December 6, 2019

# NOTICE

The Board of Directors of the Kaweah Delta Health Care District will meet in an open Quality Council Committee meeting at 7:00AM on Thursday December 12, 2019, in the Kaweah Delta Medical Center – Acequia Wing – Executive Office Conference Room {400 W. Mineral King, Visalia}.

The Board of Directors of the Kaweah Delta Health Care District will meet in a Closed Quality Council Committee meeting immediately following the 7:00AM Open Quality Council Committee meeting on Thursday December 12, 2019, in the Kaweah Delta Medical Center – Acequia Wing – Executive Office Conference Room {400 W. Mineral King, Visalia} pursuant to Health and Safety Code 32155 & 1461.

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

The disclosable public records related to agendas are available for public inspection at the Kaweah Delta 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 http://www.kaweahdelta.org.

KAWEAH DELTA HEALTH CARE DISTRICT
Nevin House, Secretary/Treasurer

Cindy Moccio
Board Clerk, Executive Assistant to CEO

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

**KAWEAH DELTA HEALTH CARE DISTRICT**
**BOARD OF DIRECTORS**
**QUALITY COUNCIL**
Thursday, December 12, 2019
Kaweah Delta Medical Center – Acequia Wing
400 W. Mineral King Avenue, Visalia, CA     Executive Conference Room

ATTENDING:     Herb Hawkins – Committee Chair, Board Member; Nevin House, Board Member; Gary Herbst, CEO; Regina Sawyer, RN, VP & CNO; Byron Mendenhall, MD, Chief of Staff; Monica Manga, MD, Professional Staff Quality Committee Chair; Daniel Hightower, MD, Secretary/Treasurer; Harry Lively, MD, Past Chief of Staff; Lori Winston, MD, DIO; Tom Gray, MD, Quality and Patient Safety Medical Director; Sandy Volchko, Director of Quality and Patient Safety; Evelyn McEntire, Director of Risk Management; Ben Cripps, Compliance and Privacy Officer, and Rosie Gonzales, Recording.

**OPEN MEETING – 7:00AM**

> **Call to order** – *Herb Hawkins, Committee Chair & Board Member*
>
> **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.
>
> 1. **Written Quality Reports –** A review of key quality metrics and actions associated with the following populations:
>
>    1.1. **Value-Based Purchasing Report**
>    1.2. **Patient Experience Report**
>    1.3. **Emergency Department Quality Report**
>    1.4. **Renal Service Quality Report**
>    1.5. **Subacute and Transitional Services Quality Report**
>    1.6. **Infection Prevention Quality Report**
>    1.7. **Hospital Acquired Pressure Injury Quality Focus Team Update**
>
> 2. **Emergency Department Quality Update** – A review of key measures and actions for the Emergency Department.  *Kona Seng, OD, Medical Director of Emergency Services, and Tom Siminski, RN Director of Emergency Services.*
>
> 3. **Update: Fiscal Year 2020 Clinical Quality Goals** - A review of current performance and actions focused on the FY 2020 clinical quality goals. *Sandy Volchko, RN, Director of Quality and Patient Safety.*
>
> 4. **Hospital Acquired Pressure Injury (HAPI) Quality Focus Team Report** – A review of current measures and actions focused on the reduction of HAPI.  *Rose Newsom, RN, Director of Nursing Practice.*

*Herb Hawkins – Zone I* *     *Lynn Havard Mirviss – Zone II* *   *John Hipskind, MD – Zone III* *     *David Francis– Zone IV* * *Nevin House– Zone V*
*Board Member*                     *President*                         *Vice President*                          *Board Member*              *Secretary/Treasurer*

5. **Approval of Quality Council Closed Meeting Agenda** – Kaweah Delta Medical Center Executive Conference Room – immediately following the open Quality Council meeting

   o **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461, report of Professional Staff Quality Committee (Pro-Staff) – *Monica Manga, MD, and Professional Staff Quality Committee Chair;*
   o **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461, report of Professional Staff Quality Committee (Pro-Staff) – *Evelyn McEntire, Director of Risk Management.*

**Adjourn Open Meeting** – *Herb Hawkins, Committee Chair & Board Member*

**CLOSED MEETING – Immediately following the 7:00AM open meeting**

**Call to order** – *Herb Hawkins, Committee Chair & Board Member*

1. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461, report of Professional Staff Quality Committee (Pro-Staff) – *Monica Manga, MD, and Professional Staff Quality Committee Chair*
2. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461, report of Professional Staff Quality Committee (Pro-Staff) – *Evelyn McEntire, Director of Risk Management.*

**Adjourn Open Meeting** – *Herb Hawkins, Committee Chair & Board Member*

*In compliance with the Americans with Disabilities Act, if you need special assistance to participate at this meeting, please contact the Board Clerk (559) 624-2330. Notification 48 hours prior to the meeting will enable the District to make reasonable arrangements to ensure accessibility to the Kaweah Delta Health Care District Board of Directors committee meeting.*

*Thursday December 12, 2019 – Quality Council*                                              *Page 2 of 2*

*Herb Hawkins – Zone I* *     *Lynn Havard Mirviss – Zone II* *   *John Hipskind, MD – Zone III* *     *David Francis– Zone IV* *  *Nevin House– Zone V*
*Board Member*                    *President*                        *Vice President*                    *Board Member*            *Secretary/Treasurer*

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# Value Base Purchasing
# FY 2020

KAWEAH DELTA HEALTH CARE DISTRICT

# Abbreviations

- CMS: Centers for Medicare and Medicaid Services

- DRG: Diagnosis Related Groups

- FY: Fiscal Year

- CY: Calendar Year

- TPS: Total Performance Score

- VPB: Value Based Purchasing

- AHRQ: Agency For Health Care Research and Quality

- PSI-90: Patient Safety Indicators-90

- SNF: Skilled Nursing Facility

- RRT: Rapid Response Team

# VBP  Payment Method

- *"The Hospital VBP Program is funded by a 2% reduction from participating hospitals' base operating diagnosis-related group (DRG) payments for FY 2018. Resulting funds are redistributed to hospitals based on their Total Performance Scores (TPS). The actual amount earned by each hospital depends on the range and distribution of all eligible/participating hospitals' TPS scores for a FY. It is possible for a hospital to earn back a value-based incentive payment percentage that is less than, equal to, or more than the applicable reduction for that program year."*

*CMS Quality Patient Assessment Instruments*



FY 2014
1.25%

FY 2015
1.50%

FY 2016
1.75%

FY 2017
2.00%
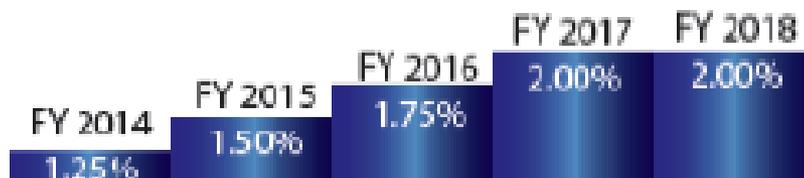
FY 2018
2.00%

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# Value Based Purchasing Measures
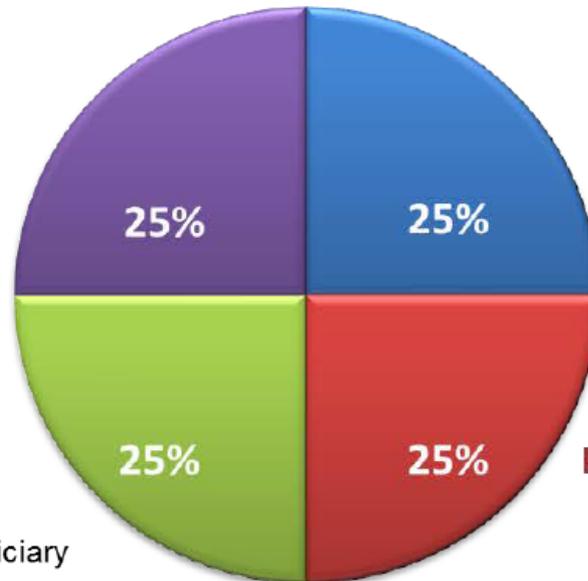## FY 2020 Payment (CY 2018 Reporting Period)

**Safety**

1. **CDI**: Clostridium difficile Infection
2. **CAUTI**: Catheter-Associated Urinary Tract Infection
3. **CLABSI**: Central Line-Associated Bloodstream Infection
4. **MRSA**: Methicillin-Resistant *Staphylococcus aureus* Bacteremia
5. **SSI**: Surgical Site Infection Colon Surgery & Abdominal Hysterectomy
6. **PC-01**: Elective Delivery Prior to 39 Completed Weeks Gestation

**Clinical Care**

1. **MORT-30-AMI**: Acute Myocardial Infarction (AMI) 30-Day Mortality Rate
2. **MORT-30-HF**: Heart Failure (HF) 30-Day Mortality Rate
3. **MORT-30-PN**: Pneumonia (PN) 30-Day Mortality Rate
4. **THA/TKA**: Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) Complication Rate

## Domain Weights



25% 25% 25% 25%

**Efficiency and Cost Reduction**

1. **MSPB**: Medicare Spending per Beneficiary

**Person and Community Engagement**

**HCAHPS Survey Dimensions**

1. Communication with Nurses
2. Communication with Doctors
3. Responsiveness of Hospital Staff
4. Communication about Medicines
5. Cleanliness and Quietness of Hospital Environment
6. Discharge Information
7. Care Transition
8. Overall Rating of Hospital

KAWEAH DELTA HEALTH CARE DISTRICT

# Kaweah Delta Performance
# FY 2020 Payment Performance

## VBP Total Performance Score

Legend: FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020

**Kaweah:** 43.21, 30.08, 25.5, 27.04, 26.37

**State:** 39.66, 34.63, 36.7, 37.4, 37.65

**National:** 40.47, 35.56, 37.43, 38.09, 38.52
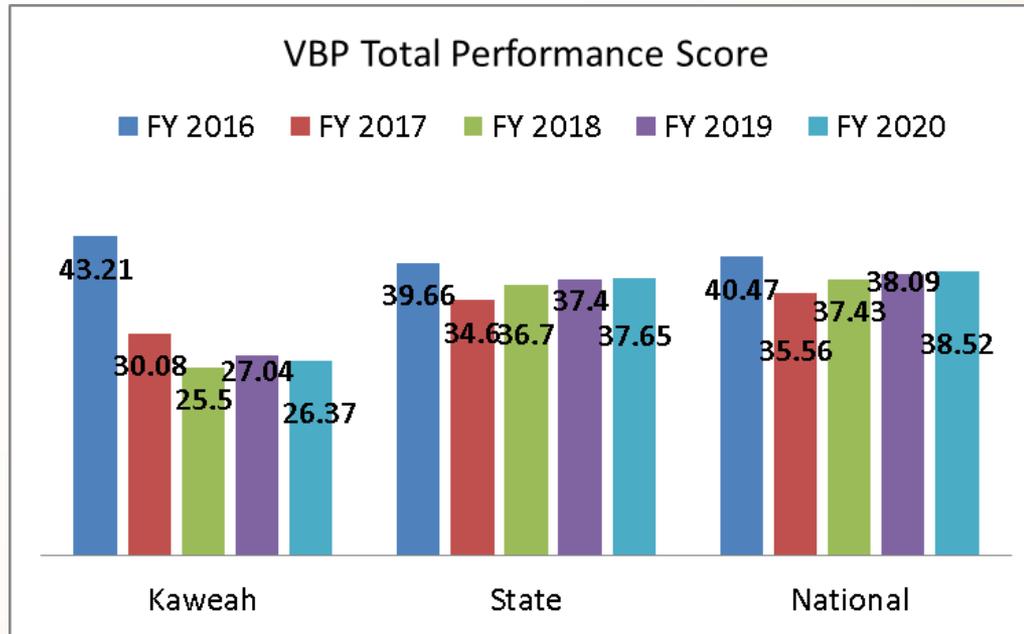
|  | Base Operating DRG Amount Reduction | Value-Base Incentive Payment % |
|---|---|---|
| **FY 2016** | 1.75% | 2.09% |
| **FY 2017** | 2% | 1.84% |
| **FY 2018** | 2% | 1.47% |
| **FY 2019** | 2% | 1.53% |
| **FY 2020** | 2% | 1.48% |

KAWEAH DELTA HEALTH CARE DISTRICT

# Actual Points & Costs

| | FY 2020 (Points Received) |
|---|---|
| **Clinical Outcomes - Domain Score** | **52.50%** |
| Acute Myocardio Infarction | 8 |
| Heart Failure | 1 |
| Pneumonia | 2 |
| Complication elective THA/TKA | 10 |
| **Safety - Healthcare Associated infections - Domain Score** | **20.00%** |
| CLABSI - Per 1000 line days | 0 |
| CAUTI - Per 1000 catheter days | 0 |
| SSI Colon - Rate Per 100 procedures | 0 |
| SSI Abdominal Hysterectomy - Rate Per 100 | 0 |
| C. difficile - Per 10,000 patient days | 7 |
| MRSA - Per 10,000 patient days | 0 |
| PC-01 Early Elective Deliveries | 5 |
| **Person and Community Engagement - Domain Score** | **13%*** |
| Communication with Nurses | 0 |
| Communication with Doctors | 0 |
| Responsiveness of Hospital Staff | 0 |
| Communication about Medicines | 0 |
| Cleanliness of Hospital Environment | 0 |
| Quietness of Hospital Environment | 0 |
| Discharge Information | 0 |
| Care Transition | 0 |
| Overall Rating of Hospital | 0 |
| **Efficiency and Cost Reduction-Domain Score** | **20.00%** |
| **Medicare Spending per Beneficiary** | 2 |

*Consistency Score

| FY 2020 VBP Cost Analysis | |
|---|---|
| Contribution | Payment Percentage |
| 2% = $1,669,200 | 1.48%=$1,236,376 |
| ($432,823) | |

# Action Plan & Teams

**Mortality**

- Mortality committee meets once month and has identified the largest improvement opportunity is earlier palliative care. Disease specific resource effectiveness teams are also working on best practices.

**Hip & Knee Complications**

- Orthopedic service line reviews all complications to assess if complications are true (re-code) and identify opportunities for improvement.

**Infection Prevention**

- Infection prevention has teams in each area meet every month.  In 2019, Kaweah implemented and IV safety team to round on all lines and monitor expired IVs.  Since this team, Kaweah  MRSA and CLABSI rates are trending down.

**Early Elective Deliveries**

- Implemented hard stop of scheduling early elective deliveries.

**Patient Experience**

- Implementation of  "Operation Always" with department specific  action plans, increased leader patient rounding, and use of new survey vendor in July 2019.

**Medicare Spending**

- Resource Effectiveness Committee teams are all working on efficiency and lowering costs.

KAWEAH DELTA HEALTH CARE DISTRICT

# Questions?

**KAWEAH DELTA HEALTH CARE DISTRICT**

## *Patient Experience – Excellent Service - HCAHPS*

The data is for patients discharged: **First Quarter 2018 through Fourth Quarter 2018**. 1469 surveys completed with a 21% response rate.

| HCAHPS Measure | Kaweah Delta Raw 1Q18-4Q18 | Kaweah Delta Mode Adj 1Q18-4Q18 | Kaweah Delta Full Adj 1Q18-4Q18 | CMS 50th percentile 1Q18-4Q18 | Kaweah Delta Mode Adj July-Aug 2019 | Comments/Improvement Efforts |
|---|---|---|---|---|---|---|
| **# of surveys** | - | **1469** | **1469** | - | 219 | - |
| **Communication with Nurses** | 84.9% | **81%** | **77% Below** | 81% | 76.92% | Opening and closing encounters Narrate the care Communication white boards |
| **Communication with Doctors** | 84.0% | **81%** | **74% Below** | 81% | 78.75% | Greet patients & companions with a smile Sit at the bedside Conclude with "Is there anything else I can do for you?" |
| **Responsiveness of Staff** | 70.2% | **69%** | **63% Below** | 70% | 68.48% | Hourly Rounding Proactive toileting |
| **Communication about Meds** | 69.5% | **68%** | **61% Below** | 66% | 58.52% | Medicine Guide |
| **Cleanliness of Environment** | 70.5% | **68%** | **67% Below** | 75% | 68.35% | Linen delivery revamp EVS competency re-validation |
| **Quietness of Environment** | 64.8% | **56%** | **48% Below** | 62% | 52.27% | *No new interventions* |
| **Discharge Information** *(Yes)* | 89.2% | **88%** | **85% Within** | 87% | 90.86% | Medicine Guide Use discharge advocates to onboard new admits of preferences and expectations Implement solution for Discharge Phone Calls Rebuild Discharge Instructions (Fall 2019) |
| **Care Transition** *(Strongly Agree)* | 50.5% | **50%** | **46% Below** | 53% | 46.76% | *Same as above* |
| **Overall Rating of Hospital** (0 = worst; 10 = best) | 76.2% | **74% (9 or 10)** | **69% (9 or 10) Below** | 73% | 76.85% | **OPERATION ALWAYS** *Purpose: Consistently provide world-class service* →Department-specific action plans reviewed by Executive Team **→Increase leader rounding on patients** →Regular monthly data and comments →New Survey Vendor: JL Morgan →Launch Gold Star Discharge Program (early discharges home) →New patient menu |
| **Willingness to Recommend** *(Definitely Recommend)* | 76.2% | **73%** | **68% Within** | 72% | 74.39% | *Same as above* |

**Legend:** 🟩 *Above or at benchmark*  🟧 *Within 3% of benchmark*  🟥 *Below benchmark by more than 3%*
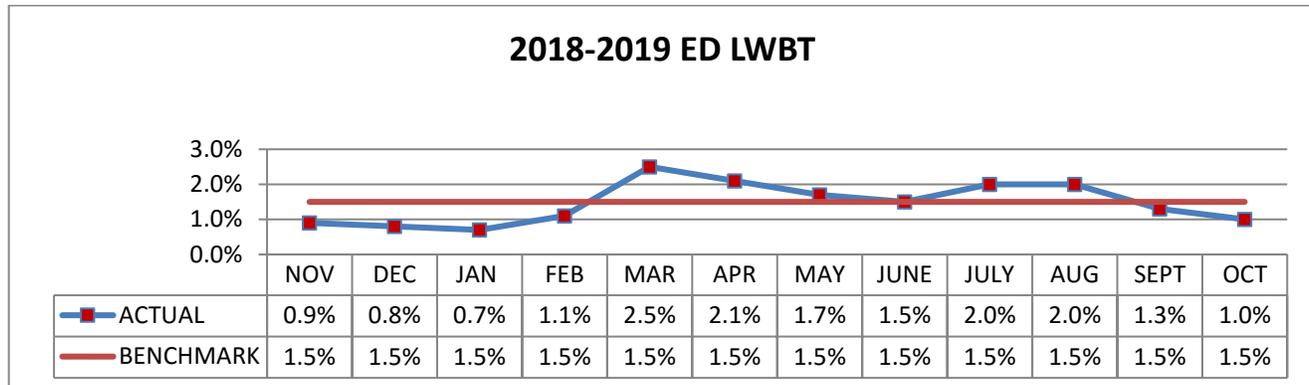
# Unit/Department Specific Data Collection Summarization
## Pro Staff Committee

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**Unit/Department:**      **Emergency Department**
**Report Date:**          <mark>NOVEMBER  2019</mark>
**Reporting Period**      <mark>NOVEMBER 2018 –OCTOBER 2019</mark>
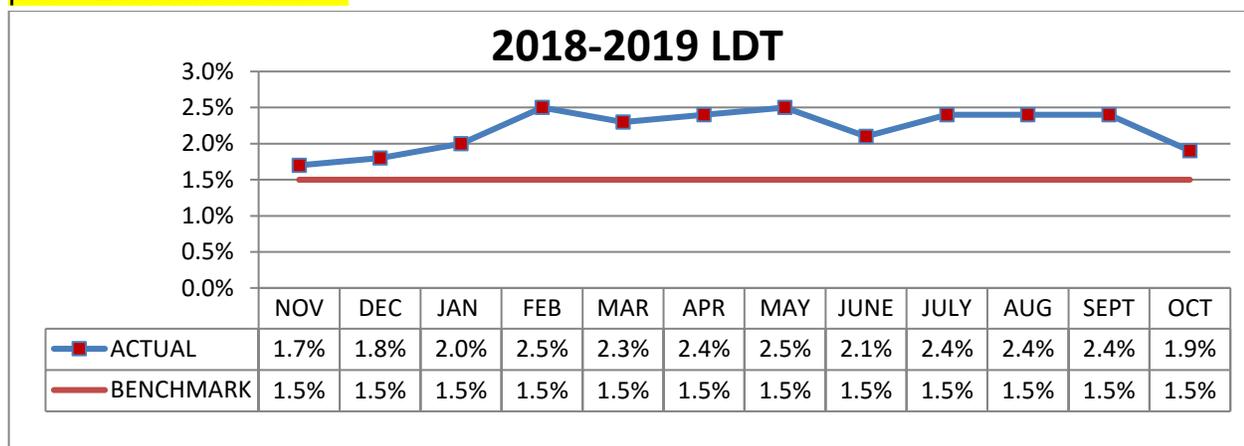
## Measure Objective/Goal

**ED Left without Being Treated rate**, *internal benchmark 1.5%,* <mark>actual observed average for the past 12 months is</mark> ***1.5%***

### 2018-2019 ED LWBT

| | NOV | DEC | JAN | FEB | MAR | APR | MAY | JUNE | JULY | AUG | SEPT | OCT |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ACTUAL | 0.9% | 0.8% | 0.7% | 1.1% | 2.5% | 2.1% | 1.7% | 1.5% | 2.0% | 2.0% | 1.3% | 1.0% |
| BENCHMARK | 1.5% | 1.5% | 1.5% | 1.5% | 1.5% | 1.5% | 1.5% | 1.5% | 1.5% | 1.5% | 1.5% | 1.5% |

The LWBT rate has decreased from 1.6% for the previous 12 months to 1.5% over the most recent 12 months.

Action: 1) medical providers are staffed in the PAT area to initiate evaluation, diagnostics and interventions; 2) dedicated space for re-evaluations to expedite dispositions and discharges 3) staffing a dedicated 24/7 phlebotomy in the ED 4) hired Patient Navigator to help improve front end patient flow, communication and updating patients in the Lobby 5) opened Zone 6 in August 2019 as Fast Track to treat lower acuity patients 6) implemented Flow Coordinator (2nd Charge Nurse) to direct patient flow to improve efficiency and communication and decrease disposition and discharge times

**ED Left during Treatment rate,** *internal benchmark of 1.5%,* <mark>actual observed average for the past 12 months is</mark> ***2.2 %***

### 2018-2019 LDT

| | NOV | DEC | JAN | FEB | MAR | APR | MAY | JUNE | JULY | AUG | SEPT | OCT |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ACTUAL | 1.7% | 1.8% | 2.0% | 2.5% | 2.3% | 2.4% | 2.5% | 2.1% | 2.4% | 2.4% | 2.4% | 1.9% |
| BENCHMARK | 1.5% | 1.5% | 1.5% | 1.5% | 1.5% | 1.5% | 1.5% | 1.5% | 1.5% | 1.5% | 1.5% | 1.5% |

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

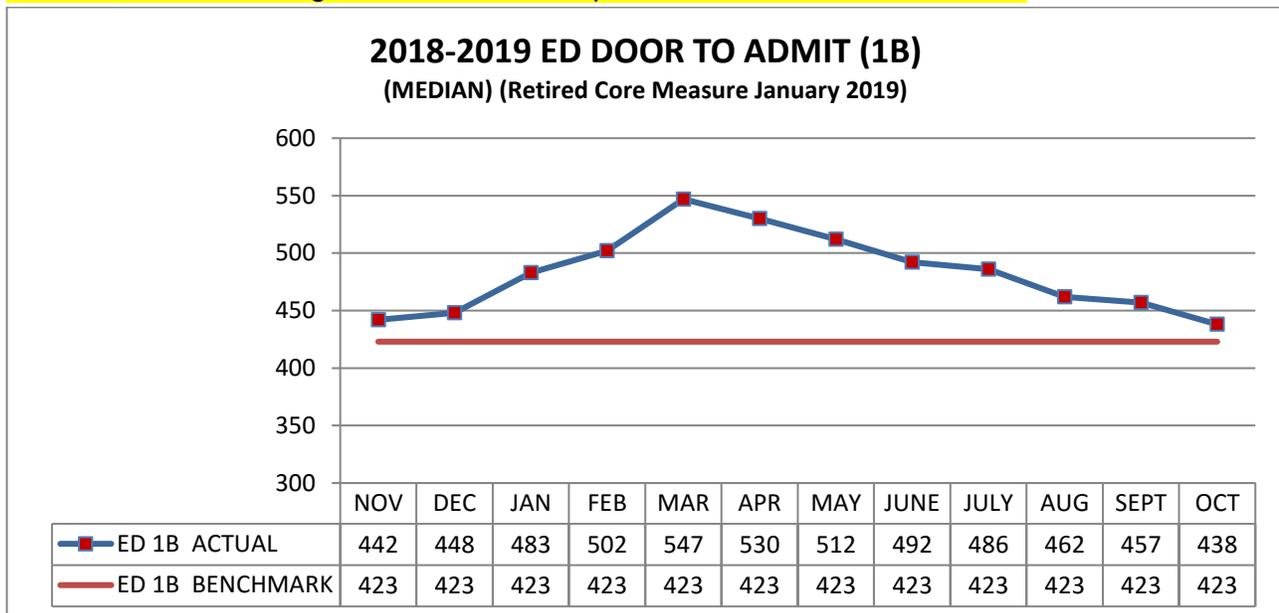The LDT rate has decreased from 3% for the previous 12 months to 2.2% over the most recent 12 months.

Action: 1) medical providers are staffed in the PAT area to initiate evaluation, diagnostics and interventions; 2) dedicated space for re-evaluations to expedite dispositions and discharges 3) staffing a dedicated 24/7 phlebotomy in the ED 4) Hired Patient Navigator to help improve front end patient flow, communication and updating patients in the Lobby 5) opened Zone 6 in August 2019 as Fast Track to treat lower acuity patients 6) Implemented Flow Coordinator (2nd Charge Nurse) to direct patient flow to improve efficiency and communication and decrease disposition and discharge times

*Median time from ED arrival to ED departure for admitted patients*, *CMS Benchmark* 423-minutes, actual average observed for the past 12 months is **483-**minutes.

### 2018-2019 ED DOOR TO ADMIT (1B)
**(MEDIAN) (Retired Core Measure January 2019)**

| | NOV | DEC | JAN | FEB | MAR | APR | MAY | JUNE | JULY | AUG | SEPT | OCT |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ED 1B ACTUAL | 442 | 448 | 483 | 502 | 547 | 530 | 512 | 492 | 486 | 462 | 457 | 438 |
| ED 1B BENCHMARK | 423 | 423 | 423 | 423 | 423 | 423 | 423 | 423 | 423 | 423 | 423 | 423 |

The ED Door to Admit Time has decreased from 513 minutes for the previous 12 months to 483 minutes over the most recent 12 months
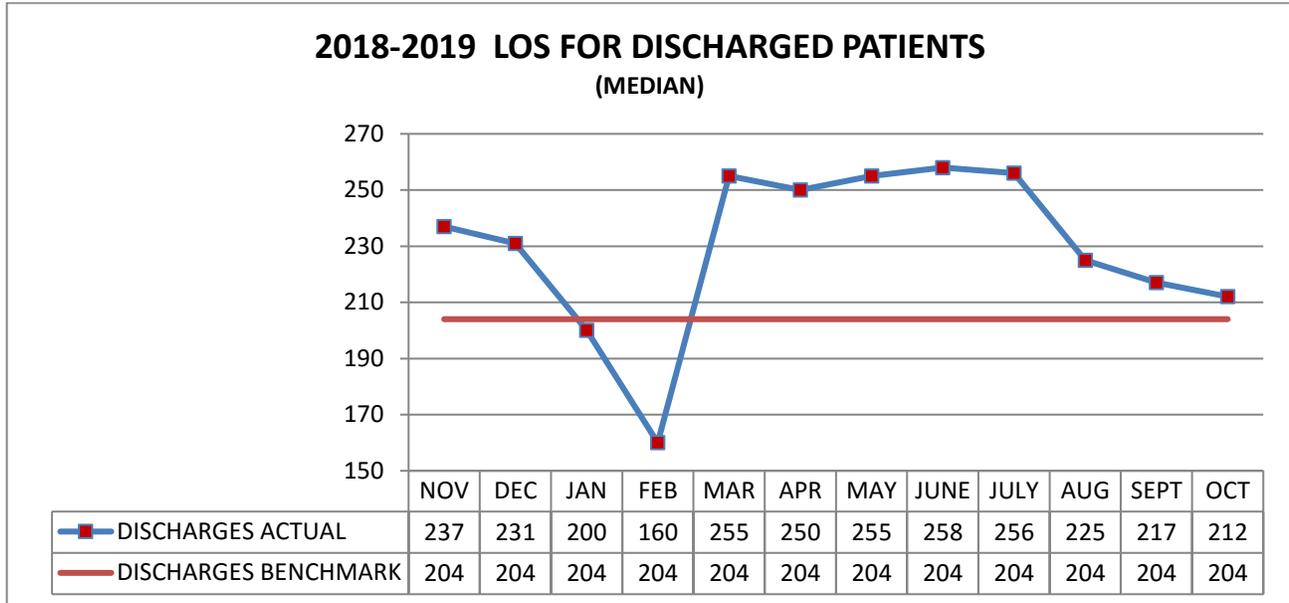
Action: 1) ED Leadership has worked closely with our inpatient team as part of the Resource Effectiveness Committee (REC) to address the LOS issues. 2) Established ED Huddles on each shift to provide a venue for the ED Charge Nurse, ED Leadership, ED providers, and the House Supervisors to identify opportunities to improve patient throughput

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

**Median time from ED arrival to ED departure for discharged patients,** *CMS Benchmark* 204-minutes, actual average observed for the past 12 months is **230**-minutes.

### 2018-2019  LOS FOR DISCHARGED PATIENTS
#### (MEDIAN)

| | NOV | DEC | JAN | FEB | MAR | APR | MAY | JUNE | JULY | AUG | SEPT | OCT |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| DISCHARGES ACTUAL | 237 | 231 | 200 | 160 | 255 | 250 | 255 | 258 | 256 | 225 | 217 | 212 |
| DISCHARGES BENCHMARK | 204 | 204 | 204 | 204 | 204 | 204 | 204 | 204 | 204 | 204 | 204 | 204 |

The ED Door to D/C time has decreased from 273 minutes for the previous 12 months to 230 minutes for the most recent 12 months.
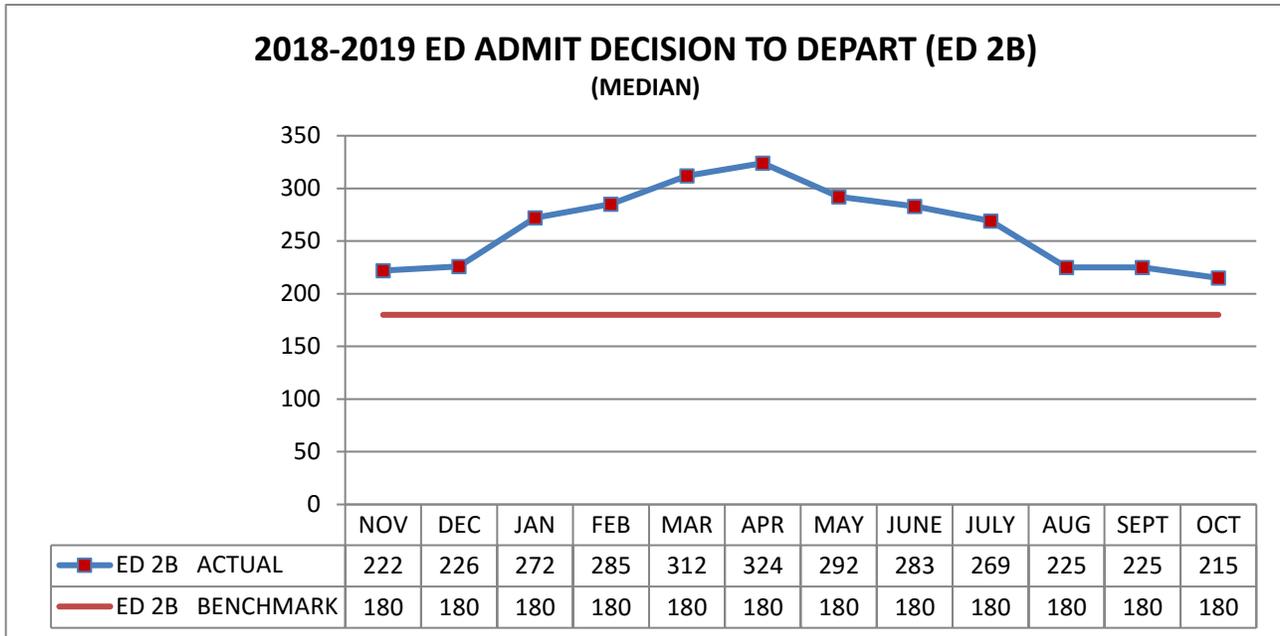
Action: 1) medical providers are staffed in the PAT area to initiate evaluation, diagnostics and interventions, 2) staffing a dedicated 24/7 phlebotomy in the ED, 3) Initiate process to expedite HCG testing and IV starts to improve efficiency in getting CT Scans done, 4) opened Zone 6 in August 2019 as Fast Track to treat lower acuity patients, 5) Implemented Flow Coordinator (2nd Charge Nurse) to direct patient flow to improve efficiency and communication and decrease disposition and discharge times 6) Established ED Operations Committee in October 2018 to address and improve ED operational issues. To date the committee has worked on improving lab turnaround times, CT and X-ray turnaround times, improved utilization of diagnostic studies to reduce duplication of lab studies, and increased utilization of POC testing to improve throughput

**Admit Decision Time to departure for admitted patients,** *CMS Benchmark180*-minutes, actual average observed for the past 12 months is **263**-minutes.

*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
## Pro Staff Committee

### 2018-2019 ED ADMIT DECISION TO DEPART (ED 2B)
#### (MEDIAN)

| | NOV | DEC | JAN | FEB | MAR | APR | MAY | JUNE | JULY | AUG | SEPT | OCT |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ED 2B ACTUAL | 222 | 226 | 272 | 285 | 312 | 324 | 292 | 283 | 269 | 225 | 225 | 215 |
| ED 2B BENCHMARK | 180 | 180 | 180 | 180 | 180 | 180 | 180 | 180 | 180 | 180 | 180 | 180 |

The ED Admit Decision Time to departure for admitted patients has increased from 234 minutes for the previous 12 months to 263 minutes for the most recent 12 months.

Actions to address the patient census and delay in movement: 1) Hired additional RNs and EDTs. 2) With the continued boarding of patients in the ED along with increased LOS from admit decision to depart the ED continues to use 1-East Nurses to care for and support the initiation of the admitting physician orders that are considered appropriate to starting in the ED. 3)The ED does not have a dedicated transport person in the ED any longer due to a change in transport operations which has led to delays in getting patients transported to the floors.( ED Leadership is working with transport leadership to assess the changes and the need for improvement in the process) 4) Working with Case Management and the ED providers to improve the workflow to expedite orders for admission to expedite the bed assignment process. 5) Working with the Inpatient Directors to evaluate and improve the efficiency of the Nurse to Nurse report process.

*CT results within 45 minutes of ED arrival for stroke patient:*; *NSQI Benchmark <45* minutes These results are captured and reported by the Stroke Program.

Actions: Stroke QFT reviews data monthly to address system issues to improve the timeliness of the CT order and interpretation. Order sets have been developed and deployed to ED providers to utilize on stroke alerts.

*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
Pro Staff Committee

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**Date range of data evaluated:** <mark>NOVEMBER 2018 – OCTOBER 2019</mark>

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

ED LWT and LDT have shown improvement from previous 12 months to the most recent 12 months**.** Length of stay for inpatient admissions and discharged patients has shown improvement from the previous 12 months to the most recent 12 months. The PAT process has improved the door to provider evaluation time which has helped with decreasing the length of stay for discharged patients.

Our mid to long term solutions include the following: the build out of the 9 bed Zone 4 which is on schedule to open early 2020 and the additional 24-bed Zone 5 addition which is on track to be completed in October 2020.
External of the Emergency department the infill project for the 5th floor Acequia a 24-bed inpatient unit adding capacity for medical surgical beds as well as intermediate critical care beds.

**Time from ED Admit Decision to ED Departure.** Working on a process to improve communication between providers and nurses to organize and enhance the admission process. Continue to investigate options with the Resource Effectiveness Committee to help facilitate throughput and significantly decrease LOS for admitted patients. Work with transportation leadership to address delays in transporting patients to the floors. Work with Inpatient leadership to improve the efficiency of the nurse to nurse report.

**Next Steps/Recommendations/Outcomes:**

**The demand for ED services remain high. In order for the ED to meet this demand for services, our ED leadership team will continue to work with the ED Operations Committee to evaluate processes and redesign processes to improve patient satisfaction, patient care, and patient throughput.**

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

Continue to work on the plan and the design on the operational processes for Zone 4 along with the new Zone 5 -24-bed unit to the ED.

Continue to work on getting data in regards to imaging and lab turnaround times to assess for areas of delay.

Continue to work with Mental Health Leadership to improve triage and disposition of Mental Health patients to decrease length of stay.

Continue to work with Case Management/Providers to improve efficiency in the process of putting ED admits into Tele-tracking.

Continue to work with Dr. Said to improve communication between the ED and the hospitalists to decrease delays in ED admissions.

Continue to work on getting real time data to aid in managing for daily improvement.

Continue to monitor the progress of Zone 6 to ensure a positive impact on patient experience and length of stay.

Continue to monitor and evaluate the 2nd charge nurse/flow coordinator role to help improve patient flow and throughput.

Continue to investigate options to help facilitate throughput and significantly decrease LOS for discharged patients and admitted patients.

Continue work within the Surge/Throughput committee to improve patient movement from ED to admit unit, discharges from the ED and management of volume surges.

**Submitted by Name:**      Tom Siminski      **Date Submitted:  December 2nd, 2019**

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

# Kaweah Delta Visalia Dialysis Facility Quality Assessment and Performance Improvement (QAPI)

The QAPI committee includes the district renal services director, medical director, facility manager, staff nurses, dieticians, social workers, data analyst, technicians and patients. The committee meets monthly and reviews data, regulatory issues, promulgates policy and procedures to improve outcomes, etc.

## Standing Agenda items

### Regulatory
Network 18 BSI (Blood Stream Infection)/Catheter Reduction/Patient Engagement Project 2019 Audits
QIP (Quality Incentive Program through Centers for Medicare/Medicaid Services (CMS)) measures review

### Patient Outcomes
Vascular Access
Infection
Adequacy of dialysis
Hospitalizations/Readmissions
Vaccinations
Mortalities
Anemia management
KDQOL (Kidney Disease Quality of Life) survey
Transplant Report
Ultrafiltration Rate

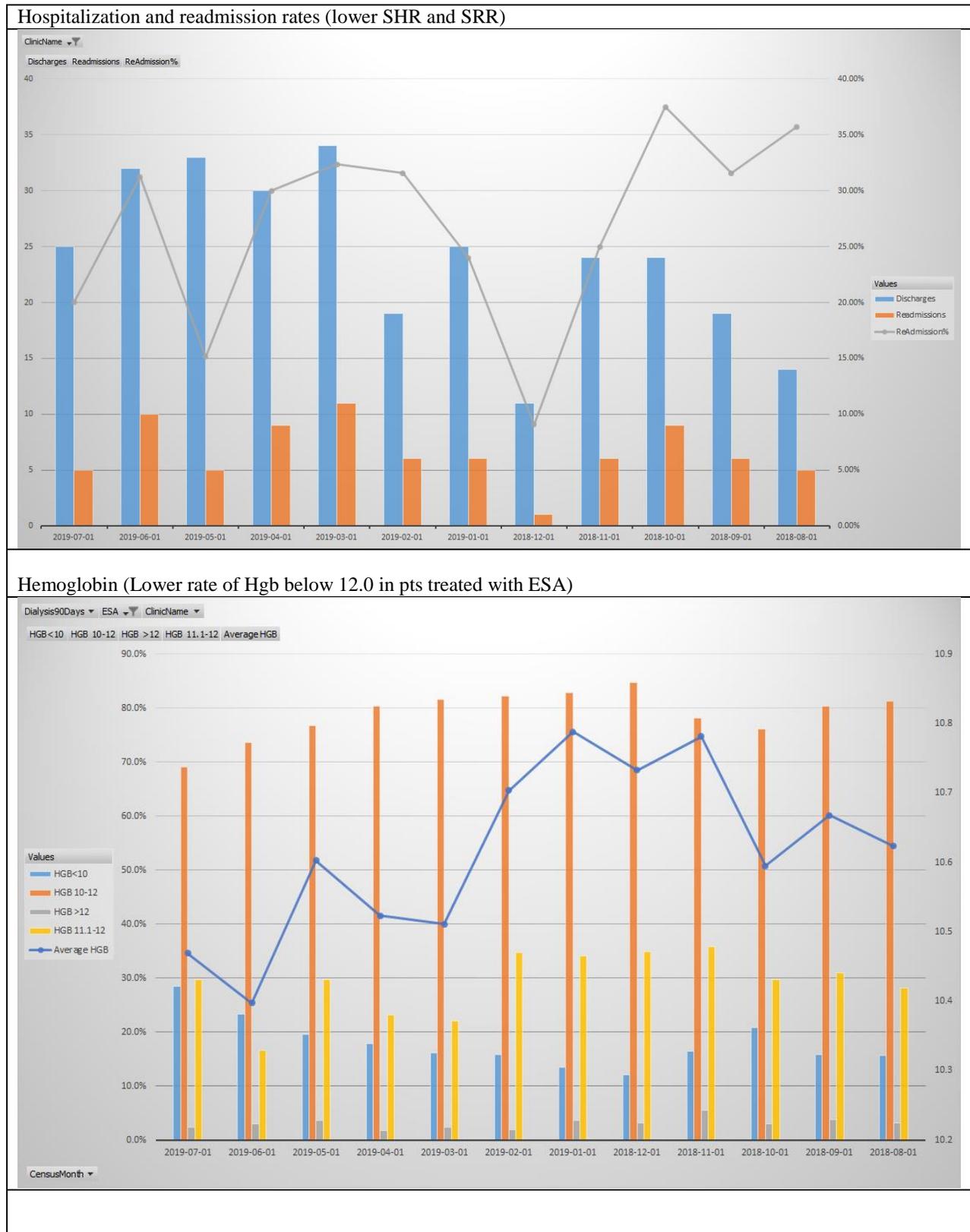### Facility Maintenance
Water Quality

### Patient Reported
Medical Errors & Occurrences
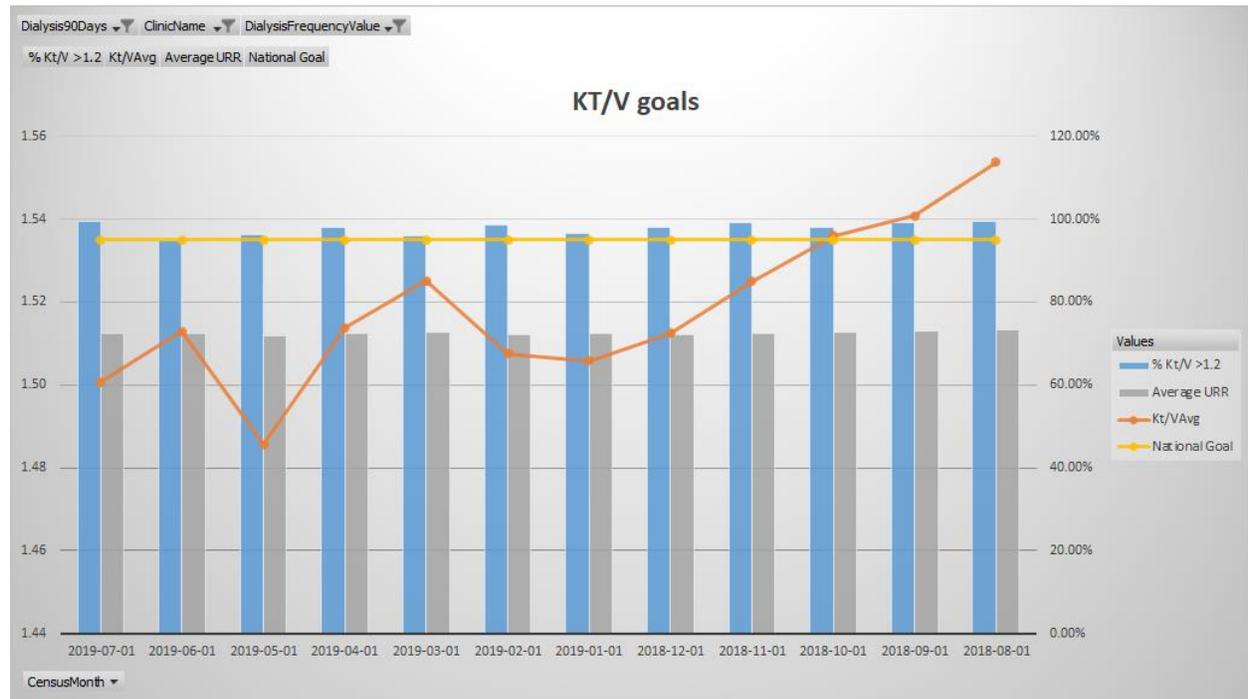Patient Complaints/Grievances

### Education

### Policy/Protocol/Order Set Review
Changing Prescribed Treatment Plan/Time Based on Patient Preferences
Continuity of Care
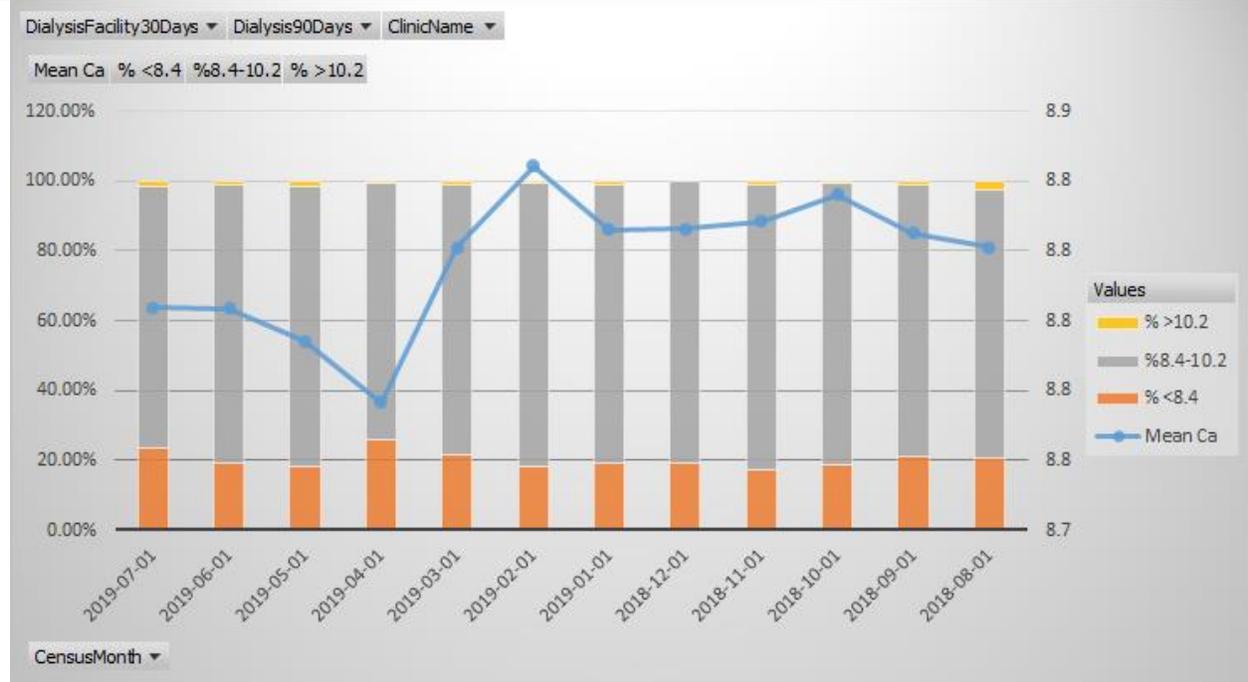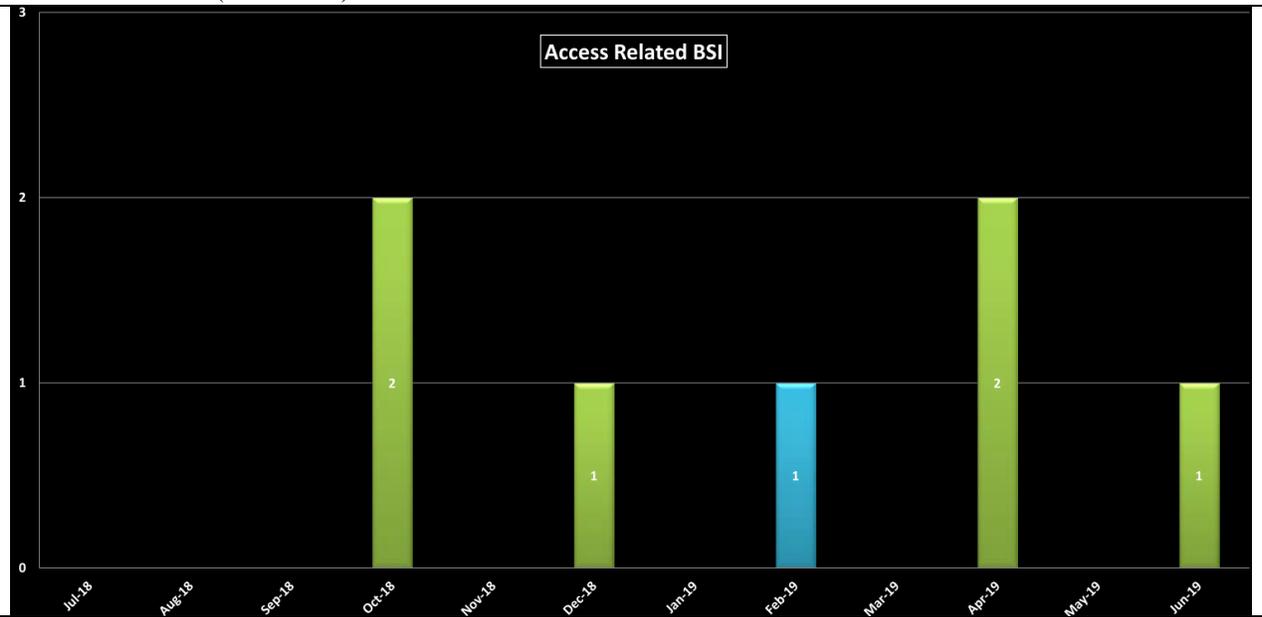
# Examples of Recent results:

**Hospitalization and readmission rates (lower SHR and SRR)**



**Hemoglobin (Lower rate of Hgb below 12.0 in pts treated with ESA)**

Adequacy (KT/V rates > 1.2)



Serum calcium (keep Ca below 10.2)

## Access relates BSI (lower rates)



Access Related BSI

## Adequacy interventions (move rechecks above goal)



QIP - Education/No Intervention/Recirculation Study — No Intervention, Goal 1.2

QIP - Increase BFR/Change DFR to 2x BFR — BFR Increased, Goal 1.2

QIP - Larger Dialyzer/Increase Tx Time — Larger Dialyzer, Goal 1.2

QIP - Cathflo and/or Access Eval/Heparin Increase — Alteplase, Goal 1.2

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**Hospitalizations - Top Discharge Categories**

Legend:
- Neurological
- Gastrointestinal
- Other
- Musculoskeletal
- Respiratory
- Cardiovascular

| Category | Jan | Feb | Mar | Apr | May | Jun |
|---|---|---|---|---|---|---|
| Neurological | 2 | 0 | 5 | 2 | 3 | 1 |
| Gastrointestinal | 0 | 3 | 2 | 4 | 3 | 3 |
| Other | 2 | 2 | 4 | 0 | 6 | 1 |
| Musculoskeletal | 2 | 1 | 6 | 3 | 5 | 7 |
| Respiratory | 4 | 5 | 8 | 5 | 6 | 4 |
| Cardiovascular | 5 | 5 | 10 | 7 | 12 | 5 |

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**QIP Readmission Rate**

Legend:
- Discharges
- Readmissions
- Readmission Rate
- Linear (Readmission Rate)

| | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Discharges | 13 | 23 | 10 | 17 | 24 | 24 | 11 | 27 | 19 | 35 | 30 | 33 |
| Readmissions | 1 | 9 | 2 | 3 | 4 | 5 | 1 | 1 | 1 | 6 | 3 | 5 |
| Readmission Rate | 8% | 39% | 20% | 18% | 17% | 21% | 9% | 4% | 5% | 17% | 10% | 15% |

# # of Mortalities

| | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 3 | 10 | 1 | 2 | 4 | 3 | 4 | 2 | 3 | 3 | 6 | 0 |

## Mortalities Tracking Tool

Legend:
- Cardiac
- Unknown
- Other
- Vascular
- Infection
- Metabolic

| Month | Cardiac | Infection | Other | Vascular | Metabolic | Unknown |
|---|---|---|---|---|---|---|
| Jul | 2 | | | | | |
| Aug | 6 | | 2 | 1 | 1 | |
| Sep | | 1 | | | | |
| Oct | | 1 | 1 | | | |
| Nov | 2 | | 1 | 1 | | |
| Dec | 2 | | | | | |
| Jan | 2 | 1 | 1 | | | |
| Feb | 2 | | | | | |
| Mar | | | | | | 3 |
| Apr | | | | | | 3 |
| May | 1 | | 1 | 1 | | 3 |
| Jun | 0 | | | | | |

**Unit/Department:**  Sub Acute, TCS, and SS Rehab **Report Date:  Oct., 2019**

**Measure Objective/Goal:**

1.  Falls (internal data),
2.  Pressure Injuries (internal data)
3.  Self-reported Moderate/Severe Pain (MDS/Casper)
4.  Psychoactive medication use (MDS/Casper)

**Date range of data evaluated:**

All categories are from the Report Period: 04/01/18-09/30/19. Comparison group: Casper Report from 10/14/2019 for time period 02/01/19-07/31/19, and 1st quarter 2018 through 2nd quarter 2019, internal data.

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

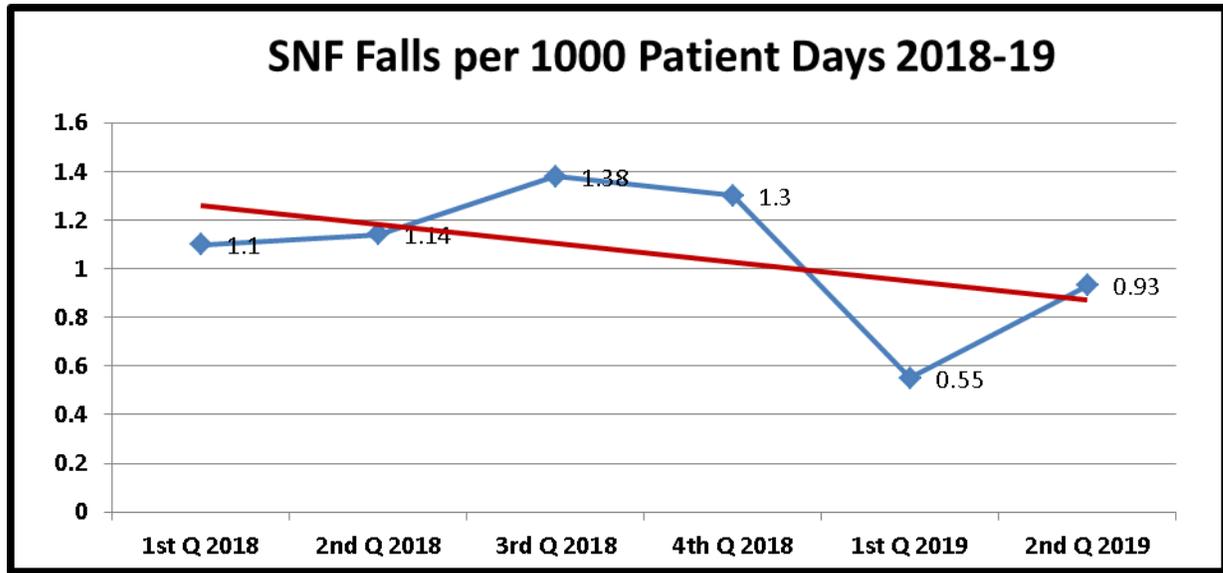## Analysis of all measures/data:  (Include key findings, improvements, opportunities)

### *Measure Objective/Goal: Falls*

The rate of falls per 1000/pt. days for 2018 through 2$^{nd}$ quarter 2019 shows an overall down-trend over time.   Typical fall incidence per quarter for the (combined) units has been maintained at 5-6 per quarter for the past two years. CASPER is the only available national benchmark for this measure.  Facility observed percent for falls for long stay patients in the most current CASPER report is 3.1%, remaining well below national average of 45.6%, placing the program in the top 1 percentile nationally.

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

## SNF Falls per 1000 Patient Days 2018-19



Data points: 1st Q 2018: 1.1; 2nd Q 2018: 1.14; 3rd Q 2018: 1.38; 4th Q 2018: 1.3; 1st Q 2019: 0.55; 2nd Q 2019: 0.93

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

Staff continues to participate in, and has a high rate of compliance with, district-wide initiatives for fall prevention. The skilled nursing units have many mobile patients and also a "no restraint" environment. While falls are infrequent, they do occur most commonly with our short-stay population, all of whom are involved with therapy programs to enhance functional mobility. We will continue full participation in the Kaweah Delta fall prevention protocols.

### *Measure Objective/Goal: Pressure Injuries*

a. There was one pressure injury stage 2, new or worsened (HAPI) reported for 2nd quarter internal data for the two departments typically housing our shorter stay clients (Transitional Care and Short Stay Rehab). Incidence of new or worsening pressure ulcers for short stay patients (which would also include Sub Acute patients with a length of stay under 100 days) as reported on the Casper report is 0.0%, well below the national average of 0.7%. This puts us at the "0" percentile nationally.

b. Patients at High risk for Pressure Ulcers (Long Stay residents, defined as high risk, who have Stage II-IV pressure ulcers) showed a decrease to 6.3% from 18.2% the prior year. This puts us at the 41st[h] percentile. The definition for this long-stay
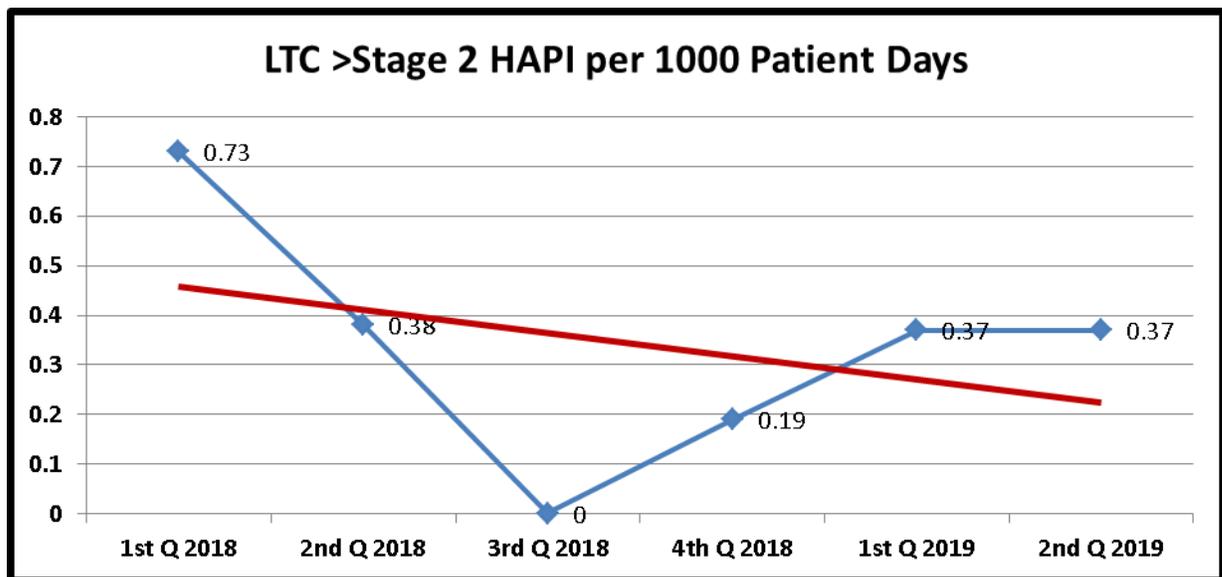
*Please submit your data along with the summary to your PI liaison 2 weeks prior to the scheduled report date.*

quality measure asks if a wound is present, not if it is acquired by the facility. This is particularly challenging in a program that preferentially admits cases with pressure ulcers for ongoing treatment. The measure is triggered until the wound is completely healed (and through the 6 month report period). Very large wounds that have healed down to very small, chronic wounds will continue to trigger this measure. So, it is common to see a delay in improvement on the CASPER report, while seeing improvement more immediately in our internal data.

c. Internal data from 2018 through 2nd quarter 2019 shows a decline in total HAPI across all settings from 19 in 2017 to 7 for 2018. Overall, the total SNF rate per 1000/pt. days for 2018 was 0.89; year-to-date for 2019 we are at an average of 0.37. All three SNF units participate in KD prevalence studies quarterly. No unexpected wounds were identified during prevalence studies during the past 6 quarters (all skin injuries had been captured by staff during routine assessments).



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

a. We will continue to participate actively in district-wide HAPI prevention plan. We will continue to work within the high standards of the District, with close

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

management of our fragile, chronic wound cases, partnering closely with the wound nurses and utilizing the standardized treatment sets available to us.

b. UBC teams for South Campus nursing will continue to monitor progress on this and review clinical cases using a Peer review methodology to assess for and remediate practice concerns.

### *Measure Objective/Goal: Self reported Moderate/Severe Pain:*

**Definitions/Assumptions:**

This measure is collected through the Minimum Data Set (MDS) assessments that are completed and submitted to CMS at defined intervals by the program. All values are expressed in percentile rankings. This particular element is collected through patient interview. Statistically, the numerator is defined by the number of patients interviewed, and the denominator is defined as those patients that report experiencing moderate to severe pain at any time in the three days prior to the interview date. In essence, this particular query to the MDS does not ask how effectively we treat or respond to pain, but whether the patient has an experience of pain.

Since the indicator is a straight percentage to reporting census, it is significantly impacted by both the size of the inpatient census at any given time, as well as the census characteristics at any given time.

Given the current environment around opioid prescription and use, it is uncertain that this will continue to be considered a national quality indicator for skilled nursing. CMS has added a query to the MDS regarding number of total doses given to residents during their assessment reference period (as of Oct. 1. 2017). They will be coming into their third year of data collection around prescription and dosing.

**Short Stay residents (<100 days)** The facility adjusted percent is 24.3%, an increase from 17%. The national average is 11.3%. This puts us at the 87th percentile currently (prior ranking was 72nd percentile). This continues to be one of our most challenging quality measures, because it is driven entirely by resident self-reports of pain, and our short stay population does have a high percentage of post-surgical cases.

*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

**Long Stay residents:** The facility adjusted percent increased to 22.5% from 16.1% the prior quarter. The national average is 6.1%, and percentile ranking is the 96th percentile (up from 88).   The particular challenge for the program is largely a statistical one.  With a denominator of only 13 patients able to participate in the interview (average long term census equals 35), and 4 patients (all with known, chronic pain syndromes) as our numerator, our results are disproportionate to the actual percent of long-term residents. The change between 1st and 2nd quarter in 2019 represents a single patient.
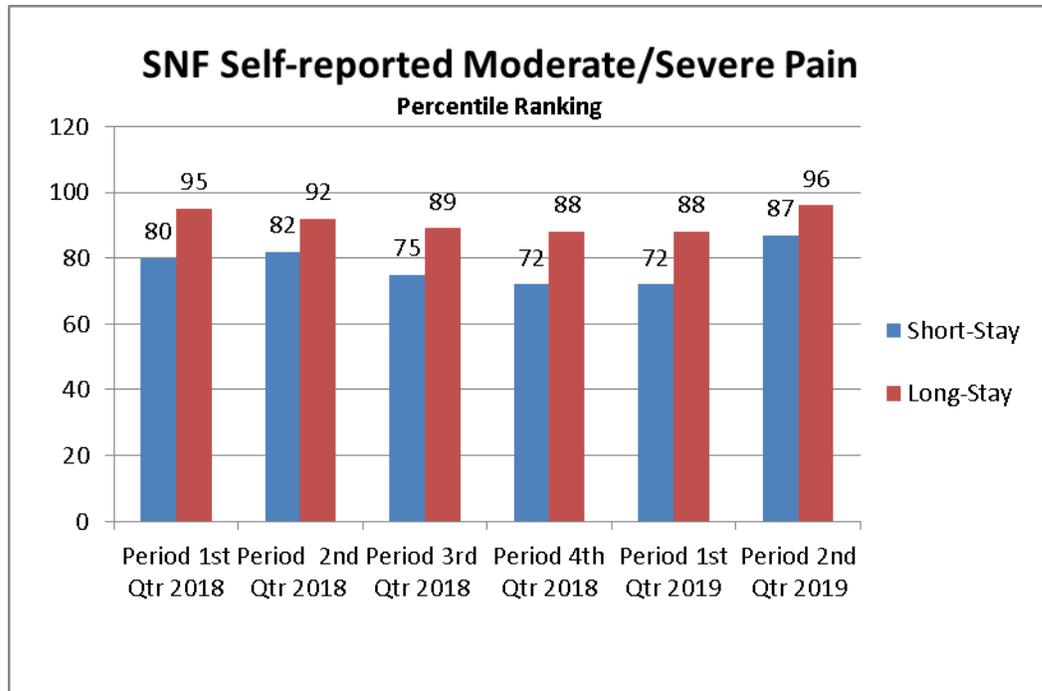


**If improvement opportunities identified, provide action plan and expected resolution date:**

MDS nurses will continue to use language developed by pain management pharmacists for assessing self-reported pain by short-term residents.  This quality measure will continue to be a challenge to the program, as target customers are frequently post-surgical cases.

Annual changes to MDS instrument expected in Oct 2019 did not include any changes to collection methodology for this measure.  However, there is more data being collected around prescription, dosing, and medication reconciliation.

*Measure Objective/Goal: Psychoactive medication use:*

**Definitions/Assumptions:**

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

Increased use of medications in the antipsychotic drug-class for management of depression is also moving our results in these measures.

Antianxiety and hypnotic medication use is not reported as a quality measure for the short-stay population. The data is collected through the MDS, but is not included in the measures that make up our quality ranking.

All values are expressed in percentile rankings.

**Short Stay residents (<100 days).** Antipsychotic medication use for short stay patients is below national average, which measures only cases with newly prescribed antipsychotics. The facility percent for short stay patients who begin a new anti-psychotic during their stay is 0.5%. The comparison national average is 1.9%. This puts us at the 51st percentile nationally. This data reflects a single individual (numerator=1) for the 90-day reporting period.
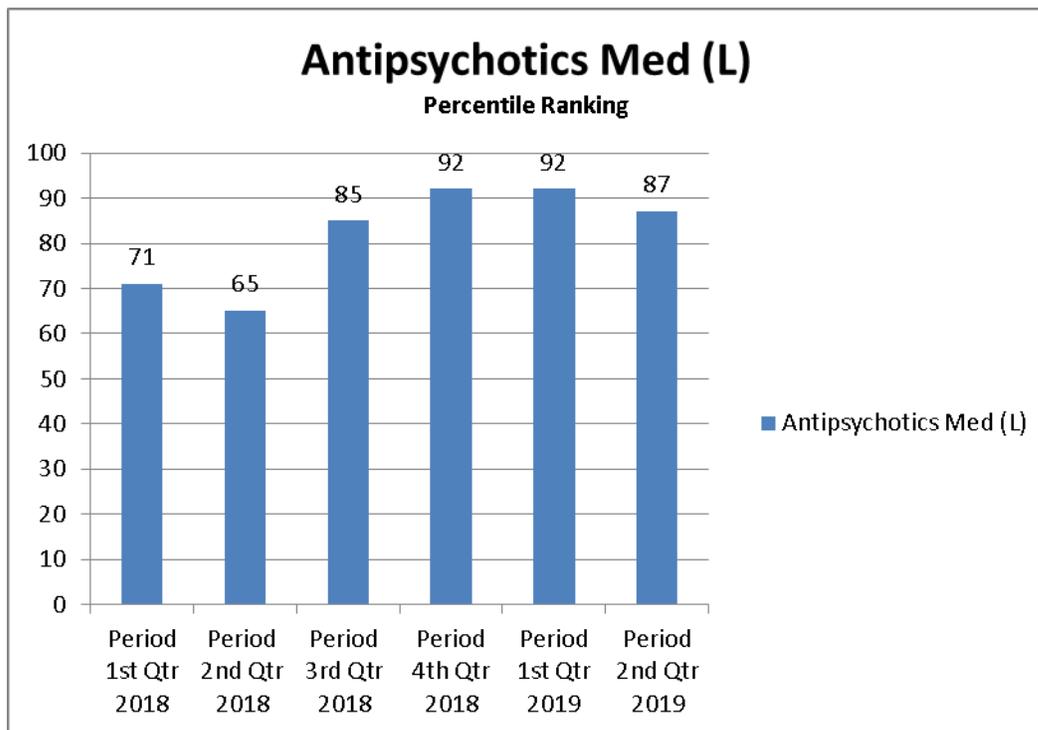
**Long Stay residents.** The facility percent for antipsychotic use in long stay residents is 23.3%, a decrease from 28.1% prior quarter and a decrease from 92nd percentile to the 87th. The national average is 14.3%. Unlike the short stay measure, which only includes newly prescribed antipsychotics, the long-stay measure includes all patients on the medication for any portion of the time (even if it was a home medication). Included in this measure are medications like quetiapine which may be used for depression or for ventilator management cases. This is another instance where our target client group for long-term care (our Sub Acute program) is the primary driver of our performance.

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

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

## Antipsychotics Med (S)
### Percentile Ranking

| Period 1st Qtr 2018 | Period 2nd Qtr 2018 | Period 3rd Qtr 2018 | Period 4th Qtr 2018 | Period 1st Qtr 2019 | Period 2nd Qtr 2019 |
|---|---|---|---|---|---|
| 0 | 57 | 57 | 0 | 0 | 51 |

## Antipsychotics Med (L)
### Percentile Ranking

| Period 1st Qtr 2018 | Period 2nd Qtr 2018 | Period 3rd Qtr 2018 | Period 4th Qtr 2018 | Period 1st Qtr 2019 | Period 2nd Qtr 2019 |
|---|---|---|---|---|---|
| 71 | 65 | 85 | 92 | 92 | 87 |
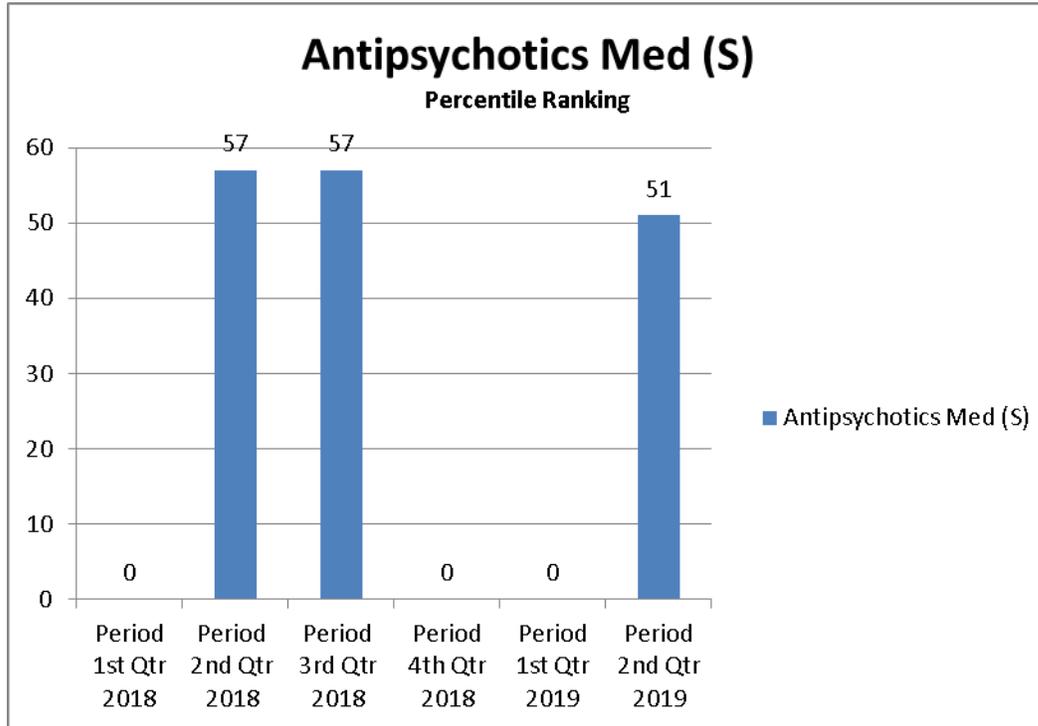
*Please submit your data along with the summary to your PI liaison 2 weeks prior to the scheduled report date.*

**Long Stay residents.**  Antianxiety/Hypnotic Medication use for long stay residents has increased to 96th from the 86th percentile prior quarter, with 40.6% utilization, compared to 40.6% prior quarter and above the 19.9% national average.  Our utilization rate is unchanged, but national rates have declined. There are no exclusions for medical diagnosis for this measure.
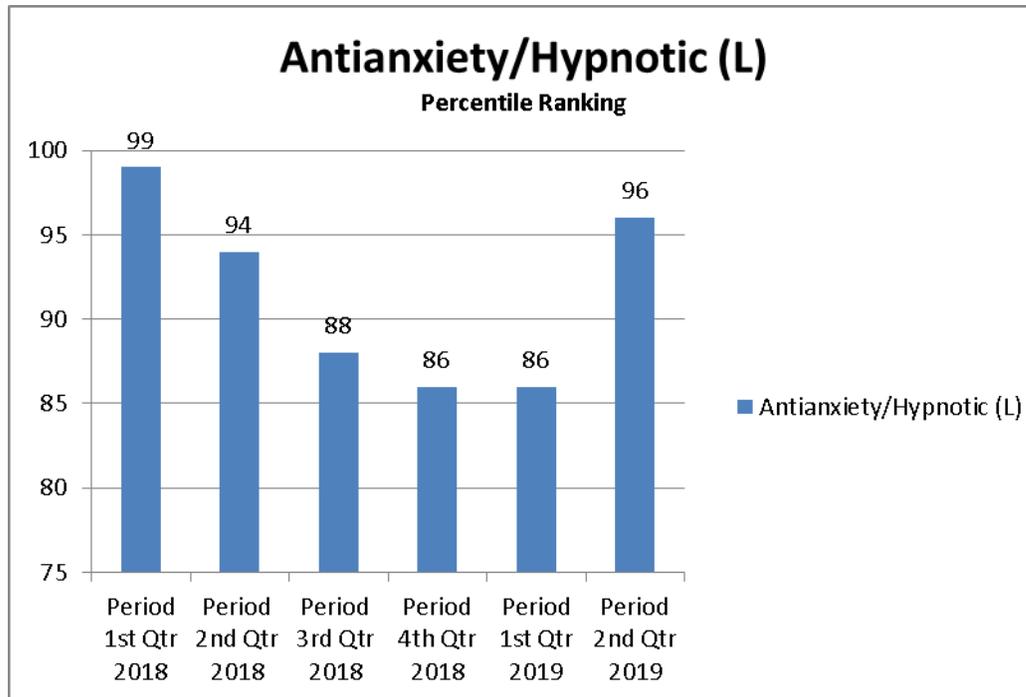


**If improvement opportunities identified, provide action plan and expected resolution date:**

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

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

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

In the past three years of CMS surveys (including most recent survey in April 2019) there have been no findings around inappropriate use of psychotropic medications in any of our programs.

It is important to note that, although the program continues to struggle with the four quality measures described in this report, we have made significant and sustained improvement in our overall quality ranking. In the past two years, the program has moved from 3-star quality rating overall to a 4 star overall quality rating. Additionally, with continued strong performance in both staffing and survey results, our quality ratings are now 4-star in every category.

**Submitted by Name:**

Mary Sisto

**Date Submitted:**

Oct 2019.

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

| Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2019 | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | Q1 | Q2 | Q3 | Q4 | AVG. or TOTAL YTD | SUMMARY / ACTION |
| **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 | | 1458 | 1493 | 1507 | | | **Annual running total: 4,458** |
| B. Total Infection Count<br>*[note: SSI events can be identified up to 90 days from the last day of the month in each quarter and only DIP and Organ Spc SSI are reported in NSHN]* | | ~~5~~<br>6 | 5 | 7 | | | **1st QTR:** ~~5~~ corrected 6 **Predicted:** 17.45<br>**2nd QTR:** 5 **Predicted:** 17.45<br>**3rd QTR:** 7 **Predicted:** 16.51 |
| C. Incidence Rate (IR)<br>[# of total SSI infections/# total procedures x 100] | Internal<br>0.70 Goal | **0.34** | **0.33** | **0.46** | | | **1st QTR:** Well exceeded the District's goal of 0.70 SSI incidence rate - 36% better.<br>**2nd QTR:** Well exceeded the District's goal of 0.70 SSI incidence rate.<br>**3rd QTR:** Consistently below the 0.70 SSI achieved District's goal for 3 quarters in a row. |
| D. SIR Confidence Interval<br>(CI-KDHCD predicted range, based on risks) | | 0.105 - 0.635 | 0.105 - 0.635 | 0.185 - 0.839 | | | **1st QTR:** Better than California 2017 SSI Benchmark of 0.89. *[Benchmark provided by CDPH 2017 Annual Report for overall top performance]*<br>**2nd QTR:** Better than California 2017 SSI Benchmark of 0.89. *[Benchmark provided by CDPH 2017 Annual Report for overall top performance*<br>**3rd QTR:** Better than California SSI Benchmark of 0.89. **For 3 quarters our total number of NHSN reportable SSI events places us in the top 8% of hospitals reporting this metric, according to recent NHSN release of 2018 summary data.** |
| E. Standardized Infection Ratio (SIR) | NHSN | **0.29** | **0.29** | **0.42** | | | **1st QTR:** SB, FUSN x 2, KPRO, FX, CHOL, PACE, COLO, VHYS, CSEC, CBGB (5 of these events were superficial and are not counted by CMS or by CDPH for public reporting)<br>**2nd QTR:** COLO x 2, HPRO, CHOL, FUSN, HER, BRST, CSEC (3 of these events were superficial and are not counted by CMS or by CDPH for public reporting)<br>**3rd QTR:** HYST x 4, CBGB, CSEC, APPY x 2, LAM (2 of these events were superficial and not counted by CMS or by CDPH for public reporting). A task force was developed to review the high quantity of HYST events. |

| Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2019 | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | Q1 | Q2 | Q3 | Q4 | AVG. or TOTAL YTD | SUMMARY / ACTION |
| F. Action Plan for Improvement | | | | | | | **1st QTR:** Scripting for 3 different Time-Out sessions almost complete (1st pre-op antibiotic administration check; 2nd universal timeout; 3rd debrief timeout verfiy whether a change in wound status occurred). Pursuuing questions about clean closure for colorectal surgeries - some surgeons have resevations about the process, whether or not it is an effective process for reducing SSI (it is supported by data meta-analysis and described prevention guidelines). **2nd QTR:** Clean closure for gastrointestinal procedures now supported by all surgeons. Timely pre-op antibiotic administration improved slightly. Hematomas were involved in SSI development for 2 events. Anastomosis leaks identified as potential source of 2 SSI events. Endogenous skin flora and care of the incision at home post-operatively is also suspected as source of infections for remaining SSI events. **3rd QTR:** Created a taskforce to determine actions related to reducing HYST events. Review new ACOG literature for reduction of HYST SSI. Deep dive review of all other cases. Identified pre-op antibiotic timing and blood glucose control, poor documentation/ communication, and patient anxiety and compliance as variables contributing to SSI events. Action plans developed to address all these factors |
| **II. Specific Surgical Review** | **SIR** | | | | | | |
| **A. Colon Surgery (COLO) CMS/VBP** | | | | | | | |
| 1. #Total Procedure Count | | 53 | 51 | 35 | | | **Annual running total:** 139 |
| 2. Total Infection Count | | 0 | 1 [1] | 0 [0] | | | **1st QTR:** 0 **Predicted:** NA **2nd QTR:**1 **Predicted:** 3.14 (note: 1 SIP COLO not reported in NHSN) **3rd QTR:** |
| 3. SIR CI (KDHCD predicted range, based on risks) | | 0 - 0.959 | 0.016 - 1.571 | , 1.475 | | | **1st QTR:** No different than 2019 National Benchmark of 0.781. **2nd QTR:** No different than 2019 National Benchmark of 0.781. **3rd QTR:** No different than 2019 National Benchmark 0.781. |

| Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2019 | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | Q1 | Q2 | Q3 | Q4 | AVG. or TOTAL YTD | SUMMARY / ACTION |
| 4. SIR (Standardized Infection Ration) total<br>   Value Based Purchasing (VBP) SIR = [ ] | | **0**<br>**[0]** | **0.32**<br>**[0.66]** | **0**<br>**[0]** | | | **1st QTR:** 1 COLO event (superficial SSI - not reported to CMS or CDPH). Intra-operatively there were 7 observers (non-staff) observing this procedure and a lot of activity going in and out of the surgery.<br>**2nd QTR**: 1 COLO event (superficial SSI - not reported to CMS or CDPH). Second COLO event is a DIP in a medicare patient.<br>**3rd QTR:** No COLO events. |
| **B. Cesarean Section (CSEC)** | | | | | | | |
| 1. #Total Procedure Count | | 351 | 351 | 394 | | | **Annual running total: 1,096** |
| 2. Total Infection Count | | **0** | **1** | **1** | | | **1st QTR:** 0 **Predicted:** NA<br>**2nd QTR:**1 **Predicted:** 2.99<br>**3rd QTR:** 1 **Predicted:** 3.31 |
| 3. SIR CI (KDHCD predicted range, based on risks) | | 0 - 0.908 | 0.017 - 1.652 | 0.015, 1.493 | | | **1st QTR:** Better than California 2016 CSEC Benchmark of 0.89.<br>**2nd QTR:** Better than California 2016 CSEC Benchmark of 0.89.<br>**3rd QTR**: Better than California 2016 CSEC Bencmark of 0.89. |
| 4. SIR (Standardized Infection Ration) total | | **0** | **0.34** | **0.303** | | | **1st QTR:** 1 CSEC event (deep SSI); this case was likely unpreventable. Patient had a spontaneous appendiceal rupture post-operatively that complicated the post-operative course.<br>**2nd QTR:** First QTR CSEC was identified in NHSN as a SIP. Second QTR CSEC is also a SIP CSEC event that occured 10 days post-op and is attributed to patient's non-compliance with care of the surgical site post discharge.<br>**3rd QTR:** 1 CSEC event likely associated with prolonged premature rupture of membranes. Group A Strep for both patient and infant. |
| **C. Spinal Fusion (FUSN)** | | | | | | | |
| 1. #Total Procedure Count | | 37 | 58 | 54 | | | **Annual running total: 149** |
| 2. Total Infection Count | | **1** | **1** | **0** | | | **1st QTR:** 1 **Predicted:** 0.47<br>**2nd QTR:**1 **Predicted:** 0.73<br>**3rd QTR:** 0 **Predicted:** 0.63 |

| Infection Prevention and Control  Committee -  IP Quality Improvement Dashboard CY 2019 | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | Q1 | Q2 | Q3 | Q4 | AVG. or TOTAL YTD | SUMMARY / ACTION |
| 3. SIR CI (KDHCD predicted range, based on risks) | | NA | NA | NA | | | **1st QTR:** Worse than California 2016 FUSN Benchmark of 0.82. **2nd QTR:** Worse than California 2016 FUSN Benchmark of 0.82. **3rd QTR:** Better than California 2016 FUSN Benchmark of 0.82. |
| 4. SIR (Standardized Infection Ration) total | | **2.12 [2.12]** | **1.36 [1.36]** | **0** | | | **1st QTR:** 2 FUSN events (2 deep SSI); A trend was identified with this particular type of SSI event. Spinal Fusion patients are transferred from the acute care setting to the District's long-term rehab facility. Identified a gap in continuity-of-care through communication of discharge orders, specialists do not follow their patients to long-term care rehab and will not be consulted regarding surgical wound healing and evaluation. Long-term care rehab nurses are unfamiliar with some interventions related to the SSI prevention bundle. Neurosurgery and Orthopedic service line representatives will now be attending SSI Prevention Committee. A midlevel practioner from the orthopedic service line will now follow patients to lont-term rehab to assess incision sites and consult. Long-term rehab nurses will be reintroduced to SSI Prevention Bundle interventions as a part of annual compentency training. **2nd QTR:** 1 FUSN event spinal abscess. Escalated this and the other two FUSN cases for physician review. **3rd QTR:** No FUSN events. |
| **D. Hysterectomy (HYST) CMS/VBP** | | | | | | | |
| 1. #Total Procedure Count | | 23 | 26 | 54 | | | **Annual running total:** 103 |
| 2. Total Infection Count | | **0** | **0** | **4 (4)** | | | **1st QTR:** 0 **Predicted:** NA **2nd QTR:** 0 **Predicted:** 0.49 (note: 2 SIP HYST not reported in NHSN) **3rd QTR:** 4 **Predicted:** 0.872 |
| 3. SIR CI (KDHCD predicted range, based on risks) | | NA | NA | NA | | | **1st QTR:**  Better than 2018 Benchmark of 0.722. **2nd QTR:** Better than 2018 Benchmark of 0.722. **3rd QTR:** Worse than 2018 Benchmark of 0.722. |

| Infection Prevention and Control  Committee -  IP Quality Improvement Dashboard CY 2019 | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | **Q1** | **Q2** | **Q3** | **Q4** | **AVG. or TOTAL YTD** | **SUMMARY / ACTION** |
| 4. SIR (Standardized Infection Ration) total<br>   Value Based Purchasing (VBP) SIR = [   ] | | **0**<br>**[0]** | **0**<br>**[0]** | **4.587**<br>**(4.36)** | | | **1st QTR:** No events.<br>**2nd QTR:** No events.<br>**3rd QTR: 4 HYST events. Taskforce identified the following variables: All events occurred less than 10 days post-op; all events were deep; Anxiety disorders were not addressed; poor glucose control; pre-op antibiotic timing too close to cut-time** |
| **II. Ventilator Associated Events (VAE)** | **SIR** | | | | | | |
| A. Ventilator Device Use<br>   SUR (standardized utilization ratio) | | **1.23** | **1.519** | **1.467** | | | **1st QTR:** 758vd **Predicted:** 615.75vd<br>**2nd QTR:**781vd **Predicted:** 514.09vd<br>**3rd QTR:** 678vd **Predicted:** 462.178vd |
| B. Total VAEs ICU (NHSN Reportable) | Includes IVAC Plus | **4** | **5** | **1** | | | **1st QTR:** 4  **Predicted:** 3.97<br>**2nd QTR:** 5 **Predicted:** 4.08<br>**3rd QTR:** 1 **Predicted:** 1.33 |
| 1. SIR Total VAE CI<br>   (KDHCD predicted range, based on risks) | | 0.320 - 2.432 | 0.448- 2.711 | 0.014 - 1.390 | | | This is an internal quality driven metric. A State or National benchmark has not been made available. |
| 2. Total VAEs SIR | | **1.35** | **2.62** | **0.282** | | | **1st QTR:** ICU had 2 VAC, 1 IVAC, 1 PVAP events.<br>**2nd QTR:** ICU had 3 VAC, 3 IVAC, 1 PVAP events.<br>**3rd QTR:** |
| C. Total IVAC Plus -ICU | | **2** | **4** | **1** | | | **1st QTR:** 2 **Predicted:** 1.48<br>**2nd QTR:** 4 **Predicted:** 2.62<br>**3rd QTR:** 1  **Predicted:** 1.327 |
| 1. Total IVAC Plus CI<br>   (KDHCD predicted range, based on risks) | | 0.226 - 4.455 | 0.832- 6.314 | 0.038, 3.718 | | | This is an internal quality driven metric. A State or National benchmark has not been made available. |
| 2. Total IVAC *Plus* ICU SIR | | **1.01** | **2.617** | **0.754** | | | **1st QTR:** 2 PVAP events<br>**2nd QTR:** 1 PVAP event<br>**3rd QTR:**  1 PVAP event |
| D. CVICU/**KDHCD** Total VAEs (not NHSN/Internal) | | **2** | **5** | **0** | | | **1st QTR:** 1 PVAP event<br>**2nd QTR:** 2 VAC & 1 IVAC event<br>**3rd QTR:**  1 VAC |

| Infection Prevention and Control  Committee -  IP Quality Improvement Dashboard CY 2019 | | | | | | |
|---|---|---|---|---|---|---|
| | | Q1 | Q2 | Q3 | Q4 | AVG. or TOTAL YTD | SUMMARY / ACTION |

| | | Q1 | Q2 | Q3 | Q4 | AVG. or TOTAL YTD | SUMMARY / ACTION |
|---|---|---|---|---|---|---|---|
| E. Total VAEs-Both Units | | **6** | **10** | **1** | | | **1st QTR:** 3 VAC,1 IVAC, 2 PVAP; pursuuing implementation of subglottic suctioning, and scheduled oral care.<br>**2nd QTR:** 5 VAC, 4 IVAC, 1 PVAP; pursuuing methods to reduce VAC events thereby reducing IVAC plus events.<br>**3rd QTR:** 1 PVAP, 1 VAC; reinforcing new recommendations to start at a PEEP of 6, pushing oral care, sedation vacation and subglottic suctioning. |
| **III. Central Line Associated Blood Stream Infections (CLABSI) CMS/VBP** | NHSN SIR | | | | | | |
| A. Total number of Central Line Days (CLD) | | 3648 | 3496 | 3665 | | | **Annual running total: 7144** |
| B. Central Line Device Use SUR (standardized utilization ratio) | | **0.76** | **0.72** | **0.817** | | | **1st QTR:** 3648 **Predicted:** 4,787.70<br>**2nd QTR:** 3496 **Predicted:** 4,814.87<br>**3rd QTR:** 3665 **Predicted:** 4,486.50 |
| C. Total Infection Count  Valule Based Purchasing (VBP) # events = [   ] | | **5**<br>**[4]** | **3**<br>**[2]** | **4**<br>**[3]** | | | **1st QTR:** 5 **Predicted:** 3.17<br>**2nd QTR:** 3  **Predicted:** 3.21<br>**3rd QTR:** 4  **Predicted:** 3.162 *(CMS) actual:3 predicted: 2.221* |
| D. SIR Confidence Interval | | 0.577 - 3.492 | 0.238 - 2.543 | 0.402 - 0.3051 | | | **1st QTR:** No different than 2019 National Benchmark of 0.784.<br>**2nd QTR:** No different than 2019 National Benchmark of 0.784.<br>**3rd QTR:** No different than 2019 National Benchmark of 0.784. |

| Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2019 | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | **Q1** | **Q2** | **Q3** | **Q4** | **AVG. or TOTAL YTD** | **SUMMARY / ACTION** |
| E. SIR (Standardized Infection Ratio) total<br>Value Based Purchasing (VBP) SIR = [ ] | | **1.58<br>[1.82]** | **0.97<br>[0.93]** | **1.265<br>[1.35]** | | | **1st QTR:** 5 events - must attempt to achieve 1 or less CLABSI events per Quarter. Implementing "Operation Stomp-Out CLABSI" interventions (29 in all). IV Safety Team has been hard at work gathering daily data from observations and intervening in the moment to ensure safe and effective line CVC and PIV line management. Transitioning interventions toward providers and GME residents. Discussing different options such as rotating the line in the IJ position for more effective dressing securement, investigating axillary vein access for subclavian line placement. Contacting hospital affiliate- Cleveland Clinic Infection Prevention to determine CLABSI prevention practices employed by that organization. Developing a CLABSI prevention CBL for residents. Continuing to offer Safety Symposium regarding CLABSI prevention for nurses.<br>**2nd QTR:** 3 events (61% decrease from 1st QTR SIR). To achieve an SIR of 0.784 <1 CLABSI is predicted per quarter. Implemented use of Prevantix CHG swabs for scrub-the-hub activities (5 sec scrub/5 second dry). Moving forward with Operation Stomp-Out CLABSI initiatives. Working on central line documentation in Cerner. IV Safety Team continues to perform interventions such as dressing changes/advocating for line discontinuation. IV Safety Team is undergoing their 6 month evaluation process as this intervention was temporarily piloted this year.<br>**3rd QTR:** 4 events of CLABSI identified within one month (September) . Two of the 4 events involved a |

| | | Q1 | Q2 | Q3 | Q4 | AVG. or TOTAL YTD | SUMMARY / ACTION |
|---|---|---|---|---|---|---|---|
| | | | | | | | bloodstream infection caused by yeast. Two of the 4 events were >4 days post insertion, the other two occured closely after insertion. All providers involved in inserting the lines implicated in a bloodstream infection received a CLABSI notification letter. Multiple factors related to each CLABSI event were identified, compared and trended. A deep dive into potential sources of yeast related bloodstream infections performed. Work is underway to develop an action plan related to these findings. |
| IV. Catheter Associated Urinary Tract Infections (CAUTI) CMS/VBP | NHSN SIR | | | | | | |
| A. Total number of Catheter Device Days (CDD) | | 3908 | 3738 | 3931 | | | **Annual running total:** 3908 |
| B. Catheter Device Days SUR   (Standardized Utilization Ratio) | | **0.743** | **0.749** | **0.802** | | | **1st QTR:** 3908 **Predicted:** 5257.86<br>**2nd QTR:** 3738 **Predicted:** 4,992.08<br>**3rd QTR:** 3931 **Predicted:** 4,903.62 |
| C. Total Infection Count   Value Based Purchasing (VBP) # of events = [    ] | | **7**<br>**[6]** | **5**<br>**[2]** | **10**<br>**[6]** | | | **1st QTR:** 7 **Predicted:** 3.95<br>**2nd QTR:** 5 **Predicted:** 3.76<br>**3rd QTR:** 10 **Predicted:** 3.96 *(CMS) actual: 6 predicted: 2.37* |
| D. SIR Confidence Interval | | 0.720 - 0.767 | 0.487- 2.945 | 1.283, 4.503 | | | **1st QTR:**  Worse than 2019 National Benchmark of 0.828<br>**2nd QTR:** No different than National Benchmark of 0.828.<br>**3rd QTR:** No different than National Benchmark of 0.828. |

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| Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2019 | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | **Q1** | **Q2** | **Q3** | **Q4** | **AVG. or TOTAL YTD** | **SUMMARY / ACTION** |
| E. SIR (Standardized Infection Ratio) total<br>   Value Based Purchasing (VBP) SIR = [   ] | | **1.77<br>[2.89]** | **1.33<br>[0.87]** | **2.526<br>[2.535]** | | | **1st QTR:** Many of these events are due to keeping the indwelling urinary catheter longer than indicated; collecting urine cultures when not indicated. Approvals are occuring for implementation of a new order set for Urine Cultures (to help ensure when cultures are ordered they are really indicated), also implementation of a CAUTI algorithim will be starting soon. Considering dual nurse insertion of indwelling urinary catheters to reduce risk of contamination during insertion.<br>**2nd QTR:** Urinalysis orderset implemented, however, provider have not used it frequently as it hasn't been added to their favorites in Cerner, ISS is working to address this. CAUTI prevention algorithm has been added to the Nursing Standard of Practice which is still under revision. CAUTI prevention algorithm will be added to physician ordersets so that nursing has greaterly flexibility to inact appropriate measures without waiting for physician approval to do so.<br>**3rd QTR:** To date CAUTI far exceeds predicted values. Infection Prevention and Advance Practice Nurses perform daily rounds for indwelling urinary catheters. Education has been provided to GME residents during their grand rounds. Infection prevention and the hospital Antimicrobial Stewardship Pharmacist intervene daily informing nurses and providerd to avoid running urine cultures in the absence of symptoms for a urinary tract infection. Nurse leaders have been notified of instances in which documentation was not present<br>to support actions such as retaining or reinserting indwelling urinary catheters. A strong effort is being made to hold healthcare personnel accountable to their actions and to ensure that alternatives to an indwelling urinary catheter are implemented fully in advance of catheter insertion. |
| **V. Clostridium *difficile* Infection (CDI) CMS/VBP** | **SIR** | | | | | | |
| A. Total Infection Count | All units | **5<br>[5]** | **3<br>[3]** | **6<br>[6]** | | | **1st QTR:** 5 **Predicted:** 16.93<br>**2nd QTR:** 3 **Predicted:** 15.62<br>**3rd QTR:** 6 **Predicted:** 15.627 |

| Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2019 | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | **Q1** | **Q2** | **Q3** | **Q4** | **AVG. or TOTAL YTD** | **SUMMARY / ACTION** |
| B. SIR CI (KDHCD predicted range, based on risks) | | 0.108 - 0.655 | 0.049-0.523 | 0.156, 0.799 | | | **1st QTR:** Better than 2019 National Benchmark of 0.852<br>**2nd QTR:** Better than 2019 National Benchmark of 0.852.<br>**3rd QTR:** Better than 2019 National Benchmark of 0.852. |
| C. SIR (Standardized Infection Ratio) total<br>  Value Based Purchasing (VBP) SIR = [ ] | | **0.3 [0.30]** | **0.19 [0.19]** | **0.384 [0.384]** | | | **1st QTR:** Continued implementation of the C. diff. algorithm, interventions provided by Antimicrobial Stewardship Pharmacist and Infection Prevention.<br>**2nd QTR:** Incredible work done to consistently maintain a low C. difficile rate to interventions described during 1st QTR.<br>**3rd QTR:** Joint effort made by Antimicrobial Stewardship Pharmacist and Infection Prevention to ensure providers and nurses follow the C. diff testing algorithm. C. diff. rates remain consistently better than national and State benchmarks. |
| **VI. Hand Hygiene** | **95%** | | | | | | |
| A. All units<br>Percentage of correct Hand Hygiene observations/opportunities (30 observations/month/unit) | | **88%** | **90%** | **90%** | | | **1st QTR:** 3,397 of 3,877 hand hygiene observations were compliant.<br>**2nd QTR:** 3,547 of 3,938 hand hygiene observations were compliant.<br>**3rd QTR:** 2,930 of 3,273 hand hygiene observations were compliant. Will initiate pilot study using a remote hand hygiene surveillance system for 6 months on 4N and ICU units starting December 2019. |
| **VII. VRE (HAI) Blood-Hospital Onset (HO)** | **BM** | | | | | | |
| A. Total Infection Count | | **0** | **0** | **0** | | | **1st QTR:** 0 **Predicted:** 0<br>**2nd QTR:** 0 **Predicted:** 0<br>**3rd QTR:** 0 **Predicted:** 0 |
| B. Prevalence Rate (x100) | | **0** | **0** | **0** | | | **1st QTR:** 0<br>**2nd QTR:** 0<br>**3rd QTR:** 0 |
| C. Number Admissions | | 7236 | 7209 | 7048 | | | 21,493 |
| **VIII. MRSA (HAI) Blood CMS/VBP** | **SIR** | | | | | | |
| A. Total Infection Count (IP Facility-wide) | | **3 [3]** | **1 [1]** | **4 [4]** | | | **1st QTR:** 3 **Predicted** 1.41<br>**2nd QTR:** 1 **Predicted:** 1.43<br>**3rd QTR:** 4 **Predicted:** 1.963 |

| | | Q1 | Q2 | Q3 | Q4 | AVG. or TOTAL YTD | SUMMARY / ACTION |
|---|---|---|---|---|---|---|---|
| **Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2019** | | | | | | | |
| B.  SIR CI (KDHCD predicted range, based on risks) | | 0.541 - 5.785 | 0.035- 3.462 | 0.647, 4.914 | | | **1st QTR:** No better than 2019 National Benchmark of 0.815. **2nd QTR:** No different than National Benchmark of 0.815. **3rd QTR**: No different than National Benchmark of 0.815. |
| C.  SIR (Standardized Infection Ration) total    Value Based Purchasing (VBP) SIR = [   ] | | **2.13 [2.13]** | **0.70 [0.70]** | **2.037 [2.037]** | | | **1st QTR:** Many of the identified MRSA BSI are also CLABSI events. Reviewing culture practices with providers through our Operation Stomp-Out CLABSI campaign. Also, working on initiating a "Do U Disinfect Everytime (D.U.D.E.) campaign to highlight the importance of hand hygiene compliance, "scrub-the-hub" and cleaning the patient environment. Trialed and will be universally using Prevantics CHG wipes to perform "scrub-the-hub" a 5 second process. Stakeholders are supporting all these interventions. **2nd QTR:** Interventions described above under 1st QTR continue. There has been evaluation underway regarding nasal decolonization products that may be useful in addressing seasonal spike in MRSA BSI during the Flu Season. **3rd QTR:** Two MRSA BSI events this quarter were due to serial blood cultures to validate effectiveness of treatment. Unfortunately, the serial testing contributed to the two events being reported as healthcare onset events. The remaining two MRSA events involved one case that appears to have been unpreventable, the last case may have been due to a combination of retaining peripheral IV access too long and poor management of the dressing. This last patient also had MRSA in respiratory secretions. In response to these findings, LVNs were added to the pilot process of the IV Safety Team. Their role includes timely removal/replacement of peripheral IV lines. |
| **IX. Influenza Rates** (Year 2018-2019) | **NHSN** | | | | | | |
| A. All Healthcare Workers 5,384 working/5,279 total vaccination (90 declined) | | **98.0%** | | | | | **Season 2018-2019**: **Action:** Once again Kaweah Delta has consistently exceeded the Healthy People 2020 goal of 90% vaccination rate. |

| Infection Prevention and Control  Committee -  IP Quality Improvement Dashboard CY 2019 | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | Q1 | Q2 | Q3 | Q4 | AVG. or TOTAL YTD | SUMMARY / ACTION |
| Approved IPC:  6/27/2019<br>Approved IPC:  9/19/2019<br>Approved IPC:<br>Approved IPC:<br><br><br>Prepared by Shawn Elkin, MPA, BSN, RN, PHN, CIC<br>            Infection Prevention Manager | | | | | | | |

# Kaweah Delta
## HEALTH CARE DISTRICT

| GENERAL METRICS | SEPTEMBER 2019 | | OCTOBER 2019 | | NOVEMBER 2019 | |
|---|---|---|---|---|---|---|
| | KDHCD | GOAL | KDHCD | GOAL | KDHCD | GOAL |
| ED Volume | 7100 | | 7117 | | 7021 | |
| Percent of Patients Left Without Being Seen | 1.3% | 1.5% | 1.0% | 1.5% | 1.1% | 1.5% |
| Percent of Patients Left During Treatment | 2.4% | 1.5% | 1.9% | 1.5% | 1.8% | 1.5% |
| Percent of Patients Left Against Medical Advice | 0.9% | NA | 1.0% | NA | 0.7% | NA |
| Percent of Patients Admitted | 24% | NA | 25% | NA | 24% | NA |
| Percent of Patients Discharged | 69% | NA | 69% | NA | 70% | NA |
| | | | | | | |
| | | CMS | | CMS | | CMS |
| ED THROUGHPUT METRICS | | Benchmark | | Benchmark | | Benchmark |
| Median Length of Stay in Minutes for Admitted Patient (Hours) | 457 (7.6) | 423 (7.05) | 438 (7.3) | 423 (7.05) | 416 (6.9) | 407 (6.8) |
| Median Length of Stay in Minutes for Discharged Patient (Hours) | 217 (3.6) | 204 (3.4) | 212 (3.5) | 204 (3.4) | 205 (3.4) | 186 (3.1) |
| Median Length of Stay in Minutes for Admit Decision to ED Depart (Hours) | 225 (3.8) | 180 (3) | 215 (3.6) | 180 (3) | 197 (3.3) | 197 (3.3) |
| Average Length of Stay in Minutes for Admitted Mental Health Patients (Hours) | 861 (14.4) | | 513 (8.6) | | 425 (7.1) | |
| | | | | | | |
| CENSUS TOTALS BY DISPOSITION | | | | | | |
| Number of Patients Arriving by Ambulance | 1799 | | 1959 | | 1882 | |
| Number of Trauma Patients | 185 | | 177 | | 147 | |
| Number of Patients Admitted | 1685 | | 1744 | | 1703 | |
| Number of Patients Discharged | 4897 | | 4893 | | 4880 | |
| Number of Mental Health Patients Admitted | 93 | | 79 | | 84 | |
| | | | | | | |
| PATIENT EXPERIENCE | | | | GOAL | | |
| Emergency Room Overall Care Percentile Ranking | | | 52% | 50% | | |
| Likelihood to Recommend the ED at KD Percentile Ranking | | | | | | |

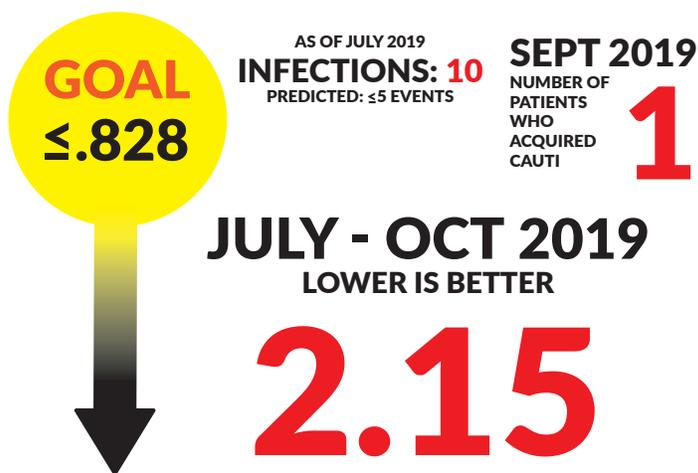| KEY | | | | | |
|---|---|---|---|---|---|
| > 10% Above Benchmark/Goal | (red) | Within 10% of Benchmark/Goal | (yellow) | Outperforming or Meeting Benchmark/Goal | (green) |

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# CLINICAL QUALITY GOALS

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

**GOAL >70%**

**SEPT 2019**
57%

**JULY-SEPT 2019**
HIGHER IS BETTER

# 66%

## MRSA
Methicillin-resistant Staphylococcus aureus (MRSA). Standardized Infection Ratio (SIR) is the the number of patients who acquired MRSA while in the hospital divided by the number of patients who were expected.

**GOAL ≤.815**

**AS OF JULY 2019**
**INFECTIONS: 4**
PREDICTED: ≤2 EVENTS

**OCT. 2019**
NUMBER OF PATIENTS WHO ACQUIRED MRSA
0

**JULY-OCT 2019**
LOWER IS BETTER

# 2.42
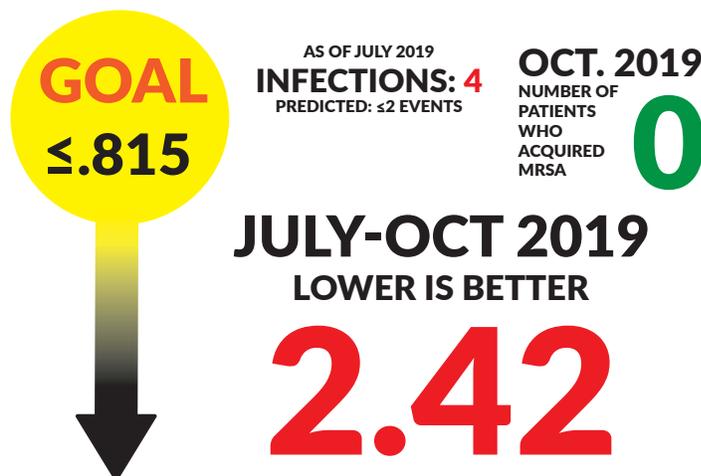
## CAUTI
A catheter-associated urinary tract infection (CAUTI). Standardized Infection Ratio is the number of patients who acquired a CAUTI while in the hospital divided by the number of patients who were expected.

**GOAL ≤.828**

**AS OF JULY 2019**
**INFECTIONS: 10**
PREDICTED: ≤5 EVENTS

**SEPT 2019**
NUMBER OF PATIENTS WHO ACQUIRED CAUTI
1

**JULY - OCT 2019**
LOWER IS BETTER

# 2.15

## CLABSI
A central line-associated bloodstream infection (CLABSI). Standardized Infection Ratio (SIR) is the number of patients who acquired a CLABSI while in the hospital divided by the number of patients who were expected.

**GOAL ≤.784**

**AS OF JULY 2019**
**INFECTIONS: 7**
PREDICTED: ≤4 EVENTS

**OCT 2019**
NUMBER OF PATIENTS WHO ACQUIRED CLABSI
4

**JULY - OCT 2019**
LOWER IS BETTER

# 1.69

## OPPORTUNITY LOS
Length of Stay (LOS). The difference between the expected LOS and the actual LOS of acute med/surg inpatients, excluding OB/Delivery, Normal Newborns, Neonatology and Uncoded plus Mental Health, Rehab, and SNF.

**GOAL ≤0.50**

**OCTOBER 2019:**
0.92

**JUL - OCT 2019:**
0.89

**COMMUNICATION BOARD**

HAPI Prevention Quality Focus
Team Update
December 2019

KAWEAH DELTA HEALTH CARE DISTRICT

# INCIDENCE DATA

## The HAPI Roundup Comparison 2018 Vs. 2019

| Total HAPIs | 2018 | 2019 |
|---|---|---|
| Jan | 27 | 21 |
| Feb | 23 | 31 |
| Mar | 17 | 19 |
| Apr | 21 | 19 |
| May | 32 | 9 |
| Jun | 19 | 7 |
| Jul | 14 | 14 |
| Aug | 12 | 14 |
| Sep | 9 | 9 |
| Oct | 34 | 17 |
| Nov | 24 | |
| Dec | 17 | |
| Total HAPIs | 249 | 160 |



Number of HAPIs per Month 2018 Vs. 2019
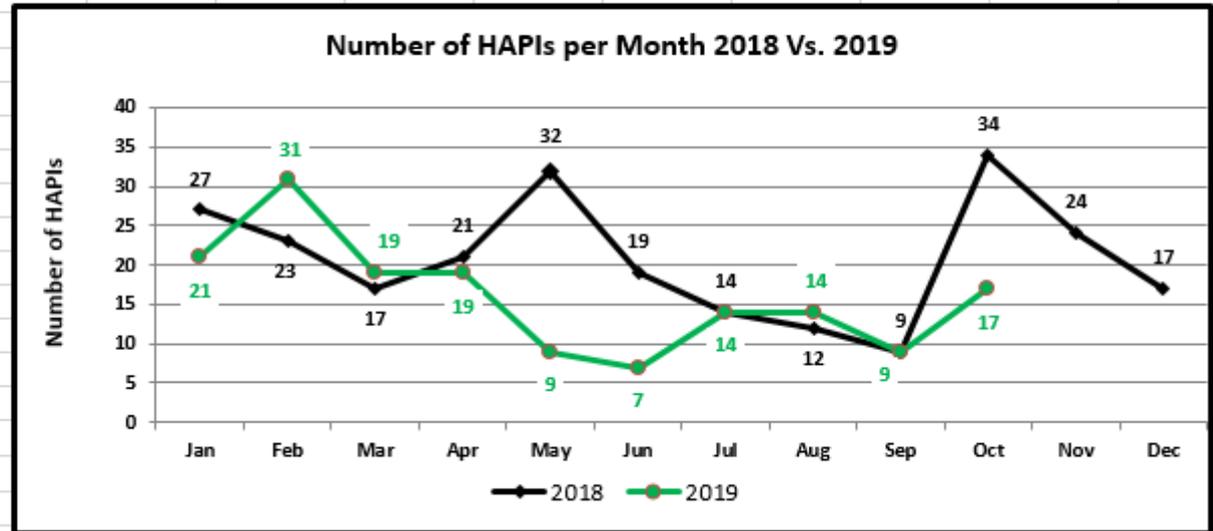
Overall, there are 48 fewer HAPIs for the period of January 1 through October 31, 2019 compared to the same period of time in 2018.  This is a 23% overall reduction in HAPIs  YTD for 2019.

KAWEAH DELTA HEALTH CARE DISTRICT

# INCIDENCE DATA

| Device Related HAPIs | 2018 | 2019 |
|---|---|---|
| Jan | 13 | 9 |
| Feb | 8 | 14 |
| Mar | 10 | 11 |
| Apr | 6 | 13 |
| May | 7 | 5 |
| Jun | 7 | 1 |
| Jul | 5 | 6 |
| Aug | 6 | 6 |
| Sep | 7 | 0 |
| Oct | 16 | 9 |
| Nov | 8 | |
| Dec | 6 | |
| Total Device Related | 99 | 74 |
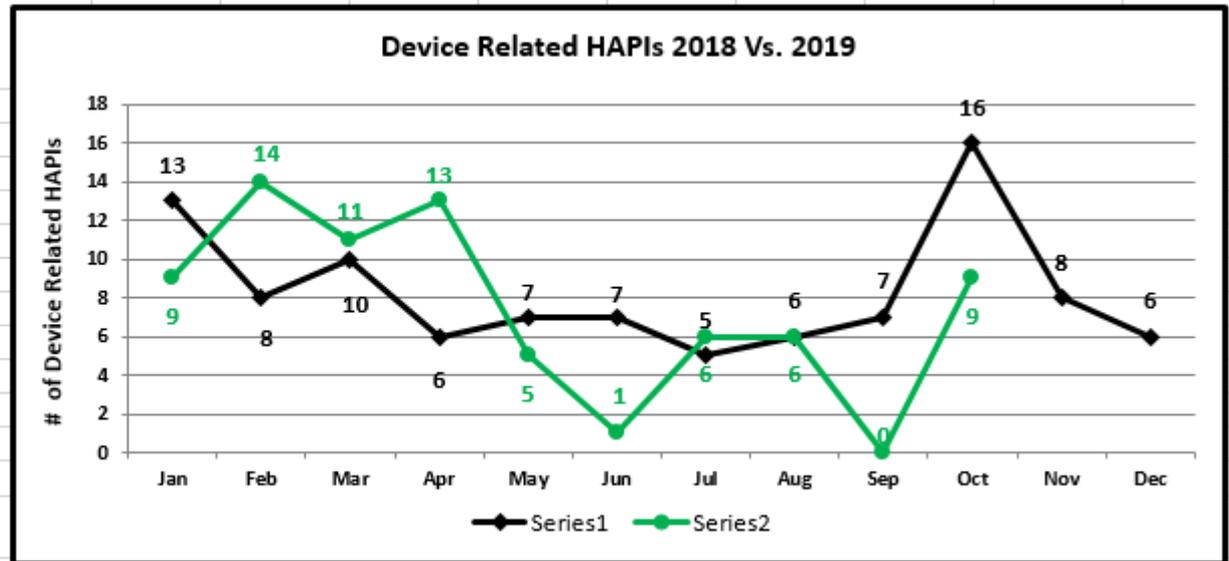


Device related HAPIs demonstrate improvement with 11 less device related HAPIs through October 2019 when compared to end of October 2018.  This has resulted in a 12% overall reduction in device related HAPIs YTD for 2019.

**KAWEAH DELTA HEALTH CARE DISTRICT**

# PREVALENCE DATA

### HAPI Quarterly Prevalence Study Summary 1st Quarter 2018 - 4th Quarter (October Only) 2019

**Number of HAPIs**

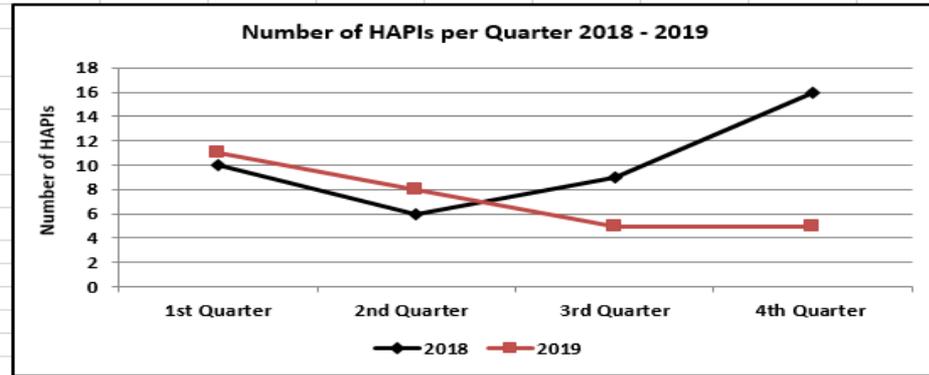| | # of Patients Assessed 2018 | # of Patients Assessed 2019 | 2018 | 2019 |
|---|---|---|---|---|
| 1st Quarter | 273 | 243 | 10 | 11 |
| 2nd Quarter | 260 | 281 | 6 | 8 |
| 3rd Quarter | 267 | 281 | 9 | 5 |
| 4th Quarter | 268 | 262 | 16 | 5 |
| Total HAPIs | 1068 | 1067 | 41 | 29 |



Number of HAPIs per Quarter 2018 - 2019

**% of all HAPIs**

| | # of Patients Assessed 2018 | # of Patients Assessed 2019 | 2018 | 2019 |
|---|---|---|---|---|
| 1st Quarter | 273 | 243 | 3.66% | 4.52% |
| 2nd Quarter | 260 | 281 | 2.30% | 2.84% |
| 3rd Quarter | 267 | 281 | 3.37% | 1.77% |
| 4th Quarter | 268 | 262 | 5.97% | 1.90% |
| Total HAPIs | 1068 | 1067 | 3.83 | 2.98 |



Percent HAPIs per Quarter 2018 - 2019
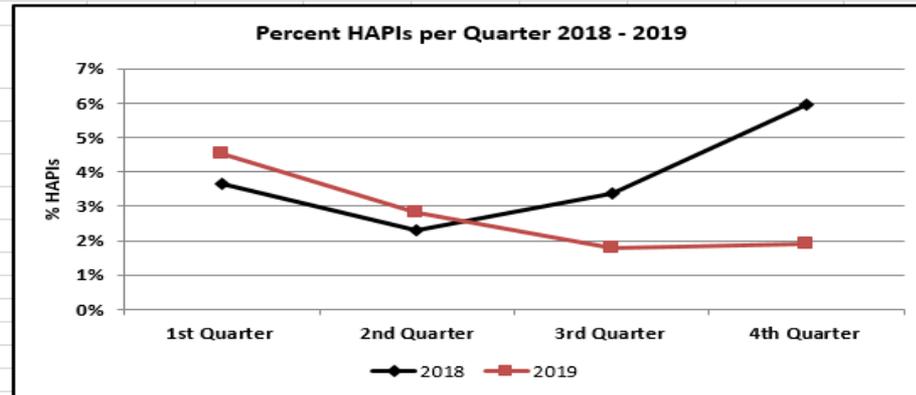
On October 10, 2019 the fourth quarter prevalence study was completed and results were sent to NDNQI. Of the 262 patients assessed for this quarter, 5 were noted to have a HAPI, which equals to 1.90% of patients assessed. Overall there is great improvement with 12 less HAPIs YTD discovered during the quarterly prevalence study for 2019 when compared to 2018.

# IMPROVEMENT OPPORTUNITIES



**Respiratory Device Related HAPIs 2018-2019**

| | 2018 | 2019 |
|---|---|---|
| Jan | 7 | 1 |
| Feb | 1 | 2 |
| Mar | 3 | 4 |
| *Apr | 2 | 10 |
| May | 5 | 3 |
| Jun | 0 | 0 |
| Jul | 1 | 1 |
| Aug | 2 | 2 |
| Sep | 0 | 0 |
| Oct | 3 | 4 |
| Nov | 1 | |
| Dec | 2 | |
| **Total** | **27** | **27** |

*April 2019 = 10 HAPIs: 3W 5; ICU 3; 3S 1
(4 patients accounted for 8 HAPIs)
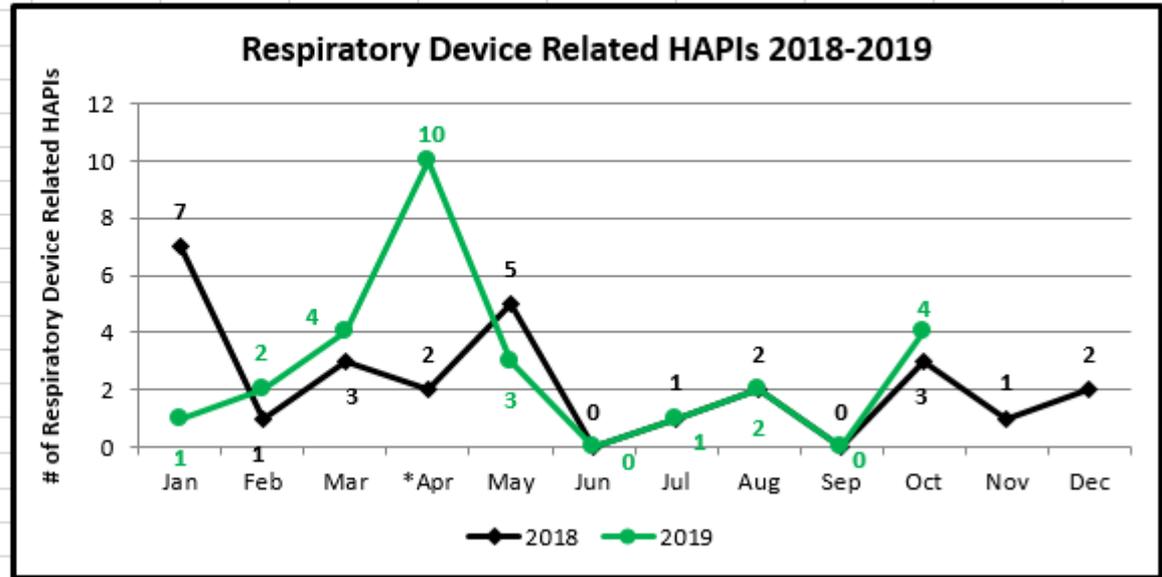
For Jan-Oct 2019 we have had the same amount of RT device related HAPIs (27) when compared to Jan-Oct. 2018.  Overall for 2019, RT device related HAPIs YTD have accounted for 36% of all device related HAPIs.

KAWEAH DELTA HEALTH CARE DISTRICT

# IMPROVEMENT OPPORTUNITIES

### Location of Non-Device Related HAPIs 2019

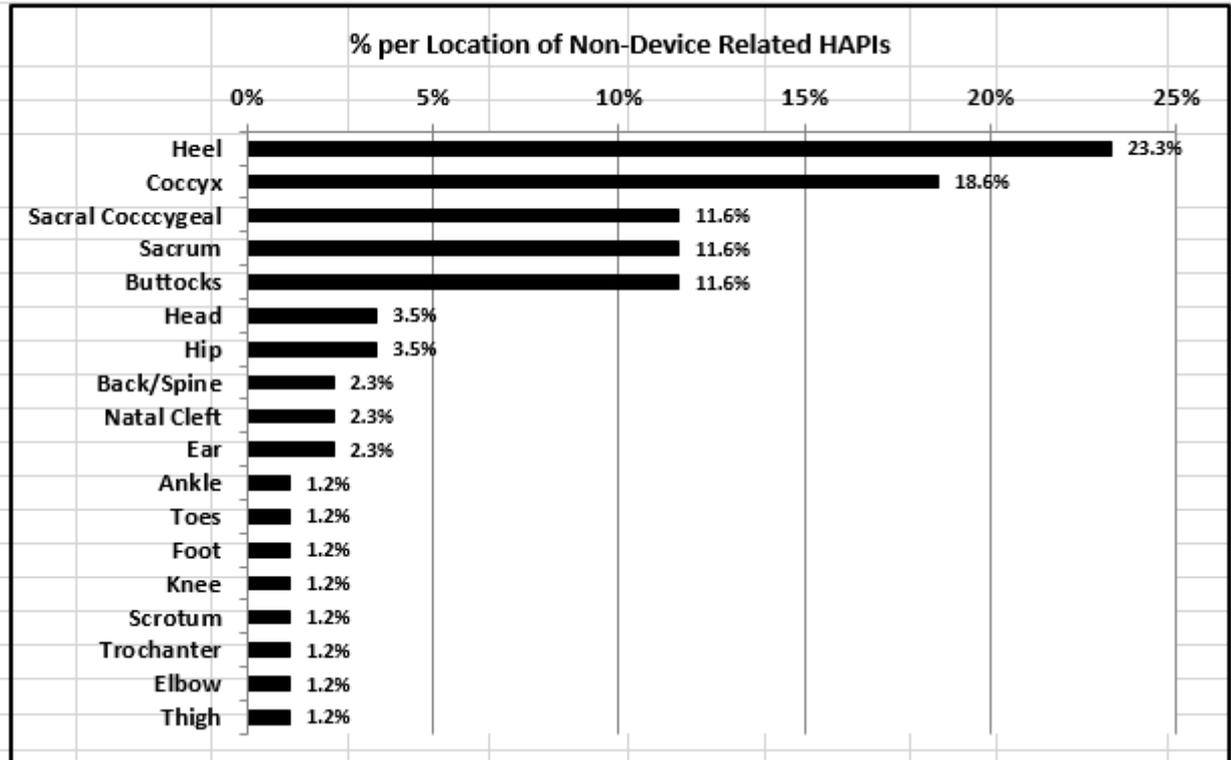| Location | Number of HAPIs | % of HAPIs |
|---|---|---|
| Heel | 20 | 23.3% |
| Coccyx | 16 | 18.6% |
| Sacral Cocccygeal | 10 | 11.6% |
| Sacrum | 10 | 11.6% |
| Buttocks | 10 | 11.6% |
| Head | 3 | 3.5% |
| Hip | 3 | 3.5% |
| Back/Spine | 2 | 2.3% |
| Natal Cleft | 2 | 2.3% |
| Ear | 2 | 2.3% |
| Ankle | 1 | 1.2% |
| Toes | 1 | 1.2% |
| Foot | 1 | 1.2% |
| Knee | 1 | 1.2% |
| Scrotum | 1 | 1.2% |
| Trochanter | 1 | 1.2% |
| Elbow | 1 | 1.2% |
| Thigh | 1 | 1.2% |
| Total | 86 | |

**% per Location of Non-Device Related HAPIs**

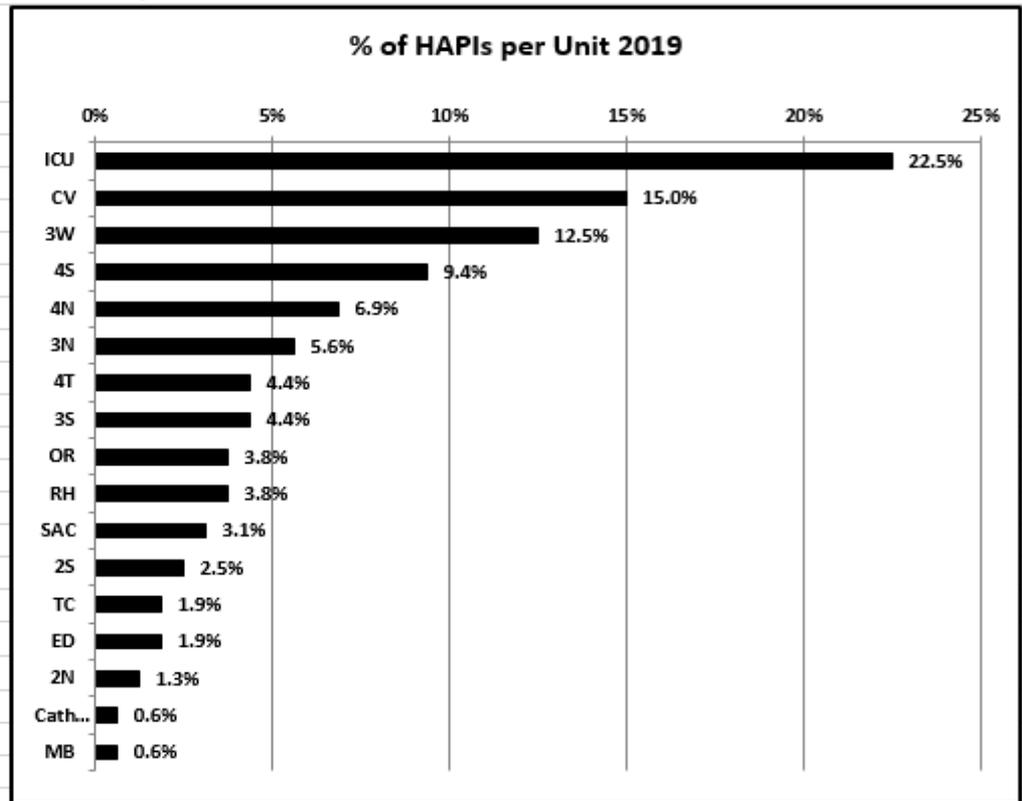| Location | % |
|---|---|
| Heel | 23.3% |
| Coccyx | 18.6% |
| Sacral Cocccygeal | 11.6% |
| Sacrum | 11.6% |
| Buttocks | 11.6% |
| Head | 3.5% |
| Hip | 3.5% |
| Back/Spine | 2.3% |
| Natal Cleft | 2.3% |
| Ear | 2.3% |
| Ankle | 1.2% |
| Toes | 1.2% |
| Foot | 1.2% |
| Knee | 1.2% |
| Scrotum | 1.2% |
| Trochanter | 1.2% |
| Elbow | 1.2% |
| Thigh | 1.2% |

The heels, coccyx, and sacrum continue to be the most common areas for non-device related HAPI development. These areas have accounted for 65% of all non-device related HAPIs for 2019.

# IMPROVEMENT OPPORTUNITIES

| Units | Device Related | Non-Device Related | Total HAPIs | % of HAPIs |
|---|---|---|---|---|
| ICU | 18 | 18 | 36 | 22.5% |
| CV | 7 | 17 | 24 | 15.0% |
| 3W | 10 | 10 | 20 | 12.5% |
| 4S | 8 | 7 | 15 | 9.4% |
| 4N | 4 | 7 | 11 | 6.9% |
| 3N | 6 | 3 | 9 | 5.6% |
| 4T | 1 | 6 | 7 | 4.4% |
| 3S | 6 | 1 | 7 | 4.4% |
| OR | 2 | 4 | 6 | 3.8% |
| RH | 2 | 4 | 6 | 3.8% |
| SAC | 1 | 4 | 5 | 3.1% |
| 2S | 4 | 0 | 4 | 2.5% |
| TC | 1 | 2 | 3 | 1.9% |
| ED | 3 | 0 | 3 | 1.9% |
| 2N | 1 | 1 | 2 | 1.3% |
| Cath Lab | 0 | 1 | 1 | 0.6% |
| MB | 0 | 1 | 1 | 0.6% |
| Total | 74 | 86 | 160 | |

### HAPIs per Unit 2019

**% of HAPIs per Unit 2019**

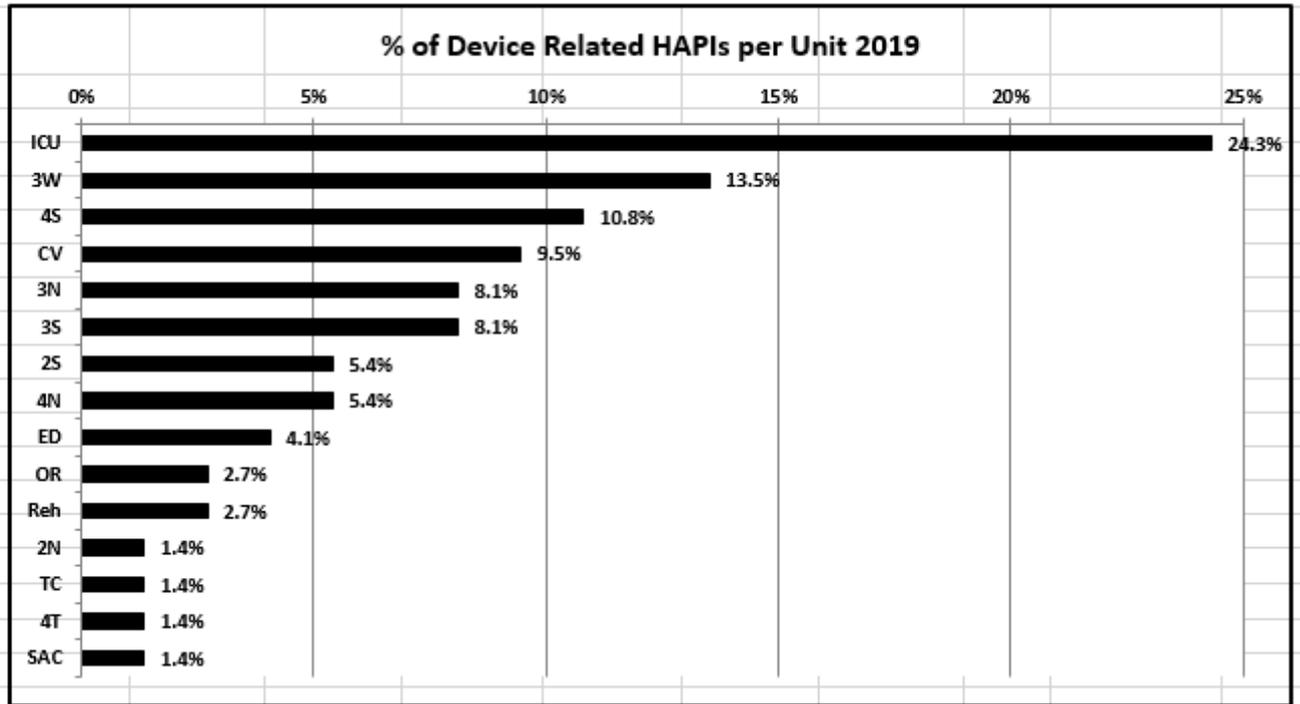| Unit | % |
|---|---|
| ICU | 22.5% |
| CV | 15.0% |
| 3W | 12.5% |
| 4S | 9.4% |
| 4N | 6.9% |
| 3N | 5.6% |
| 4T | 4.4% |
| 3S | 4.4% |
| OR | 3.8% |
| RH | 3.8% |
| SAC | 3.1% |
| 2S | 2.5% |
| TC | 1.9% |
| ED | 1.9% |
| 2N | 1.3% |
| Cath... | 0.6% |
| MB | 0.6% |

Critical care units (ICU, CVICU, 3W) and one Medical Surgical Unit (4S) continue to account for 59.4% of all HAPIs for 2019 YTD which is down by 3.8% when compared to 2018 .

KAWEAH DELTA HEALTH CARE DISTRICT

# IMPROVEMENT OPPORTUNITIES



| Units | Device Related | % of HAPIs |
|-------|---------------|-----------|
| ICU | 18 | 24.3% |
| 3W | 10 | 13.5% |
| 4S | 8 | 10.8% |
| CV | 7 | 9.5% |
| 3N | 6 | 8.1% |
| 3S | 6 | 8.1% |
| 2S | 4 | 5.4% |
| 4N | 4 | 5.4% |
| ED | 3 | 4.1% |
| OR | 2 | 2.7% |
| Reh | 2 | 2.7% |
| 2N | 1 | 1.4% |
| TC | 1 | 1.4% |
| 4T | 1 | 1.4% |
| SAC | 1 | 1.4% |
| **Total** | **74** | |

Device Related HAPIs 2019 — % of Device Related HAPIs per Unit 2019

Critical care units (ICU, CVICU, 3W) and one Medical Surgical Unit (4S) continue to account for 58.1% of all device related HAPIs YTD. This is an improvement from 2018, resulting in a 12.7% device related HAPI reduction for 2019 YTD.

KAWEAH DELTA HEALTH CARE DISTRICT

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

**Unit/Department:Acute Wound Care Services  ProStaff/QIC Report Date: October 2019**
**Measure Objective/Goal:**

1. Decrease device related HAPIs in ICU, CVICU, 3W and 4S by the end of Q 1, 2020.
2. Implement unit-level interventions/plans to decrease incidence of device related HAPIs in the units listed above.
3. Establish a multi-disciplinary HAPI Prevention QFT structure with Executive Team sponsorship.

**Date range of data evaluated: January 2018 through August 2019**

### The HAPI Roundup Comparison 2018 Vs. 2019

| Total HAPIs | 2018 | 2019 |
|---|---|---|
| Jan | 27 | 21 |
| Feb | 23 | 31 |
| Mar | 17 | 19 |
| Apr | 21 | 19 |
| May | 32 | 9 |
| Jun | 19 | 7 |
| Jul | 14 | 14 |
| Aug | 12 | 14 |
| Sep | 9 | |
| Oct | 34 | |
| Nov | 24 | |
| Dec | 17 | |
| Total HAPIs | 249 | 134 |



Number of HAPIs per Month 2018 Vs. 2019
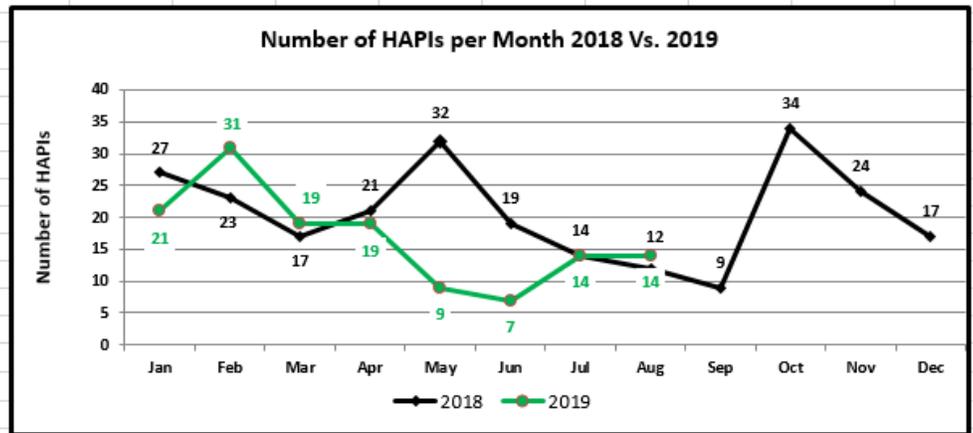
For 2019, overall HAPIs demonstrates a consistent downward trend from February 2019 through June 2019.  There was a slight upward trend for July and August of 2019 of 14 HAPIs for each month.  Overall when compared to 2018, there is a slight improvement with 31 less HAPIs at the end of August 2019 when compared to end of August 2018.

| Device Related HAPIs | 2018 | 2019 |
|---|---|---|
| Jan | 13 | 9 |
| Feb | 8 | 14 |
| Mar | 10 | 11 |
| Apr | 6 | 13 |
| May | 7 | 5 |
| Jun | 7 | 1 |
| Jul | 5 | 6 |
| Aug | 6 | 6 |
| Sep | 7 | |
| Oct | 16 | |
| Nov | 8 | |
| Dec | 6 | |
| Total Device Related | 99 | 65 |



Device Related HAPIs 2018 Vs. 2019
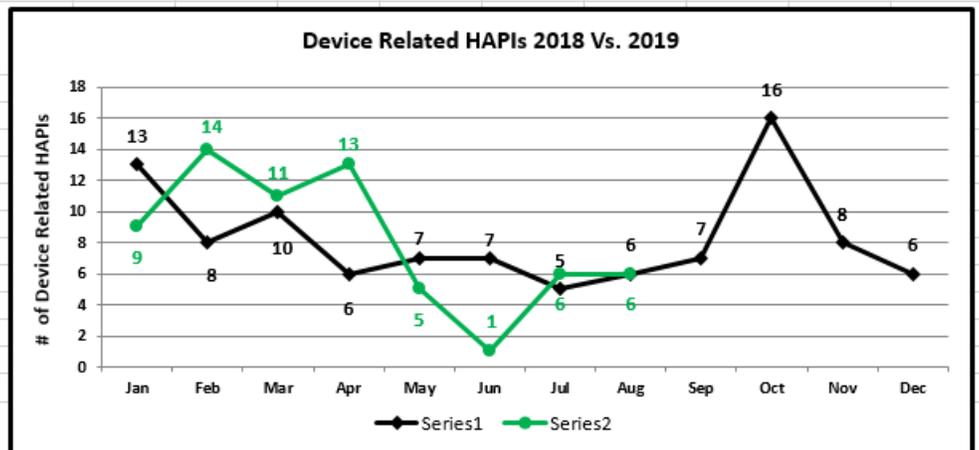
2019 device related HAPIs demonstrate a downward trend for April, May, and June with a slight upward trend for July and August, with 6 HAPI's each month.  Overall, trends are slightly worse with 3 more device related HAPIs at the end of August 2019 vs. end of August 2018.

***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

## Hospital Acquired Pressure Injury (HAPI) Summary - Quarters 1-3 (July/August) 2019

### HAPIs per Quarter 2019

| 2019 | Device Related | Non-Device Related | Total # of HAPIs | % of HAPIs per Quarter |
|---|---|---|---|---|
| 1st qtr | 34 | 37 | 71 | 53.0% |
| 2nd qtr | 19 | 16 | 35 | 26.1% |
| 3rd qtr (J/A) | 12 | 16 | 28 | 20.9% |
| 4th qtr | | | 0 | 0.0% |
| Total | 65 | 69 | 134 | |

**% of YTD Total # of HAPI Incidence Per Quarter**
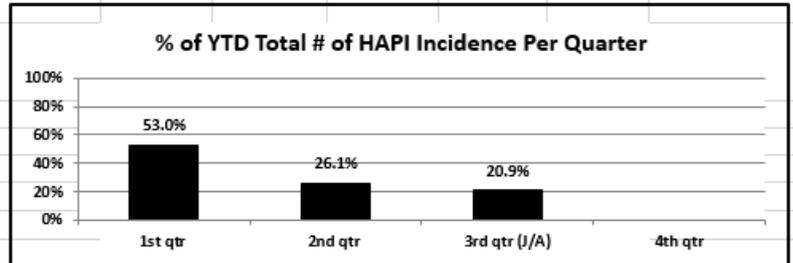


| 2019 | Device Related | Total # of HAPIs | % of Device Related HAPIs |
|---|---|---|---|
| 1st qtr | 34 | 71 | 47.9% |
| 2nd qtr | 19 | 35 | 54.3% |
| 3rd qtr (J/A) | 12 | 28 | 42.9% |
| 4th qtr | | | #DIV/0! |
| Total | 65 | 134 | 48.5% |

**% of Device Related HAPIs per Quarter 2019**
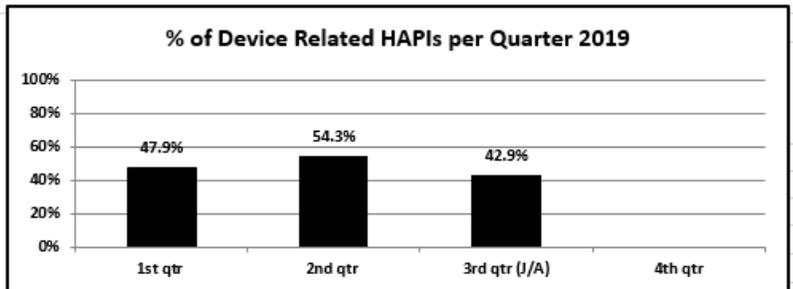


| 2019 | Non-Device Related | Total # of HAPIs | % of Non-Device Related HAPIs |
|---|---|---|---|
| 1st qtr | 37 | 71 | 52.1% |
| 2nd qtr | 16 | 35 | 45.7% |
| 3rd qtr (J/A) | 16 | 28 | 57.1% |
| 4th qtr | | | #DIV/0! |
| Total | 69 | 134 | 51.5% |

**% of Non-Device Related HAPIs per Quarter 2019**
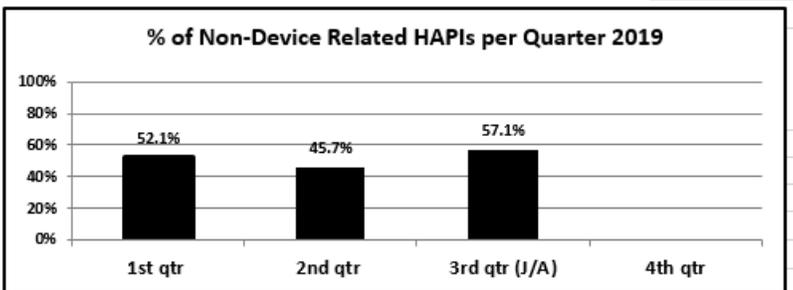


In Q2 2019, with the inception of the HAPI Prevention Quality Focus Team, a renewed focus on the reduction of device related hospital acquired pressure injuries began.  In Q2 2019, there was a slight increase compared to Q1 2019.  Year to date, Q3 2019 has demonstrated a slight decrease in device related HAPIs compared to Q1 and Q2 2019.  The percentage of non-device related HAPIs per quarter demonstrates an Inverse relationship to device related HAPIs with current device related HAPIs accounting for 48.5% of total HAPIs. Overall,  improvement has been noted with a consistent downward trend of total HAPI's from Q1 to Q3 2019, with Q3 accounting for only 20.9% of the HAPI's for the year.

*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
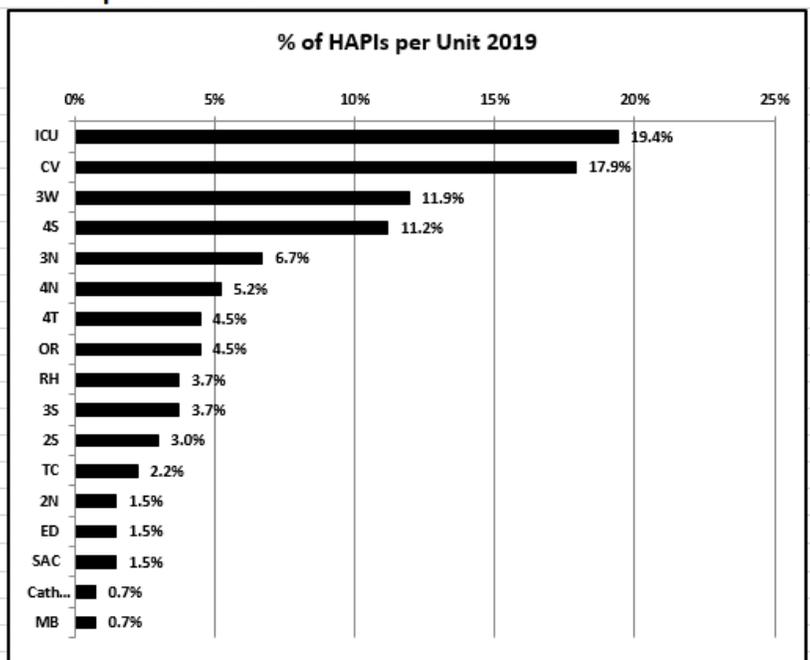Professional Staff Quality Committee/Quality Improvement Committee

## HAPIs per Unit 2019

| Units | Device Related | Non-Device Related | Total HAPIs | % of HAPIs |
|---|---|---|---|---|
| ICU | 15 | 11 | 26 | 19.4% |
| CV | 7 | 17 | 24 | 17.9% |
| 3W | 8 | 8 | 16 | 11.9% |
| 4S | 7 | 8 | 15 | 11.2% |
| 3N | 6 | 3 | 9 | 6.7% |
| 4N | 4 | 3 | 7 | 5.2% |
| 4T | 1 | 5 | 6 | 4.5% |
| OR | 2 | 4 | 6 | 4.5% |
| RH | 2 | 3 | 5 | 3.7% |
| 3S | 4 | 1 | 5 | 3.7% |
| 2S | 4 | 0 | 4 | 3.0% |
| TC | 1 | 2 | 3 | 2.2% |
| 2N | 1 | 1 | 2 | 1.5% |
| ED | 2 | 0 | 2 | 1.5% |
| SAC | 1 | 1 | 2 | 1.5% |
| Cath Lab | 0 | 1 | 1 | 0.7% |
| MB | 0 | 1 | 1 | 0.7% |
| **Total** | **65** | **69** | **134** | |



% of HAPIs per Unit 2019

| | ICU | CV | 3W | 4S | 3N | 4N | 4T | OR | RH | 3S | 2S | TC | 2N | ED | SAC | Cath... | MB |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 19.4% | 17.9% | 11.9% | 11.2% | 6.7% | 5.2% | 4.5% | 4.5% | 3.7% | 3.7% | 3.0% | 2.2% | 1.5% | 1.5% | 1.5% | 0.7% | 0.7% |

## Device Related HAPIs 2019

| Units | Device Related | % of HAPIs |
|---|---|---|
| ICU | 15 | 23.1% |
| 3W | 8 | 12.3% |
| 4S | 7 | 10.8% |
| CV | 7 | 10.8% |
| 3N | 6 | 9.2% |
| 2S | 4 | 6.2% |
| 4N | 4 | 6.2% |
| 3S | 4 | 6.2% |
| ED | 2 | 3.1% |
| OR | 2 | 3.1% |
| Reh | 2 | 3.1% |
| 2N | 1 | 1.5% |
| TC | 1 | 1.5% |
| 4T | 1 | 1.5% |
| SAC | 1 | 1.5% |
| **Total** | **65** | |



% of Device Related HAPIs per Unit 2019

| | ICU | 3W | 4S | CV | 3N | 2S | 4N | 3S | ED | OR | Reh | 2N | TC | 4T | SAC |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 23.1% | 12.3% | 10.8% | 10.8% | 9.2% | 6.2% | 6.2% | 6.2% | 3.1% | 3.1% | 3.1% | 1.5% | 1.5% | 1.5% | 1.5% |

In 2019, there was a trend in critical care units (ICU, CVICU, 3W) and one Medical Surgical Unit (4s) in which these units accounted for 60.4% of total HAPIs district wide.  Additionally,  a trend was noted that these units accounted for 57% of total device related HAPIs district wide.  This is a slight improvement from 2018, where these units accounted for 61.9% of total HAPIs and accounted for 66.6% of our total device related HAPIs district wide.

*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
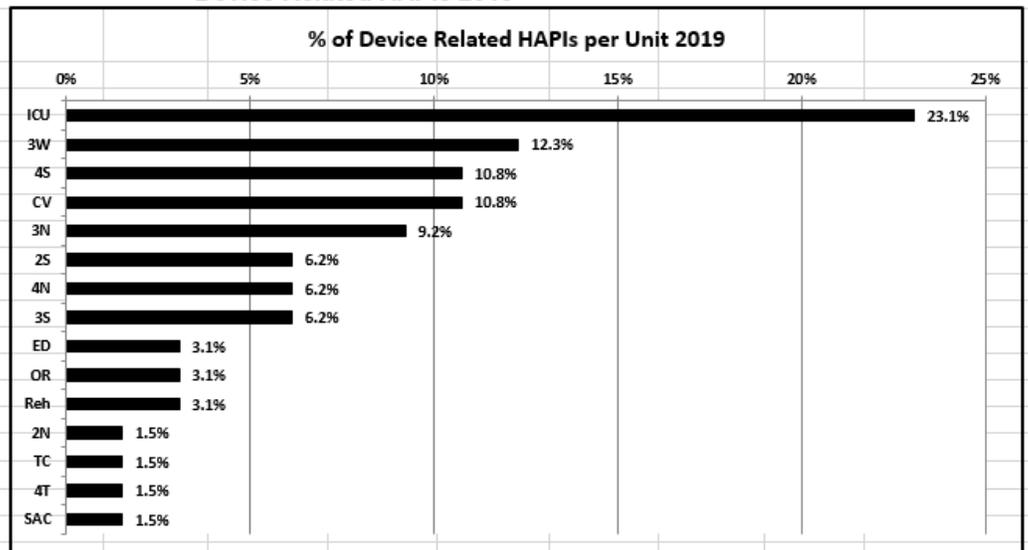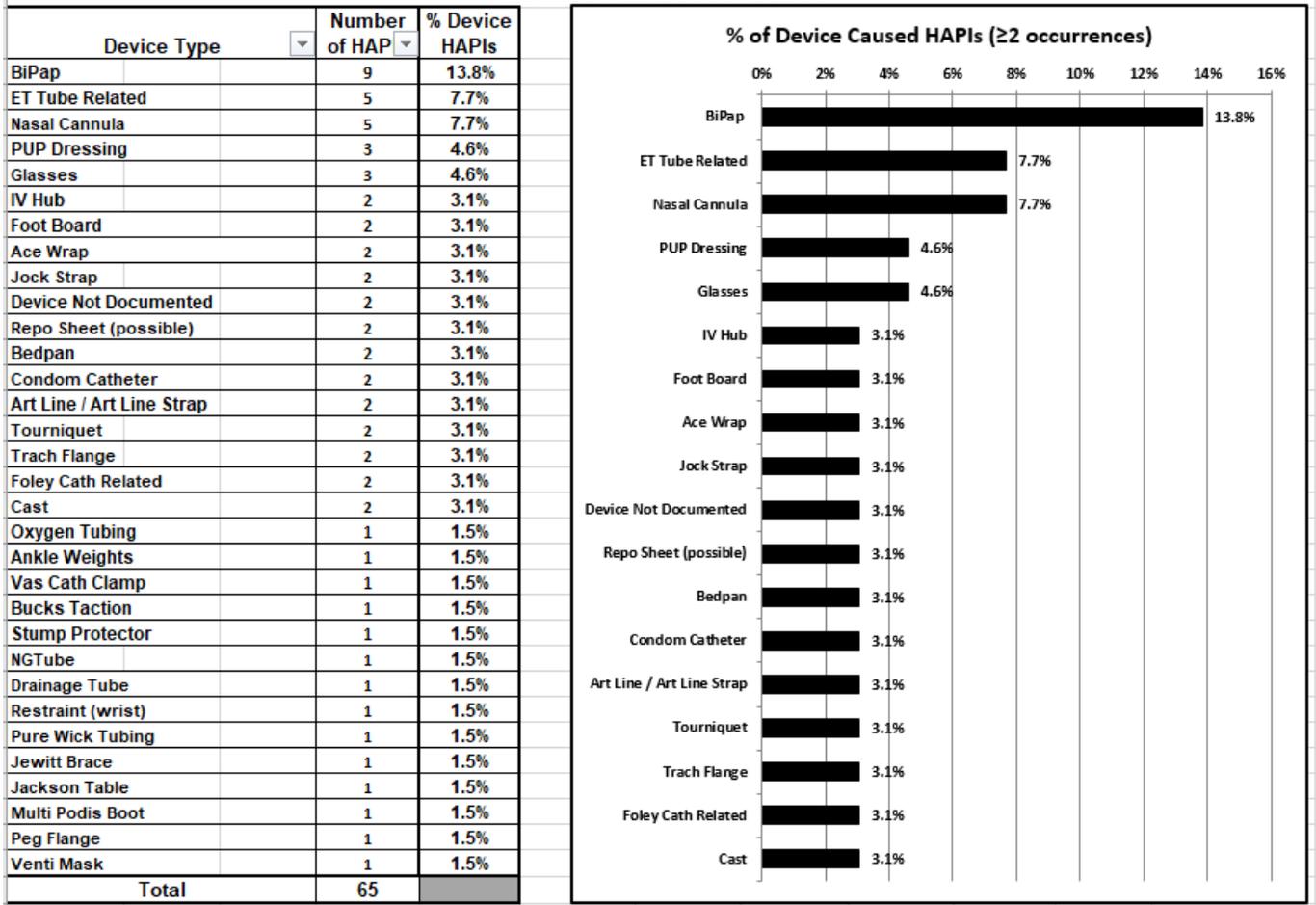Professional Staff Quality Committee/Quality Improvement Committee

## Devices Related HAPIs 2019

| Device Type | Number of HAP | % Device HAPIs |
|---|---|---|
| BiPap | 9 | 13.8% |
| ET Tube Related | 5 | 7.7% |
| Nasal Cannula | 5 | 7.7% |
| PUP Dressing | 3 | 4.6% |
| Glasses | 3 | 4.6% |
| IV Hub | 2 | 3.1% |
| Foot Board | 2 | 3.1% |
| Ace Wrap | 2 | 3.1% |
| Jock Strap | 2 | 3.1% |
| Device Not Documented | 2 | 3.1% |
| Repo Sheet (possible) | 2 | 3.1% |
| Bedpan | 2 | 3.1% |
| Condom Catheter | 2 | 3.1% |
| Art Line / Art Line Strap | 2 | 3.1% |
| Tourniquet | 2 | 3.1% |
| Trach Flange | 2 | 3.1% |
| Foley Cath Related | 2 | 3.1% |
| Cast | 2 | 3.1% |
| Oxygen Tubing | 1 | 1.5% |
| Ankle Weights | 1 | 1.5% |
| Vas Cath Clamp | 1 | 1.5% |
| Bucks Taction | 1 | 1.5% |
| Stump Protector | 1 | 1.5% |
| NGTube | 1 | 1.5% |
| Drainage Tube | 1 | 1.5% |
| Restraint (wrist) | 1 | 1.5% |
| Pure Wick Tubing | 1 | 1.5% |
| Jewitt Brace | 1 | 1.5% |
| Jackson Table | 1 | 1.5% |
| Multi Podis Boot | 1 | 1.5% |
| Peg Flange | 1 | 1.5% |
| Venti Mask | 1 | 1.5% |
| **Total** | **65** | |

### % of Device Caused HAPIs (≥2 occurrences)

| Device Type | % |
|---|---|
| BiPap | 13.8% |
| ET Tube Related | 7.7% |
| Nasal Cannula | 7.7% |
| PUP Dressing | 4.6% |
| Glasses | 4.6% |
| IV Hub | 3.1% |
| Foot Board | 3.1% |
| Ace Wrap | 3.1% |
| Jock Strap | 3.1% |
| Device Not Documented | 3.1% |
| Repo Sheet (possible) | 3.1% |
| Bedpan | 3.1% |
| Condom Catheter | 3.1% |
| Art Line / Art Line Strap | 3.1% |
| Tourniquet | 3.1% |
| Trach Flange | 3.1% |
| Foley Cath Related | 3.1% |
| Cast | 3.1% |

In 2019, there has been an increase in respiratory therapy device related HAPIs (BiPap, ET Tube, Nasal Cannula) which have accounted for 29.2% of all device related HAPIs. This statistic is worse when compared to 2018 where respiratory device related HAPIs (BiPap, Nasal Cannula, and High Flow Nasal Cannula) accounted for 17.2% of total HAPI's.
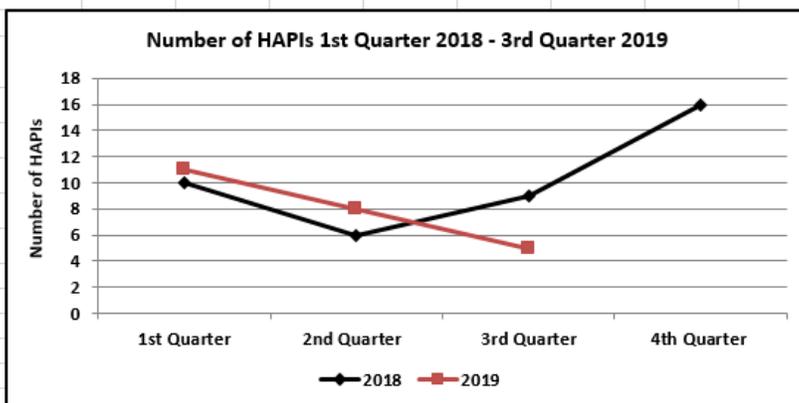
*Please submit your data along with the summary to your PI liaison 2 weeks prior to the scheduled report date.*

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

## HAPI Quarterly Prevalence Study Summary 1st Quarter 2018 - 3rd Quarter 2019

### Number of HAPIs

| | # of Patients Assessed 2018 | # of Patients Assessed 2019 | 2018 | 2019 |
|---|---|---|---|---|
| 1st Quarter | 273 | 243 | 10 | 11 |
| 2nd Quarter | 260 | 281 | 6 | 8 |
| 3rd Quarter | 267 | 281 | 9 | 5 |
| 4th Quarter | 268 | | 16 | |
| Total HAPIs | 1068 | 805 | 41 | 24 |



Number of HAPIS 1st Quarter 2018 - 3rd Quarter 2019

### % of all HAPIs

| | # of Patients Assessed 2018 | # of Patients Assessed 2019 | 2018 | 2019 |
|---|---|---|---|---|
| 1st Quarter | 273 | 243 | 3.66% | 4.52% |
| 2nd Quarter | 260 | 281 | 2.30% | 2.84% |
| 3rd Quarter | 267 | 281 | 3.37% | 1.77% |
| 4th Quarter | 268 | | 5.97% | |
| Total HAPIs | 1068 | 805 | 3.83 | 2.98 |



Percent HAPIs 1st Quarter 2018 - 3rd Quarter 2019
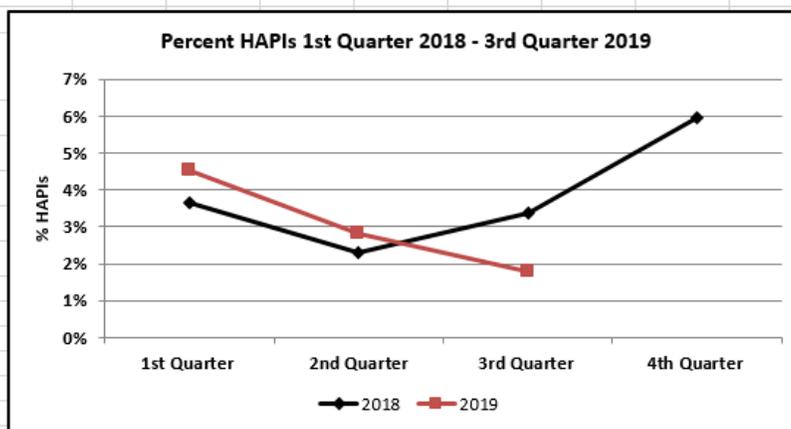
On August 8, 2019 the third quarter prevalence study was completed and results were sent to NDNQI. Of the 281 patients assessed for this quarter, 5 were noted to have a HAPI, which equals to 1.77% of patients assessed. These results demonstrate improvement from the previous prevalence study with a steady downward trend of HAPI's discovered during the study since Q1 2019.

## 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):

- Device associate pressure injuries comprise 50% of all HAPIs in the Medical Center.
- A request was made to Quality Council on June 13th to establish a HAPI QFT in an effort to emphasize the urgency of needed corrective action. This change should also include a member of the Executive Team to serve as sponsor. Initially, this sponsorship would include attendance at the meetings to emphasize the urgency of corrective action.
- Analysis of the data indicates that ICU (23.1%), CVIUC (10.8%), 3W (12.3%) and 4South (10.8%) are the units with the highest incidence of device related pressure injuries. Work conducted in the CVICU identified hemodynamic instability places patients at higher risk for development of device related (and other) HAPIs. The CV has implemented a "turn q 2 and adjust" program in which devices are released and repositioned as long as safe to do so.
- Bipap, ET tubes and nasal cannulas are the primary devices associated with device related HAPIs.

*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

- Q3 Prevalence study indicates improvements compared to 2019 Q 1 & 2.
- Heels, sacrum and coccyx are the most common areas identified in non-device related HAPIs.
- Opportunities to enhance and improve previous Wound Committee structure, planning and collaboration were identified and changes implemented.
- Analysis of RN onboarding/education process indicated inconsistent completion of required core competencies.  Knowledge deficits exist and primary opportunities begin with new hire orientation. The current process includes a computer based learning module, didactic class and time with the wound nurses. Tracking completion of these requirements has been a manual process completed by the unit nurse manager.
- Opportunities exist in the general and cardiac surgery areas to enhance pressure relief. Table surfaces have been evaluated.
- The current wound policy, while adequate, could benefit from a comprehensive review and revision.

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

1. HAPI Prevention QFT was established June 19, 2019 and meets every 2 weeks until consistent improvement in device related HAPIs occurs. Membership includes directors, nurse managers, clinical education and APN representative of the units with the highest numbers of fall outs. Additional members include Respiratory Therapy and Float Pool nursing leaders. Malinda Tupper, CFO serves as the ET sponsor.
2. Respiratory Therapy facilitated immediate implementation of the following interventions:
   a) RT staff education on HAPI prevention and assessment.
   b) Skin assessment and HAPI prevention now included in new hire orientation checklist.
   c) RT skin assessment frequency increased from q12 hours to q4 hours.
   d) Partnering with nursing staff in critical care areas to round on patients with respiratory devices to release, assess skin and mucosal tissues and then readjust devices.
   e) Developing a plan to round on patients utilizing Bipap or Cpap on the adult med/surg units q4 hours to release, assess and readjust devices in collaboration with nursing.
3. Comprehensive review and redesign of nursing HAPI prevention onboarding and education. This process includes 3 separate educational segments and will now include skill validation checklists for all new hires. The first revision, completion of the computer based learning module, will require RNs to complete this module no later than 12/31/19. Completion of the comprehensive review and revision of the didactic and wound nurse shadow experience is targeted for Q1, 2020. This will also include a completion time of 6 months. Previously, new RNs had 12 months to complete all three elements of education.
4. Tracking of RN completion of the core curriculum will now be assigned to all new hires utilizing MyNetLearning, automating the process and accountability for completion.
5. Comprehensive review and revision of wound care policies, procedures and power plans is currently under way utilizing best practice reviews in the revision process. Completion of this review is targeted for Q2, 2020.
6. Development of a "Protective Wound Dressing Power Plan" is currently in development to help bridge care and protect wound beds between orders for a wound nurse consultation and actual consultation. Completion and implementation of this power plan is targeted for Q4, 2019.

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

7. Expansion of wound care nurse scheduling to include Saturday and holiday coverage is targeted for 11/3/19. This will increase coverage and decrease consultation delays.

8. Surgical Services (general and CV) has conducted a review of table surfaces and replaced mattresses which were in need of replacement. Exploring use of waffle mattresses for select cases. The team is working collaboratively with the wound nurses to track outcomes related to use of preventive measures on cases with long table times. Also placing protective dressings to the sacrum and coccyx as case urgency allows.

9. Streamlined quarterly NDNQI Prevalence Study process. Eliminated unnecessary data collection and implemented a pre-survey huddle to streamline data collection and accuracy.

10. Re-establish unit-level accountability through a monthly review of device related pressure injuries. This will require NMs of the areas with the injuries to meet with the chair of the HAPI Prevention QFT to discuss strategies/interventions to prevent the next injury from occurring. Targeted implementation no later than Q1, 2020.

## Next Steps/Recommendations/Outcomes:

See above for details.

1. The wound nurses recommend annual hands on competency fair to allow nurses to refresh and validate skills related to wound care treatment, staging and documentation.

## Submitted by Name:                                    Date Submitted:

Rose Newsom, MSN                                         October 2, 2019
Director of Nursing Practice
Chair, HAPI QFT

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