
2N
4T
Critical Care Services
Intensive Care Unit
3W
Rehabilitation Services
Rehabilitation
Inpatient Therapies (KDMC, Rehab, South Campus)

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PROFESSIONAL and PATIENT CARE SERVICES
Outpatient Therapies: Medical Office Building (MOB), Exeter, Sunnyside, Dinuba, Lovers Lane, Therapy Specialists at Rehab
Outpatient Wound Care at Rehab
Post Acute Services
KD Home Infusion Pharmacy
Home Care Services (Home Health & Hospice)
Transitional Care Svc/Short-Stay Rehab
Skilled Nursing Services
Surgical Services
Ambulatory Surgery Center/PACU/KATS
Operating Room
SPD
Broderick Pavilion
3N
4 South
Renal Services
4 North -
CAPD/ CCPD (Dialysis Maintenance)
Visalia Dialysis
Med/Surg
2S
3S
PUBLICALLY REPORTED MEASURES
Infection Prevention
Patient Safety Indicators/HACs
Value Based Purchasing Report
Patient Experience
Core Measures
Hospital Compare Quarterly Report
Healthgrades
Leapfrog Hospital Safety Score
COMMITTEES
Med Safety & ADE
Disparities in care
Falls committee
RRT/Code Blue
Pain Management
Resource Effectiveness Committee
Sepsis Quality Focus Team
Stroke
Diabetes QFT
Blood Utilization
Handoff Communication QFT
Accreditation Regulatory Committee
Diversion Prevention Committee

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2023 Strategic Initiative Charter: Outstanding Health Outcomes

Objective	Chair	ET Sponsor	Board Member
To consistently deliver high quality care across the health care continuum	Sonia Duran-Aguilar	Doug Leeper	Dave Francis

Performance Measure	Baseline	FY23 Goal	FY24 Goal	FY25 Goal
Standardized Infection Ratio (SIR) CAUTI, CLABSI, MRSA (CMS Data)	CAUTI 0.84￼CLABSI 1.33￼MRSA 2.53	TBD	TBD	TBD
Percent Sepsis Bundle Compliance (SEP-1) (CMS Data)	75% (July-Dec2020)	TBD	TBD	TBD
Hospital Readmissions (%)	(FY2019)￼AMI – 12.34￼COPD – 16.09￼HF – 18.22￼PN Viral/Bacterial – 14.13	TBD	TBD	TBD
Decrease Mortality Observed/Expected Rates	AMI - 0.75￼COPD – 2.40￼HF – 1.78￼PN Bacterial – 1.85￼PN Viral – 1.34	TBD	TBD	TBD
Team Round Implementation	Rolled out to Hospitalist patients only in Med Surge units.	Roll out to Primary Care physician groups and Acute Care Trauma and Surgical Services (ACTSS) on med surge units.	Roll out into the critical care spaces.￼￼Achieve 80% Adherence for all units and participating physician groups.	TBD

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Performance Measure	Baseline	FY23 Goal	FY24 Goal	FY25 Goal
Meet QIP measure performance	N/A (Available end of FY22)	100% (20 of 20 measures)	100% (20 of 20 measures)	100% (20 of 20 measures)
Humana % PAF Completion/ HCC reassessment in RHCs, SHWC and KHMG	80.4%	>80%	>85%	>85%
Medicare Advantage STAR Rating for Humana lives	4.0	4.0	4.0	4.0
Improve Time to Target	N/A	Establish baseline data	TBD	TBD
Reduce Hypoglycemic events	N/A	Establish baseline data	TBD	TBD

Policy Number: AP175	Date Created: Not Set
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	Date Approved: Not Set
Approvers: Board of Directors (Administration), Cindy Moccio (Board Clerk/Exec Assist-CEO)	
Patient Safety Plan	

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

I.   Purpose

- Encourage organizational learning about medical/health care risk events and near misses
- Encourage recognition and reporting of medical/health events and risks to patient safety using just culture concepts
- Collect and analyze data, evaluate care processes for opportunities to reduce risk and initiate actions
- Report internally what has been found and the actions taken with a focus on processes and systems to reduce risk
- Support sharing of knowledge to effect behavioral changes in itself and within Kaweah Delta Healthcare District dba Kaweah Health (Kaweah Health)

II.   Scope

All Kaweah Health facilities, departments, patient care delivery units and/or service areas fall within the scope of the quality improvement and patient safety plan requirements.

III.   Structure and Accountability

A.   Board of Directors

The Board of Directors retains overall responsibility for the quality of patient care and patient safety.   The Board approves annually the Patient Safety Plan and assures that appropriate allocation of resources is available to carry out that plan.

The Board receives reports from the Patient Safety Committee through the Professional Staff Quality Committee. The Board shall act as appropriate on the recommendations of these bodies and assure that efforts undertaken are effective and appropriately prioritized.

B.   Quality Council

The Quality Council is responsible for establishing and maintaining the organization's Patient Safety Plan and is chaired by a Board member. The Quality Council shall consist of the Chief Executive Officer, representatives of the Medical Staff and other key hospital leaders. It shall hold primary responsibility for the functioning of the Quality Assessment and Performance Improvement program. Because District performance improvement activities may involve both the Medical Staff and other representatives of the District, membership is multidisciplinary. The Quality Council requires the Medical Staff and the organization's staff to implement and report on the activities for identifying and evaluating opportunities to improve patient care and services throughout the organization. The effectiveness of the quality improvement and patient safety activities will be evaluated and reported to the Quality Council.

C.   Patient Safety Committee

The Patient Safety Team is a standing interdisciplinary group that manages the organization's Patient Safety Program through a systematic, coordinated, continuous approach. The Team will meet monthly to assure the maintenance and improvement of Patient Safety in establishment of plans, processes and mechanisms involved in the provision of the patient care.

The scope of the Patient Safety Team includes medical/healthcare risk events involving the patient population of all ages, visitors, hospital/medical staff, students and volunteers. Aggregate data* from internal (IS data collection, incident reports, questionnaires,) and external resources (Sentinel Event Alerts, evidence based medicine, etc.) will be used for review and analysis in prioritization of improvement efforts, implementation of action steps and follow-up monitoring for effectiveness. The Patient Safety Committee has oversight of KDHCD activities related to the National Quality Forum's (NQF) Safe Practices (SP) Medication Safety, Section #4 Maternity Care, #5 ICU physician staffing, #6 A-D Culture of Safety Leadership Structures & System Documentation, Culture Measurement, Feedback & Intervention Documentation, Nursing workforce and Hand Hygiene, #7 Managing Serious Errors, and #8 Bard Code Medication Administration.

1. The Patient Safety Officer is the Chief Quality Officer

2. The Patient Safety Committee is chaired by the Patient Safety Officer or designee.

3. The responsibilities of the Patient Safety Officer include institutional compliance with patient safety standards and initiatives, reinforcement of the expectations of the Patient Safety Plan, and acceptance of accountability for measurably improving safety and reducing errors. These duties may include listening to employee and patient concerns, interviews with staff to determine what is being done to safeguard against occurrences, and immediate response to reports concerning workplace conditions.

4. Team membership includes services involved in providing patient care, such as: Pharmacy, Laboratory, Surgical Services, Risk Management, Infection Prevention, Medical Imaging, and Nursing. The medical staff representative on the team will be the Vice Chief of Staff.

D. Medication Safety Quality Focus Team

The Medication Safety Quality Focus Team (MSQFT) is an interdisciplinary group that manages the organizations Medication Safety Program including the District Medication Error Reduction Plan (MERP).

The purpose of the MSQFT is to direct system actions regarding reductions in errors attributable to medications promoting effective and safe use of medication throughout the organization. Decisions are made utilizing data review, approval of activities, resource allocation, and monitoring activities. Activities include processes that are high risk, high volume, or problem prone, some of which may be formally approved by the MSQFT as a District MERP goal (see Policy AP154 Medication Error Reduction Plan).

The MSQFT provides a monthly report to the Pharmacy and Therapeutics Committee and quarterly reports to the Professional Staff Quality Committee and directly to Quality Council. The MSQFT Chair is a member of the Patient Safety Committee. A quarterly report is presented at Patient Safety Committee in addition to active participation in patient safety activities related to medication use.

IV. Organization and Function

A. The mechanism to insure all components of the organization are integrated into the program is through a collaborative effort of multiple disciplines. This is accomplished by:

1. Reporting of potential or actual occurrences through the Occurrence Reporting Process Policy (AP10) by any employee or member of the medical staff. Examples of potential or actual occurrences include pressure ulcers, falls, adverse drug events, and misconnecting of: intravenous lines, enteral feeding tubes and epidural lines.

2. Reporting of potential or actual concerns in a daily leadership safety huddle which involves issues which occurred within the last 24 hours, a review the steps taken to resolve those matters when applicable, and anticipate challenges or safety issues in the next 24 hours. The daily safety huddle occurs Monday to Friday with the exception of holidays and includes directors and vice presidents that represent areas throughout the organization. The purpose of the daily safety huddle is immediate organizational awareness and action when warranted. Examples of issues brought forth in the Daily Safety Huddle include, patients at risk for elopement, violence, or suicide, and also can include potential diversion events, patient fall events, and medication related events.

3. Communication between the Patient Safety Officer and the Chief Operating Officer to assure a comprehensive knowledge of not only clinical, but also environmental factors involved in providing an overall safe environment.

4. Reporting of patient safety and operational safety measurements/activity to the performance improvement oversight committees, Professional Services Quality Committee "Prostaff" and Quality Improvement Committee (QIC). Prostaff is a multidisciplinary medical staff committee composed of various key organizational leaders including: Medical Executive Committee members, Chief Executive Officer, Chief Operating Officer, Chief Medical Officer/Chief Quality Officer, Chief Nursing Officer, Member of the Board of Directors, and Directors of Nursing, Performance Improvement, Risk Management, and Pharmacy. QIC is a multidisciplinary committee comprised of various key organizational leaders including the CEO, CNO, CIO, CFO, COO, Chief Human Resources Officer, , Directors of Quality & Patient Safety, Risk Management, and Nursing Practice and the manager of Infection Prevention.

5. Graduate Medical Education

   i. Graduate Medical Education (Designated Institutional Official (DIO), faculty and residents, are involved in achieving quality and patient safety goals and improving patient care through several venues including but not limited to:

      1. Collaboration between Quality and Patient Safety Department, Risk Management, and GME Quality Subcommittee

      2. GME participation in Quality Improvement Committee and Patient Safety Committee

      3. GME participation in KDHCD quality committees and root cause analysis (including organizational dissemination of lessons learned)

B. The mechanism for identification and reporting a Sentinel Event/other medical error will be as indicated in Organizational Policies AP87. Any root cause analysis of hospital processes conducted on either Sentinel Events or near misses will be submitted for review/recommendations to the Patient Safety Committee, Professional Staff Quality Committee and Quality Council.

C. As this organization supports the concept that events most often occur due to a breakdown in systems and processes, staff involved in an event with an adverse outcome will be supported by:

   1. A non-punitive approach without fear of reprisal (just culture concepts).
   2. Voluntary participation into the root cause analysis for educational purposes and prevention of further occurrences.
   3. Resources such as Pastoral Care, Social Services, or EAP should the need exist to counsel the staff
   4. Safety culture staff survey (i.e. the Safety Attitudes Questionnaire) administered at least every 2 years to targeted staff and providers.

D. As a member of an integrated healthcare system and in cooperation with system initiatives, the focus of Patient Safety activities include processes that are high risk, high volume or problem prone, and may include:
   1. Adverse Drug Events
   2. Nosocomial Infections
   3. Decubitus Ulcers
   4. Blood Reactions
   5. Slips and Falls
   6. Restraint Use
   7. Serious Event Reports
   8. DVT/PE

E. A proactive component of the program includes the selection at least every 18 months of a high risk or error prone process for proactive risk assessment such as a Failure Modes

Effects Analysis (FMEA), ongoing measurement and periodic analysis. The selected process and approach to be taken will be approved by the Patient Safety Committee and Quality Council.

The selection may be based on information published by The Joint Commission (TJC) Sentinel Event Alerts, and/or other sources of information including risk management, performance improvement, quality assurance, infection prevention, research, patient/family suggestions/expectations or process outcomes.

F. Methods to assure ongoing inservices, education and training programs for maintenance and improvement of staff competence and support to an interdisciplinary approach to patient care is accomplished by:

1. Providing information and reporting mechanisms to new staff in the orientation training.
2. Providing ongoing education in organizational communications such as newsletters and educational bundles.
3. Obtaining a confidential assessment of staff's willingness to report medical errors at least once every two years.

G. Internal reporting – To provide a comprehensive view of both the clinical and operational safety activity of the organization:

1. The minutes/reports of the Patient Safety Committee, as well as minutes/reports from the Environment of Care Committee will be submitted through the Director of Performance Improvement and Patient Safety to the Professional Staff Quality Committee.

2. These monthly reports will include ongoing activities including data collection, analysis, and actions taken and monitoring for the effectiveness of actions.

3. Following review by Professional Staff Quality Committee, the reports will be forwarded to Quality Council.

H. The Patient Safety Officer or designee will submit an Annual Report to the KDHCD Board of Directors and will include:

1. Definition of the scope of occurrences including sentinel events, near misses and serious occurrences

2. Detail of activities that demonstrate the patient safety program has a proactive component by identifying the high-risk process selected

3. Results of the high-risk or error-prone processes selected for proactive risk assessment.

4. The results of the program that assesses and improves staff willingness to report medical/health care risk events

5. A description of the examples of ongoing in-service, and other education and training programs that are maintaining and improving staff competence and supporting an interdisciplinary approach to patient care.

V. Evaluation and Approval

The Patient Safety Plan will be evaluated at least annually or as significant changes occur, and revised as necessary at the direction of the Patient Safety Committee, Professional Staff Quality Committee, and/or Quality Council. Annual evaluation of the plan's effectiveness will be documented in a report to the Quality Council and the Kaweah Health Board of Directors.

VI. Confidentiality

All quality assurance and performance improvement activities and data are protected under the Health Care Quality Improvement Act of 1986, as stated in the Bylaws, Rules and Regulations of the Medical Staff, and protected from discovery pursuant to California Evidence Code §1157.

Attachments - Attachment 1: Quality Improvement/Patient Safety Committee Structure

"These guidelines, procedures, or policies herein do not represent the only medically or legally acceptable approach, but rather are presented with the recognition that acceptable approaches exist. Deviations under

appropriate circumstances do not represent a breach of a medical standard of care. New knowledge, new techniques, clinical or research data, clinical experience, or clinical or bio-ethical circumstances may provide sound reasons for alternative approaches, even though they are not described in the document."

Attachment 1

Kaweah Health
Quality Reporting Structure

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                        │    Board of Directors    │
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       ┌──────────────────────────┐   ┌─────────────────────────┐
       │ Medical Executive        │   │    Quality Council      │
       │ Committee                │   └─────────────────────────┘
       └──────────────────────────┘            ▲
                     ▲       ┌──────────────────────────┐
                     │       │ Professional Staff Quality│
                     └───────│ Committee (Prostaff)      │
                             └──────────────────────────┘
                              ▲                ▲
   ┌──────────────────────────┐        ┌──────────────────────────┐
   │ Patient Safety Committee │ ─────▶ │ Quality Improvement      │
   └──────────────────────────┘        │ Committee                │
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                                        │ Quality Focus Teams,     │
                                        │ Medication Safety        │
                                        │ Committee, and QI        │
                                        │ Committees               │
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FY23 Clinical Quality Goals

	July-Sept 22 Higher is Better	FY23 Goal	FY22	FY22 Goal
SEP-1 (% Bundle Compliance)	81%	≥ 77%	76%	≥ 75%

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.

Lower is Better	July 2022	Aug 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	June 2023	Estimated Annual Number Not to Exceed to Achieve Goal*	FYTD SIR** (number of actual/ number expected)	FY23 Goal (VBP 2024; National Mean 2019)	FY22 FY21 FY20
CAUTI Catheter Associated Urinary Tract Infection Excluding COVID INCLUDING COVID-19 PATIENTS	1 / 0	1 / 0	2 / 0	1 / 0									14 (23 predicted over 12 months)	0.697 0.697 Including COVID	≤0.650	1.092 0.54 1.12
CLABSI Central Line Associated Blood Stream Infection Excluding COVID INCLUDING COVID-19 PATIENTS	3 / 0	0 / 0	0 / 0	0 / 1									10 (17 predicted over 12 months)	0.594 0.792 Including COVID	≤0.589	1.132 0.75 1.20
MRSA Methicillin-Resistant Staphylococcus Aureus Excluding COVID INCLUDING COVID-19 PATIENTS	2 / 0	0 / 0	0 / 0	0 / 0									5 (8 predicted over 12 months	0.873 0.873 Including COVID	≤0.726	1.585 2.78 1.02

*based on July 2021-June 2022 NHSN predicted

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

More than medicine. Life.

Kaweah Health