September 15, 2023

NOTICE

The Board of Directors of the Kaweah Delta Health Care District will meet in a Quality Council Committee meeting at 7:30AM on Thursday, September 21, 2023, in the Kaweah Health Lifestyle Fitness Center Conference Room, 5105 W. Cypress Avenue, Visalia, CA 93277.

The Board of Directors of the Kaweah Delta Health Care District will meet in a Closed Quality Council Committee at 7:31AM on Thursday, September 21, 2023, in the Kaweah Health Lifestyle Fitness Center Conference Room, 5105 W. Cypress Avenue, Visalia, CA 93277, pursuant to Health and Safety Code 32155 & 1461.

The Board of Directors of the Kaweah Delta Health Care District will meet in an open Quality Council Committee meeting at 8:00AM on Thursday, September 21, 2023, in the Kaweah Health Lifestyle Fitness center Conference Room, 5105 W. Cypress Avenue, Visalia, CA 93277.

All Kaweah Delta Health Care District regular board meeting and committee meeting notices and agendas are posted 72 hours prior to meetings in the Kaweah Health Medical Center, Mineral King Wing entry corridor between the Mineral King lobby and the Emergency Department waiting room.

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

KAWEAH DELTA HEALTH CARE DISTRICT
Michael Olmos, Secretary/Treasurer

Cindy Moccio

Cindy Moccio
Board Clerk, Executive Assistant to CEO

DISTRIBUTION:
Governing Board, Legal Counsel, Executive Team, Chief of Staff
http://www.kaweahhealth.org

KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS
QUALITY COUNCIL

Thursday, September 21, 2023
5105 W. Cypress Avenue
Kaweah Health Lifestyle Fitness Center Conference Room

ATTENDING: Board Members; David Francis – Committee Chair, Michael Olmos; Gary Herbst, CEO; Dr. Tom Gray CMO/CQO; Keri Noeske, RN, BSW, DNP, Chief Nursing Officer; Julianne Randolph, MD, Chief of Staff and Professional Staff Quality Committee Chair; LaMar Mack, MD, Quality and Patient Safety Medical Director; Sandy Volchko DNP, RN CLSSBB, Director of Quality and Patient Safety; Ben Cripps, Chief Compliance and Risk Management Officer; Evelyn McEntire, Director of Risk Management; and Sylvia Salinas, Recording.

OPEN MEETING – 7:30AM

1. **Call to order** – *David Francis, Committee Chair*
2. **Public / Medical Staff participation –** Members of the public may comment on agenda items before action is taken and after it is discussed by the Board. Each speaker will be allowed five minutes. Members of the public wishing to address the Board concerning items not on the agenda and within the jurisdiction of the Board are requested to identify themselves at this time. For those who are unable to attend the beginning of the Board meeting during the public participation segment but would like to address the Board, please contact the Board Clerk (Cindy Moccio 559-624-2330) or cmoccio@kaweahhealth.org to make arrangements to address the Board.
3. **Approval of Quality Council Closed Meeting Agenda** – 7:31AM
   - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Julianne Randolph, MD, Chief of Staff and Professional Staff Quality Committee Chair*
   - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Evelyn McEntire, RN, BSN, Director of Risk Management and Ben Cripps, Chief of Compliance and Risk Officer.*
4. **Adjourn Open Meeting** – *David Francis, Committee Chair*

CLOSED MEETING – 7:31AM

1. **Call to order** – *David Francis, Committee Chair & Board Member*
2. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Daniel Hightower, MD, Chief of Staff 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. Safety Culture Action Plan Update
   - 3.2. Fall Prevention Committee Report
   - 3.3. Hospital Acquired Pressure Injury (HAPI) Committee Report
   - 3.4. Infection Prevention Quarterly Dashboard
   - 3.5. Maternal Child Health Quality Report

4. **Diversion Prevention Committee –** A review of key initiatives to maintain safety by recognizing, preventing, and reporting potential medication drug diversion. *Evelyn McEntire, RN, BSN, Director of Risk Management and Shannon Cauthen MSN, RN, CCRN-K, Director of Cardiovascular and Critical Care Services*

5. **Handoff Quality Focus Team Report –** Action plans and metrics related to handoff process of patient information in the medical center. *Franklin Martin, BSN, Director of Trauma Services*

6. **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.*

7. **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.

Safety Culture Survey Results and Next Steps

Quality Council September 21, 2023

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

Kaweah Health Safety Culture Survey Summary

- Survey administered Jan-Feb 2023
- Response Rate: 66% (2,445/3,711)
- Kaweah Health overall Safety Culture Index 3.92, +0.06 better than Press Ganey like comparison of US facilities >400 beds (overall measure of safety culture)
- Press Ganey Groups questions together into 3 Safety Culture subcategories:
  - Prevention & Reporting (8 items) – Kaweah Health score 4.15, +0.10 BETTER than like comparison of US facilities >400 beds
  - Resources & Teamwork (7 items) - Kaweah Health score 3.62, +0.04 BETTER than like comparison of US facilities >400 beds
  - Pride & Reputation (4 items) - Kaweah Health score 3.97, -0.03 BELOW like comparison of US facilities >400 beds
- Results analyzed and disseminated to leaders based on location and role
- Action plans submitted by all staff locations surveyed

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Timeline for Leaders

Unit/Department Level Reports and COMPLETED Action Plans

Report Dissemination and Leader Training

Apr- May 2023

- Units/department leaders receive reports
- Leaders attended 1 Press Ganey Session “How to read and interpret your report and action plan”.

Staff Survey Results Debriefing

May - June 2023

- Staff Debriefing completion by June 9, 2023
- Staff in roles and units/departments with lowest significant overall safety culture index score debriefed with a Quality & Patient Safety Facilitator.
- Unit level results disseminated in a standardized format and messaging through a Power point template provided to leaders

Action Planning

- Unit/department action plans submitted to Quality & Patient Safety Department by June 23, 2023
- Action plans submitted on Stop Light Report template which provides visual display to staff on status of action plans; provided to leaders

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Recommended Timeline

Organizational Level Reports and COMPLETED Action Plans

Report Dissemination

- Overall initial results to Quality Improvement Committee (QIC), Leadership meeting and Quality Council completed April – May 2023

Analysis & Debriefing

- Review “concern” questions and other low scoring items. Analysis conducted by work setting and role and presented to Patient Safety Committee completed July 2023 for action plan recommendations
- Recommendations presented for discussion and approval to Quality Improvement Committee completed August 2023

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Kaweah Health Focus Areas

- Question #14 *"The amount of job stress I feel is reasonable"*
  - the 1 question that Press Ganey identified as "concern" for Kaweah Health when compared to like facilities (facilities >400 beds). A "concern" is a question that is scoring significantly lower than the comparison
  - ACTION: QIC analyzed the data by location and determined that each location has individualized concerns specific to that work setting (ie. staffing). The Chiefs will work with each low scoring location identified on this question to address the individualized concerns.
- Question #6 "When a mistake is reported, I feel like the focus on solving the problem, rather than writing up the person", and question #26 "The Midas event reporting system is easy to use
  - Question #6 is a custom question, there is no national benchmark. When compared to last survey there has been no improvement. Question #26 are performing above the mean when compared to like facilities >400 beds, but is lower than the Press Ganey overall national comparison.

    ACTION:
  - Evaluating the default of "anonymous" in the name field of Midas event reporting system. The perception of some staff is that they do not receive follow up or see resolution on submitted events. One root cause identified is that follow up is not possible as many event reports are submitted anonymously due to the default function. This issue will return to QIC for follow up until resolved
  - QIC delegated further analysis and action planning to the Just Culture Steering Committee, to be reported through Patient Safety Committee quarterly.
  - Just Culture Steering Committee reviewed analyzed data and is evaluating changes to the leadership training provided on event report response and closing the loop with staff who submit event reports. Committee will further drill down on Midas functionality feedback to evaluate changes to the Midas system.

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Kaweah Health Focus Areas

- Safety Culture Scores by Role
- 2 roles were identified by Press Ganey as being “disengaged” (lowest scoring roles)
- Results reviewed with leaders and debrief sessions held with staff to gain insight into survey results and guide action planning
- “Stop Light” action plans developed for each role and included in the following slides/pages. The action plans are in process and the Stop Light report allows a mechanism to communicate status of action plans directly to staff

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Kaweah Health Focus Areas

Safety Culture Scores by Role

Kaweah care Stoplight Report

Department: Acute Wound 6191 Date: June 21, 2023 to June 20, 2024

Completed:

(Enter text here)

The following are the Team's top priorities as indentified in the Safety Culture Survey:
Key strategies for hardwiring accountability were adopted by the team on June, 21st:
1. Call staff to make appointments to see patients at the nurse's convenience.
2. Provided ACTS team with education re: wound care and wound vacs. Met with residents and surgical attendings on March 17,2023.
3. Recognized certified wound nurses on Certified Nurses Day on March 19, 2023

In progress:

(Enter text here)

1. Involved in interdisciplinary rounding to view wounds together, discuss plan of care and provide input and ensure wound orders are completed in a timely manner and are sufficient for the patient.
2. Surgeons to contact wound nurses when they want a consult to view wound and if urgency to consult. 8/30/2023: happening infrequently. Will provide education to new surgery residents, starting with sending emails to Dr. Casaro to arrange time to talk to new residents.
3. Request that NM/ANM in shift huddles monthly and add in CSI email to remind

Can't be completed at this time, and here's why:

(Enter text here)

1. Re-establish Kaweah Care. Going above and beyond does not exist anymore. Unable to re-establish as the wound team, but can bring forward to leadership to see if we can start again or investigate another initiative.

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Kaweah Health Focus Areas

Safety Culture Scores by Role

Kaweah care Stoplight Report

Department: Patient Access ED Date: 6/22/23 to

Completed:

(Enter text here)

*Hiring process to include staff/staff leads - this is in place
*Staff feel they need a place to sit - 2 stationary workstations are now available.
*Education on how to enter Midas events - job aid from Risk Management was shared
*WOW's may not be safe, wires exposed - ticket opened SD-294937 to review speed, privacy and wires - Completed by ISS
*Registration is not notified of changes - Strong partnership in place between leaders and communication will be channeled through the start desk

In progress:

(Enter text here)

*Some people do not want to come to work
Action: Holding people accountable, Rounding, Addressing personnel issues as they arise
*Communication with Emergency department is difficult
Action: PA leaders working with clinical leaders, attended Kai Zen event
*Communication with certain individuals is difficult
Action: Teambuilding exercises - Staff meetings scheduled for 10/17 & 10/19

Can't be completed at this time, and here's why:

(Enter text here)

Is there an "other" option in language - Not available in system, there is only "patient declined"

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Questions?

Kaweah Health Safety Culture Survey Reference Materials

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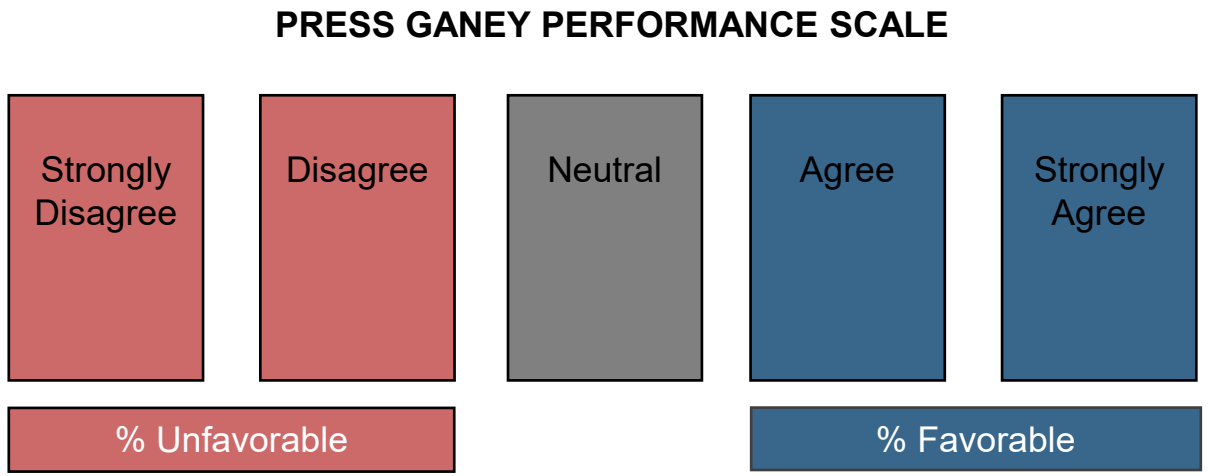
Measuring Culture of Safety

There are 19 survey questions that make up the **Safety Culture Module/Index**

- Subcategory 1: “Prevention & Reporting” = 8 items
- Subcategory 2: “Resources & Teamwork” = 7 items
- Subcategory 3: “Pride & Reputation” = 4 items



Safety Culture Subcategories

Prevention & Reporting (8 items)	Items that focus on prevention. If there is an error, employees feel comfortable speaking up, and that mistakes are used as learning experiences.
Resources & Teamwork (7 items)	Items that measure if employees feel they are well equipped, and that there is effective communication and teamwork within and between departments.
Pride & Reputation (4 items)	Employees feel the organization places an emphasis on safety and would feel comfortable recommending their organization for patient care.

Safety Culture Survey Results

How to Read the Results

- Questions were answered on a 5 point scale – strongly agree to strongly disagree
- Results are reported as the % of staff who had a positive response to the question, marked “agree” or “strongly agree”

Benchmark	Description
Bed Size – Organizations >400 beds	This is a Press Ganey customized benchmark. Unless otherwise noted, all PG client data is compared to this norm. • *56 clients, 78 facilities, and 177,113 respondents**

** Collected Jan 2021 – Dec 2022*

Kaweah Health vs. Benchmarks (all respondents)

Response Rate: 66% (2,445/3,711)

PressGaney

Kaweah Health: 2445 Respondents

2023 Kaweah Health Culture of Safety Survey

Organization	Manager	Employee
3.85	4.15	4.09
+0.05 vs. Nat'l Healthcare >400 Bed Avg 2023	Benchmark Not Applicable	+0.12 vs. Nat'l Healthcare >400 Bed Avg 2023

Safety Culture Index

+0.06 vs. Nat'l Healthcare >400 Bed Avg 2023

	Score	vs. Nat'l Healthcare >400 Bed Avg 2023
Safety Culture	3.92	+0.06
Prevention & Reporting	4.15	+0.10
Resources & Teamwork	3.62	+0.04
Pride & Reputation	3.97	-0.03

Kaweah Health Results - STRENGTHS

	Item	Domain	Distribution (Unfavorable / Neutral / Favorable)	Score	vs. Nat'l Healthcare >400 Bed Avg 2023	Responses
Strengths						
1	I can report patient safety mistakes without fear of punishment.	Organization	4% / 8% / 87%	4.29	+0.18	2,419
4	We are actively doing things to improve patient safety.	Organization	3% / 10% / 87%	4.28	+0.16	2,422
2	In my work unit, we discuss ways to prevent errors from happening again.	Employee	3% / 7% / 89%	4.32	+0.13	2,423
9	My work unit works well together.	Employee	4% / 10% / 85%	4.25	+0.09	2,432
7	Where I work, employees and management work together to ensure the safest possible working conditions.	Employee	7% / 13% / 80%	4.08	+0.13	2,431
8	I feel free to raise workplace safety concerns.	Employee	5% / 10% / 85%	4.18	+0.08	2,438
3	Employees will freely speak up if they see something that may negatively affect patient care.	Employee	5% / 10% / 84%	4.19	+0.09	2,420
20	Nurses/staff support a culture of patient safety in this work unit.	Organization	3% / 12% / 86%	4.15	-	2,387
22	I enter reports about events in which I was involved.	Employee	3% / 12% / 86%	4.15	-	2,137
23	I make Kaweah Health a safer place for patients by entering event reports.	Employee	2% / 11% / 86%	4.20	-	2,178

Kaweah Health Results - CONCERNS

PressGaney

Kaweah Health: 2445 Respondents

Concerns Report

	Item	Domain	Distribution			Score	vs. Nat'l Healthcare >400 Bed Avg 2023	Responses
			Unfavorable	Neutral	Favorable			
Concerns								
14	The amount of job stress I feel is reasonable.	Employee	23%	24%	53%	3.36	+0.06	2,423

Kaweah Health All Question Results

	Item	Domain	Distribution (Unfavorable / Neutral / Favorable)	Score	vs. Overall Organization	vs. Nat'l Healthcare >400 Bed Avg 2023	Responses
Current View: All Items							
1	I can report patient safety mistakes without fear of punishment.	Organization	4% / 8% / 87%	4.29	0.00	+0.18	2,419
2	In my work unit, we discuss ways to prevent errors from happening again.	Employee	3% / 7% / 89%	4.32	0.00	+0.13	2,423
3	Employees will freely speak up if they see something that may negatively affect patient care.	Employee	5% / 10% / 84%	4.19	0.00	+0.09	2,420
4	We are actively doing things to improve patient safety.	Organization	3% / 10% / 87%	4.28	0.00	+0.16	2,422
5	Mistakes have led to positive changes here.	Organization	5% / 18% / 77%	4.01	0.00	+0.06	2,389
6	When a mistake is reported, it feels like the focus is on solving the problem, not writing up the person.	Organization	11% / 20% / 69%	3.82	0.00	-0.04	2,398
7	Where I work, employees and management work together to ensure the safest possible working conditions.	Employee	7% / 13% / 80%	4.08	0.00	+0.13	2,431
8	I feel free to raise workplace safety concerns.	Employee	5% / 10% / 85%	4.18	0.00	+0.08	2,438
9	My work unit works well together.	Employee	4% / 10% / 85%	4.25	0.00	+0.09	2,432
10	Different work units work well together in this organization.	Organization	9% / 26% / 64%	3.74	0.00	+0.04	2,370
11	There is effective teamwork between physicians and nurses at this hospital.	Organization	9% / 25% / 66%	3.73	0.00	-0.06	2,236
12	My work unit is adequately staffed.	Organization	33% / 22% / 45%	3.13	0.00	+0.17	2,425

Kaweah Health All Question Results

	Item	Domain	Distribution (Unfavorable / Neutral / Favorable)	Score	vs. Overall Organization	vs. Nat'l Healthcare >400 Bed Avg 2023	Responses
13	Communication between work units is effective in this organization.	Organization	15% / 26% / 59%	3.57	0.00	+0.06	2,412
14	The amount of job stress I feel is reasonable.	Employee	23% / 24% / 53%	3.36	0.00	+0.06	2,423
15	Communication between physicians, nurses, and other medical personnel is good in this organization.	Organization	13% / 29% / 58%	3.56	0.00	-0.05	2,357
16	This organization provides high-quality care and service.	Organization	5% / 17% / 78%	4.02	0.00	-0.06	2,435
17	I would recommend this organization to family and friends who need care.	Engagement Indicator	7% / 19% / 74%	3.93	0.00	-0.11	2,438
18	This organization makes every effort to deliver safe, error-free care to patients.	Organization	6% / 14% / 80%	4.03	0.00	0.00	2,434
19	Senior management provides a work climate that promotes patient safety.	Organization	8% / 19% / 74%	3.89	0.00	+0.04	2,417
20	Nurses/staff support a culture of patient safety in this work unit.	Organization	3% / 12% / 86%	4.15	0.00	-	2,387

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Kaweah Health All Question Results

	Item	Domain	Distribution Unfavorable Neutral Favorable	Score	vs. Overall Organization	vs. Nat'l Healthcare >400 Bed Avg 2023	Responses
21	The manager supports and leads a culture of safety in my work unit.	Manager	4% 12% 84%	4.17	0.00	-	2,417
22	I enter reports about events in which I was involved.	Employee	3% 12% 86%	4.15	0.00	-	2,137
23	I make Kaweah Health a safer place for patients by entering event reports.	Employee	2% 11% 86%	4.20	0.00	-	2,178
24	The unit/department Director supports and leads a culture of safety in my work unit.	Manager	4% 14% 82%	4.12	0.00	-	2,401
25	Physicians support a culture of patient safety in my work unit.	Organization	5% 20% 74%	3.93	0.00	-	2,296
26	The Midas event reporting system is easy to use.	Organization	17% 28% 55%	3.49	0.00	-	2,171

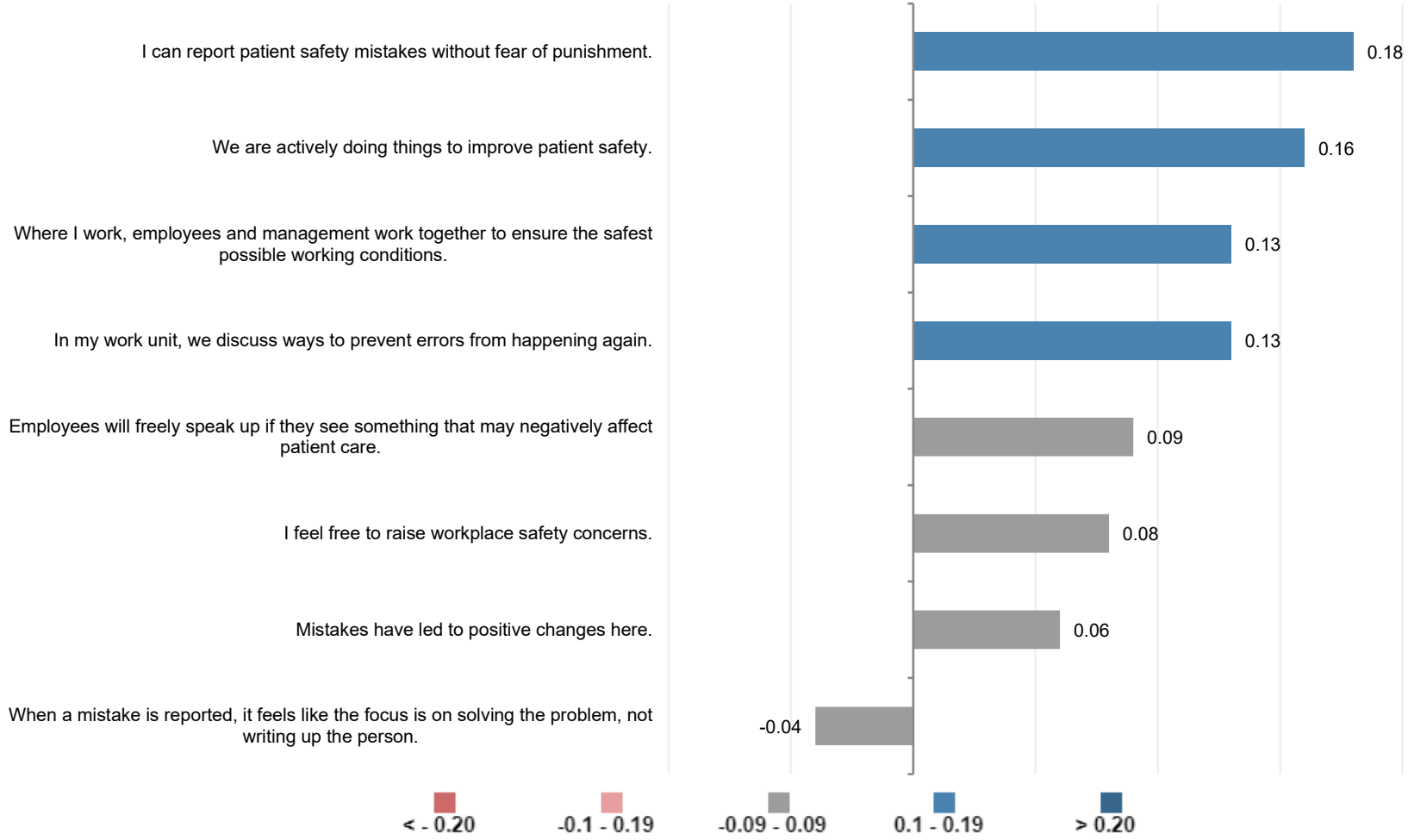
Safety Culture

+0.06 vs. Nat'l Healthcare >400 Bed Avg 2023

Prevention & Reporting 4.15

Items that focus on prevention. If there is an error, employees feel comfortable speaking up, and that mistakes are used as learning experiences.

vs. Nat'l Healthcare >400 Bed Avg 2023



PressGaney

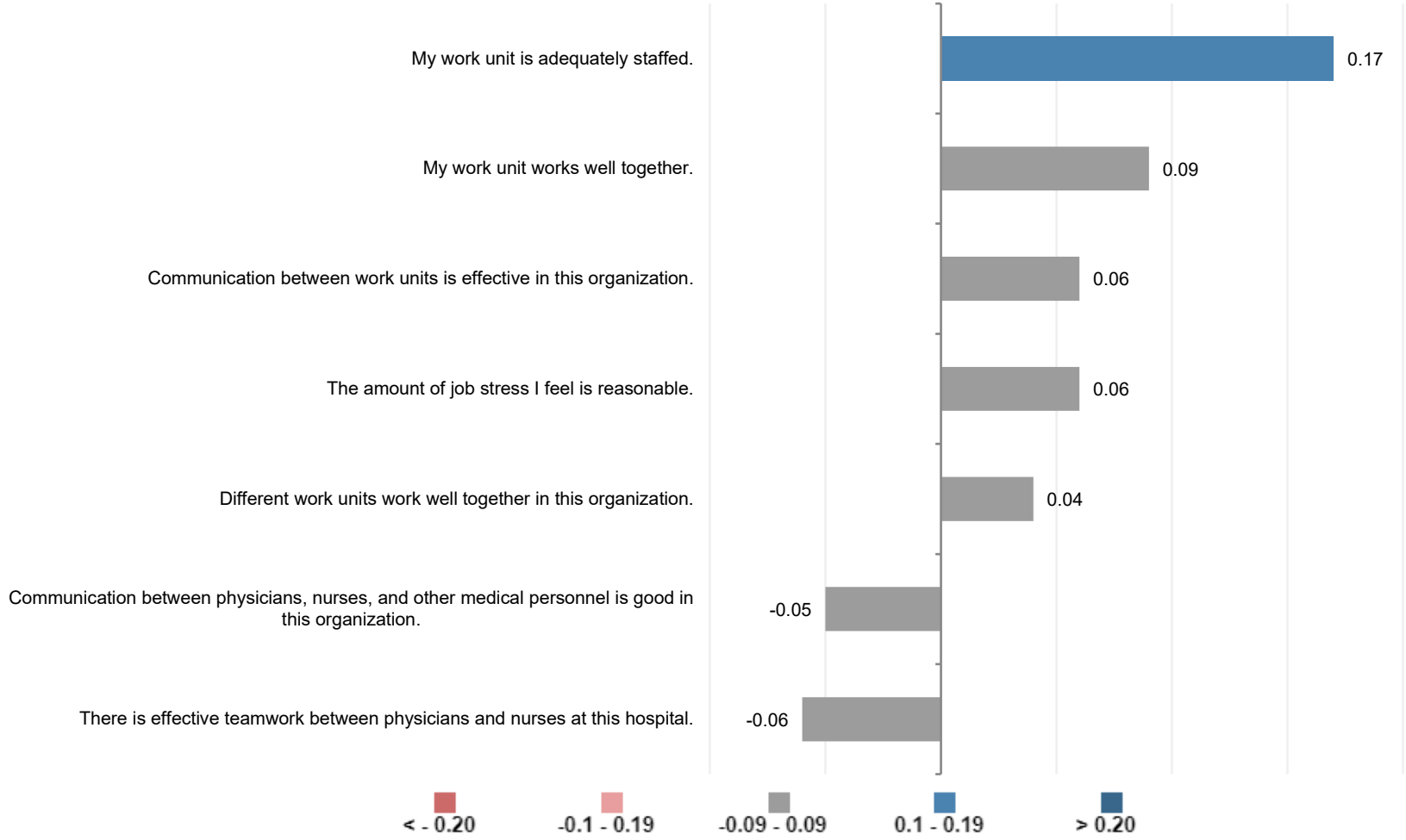
Safety Culture

+0.06 vs. Nat'l Healthcare >400 Bed Avg 2023

Resources & Teamwork 3.62

Items that measure if employees feel they are well equipped, and that there is effective communication and teamwork within and between departments.

vs. Nat'l Healthcare >400 Bed Avg 2023



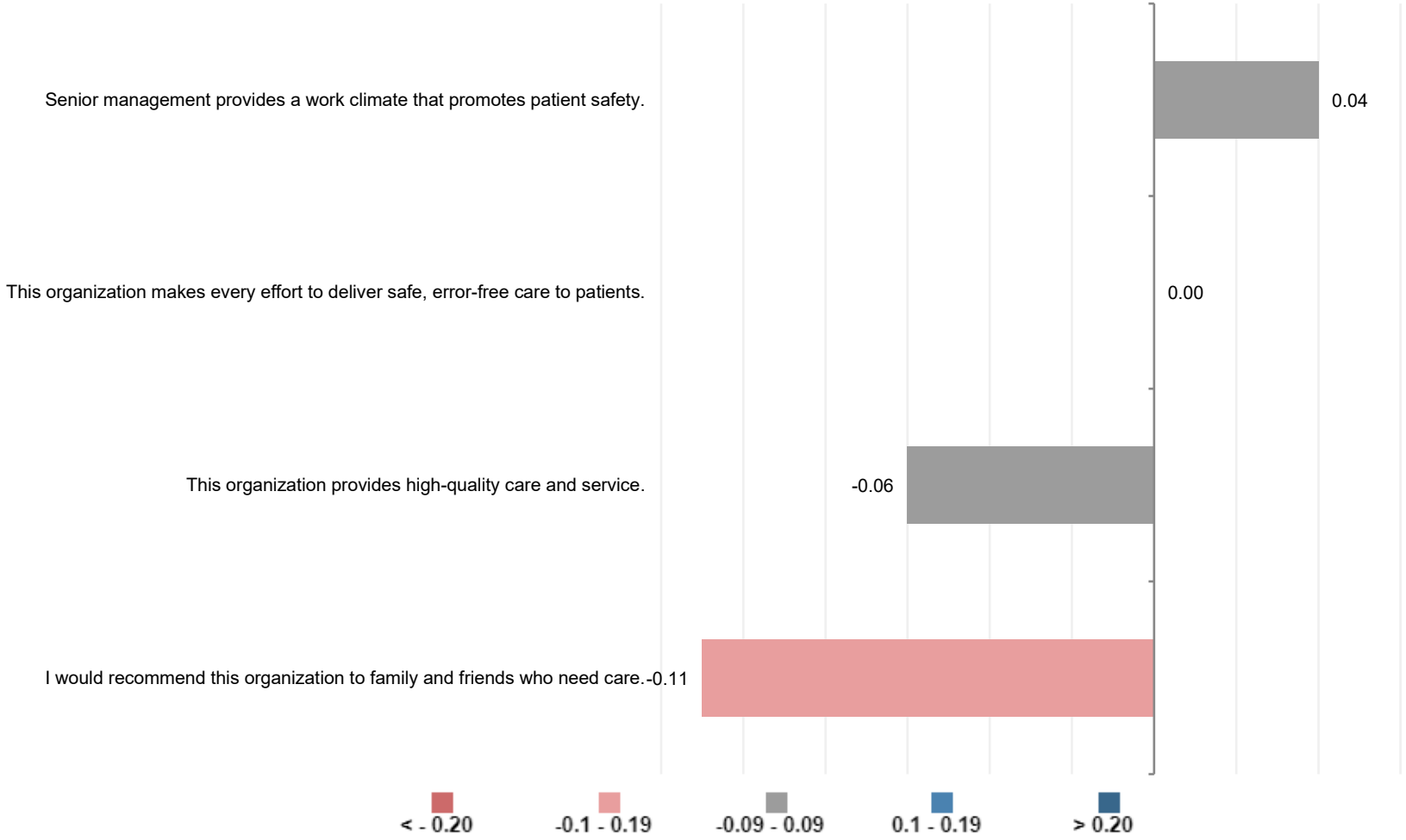
Safety Culture

+0.06 vs. Nat'l Healthcare >400 Bed Avg 2023

Pride & Reputation 3.97

Employees feel the organization places an emphasis on safety and would feel comfortable recommending their organization for patient care.

vs. Nat'l Healthcare >400 Bed Avg 2023



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Kaweah Health Positions & Safety Culture Engagement

To determine the level of engagement specific to the culture of safety at Kaweah Health, each position needs to meet a Reporting Threshold = 3 or more respondents.

Highly Engaged	Mean score between 5.00 - 4.50
Engaged	Mean score between 4.49 - 4.00
Neutral Engaged	Mean score between 3.99 - 3.75
Neutral	Mean score between 3.74 - 3.50
Neutral Disengaged	Mean score between 3.49 – 3.00
Disengaged	Mean score between 2.99 and under

PressGaney

Kaweah Health Positions: Safety Culture Overall

Highly Engaged	Engaged	
Chaplain	Assistant Nurse Manager	OP Registration/Cust Svc Rep
CT Technologist	Biomedical Technician II	Patient Care Pharmacy Tech
Nurse Practitioner-Clinics	Cardiac Sonographer-Registered	Personal Care Aide-OAH
Occupational Therapist III (d)	Certified Hemodialysis Tech	Pharmacist-Clinical
Pharmacist-Retail	Certified Nursing Assist-EKG	Pharmacy Tech I
Therapy Manager	Driver/Cust Sv Rep/Gurney Tran	Pharmacy Tech II
Transcriber-Secretary	ED Tech II	Pharmacy Tech/Biller
	EVS Floor Tech	Physical Therapist
	EVS/Pt Transport Dispatcher	Physical Therapist II
	HHA-Hospice	Physical Therapy Assistant
	Imaging Office Specialist	Physical Therapy Assistant II
	Imaging Specialist	Physical Therapy Assistant III
	Imaging Tech-In Patient	Practice Manager
	Interpreter	Radiation Therapist
	Interpreter II	Registered Dietitian
	Lab Services Coordinator	Rehab Aide
	LVN-Clinics Lead	RN-Admissions/Transfer Center
	Medical Assistant	RN-Clinical Documentation Spec
	Medical Business Office Assist	RN-Nurse Liaison
	Nurse Manager	RN-PPS/MDS Coordinator
	Nursing Assistant	Security Officer (driving)
	Occupational Therapist II	Social Work Assistant
	Occupational Therapist III	Student Nurse Intern

PressGaney

Kaweah Health Positions: Safety Culture Overall

Neutral Engaged		Neutral	Neutral Disengaged
Aide	Newborn Tech	Advanced Practice Provider	Laboratory Technician
ASW/AMFT	Occupational Therapist	Anesthesia Tech	LCSW/LMFT
ASW-Clinics	Overall Organization	Cardiac Sonographer-Unreg	Licensed Psych Tech
Business Services Coordinator	Patient Access Specialist	Charge Nurse	MRI Technologist
Care Coordination Specialist	Patient Transport Aide	Clinic Business Office Lead	RN-First Assistant
Cath Lab Tech II	Pharmacy Coordinator	Clinical UR Specialist	RN-Rapid Response Nurse
Certified Nursing Assistant	Phlebotomist I	EVS-Operating Room	Security Officer Lead
Clinical Lab Scientist-CLS	Phlebotomist II	Financial Counselor	SP Tech Certified
ED Tech I	Physical Therapist III	Health Unit Coordinator	Telemetry Monitor Technician
Environmental Services Aide	Physician	Nutrition Host	Ultrasound Tech-Registered
Environmental Services Lead	Polysomno Technologist-Reg	Physician Assistant	
GME Resident	Registered Nurse	RN-Nurse Practitioner	
Imaging Services Aide	Respiratory Therapist	RN-Oncology Office	
Imaging Technologist	Respiratory Therapist-Reg	Security Officer III	
Lab Aide I	RN-Case Manager	Staff Facilitator	
Lab Aide II	RN-Clinical Educator	Surgical Team Assistant	
Laboratory Section Chief	RN-Clinical Educator with ACLS	Surgical Tech	
Licensed Vocational Nurse	Security Officer II	Tele Sitter	
LVN-Skilled Nursing	Security Services Supervisor	Unit Secretary	
Mammography SpecialistMental	SP Tech I Non-Certified		
Health Worker	Student Nurse Aide		

PressGaney

Kaweah Health Positions: Safety Culture Overall

Disengaged

Medical Social Worker
RN-Acute Wound Care Nurse III

PressGaney

Falls Prevention and Assessment

Date: September 19, 2022

For Presentation To: Quality Improvement Committee (QIC)

Project leaders: Emma Camarena

Situation

Fall Prevention - Inpatient. Several instances noted during tracers of not completing fall risk assessment per shift, interventions not documented. During record review (house-wide), patients were meeting criteria for fall precautions (per policy) but there was evidence of:

- incomplete fall risk assessment per shift
- interventions not initiated or documented
- fall precautions implemented, not documented in the medical record
- fall care plans were not being initiated

Background

In the past, staff learned about fall prevention strategies through didactic education and yearly follow up competency testing. Education included use of the Johns Hopkins Falls risk assessment, fall prevention strategies, use of bed alarms and fall prevention devices, and documentation of individualized plans of care (IPOC). The pandemic caused a disruption in the normal care of patients and supplies. With surge charting, staff were required to chart risk assessments once per shift and with changes and IPOCs completed if time permitted. Staff turnover also played a part in the disruption of care with experienced staff leaving, stepping away from patient care and retiring. With staff shortages, contract staff unfamiliar with Kaweah Health policies and procedures are now staffing all patient care units.

See following examples of inpatient findings.

In-patient: During record review (house-wide), patients were meeting criteria for fall precautions (per policy) but there was no evidence of fall precautions being implemented in the medical record. Fall care plans were not being initiated.

On 4T, patient was admitted as a cardiac alert and was actively on a Heparin drip awaiting cardiac surgery. Per the fall scale, the patient was at a moderate risk for fall however no fall precautions had been implemented. When the nurse was asked why, she stated the patient ambulated all over the unit and was "self-care". The nurse was questioned about the infusing Heparin drip and whether this made the patient at risk. The nurse indicated it didn't make him a fall risk, only high risk for injury in the event of a fall.

There were many examples of nursing using their judgement to override indicated precautions, which generally, is acceptable as long as there is supporting documentation. In this instance however, the justification was not documented and was actually contradictory to best practice. Due to the Heparin drip and risk for injury, the patient likely should have been "High Risk" for fall due to his risk of injury.

There were several instances noted during chart reviews in which patients were "at risk" per the Johns Hopkins Fall Scale but no Fall Precautions were documented.

Analysis

Initial root causes include (specific to inpatient)

1. Lack of established process to:
    - help staff determine process for patients who are at high risk for injury if the patient falls (ABC assessment)
2. Noncompliance/drift with hospital policy (knowledge and accountability)
    - Proper monitoring of at risk patients (fall risk and ABCs assessment)
    - IPOC documentation
    - Fall risk assessment documentation and interventions
3. Goals:
    - Ensure staff know what to do with patients who are low risk for fall but at high risk for injury if they fall (policy change)
    - Update post fall process and provide education
    - Post education: Continue to monitor Falls and Statit data for compliance.
4. All actions complete except for post-falls EHR changes for MCH and ED. MCH needs to update policies for newborn drops and OB falls. ED will update their post falls EHR. Both areas will continue with paper post falls until they can fully proceed to electronic charting.

Falls assessment inquiries occur during tracer rounds performed on inpatient units. From December 2021 to March 2022, improved compliance of fall risk assessment, IPOC documentation and patient education is noted (see chart below).

	Observations	Total Observations March 2022	Yes	No	March 2022 % Compliant	Feb 2022 % Compliant	Jan 2022 % Compliant	Dec % Compliant	Nov % Compliant	Oct % Compliant	Sept. % Compliant	Aug % Compliant	July % Compliant	June % Compliant	May % Compliant
5	Fall Assessments: Is the Johns Hopkins risk score completed each shift?	50	45	5	90.0%	90.0%	100.0%	96.4%	77.1%	80.0%	92.3%	88.6%	88.6%	93.0%	95.8%
6	Fall Assessments: If a patient is identified as a fall risk, is there an individualized IPOC with interventions?	25	25	0	100.0%	87.0%	100.0%	100.0%	66.7%	66.7%	84.6%	85.2%	87.9%	84.8%	85.7%
7	Fall Assessments: If the patient is a fall risk, is there documentatiom that the patient and family have been provided with fall prevention education?	20	19	1	95.0%	100.0%	100.0%	100.0%	80.0%	50.0%	63.6%	81.0%	76.0%	87.5%	61.9%

Statit Falls information:

Percent of encounters with one assessment (Johns Hopkins Fall Risk) per shift

	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	Jun 2023	Jul 2023
# Pts w moderate or High Falls Risk Score	1236	1181	1406	1256	1332	1348	1305
# Pts Encounters	1242	1184	1410	1260	1339	1351	1307
% Encounters w One Assessment Per Shift	99.5%	99.7%	99.7%	99.7%	99.5%	99.8%	99.8%

Percent of encounters screened within 14 hours from admission

	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	Jun 2023	Jul 2023
# Encounters Screened w/i 14 Hrs	202	207	243	242	1077	243	240
# Encounters Admitted	251	236	289	415	1489	277	270
% Encounters Screened w/i 14 Hrs	80.5%	87.7%	84.1%	58.3%	72.3%	87.7%	88.9%

Percent of encounters with an IPOC (plan of care) within 14 hours. Work on IPOC completion is an issue for all assessment areas and being addressed. We had changes to the names of our IPOCs. Reminders to use IPOCs per policy will be sent out for Huddle topics. RNs are responsible for initiating IPOCS for LVNs, but this could be an issue that will be addressed in future education.

	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	Jun 2023	Jul 2023
# Encounters w IPOC w/i 14 Hrs	769	792	906	823	730	660	549
# Encounters w Risk	1471	1362	1609	1475	1556	1601	1519
% Encounters w IPOC w/i 14 Hrs	52.3%	58.1%	56.3%	55.8%	46.9%	41.2%	36.1%

Kaweah Health's total patient falls per 1000 patient days is consistently below the NDNQI benchmark except for the first quarter 2021. Falls with injury increased in the first quarter of 2022 but the falls with moderate or severe injuries continue to stay below the NDNQI benchmark (see chart below).

Kaweah Health Overall	Benchmark 1Q2022 only	2Q 2020	3Q 2020	4Q 2020	1Q 2021	2Q 2021	3Q 2021	4Q 2021	1Q 2022
Total Falls	2.37								2.14
Injury Falls	0.49								0.53
Moderate or Greater Injury Falls	2.93								1.67

Updated Falls Dashboard: second quarter data for Kaweah Health overall: below the benchmark in all areas.

Kaweah Health Overall	Benchmark 2Q2022 only	3Q 2020	4Q 2020	1Q 2021	2Q 2021	3Q 2021	4Q 2021	1Q 2022	2Q 2022
Total Falls	2.57								1.82
Injury Falls	0.50								0.33
Moderate or Greater Injury Falls	2.88								2.00

Updated Falls Dashboard: 4th quarter data for KH overall: below the benchmark in all areas.

Kaweah Health Overall	Benchmark 4Q2022 only	1Q 2021	2Q 2021	3Q 2021	4Q 2021	1Q 2022	2Q 2022	3Q 2022	4Q 2022
Total Falls	2.29								2.26
Injury Falls	0.49								0.47
Moderate or Greater Injury Falls	3.42								3.23

Updated Falls Dashboard: first quarter data for KH overall: below the benchmark in all areas.

Outcome Measures Kaweah Health Overall	Benchmark 1Q2023 only	2Q 2021	3Q 2021	4Q 2021	1Q 2022	2Q 2022	3Q 2022	4Q 2022	1Q 2023
Total Falls	1.72								1.32
Injury Falls	0.46								0.18
Moderate or Greater Injury Falls	3.00								2.78

Recommended Next Steps

Who Is Recommending	What (Action/IOU)	When Due (Status)	Action Responsibility
Falls Committee	Review and revise policy PC.88	09-12-2022	Emma Camarena
	Will revise PC.88 to add verbiage for a positive ABCS assessment and intervention. Current policy does not let staff know what to do with a positive ABCS assessment. Will have policy revised for next Policy Committee meeting.	10/20/22 Updated to 11/1/22	Emma Camarena
	PC.88 was revised and presented to committee for approval, committee approved. Needs to go to policy committee for approval	12/7/22	Emma Camarena
	PC.88 policy revision complete and presented at Policy Committee meeting on 2/2/23		Emma Camarena
	Policy updated and live 4/3/2023	Complete	
	Working with Monica Romero to see if EMR charting triggers an alert. (It does not)	Complete	Monica Romero
	Monica reviewing to see if an existing IPOC is available to use from Cerner for a positive ABCS assessment or if one will need to be built. No progress at this time (Integrated testing in progress)	10/20/22	
	Waiting for Cerner update to be completed. Meeting with Monica and Kim to discuss next steps. No IPOC related to ABCS available. Will use current IPOC.	11/21/22	
	Presented information at Patient Care Division re: policy changes, post fall documentation and fall's equipment. Feedback received and appropriate changes made.	11/30/22	Emma Camarena

Who Is Recommending	What (Action/IOU)	When Due (Status)	Action Responsibility
Falls Committee	Standardize Falls prevention equipment (Tabs alarms, crash mats, fall socks, etc.). Purchase fall alarms/equipment. Trial new fall prevention technology (i.e. Bluetooth alarms).	Currently in progress.	Alisha Sandidge Emma Camarena
	Met with Jill and Rudy on Wed, Sept 22nd to review full Fall Management analysis report. Discuss next steps/project plan needs.	9/16/22	Emma Camarena, Jill Anderson, Rudy Carrera
	Meeting with Posey/Tidi rep (Sept 28th) to determine availability of product and upgrades if needed.	Cancelled	
	Meeting with Posey/Tidi rep rescheduled to Oct. 19 because COVID happens. Also contacted Stryker rep for a product and price comparison	10/20/22	
	Met with Mountaineer Medical rep: pricing comparable to Posey. Will stay with Posey, staff familiar with Posey product.	11/2/22	
	Meet with Jill Anderson to review costs and order fall prevention equipment: Education for Falls prevention equipment tentatively scheduled for Feb. 13th	2/2/2023	Emma Camarena Jill Anderson
	Falls equipment ordered, new Falls sensors in-house. In-service scheduled for 3rd week of April. Had sneak peak of chair pad and sensor at Safety Fair on 3/15/23	4/23/2023	Emma Camarena Kari Moreno

Who Is Recommending	What (Action/IOU)	When Due (Status)	Action Responsibility
Falls Committee	Optimize EMR charting for care planning (IPOCs), pre and post intervention	In progress/TBD	Kim Roller Monica Romero
	EMR charting component for Post Falls is complete. Will need to add Kinder1 into charting once ED is educated on its use, but should not hold up staff education for the new EMR documentation/process.	11/1/22	Emma Camarena Monica Romero
	Completed Post Falls Checklist. Presented to Falls committee on 10/12. Minor changes made, ready for Fall Prevention education (see below)	10/13/22	Emma Camarena
	Met with all clinical areas determine if post falls documentation is adequate for all areas-found that adjustments to the documentation need to be made for NICU/Peds areas.	12/5/22	Kim Roller/Emma Camarena
	Follow-up meeting scheduled for week of Dec. 19th to review updated changes.	12/19/22	Kim Roller
	Working on ped's charting (EMR), Next meeting Feb 6th.	2/2/23	Kim Roller
	Post Falls EMR charting done for all areas except MCH and ED. MCH and ED have to complete their process and decision was made by Falls Committee to go forward with all other areas.	3/9/2023	Kim Roller Falls Committee

Who Is Recommending	What (Action/IOU)	When Due (Status)	Action Responsibility
Falls Committee	Staff education once above are complete to include basic fall prevention, policy updates, falls prevention equipment, IPOCs, etc. Sent a Clinical Education Request for Falls Education to ensure time placed on Clin Ed roadmap. Meeting with Monica Romero and Clinical Educators to review changes and develop education plan Staff education in progress to include information on policy revision, new falls equipment and post-falls documentation on EHR	11/7/22 9/23/22 4/3/2023	Emma Camarena Gloria Dickerson Gloria Dickerson Enri Santoyo Emma Camarena

UPDATE:

Falls education completed on 4/25.

EMR post fall's documentation delayed and will go live on 5/9

Falls Sensor education complete and now live on the units.

No updated data at this time.

Continue to work on ED and MCH documentation

UPDATE: 5/30/2023

EMR post fall documentation is now live.

Will continue to monitor

Summary for May and June:

No additional data to report at this time for # encounters screened with 14 hour from admission, # encounters with risk or % encounters with IPOC w/in 14 hours. Data for this information should be out around the middle of July.

All interventions are complete.

Update: 7/3/2023

Updated Falls Dashboard: 1st quarter 2023 data for KH overall: below the benchmark in all areas for the 4th quarter in a row.

Update: 9/12/2023

Updated Falls information. Had very low (5 and 6%) for initiation of Falls IPOC for patients at risk for Falls. Investigated this information and found that the correct IPOCs were not being accounted for in Statit. Continue to have low IPOC implementation. Will send out reminders to be used in Huddles via Falls U take-aways.

Did your patient fall?

Now what to do…

- ☐ Implement Post Fall Nursing order set linked in IView
- ☐ Rapid Assessment of patient when found down
  - Pain, bleeding, injury
    - ✓ Is it safe to move the patient
    - ✓ Are C-Spine precautions appropriate?
  - Baseline observation:
    - ✓ Obtain VS, Blood glucose, GCS, 10 SOV and RASS if indicated
- ☐ Notifications:
  - ✓ Medical Provider
  - ✓ Family/primary contact
- ☐ Complete Post Fall Evaluation assessment in Cerner IView.
  - ✓ Follow interventions and document.
- ☐ Document IPOC Fall Prevention & Management.
  - ✓ Initiate Post-Fall Care (right click on FP&M IPOC).
- ☐ Review Fall Agreement with patient and have patient sign agreement
  - ✓ English & Spanish versions linked in IView Fall Risk section
- ☐ Document education given
- ☐ Submit occurrence report with details and learned opportunities
- ☐ **Place patient sticker on this form and turn into Nurse Manager**

Check that beds are plugged in to the wall

Unit/Department Specific Data Collection Summarization

Quality Improvement Committee

Unit/Department: HAPI & Inpatient Wound Prevention **Report Date:** June 2023

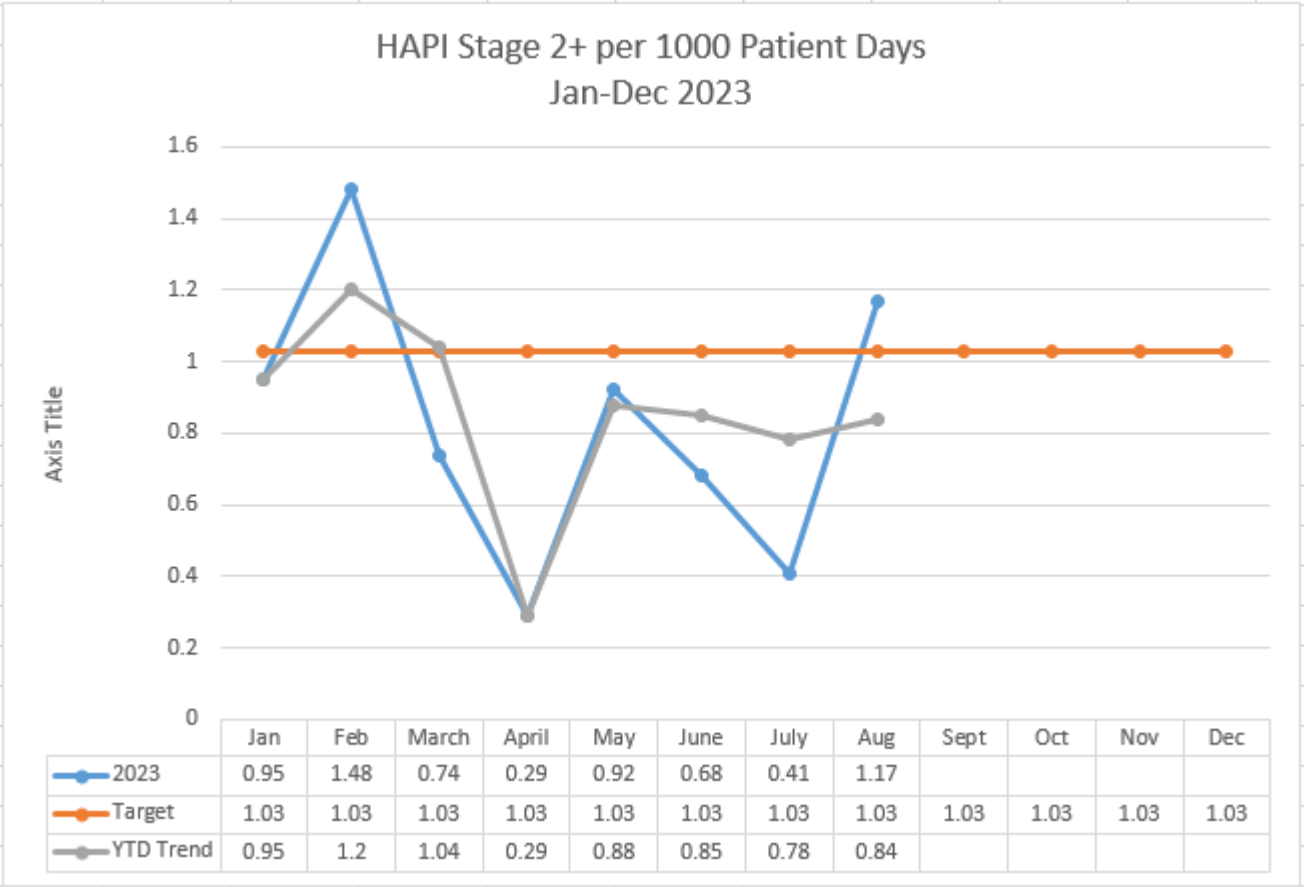
Measure Objective / Goal:

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 2-4, unstageable, suspected deep tissue pressure injury (DTPI).

Indicator #1 HAPI Stage 2+ per 1000 Patient Days

Goal 1.03 (-10% from 2022)

Date Range Jan 2023-Aug 2023



	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
2023	0.95	1.48	0.74	0.29	0.92	0.68	0.41	1.17				
Target	1.03	1.03	1.03	1.03	1.03	1.03	1.03	1.03	1.03	1.03	1.03	1.03
YTD Trend	0.95	1.2	1.04	0.29	0.88	0.85	0.78	0.84				

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

- ✓ **Goal #1** Partially Met: Maintained below target of 1.03 from March to July with an uptick in August to 1.17. Multiple patient care units above the goal.
- ✓ Met: Cumulative YTD below target (.84) from April to August.

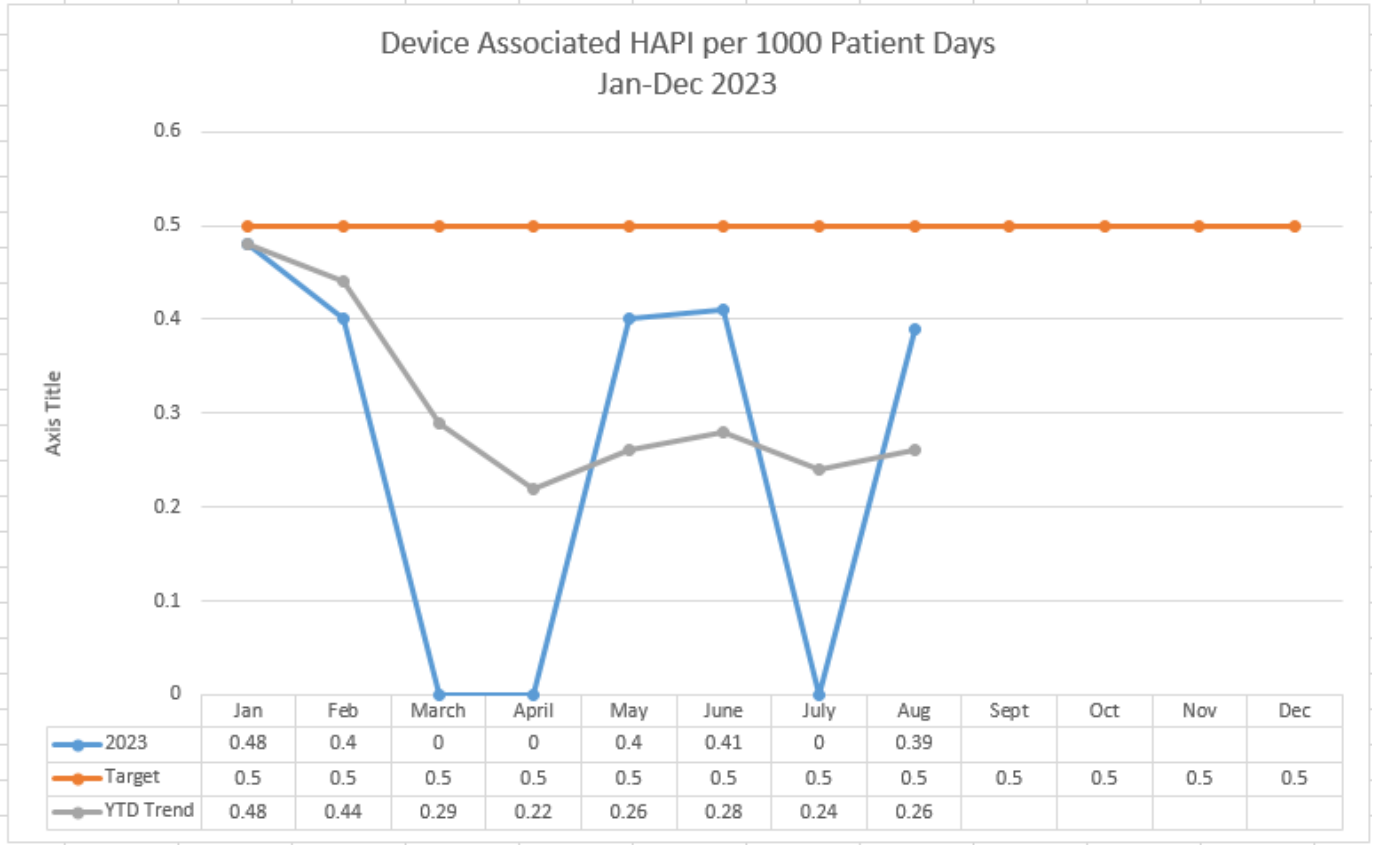
Update: HAPI ended as a quality focus team in March 2023. CSI was reinstituted beginning February 1st and meets every other week. Staff and leadership review and prepare CSI reports for review by the

Wound Care team. Take-aways learned from staff and nurse manager investigations are shared with all patient care units. The wound team attended a staff meeting to review preventative measures and answer questions related to HAPIs and their role as wound care RNs. The information was well received. The team will proactively seek out opportunities to attend other staff meetings.

Indicator #2 Device Associated HAPI per 1000 Patient Days

Goal 0.50 (-10% from 2022)

Date Range Jan 2023-Aug 2023



	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
2023	0.48	0.4	0	0	0.4	0.41	0	0.39				
Target	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5
YTD Trend	0.48	0.44	0.29	0.22	0.26	0.28	0.24	0.26				

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

- ✓ **Goal #1** Met: Met for all months YTD.
- ✓ Met: Cumulative YTD below target (0.26)

Our device related HAPIs remain below the target of 0.5. The HAPI committee meets on a monthly basis to review data and discuss ongoing individual unit issues.

Unit/Department Specific Data Collection Summarization

Quality Improvement Committee

2023 Stage 2+ HAPI Dashboard

Measure Description Outcome Measures	2023 Benchmark/ Target	2020 Baseline	2021 Baseline	2022 Baseline	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	YTD 2023
HAPI Stage 2+ per 1,000 pt days (all HAPIs)	1.03 (-10% from 2022 target)	1.61	1.26	0.69	0.95	1.48	0.74	0.29	0.92	0.68	0.41	1.17					0.84
Device Associated HAPI per 1,000 pt days	0.50 (-10% from 2022 target)	0.72	0.61	0.23	0.48	0.40	0.00	0.00	0.40	0.41	0.00	0.39					0.26
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)	0.95	1.42	0.19	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00					0.00
Process Measures	(-10% from 2022 target)	2020	2021	2022	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	YTD 2023
Respiratory Device associated HAPI per 1,000 pt days	0.32	0.44	0.40	0.05	0.00	0.13	0.00	0.00	0.00	0.00	0.00	0.13					0.03
% of Respiratory Device associated HAPI's (out of all of the device associated HAPI's)	48%	61%	65%	22%	0%	33%	0%	0%	0%	0%	0%	33%					13%
Unit Level	(-10% from 2022 target)	2020	2021	2022	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	YTD 2023
4N - HAPI 2+ per 1,000 pt days	1.00	2.02	1.22	0.31	0.00	6.54	0.00	0.00	0.00	1.30	2.51	0.00					1.27
3W - HAPI 2+ per 1,000 pt days	2.06	3.2	2.55	0.79	0.00	0.00	8.10	0.00	4.44	0.00	0.00	0.00					1.67
ICU - HAPI 2+ per 1,000 pt days	3.35	7.44	4.14	2.38	0.00	8.17	5.10	0.00	5.32	0.00	0.00	0.00					2.40
CVICU - HAPI 2+ per 1,000 pt days	3.48	6.23	4.31	1.51	0.00	0.00	0.00	4.85	0.00	12.15	0.00	4.81					2.70
2N - HAPI 2+ per 1,000 pt days	0.57	0.22	0.71	0.30	1.07	0.00	0.00	0.00	0.00	0.00	1.21	1.18					0.45
2S - HAPI 2+ per 1,000 pt days	0.73	1.51	0.90	0.30	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00					0.00
3N - HAPI 2+ per 1,000 pt days	0.89	0.72	1.11	0.87	2.70	0.00	0.00	1.12	0.00	1.09	0.00	1.97					0.90
3S - HAPI 2+ per 1,000 pt days	0.07	0.5	0.09	0.09	0.00	1.17	0.00	0.00	0.00	0.00	0.00	0.00					0.14
4S - HAPI 2+ per 1,000 pt days	0.93	0.66	1.15	0.91	3.19	0.00	0.00	0.00	0.00	0.00	0.00	5.17					1.10
4T - HAPI 2+ per 1,000 pt days	0.22	0.45	0.28	0.55	1.53	1.75	0.00	0.00	0.00	0.00	0.00	0.00					0.42
BP - HAPI 2+ per 1,000 pt days	0	0.62	0	0	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	0.13	0.00	0.16	0.48	0.00	0.00	0.00	0.00	4.90	0.00	0.00	0.00					0.67
5T - HAPI 2+ per 1,000 pt days	1.18	0.4	1.46	1.11	0.00	1.65	0.00	0.00	0.00	0.00	0.00	0.00					0.19
Other Units	2023 Benchmark/ Target	2020	2021	2022	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	YTD 2023
Sub-Acute	decrease from baseline	6	5	2	1	0	0	0	0	0	0	2					3
Labor & Delivery					0	0	0	1	0	0	0	0					1

Meeting or Better than Target

Within 10% of goal

Does not meet Target

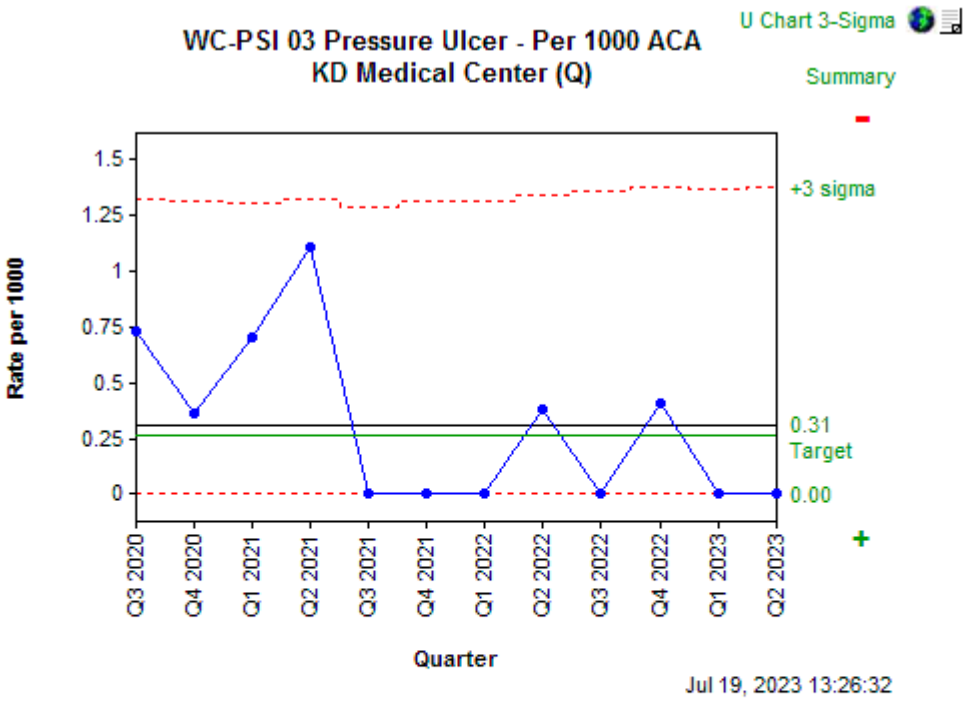
PSI 03: Pressure Ulcer Rate

Pressure ulcers have been associated with an extended length of hospitalization, sepsis, and mortality. The Agency for Healthcare Research and 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 Q2 2023



Quarter	Numerator	Denominator	Rate per 1000
Q2 2023	0	2468.00	0.00
Q1 2023	0	2529.00	0.00

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

- ✓ **Goal #3** Met for January to May 2023

We had zero PSI 03 pressure ulcers from January to May of 2023. Data continues to trend in the right direction.

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

HAPI committee continues to meet as a committee to track and trend our data and quality measures surrounding HAPIs. Ongoing education and support from the wound care team and clinical education are happening on all floors and at NPC. Competency now required yearly for all bedside nurses. Reporting avenue and review is occurring regularly on all floors. We continue to monitor and report findings as needed.
Wound care classes designed specifically for mental health started June 2023. Additional classes requested for the upcoming year to accommodate newly hired RNs and LVNs.
New members have been invited to attend HAPI committee meetings.
Invite units with increased HAPIs to discuss plans of corrections to help improve HAPI rates.

<u>Ongoing</u>

- ✓ Due to a huge decrease in participation, we stopped holding regular CSI meetings with leadership and staff. The format of CSI changed to a discussion of the HAPI review sheets by the wound care team. The wound care team sends out review sheets to managers every other week to help guide the investigation of HAPIs found on their units. After discussion, CSI takeaways are sent out to units to share with staff root causes and key takeways to help prevent future HAPIs.

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

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

- ✓ Education and maintenance of wound certification for the wound RNs to strengthen knowledge base and provide best practice to patients and nursing staff, improving patient outcomes.

Submitted By: **Date Submitted:** September 12, 2023
Emma Camarena, Director of Nursing Practice

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2023							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
I. Environmental Surveillance							
A. **Sterilization and High Level Disinfection Quality Control**							
Goal <2% of Immediate Use Sterilization		**1.60%**	**1.28%**				**1st QTR:** There were a total of 44 IUS events out of 2,724 cases performed. **2nd QTR:** There were 44 IUS events out of 3,427 cases performed. **3rd QTR:** **4th QTR:**
B. Dialysis Water/Dialysate Quality Control (AAMI RD52:2004) (% of machines that did not exceed limits)							
Acute Dialysis (Inpatient) RO Water [Target: <200cfu] [Action: > or = 50cfu] Endotoxin [Target: <2EU] [Action: > or = 1EU]		**100%**	**100%**				**1st QTR:** 51 Reverse Osmosis and 6 Dialysate samples tested all below maximum allowable limits - no action required. **2nd QTR:** 51 Reverse Osmosis and 6 Dialysate samples tested all below maximum allowable limits - no action required. **3rd QTR:** **4th QTR:**
Outpatient Dialysis RO Water [Target: <200cfu] [Action: > or = 50cfu] Endotoxin [Target: <2EU] [Action: > or = 1EU]		**100%**	**100%**				**1st QTR** 8 Reverse Osmosis and 6 Dialysate samples tested all below maximum allowable limits - no action required. **2nd QTR:** 8 Reverse Osmosis and 6 Dialysate samples tested all below maximum allowable limits - no action required. **3rd QTR:** **4th QTR:**
C. Environmental Cleaning (ATP testing surfaces)							
Pass/Fail based on a threshold of ATP score of <200. Multiple high-touch surfaces tested each month.	Goal 100%	**81%**	**81.9%**				**1st QTR:** A total of 223 first pass cleanings out of 275 opportunties. The devices with the highest first pass rate: Room sink; handrail, flush handle, counter. The devices with the lowest first pass rate: call button, rest room sink, telephone, bedrail. All fallouts result in room being re-cleaned. **2nd QTR:** A total of 240 first pass cleaning out of 293 opportunities. The devices with the highest first rate: Room sink, OR Bed Control, Flush Handle. The devices with the lowest first pass rate: Room Light Switch, Bedrail, Call Button, Telephone. All fallout results in room being re-cleaned. Areas with highest first pass rates: OB OR, Cath Lab. Areas with lowest first pass rates: ICU, CVICU. **3rd QTR:** **4th QTR**
II. Antimicrobial Stewardship Measures							

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2023							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
# of antibiotic IV to PO conversion		112	148				**1st QTR:** The majority of IV-to-PO conversions over the past 3 months occurred in the ICU and CVICU, 19 and 21, respectively. **2nd QTR:** IV-to-PO conversions increased by 32% from previous quarter. The majority of IV-to-PO conversions occured in CVICU followed by ICU and 3W. **3rd QTR:** **4th QTR:**
Average Days of Therapy per 1,000 patient days - Fluoroquinolones		NA					**1st QTR:** This information is unavailable at this time. **2nd QTR:** This informaiton is difficult to provide quarterly. This metric will no longer be reported on. The information is ultimately shared in the Antimicrobial Stewardship Committee. **3rd QTR: ----** **4th QTR: ----**
Average Days of Therapy per 1,000 patient days - Carbapenems		NA					**1st QTR:** This information is unavailable at this time. **2nd QTR:** This informaiton is difficult to provide quarterly. This metric will no longer be reported on. The information is ultimately shared in the Antimicrobial Stewardship Committee. **3rd QTR:** ---- **4th QTR: -----**
III. Employee Health							
A. Needlestick Injuries							
Number of sharps/needle stick reports		**22**	**17**				**1st QTR:** Majority (10) of needlestick injuries occur when engaging the needle safety mechanism. The majority of the sharps exposures involve RN's (9) followed by Residents (7). **2nd QTR:** Majorioty of needlestick injuries involve RN's (6), followed by, LVN's (4), Techs (4) GME Residents (2), and EVS (1). Most events associated with discarding needles (8), recapping (1), activating safety mechanism (1), lack of attention (3), surgery (2), needle disposed in trash and EVS worker poked (1). **3rd QTR:** **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		448	1258				**Cumulative Ct:** 1,706
B. Total Infection Count *[note: SSI events can be identified up to 90 days from the last day of the month in each quarter and only DIP and Organ Spc SSI are reported in NSHN]*		**2**	**14**				**1st QTR:** 2 **Predicted:** 7.991 **2nd QTR:** 14 **Predicted:** 16.348 **3rd QTR: Predicted:** **4th QTR: Predicted:**

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		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
D. SIR Confidence Interval (CI-KDHCD predicted range, based on risks)		0.042, 0.827	0.487, 1.403				**1st QTR:** Better than state average. **2nd QTR:** Better than state average. **3rd QTR:** **4th QTR:**
E. Standardized Infection Ratio (SIR) for all surgical procedures.	**<1.0**	**0.25**	**0.856**				**1st QTR:** There was 1 appendectomy and 1 colorectal surgical site infection. **2nd QTR:** There was 1 appendectomy, 1 small bowel, 1 gallbladder surgery, 1 heart bypass, 1 craniotomy, 1 spinal fusion, 1 total abdominal hysterectomy, 1 exploratory surgery, 3 colorectal surgeries, 3 cesarean section surgeries **3rd QTR:** **4th QTR:**
V. Specific Surgical Review	**SIR**						
A. Colon Surgery (COLO) CMS/VBP							
1. #Total Procedure Count		41	40				**Cumulative Ct:** 81
2. Total Infection Count		**1** **[1]**	**3** **[3]**				**1st QTR:** 1 **Predicted:** 2.945/**CMS** 1 **Predicted:** 1.358 **2nd QTR:** 3 **Predicted:** 2.274/**CMS** 3 **Predicted:** 1.107 **3rd QTR: Predicted: /CMS Predicted:** **4th QTR: Predicted: /CMS Predicted:**
3. SIR CI (KDHCD predicted range, based on risks)		0.017, 1.675	0.336, 3.591				**1st QTR:** Better than national average. **2nd QTR:** Better than national average. **3rd QTR:** **4th QTR:**
4. SIR (Standardized Infection Ration) total Value Based Purchasing (VBP) SIR = [ ]	VBP Goal <0.717	**0.34**	**1.319**				**1st QTR:** One event in which clean closure was not performed. The surgical quality improvement committee is working on ensuring clean closure practice is performed for procedures it is indicated. **2nd QTR:** There were 3 colorectal SSI events reported. Opportunities to improve documentation to support PATOS criteria. All events occurred at the organ-space. **3rd QTR:** **4th QTR:**
B. Gallbladder Surgery (CHOL)							
1. #Total Procedure Count		0	100				**Cumulative Ct:** 100
2. Total Infection Count		**0**	**1**				**1st QTR:** 0 **Predicted:** 0 **2nd QTR:** 1 **Predicted:** 0.157 **3rd QTR: Predicted:** **4th QTR: Predicted:**
3. SIR CI (KDHCD predicted range, based on risks)		0	0.00				**1st QTR:** No procedures performed. **2nd QTR:** Worse than national average. **3rd QTR:** **4th QTR:**

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		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
4. SIR (Standardized Infection Ration) total	Goal SIR <1.00	0.00	6.37				**1st QTR:** No procedures performed. **2nd QTR:** 1 event in which patient developed a post-op seroma that eventually was identified to be an abscess with a possible bile leak from the surgical site. E. coli was identified by specimen culture. This was an organ-space SSI event. **3rd QTR:** **4th QTR:**
C. Spinal Fusion (FUSN)							
1. #Total Procedure Count		26	94				**Cumulative Ct:** 120
2. Total Infection Count		0	1				**1st QTR:** 0 **Predicted:** 0.468 **2nd QTR:** 1 **Predicted:** 1.391 **3rd QTR: Predicted:** **4th QTR: Predicted:**
3. SIR CI (KDHCD predicted range, based on risks)		0	0.036, 3.545				**1st QTR:** Better than national average. **2nd QTR:** No different than national average. **3rd QTR:** **4th QTR:**
4. SIR (Standardized Infection Ration) total	Goal SIR <1.00	0.00	0.72				**1st QTR:** No events. **2nd QTR:** No events. **3rd QTR:** 1 superficial incisional primary surgical site infection event. **4th QTR:**
D. Knee Replacement (KPRO)							
1. #Total Procedure Count		24	84				**Cumulative Ct:** 108
2. Total Infection Count		0	0				**1st QTR:** 0 **Predicted:** 0.198 **2nd QTR:** 1 **Predicted:** 0.556 **3rd QTR: Predicted:** **4th QTR: Predicted:**
3. SIR CI (KDHCD predicted range, based on risks)		0	0				**1st QTR:** Better than national average. **2nd QTR:** Better than national average. **3rd QTR:** **4th QTR:**
4. SIR (Standardized Infection Ration) total	Goal SIR <1.00	0.00	0.00				**1st QTR:** No events. **2nd QTR:** No events. **3rd QTR:** **4th QTR:**
E. Small Bowel (SB)							
1. #Total Procedure Count		12	27				**Cumulative Ct:** 39
2. Total Infection Count		0.00	1				**1st QTR:** 0 **Predicted:** 0.484 **2nd QTR:** 1 **Predicted:** 1.218 **3rd QTR: Predicted:** **4th QTR: Predicted:**
3. SIR CI (KDHCD predicted range, based on risks)		0	0.041, 4.049				**1st QTR:** Better than national average. **2nd QTR:** No different than national average. **3rd QTR:** **4th QTR:**

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		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
4. SIR (Standardized Infection Ration) total	Goal SIR <1.00	0.00	0.821				**1st QTR:** No events. **2nd QTR:** 1 superficial incisional primary surgical site infection of the small bowel SSI event 9 days post-op. **3rd QTR:**
F. Hysterectomy (HYST) CMS/VBP							
1. #Total Procedure Count		6	30				**Cumulative Ct:** 36
2. Total Infection Count		0 [0]	1 [1]				**1st QTR:** 6 **Predicted:** 0.096/**CMS** 0 **Predicted:** 0.042 **2nd QTR:** 1 **Predicted:** 0.536/**CMS** 1 **Predicted:** 0.253 **3rd QTR: Predicted: /CMS Predicted:** **4th QTR: Predicted: /CMS Predicted:**
3. SIR CI (KDHCD predicted range, based on risks)		0	0				**1st QTR:** Better than national average. **2nd QTR:** Better than national average. **3rd QTR:** **4th QTR:**
4. SIR (Standardized Infection Ration) total Value Based Purchasing (VBP) SIR = [ ]	VBP Goal <0.738	0.00	1.87				**1st QTR:** No events. **2nd QTR:** 1 organ-space total abdominal hysterectomy surgical site infection event. **3rd QTR:** **4th QTR:**
G. Coronary Bypass Graft (CBGB)							
1. #Total Procedure Count		12	66				**Cumulative Ct:** 78
2. Total Infection Count		0	1				**1st QTR:** 0 **Predicted:** 0.260 **2nd QTR:** 1 **Predicted:** 1.294 **3rd QTR: Predicted:** **4th QTR: Predicted:**
3. SIR CI (KDHCD predicted range, based on risks)		0	0.039, 3.813				**1st QTR:** Better than national average. **2nd QTR:** No different than national average. **3rd QTR:** **4th QTR:**
4. SIR (Standardized Infection Ration) total Value Based Purchasing (VBP) SIR = [ ]	Goal SIR <1.00	0.00	0.77				**1st QTR:** No events. **2nd QTR:** 1 deep incisional primary surgical site infection event. **3rd QTR:** **4th QTR:**
H. Fractures (FX)							
1. #Total Procedure Count		20	50				**Cumulative Ct:** 70
2. Total Infection Count		0	0				**1st QTR:** 0 **Predicted:** 0.194 **2nd QTR:** 0 **Predicted:** 0.550 **3rd QTR: Predicted:** **4th QTR: Predicted:**
3. SIR CI (KDHCD predicted range, based on risks)		0	0				**1st QTR:** Better than national average. **2nd QTR:** Better than national average. **3rd QTR:** **4th QTR:**
4. SIR (Standardized Infection Ration) total Value Based Purchasing (VBP) SIR = [ ]	Goal SIR <1.00	0.00	0.00				**1st QTR:** No events. **2nd QTR:** No events. **3rd QTR:** **4th QTR:**
VI. Ventilator Associated Events (VAE)	**SIR**						

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		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
A. Ventilator Device Use SUR (standardized utilization ratio)		1.76	1.99				**1st QTR:** 811 **Predicted:** 459.943 **2nd QTR:** 810 **Predicted:** 407.023 **3rd QTR: Predicted:** **4th QTR: Predicted:**
B. Total VAEs ICU (NHSN Reportable)	Includes IVAC Plus						
1. SIR Total VAE CI (KDHCD predicted range, based on risks)		1.645, 1.888	, 1.261				**1st QTR:** Better than national average. **2nd QTR:** Better than national average. **3rd QTR:** **4th QTR:**
2. Total VAEs SIR	<1.0	0.16	0				**1st QTR:** 1 VAE event, 6.409 predicted. **2nd QTR:** No events. **3rd QTR:** **4th QTR:**
C. Total IVAC Plus -ICU		1	0				**1st QTR:** 1 IVAC event very likely due to aspiration pneumonia secondary to large cerebellar infarction. Patient nares colonized with MRSA and he developed MRSA pneumonia. Mupirocin ordered 3 days after admission after IVAC identified. **2nd QTR:** No events. **3rd QTR:** **4th QTR:**
1. Total IVAC Plus CI (KDHCD predicted range, based on risks)		0.021, 2.074	, 1.261				**1st QTR:** Better than national average. **2nd QTR:** Better than national average. **3rd QTR:** **4th QTR:**
2. Total IVAC *Plus* ICU SIR		0.42	0				**1st QTR:** 1. IVAC event, 2.378 predicted **2nd QTR:** No events. **3rd QTR:** **4th QTR:**
1. Process Measures							
% of patients with head of bed >30 dregrees per visual inspection.	**Goal = 100%**	NA	NA				**1st QTR:** Rounding not performed due to limited resources. **2nd QTR:** Rounding not performed due to limited resources. **3rd QTR:** **4th QTR:**
% Sedation Vacation	**Goal = 100%**	NA	NA				**1st QTR:** Rounding not performed due to limited resources. **2nd QTR:** Rounding not performed due to limited resources. **3rd QTR:** **4th QTR:**
% Oral Care Provided (per visual inspection)	**Goal = 100%**	NA	NA				**1st QTR:** Rounding not performed due to limited resources. **2nd QTR:** Rounding not performed due to limited resources. **3rd QTR:** **4th QTR:**

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		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
% CHG Bath within last 24 hours	**Goal = 100%**	NA	NA				**1st QTR:** Rounding not performed due to limited resources. **2nd QTR:** Rounding not performed due to limited resources. **3rd QTR:** **4th QTR:**
% Vent Tubing Position Appropriately (drain away from patient - visual inspection)	**Goal = 100%**	NA	NA				**1st QTR:** Rounding not performed due to limited resources. **2nd QTR:** Rounding not performed due to limited resources. **3rd QTR:** **4th QTR:**
VII. Central Line Associated Blood Stream Infections (CLABSI) CMS/VBP	**NHSN SIR**						
A. Total number of Central Line Days (CLD)		3,650	3,747				**Cumulative Ct:** 7,397
B. Central Line Device Use SUR (standardized utilization ratio)		**0.672**	**0.769**				**1st QTR:** 3,650 CLD **Predicted:** 5,429.792 **2nd QTR:** 3,747 CLD **Predicted:** 4,870.352 **3rd QTR:** CLD **Predicted:** **4th QTR:** CLD **Predicted:**
C. Total Infection Count Valule Based Purchasing (VBP) # events = [ ]		**3** **[3]**	**5** **[3]**				**1st QTR:** 3 **Predicted:** 3.548 **/CMS:** 3 **Predicted:** 2.174 **2nd QTR:** 5 **Predicted:** 3.671**/CMS:** 3 **Predicted:** 2.204 **3rd QTR: Predicted: /CMS: Predicted:** **4th QTR: Predicted: /CMS: Predicted:**
D. SIR Confidence Interval		0.215, 2.301	0.499, 3.019				**1st QTR:** No different than national average. **2nd QTR:** Worse than national average. **3rd QTR:** **4th QTR:**
E. SIR (Standardized Infection Ratio) total Value Based Purchasing (VBP) SIR = [ ]	**≤ 0.589 excluding COVID population**	**0.845**	**1.362**				**1st QTR:** 1 CLABSI event with Candidemia, on TPN, Diabetic; 1 CLABSI event with Candidemia in patient with multiple femoral CVCs, on Steroids, and receiving TPN/Fat Emulsion, Diabetic. CLABSI QFT is working with CMO/CQO, Medical Director for Quality, Medical Director for Infection Prevention on pursuing a comprehensive approach to reducing CLABSI events. **2nd QTR:** 5 CLABSI events. Improvement opportunities: Hand hygiene compliance, culturing practices, extended femoral access, multiple peripheral IVs (just-in-case-culture), documentation and actions related to most likely primary source of bloodstream infection (e.g. endocarditis, osteomyelitis). **3rd QTR:** **4th QTR:**
F. Process Measures							
% of patients with a bath within 24 hours	**Goal 100%**	**92.1%**	**87.2%**				**1st QTR:** 2,655 responses out of 2,884 responses (total of 3,511 rounds) **2nd QTR:** 2,467 responses out of 2,829 responses (total of 3,190 rounds) **3rd QTR:** **4th QTR:**

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		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
% of central lines inserted with a valid rationale	**Goal 100%**	**91.7%**	**97.3%**				**1st QTR:** 1,568 responses out of 1,710 responses (total of 3,511 rounds). **2nd QTR:** 1,533 responses out of 1,575 responses (total of 3,190 rounds). **3rd QTR:** **4th QTR:**
% of central line dressings clean, dry and intact	**Goal 100%**	**98.1%**	**98.6%**				**1st QTR:** 1,693 responses out of 1,725 responses (total of 3,511 rounds). **2nd QTR:** 1,558 responses out of 1,580 responses (total of 3,190 rounds). **3rd QTR:** **4th QTR:**
% of central line dressing changes no > than 7 days	**Goal 100%**	**98.3%**	**99.0%**				**1st QTR:** 1,693 responses out of 1,723 responses (total of 3,511 rounds). **2nd QTR:** 1,570 responses out of 1,586 respones (total of 3,190 rounds). **3rd QTR:** **4th QTR:**
% of patients with properly placed CHG patch	**Goal 100%**	**97.2%**	**97.9%**				**1st QTR:** 963 responses out of 991 responses (total of 3,511 rounds). **2nd QTR:** 870 responses out of 889 responses (total of 3,190 rounds). **3rd QTR:** **4th QTR:**
% of patients with appropriate & complete documentation	**Goal 100%**	**96.2%**	**96.0%**				**1st QTR:** 1,660 responses out of 1,726 responses (total of 3,511 rounds). **2nd QTR:** 1,521 responses out of 1,585 responses (total of 3,190 rounds). **3rd QTR:** **4th QTR:**
# of central line days rounded on		1,661	1,586				**1st QTR:** Total of 1,661 central lines were rounded on in multiple patient care units. **2nd QTR**: Total of 1,586 central lines were rounded on in multiple patient care units. **3rd QTR:** **4th QTR:**.
Skilled Nursing/Acute Rehab % of central dressing clean/dry/intact	**Goal 100%**	**100.0%**	**100.0%**				**1st QTR:** Total of 93 responses out of 93 responses (total of 257 rounds). **2nd QTR:** Total of 128 resposes out of 128 responses (total of 325 rounds). **3rd QTR:** **4th QTR:**
Skilled Nursing/Acute Rehab % of central line dressings changed no > 7 days	**Goal 100%**	**100.0%**	**100.0%**				**1st QTR:** Total of 93 responses out of 93 responses (total of 257 rounds). **2nd QTR:** Total 129 responses out of 129 responses (total of 325 rounds). **3rd QTR:** **4th QTR:**
VIII. Catheter Associated Urinary Tract Infections (CAUTI) CMS/VBP	**NHSN SIR**						

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2023							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
A. Total number of Catheter Device Days (CDD)		4,247	4,013				**Cumulative Ct:** 8,260
B. Catheter Device Days SUR (Standardized Utilization Ratio)		**0.933**	**0.973**				**1st QTR:** 4,247 CDD **Predicted:** 4,550.281 CDD **2nd QTR**: 4,013 CDD **Predicted:** 4,122.823 CDD **3rd QTR:** CDD **Predicted**: CDD **4th QTR:** CDD **Predicted:** CDD
C. Total Infection Count Value Based Purchasing (VBP) # of events = [ ]		**0**	**3**				**1st QTR:** 0 **Predicted:** 5.505 **/CMS:** 0 **Predicted:** 3.091 **2nd QTR:** 3 **Predicted:** 5.234**/CMS:** 2 **Predicted:** 2.674 **3rd QTR: Predicted: /CMS: Predicted:** **4th QTR: Predicted: /CMS: Predicted:**

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2023							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
D. SIR Confidence Interval		0	0.146, 1.560				**1st QTR:** Better than national average. **2nd QTR:** Better than national average. **3rd QTR:** **4th QTR**:
E. SIR (Standardized Infection Ratio) total Value Based Purchasing (VBP) SIR = [ ]	**≤ 0.650 excluding COVID population**	**0**	**0.573**				**1st QTR:** No events. **2nd QTR:** 3 CAUTI events. Opportunities for improvement: Pursue an alternative to an indwelling urinary catheter, ordering cultures for patients on comfort care, stool management, hand hygiene compliance. **3rd QTR:** **4th QTR:**
F. Process Measures							
% of patients with appropriate cleanliness (a minimum of peri-care in the last 12 hours)	**Goal 99%**	**95.9%**	**96.8%**				**1st QTR:** 1,862 responses out of 1,862 responses (total of 3,511 rounds). **2nd QTR:** 1,749 responses out of 1,806 responses (total 3,190). **3rd QTR:** **4th QTR:**
% of IUCs with order and valid rationale	**Goal 100%**	**93.3%**	**93.0%**				**1st QTR:** 1,803 responses out of 1,932 responses (total of 3,511 rounds). **2nd QTR:** 1,676 responses out of 1,807 responses (total of 3,190 rounds). **3rd QTR:** **4th QTR:**
% of IUCs where removal was attempted		**1.9%**	**11.4%**				**1st QTR:** 36 responses out of 1,945 responses (total of 3,511 rounds). **2nd QTR:** 130 responses out of 1,139 responses (totai of 3,190 rounds). **3rd QTR:** **4th QTR:**
% of patients where alternatives have been attempted		**4.0%**	**8.0%**				**1st QTR:** 78 responses out of 1,192 responses (total of 3,511 rounds). **2nd QTR:** 103 responses out of 1,216 responses (total of 3,190 rounds). **3rd QTR:** **4th QTR:**
% of IUCs removed because of unit "GEMBA" rounds		**2.2%**	**2.9%**				**1st QTR:** 42 responses out of 1,929 responses (total of 3,511 rounds). **2nd QTR:** 53 responses out of 1,799 responses (total of 3,190 rounds). **3rd QTR:** **4th QTR:**
# of IUCs removed because of unit "GEMBA" rounds		42	53				**1st QTR:** No additional comments. **2nd QTR:** No additional comments. **3rd QTR:** **4th QTR:**

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

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2023							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
A. Total Infection Count	All units	11	8				**1st QTR:** 11 **Predicted:** 16.868 **2nd QTR:** 8 **Predicted:** 16.230 **3rd QTR: Predicted:** **4th QTR: Predicted:**
B. SIR CI (KDHCD predicted range, based on risks)		0.342, 1.133	0.229, 0.936				**1st QTR:** No difference from national average. **2nd QTR:** Better than national average. **3rd QTR:** **4th QTR:**
C. SIR (Standardized Infection Ratio) total Value Based Purchasing (VBP) SIR = [ ]	VBP Goal <0.520	0.652	0.493				**1st QTR:** There is ongoing work to develop a pop-up in the EMR for providers reminding them not to order C. diff. testing for patients on a bowel program. Additionally, an automatic discontinuation of C. diff. orders that are not completed within 24 hours is being developed. **2nd QTR:** At the end of the second quarter the medical record pop-up reminder and auto-cancellation at 24 hours for C. difficile orders in which a specimen wasn't collected all went live. Continued education and just-in-time interventions to reduce inappropriate C. difficile testing performed throughout this quarter. **3rd QTR:** **4th QTR:**
XII. Hand Hygiene	**95%**						
A. Total Hand Hygiene Observations (combination of manual and electronic hand hygiene surveillance)		96.5%	96.09%				**1st QTR:** 2,766,588 compliant out of 2,866,337 opportunities. **2nd QTR:** 2,663,467 compliant out of 2,771,846 oppportunities. **3rd QTR:** **4th QTR:**
B. All units Percentage of Hand Hygiene compliance based on observations/opportunities (>200 observations/ month/unit) *(note these are partially patient observations)*		82.9%	87.9%				1st QTR: Mental Health 756 compliant out of 756 opportunities or 100% compliance rate. All Clinics (including KHMG) NRC patient observations of HCP HH activities = 4,376 out of 5,438 opportunities or 80.5% compliance rate. 2nd QTR: Mental Health 663 compliant out of 663 opportunities or 100% compliance rate. All Clinics NRC patient observations of HCP HH activities = 1,754 compliant out of 2,087 opportunities or 84% compliance rate. 3rd QTR: 4th QTR:
C. Percentage of Hand Hygiene compliance performed during "Day Shift"		96.5%	96.1%				**1st QTR:** 1,629,768 compliant out of 1,688,354 opportunities. **2nd QTR:** 1,517,880 compliant out of 1,579,480 opportunities. **3rd QTR:** **4th QTR:**

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

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2023							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
Subacute (# of Infections/ Incidence Rate)		0	0				**1st QTR:** No events. **2nd QTR:** No events. **3rd QTR:** **4th QTR:**
XVI. Influenza Rates (Year 2020-2021)	**NHSN**						
A. All Healthcare Workers	**>90%**		84%				**2nd QTR:** A total of 4,096 employees received flu vaccination either with Kaweah Health or elsewhere out of a total number of 4,888 employees who worked at least 1 day at Kaweah Health during the influenza season. Employee = 84% vaccinated (3,451/4,113) LIP = 88% vaccinated (456/517) Students = 73% vaccinated (189/258)

Approved IPC: 4/27/23
Approved IPC:
Approved IPC:
Approved IPC:

Prepared by: Shawn Elkin, Infection Prevention Manager

Kaweah Health
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Maternal Child Health Quality Improvement Dashboard

LABOR AND DELIVERY	Goal	2022	Jan 2023	Feb 2023	Mar 2023	3rd Quarter FY 2023	Apr 2023	May 2023	June 2023	4th Quarter FY23	YTD
Early Elective Deliveries: PC-01	0%	2.5%	2.5%	8.7%	2%	4.4%	0%	4.2%	Unavailable	2.1%	3.5%
Decision to Ready Time	90%	85.5%	54%	56%	36%	49%	34%	52%	52%	46%	47.3%
Pitocin Use for Labor Induction/Augmentation	90%	N/A	100%	96.7%	96.7%	98%	93.3%	90%	96.7%	93.3%	95.6%
Pitocin Increase Compliance	90%	N/A	86.7%	63.3%	86.7%	79%	83.3%	80%	83.3%	82.2%	80.6%
Hand Hygiene Compliance	95%	96.4%	96.9%	97.2%	97%	97%	97.5%	97.5%	97.5%	97.5%	97.3%
MOTHER-BABY											
Exclusive Breastmilk: PC-05	52.4%	61.5%	66.2%	61%	63.4%	63.5%	64.7%	66.7%	63.2%	64.9%	64.2%
Latch Assessment Compliance	100%	82.5%	70%	70%	87%	75.7%	90%	90%	47.4%	75.8%	75.7%
Completion of Whiteboards	100%	95.7%	96%	90%	100%	95.3%	80%	80%	90%	83%	89%
Hand Hygiene Compliance	95%	97.7%	97.5%	97.5%	97.8%	97.6%	97.1%	97.7%	97.6%	97.5%	97.5%
NEONATAL-NICU											
CLABSI per 1000 Patient Days	0	0	0	0	0	0	0	0	0	0%	0
VAP per 1000 Patient Days	0	0	0	0	0	0	0	0	0	0%	0
Hand Hygiene Compliance	95%	96.8%	99.5%	99.5%	99.6%	99.5%	99.5%	99.4%	99.6%	100%	99.52%
PEDIATRICS											
PEWS Compliance	90%	95%	96%	100.0%	91.6%	95.9%	95%	100%	100%	98%	97.1%
PIV Compliance	90%	98%	97%	95%	96%	96%	97%	100%	100%	99%	97.5%
Patient Falls per 1000 Patient Days	0	0	0	0	0	0	0	0	0	0	0
CAUTI	0	0	0	0	0	0	0	0	0	0	0
CLABSI	0	0	0	0	0	0	0	0	0	0	0
HAPI per 1000 Patients Days	0	0	0	0	0	0	0	0	0	0	0
Injury Falls per 1000 Patient Days	0.17	0	0	0	0	0	0	0	0	0	0
Hand Hygiene Compliance	95%	97%	97.3%	96.9%	97.9%	97.4%	97.1%	97.6%	98.1%	97.6%	97.5%

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

Labor and Delivery Decision to Ready Time

Goal: The goal is to have 90% of patients who are having unscheduled c-sections ready for the procedure in less than or equal to 30 minutes from the time the provider made the decision.	**Med Staff Champion: Dr. Betre/Banks**	**Subject Experts: Laura Robertson, Christine Chavez**	**Time Period: January 2023-June 2023**
Team Leader: Laura Robertson	**Team members: All Staff**		**Revision (date):**
PI Liaison: Stacey Cajimat			**Revision #:**

PLAN (DEFINE/MEASURE/ANALYZE)

Background/Problem Statement:
Patients who are having unscheduled cesarean sections should be ready for the procedure in less than or equal to 30 minutes from the time the provider made the decision.

Current Condition: YTD 47.3%, we have not met goal the last 2 quarters.

Target / Goal: 90%

Problem Analysis / Root Cause, Gap:

1. There is a gap in the documentation process. We are currently evaluating the location and who is responsible for charting this information. Once the decision has been made to move forward with a cesarean section, many times it is not the same nurse doing the prep and documenting the ready time.

DO

Countermeasure / Action Plan / Solutions:
The Nurse Manager is working to develop standard workflow identifying who is responsible for documenting this information.

CHECK

Results / Metrics:
We will continue to monitor compliance.

ACT / ADJUST

Follow-Up / Sustainability:
We will continue to monitor for compliance.

Labor and Delivery Early Elective Delivery

Goal: The goal is to have zero early elective deliveries.	**Med Staff Champion: Dr. Betre/Banks**	**Subject Experts: Laura Robertson, Christine Chavez**	**Time Period: January 2023-June 2023**
Team Leader: Laura Robertson	**Team members: All OB Providers**		**Revision (date):**
PI Liaison: Stacey Cajimat			**Revision #:**

PLAN (DEFINE/MEASURE/ANALYZE)

Background/Problem Statement:
Patients with an induction or cesarean procedure prior to labor including patients with 37/38 week deliveries, excluding those with a condition justifying an elective delivery (per The Joint Commission) or a history of prior stillbirth IF induction or cesarean performed in current delivery.

Current Condition: YTD 3.5%
Jan – Mar 2023 = 4.4%
Apr – Jun 2023 = 2.1% (excluding June's data, California Maternal Quality Care Collaborative operates about 6 weeks behind)

Target / Goal: 0%

Problem Analysis / Root Cause, Gap:

1. There is no stop gap when a provider calls to schedule an early elective delivery.

DO

Countermeasure / Action Plan / Solutions:
Meeting with Dr. Betre/Banks 07/18/23 to discuss how the providers can assist us in meeting this metric and develop an action plan.
09/2023 – Development of task force in progress. 1st meeting to occur week of September 18th.

CHECK

Results / Metrics:
We will continue to monitor compliance.

ACT / ADJUST

Follow-Up / Sustainability:

We will continue to monitor for compliance.

Labor and Delivery Hand Hygiene

Goal: Hand hygiene compliance is 95% or greater.	**Med Staff Champion: Dr. Betre/Banks**	**Subject Experts: Laura Robertson, Christine Chavez**	**Time Period: January 2023-June 2023**
Team Leader: Laura Robertson	**Team members: All Staff**		**Revision (date):**
PI Liaison: Stacey Cajimat			**Revision #:**

PLAN (DEFINE/MEASURE/ANALYZE)

Background/Problem Statement:
This measure looks at how many opportunities were identified by the Biovigil system for hand hygiene and how many were compliant. All staff entering a patient's room should participate in hand hygiene utilizing the Biovigil system.

Current Condition: YTD 97.3%
Jan-Mar 2023 = 97%
Apr-Jun 2023= 97.5%

Target / Goal: 95%

Problem Analysis / Root Cause, Gap:
Continue to ensure the team is compliant by running reports and holding staff accountable to usage.

DO

Countermeasure / Action Plan / Solutions:
Identification of usage and compliance through reports.

CHECK

Results / Metrics:
Goal Met

ACT / ADJUST

Follow-Up / Sustainability:
We will continue to monitor for compliance.

Kaweah Health

Labor and Delivery Pitocin Increases

<table>
<tr><td colspan="2">Goal: The goal is to have 90% of patients who are receiving Pitocin increased by 2mu/min or 5mu/min (depending on order) every 30 minutes until regular uterine contractions achieved defined as contractions every 2-3 minutes, lasting 80-90 seconds.</td><td>Med Staff Champion: Dr. Betre/Banks</td><td colspan="2" rowspan="3">Subject Experts: Laura Robertson, Christine Chavez</td><td>Time Period: January 2023-June 2023</td></tr>
<tr><td colspan="2">Team Leader: Laura Robertson</td><td rowspan="2">Team members: All Staff</td><td>Revision (date):</td></tr>
<tr><td colspan="2">PI Liaison: Stacey Cajimat</td><td>Revision #:</td></tr>
<tr><td rowspan="4">PLAN (DEFINE/MEASURE/ANALYZE)</td><td colspan="2">Background/Problem Statement:
Those patients who had Pitocin infusing would receive increases by 2mu/min or 5mu/min (depending on provider order) every 30 minutes until regular uterine contraction achieved. Regular uterine contractions are defined as contractions every 2-3 minutes, lasting 80-90 seconds OR consistent achievement of 200-220 Montevideo Units when an Intrauterine Pressure Catheter is in place.</td><td rowspan="2">DO</td><td colspan="3" rowspan="2">Countermeasure / Action Plan / Solutions:
Laura has been working hard on staffing the unit. Travelers are in place for those on orientation and any vacancies. There are currently 6 Registered Nurses on orientation, 6 Registered Nurses to start orientation in the next month and 6 Registered Nurse open positions.</td></tr>
<tr><td colspan="2">Current Condition: YTD 80.6%
Jan-Mar 2023 = 79%
Mar-Jun 2023= 82.2%</td></tr>
<tr><td colspan="2">Target / Goal: 90%</td><td rowspan="2">CHECK</td><td colspan="3" rowspan="2">Results / Metrics:
We will continue to monitor compliance.</td></tr>
<tr><td colspan="2">Problem Analysis / Root Cause, Gap:
The team identified that staffing challenges have contributed to Registered Nurses not increasing the Pitocin due to safety concerns with staffing.</td></tr>
</table>

Labor and Delivery Pitocin Increases

		ACT / ADJUST	**Follow-Up / Sustainability:** We will continue to monitor for compliance.

Labor and Delivery Pitocin Orders

Goal: The goal is to have 90% of patients who have Pitocin ordered for labor induction/augmentation started on the medication within 1 hour of it being ordered.	**Med Staff Champion: Dr. Betre/Banks**	**Subject Experts: Laura Robertson, Christine Chavez**	**Time Period: January 2023-June 2023**
Team Leader: Laura Robertson	**Team members: All Staff**		**Revision (date):**
PI Liaison: Stacey Cajimat			**Revision #:**

PLAN (DEFINE/MEASURE/ANALYZE)

Background/Problem Statement:
Those patients who had Pitocin ordered for labor induction/augmentation, were started on the medication within 1 hour of the order being placed.

Current Condition: YTD 95.6%
Jan-Mar 2023 = 98%
Mar-Jun 2023= 93.3%

Target / Goal: 90%

Problem Analysis / Root Cause, Gap:
Staff were not starting the Pitocin due to staffing challenges and feeling safe to be able to monitor their patients.

DO

Countermeasure / Action Plan / Solutions:
Laura has been working hard on staffing the unit. Travelers are in place for those on orientation and any vacancies. There are currently 6 Registered Nurses on orientation, 6 Registered Nurses to start orientation in the next month and 6 Registered Nurses open positions.

CHECK

Results / Metrics:
Goal Met

ACT / ADJUST

Follow-Up / Sustainability:
We will continue to monitor for compliance.

Kaweah Health

Mother Baby Exclusive Breastmilk

Goal: The goal is 52.4% (The Joint Commission) or greater of single term live born newborns discharged alive from the hospital were fed breast milk only since birth.	**Med Staff Champion: Dr. Betre/Banks**	**Subject Experts: Stephanie Genetti**	**Time Period: January 2023-June 2023**
Team Leader: Stephanie Genetti	**Team members: All Staff**		**Revision (date):**
PI Liaison: Stacey Cajimat			**Revision #:**

PLAN (DEFINE/MEASURE/ANALYZE)

Background/Problem Statement:
The goal is that at least 52.4% of our single term live born newborns discharged alive from the hospital were fed breast milk only since birth.

Current Condition: YTD 64.2%
Jan – Mar 2023 = 63.5%
Apr – Jun 2023 = 64.9%

Target / Goal: 52.4%

Problem Analysis / Root Cause, Gap:
Continue to enforce the breastfeeding bundle and support our patients in their feeding preferences.

DO

Countermeasure / Action Plan / Solutions:
The breastfeeding bundle has been implemented across all staff and new hires will receive the information, training and competencies during orientation.

CHECK

Results / Metrics:
Goal Met

ACT / ADJUST

Follow-Up / Sustainability:
We will continue to monitor for compliance.

Mother Baby Exclusive Breastmilk

Mother Baby Hand Hygiene

Goal: Hand hygiene compliance is 95% or greater.	**Med Staff Champion: Dr. Betre/Banks**	**Subject Experts: Stephanie Genetti**	**Time Period: January 2023-June 2023**
Team Leader: Stephanie Genetti	**Team members: All Staff**		**Revision (date):**
PI Liaison: Stacey Cajimat			**Revision #:**

PLAN (DEFINE/MEASURE/ANALYZE)

Background/Problem Statement:
This measure looks at how many opportunities were identified by the Biovigil system for hand hygiene and how many were compliant. All staff entering a patient's room should participate in hand hygiene utilizing the Biovigil system.

Current Condition: YTD 97.5%
Jan-Mar 2023 = 97.6%
Apr-Jun 2023= 97.5%

Target / Goal: 95%

Problem Analysis / Root Cause, Gap:
Continue to ensure the team is compliant by running reports and holding staff accountable to usage.

DO

Countermeasure / Action Plan / Solutions:
Identification of usage and compliance through reports.

CHECK

Results / Metrics:
Goal Met

ACT / ADJUST

Follow-Up / Sustainability:
We will continue to monitor for compliance.

Mother Baby LATCH Assessment

Goal: The goal is 100% of our patients who are exclusively breastfeeding will have a LATCH assessment documented at least once per shift.	**Med Staff Champion: Dr. Betre/Banks**	**Subject Experts: Stephanie Genetti**	**Time Period: January 2023-June 2023**
Team Leader: Stephanie Genetti	**Team members: All Staff**		**Revision (date):**
PI Liaison: Stacey Cajimat			**Revision #:**

PLAN (DEFINE/MEASURE/ANALYZE)

Background/Problem Statement:
The goal is 100% of our patients who are exclusively breastfeeding will have a LATCH assessment documented at least once per shift as required per our standards of care following California Department of Public Health Model Hospital Policy, excluding any patients that are formula feeding only.

Current Condition: YTD 75.73%
Jan – Mar 2023 = 75.7%
Apr – Jun 2023 = 75.8%

Target / Goal: 100%

Problem Analysis / Root Cause, Gap:
Staff identified the location of the LATCH assessment was the issue in not completing the documentation. Also note that the patients do not call for every feeding and in turn some opportunities to assess are lost.

DO

Countermeasure / Action Plan / Solutions:
An ISS ticket was submitted to relocate the DTA's required to chart on for LATCH assessment, making it easier to document. MB is still waiting for this change to take place. Unit Based Council/Breast Is Best/Charge Nurse staff have all been included in problem solving and compliance. UBC with lactation team is working on these audits at this time. Moving forward discipline will have to be considered.

CHECK

Results / Metrics:
Will continue to monitor compliance. Unit Based Council is reporting the findings on a monthly basis to staff who have started to also hold one another responsible during change of shift reports

ACT / ADJUST

Follow-Up / Sustainability:
We will continue to monitor for compliance.

Kaweah Health

Mother Baby Whiteboard Completion

Goal: The goal is 100% of our patients whiteboards are completed and updated when necessary throughout the shift.	**Med Staff Champion: Dr. Betre/Banks**	**Subject Experts: Stephanie Genetti**	**Time Period: January 2023-June 2023**
Team Leader: Stephanie Genetti	**Team members: All Staff**		**Revision (date):**
PI Liaison: Stacey Cajimat			**Revision #:**

PLAN (DEFINE/MEASURE/ANALYZE)

Background/Problem Statement:
The goal is 100% of our patient whiteboards will be completed and updated when necessary throughout the shift.

Current Condition: YTD 89.33%
Jan – Mar 2023 = 95.3%
Apr – Jun 2023 = 83.3%

Target / Goal: 100%

Problem Analysis / Root Cause, Gap:
Will continue to enforce and hold staff accountable. More staff members has also been encouraged to update the white boards as patient goals evolve throughout the course of the stay. Patients are also being educated and encouraged to participate in the establishment of the goals especially during bedside reports.

DO

Countermeasure / Action Plan / Solutions:
Remind staff at the beginning of the shift during safety huddles. Certified Nursing Assistant staff may update the whiteboards as the patients plan changes as well. Auditor encouraged to revise the action plan if there are any parts of the board that are missing.

CHECK

Results / Metrics:
Will continue to monitor compliance. Has become a Unit Based Council topic to report and provide monthly feedback to the team which has been effective and has raised topic awareness.

ACT / ADJUST

Follow-Up / Sustainability:
We will continue to monitor for compliance. Staff are often presenting the board and its use to the patient and their families.

Neonatal Intensive Care Unit CLABSI

Goal: Zero CLABSI in the NICU	**Med Staff Champion: Dr. Dosado**	**Subject Experts: Felicia Vaughn, Daniel Castaneda**	**Time Period: January 2023-June 2023**
Team Leader: Felicia Vaughn	**Team members: All Staff**		**Revision (date):**
PI Liaison: Stacey Cajimat			**Revision #:**

PLAN (DEFINE/MEASURE/ANALYZE)

Background/Problem Statement:
This measure looks at total number of patient days and how many of those days there was a central line-associated bloodstream infection.

Current Condition: YTD 0%
Jan-Mar 2023 = 0%
Apr-Jun 2023= 0%

Target / Goal: 0%

Problem Analysis / Root Cause, Gap:
N/A

DO

Countermeasure / Action Plan / Solutions:
Continue sterile technique for dressing changes.
Continue to perform hand hygiene.

CHECK

Results / Metrics:
Goal Met

ACT / ADJUST

Follow-Up / Sustainability:
We will continue to monitor for compliance.

Neonatal Intensive Care Unit Hand Hygiene

Goal: Hand hygiene compliance is 95% or greater.	**Med Staff Champion: Dr. Dosado**	**Subject Experts: Felicia Vaughn, Daniel Castaneda**	**Time Period: January 2023-June 2023**
Team Leader: Felicia Vaughn	**Team members: All Staff**		**Revision (date):**
PI Liaison: Stacey Cajimat			**Revision #:**

PLAN (DEFINE/MEASURE/ANALYZE)

Background/Problem Statement:
This measure looks at how many opportunities were identified by the Biovigil system for hand hygiene and how many were compliant. All staff entering a patient's room should participate in hand hygiene utilizing the Biovigil system.

Current Condition: YTD 99.5%
Jan-Mar 2023 = 99.5%
Apr-Jun 2023= 100%

Target / Goal: 95%

Problem Analysis / Root Cause, Gap:
Continue to ensure the team is compliant by running reports and holding staff accountable to usage.

DO

Countermeasure / Action Plan / Solutions:
Identification of usage and compliance through reports.

CHECK

Results / Metrics:
Goal Met

ACT / ADJUST

Follow-Up / Sustainability:
We will continue to monitor for compliance.

Kaweah Health

Neonatal Intensive Care Unit VAP

Goal: Zero VAP in the NICU per 1000 patient days.	**Med Staff Champion: Dr. Dosado**	**Subject Experts: Felicia Vaughn, Daniel Castaneda**	**Time Period: January 2023-June 2023**
Team Leader: Felicia Vaughn	**Team members: All Staff**		**Revision (date):**
PI Liaison: Stacey Cajimat			**Revision #:**

PLAN (DEFINE/MEASURE/ANALYZE)

Background/Problem Statement:
This measure looks at total number of patient days and how many of those days there was ventilator-associate pneumonia in the Neonatal Intensive Care Unit.

Current Condition: YTD 0%
Jan-Mar 2023 = 0%
Apr-Jun 2023= 0%

Target / Goal: 0%

Problem Analysis / Root Cause, Gap:
N/A

DO

Countermeasure / Action Plan / Solutions:
Adhere to the NICU Ventilator Associated Pneumonia Bundle

CHECK

Results / Metrics:
Goal Met

ACT / ADJUST

Follow-Up / Sustainability:
We will continue to monitor for compliance.

Kaweah Health

Pediatrics CAUTI

Goal: Zero CAUTI in the Pediatrics Unit	**Med Staff Champion: Dr. Loomba/Randolph**	**Subject Experts: Danielle Grimaldi**	**Time Period: January 2023-June 2023**
Team Leader: Danielle Grimaldi	**Team members: All Staff**		**Revision (date):**
PI Liaison: Stacey Cajimat			**Revision #:**

PLAN (DEFINE/MEASURE/ANALYZE)

Background/Problem Statement:
This measure looks at total number of patient days and how many of those days there was a catheter-associated urinary tract infection.

Current Condition: YTD 0%
Jan-Mar 2023 = 0%
Apr-Jun 2023= 0%

Target / Goal: 0%

Problem Analysis / Root Cause, Gap:
N/A

DO

Countermeasure / Action Plan / Solutions:
Continue to limit the use of indwelling foley catheters.

CHECK

Results / Metrics:
Goal Met

ACT / ADJUST

Follow-Up / Sustainability:
We will continue to monitor for compliance.

Pediatrics CLABSI

Goal: Zero CLABSI in the Pediatrics Unit	**Med Staff Champion: Dr. Loomba/Randolph**	**Subject Experts: Danielle Grimaldi**	**Time Period: January 2023-June 2023**
Team Leader: Danielle Grimaldi	**Team members: All Staff**		**Revision (date):**
PI Liaison: Stacey Cajimat			**Revision #:**

PLAN (DEFINE/MEASURE/ANALYZE)

Background/Problem Statement:
This measure looks at total number of patient days and how many of those days there was a central line-associated bloodstream infection in the Pediatric Unit.

Current Condition: YTD 0%
Jan-Mar 2023 = 0%
Apr-Jun 2023= 0%

Target / Goal: 0%

Problem Analysis / Root Cause, Gap:
N/A

DO

Countermeasure / Action Plan / Solutions:
Continue sterile technique for dressing changes.
Continue to perform hand hygiene.

CHECK

Results / Metrics:
Goal Met

ACT / ADJUST

Follow-Up / Sustainability:
We will continue to monitor for compliance.

Kaweah Health

Pediatrics Early Warning Score

Goal: 90% compliance in documenting a PEWS score.	**Med Staff Champion: Dr. Loomba/Randolph**	**Subject Experts: Danielle Grimaldi**	**Time Period: January 2023-June 2023**
Team Leader: Danielle Grimaldi	**Team members: All Staff**		**Revision (date):**
PI Liaison: Stacey Cajimat			**Revision #:**

PLAN (DEFINE/MEASURE/ANALYZE)

Background/Problem Statement:
This measure looks at how many pediatric patients had a Pediatric Early Warning Score documented.

Current Condition: YTD 97.1%
Jan-Mar 2023 = 95.9%
Apr-Jun 2023= 99%

Target / Goal: 90%

Problem Analysis / Root Cause, Gap:
N/A

DO

Countermeasure / Action Plan / Solutions:
Continue to audit weekly and remind staff to complete the assessments.

CHECK

Results / Metrics:
Goal Met

ACT / ADJUST

Follow-Up / Sustainability:
We will continue to monitor for compliance.

Kaweah Health

Pediatrics HAPI

Goal: Zero HAPI's in the Pediatrics Unit	**Med Staff Champion: Dr. Loomba/Randolph**	**Subject Experts: Danielle Grimaldi**	**Time Period: January 2023-June 2023**
Team Leader: Danielle Grimaldi	**Team members: All Staff**		**Revision (date):**
PI Liaison: Stacey Cajimat			**Revision #:**

PLAN (DEFINE/MEASURE/ANALYZE)

Background/Problem Statement:
This measure looks at percent of patients with stage 2 or greater hospital acquired pressure injuries per 1,000 patient days.

Current Condition: YTD 0%
Jan – Mar = 0%
Apr – Jun = 0%

Target / Goal: 0%

Problem Analysis / Root Cause, Gap:
N/A

DO

Countermeasure / Action Plan / Solutions:
Staff will continue to take all measures to prevent our pediatric patients from acquiring pressure injuries during their hospital admission.

CHECK

Results / Metrics:
Goal Met

ACT / ADJUST

Follow-Up / Sustainability:
We will continue to monitor for compliance.

Pediatrics Injury Falls

Goal: Zero patient falls with injuries in the Pediatric Unit.	**Med Staff Champion: Dr. Loomba/Randolph**	**Subject Experts: Danielle Grimaldi**	**Time Period: January 2023-June 2023**
Team Leader: Danielle Grimaldi	**Team members: All Staff**		**Revision (date):**
PI Liaison: Stacey Cajimat			**Revision #:**

PLAN (DEFINE/MEASURE/ANALYZE)

Background/Problem Statement:
This measure looks at patient falls with injuries per 1,000 patient days.

Current Condition: YTD 0%
Jan – Mar = 0%
Apr – Jun = 0%

Target / Goal: 0%

Problem Analysis / Root Cause, Gap:
N/A

DO

Countermeasure / Action Plan / Solutions:
Staff will continue to take all measures to prevent our pediatric patients from falling during their hospital admission.

CHECK

Results / Metrics:
Goal Met

ACT / ADJUST

Follow-Up / Sustainability:
We will continue to monitor for compliance.

Pediatrics Patient Falls

Goal: Zero patient falls in the Pediatric Unit.	**Med Staff Champion: Dr. Loomba/Randolph**	**Subject Experts: Danielle Grimaldi**	**Time Period: January 2023-June 2023**
Team Leader: Danielle Grimaldi	**Team members: All Staff**		**Revision (date):**
PI Liaison: Stacey Cajimat			**Revision #:**

PLAN (DEFINE/MEASURE/ANALYZE)

Background/Problem Statement:
This measure looks at patient falls per 1,000 patient days.

Current Condition: YTD 0%
Jan – Mar = 0%
Apr – Jun = 0%

Target / Goal: 0%

Problem Analysis / Root Cause, Gap:
N/A

DO

Countermeasure / Action Plan / Solutions:
Staff will continue to take all measures to prevent our pediatric patients from falling during their hospital admission.

CHECK

Results / Metrics:
Goal Met

ACT / ADJUST

Follow-Up / Sustainability:
We will continue to monitor for compliance.

Kaweah Health

Pediatrics Peripheral IV

Goal: 90% compliance in checking the peripheral intravenous line every 4 hours in each patient.	**Med Staff Champion: Dr. Loomba/Randolph**	**Subject Experts: Danielle Grimaldi**	**Time Period: January 2023-June 2023**
Team Leader: Danielle Grimaldi	**Team members: All Staff**		**Revision (date):**
PI Liaison: Stacey Cajimat			**Revision #:**

PLAN (DEFINE/MEASURE/ANALYZE)

Background/Problem Statement:
This measure looks at total number of patients and the compliance of checking the peripheral IV line every 4 hours.

Current Condition: YTD 97.5%
Jan-Mar 2023 = 96%
Apr-Jun 2023= 99%

Target / Goal: 90%

Problem Analysis / Root Cause, Gap:
N/A

DO

Countermeasure / Action Plan / Solutions:
Staff will continue to assess peripheral intravenous line every 4 hours.

CHECK

Results / Metrics:
Goal Met

ACT / ADJUST

Follow-Up / Sustainability:
We will continue to monitor for compliance.

Pediatrics Hand Hygiene

Goal: Hand hygiene compliance is 95% or greater.	**Med Staff Champion: Dr. Loomba/Randolph**	**Subject Experts: Danielle Grimaldi**	**Time Period: January 2023-June 2023**
Team Leader: Danielle Grimaldi	**Team members: All Staff**		**Revision (date):**
PI Liaison: Stacey Cajimat			**Revision #:**

PLAN (DEFINE/MEASURE/ANALYZE)

Background/Problem Statement:
This measure looks at how many opportunities were identified by the Biovigil system for hand hygiene and how many were compliant. All staff entering a patient's room should participate in hand hygiene utilizing the Biovigil system.

Current Condition: YTD 97.5%
Jan-Mar 2023 = 97.4%
Apr-Jun 2023= 97.6%

Target / Goal: 95%

Problem Analysis / Root Cause, Gap:
Continue to ensure the team is compliant by running reports and holding staff accountable to usage.

DO

Countermeasure / Action Plan / Solutions:
Identification of usage and compliance through reports.

CHECK

Results / Metrics:
Goal Met

ACT / ADJUST

Follow-Up / Sustainability:
We will continue to monitor for compliance.

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

Unit/Department: Kaweah Health – Diversion Prevention Committee

ProStaff/QIC Report Date: 6/1/2023

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: January-March 2023

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 January-March 2023 the following goals were achieved:

Diversion Prevention Awareness Mandatory Education (Ongoing):

- Diversion Prevention Strategies Education and Monitoring (ongoing) – All Employees:
  - **No new data** - July – October 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.
  - **Goal Met**- April 2023 - 97% of hospital staff completed the Mandatory Annual Training-Diversion Prevention Module, due April 26th.
- Leadership Awareness Education (ongoing):
  - **Goal Met** - March 2023: Shannon Cauthen developed "Strange Education" that was approved by DPC on March 28th. Education was sent out to Patient Care Leaders to share with their teams.
  - **Goal Met** – March 2023: Education sent out to all Patient Care Leaders about how to investigate for possible diversion and expectations for responding to Bluesight variances and investigations (including, but not limited to, IRIS). Additionally, Bluesight CBL was assigned to all nurse managers by the med safety specialist.

Pharmacy-Related Monitoring:

- Pharmacy continues to monitor on a monthly basis with random and reduced sample size and bring to DPC should new trends arise. No concerns or trends noted for this time period.

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.

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.

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

Two different tools were developed and sent to Patient Care Leaders to assist them in reviewing data and investigating potential diversion concerns. The tools were titled “Diversion Prevention Guidance for Managers” and “Investigation Questionnaire.” These two documents will provide information to leaders about when an investigation should be conducted, how and when to respond in Bluesight and when to involve HR/Risk.

In addition to this, from the sub-committee, a process was established where the IRIS investigations will be reviewed in greater detail to ensure there are no gaps in the process. The committee decided they would review the following in their meeting during the first week of each month:

- Review the IRIS investigation on an employee who has had two or more elevated IRIS scores within 6 months.
    - Any questions or concerns regarding the investigation will be immediately escalated to the unit Manager/Director and a response will be requested within 5 days.
    - Will draft and share more specific guidelines/expectations on responses with managers/directors on an as-needed basis.
- Complete random spot checks on open investigations (try to target units where cases are not already being reviewed for the above reason to ensure we are looking at practices on all units).

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:
June 5th, 2023

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

Handoff

9/12/2023

Franklin Martin

kaweahhealth.org

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Background

- A Sentinel Event Alert (SEA) was issued by The Joint Commission (TJC) in September 2017. After the alert was issued, a review of internal event reporting data and a gap analysis were conducted based on the recommendations by TJC in the SEA. The gap analysis indicated that Kaweah Health at the time had several opportunities to address TJCs recommendations and improve the handoff process adequately. Gaps included:
  a. No institutional approach to handoff that identifies/defines critical content of the handoff.
  b. Utilize/enhance handoff with electronic medical record (EMR) capabilities.
  c. Measure and monitor the use of standardized handoff and the impact of poor handoff.

Team Mission

- Implement a standardized structure for a nurse-to-nurse handoff when admitting a patient or handoff between shifts.

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

Team Deliverables & Goals

Deliverables

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

Goals

<u>Quality of Handoff Measurement</u>

1. 80% compliance and adherence to the EMR handoff tool.
2. Reduction of handoff-related Midas Events

Handoff Tool Builds

- Completed departments include: 2 north, 2 south, ICU, CVICU, 3 West, 3 North, 3 South, 4 North, 4 South, Pediatrics, Emergency Department, 4 Tower, and 5 Tower, mother baby, labor and delivery, and NICU.
- Audits for these floors are in progress.
- Currently, we have 17 departments with completed EMR handoff tools.
- Surgical and Cardiac services are being built (ETA end of early 2024).
- We have prioritized the remaining areas to be completed over the rest of this year (Rehab, Behavioral Health).
  - Build for Behavioral Health will be first (meeting to be scheduled October).
- Each build is created based on the needs of each floor.

Education and Training

- Education Video and Mandatory training created in October 2022
  - The video addresses why, how, where, and when to use the new tool.

- Handoff education added to all new hire orientation packets to complete (this includes travelers).

Handoff Audit

- Universal audit tool created and approved by the nursing leadership team
- Audit process
  - Each department is to complete 5 weekly audits
  - The goal is an 80% monthly compliance rate utilizing the Handoff EMR tool.
  - When each department is successful for three consecutive months with an 80% success rate, they will move to a quarterly audit (We currently have 16 nursing units on quarterly audits).
- The audit started Jan 16th, 2023.
- The audit started with a low floor compliance rate, but as the weeks progressed, the compliance increased.
  - Email reminders are sent out every week to all leaders.
  - One-on-one emails are sent to those who do not respond.
- On 8/25/23, Cindy from Quality did a handoff audit validation and surveyed 10 nurses. They all passed with 100% compliance based on our audit criteria for this project.

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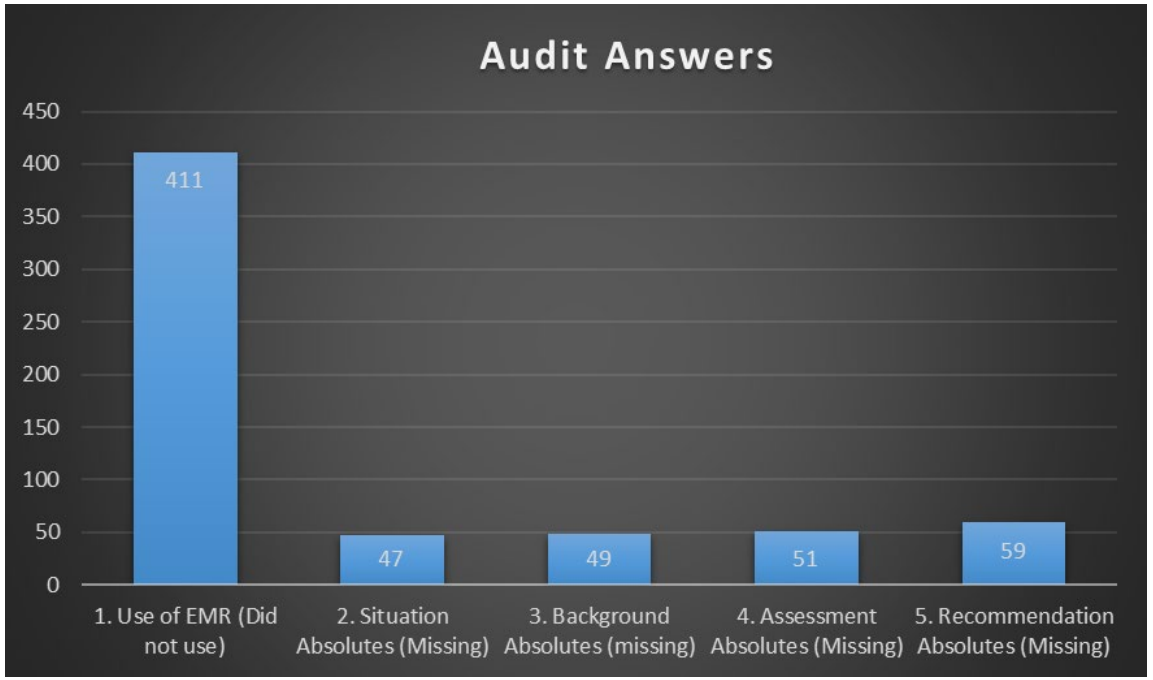
Handoff Audit

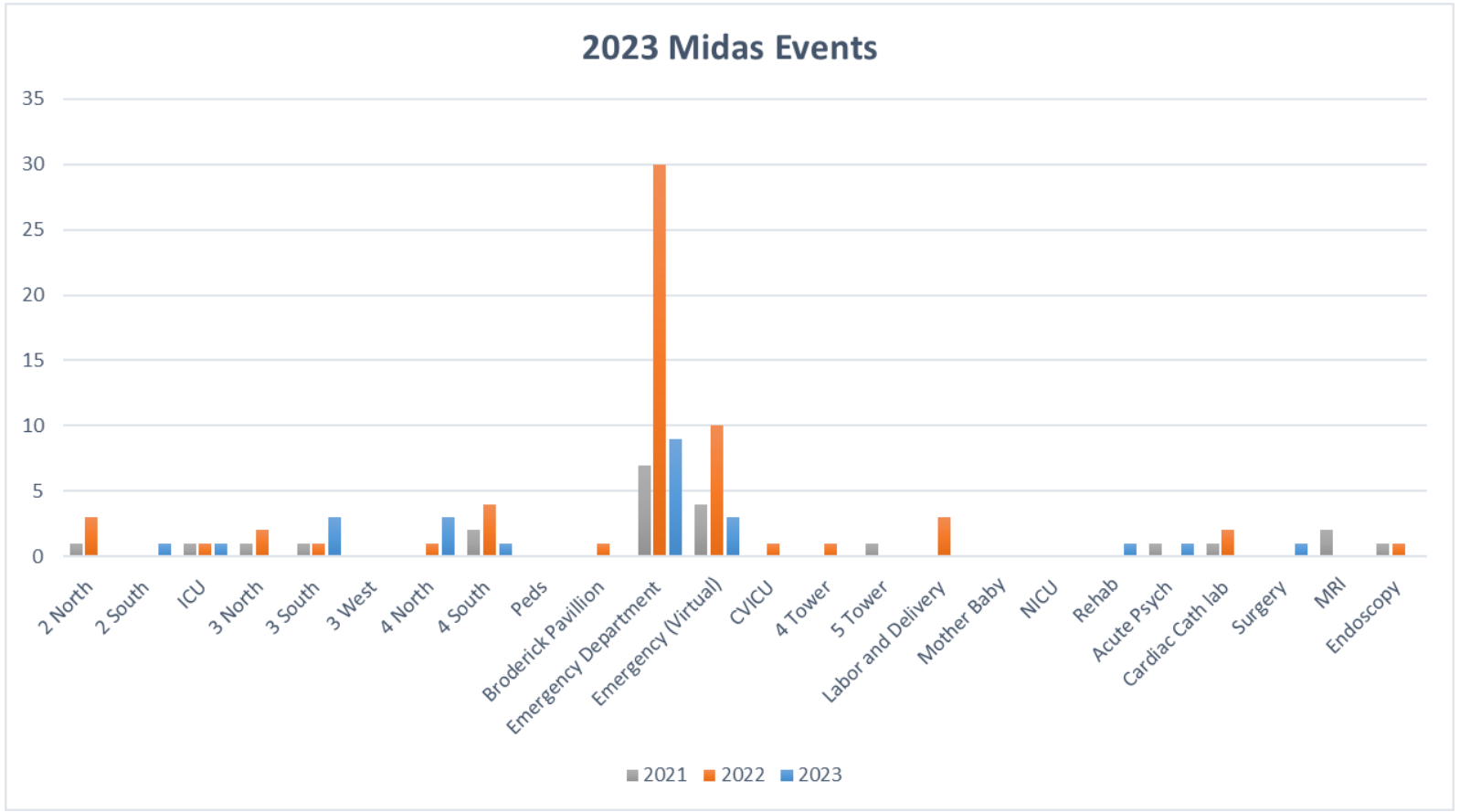
SBAR handoff Tracking	Benchmark	Partial Month Feb - 23	Mar - 23	Apr - 23	May - 23	June - 23	July - 23	Aug - 23
2 North	80%	93%	69%	68%	72%	100%	96%	100%
2 South	80%	94%	92%	96%	n/a	n/a	100%	n/a
ICU	80%	85%	72%	81%	64%	98%	92%	94%
3 North	80%	48%	75%	97%	97%	100%	n/a	n/a
3 South	80%	99%	97%	98%	n/a	n/a	n/a	96%
3 West	80%	92%	94%	91%	n/a	n/a	100%	n/a
4 North	80%	88%	92%	98%	n/a	n/a	n/a	96%
4 South	80%	72%	49%	74%	84%	99%	100%	n/a
Peds	80%	0%	75%	45%	98%	80%	90%	100%
Broderick Pavillion	80%	62%	80%	78%	77%	80%	80%	80%
Emergency Department	80%	99%	90%	85%	n/a	n/a	n/a	100%
CVICU	80%	80%	100%	95%	n/a	n/a	n/a	100%
4 Tower	80%	60%	92%	92%	88%	n/a	n/a	n/a
5 Tower	80%	100%	100%	100%	n/a	n/a	n/a	100%
Labor and Delivery	80%	n/a	n/a	n/a	n/a	48%	97%	99%
Mother Baby	80%	n/a	n/a	n/a	n/a	94%	99%	98%
NICU	80%	n/a	n/a	n/a	n/a	98%	100%	100%
Midas Event	0	5	3	1	5	3	2	2
Overall								
All Patients	80%	76.0%	78.1%	85.6%	82.9%	88.6%	94.3%	96.3%

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



	HANDOFF AUDIT			
DATE:	Unit/Floor:			
RN Giving Handoff:	RN Receiving Handoff:			
		Yes	**No**	**Why not?**
1	When giving report did you use the electronic SBAR Handoff tool? If no, why?	YES	NO	
	When receiving report did the nurse giving report give			**Missing**
2	**Situation Absolutes**: name, age, allergies, code status, admitting provider, diagnosis, and family/support?	YES	NO	
	If "NO", what was missing?			
3	**Background Absolutes:** pertinent history, meds and tx received, pertinent labs & results?	YES	NO	
	If "NO", what was missing?			
4	**Assessment Absolutes**: Head to Toe, Mobility, Risk Assessments/Precautions, V.S., Blood Glucose?	YES	NO	
	If "NO", what was missing?			
5	**Recommendation Absolutes:** Next Steps or Action List: any new orders/tests, clinical notes?	YES	NO	
	If "NO", what was missing?			

- The audit tool consists of 5 questions.
  1. If the nurse giving the report used the EMR for handoff.
  2. If they received the Situation Absolutes.
  3. If they received the Background Absolutes.
  4. If they received the Assessment Absolutes.
  5. If they received the Recommendation Absolutes.



- Year to date, we currently have 24 Midas events related to handoff, which is less than half of our 2022 totals (61 events).

Next steps

- Complete builds Surgical Services, Cardiac Services, and Behavioral health.
- Review potential needs for changes in the Handoff tool as the audit continues.
- Continue to monitor Midas Reports.

Questions?

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