January 13, 2022

NOTICE

The Board of Directors of the Kaweah Delta Health Care District will meet in a Quality Council Committee meeting at 7:00AM on Thursday, January 20, 2022, in the Kaweah Health Lifestyle Fitness Center Conference Room, 5105 W. Cypress Avenue, Visalia, CA 93277.
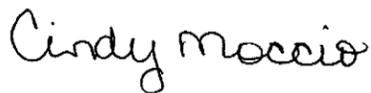
The Board of Directors of the Kaweah Delta Health Care District will meet in a Closed Quality Council Committee at 7:01AM on Thursday, January 20, 2022, in the Kaweah Health Lifestyle Fitness Center Conference Room, 5105 W. Cypress Avenue, Visalia, CA 93277, pursuant to Health and Safety Code 32155 & 1461.

The Board of Directors of the Kaweah Delta Health Care District will meet in an open Quality Council Committee meeting at 8:00AM on Thursday, January 20, 2022, in the Kaweah Health Lifestyle Fitness center Conference Room, 5105 W. Cypress Avenue, Visalia, CA 93277.

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

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

KAWEAH DELTA HEALTH CARE DISTRICT
Michael Olmos, Secretary/Treasurer

Cindy Moccio
Board Clerk, Executive Assistant to CEO

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

![Kaweah Health]

KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS
QUALITY COUNCIL
Thursday, January 20, 2022
5105 W. Cypress Avenue
Kaweah Health Lifestyle Fitness Center Conference Room

ATTENDING: Board Members; David Francis – Committee Chair, Michael Olmos; Gary Herbst, CEO; Keri Noeske, RN, BSW, DNP, Vice President & CNO; Monica Manga, MD, Chief of Staff; Daniel Hightower, MD, Professional Staff Quality Committee Chair; Tom Gray, MD, Quality and Patient Safety Medical Director; Sandy Volchko DNP, RN CLSSBB, Director of Quality and Patient Safety; Ben Cripps, Vice President, Chief Compliance and Risk Management Officer; Evelyn McEntire, Director of Risk Management; and Michelle Adams, Recording.

OPEN MEETING – 7:00AM

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

2. **Public / Medical Staff participation –** Members of the public may comment on agenda items before action is taken and after it is discussed by the Board. Each speaker will be allowed five minutes. Members of the public wishing to address the Board concerning items not on the agenda and within the jurisdiction of the Board are requested to identify themselves at this time. For those who are unable to attend the beginning of the Board meeting during the public participation segment but would like to address the Board, please contact the Board Clerk (Cindy Moccio 559-624-2330) or cmoccio@kaweahhealth.org to make arrangements to address the Board.

3. **Approval of Quality Council Closed Meeting Agenda** – 7:01AM
   o **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Daniel Hightower, MD, and Professional Staff Quality Committee Chair; James McNulty*
   o **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Evelyn McEntire, RN, BSN, Director of Risk Management and Ben Cripps, Vice President & Chief Compliance and Risk Officer.*

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

CLOSED MEETING – 7:01AM

1. **Call to order** – *David Francis, Committee Chair & Board Member*
2. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Daniel Hightower, MD, and Professional Staff Quality Committee Chair*

3. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Evelyn McEntire, RN, BSN, Director of Risk Management, and Ben Cripps, Vice President & Chief Compliance and Risk Officer.*

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

OPEN MEETING – 8:00AM

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

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

3. **Written Quality Reports** – A review of key quality metrics and actions associated with the following improvement initiatives:
   3.1. Renal Services – Network 18 Quality Report
   3.2. Rapid Response Team (RRT) Quality Update
   3.3. Stroke Program Quality Report
   3.4. Sepsis Quality Focus Team (QFT) Update
   3.5. CAUTI Quality Focus Team (QFT) Update

4. **Update: Clinical Quality Goals** - A review of current performance and actions focused on the fiscal year 2022 clinical quality goals. *Sandy Volchko, RN, DNP, Director of Quality and Patient Safety*.

5. **Annual Review of Quality and Patient Safety Plans** – A review of the AP.41 Quality Improvement Plan and AP.175 Patient Safety Plan including high risk, problem prone, high volume quality improvement initiatives for 2022. *Sandy Volchko, RN, DNP, Director of Quality and Patient Safety*

6. **Rehabilitation Services Quality Report** – Review of key quality indicators and associated action plans for improvement focused on the rehabilitation patient population. *Molly Niederreiter, Director of Rehabilitation Services & Elisa Venegas, Director of Nursing Rehabilitation and Skilled Nursing Services.*

7. **Adjourn Open Meeting** – *David Francis, Committee Chair*

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

KAWEAH DELTA VISALIA HEMODIALYSIS — Year: 2021

QAPI Indicators

Month / INDICATORS	QIP Benchmark (90th percentile)	QIP Performance Standard (50th percentile)	QIP Achievement Threshold (15th percentile)	US Threshold (Core Survey)	Optimal Goal	Clinic Goal	J HD	F HD	M HD	A HD	M HD	J HD	J HD	A HD	S HD	O HD	N HD	D HD	AVG HD
Total Patient Census							135	138	143	140	140	141	139	140	144	141	137		140
> 90 days on ESRD, > 30 days in clinic (as indicated by QIP)							126	122	120	117	119	124	132	130	132	125	122		124

RENAL CARE COORDINATOR

INDICATORS	QIP Benchmark (90th percentile)	QIP Performance Standard (50th percentile)	QIP Achievement Threshold (15th percentile)	US Threshold (Core Survey)	Optimal Goal	Clinic Goal	J HD	F HD	M HD	A HD	M HD	J HD	J HD	A HD	S HD	O HD	N HD	D HD	AVG HD
% KT/V ≥ 1.2 (QIP)	99.42%	97.61%	94.33%	97.9%	99.42%	97.61%	97.3%	93.0%	97.3%	95.6%	94%	96%	94%	97%	96.7%	97.3%	100%		96.20%
Standardized Transfusion Ratio (STrR) Reporting Measure (QIP)	Yes	Yes	Yes		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		
# of Transfusions					0	0	4	1	4	0	2	0	0	3	2	3	3		
NHSN BSI Ratio (SIR = # observed BSI / # of predicted BSI) (QIP)	0	0.516	1.193		0	1.5	4.662	0	3.493	3.461	2.626	0.907	3.951	1.815	3.195	3.069	0.898		2.552
# of BSI's	0	9	20		0	1	5	0	4	4	3	1	5	2	3	3	1		31
Dialysis events/ required components reported in NHSN (QIP)	Yes	Yes	Yes		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		
Standardized Readmission Ratio (SRR) (QIP & DFC) (2 months behind QAPI reporting)	0.629	0.998	1.268		0.629	0.998	2.198	2.198	1.709	1.465	1.465	2.197	1.953	1.953	1.709	1.953			1.880
# of Readmissions	31	49	62		2.5	4	9	9	7	6	6	9	8	8	7	8			
Standardized Hospitalization Ratio (SHR) (QIP & DFC)	0.670	0.967	1.248		0.670	0.967	1.786	1.471	1.628	0.735	1.156	1.103	1.155	1.313	1.260	1.365	1.208		1.289
Total # of Hospitalizations	153	228	289		12.75	19	34	28	31	14	22	21	22	25	24	26	23		
# of Patients with a Hospitalization							32	23	25	10	19	18	19	19	20	21	20		
% of Patients with Hepatitis B Complete Series (including currently receiving)							83.7%	91.1%	84.1%	82.2%	76.0%	76.4%	81.0%	76.3%	DATA NOT AVAILABLE				81.4%
Hepatitis B - # Immune							79	91	93	88	81	79	81	78	DATA NOT AVAILABLE				
Hepatitis B - # Currently Receiving							22	19	27	13	10	11	16	11	DATA NOT AVAILABLE				
Hepatitis B - # Refusing							5	4	4	5	5	12	12	12	DATA NOT AVAILABLE				
Hepatits B - # Nonresponders							12	13	15	15	15	17	17	17	DATA NOT AVAILABLE				
% of Patients with Influenza Vaccine (9/2020 - 8/2021 Season) (9/2021 - CURRENT)							89.1%	87.0%	81.0%	70.0%	77.1%	75.0%	77.4%	74.1%	0.7%	52.5%	59.1%		
% of Patients with Pneumococcal Vaccine							93.4%	96.6%	83.5%	86.0%	81.4%	76.4%	82.3%	81.3%	DATA NOT AVAILABLE				
% of Patients with COVID-19 Vaccine							0.1%	0.2%	47.5%	69.2%	72.8%	73.0%	77.0%	80.5%	81.9%	86.5%	91.9%		

DIETITIANS

INDICATORS	QIP Benchmark (90th percentile)	QIP Performance Standard (50th percentile)	QIP Achievement Threshold (15th percentile)	US Threshold (Core Survey)	Optimal Goal	Clinic Goal	J HD	F HD	M HD	A HD	M HD	J HD	J HD	A HD	S HD	O HD	N HD	D HD	AVG HD
% Albumin < 3.5 g/dL (lower is better)				67.7%	0.0%	20.0%	17.52%	24.48%	27.59%	6.29%	2.80%	4.90%	9.09%	11.51%	9.22%	7.30%	6.67%		11.58%
% Calcium uncorrected > 10.2 mg/dL (all patients) (lower is better)				1.3%	0.0%	0.95%	2.19%	1.40%	0.69%	0.69%	0.70%	2.10%	1.39%	0.00%	0.00%	0.00%	0.74%		0.90%
% Hypercalcemia (Uncorrected serum calcium > 10.2 mg/dL) (QIP) (3 month rolling avg) (lower is better)	0.00%	0.49%	1.54%		0.0%	0.49%	0.72%	1.38%	1.37%	0.69%	0.00%	1.39%	0.68%	1.43%	0.70%	0.00%	0.00%		0.76%
% Phosphorus > 7.0 mg/dL (lower is better)				12.6%	10%	12.6%	7.3%	8.39%	5.52%	10.49%	10.49%	10.49%	8.39%	7.91%	7.80%	4.38%	7.41%		8.05%
% Phosphorus > 5.5 mg/dL (lower is better)					20%	35%	30.66%	35.66%	32.41%	40.56%	45.45%	39.86%	40.56%	33.81%	34.04%	30.66%	32.59%		36.02%

CLINIC PHARMACIST

INDICATORS	QIP Benchmark (90th percentile)	QIP Performance Standard (50th percentile)	QIP Achievement Threshold (15th percentile)	US Threshold (Core Survey)	Optimal Goal	Clinic Goal	J HD	F HD	M HD	A HD	M HD	J HD	J HD	A HD	S HD	O HD	N HD	D HD	AVG HD
% Intact PTH 150 - 600 (3 month rolling avg) (All patients) (higher is better)					80%	70%	72.3%	69.30%	69.35%	70.60%	70.10%	63.72%	58.59%	56.68%	55.40%	57.40%	56.80%		63.66%
% Intact PTH > 600 (all patients) (lower is better)					10%	15%	21.4%	17.30%	15.16%	15.97%	18.50%	29.08%	35.35%	37.89%	34.04%	35.40%	35.70%		26.89%
% Hgb 10 - 12g/dL (higher is better)					90%	70%	69.0%	62.8%	72.1%	71.2%	64.4%	77.1%	66.0%	66.4%	73.6%	74.6%	75.2%		70.2%

Month	QIP Benchmark (90th percentile)	QIP Performance Standard (50th percentile)	QIP Achievement Threshold (15th percentile)	US Threshold (Core Survey)	Optimal Goal	Clinic Goal	J	F	M	A	M	J	J	A	S	O	N	D	AVG
INDICATORS							HD	HD	HD	HD	HD	HD	HD	HD	HD	HD	HD	HD	HD
% Hgb 9-12g/dL (higher is better)					100%	80%	81.0%	73.8%	86.4%	84.3%	81.5%	86.8%	77.8%	80.0%	84.7%	86.9%	89.7%		
% Hgb < 10g/dL (lower is better)				16.8%	16.8%	20%	25.4%	30.3%	22.4%	20.5%	26.7%	16.0%	24.3%	25.0%	20.0%	21.0%	21.2%		23.0%
% Saturation ≥ 20 (3 month rolling avg) (higher is better)					70%	65%	65.0%	61.6%	63.3%	61.3%	63.6%	64.4%	62.6%	69.2%	71.7%	72.8%	69.9%		65.9%
% Ferritin 200 - 1200ng/ml (3 month rolling avg) (higher is better)					70%	65%	81.0%	81.0%	79.0%	75.2%	74.9%	77.0%	79.4%	77.4%	79.6%	84.1%	84.5%		79.4%
CHRONIC RENAL ACCESS COORDINATOR (CRAC)																			
Standardized Fistula Rate (SFR) (% AVF using 2 needles) (QIP & DFC) (higher is better)	76.77%	64.36%	53.29%		70%	62%	57.00%	55.10%	51.00%	52.00%	51.70%	51.40%	51.40%	56.00%	55.50%	56.00%	56.20%		53.94%
% AVG							9.9%	8.8%	10.2%	10.1%	9.5%	11.0%	10.8%	9.9%	11.6%	10.6%	9.50%		10.2%
Long Term Catheter Rate (% Catheters > 90 days) (QIP & DFC) (lower is better)	4.69%	11.04%	18.35%	10.7%	10%	17%	21.10%	22.90%	25.10%	23.40%	27.00%	27.00%	24.30%	24.10%	24.60%	21.30%	21.20%		23.82%
Catheter Rate (All Patients)							33.1%	36.45%	38.7%	38.2%	39.2%	38.0%	37.8%	34.0%	32.8%	33.4%	34.3%		36.00%
% Catheter + AVF							5.6%	5.4%	6.1%	6.7%	6.1%	9.0%	10.1%	8.5%	7.5%	2.6%	3.6%		6.5%
% Catheter + AVG							0.7%	2.0%	2.0%	1.3%	2.0%	1.4%	2.0%	2.1%	0.7%	0.0%	0.0%		1.3%
% Catheter < 90 days							12.0%	13.5%	13.6%	14.8%	12.2%	11.0%	13.5%	9.9%	8.2%	9.5%	9.5%		11.6%
Thrombosis Events: AVF % < 2							NO DATA	NO DATA	NO DATA	NO DATA	NO DATA	NO DATA	NO DATA	NO DATA	NO DATA	NO DATA	NO DATA		
# of AVF Thrombosis Events							1	0	0	1	0	0	0	0					
Thrombosis Events: AVG % < 1							NO DATA	NO DATA	NO DATA	NO DATA	NO DATA	NO DATA	NO DATA	NO DATA	NO DATA	NO DATA	NO DATA		
# of AVG Thrombosis Events							1	1	1	0	0	2	1	1					
VA patency: % w/AVF > 3 years							NO DATA	NO DATA	NO DATA	NO DATA	NO DATA	NO DATA	NO DATA	NO DATA	NO DATA	NO DATA	NO DATA		
VA patency: % w/AVG > 2 years							NO DATA	NO DATA	NO DATA	NO DATA	NO DATA	NO DATA	NO DATA	NO DATA	NO DATA	NO DATA	NO DATA		
Infections per use-life of AVF < 1%							NO DATA	NO DATA	NO DATA	NO DATA	NO DATA	NO DATA	NO DATA	NO DATA	NO DATA	NO DATA	NO DATA		
# of AVF Infections							0	0	1	1	0	1	3	0	0	0	0		
Infections per use-life of AVG < 10%							NO DATA	NO DATA	NO DATA	NO DATA	NO DATA	NO DATA	NO DATA	NO DATA	NO DATA	NO DATA	NO DATA		
# of AVG Infections							1	0	0	1	0	0	0	0	0	2	0		
CLINIC MANAGER																			
Hand Hygiene Observed by Staff					100%	100%	100%	100%	100%	100%	100%	98%	100%	100%	100%	100%	95%		99.4%
Hand Sanitizer Observed by Staff					100%	100%	100%	100%	100%	100%	100%	100%	100%	90%	100%	100%	100%		99.1%
Catheter Connection					100%	100%	100%	100%	60%	100%	100%	100%	100%	100%	100%	80.0%	100.0%		94.5%
Catheter Disconnection					100%	100%	100%	100%	100%	100%	67%	100%	100%	86%	100%	100.0%	100.0%		95.7%
CVC Exit Site Care					100%	100%	83%	100%	67%	100%	86%	100%	100%	80%	100%	100.0%	100.0%		92.4%
AVF/AVG Cannulation					100%	100%	100%	89%	67%	80%	90%	88%	83%	100%	40%	75.0%	100.0%		82.9%
AVF/AVG Decannulation					100%	100%	100%	83%	67%	40%	100%	67%	13%	88%	78%	80.0%	100.0%		74.2%
Dialysis Station Disinfection					100%	100%	55%	65%	65%	60%	40%	60%	60%	70%	60%	75.0%	76.0%		62.4%
Injection Safety Preparation					100%	100%	100%	42%	40%	70%	80%	90%	86%	100%	100%	91.0%	100.0%		81.7%
Infection Safety Administration					100%	100%	78%	65%	74%	95%	75%	95%	90%	95%	100%	90.0%	95.0%		86.5%
Hand Hygiene Observed by Patients					100%	100%	93%	88%	100%	100%	96%	96%	NO DATA	100%	80%	100.0%	100.0%		95.3%

Month	QIP Benchmark (90th percentile)	QIP Performance Standard (50th percentile)	QIP Achievement Threshold (15th percentile)	US Threshold (Core Survey)	Optimal Goal	Clinic Goal	J	F	M	A	M	J	J	A	S	O	N	D	AVG
INDICATORS							HD	HD	HD	HD	HD	HD	HD	HD	HD	HD	HD	HD	HD
Station Disinfection Observed by Patients					100%	100%	70%	40%	70%	50%	60%	60%	NO DATA	90%	40%	90.0%	70.0%		64.0%
ICH CAHPS: Overall Rating of Dialysis Center Staff (QIP)	78.30%	63.37%	50.02%		78.30%	63.37%	77.8%			90.5%									
ICH CAHPS: Overall Rating of the Dialysis Facility (QIP)	83.72%	69.04%	54.51%		83.72%	69.04%	85.2%			85.7%									
ICH CAHPS: Nephrologists' Communication and Caring (QIP)	79.15%	67.90%	58.20%		79.15%	67.90%	63.8%			82.6%									
ICH CAHPS: Quality of Dialysis Center Care and Operations (QIP)	72.66%	63.08%	54.64%		72.66%	63.08%	65.6%			81.4%									
ICH CAHPS: Providing Information to Patients (QIP)	87.80%	81.09%	74.49%		87.80%	81.09%	71.1%			81.9%									
ICH CAHPS: Overall Rating of Nephrologists (QIP)	76.57%	62.22%	49.33%		76.57%	62.22%	71.9%			81.8%				(Fall Survey Period October 2021 - January 2022)					
Total # missed treatments							145	86	112	73	69	89	69	117	108	83	75		
# pts with 1 missed treatment							17	32	30	22	23	17	14	28	25	24	11		
# pts with 2 missed treatments							9	8	9	12	4	9	6	5	12	10	13		
# pts with ≥ 3 missed treatments							28	9	15	7	8	11	10	19	13	8	9		
# Restart							0	0	0	0	0	0	0	1	0	0	0		
# Recovered Function							0	1	0	0	2	2	1	1	0	0	0		
# New Admissions							2	6	7	3	4	5	1	0	1	3	0		
# Acute Kidney Injury							5	7	4	6	4	2	3	3	3	3	0		
# Transients							5	2	3	3	3	1	2	1	3	3	0		
# Transfer in (includes modality change)							0	2	0	2	2	3	3	1	1	2	0		
# Transfer out (chronic, acute, transients, transplant, discontinue)							6	3	8	4	7	6	5	0	5	6	2		
# Transfer out due to hospital > 30 days							0	0	0	0	0	0	0	0	0	0	0		
# of Mortalities (DFC: Standardized Mortality Rate (SMR))							3	5	5	3	0	2	2	0	7	2	0		
# Medical Errors and Occurrences							12	16	6	6	3	5	10	8	4	8	2		
% Patients with Avg UFR > 13 ml/kg/hr (lower is better)				9.4%	0%	30%	13.87%	12.32%	13.38%	13.48%	16.08%	12.06%	14.7%	9.4%	21.9%	19.4%	21.80%		15.3%
Ultrafiltration Rate Reporting Measure (QIP)	Yes	Yes	Yes		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		
Patient education and training: experience, treatment options, self-care, QOL, infection prevention, rehabilitation, etc.					Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		
Medication Reconciliation Reporting Measure (QIP)	Yes	Yes	Yes		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		
% of Medication Reconciliations Completed					100%	100%	92.3%	93.8%	84.6%	93.2%	90.0%	92.8%	93.1%	97.8%	100.0%	100.0%	100.0%		94.3%
SOCIAL WORKERS																			
% Prevalent Patients Waitlisted (PPPW) (QIP)	33.90%	16.73%	8.12%	20.1%	33.90%	20.1%	27.5%	27.0%	26.0%	26.0%	27.0%	29.0%	29.0%	29.0%	31.0%				27.9%
% of KDQOL Assessments completed within 3 months of initial treatment					100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%				100%
% of KDQOL Assessments completed annually					100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%				100%
Grievances - Total #							0	0	0	0	0	0	0	1	0				
Grievances - # Resolved							0	0	0	0	0	0	0	1	0				
Grievances - # Escalated							0	0	0	0	0	0	0	0	0				
Clinical depression screening and follow up Reporting Measure (QIP)	Yes	Yes	Yes		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		

FACILITY: Kaweah Delta Visalia Hemodialysis				Month:	Oct - Nov	Year:	2021

ADEQUACY MANAGEMENT - Response by Clinical Coordinator —

QIP needed?	Yes	**X**	No	
Follow up needed?	Yes	**X**	No	

Data Comparison

| QIP Benchmark	QIP Perf Standard	QIP Achieve Threshold	US Threshold (Core Survey)	Optimal Goal	Clinic Goal
99.42%	97.61%	94.33%	97.90%	99.42%	97.61%

Notes

Data Source: QMAT, Clinical Coordinator internal tracking

% Kt/V >/= 1.2 (QIP)

	J	F	M	A	M	J	J	A	S	O	N	D
% Kt/V >/= 1.2 (QIP)	97.3%	93.0%	97.3%	95.6%	94%	96%	94%	97%	96.7%	97.3%	100%	
Optimal Goal	99.42%	99.42%	99.42%	99.42%	99.42%	99.42%	99.42%	99.42%	99.42%	99.42%	99.42%	99.42%
Clinic Goal	97.61%	97.61%	97.61%	97.61%	97.61%	97.61%	97.61%	97.61%	97.61%	97.61%	97.61%	97.61%

PDCA CYCLE

FINDINGS:4 patients did not meet Clearance, Kt/V <1.2 (Clinic Goal >1.2)
Related to :
1. New AVF, just graduated to #15g needles prior to end of month.

INTERVENTIONS:
1. Review kt/V with monthly labs , and consult with MD if order changes needed now that patient is on #15g needles.
2. Continue to alert MD's of patients not meeting clinic goal of >1.2, and attempting to receive new orders.

Plan: 1. Redraw Kt/V with monthly lab draws. 2. Consult with MD regarding all patients not meeting clinic goal of 1.2 and obtain orders as needed.
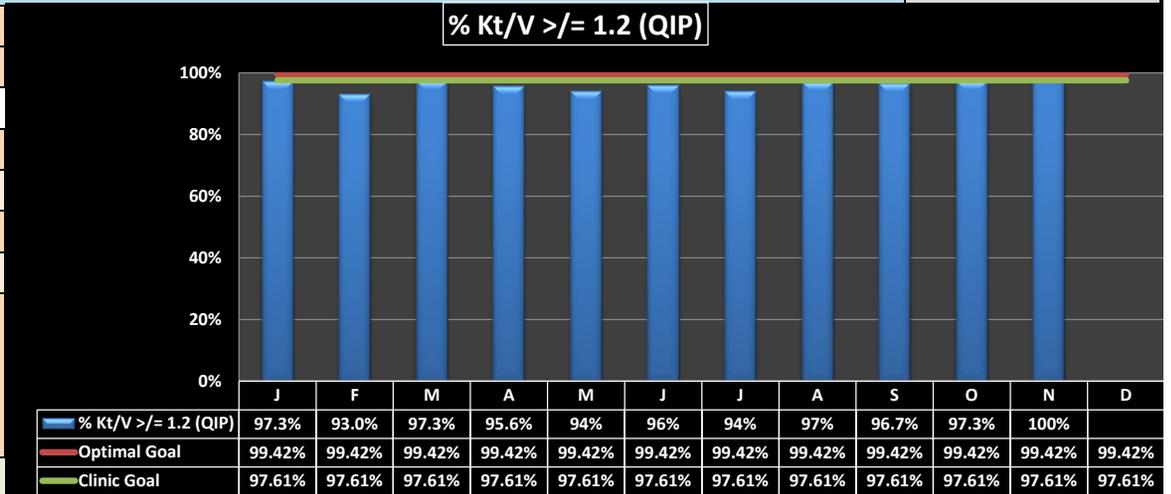
INFECTIONS: NHSN BSI Rate - Response by Clinical Coordinator —

QIP needed?	Yes	**X**	No	
Follow up needed?	Yes	**X**	No	

Data Comparison

QIP Benchmark	QIP Perf Standard	QIP Achieve Threshold	US Threshold (Core Survey)	Optimal Goal	Clinic Goal
0.000	0.516	1.193	N/A	0.000	1.500

Notes

Data Source: NHSN, Clinical Coordinator internal tracking

NHSN SIR (SIR=# observed BSI/# predicted BSI) (QIP)
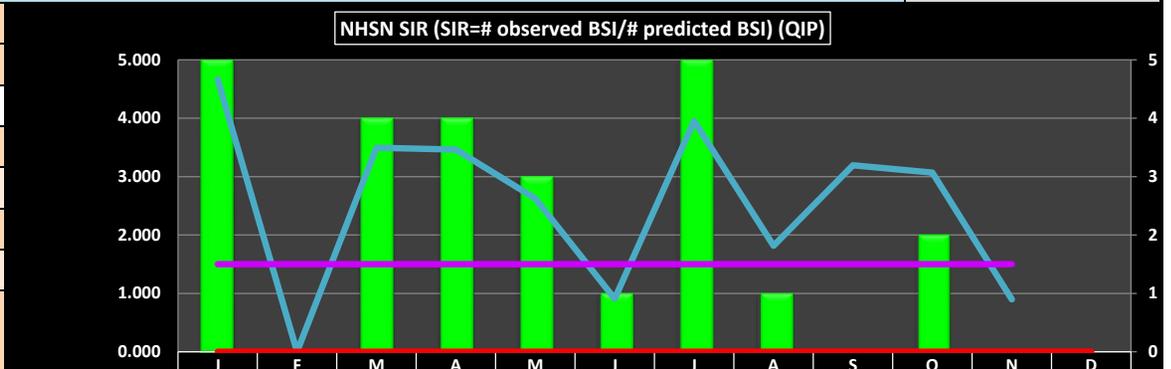
# of ARBSI's	5	0	4	4	3	1	5	1	0	2	0	
NHSN SIR	4.662	0	3.493	3.461	2.626	0.907	3.951	1.815	3.195	3.069	0.898	
Clinic Goal	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	
Optimal Goal	0	0	0	0	0	0	0	0	0	0	0	0

PDCA CYCLE

FINDINGS: 3 BSI's in August; 2 reportable
1. Contaminant in ER- Staph epidermidis/coag neg staph. Occurrence report filled out for tracking purposes.
2. Staph haemolyticus/enterococcus faecium.

INTERVENTIONS: Notify nephrologist of any abnormal results. Obtain orders for antibiotics and f/u lab work per MD.

PLAN:
Continue to monitor results for clinic drawn and externally drawn blood cultures. Report all BSI's to NHSN monthly.

HEALTH OUTCOMES: Standardized Readmission Ratio - Response by Clinical Coordinator   DATA

QIP needed?		Yes	**X**	No	
Follow up needed?		Yes	**X**	No	

Data Comparison

QIP Benchmark	QIP Perf Standard	QIP Achieve Threshold	US Threshold (Core Survey)	Optimal Goal	Clinic Goal
0.629	0.998	1.268	N/A	0.629	0.998

Notes

Data Source: QMAT, Clinical Coordinator internal tracking; Benchmark = 31, Performance Standard = 49, Achievement Threshold = 62

PDCA CYCLE

Standardized Readmission Ratio (SRR) (QIP & DFC) (2 months behind QAPI reporting)

	J	F	M	A	M	J	J	A	S	O	N	D
# of Readmissions	9	9	7	6	6	9	8	8	7	8		
Standardized Readmission Ratio (SRR) (QIP & DFC) (2 months behind QAPI reporting)	2.198	2.198	1.709	1.465	1.465	2.197	1.953	1.953	1.709	1.953		
Clinic Goal	0.998	0.998	0.998	0.998	0.998	0.998	0.998	0.998	0.998	0.998	0.998	0.998
Optimal Goal	0.629	0.629	0.629	0.629	0.629	0.629	0.629	0.629	0.629	0.629	0.629	0.629
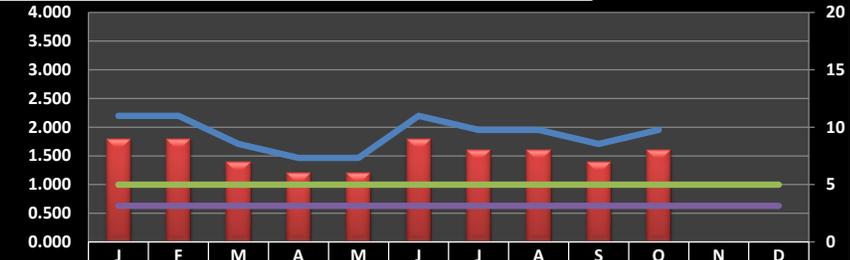
FINDINGS: 8 Readmissions (between 4-30days), involving 6 patients for the month of July (2 months before). After evaluating all cases, it was decided none were preventable.

INTERVENTIONS: Continuous follow up while admitted.

PLAN: Verify new orders as appropriate and communicate changes to staff. Seek opportunities to reduce readmission with IT core meetings. Provide education to staff.

HEALTH OUTCOMES: Standardized Hospitalization Ratio - Response by Clinical Coordinator   DATA

QIP needed?		Yes	**X**	No	

Standardized Hospitalization Ratio (SHR) (QIP & DFC)

Kaweah Health
MORE THAN MEDICINE. LIFE.

Follow up needed?	Yes	X	No	

Data Comparison

QIP Benchmark	QIP Perf Standard	QIP Achieve Threshold	US Threshold (Core Survey)	Optimal Goal	Clinic Goal
0.670	0.967	1.248	N/A	0.670	0.967

Notes

Data Source: Clarity, Clinical Coordinator internal tracking; Benchmark = 153, Performance Standard = 228, Achievement Threshold = 289

	J	F	M	A	M	J	J	A	S	O	N	D
# of Hospitalizations	34	28	31	14	22	21	22	25	24	26	23	
Standardized Hospitalization Ratio (SHR) (QIP & DFC)	1.786	1.471	1.628	0.735	1.156	1.103	1.155	1.313	1.260	1.365	1.208	
Clinic Goal	0.967	0.967	0.967	0.967	0.967	0.967	0.967	0.967	0.967	0.967	0.967	0.967
Optimal Goal	0.67	0.67	0.67	0.67	0.67	0.67	0.67	0.67	0.67	0.67	0.67	0.67

PDCA CYCLE
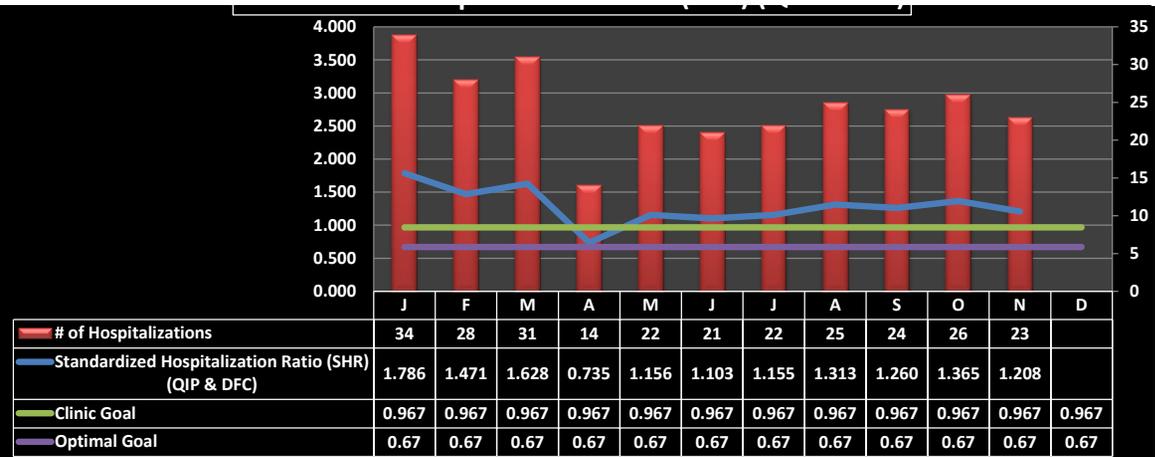
FINDINGS:
• Cardiovascular (8)
• Neurological (2)
• Musculoskeletal (1)
• Respiratory (4)
• Genitourinary
• Gastrointestinal (4)
• Endocrine (3)

INTERVENTIONS: Continuous follow up while admitted. Upon discharge, assess for fluid status and need for EDW adjustment.

PLAN: Verify new orders as appropriate and communicate changes to staff. Seek opportunities to prevent readmission with IDT core meetings.

VACCINATIONS - Hepatitis B - Response by Clinical Coordinator [DATA](#)

QIP needed?	Yes		No	X
Follow up needed?	Yes		No	

Data Comparison

QIP Benchmark	QIP Perf Standard	QIP Achieve Threshold	US Threshold (Core Survey)	Optimal Goal	Clinic Goal
N/A	N/A	N/A	N/A	N/A	N/A

Notes

Data Source: Clarity, Clinical Coordinator internal tracking

Hepatitis B

	J	F	M	A	M	J	J	A	S	O	N	D
# Immune	79	91	93	88	81	79	81	78				

# Immune													
# Currently Receiving	22	19	27	13	10	11	16	11					
# Refusing	5	4	4	5	5	12	12	12					
# Nonresponders	12	13	15	15	15	17	17	17					
% Patients w/Complete Series	83.7%	91.1%	84.1%	82.2%	76.0%	76.4%	81.0%	76.3%	0.0%				

PDCA CYCLE

FINDINGS:

INTERVENTIONS: Patient education at chairside provided monthly with topics to include but not limited to vaccinations.

PLAN: Offer vaccination quarterly to patients that have refused. Upon consent, begin administration of vaccination to newly admitted patients that are not hepatitis B antibody positive. Schedule all new patients that consented for month of June.

VACCINATIONS - Influenza Vaccine - Response by Clinical Coordinator   DATA

QIP needed?	Yes		No	X
Follow up needed?	Yes		No	

		Data Comparison			
QIP Benchmark	QIP Perf Standard	QIP Achieve Threshold	US Threshold (Core Survey)	Optimal Goal	Clinic Goal
N/A	N/A	N/A	N/A	N/A	N/A

Notes
Data Source: Clarity, Clinical Coordinator internal tracking

% Patients with Influenza Vaccine

	J	F	M	A	M	J	J	A	S	O	N	D
% of Patients with Influenza Vaccine (9/2020 - 8/2021 Season) (9/2021 - CURRENT)	89.1%	87.0%	81.0%	70.0%	77.1%	75.0%	77.4%	74.1%	0.7%	52.5%	59.1%	
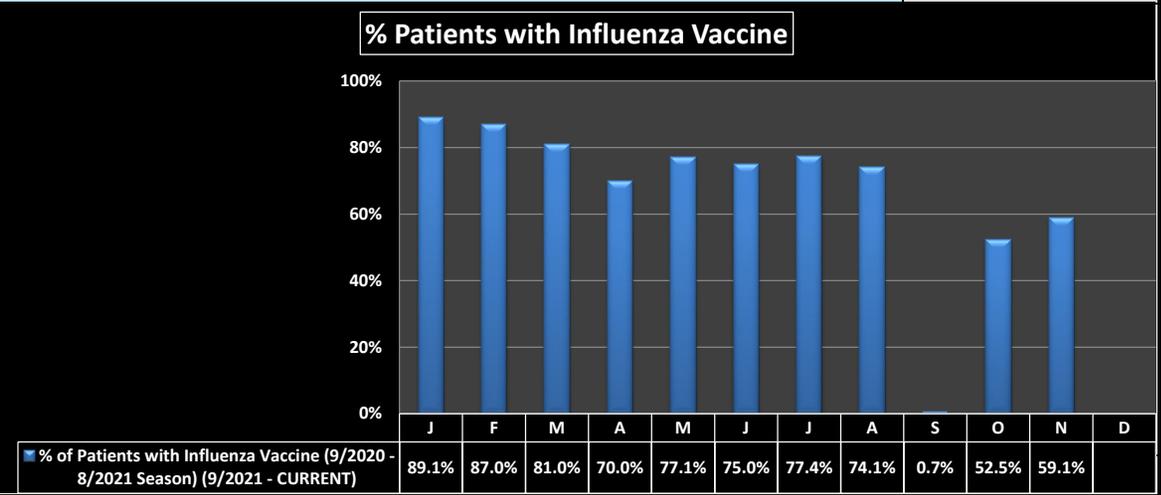
PDCA CYCLE

FINDINGS: 2021 - 2022 season; September - 1 received
October - 73 received, 1 cancelled, 7 refuse
November - 7 received, 1 cancelled

INTERVENTIONS: Vaccinations were rescheduled for patients that were in the hospital or out of town.

PLAN: Continue to administer to newly admitted patients throughout the season. Patient education at chairside provided monthly with topics to include but not limited to vaccinations.

VACCINATIONS - Pneumococcal Vaccine - Response by Clinical Coordinator

QIP needed?	Yes		No	X
Follow up needed?	Yes		No	

Data Comparison

QIP Benchmark	QIP Perf Standard	QIP Achieve Threshold	US Threshold (Core Survey)	Optimal Goal	Clinic Goal
N/A	N/A	N/A	N/A	N/A	N/A

Notes

Data Source: Clarity, Clinical Coordinator internal tracking

% of Patients with Pneumococcal Vaccine

	J	F	M	A	M	J	J	A	S	O	N	D
% of Patients with Pneumococcal Vaccine	93.4%	96.6%	83.5%	86.0%	81.4%	76.4%	82.3%	81.3%	0.0%			

PDCA CYCLE

FINDINGS:

INTERVENTIONS: Patient education at chairside provided monthly with topics to include but not limited vaccinations.

PLAN: Provide pneumococcal vaccine information sheets annually and offer pneumococcal vaccination yearly to patients that have previously refused. Obtain vaccination status on all newly admitted patients and offer and administer vaccination when consented.
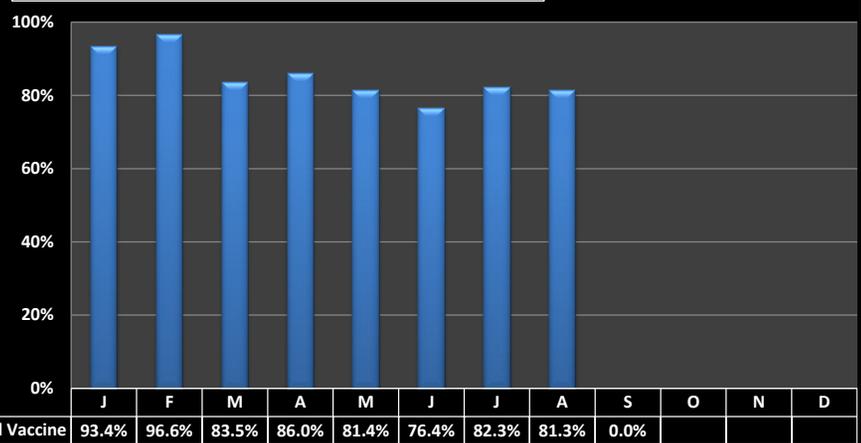
VACCINATIONS - COVID-19 Vaccine - Response by Clinical Coordinator

QIP needed?	Yes		No	X
Follow up needed?	Yes		No	

Data Comparison

QIP Benchmark	QIP Perf Standard	QIP Achieve Threshold	US Threshold (Core Survey)	Optimal Goal	Clinic Goal
N/A	N/A	N/A	N/A	N/A	N/A

Notes

Data Source: Clarity, Clinical Coordinator internal tracking

% of Patients with COVID-19 Vaccine

PDCA CYCLE		J	F	M	A	M	J	J	A	S	O	N	D
■ % of Patients with COVID-19 Vaccine	0%	0.1%	0.2%	47.5%	69.2%	72.8%	73.0%	77.0%	80.5%	81.9%	86.5%	91.9%	

FINDINGS: 112 patients have received at least one dose of the COVID Vaccine.

INTERVENTIONS: Patient education provided.

PLAN: Each treatment staff asking patient if vaccine received, if so request immunization card to verify dates and enter information into Clarity and Cerner.

FACILITY: Kaweah Delta Visalia Hemodialysis					Month:	Oct - Nov	Year:	2021

NUTRITIONAL STATUS: Albumin - Response by Dietitians — DATA

QIP needed?	Yes		No	X
Follow up needed?	Yes		No	

Data Comparison

QIP Benchmark	QIP Perf Standard	QIP Achieve Threshold	US Threshold (Core Survey)	Optimal Goal	Clinic Goal
N/A	N/A	N/A	67.70%	0.00%	20.00%

Notes

Data Source: QMAT, Clarity, Dietitian internal tracking

% Albumin ≤ 3.5 g/dL

	J	F	M	A	M	J	J	A	S	O	N	D
% Albumin < 3.5 g/dL (lower is better)	17.52%	24.48%	27.59%	6.29%	2.80%	4.90%	9.09%	11.51%	9.22%	7.30%	6.67%	
Clinic Goal	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%
Optimal Goal	0	0	0	0	0	0	0	0	0	0	0	0

PDCA CYCLE

FINDINGS: Goal met Oct/November

INTERVENTIONS:

PLAN: Continue with present management.

MINERAL METABOLISM: Calcium - Response by Dietitians — DATA

QIP needed?	Yes		No	X
Follow up needed?	Yes		No	

Data Comparison

QIP Benchmark	QIP Perf Standard	QIP Achieve Threshold	US Threshold (Core Survey)	Optimal Goal	Clinic Goal
N/A	N/A	N/A	1.30%	0.00%	0.95%

Notes

Data Source: QMAT, Clarity, Dietitian internal tracking

% Calcium >10.2 mg/dL (all patients)
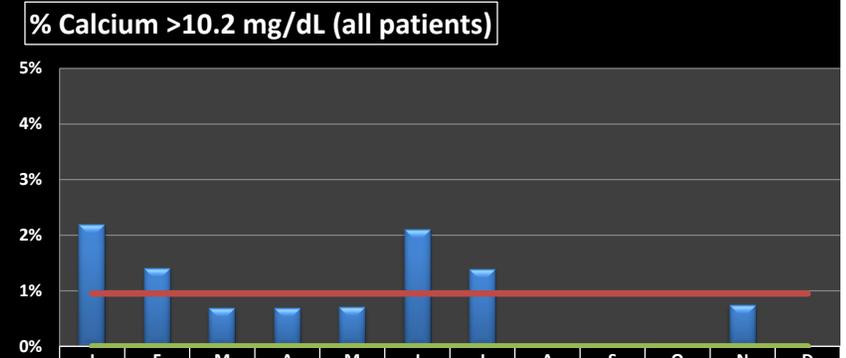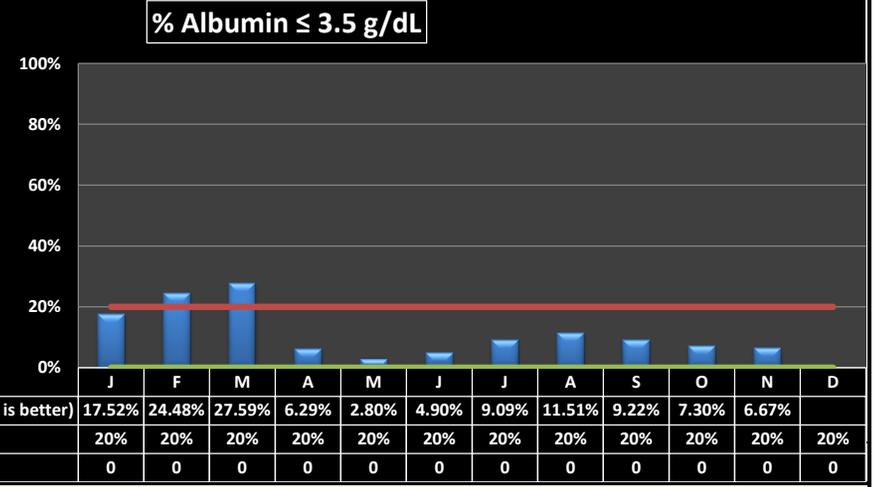
	J	F	M	A	M	J	J	A	S	O	N	D
% Calcium uncorrected > 10.2 mg/dL (all patients) (lower is better)	2.19%	1.40%	0.69%	0.69%	0.70%	2.10%	1.39%	0.00%	0.00%	0.00%	0.74%	
Clinic Goal	0.95%	0.95%	0.95%	0.95%	0.95%	0.95%	0.95%	0.95%	0.95%	0.95%	0.95%	0.95%
Optimal Goal	0	0	0	0	0	0	0	0	0	0	0	0

PDCA CYCLE

FINDINGS: Goal met Oct/November

INTERVENTIONS: Evaluation of calcium baths, calcium based binders, vitamin D analogs dosing, calcimimetic dosing, nutritional vitamin D supplementation. Recommendations for adjustments made accordingly and discussed during POC meetings as appropriate.

PLAN: Continue with present management.

MINERAL METABOLISM: Hypercalcemia - Response by Dietitians DATA

QIP needed?	Yes	X	No	
Follow up needed?	Yes		No	

Data Comparison					
QIP Benchmark	QIP Perf Standard	QIP Achieve Threshold	US Threshold (Core Survey)	Optimal Goal	Clinic Goal
0.00%	0.49%	1.54%	N/A	0.00%	0.49%

Notes
Data Source: QMAT, Clarity, Dietitian internal tracking

% Hypercalcemia >10.2 mg/dL (QIP) (3 Month Rolling Avg)

	J	F	M	A	M	J	J	A	S	O	N	D
% Hypercalcemia (Uncorrected serum calcium > 10.2 mg/dL) (QIP) (3 month rolling avg) (lower is better)	0.72%	1.38%	1.37%	0.69%	0.00%	1.39%	0.68%	1.43%	0.70%	0.00%	0.00%	
Clinic Goal	0.49%	0.49%	0.49%	0.49%	0.49%	0.49%	0.49%	0.49%	0.49%	0.49%	0.49%	0.49%
Optimal Goal	0	0	0	0	0	0	0	0	0	0	0	0

PDCA CYCLE

FINDINGS: Goal met Oct/November

INTERVENTIONS: Evaluation of calcium baths, calcium based binders, vitamin D analogs dosing, calcimimetic dosing, nutritional vitamin D supplementation. Recommendations for adjustments made accordingly and discussed during POC meetings as appropriate.

PLAN: Ongoing evaluation.

MINERAL METABOLISM: Phosphorus > 7.0 - Response by Dietitians DATA

QIP needed?	Yes		No	X

% Phosphorous > 7.0 mg/dL

|					
Follow up needed?		Yes		No	

Data Comparison

| QIP Benchmark	QIP Perf Standard	QIP Achieve Threshold	US Threshold (Core Survey)	Optimal Goal	Clinic Goal
N/A	N/A	N/A	12.60%	10.00%	12.60%

Notes

Data Source: QMAT, Clarity, Dietitian internal tracking
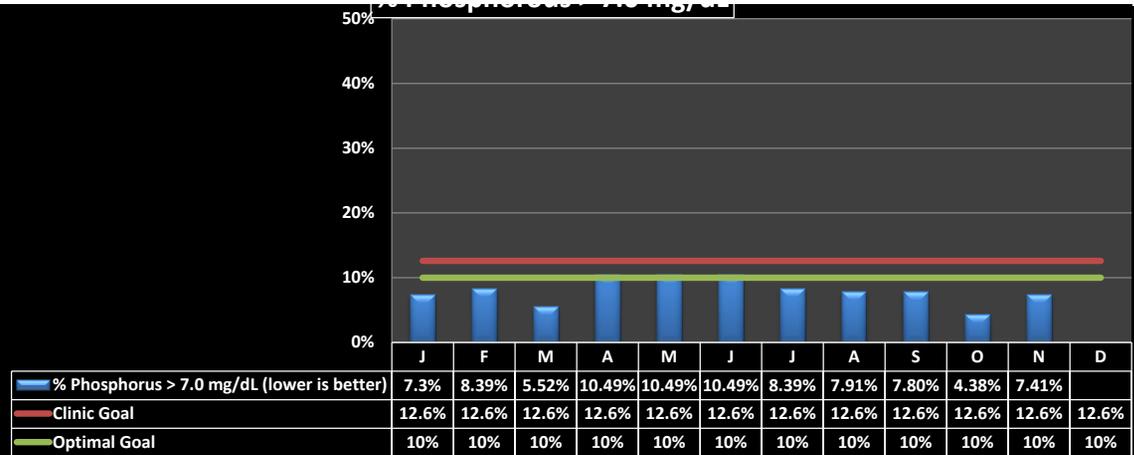
PDCA CYCLE

% Phosphorous > 7.0 mg/dL

	J	F	M	A	M	J	J	A	S	O	N	D
% Phosphorus > 7.0 mg/dL (lower is better)	7.3%	8.39%	5.52%	10.49%	10.49%	10.49%	8.39%	7.91%	7.80%	4.38%	7.41%	
Clinic Goal	12.6%	12.6%	12.6%	12.6%	12.6%	12.6%	12.6%	12.6%	12.6%	12.6%	12.6%	12.6%
Optimal Goal	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%

FINDINGS: Goal met Oct/November

INTERVENTIONS:

PLAN: Continue with present management.

MINERAL METABOLISM: Phosphorus > 5.5 - Response by Dietitians DATA

QIP needed?		Yes		No	X
Follow up needed?		Yes		No	

Data Comparison

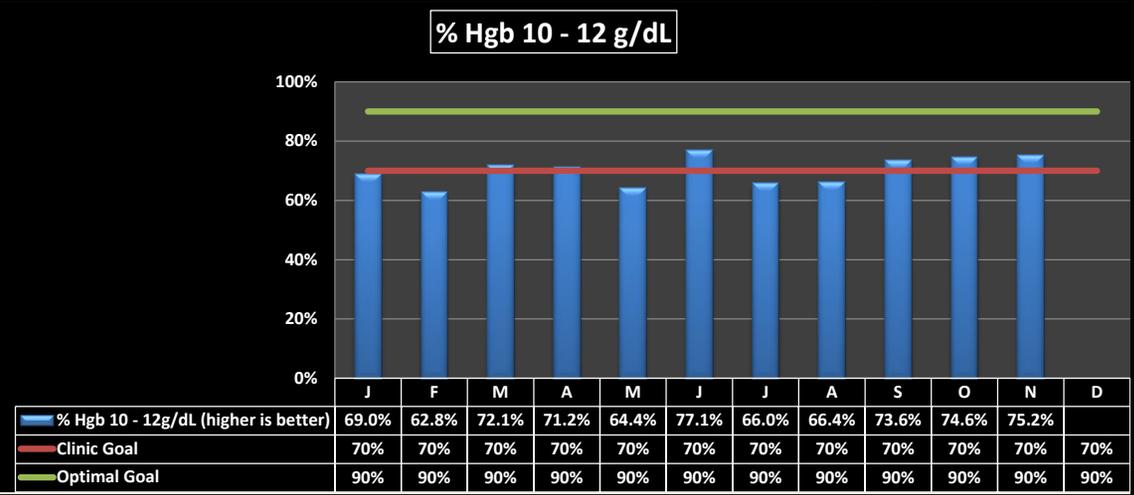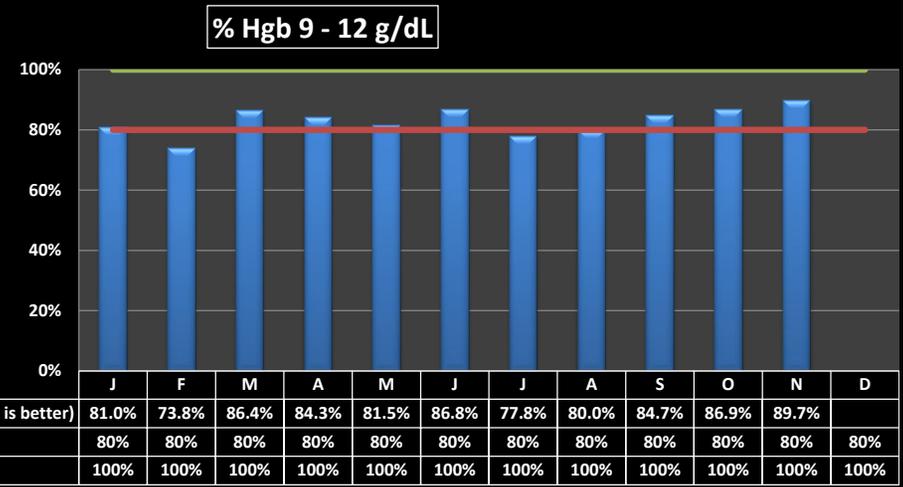| QIP Benchmark	QIP Perf Standard	QIP Achieve Threshold	US Threshold (Core Survey)	Optimal Goal	Clinic Goal
N/A	N/A	N/A	N/A	20.00%	35.00%

Notes

Data Source: QMAT, Clarity, Dietitian internal tracking

PDCA CYCLE

% Phosphorous > 5.5 mg/dL

	J	F	M	A	M	J	J	A	S	O	N	D
% Phosphorus > 5.5 mg/dL (lower is better)	30.66%	35.66%	32.41%	40.56%	45.45%	39.86%	40.56%	33.81%	34.04%	30.66%	32.59%	
Clinic Goal	35.00%	35.00%	35.00%	35.00%	35.00%	35.00%	35.00%	35.00%	35.00%	35.00%	35.00%	35.00%
Optimal Goal	20.00%	20.00%	20.00%	20.00%	20.00%	20.00%	20.00%	20.00%	20.00%	20.00%	20.00%	20.00%
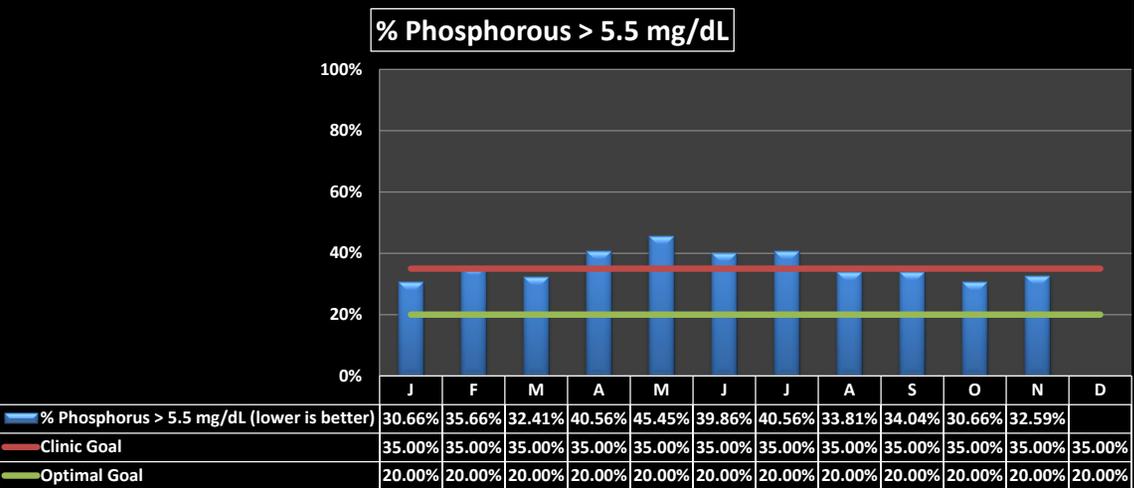
FINDINGS: Goal met Oct/November

INTERVENTIONS: Counsel patients to follow a low phosphorus diet and take binders as prescribed. Ongoing education on low phosphorus diet. Recommmend changes in binder dosing as indicated. Involve IDT when barriers to patients achieving goal are identified. Providing Kidney Bucks to encourage patients to work toward their goals.

PLAN: Continue with present management.

| FACILITY: Kaweah Delta Visalia Hemodialysis | | | Month: | Oct - Nov | Year: | 2021 |

MINERAL METABOLISM: Intact PTH 150 - 600 - Response by Clinic Pharmacist DATA

QIP needed?	Yes		No	**X**
Follow up needed?	Yes		No	

Data Comparison

QIP Benchmark	QIP Perf Standard	QIP Achieve Threshold	US Threshold (Core Survey)	Optimal Goal	Clinic Goal
N/A	N/A	N/A	N/A	80%	70%

Notes

Data Source: QMAT, Clarity, Clinic Pharmacist internal tracking

% Intact PTH 150 - 600 (3 Month Rolling Avg) (All patients)

	J	F	M	A	M	J	J	A	S	O	N	D
% Intact PTH 150 - 600 (3 month rolling avg) (All patients) (higher is better)	72.3%	69.30%	69.35%	70.60%	70.10%	63.72%	58.59%	56.68%	55.40%	57.40%	56.80%	
Clinic Goal	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%
Optimal Goal	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%

PDCA CYCLE

FINDINGS: Below goal

INTERVENTIONS: The HD clinic switched to ORAL in-center calcitriol the first week of May 2021 due to drug shortage issues. Hectorol injectable became available again end of Sept 2021 and patients were switched back. Many patients experienced rising PTH levels above goal with the med change. Dose adjustments continue to be made per protocol to address the PTH levels. Also, Parsabiv use was discontinued in mid May due to cost and reimbursement issues. There was a 4 week washout required before in-center PO Sensipar could be started in the patients who were on Parsabiv. PTH levels rose in the majority of these patients and Sensipar was initiated in mid June with dose adjustments ongoing per protocol (about 25-30% of the patients below goal are in this group). The full PTH effects of calcimimetics tend to be delayed several months.Other trends identified include a number of patients who frequently miss tx (14%), and patients requiring dose de-escalations of doxercalciferol due to hypercalcemia (7%)

PLAN: Continue to monitor labs and continue medication adjustments per protocols.

MINERAL METABOLISM: Intact PTH > 600 - Response by Clinic Pharmacist DATA

QIP needed?	Yes		No	**X**
Follow up needed?	Yes		No	

Data Comparison

QIP Benchmark	QIP Perf Standard	QIP Achieve Threshold	US Threshold (Core Survey)	Optimal Goal	Clinic Goal
N/A	N/A	N/A	N/A	10%	15%

Notes

Data Source: QMAT, Clarity, Clinic Pharmacist internal tracking
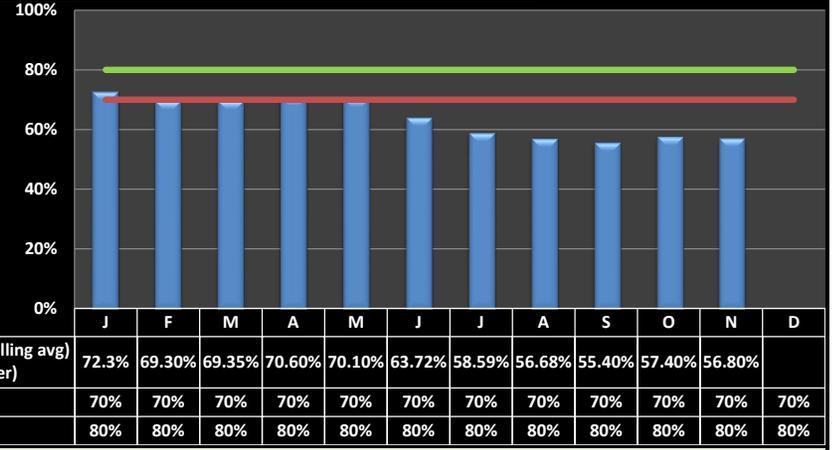
% Intact PTH > 600 (Patients on medication)
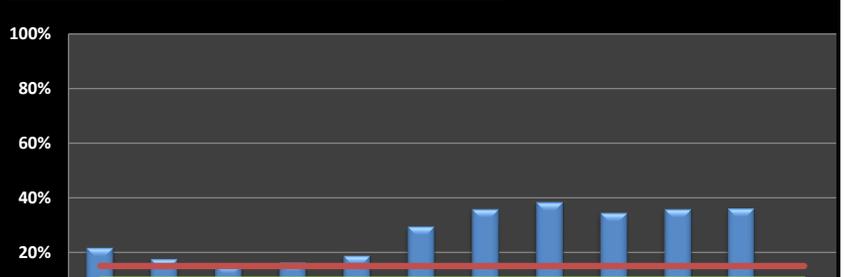
	J	F	M	A	M	J	J	A	S	O	N	D
% Intact PTH > 600 (all patients) (lower is better)	21.4%	17.30%	15.16%	15.97%	18.50%	29.08%	35.35%	37.89%	34.04%	35.40%	35.70%	
Clinic Goal	15%	15%	15%	15%	15%	15%	15%	15%	15%	15%	15%	15%
Optimal Goal	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%

PDCA CYCLE

FINDINGS: Not meeting goals, unfavorable trend (lower is better)

INTERVENTIONS: see above

PLAN: Continue to monitor labs and continue medication adjustments per protocols.

ANEMIA MANAGEMENT: Hgb 10-12 - Response by Clinic Pharmacist   DATA

QIP needed?	Yes		No	**X**
Follow up needed?	Yes		No	

Data Comparison

QIP Benchmark	QIP Perf Standard	QIP Achieve Threshold	US Threshold (Core Survey)	Optimal Goal	Clinic Goal
N/A	N/A	N/A	N/A	90%	70%

Notes

Data Source: QMAT, Clarity, Clinic Pharmacist internal tracking

% Hgb 10 - 12 g/dL

	J	F	M	A	M	J	J	A	S	O	N	D
% Hgb 10 - 12g/dL (higher is better)	69.0%	62.8%	72.1%	71.2%	64.4%	77.1%	66.0%	66.4%	73.6%	74.6%	75.2%	
Clinic Goal	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%
Optimal Goal	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%

PDCA CYCLE

FINDINGS: Clinic goal met

INTERVENTIONS:

PLAN: Continue to monitor labs and continue medication adjustments per protocols

ANEMIA MANAGEMENT: Hgb 9-12 - Response by Clinic Pharmacist

QIP needed?	Yes		No	X
Follow up needed?	Yes		No	

Data Comparison

QIP Benchmark	QIP Perf Standard	QIP Achieve Threshold	US Threshold (Core Survey)	Optimal Goal	Clinic Goal
N/A	N/A	N/A	N/A	100%	80%

Notes

Data Source: QMAT, Clarity, Clinic Pharmacist internal tracking

% Hgb 9 - 12 g/dL

	J	F	M	A	M	J	J	A	S	O	N	D
% Hgb 9-12g/dL (higher is better)	81.0%	73.8%	86.4%	84.3%	81.5%	86.8%	77.8%	80.0%	84.7%	86.9%	89.7%	
Clinic Goal	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%
Optimal Goal	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

PDCA CYCLE

FINDINGS: Clinic goal met

INTERVENTIONS:

PLAN: Continue to monitor labs and continue medication adjustments per protocols

ANEMIA MANAGEMENT: Hgb < 10 - Response by Clinic Pharmacist

QIP needed?	Yes		No	X
Follow up needed?	Yes		No	

Data Comparison

QIP Benchmark	QIP Perf Standard	QIP Achieve Threshold	US Threshold (Core Survey)	Optimal Goal	Clinic Goal
N/A	N/A	N/A	16.8%	16.8%	20%

Notes

Data Source: QMAT, Clarity, Clinic Pharmacist internal tracking

% Hgb <10 g/dL

J	F	M	A	M	J	J	A	S	O	N	D
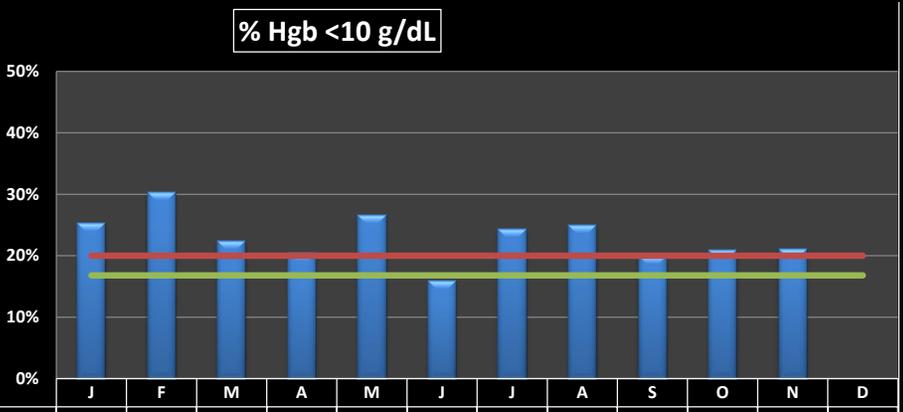
	J	F	M	A	M	J	J	A	S	O	N	D
% Hgb < 10g/dL (lower is better)	25.4%	30.3%	22.4%	20.5%	26.7%	16.0%	24.3%	25.0%	20.0%	21.0%	21.2%	
Clinic Goal	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%
Optimal Goal	16.8%	16.8%	16.8%	16.8%	16.8%	16.8%	16.8%	16.8%	16.8%	16.8%	16.8%	16.8%

PDCA CYCLE

FINDINGS: Clinic goal met

INTERVENTIONS: 29 patients below goal in August (13 pts, 45%, below 9 g/dL). Some trends identified in Sept for Hgb <9: most of these patients with recent or during month hospitalization (majority received EPO inpatient); 3 patients idenditied as frequently missing treatments; 4 patients with COVID infection; 5 with acute blood loss; 5 were new patients

PLAN: Will continue to monitor labs and continue medication adjustments per protocols

---

ANEMIA MANAGEMENT: Iron Saturation - Response by Clinic Pharmacist   DATA

QIP needed?	Yes		No	X
Follow up needed?	Yes		No	

Data Comparison

QIP Benchmark	QIP Perf Standard	QIP Achieve Threshold	US Threshold (Core Survey)	Optimal Goal	Clinic Goal
N/A	N/A	N/A	N/A	70%	65%

Notes

Data Source: QMAT, Clarity, Clinic Pharmacist internal tracking

% Saturation ≥ 20 (3 month rolling avg)

	J	F	M	A	M	J	J	A	S	O	N	D
% Saturation ≥ 20 (3 month rolling avg) (higher is better)	65.0%	61.6%	63.3%	61.3%	63.6%	64.4%	62.6%	69.2%	71.7%	72.8%	69.9%	
Clinic Goal	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%
Optimal Goal	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%

PDCA CYCLE

FINDINGS: Goals met

INTERVENTIONS: None to report

PLAN: Continue to monitor labs and continue medication adjustments per protocols

---

ANEMIA MANAGEMENT: Ferritin 200 - 1200 - Response by Clinic Pharmacist   DATA

QIP needed?	Yes		No	X
Follow up needed?	Yes		No	

% Ferritin 200 - 1200 ng/ml (3 month rolling avg)

Data Comparison					
QIP Benchmark	QIP Perf Standard	QIP Achieve Threshold	US Threshold (Core Survey)	Optimal Goal	Clinic Goal
N/A	N/A	N/A	N/A	70%	65%
Notes					
Data Source: QMAT, Clarity, Clinic Pharmacist internal tracking					

	J	F	M	A	M	J	J	A	S	O	N	D
% Ferritin 200 - 1200ng/ml (3 month rolling avg) (higher is better)	81.0%	81.0%	79.0%	75.2%	74.9%	77.0%	79.4%	77.4%	79.6%	84.1%	84.5%	
Clinic Goal	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%
Optimal Goal	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%

PDCA CYCLE

FINDINGS: Both goals achieved.

INTERVENTIONS: None to report

PLAN: Continue to monitor labs and continue medication adjustments per protocols
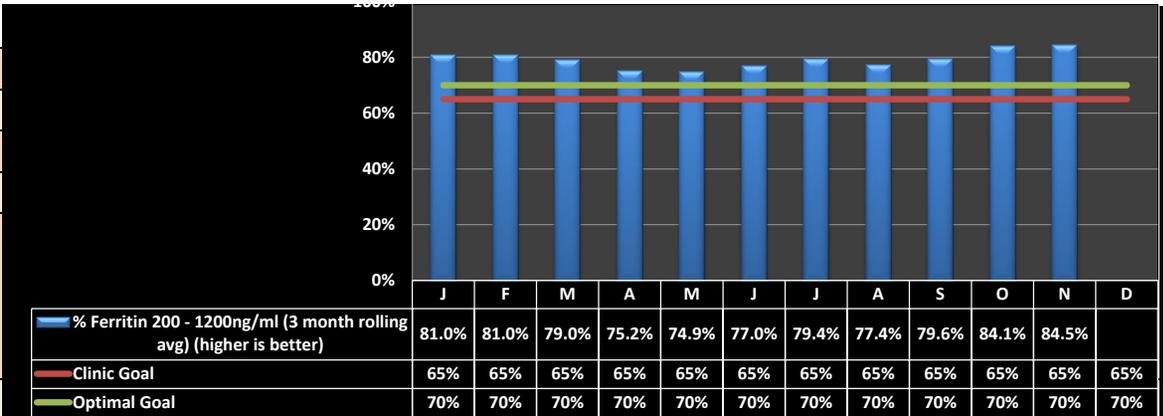
FACILITY: Kaweah Delta Visalia Hemodialysis				Month:		Oct - Nov	Year:		2021

VASCULAR ACCESS: Standardized Fistula Rate - Response by Renal Access Coordinator —

QIP needed?		Yes	**X**	No	
Follow up needed?		Yes	**X**	No	

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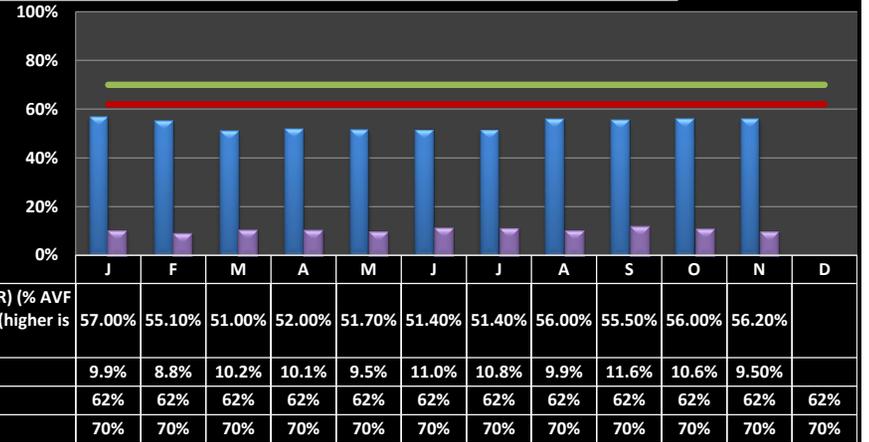
Data Comparison

QIP Benchmark	QIP Perf Standard	QIP Achieve Threshold	US Threshold (Core Survey)	Optimal Goal	Clinic Goal
76.77%	64.36%	53.29%	N/A	70.00%	62.00%

Notes

Data Source: QMAT, Clarity, Chronic Renal Access Coordinator internal tracking

	J	F	M	A	M	J	J	A	S	O	N	D
Standardized Fistula Rate (SFR) (% AVF using 2 needles) (QIP & DFC) (higher is better)	57.00%	55.10%	51.00%	52.00%	51.70%	51.40%	51.40%	56.00%	55.50%	56.00%	56.20%	
% AVG	9.9%	8.8%	10.2%	10.1%	9.5%	11.0%	10.8%	9.9%	11.6%	10.6%	9.50%	
AVF Clinic Goal	62%	62%	62%	62%	62%	62%	62%	62%	62%	62%	62%	62%
AVF Optimal Goal	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%

PDCA CYCLE

FINDINGS: Not currently meeting goal of 70%. In the month of August, fistula rate increased about 5%. There are currently 10 patients that have been referred for AVF/AVG placement, and have vein mapping appt's scheduled and/or waiting on their AVF surgery scheduled dates. We hope to see the percentage of fistulas increase in the upcoming months.

INTERVENTIONS: CRAC continues to educate patients with TDC's who refuse permanent access about TDC vs AVF/AVG. CRAC also continues refer patients for AVF/AVG placement on a consistent basis, especially new admissions.

PLAN: The Chronic Renal Access Coordinator continuously working towards permanent access preservation by means of patient education in areas such as washing access prior to tx, and other access management strategies. Also, educating patient care staff in areas such as cannulation techniques, infection control measures, access management and problem management.

VASCULAR ACCESS: Long Term Catheter Rate (QIP) and Maturing Access - Response by Renal Access Coordinator —

QIP needed?		Yes	**X**	No	
Follow up needed?		Yes	**X**	No	

Long Term Catheter Rate (QIP & DFC) and Maturing Accesses
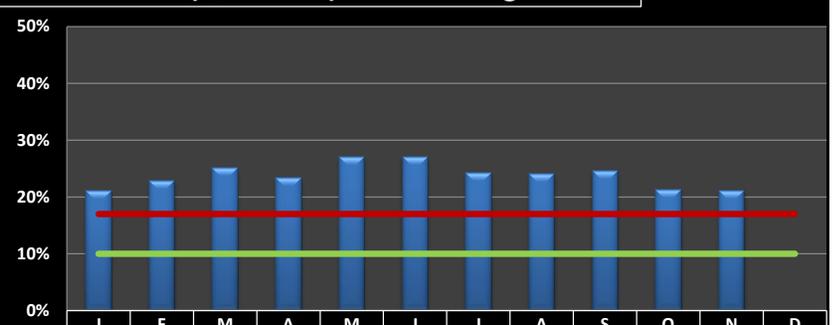
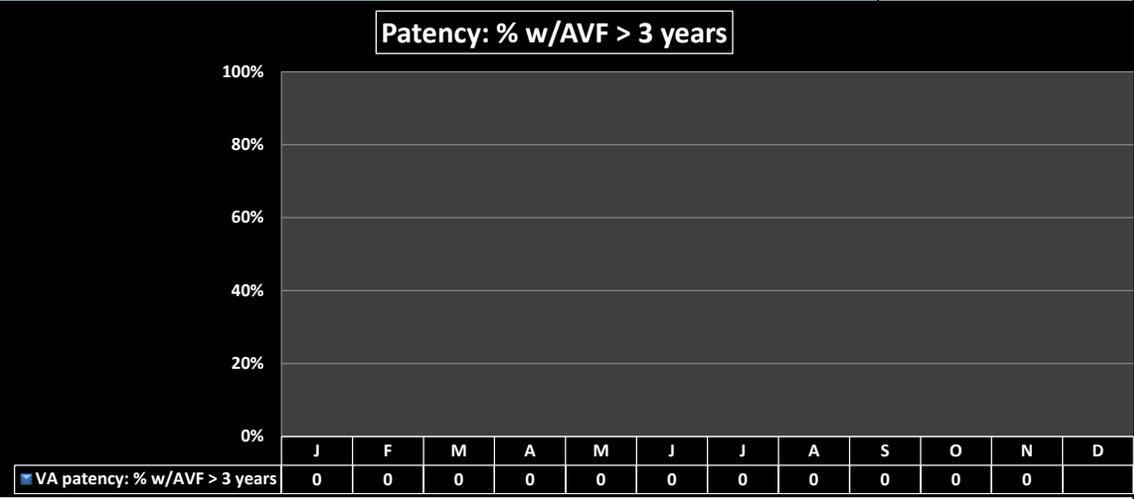#### Data Comparison

QIP Benchmark	QIP Perf Standard	QIP Achieve Threshold	US Threshold (Core Survey)	Optimal Goal	Clinic Goal
4.69%	11.04%	18.35%	10.70%	10.00%	17.00%

Notes

Data Source: QMAT, Clarity, Chronic Renal Access Coordinator internal tracking

	J	F	M	A	M	J	J	A	S	O	N	D
Long Term Catheter Rate (% Catheters > 90 days) (QIP & DFC) (lower is better)	21.10%	22.90%	25.10%	23.40%	27.00%	27.00%	24.30%	24.10%	24.60%	21.30%	21.20%	
Clinic Goal	17%	17%	17%	17%	17%	17%	17%	17%	17%	17%	17%	
Optimal Goal	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%	

PDCA CYCLE

FINDINGS: Currently not achieving goal of 10%. Noted slight decrease in long term catheters from previous month. The goal is to keep this trend moving forward. There were 5 TDC removals in the month of August. There are currently 3 pt's scheduled for TDC removal next month so far. There are currently 4 patients that are being cannulated that still need to be scheduled for TDC removal. We anticipate another decrease in long term catheter in the upcoming months.

INTERVENTIONS: CRAC continues to work effortlessly in monitoring maturing accesses and assessing when it is appropiate for TDC to be removed. CRAC also continue to collaborate with PD departement in regards to PD referrals and follow up.

PLAN: CRAC is actively strategizing, planning/implementing interventions with IDT for TDC rate reduction. For new patients, the referral will be sent on the day of their first HD treatment. Within one week of admission to the clinic, the CRAC will meet with the pt to provide education on either new access/or preserving existing permanent access. If the pt has a TDC, he/she should be educated in the process of access placement and risks of catheter. If the pt has AVF/AVG, the pt should be educated in preservation of access (washing access prior to tx, quarterly follow up appointments and recognizing abnormalities). Within one week of sending referral, CRAC will follow up to obtain an appt. Upon obtaining evaluation appt, CRAC will work with AA to solidify transportation for said appt. CRAC will work with AA to conduct reminder calls to the pt and confirmation of transportation the day before appt. Reminder note will be provided to the patient at HD treatment prior to appt as well. The same process will be for all vascular access appointments. Once the pt has had vascular access placement, all orders are entered by CRAC and an email is sent to the RN team, inclusive of RN, TL, RCC, and Manager. Upon removal of tunneled catheter, schedule a celebration on first day back at clinic.

VASCULAR ACCESS: Catheters - Response by Renal Access Coordinator [DATA](#)

QIP needed?	Yes	X	No	
Follow up needed?	Yes	X	No	

Data Comparison					
QIP Benchmark	QIP Perf Standard	QIP Achieve Threshold	US Threshold (Core Survey)	Optimal Goal	Clinic Goal
N/A	N/A	N/A	N/A	N/A	N/A

Notes
Data Source: QMAT, Clarity, Chronic Renal Access Coordinator internal tracking

PDCA CYCLE

Catheters

	J	F	M	A	M	J	J	A	S	O	N	D
Catheter Rate (All Patients)	33.1%	36.45%	38.7%	38.2%	39.2%	38.0%	37.8%	34.0%	32.8%	33.4%	34.3%	
% Catheter + AVF	5.6%	5.4%	6.1%	6.7%	6.1%	9.0%	10.1%	8.5%	7.5%	2.6%	3.6%	
% Catheter + AVG	0.7%	2.0%	2.0%	1.3%	2.0%	1.4%	2.0%	2.1%	0.7%	0.0%	0.0%	
% Catheter < 90 days	12.0%	13.5%	13.6%	14.8%	12.2%	11.0%	13.5%	9.9%	8.2%	9.5%	9.5%	

FINDINGS: This is the catheter rate for ALL patients including transient patients and AKI patients. There two patients admitted with a TDC in the month of August.

INTERVENTIONS: CRAC continues to follow up with AVF and PD referrals on a consistent basis. PD referrals may take longer at times with education being provided first, then referral to the surgeon, surgery to have PD catheter placed, training for a couple of weeks, then waiting for pt to be established at home with PD prior to TDC being removed.

PLAN: CRAC is actively strategizing, planning/implementing interventions with IDT for TDC rate reduction. For new patients, the referral will be sent on the day of their first HD treatment. Within one week of admission to the clinic, the CRAC will meet with the pt to provide education on new permanent access. If the pt has a TDC, he/she should be educated in the process of access placement and risks of catheter

admission to the clinic, the CRAC will meet with the pt to provide education on new permanent access. If the pt has a TDC, he/she should be educated in the process of access placement and risks of catheter. Within one week of sending referral, CRAC will follow up to obtain an appt. Once the pt has had vascular access placement, all orders are entered by CRAC and an email is sent to the RN team, inclusive of RN, TL, RCC, and Manager. Upon removal of tunneled catheter, schedule a celebration on first day back at clinic. CRAC to follow up with Nephrologist on AKI pt's 3 months after admission to determine pt's status. If pt is deemed ESRD, CRAC to follow same procedure as mentioned above to obtain permanent access for pt. CRAC to monitor TDC status of transient pt's for duration they are dialyzing in the clinic.

VASCULAR ACCESS: Thrombosis AVF - Response by Renal Access Coordinator — DATA

| QIP needed? | Yes | | No | X |
| Follow up needed? | Yes | | No | |

Data Comparison

QIP Benchmark	QIP Perf Standard	QIP Achieve Threshold	US Threshold (Core Survey)	Optimal Goal	Clinic Goal
N/A	N/A	N/A	N/A	N/A	N/A

Notes

Data Source: QMAT, Clarity, Chronic Renal Access Coordinator internal tracking

# of AVF Thrombosis Events

# of AVF Thrombosis Events	J	F	M	A	M	J	J	A	S	O	N	D
	1	0	0	1	0	0	0	0				

PDCA CYCLE

FINDINGS: There were 0 clotted AVF's in the month of August.

INTERVENTIONS: CRAC continues to monitor access flows monthly to assess for low blood flow, and refer the patient to the Vascular Surgeon for intervention.

PLAN: Clinic Analyst and Clinic Manager working with EMR vendor to develop. In the interim, Clinic Manager will in-service team to document as an adverse occurrence in MIDAS for manual tracking purposes.

VASCULAR ACCESS: Thrombosis AVG - Response by Renal Access Coordinator — DATA

| QIP needed? | Yes | | No | X |
| Follow up needed? | Yes | | No | |

Data Comparison

QIP Benchmark	QIP Perf Standard	QIP Achieve Threshold	US Threshold (Core Survey)	Optimal Goal	Clinic Goal
N/A	N/A	N/A	N/A	N/A	N/A

Notes

# of AVG Thrombosis Events

Data Source: QMAT, Clarity, Chronic Renal Access Coordinator internal tracking		2											
		1											
		0											
PDCA CYCLE			**J**	**F**	**M**	**A**	**M**	**J**	**J**	**A**	**S**	**O**	**N**	**D**
	▪ # of AVG Thrombosis Events		1	1	1	0	0	2	1	1				

FINDINGS: There was 1 clotted AVG in the month of August, with a successful thrombectomy.

INTERVENTIONS: CRAC continues to monitor access flows monthly to assess for low blood flow, and refer the patient to the Vascular Surgeon for intervention.

PLAN: Clinic Analyst and Clinic Manager working with EMR vendor to develop. In the interim, Clinic Manager will in-service team to document as an adverse occurrence in MIDAS for manual tracking purposes.

VASCULAR ACCESS: Patency AVF - Response by Renal Access Coordinator   <u>DATA</u>

QIP needed?	Yes		No	X
Follow up needed?	Yes		No	

Patency: % w/AVF > 3 years

			Data Comparison		
QIP Benchmark	QIP Perf Standard	QIP Achieve Threshold	US Threshold (Core Survey)	Optimal Goal	Clinic Goal
N/A	N/A	N/A	N/A	N/A	N/A

		Notes			
Data Source: QMAT, Clarity, Chronic Renal Access Coordinator internal tracking					

PDCA CYCLE	**J**	**F**	**M**	**A**	**M**	**J**	**J**	**A**	**S**	**O**	**N**	**D**
▪ VA patency: % w/AVF > 3 years	0	0	0	0	0	0	0	0	0	0	0	

Medical Director currently looking in to.

VASCULAR ACCESS: Patency AVG - Response by Renal Access Coordinator   <u>DATA</u>

QIP needed?	Yes		No	X

Patency: % w/AVG > 2 years

Follow up needed?	Yes		No		

Data Comparison					
QIP Benchmark	QIP Perf Standard	QIP Achieve Threshold	US Threshold (Core Survey)	Optimal Goal	Clinic Goal
N/A	N/A	N/A	N/A	N/A	N/A
Notes					
Data Source: QMAT, Clarity, Chronic Renal Access Coordinator internal tracking					

Month	J	F	M	A	M	J	J	A	S	O	N	D
VA patency: % w/AVG > 2 years	0	0	0	0	0	0	0	0	0	0	0	

PDCA CYCLE

Medical Director currently looking in to.

VASCULAR ACCESS: Infections AVF - Response by Renal Access Coordinator　　　　DATA

QIP needed?	Yes		No		X
Follow up needed?	Yes		No		

of AVF Infections

Data Comparison					
QIP Benchmark	QIP Perf Standard	QIP Achieve Threshold	US Threshold (Core Survey)	Optimal Goal	Clinic Goal
N/A	N/A	N/A	N/A	N/A	N/A
Notes					
Data Source: QMAT, Clarity, Chronic Renal Access Coordinator internal tracking					

Month	J	F	M	A	M	J	J	A	S	O	N	D
# of AVF Infections	0	0	1	1	0	1	3	0	0	0	0	

PDCA CYCLE

FINDINGS: There were 2 AVF infections in the month of August, which were treated appropiately and has since resolved.

INTERVENTIONS: Continue to educate patients on significance of washing access with soap and water prior to initiation of treatment. Staff encouraged to continue use of alcohol and betadine prior to cannulation, and encouraging patients to wash their access with soap and water prior to initiating treatment.

PLAN: Continue to educate patients and staff on access preservation and management.

VASCULAR ACCESS: Infections AVG - Response by Renal Access Coordinator			DATA

QIP needed?	Yes		No	X
Follow up needed?	Yes		No	

Data Comparison

QIP Benchmark	QIP Perf Standard	QIP Achieve Threshold	US Threshold (Core Survey)	Optimal Goal	Clinic Goal
N/A	N/A	N/A	N/A	N/A	N/A

Notes

Data Source: QMAT, Clarity, Chronic Renal Access Coordinator internal tracking

PDSA CYCLE

# of AVG Infections

	J	F	M	A	M	J	J	A	S	O	N	D
# of AVG Infections	1	0	0	1	0	0	0	0	0	2	0	

FINDINGS: There were 0 AVG infections for the month of August.

INTERVENTIONS: Continue to educate patients on significance of washing access with soap and water prior to initiation of treatment. Staff encouraged to continue use of alcohol and betadine prior to cannulation, and encouraging patients to wash their access with soap and water prior to initiating treatment.

PLAN: Continue to educate patients and staff on access preservation and management.

Kaweah Health
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| FACILITY: Kaweah Delta Visalia Hemodialysis | | | | | Month: | | Oct - Nov | Year: | | 2021 |

INFECTION PREVENTION: (NHSN) Monthly Audits Hand Hygiene - Response by Clinic Manager   DATA

| QIP needed? | | Yes | | No | X |
| Follow up needed? | | Yes | | No | |

Data Comparison

QIP Benchmark	QIP Perf Standard	QIP Achieve Threshold	US Threshold (Core Survey)	Optimal Goal	Clinic Goal
N/A	N/A	N/A	N/A	100%	100%

Notes

Data Source: Database Reporting Analyst internal tracking

Hand Hygiene/Hand Sanitizer Observed by Staff

	J	F	M	A	M	J	J	A	S	O	N	D
Hand Hygiene Observed by Staff	100%	100%	100%	100%	100%	98%	100%	100%	100%	100%	95%	
Hand Sanitizer	100%	100%	100%	100%	100%	100%	100%	90%	100%	100%	100%	
Clinic Goal	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Optimal Goal	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
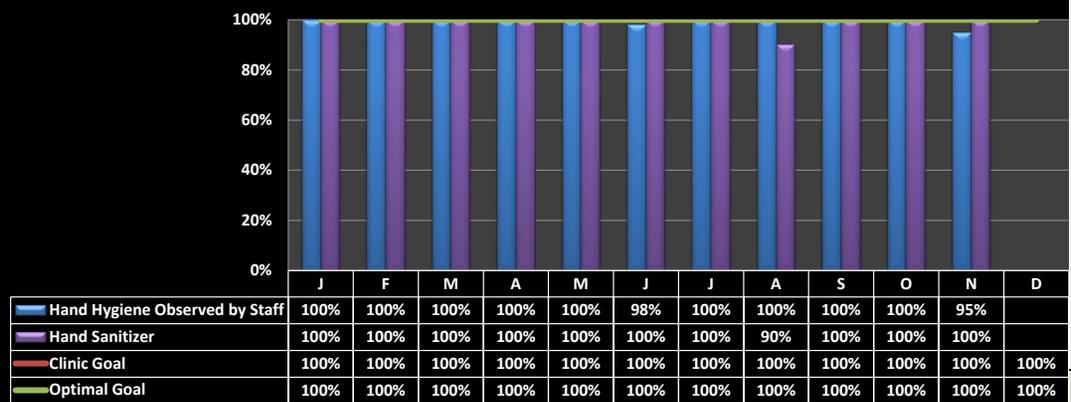
PDCA CYCLE

FINDINGS: Hand Hygiene - goal met, 27 audits successful out of 27 observations
Hand Sanitizer - goal met, 61 audits successful out of 61 observations

INTERVENTIONS:

PLAN:

INFECTION PREVENTION: (NHSN) Monthly Audits CVC Connect/Disconnect - Response by Clinic Manager   DATA

| QIP needed? | | Yes | | No | X |
| Follow up needed? | | Yes | | No | |

Data Comparison

QIP Benchmark	QIP Perf Standard	QIP Achieve Threshold	US Threshold (Core Survey)	Optimal Goal	Clinic Goal
N/A	N/A	N/A	N/A	100%	100%

Notes

Data Source: Database Reporting Analyst internal tracking

Catheter Connection/Disconnection

	J	F	M	A	M	J	J	A	S	O	N	D
Catheter Connection	100%	100%	60%	100%	100%	100%	100%	100%	100%	80.0%	100.0%	
Catheter Disconnection	100%	100%	100%	100%	67%	100%	100%	86%	100%	100.0%	100.0%	
Clinic Goal	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Optimal Goal	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
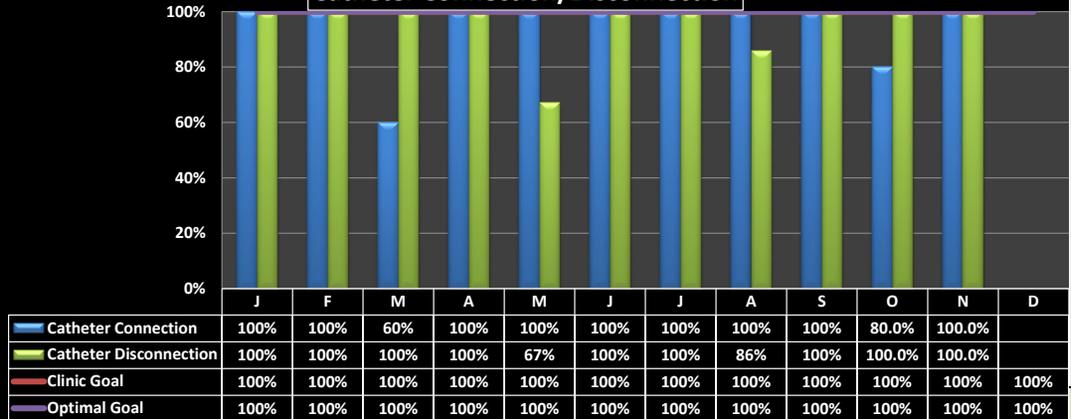
PDCA CYCLE

FINDINGS: Catheter Connection - goal met, 5 audits successful out of 5 observations
Catheter Disconnection - goal met, 5 audits successful out of 5 observations

42/145

Catheter Disconnection - goal met, 5 audits successful out of 5 observations

INTERVENTIONS:

PLAN: Charge nurses ensuring monthly audits are completed

INFECTION PREVENTION: (NHSN) Monthly Audits CVC Exit Site Care - Response by Clinic Manager

QIP needed?	Yes		No	X
Follow up needed?	Yes		No	

Data Comparison

QIP Benchmark	QIP Perf Standard	QIP Achieve Threshold	US Threshold (Core Survey)	Optimal Goal	Clinic Goal
N/A	N/A	N/A	N/A	100%	100%

Notes

Data Source: Database Reporting Analyst internal tracking

CVC Exit Site Care

	J	F	M	A	M	J	J	A	S	O	N	D
CVC Exit Site Care	83%	100%	67%	100%	86%	100%	100%	80%	100%	100.0%	100.0%	
Clinic Goal	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Optimal Goal	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

PDCA CYCLE

FINDINGS: Goal met, 5 audits successful out of 5 observations

INTERVENTIONS:

PLAN: Charge nurses ensuring monthly audits are completed

INFECTION PREVENTION: (NHSN) Monthly Audits AVF/AVG Cannulation/Decannulation - Response by Clinic Manager

QIP needed?	Yes		No	X
Follow up needed?	Yes		No	

Data Comparison

QIP Benchmark	QIP Perf Standard	QIP Achieve Threshold	US Threshold (Core Survey)	Optimal Goal	Clinic Goal
N/A	N/A	N/A	N/A	100%	100%

Notes

Data Source: Database Reporting Analyst internal tracking

AVF/AVG Cannulation/Decannulation

AVF/AVG Cannulation	100%	89%	67%	80%	90%	88%	83%	100%	40%	75.0%	100.0%	
AVF/AVG Decannulation	100%	83%	67%	40%	100%	67%	13%	88%	78%	80.0%	100.0%	
Clinic Goal	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Optimal Goal	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

PDCA CYCLE

FINDINGS: AVF/AVG Cannulation - goal not met, 2 audits successful out of 5 observations
AVF/AVG Decannulation - goal not met, 7 audits successful out of 9 observations

INTERVENTIONS:

PLAN: Charge nurses ensuring monthly audits are completed

INFECTION PREVENTION: (NHSN) Monthly Audits Dialysis Station Disinfection - Response by Clinic Manager   DATA

QIP needed?		Yes		No	X
Follow up needed?		Yes		No	

Data Comparison

QIP Benchmark	QIP Perf Standard	QIP Achieve Threshold	US Threshold (Core Survey)	Optimal Goal	Clinic Goal
N/A	N/A	N/A	N/A	100%	100%

Notes

Data Source: Database Reporting Analyst internal tracking

Dialysis Station Disinfection

	J	F	M	A	M	J	J	A	S	O	N	D
Dialysis Station Disinfection	55%	65%	65%	60%	40%	60%	60%	70%	60%	75.0%	76.0%	
Clinic Goal	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Optimal Goal	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

PDCA CYCLE

FINDINGS: Goal not met, 12 audits successful out of 20 observations

INTERVENTIONS:

PLAN: Charge nurses ensuring monthly audits are completed

INFECTION PREVENTION: (NHSN) Monthly Audits Injection Safety Preparation - Response by Clinic Manager   DATA

QIP needed?		Yes		No	X
Follow up needed?		Yes		No	

Data Comparison

QIP Benchmark	QIP Perf Standard	QIP Achieve Threshold	US Threshold (Core Survey)	Optimal Goal	Clinic Goal

Injection Safety Preparation

N/A	N/A	N/A	N/A	100%	100%

Notes

Data Source: Database Reporting Analyst internal tracking

	J	F	M	A	M	J	J	A	S	O	N	D
Injection Safety Preparation	100%	42%	40%	70%	80%	90%	86%	100%	100%	91.0%	100.0%	
Clinic Goal	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Optimal Goal	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

PDCA CYCLE

FINDINGS: Goal met, 14 audits successful out of 14 observations

INTERVENTIONS:

PLAN: Charge nurses ensuring monthly audits are completed

INFECTION PREVENTION: (NHSN) Monthly Audits Injection Safety Administration - Response by Clinic Manager DATA

QIP needed?	Yes		No	X
Follow up needed?	Yes		No	

Data Comparison

QIP Benchmark	QIP Perf Standard	QIP Achieve Threshold	US Threshold (Core Survey)	Optimal Goal	Clinic Goal
N/A	N/A	N/A	N/A	100%	100%

Notes

Data Source: Database Reporting Analyst internal tracking

Injection Safety Administration

	J	F	M	A	M	J	J	A	S	O	N	D
Infection Safety Administration	78%	65%	74%	95%	75%	95%	90%	95%	100%	90.0%	95.0%	
Clinic Goal	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Optimal Goal	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

PDCA CYCLE

FINDINGS: Goal met, 20 audits successful out of 20 observations

INTERVENTIONS:

PLAN: Charge nurses ensuring monthly audits are completed

INFECTION PREVENTION: (NHSN) Monthly Audits Hand Hygiene Observed by Patients - Response by Clinic Manager DATA

QIP needed?	Yes		No	X

Hand Hygiene Observed by Patients

Follow up needed?	Yes		No	

Data Comparison					
QIP Benchmark	QIP Perf Standard	QIP Achieve Threshold	US Threshold (Core Survey)	Optimal Goal	Clinic Goal
N/A	N/A	N/A	N/A	100%	100%
Notes					
Data Source: Database Reporting Analyst internal tracking					

	J	F	M	A	M	J	J	A	S	O	N	D
Hand Hygiene Observed by Patients	93%	88%	100%	100%	96%	96%	0	100%	80%	100.0%	100.0%	
Clinic Goal	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Optimal Goal	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

PDCA CYCLE

FINDINGS: Goal not met, 16 audits successful out of 20 observations

INTERVENTIONS:

PLAN: Charge nurses ensuring monthly audits are completed

INFECTION PREVENTION: (NHSN) Monthly Audits Station Disinfection Observed by Patients - Response by Clinic Manager   DATA

QIP needed?	Yes		No	X
Follow up needed?	Yes		No	

Station Disinfection Observed by Patients

Data Comparison					
QIP Benchmark	QIP Perf Standard	QIP Achieve Threshold	US Threshold (Core Survey)	Optimal Goal	Clinic Goal
N/A	N/A	N/A	N/A	100%	100%
Notes					
Data Source: Database Reporting Analyst internal tracking					

	J	F	M	A	M	J	J	A	S	O	N	D
Station Disinfection Observed by Patients	70%	40%	70%	50%	60%	60%	0	90%	40%	90.0%	70.0%	
Clinic Goal	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Optimal Goal	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

PDCA CYCLE

FINDINGS: Goal not met, 4 audits successful out of 10 observations

INTERVENTIONS:

PLAN: Charge nurses ensuring monthly audits are completed

ICH CAHPS: Overall Rating of Dialysis Center Staff - Response by Clinic Manager

QIP needed?	Yes	X	No	
Follow up needed?	Yes		No	
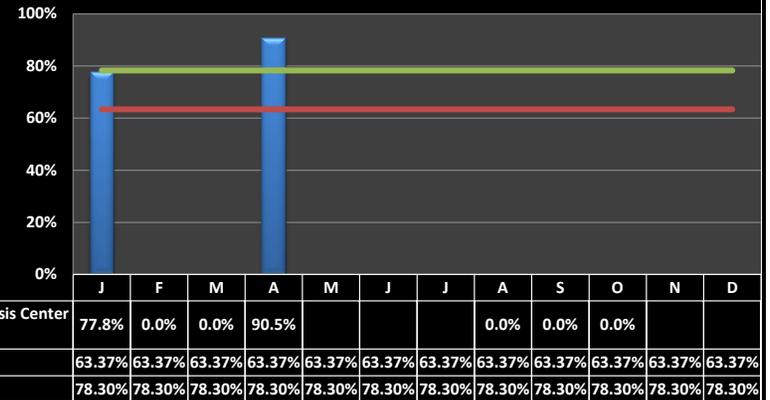
Data Comparison

QIP Benchmark	QIP Perf Standard	QIP Achieve Threshold	US Threshold (Core Survey)	Optimal Goal	Clinic Goal
78.30%	63.37%	50.02%	N/A	78.30%	63.37%

Notes

Data Source: Press Ganey

ICH CAHPS Overall Rating of Dialysis Center Staff

	J	F	M	A	M	J	J	A	S	O	N	D
ICH CAHPS: Overall Rating of Dialysis Center Staff (QIP)	77.8%	0.0%	0.0%	90.5%				0.0%	0.0%	0.0%		
Clinic Goal	63.37%	63.37%	63.37%	63.37%	63.37%	63.37%	63.37%	63.37%	63.37%	63.37%	63.37%	63.37%
Optimal Goal	78.30%	78.30%	78.30%	78.30%	78.30%	78.30%	78.30%	78.30%	78.30%	78.30%	78.30%	78.30%

PDCA CYCLE

FINDINGS: Goals met, score increased since previous survey from 77.8% to 90.5%

INTERVENTIONS:

PLAN: Will continue to survey patient population quarterly. Results will be reviewed by IDT and interventions applied as appropriate. Weekly Team Huddles are being implemented, monthly staff meetings and staff in-services offered in topics including but not limited to customer service.

ICH CAHPS: Overall Rating of the Dialysis Facility - Response by Clinic Manager

QIP needed?	Yes	X	No	
Follow up needed?	Yes		No	
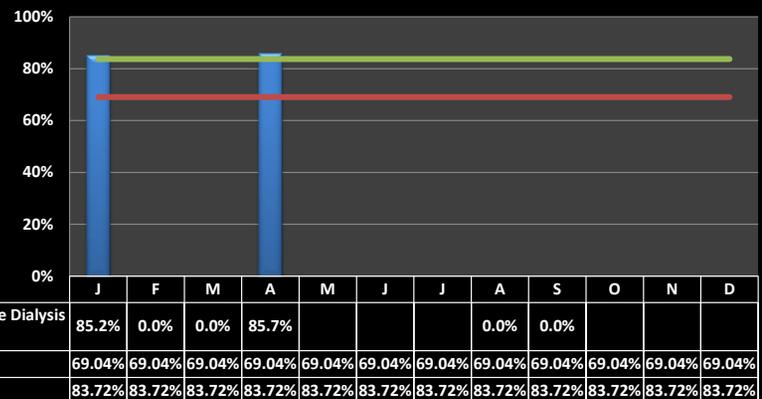
Data Comparison

QIP Benchmark	QIP Perf Standard	QIP Achieve Threshold	US Threshold (Core Survey)	Optimal Goal	Clinic Goal
83.72%	69.04%	54.51%	N/A	83.72%	69.04%

Notes

Data Source: Press Ganey

ICH CAHPS Overall Rating of the Dialysis Facility

	J	F	M	A	M	J	J	A	S	O	N	D
ICH CAHPS: Overall Rating of the Dialysis Facility (QIP)	85.2%	0.0%	0.0%	85.7%				0.0%	0.0%			
Clinic Goal	69.04%	69.04%	69.04%	69.04%	69.04%	69.04%	69.04%	69.04%	69.04%	69.04%	69.04%	69.04%
Optimal Goal	83.72%	83.72%	83.72%	83.72%	83.72%	83.72%	83.72%	83.72%	83.72%	83.72%	83.72%	83.72%

PDCA CYCLE

FINDINGS: Goals met, score increased since previous survey from 85.2% to 85.7%

INTERVENTIONS:

PLAN: Will continue to survey patient population quarterly. Results will be reviewed by IDT and interventions applied as appropriate. Weekly Team Huddles are being implemented, monthly staff meetings and staff in-services offered in topics including but not limited to customer service.

ICH CAHPS: Nephrologists' Communication and Caring - Response by Clinic Manager			DATA

QIP needed?	Yes	**X**	No	
Follow up needed?	Yes		No	
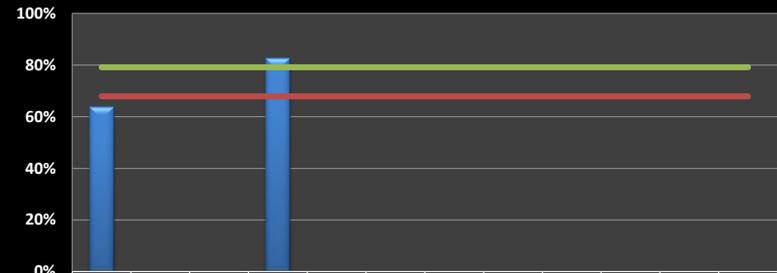
Data Comparison

QIP Benchmark	QIP Perf Standard	QIP Achieve Threshold	US Threshold (Core Survey)	Optimal Goal	Clinic Goal
79.15%	67.90%	58.20%	N/A	79.15%	67.90%

Notes

Data Source: Press Ganey

ICH CAHPS Nephrologists' Communication and Caring

	J	F	M	A	M	J	J	A	S	O	N	D
ICH CAHPS: Nephrologists' Communication and Caring (QIP)	63.8%	0.0%	0.0%	82.6%				0.0%	0.0%			
Clinic Goal	67.90%	67.90%	67.90%	67.90%	67.90%	67.90%	67.90%	67.90%	67.90%	67.90%	67.90%	67.90%
Optimal Goal	79.15%	79.15%	79.15%	79.15%	79.15%	79.15%	79.15%	79.15%	79.15%	79.15%	79.15%	79.15%

PDCA CYCLE

FINDINGS: Goals met, score increased since previous survey from 63.8% to 82.6%

INTERVENTIONS:

PLAN: Will continue to survey patient population quarterly. Results will be reviewed by IDT and interventions applied as appropriate. Monthly POC meetings offered in conjunction with Nephrologist, results of surveys made available to each nephrologist. Support offered to nephorologist to provide a satisfactory level of care.

ICH CAHPS: Quality of Dialysis Center Care and Operations - Response by Clinic Manager			DATA

QIP needed?	Yes	**X**	No	
Follow up needed?	Yes		No	

Data Comparison

QIP Benchmark	QIP Perf Standard	QIP Achieve Threshold	US Threshold (Core Survey)	Optimal Goal	Clinic Goal
72.66%	63.08%	54.64%	N/A	72.66%	63.08%

Notes

Data Source: Press Ganey

ICH CAHPS Quality of Dialysis Center Care and Operations

	J	F	M	A	M	J	J	A	S	O	N	D
ICH CAHPS: Quality of Dialysis Center Care and Operations (QIP)	65.6%	0.0%	0.0%	81.4%				0.0%	0.0%			
Clinic Goals	63.08%	63.08%	63.08%	63.08%	63.08%	63.08%	63.08%	63.08%	63.08%	63.08%	63.08%	63.08%
Optimal Goal	72.66%	72.66%	72.66%	72.66%	72.66%	72.66%	72.66%	72.66%	72.66%	72.66%	72.66%	72.66%

PDCA CYCLE

FINDINGS: Goals met, score increased since previous survey from 65.6% to 81.4%

INTERVENTIONS:

PLAN: Will continue to survey patient population quarterly. Results will be reviewed by IDT and interventions applied as appropriate. Weekly Team Huddles are being implemented, monthly staff meetings and staff in-services offered in topics including but not limited to customer service. Additionally, current practices are being reviewed for potential improvement opportunities.

ICH CAHPS: Providing Information to Patients - Response by Clinic Manager DATA

Follow up needed?		
QIP needed?	Yes	X	No

QIP needed?	Yes	**X**	No
Follow up needed?	Yes		No

ICH CAHPS Providing Information to Patients

Data Comparison					
QIP Benchmark	QIP Perf Standard	QIP Achieve Threshold	US Threshold (Core Survey)	Optimal Goal	Clinic Goal
87.80%	81.09%	74.49%	N/A	87.80%	81.09%

Notes
Data Source: Press Ganey

	J	F	M	A	M	J	J	A	S	O	N	D
ICH CAHPS: Providing Information to Patients (QIP)	71.1%	0.0%	0.0%	81.9%				0.0%	0.0%			
Clinic Goal	81.09%	81.09%	81.09%	81.09%	81.09%	81.09%	81.09%	81.09%	81.09%	81.09%	81.09%	81.09%
Optimal Goal	87.80%	87.80%	87.80%	87.80%	87.80%	87.80%	87.80%	87.80%	87.80%	87.80%	87.80%	87.80%

PDCA CYCLE
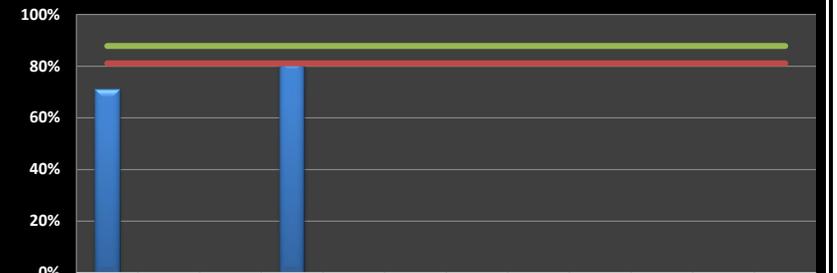
FINDINGS: Clinic goal met, score increased since previous survey from 71.1% to 81.9%

INTERVENTIONS:

PLAN: Will continue to survey patient population quarterly. Results will be reviewed by IDT and interventions applied as appropriate. Weekly Team Huddles are being implemented, monthly staff meetings and staff in-services offered in topics including but not limited to patient communication.

ICH CAHPS: Overall Rating of Nephrologists - Response by Clinic Manager DATA

QIP needed?	Yes	**X**	No
Follow up needed?	Yes		No

Data Comparison		

ICH CAHPS Overall Rating of Nephrologists
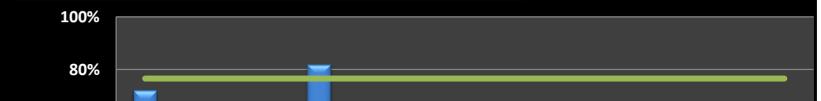
QIP Benchmark	QIP Perf Standard	QIP Achieve Threshold	US Threshold (Core Survey)	Optimal Goal	Clinic Goal
76.57%	62.22%	49.33%	N/A	76.57%	62.22%

Notes

Data Source: Press Ganey

	J	F	M	A	M	J	J	A	S	O	N	D
ICH CAHPS: Overall Rating of Nephrologists (QIP)	71.9%	0.0%	0.0%	81.8%				0.0%	0.0%			
Clinic Goal	62.22%	62.22%	62.22%	62.22%	62.22%	62.22%	62.22%	62.22%	62.22%	62.22%	62.22%	62.22%
Optimal Goal	76.57%	76.57%	76.57%	76.57%	76.57%	76.57%	76.57%	76.57%	76.57%	76.57%	76.57%	76.57%
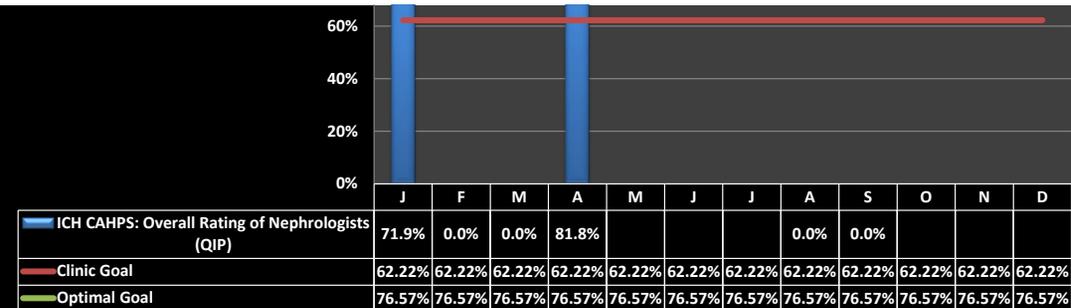
PDCA CYCLE

FINDINGS: Goals met, score increased since previous survey from 71.9% to 81.8%

INTERVENTIONS:

PLAN: Will continue to survey patient population quarterly. Results will be reviewed by IDT and interventions applied as appropriate. Monthly POC meetings offered in conjunction with Nephrologist, results of surveys made available to each nephrologist. Support offered to nephorologist to provide a satisfactory level of care.

CARE COORDINATION: Total Missed Treatments - Response by Clinic Manager — DATA

QIP needed?	Yes		No	X
Follow up needed?	Yes		No	

Data Comparison

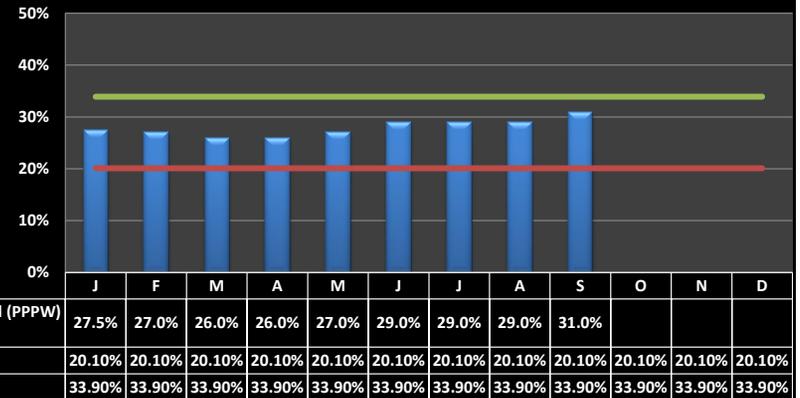| QIP Benchmark	QIP Perf Standard	QIP Achieve Threshold	US Threshold (Core Survey)	Optimal Goal	Clinic Goal
N/A	N/A	N/A	N/A	N/A	N/A

Notes

Data Source: QMAT

PDCA CYCLE

Total Missed Treatments

	J	F	M	A	M	J	J	A	S	O	N	D
Total # missed treatments	145	86	112	73	69	89	69	117	108	83	75	

FINDINGS:

INTERVENTIONS:

PLAN: missed treatments reviewed for possible trends or preventable omissions. Findings discussed with the IDT and reviewed with Medical Director.

CARE COORDINATION: 1 Missed Treatment - Response by Clinic Manager — DATA

QIP needed?	Yes		No	X
Follow up needed?	Yes		No	

Data Comparison

QIP Benchmark	QIP Perf Standard	QIP Achieve Threshold	US Threshold (Core Survey)	Optimal Goal	Clinic Goal
N/A	N/A	N/A	N/A	N/A	N/A

Notes

Data Source: QMAT

PDCA CYCLE

Patients with 1 missed treatment

	J	F	M	A	M	J	J	A	S	O	N	D
# pts with 1 missed treatment	17	32	30	22	23	17	14	28	25	24	11	

FINDINGS:

INTERVENTIONS:

PLAN: missed treatments reviewed for possible trends or preventable omissions.   Findings discussed with the IDT and reviewed with Medical Director.

CARE COORDINATION: 2 Missed Treatments - Response by Clinic Manager   DATA

QIP needed?	Yes		No	X
Follow up needed?	Yes		No	

Data Comparison

QIP Benchmark	QIP Perf Standard	QIP Achieve Threshold	US Threshold (Core Survey)	Optimal Goal	Clinic Goal
N/A	N/A	N/A	N/A	N/A	N/A

Notes

Data Source: QMAT

PDCA CYCLE

Patients with 2 missed treatments

	J	F	M	A	M	J	J	A	S	O	N	D
# pts with 2 missed treatments	9	8	9	12	4	9	6	5	12	10	13	

FINDINGS:

INTERVENTIONS:

PLAN: missed treatments reviewed for possible trends or preventable omissions.   Findings discussed with the IDT and reviewed with Medical Director.

CARE COORDINATION: ≥ 3 Missed Treatments - Response by Clinic Manager				DATA

QIP needed?	Yes		No	X
Follow up needed?	Yes		No	

Data Comparison					
QIP Benchmark	QIP Perf Standard	QIP Achieve Threshold	US Threshold (Core Survey)	Optimal Goal	Clinic Goal
N/A	N/A	N/A	N/A	N/A	N/A

Notes

Data Source: QMAT

Patients with ≥3 missed treatments
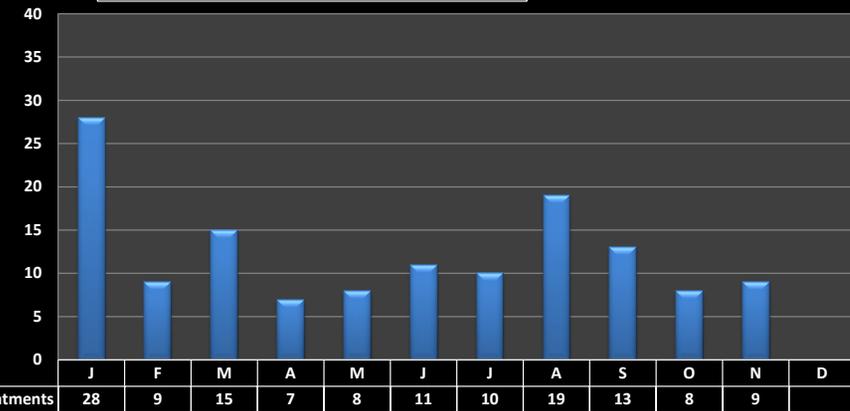
	J	F	M	A	M	J	J	A	S	O	N	D
# pts with ≥ 3 missed treatments	28	9	15	7	8	11	10	19	13	8	9	

PDCA CYCLE

FINDINGS:

INTERVENTIONS:

PLAN: missed treatments reviewed for possible trends or preventable omissions.   Findings discussed with the IDT and reviewed with Medical Director.

CARE COORDINATION: Restart - Response by Clinic Manager				DATA

QIP needed?	Yes		No	X
Follow up needed?	Yes		No	

Data Comparison					
QIP Benchmark	QIP Perf Standard	QIP Achieve Threshold	US Threshold (Core Survey)	Optimal Goal	Clinic Goal
N/A	N/A	N/A	N/A	N/A	N/A

Notes

Data Source: QMAT

Restart

PDCA CYCLE															
# Restart	0	0	0	0	0	0	0	1	0	0	0

FINDINGS: 1 patient restart

INTERVENTIONS:

PLAN:

CARE COORDINATION: Recovered Function - Response by Clinic Manager		DATA

QIP needed?	Yes		No	X
Follow up needed?	Yes		No	

Data Comparison					
QIP Benchmark	QIP Perf Standard	QIP Achieve Threshold	US Threshold (Core Survey)	Optimal Goal	Clinic Goal
N/A	N/A	N/A	N/A	N/A	N/A

Notes
Data Source: QMAT

Recovered Function

	J	F	M	A	M	J	J	A	S	O	N	D
# Recovered Function	0	1	0	0	2	2	1	1	0	0	0

PDCA CYCLE

FINDINGS: 1 recovered function

INTERVENTIONS:

PLAN:

CARE COORDINATION: New Admissions - Response by Clinic Manager		DATA

QIP needed?	Yes		No	X
Follow up needed?	Yes		No	

Data Comparison					
QIP Benchmark	QIP Perf Standard	QIP Achieve Threshold	US Threshold (Core Survey)	Optimal Goal	Clinic Goal
N/A	N/A	N/A	N/A	N/A	N/A

Notes

New Admissions

Data Source: QMAT			

	J	F	M	A	M	J	J	A	S	O	N	D
# New Admissions	2	6	7	3	4	5	1	0	1	3	0	

PDCA CYCLE

FINDINGS: No new admissions

INTERVENTIONS:

PLAN:

CARE COORDINATION: Acute Kidney Injury - Response by Clinic Manager			DATA
QIP needed?	Yes		No	X
Follow up needed?	Yes		No	

Data Comparison					
QIP Benchmark	QIP Perf Standard	QIP Achieve Threshold	US Threshold (Core Survey)	Optimal Goal	Clinic Goal
N/A	N/A	N/A	N/A	N/A	N/A
Notes					
Data Source: QMAT					

Acute Kidney Injury

	J	F	M	A	M	J	J	A	S	O	N	D
# Acute Kidney Injury	5	7	4	6	4	2	3	3	3	3	0	

PDCA CYCLE

FINDINGS: 3 AKI patients for the month

INTERVENTIONS:

PLAN: Patient status reviewed for potential changes weekly at Core Team meeting and monthly for Plan of Care, monthly assessment or at comprehensive assessment.

CARE COORDINATION: Transients - Response by Clinic Manager			DATA
QIP needed?	Yes		No	X
Follow up needed?	Yes		No	

Transients

Data Comparison					
QIP Benchmark	QIP Perf Standard	QIP Achieve Threshold	US Threshold (Core Survey)	Optimal Goal	Clinic Goal
N/A	N/A	N/A	N/A	N/A	N/A

Notes
Data Source: QMAT

PDCA CYCLE

	J	F	M	A	M	J	J	A	S	O	N	D
# Transients	5	2	3	3	3	1	2	1	3	3	0	

FINDINGS: 1 transient patient

INTERVENTIONS:

PLAN: Transient patients are cared for according to policy as all other patients. All relevent health information is provided to home facility upon return.

CARE COORDINATION: Transfer In - Response by Clinic Manager   DATA

QIP needed?	Yes		No	X
Follow up needed?	Yes		No	

Data Comparison					
QIP Benchmark	QIP Perf Standard	QIP Achieve Threshold	US Threshold (Core Survey)	Optimal Goal	Clinic Goal
N/A	N/A	N/A	N/A	N/A	N/A

Notes
Data Source: QMAT

PDCA CYCLE

Transfer In

	J	F	M	A	M	J	J	A	S	O	N	D
# Transfer in (includes modality change)	0	2	0	2	2	3	3	1	1	2	0	

FINDINGS: 1 patient transferred in

INTERVENTIONS:

PLAN:

CARE COORDINATION: Transfer Out - Response by Clinic Manager

QIP needed?	Yes		No	X
Follow up needed?	Yes		No	

Data Comparison

QIP Benchmark	QIP Perf Standard	QIP Achieve Threshold	US Threshold (Core Survey)	Optimal Goal	Clinic Goal
N/A	N/A	N/A	N/A	N/A	N/A

Notes

Data Source: QMAT

Transfer Out

	J	F	M	A	M	J	J	A	S	O	N	D
# Transfer out (chronic, acute, transients, transplant, discontinue)	6	3	8	4	7	6	5	0	5	6	2	

PDCA CYCLE

FINDINGS: No patients transferred out

INTERVENTIONS:

PLAN: All transfers are reviewed to ensure patient satisfaction, the IDT works with patient to ensure a smooth transition to receiving facility.

CARE COORDINATION: Transfer Out Due to Hospital > 30 Days - Response by Clinic Manager

QIP needed?	Yes		No	X
Follow up needed?	Yes		No	

Data Comparison

QIP Benchmark	QIP Perf Standard	QIP Achieve Threshold	US Threshold (Core Survey)	Optimal Goal	Clinic Goal
N/A	N/A	N/A	N/A	N/A	N/A

Notes

Data Source: AA census binder, Clarity

Transfer out due to hospital >30 days

	J	F	M	A	M	J	J	A	S	O	N	D
# Transfer out due to hospital > 30 days	0	0	0	0	0	0	0	0	0	0	0	

PDCA CYCLE

FINDINGS: None to report
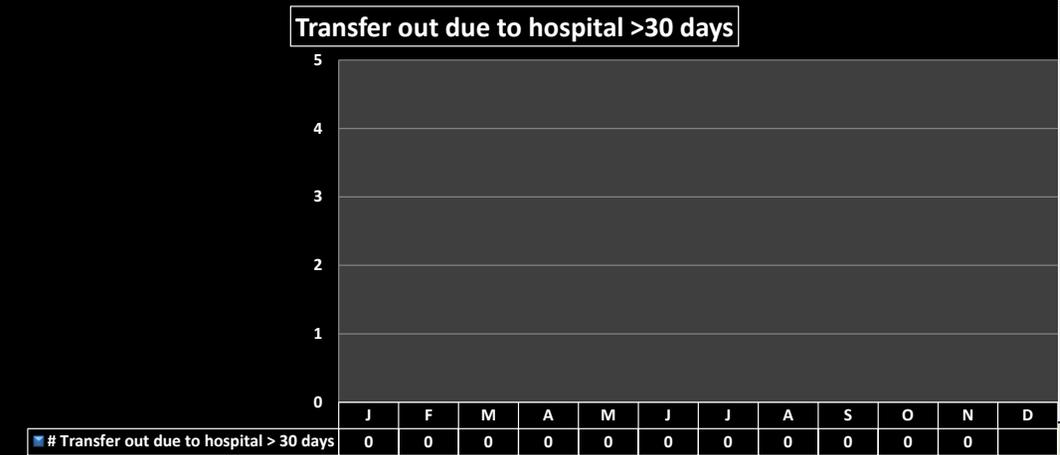
INTERVENTIONS:

PLAN:

HEALTH OUTCOMES: Standardized Mortality Ratio - Response by Clinic Manager						DATA

QIP needed?	Yes		No	X
Follow up needed?	Yes		No	

Data Comparison

QIP Benchmark	QIP Perf Standard	QIP Achieve Threshold	US Threshold (Core Survey)	Optimal Goal	Clinic Goal
N/A	N/A	N/A	N/A	N/A	N/A

Notes

Data Source: AA census binder, Clarity

of Mortalities

	J	F	M	A	M	J	J	A	S	O	N	D
# of Mortalities	3	5	5	3	0	2	2	0	7	2	0	

PDCA CYCLE

FINDINGS: No deaths

INTERVENTIONS:

PLAN: Mortality review completed and shared with Medical Director.

HEALTH OUTCOMES: Medical Errors and Occurrences - Response by Clinic Manager						DATA

QIP needed?	Yes		No	X
Follow up needed?	Yes		No	

Data Comparison

QIP Benchmark	QIP Perf Standard	QIP Achieve Threshold	US Threshold (Core Survey)	Optimal Goal	Clinic Goal
N/A	N/A	N/A	N/A	N/A	N/A

Notes

Data Source: MIDAS

Medical Errors and Occurrences

	J	F	M	A	M	J	J	A	S	O	N	D
■ Occurrences	1	4	0	3	2	1	5	6	0	2	1	
■ Transfer to higher level of care	11	12	6	3	1	4	5	2	4	6	1	

PDCA CYCLE

FINDINGS: 8 total medical errors/occurrences - 2 transferred to higher level of care, 6 occurrences

INTERVENTIONS:

PLAN: Clinic Manager reviews each event as reported, involving IDT and Medical Director as applicable. All issues have been resolved or attended to.
Clinic Manager will in-service staff to the appropriate use of reporting tool to ensure capturing all relevant opportunities for improvement.

HEALTH OUTCOMES: Ultrafiltration Rate - Response by Clinic Manager | DATA

| QIP needed? | Yes | X | No | |
| Follow up needed? | Yes | | No | |

Data Comparison					
QIP Benchmark	QIP Perf Standard	QIP Achieve Threshold	US Threshold (Core Survey)	Optimal Goal	Clinic Goal
N/A	N/A	N/A	9.40%	0%	30%

Notes
Data Source: QMAT

% Patients with Avg UFR < 13ml/kg/hr

	J	F	M	A	M	J	J	A	S	O	N	D
■ % Patients with Avg UFR > 13 ml/kg/hr (lower is better)	13.87%	12.32%	13.38%	13.48%	16.08%	12.06%	14.7%	9.4%	21.9%	19.4%	21.80%	
■ Clinic Goal	30%	30%	30%	30%	30%	30%	30%	30%	30%	30%	30%	30%
■ Optimal Goal	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
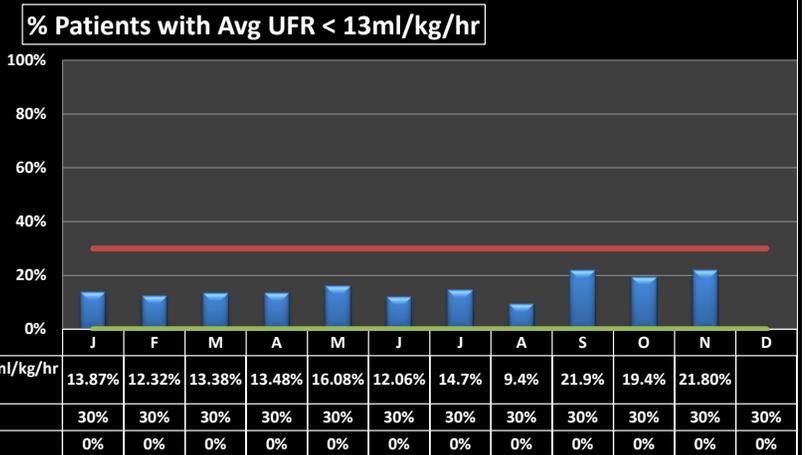
PDCA CYCLE

FINDINGS: Clinic goal met

INTERVENTIONS:

PLAN:

HEALTH OUTCOMES: Medication Reconciliation Completed - Response by Clinic Manager | DATA

| QIP needed? | Yes | X | No | |
| Follow up needed? | Yes | | No | |

Data Comparison					
QIP Benchmark	QIP Perf Standard	QIP Achieve Threshold	US Threshold (Core Survey)	Optimal Goal	Clinic Goal
N/A	N/A	N/A	N/A	100%	100%

% Medication Reconciliatons Completed

	Notes
	Data Source: Clarity

	J	F	M	A	M	J	J	A	S	O	N	D
% of Medication Reconciliations Completed	92.3%	93.8%	84.6%	93.2%	90.0%	92.8%	93.1%	97.8%	100.0%	100.0%	100.0%	
Clinic Goal	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Optimal Goal	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

PDCA CYCLE

FINDINGS: Goal not met, 139 out of 142 medication reconciliations completed

INTERVENTIONS:

PLAN:

FACILITY: Kaweah Delta Visalia Hemodialysis					Month:		Oct - Nov	Year:		2021

TRANSPLANT WAITLIST: Prevalent Patients Waitlisted - Response by Social Workers DATA

QIP needed?	Yes		No	X
Follow up needed?	Yes		No	

Data Comparison

QIP Benchmark	QIP Perf Standard	QIP Achieve Threshold	US Threshold (Core Survey)	Optimal Goal	Clinic Goal
33.90%	16.73%	8.12%	20.10%	33.90%	20.10%

Notes

Data Source: Social Workers internal tracking

PDCA CYCLE

% Prevalent Patients Waitlisted (PPPW)

	J	F	M	A	M	J	J	A	S	O	N	D
% Prevalent Patients Waitlisted (PPPW) (QIP)	27.5%	27.0%	26.0%	26.0%	27.0%	29.0%	29.0%	29.0%	31.0%			
Clinic Goal	20.10%	20.10%	20.10%	20.10%	20.10%	20.10%	20.10%	20.10%	20.10%	20.10%	20.10%	20.10%
Optimal Goal	33.90%	33.90%	33.90%	33.90%	33.90%	33.90%	33.90%	33.90%	33.90%	33.90%	33.90%	33.90%

FINDINGS: Clinic goal met for September; 29 out of 92 patient on the waitlist.

INTERVENTIONS:

PLAN: SW will continue to work with the IDT to identify barriers, provide support, education and encouragement for potential listing.

% of KDQOL Assessment Completed Within 3 months of Initial Treatment - Response by Social Workers DATA

QIP needed?	Yes		No	X
Follow up needed?	Yes		No	

Data Comparison

QIP Benchmark	QIP Perf Standard	QIP Achieve Threshold	US Threshold (Core Survey)	Optimal Goal	Clinic Goal
N/A	N/A	N/A	N/A	100%	100%

Notes

Data Source: Social Workers internal tracking

PDCA CYCLE

% of KDQOL Assessments Completed within 3 Months of Initial Tx

	J	F	M	A	M	J	J	A	S	O	N	D
% of KDQOL Assessments completed within 3 months of initial treatment	100%	100%	100%	100%	100%	100%	100%	100%	100%			
Clinic Goal	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Optimal Goal	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

FINDINGS: Optimal goal met for September; 0 of 0 surveys completed.

INTERVENTIONS:

PLAN: Social worker will continue to assess patients' needs, situations, strengths, vision impairments, physical limitations, and language barriers to provide the appropriate accommodations, to assure patients continue to complete their annual and 90-day Kidney Disease Quality of Life survey (KDQOL).

% of KDQOL Assessments Completed Annually - Response by Social Workers						DATA

QIP needed?	Yes		No	X
Follow up needed?	Yes		No	

% of KDQOL Assessments Completed Annually
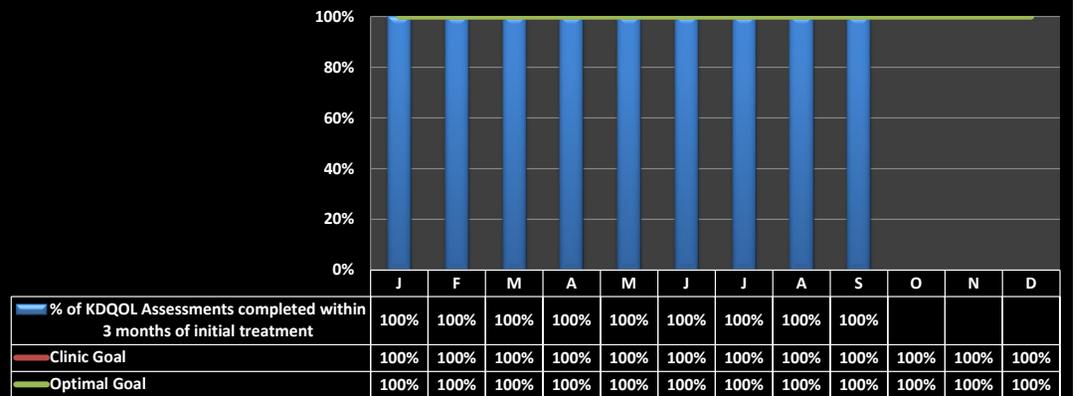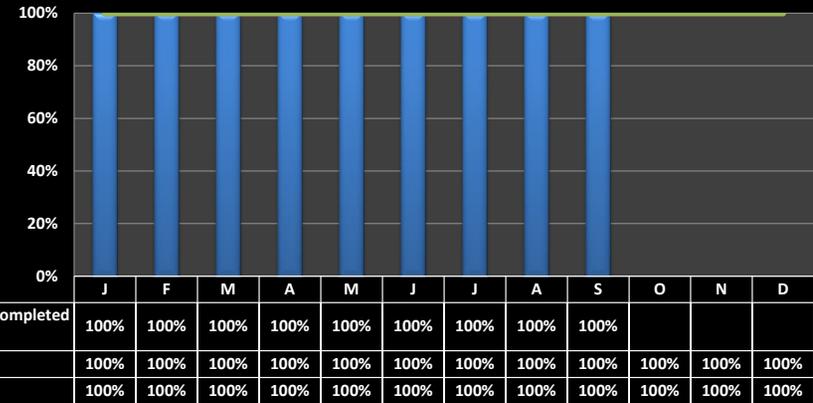
Data Comparison					
QIP Benchmark	QIP Perf Standard	QIP Achieve Threshold	US Threshold (Core Survey)	Optimal Goal	Clinic Goal
N/A	N/A	N/A	N/A	100%	100%

Notes
Data Source: Social Workers internal tracking

	J	F	M	A	M	J	J	A	S	O	N	D
% of KDQOL Assessments completed annually	100%	100%	100%	100%	100%	100%	100%	100%	100%			
Clinic Goal	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Optimal Goal	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

PDCA CYCLE

FINDINGS: Optimal goal met for September; 7 of 7 surveys completed

INTERVENTIONS:

PLAN: Social worker will continue to assess patients' needs, situations, strengths, vision impairments, physical limitations, and language barriers to provide the appropriate accommodations, to assure patients continue to complete their annual and 90-day Kidney Disease Quality of Life survey (KDQOL).

CARE COORDINATION: Patient Grievances - Response by Social Workers						DATA

QIP needed?	Yes		No	X
Follow up needed?	Yes		No	

Patient Grievances

Data Comparison					
QIP Benchmark	QIP Perf Standard	QIP Achieve Threshold	US Threshold (Core Survey)	Optimal Goal	Clinic Goal
N/A	N/A	N/A	N/A	N/A	N/A

Notes
Data Source: Social Workers internal tracking

	J	F	M	A	M	J	J	A	S	O	N	D
📊 Grievances - Total #	0	0	0	0	0	0	0	1	0			
📉 # Resolved	0	0	0	0	0	0	0	1	0			
📊 # Escalated	0	0	0	0	0	0	0	0	0			

PDCA CYCLE

FINDINGS: 0 Grievance to report for the month of September.

INTERVENTIONS:

INTERVENTIONS: SW Team will continue to provide education on ways to file a grievenve and provide support as needed.

Column1	Column2
BSI	The Standardized Infection Ratio (SIR) of Bloodstream Infections (BSI) will be calculated among patients receiving hemodialysis (HD) at outpatient HD centers.
ICH CAHPS	Patient Experience of Care: In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems. Percentage of patient responses to multiple survey measures to assess their dialysis providers, the quality of dialysis care they receive, and information sharing about their disease. (Survey is administered twice a year).
Standardized Readmission Ratio (SRR)	Ratio of the number of observed unplanned 30-day hospital readmissions to the number of expected unplanned 30-day hospital readmissions
Standardized Transfusion Ratio (STrR)	Dialysis facility reporting of data on Medicare claims and in EQRS1 that are used to determine the number of eligible patient years at risk for calculating the risk adjusted facility level transfusion ratio (STrR) for adult Medicare dialysis patients.
Standardized Hospitalization Ratio (SHR)	Risk-adjusted standardized hospitalization ratio of the number of observed hospitalizations to the number of expected hospitalizations.
Kt/V Dialysis Adequacy	Percentage of all patient-months for patients whose delivered dose of dialysis (either hemodialysis [HD] or peritoneal dialysis) met the specified threshold during the reporting period.
Hemodialysis Vascular Access: Standardized Fistula Rate (SFR)	Adjusted percentage of adult hemodialysis (HD) patient-months using an autogenous arteriovenous fistula (AVF) as the sole means of vascular access.
Hemodialysis Vascular Access: Long-term Catheter Rate	Percentage of adult hemodialysis (HD) patient-months using a catheter continuously for three months or longer for vascular access.
Hypercalcemia	Proportion of all adult patient-months with 3-month rolling average of total uncorrected serum or plasma calcium greater than 10.2 mg/dL or missing.
Ultrafiltration Rate	Percentage of patient-months for which a facility reports all required data elements for ultrafiltration rate (UFR) in EQRS1 for all hemodialysis (HD) sessions during the week of the monthly Kt/V draw submitted for that clinical month for each eligible patient.
Medication Reconciliation (MedRec)	The percentage of patient-months for which medication reconciliation was performed and documented by an eligible professional
Clinical Depression Screening and Follow-Up	The percentage of eligible patients for which a facility reports in EQRS1 one of four conditions related to clinical depression screening and follow-up before the close of the December 2021 clinical month in EQRS.
NHSN Dialysis Event Reporting Measure	Number of months for which facility reports National Healthcare Safety Network (NHSN) Dialysis Event data to the CDC's NHSN system.

RRT/Code Blue ProStaff Report
Q3 2021

Dr. Tang, Shannon Cauthen and Stacey Cajimat

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GWTG Resuscitation Criteria

- The RRT/Code Blue Committee has joined Get with the Guidelines (GWTG) Resuscitation, AHA's National Registry, to have access to national and state benchmarks for code blue and RRT measures.

- This information has been used to create a new RRT and Resuscitation Scorecard.

- The RRT/Code Blue Committee will also begin measuring GWTG hospital recognition criteria benchmarks as well. These will improve the quality of our codes and qualify us for awards.
    1. Confirmation of airway device placement
    2. Time to first shock
    3. Time to IV epinephrine
    4. Percent of Pulseless Events monitored or witnessed

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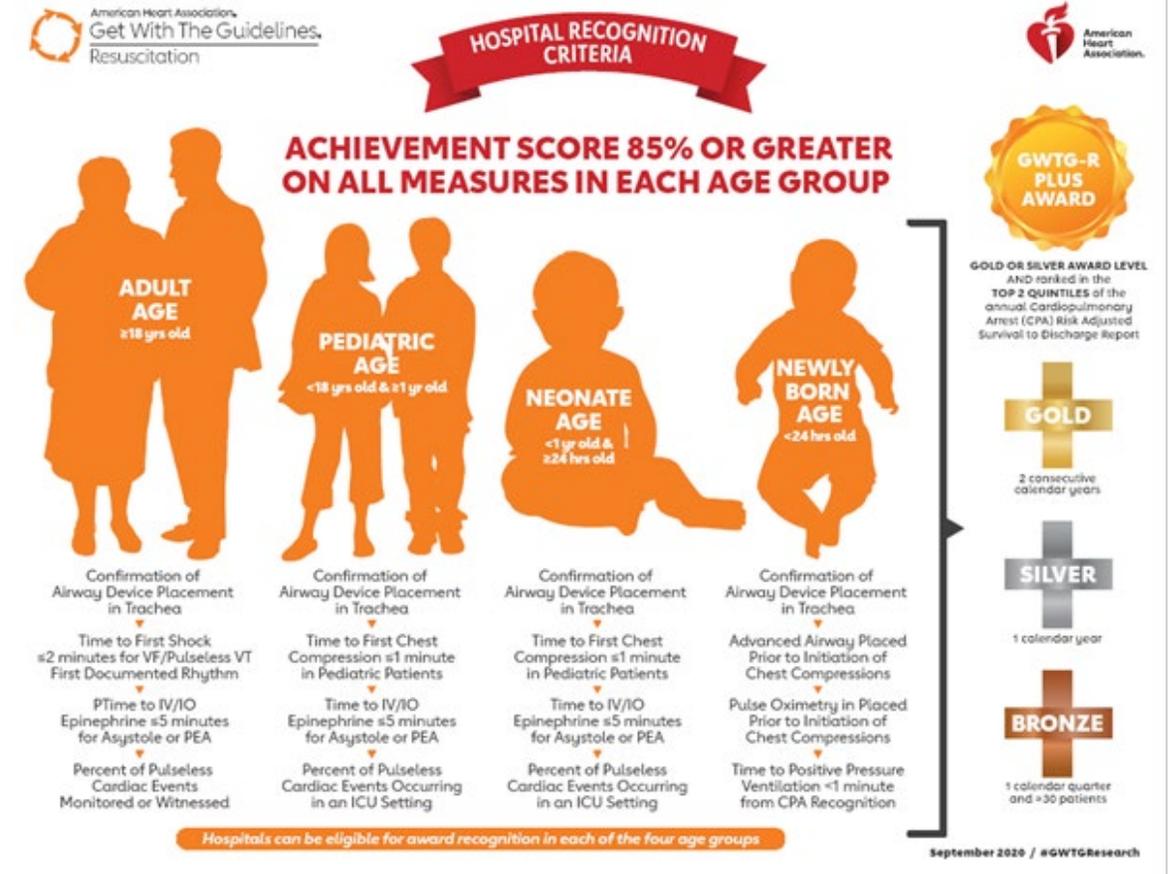
RRT and Resuscitation Quality Scorecard

	RRT and Resuscitation - Quality Scorecard										
Measure Description	**California Hospitals External Benchmark**	**Jan-21**	**Feb-21**	**Mar-21**	**Apr-21**	**May-21**	**Jun-21**	**Jul-21**	**Aug-21**	**Sep-21**	**Mean YTD 2021**
Code Blue Data											
Total Code Blues		27	30	17	15	12	10	16	15	30	19
Total COVID-19 Positive Code Blues		17	14	0	0	0	0	1	9	13	6
Code Blues per 1000 Discharges Med Surg		8	8	5	8	7	1	5	5	6	6
Code Blues per 1000 Discharges Critical Care		12	17	7	4	2	7	7	7	17	9
Percent of Codes in Critical Care	72% (↑ is better)	59%	50%	59%	33%	25%	90%	56%	60%	73%	56%
Code Blue: Survival to Discharge	23% (↑ is better)	11%	7%	18%	27%	25%	40%	25%	0%	7%	18%
Deaths from Cardiac Arrest		24	15	5	8	5	2	6	6	10	9
Overall Hospital Mortality per 1000 Patients		7.629	5.661	3.29	3.132	2.778	1.897	2.539	3.323	5.279	3.95
RRT Data											
RRTs per 1000 patient discharge days		131	129	109	101	117	75	82	106	145	111
RRT mortality percentage	22% (↓ is better)	40% n-70	31% n-47	20% n-22	23% n-23	15% n-18	16% n-16	20% n-22	27% n-36	33% n-61	25%
RRTs within 24 hours of Admit from ED (percentage)	15% (↓ is better)	20% n-30	16% n-26	29% n-29	28% n-28	27% n-32	29% n-30	28% n-31	16% n-22	18% n-33	23%
Green	Better than Target										
Yellow	Within 10% of Target										
Red	Does not meet Target										

Code Blues by Location

Code Blue Locations

	2N	2S	3N	3S	4N	4S	4T	ICU	CVICU	CVICCU	3W	5T	BP
2019 n=115	7	1	6	3	7	7	4	37	17	6	20	0	0
2020 n=200	16	10	11	2	12	5	3	61	38	6	22	13	0
2021 n=172	8	7	3	5	6	9	5	56	41		17	15	0

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RRTs by Location

RRT Locations

	3W	4S	5T	2S	3N	2N	4N	3S	4T	1E	CVICU	ICU	BP
2019	305	212	0	73	134	137	121	151	106	49	59		
2020	265	188	159	156	152	147	137	134	85	50	30		
2021	137	133	162	104	119	105	89	79	74	59	11	6	17
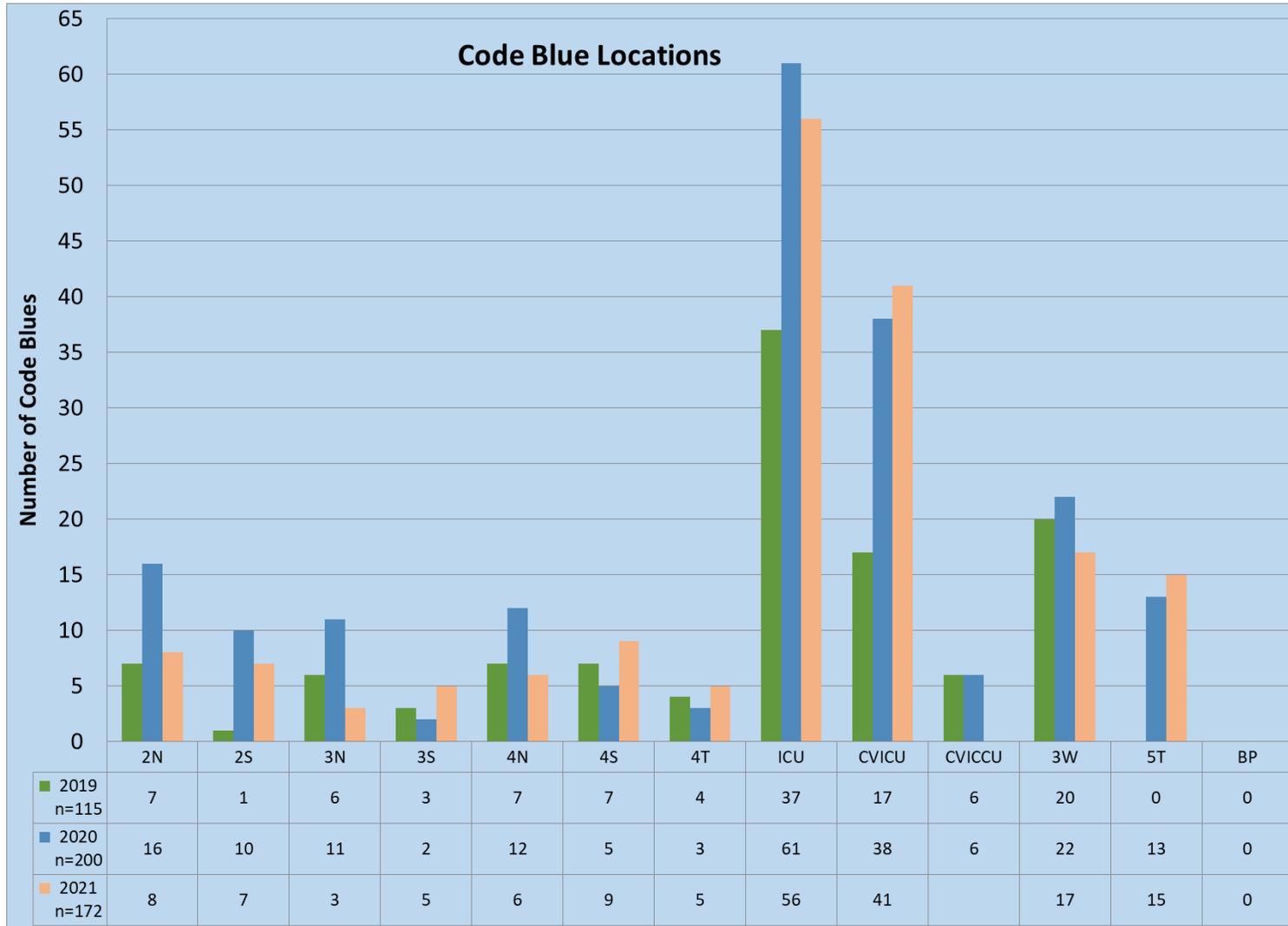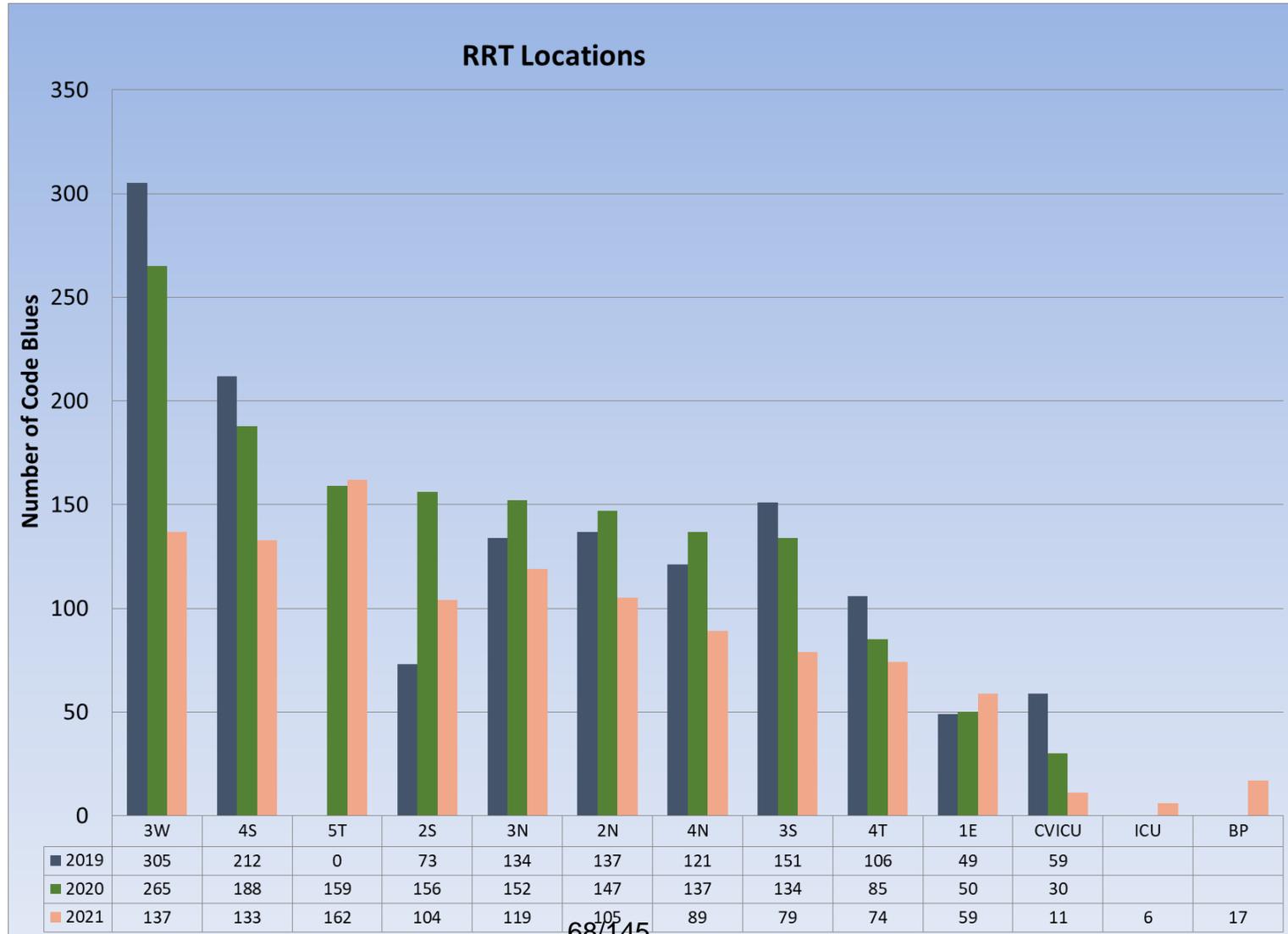
GWTG Recognition Measures- IMPROVEMENTS!
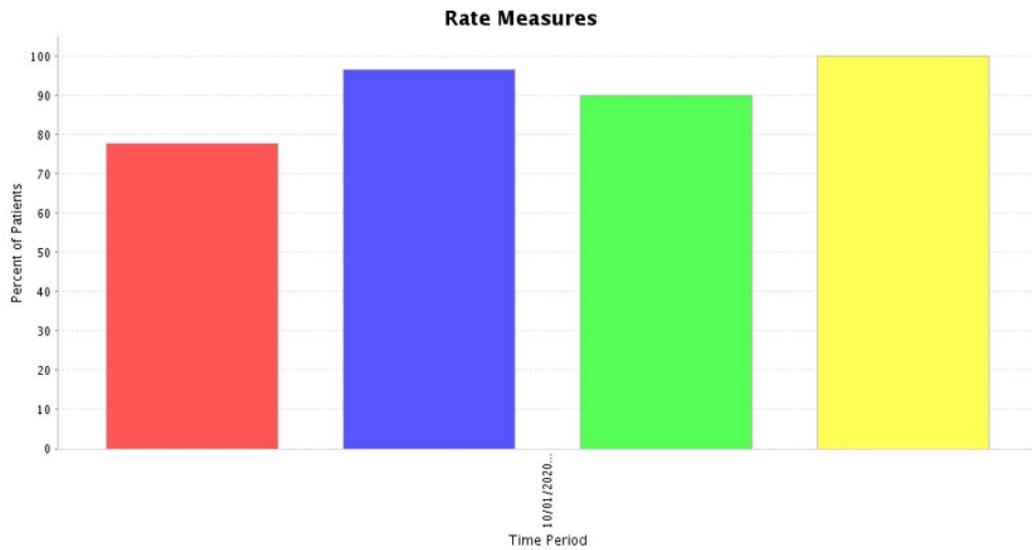
Rate Measures

October 2020-January 2021
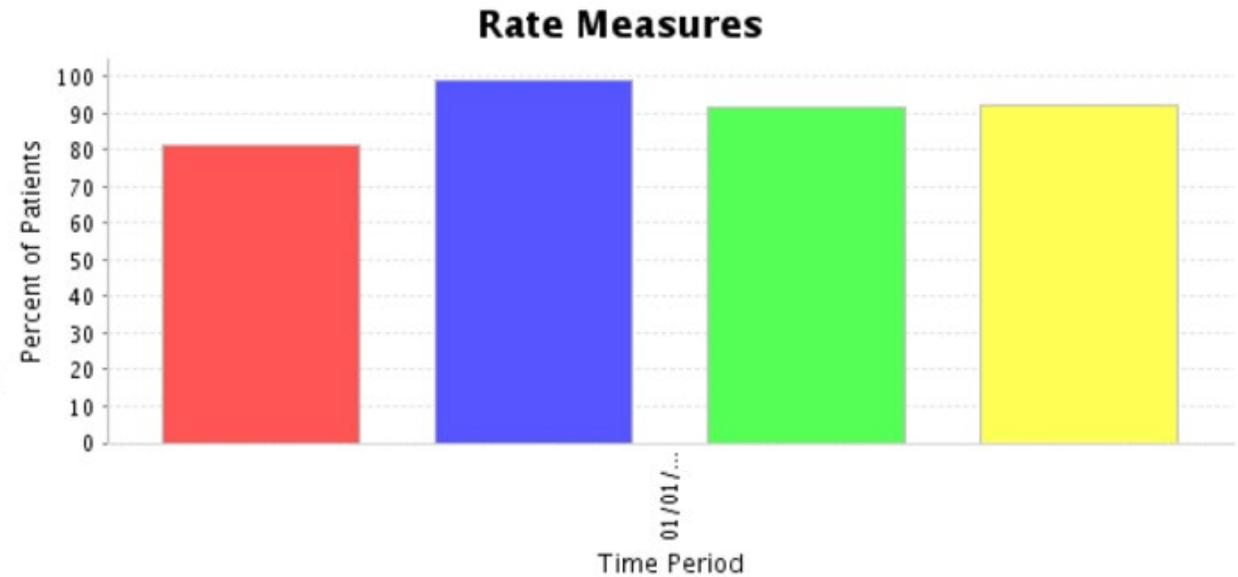
Rate Measures

January-August 2021

Despite the current climate in our hospital, the Rapid Response Team demonstrated improvements (albeit slight) in three of the 4 GWTG Recognition Measures: **Time to First Shock**, **Time to First IV/IO Epinephrine**, and **Percent of witnessed pulseless cardiac events**.

Code Blues and RRTs Q3-2021

Code Blue Summary

- The goal of the Rapid Response Team is to respond to the early recognition of patient deterioration through the use of the 7 Signs of Vitality (SOV) for activation of a Rapid Response. Additionally, early identification helps aide in the reduction of events that convert from a rapid response to a cardiac arrest and it helps hospital staff appropriately place patients to try and reduce the number of cardiac arrests/code blues that occur outside of the ICU. The hospital is currently inundated with patients who are acutely and very critically ill. Our current census has required us to overflow ICU patients to our intermediate critical cares (3W and 5T) and code blues in these areas are not considered to be within critical care, even though our ICCUs have many of the same resources as our ICUs. As such, the number of code blues occurring outside of critical care is very high despite our best efforts to funnel the sickest patients into one of our 41 ICU beds.

- Code blue survival to discharge benchmark had started to show signs of improvement at the end of Q2 but with the resurgence of COVID in our hospital, the code blue survival to discharge plummeted to o% for the month of August- bringing our yearly mean down to 18% (5% below the California benchmark).

- There were slight improvements in 3 of the 4 GWTG Measures
  - Time to first shock (improvement by 3%, still measuring below goal of 85%)
  - Time to first epi (increased by 1% and currently performing well above goal of 85%)
  - Percent of witnessed arrests (increased by 1% and currently performing above goal of 85%)

- Rapid Response Team Summary
  - Highest amount of RRTs per 1000 patient discharge days: 145 in September (a new high for this year- the previous high was in January-131)
  - Highest mortality percentage: 33% in September → Previously, January had the highest mortality (40%). Since September had more rapid response events and resulted in less deaths, it means we are catching patients sooner and intervening to help prevent further deterioration and even death! This is great news!

- Average 2021 RRTs within 24 hours of Admit from ED are down 2% from last quarter (25% down to 23%). While still over the state average by 5%, the decrease in RRTs within 24 hours from ED Is great news!

Code Blues and RRTs 2021

Analysis
- Observed a direct correlation in number of COVID patients and increased volume of code blues, RRTs, and mortality which directly affected our code blue to survival to discharge metrics.
- In spite of the COVID census at KH, we have improved compliance with 3 of the 4 GWTG Measures!
- The overall volume and acuity of calls are increased but the RRT statistics show that we are catching patients earlier and intervening to prevent further deterioration in our patients- GREAT NEWS!

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Next Steps

- Recruit and fill Medical Director Position- Dr. Tang leaving end of December. In-progress
- Revise code blue form to easily capture all code blue process elements to meet GWTG standards. Point person-Abel. In-progress
- Review of Redivus Code Blue App for Consistent Documentation and Data collection. Point person- Evan. In-progress
- Teach nursing staff to use AED "Analyze" function in code blues. Point persons- Rosalinda and Shannon. In-progress
- Formalization of non-licensed staff and family activated RRT process. Pending
- Re-instate Hi-Fidelity mock in-situ code blues. Point Person- Shannon. Pending
- Formalization of role definition of each team member of the Code team using the developed assignment sheet. Complete
- Quality RN and Resident Physician to review all 130 RRTs that were activated within 24-hours of admit from ED to observe for trends and then QFT team to determine action plan. Unable to complete-no resident available.

Next Steps: Education

- Resume using Sim Lab/Sim Man for In-Situ Mock Codes-Shannon working w/ Dr. Sokol.
- RRT nurse will be working to form partnerships with specific units to "champion" and be a go-to person to help with education and reinforce utilizing RRT.
- Looking to start a project to teach staff to utilize AED function on ZOLLS while awaiting code team-will decrease time to first shock per GWTG criteria-Shannon and Rosalinda working with Clin Ed team.
- TCAR (Trauma Care After Resuscitation) and CALS (Cardiovascular Advanced Life Support) are now actively being taught to some of our team members. All staff who care for these special populations of patients will be receiving this specialty training in the next 4-6 months.

Questions?
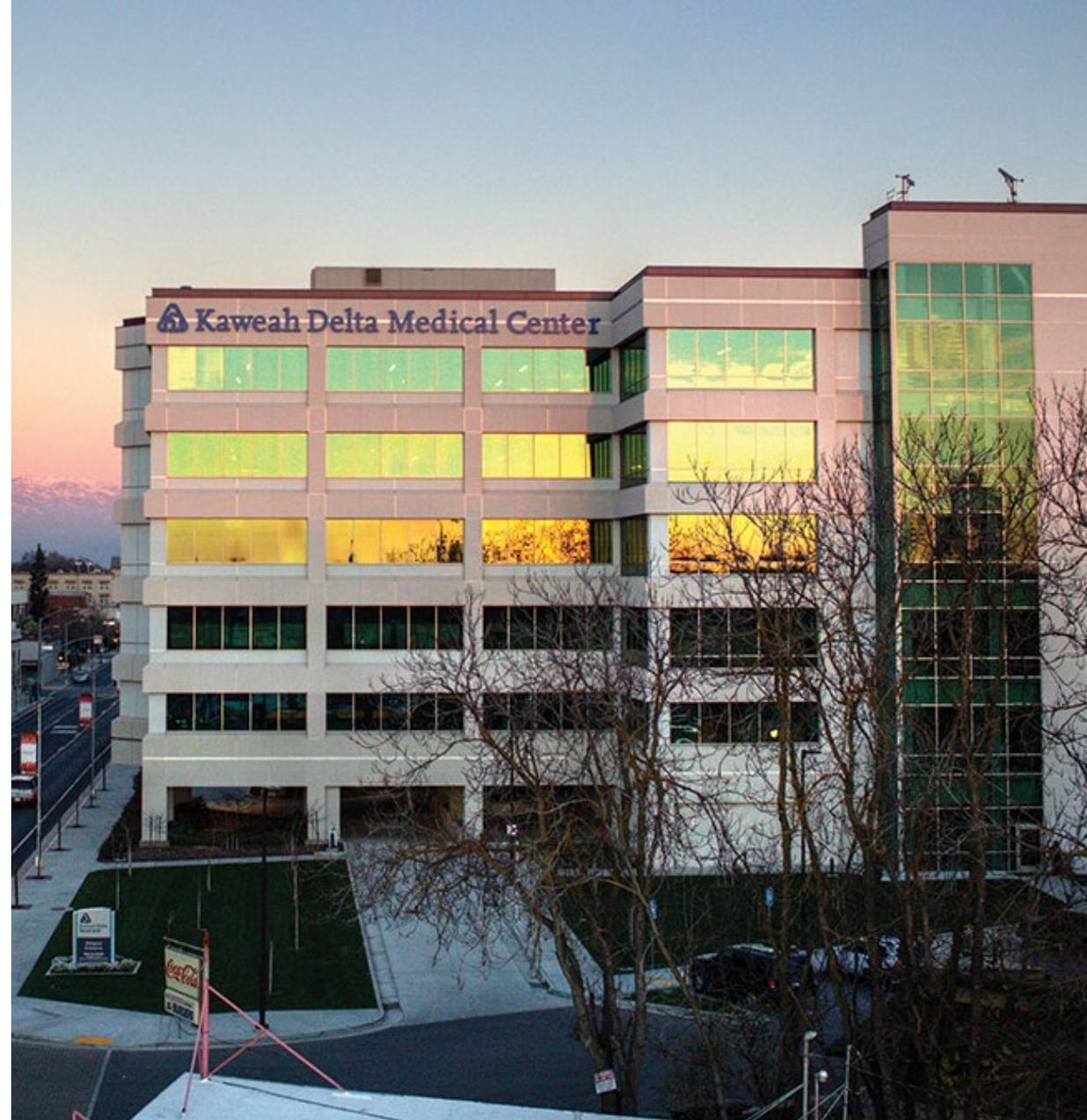
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2020-2021 Stroke Alert Dashboard

Door to Stroke Alert (median times)

Legend: ■ Door to Stroke Alert (EMS) ■ Door to Stroke Alert (Triage) — Triage goal time — EMS goal time
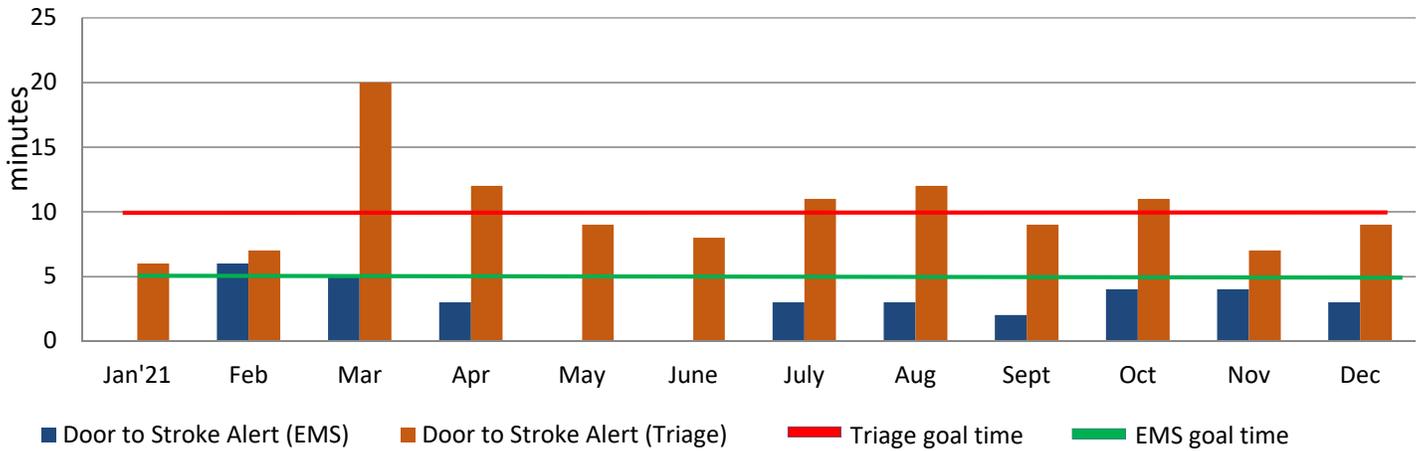
Per KDH ED Stroke Alert process; stroke alerts to be called within 5 min for EMS and 10 min for Triage. ED Stroke Alert Triage task force convened to look for opportunities for improvement March 2020.

Door to MD Seen (median time)

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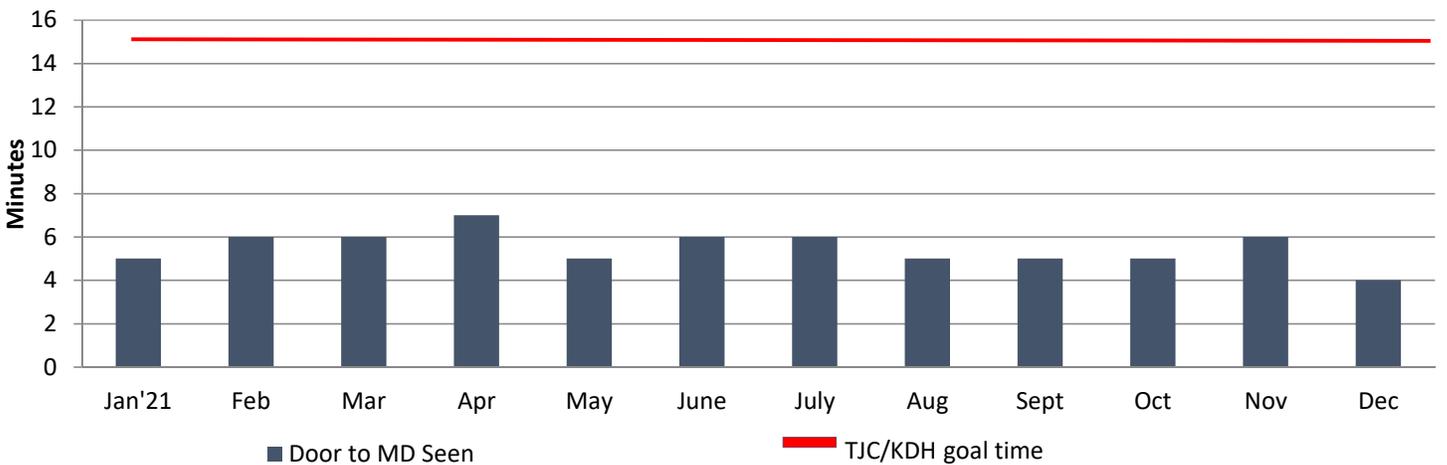
The expectation is that the physician will see the stroke alert patient within 15 minutes of arrival. Improvements made throughout the past year include: early notification from EMS, MD meets the pt at the door upon arrival, scribe documents first seen time in the record.

% NIHSS Complete

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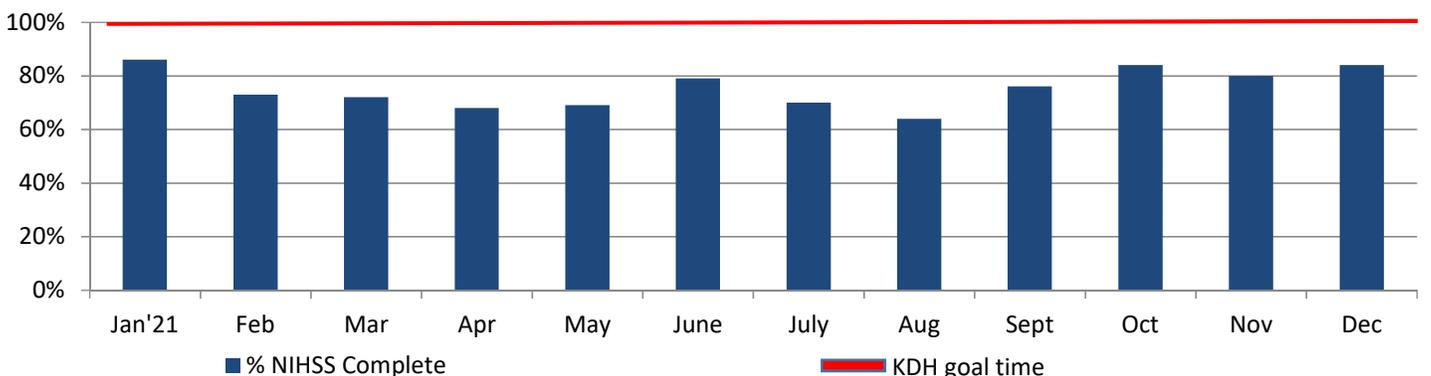
The expectation is that all stroke alert patients will have a NIHSS completed by a certified ED staff member and/or the attending physician; the primary responsible person is the attending/resident physician. This audit ONLY tracks if attending/resident physician have completed a full NIHSS in the ED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

2020-2021 Stroke Alert Dashboard

Door to CT Times (median times)

Legend:
- ■ Door to CT Order (min)
- ■ CT Order to Perform (min)
- ■ CT Perform to Read (min)
- ━ TJC/KDH perform goal
- ━ KDH read time goal
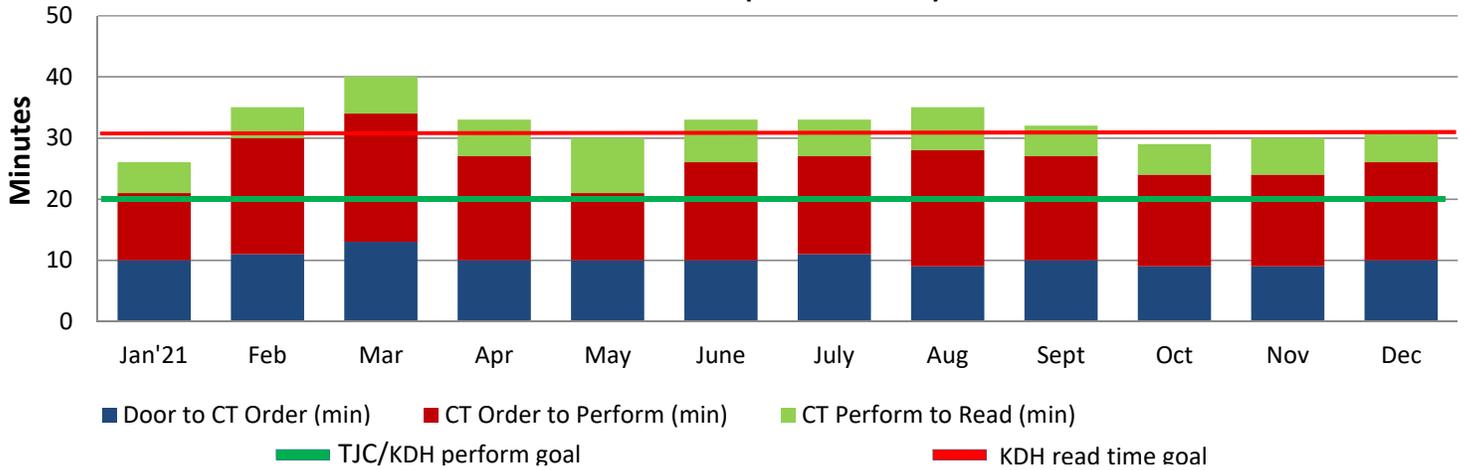
CMS and TJC expectation is that the CT will be performed by 20 minutes and read by 45 minutes of arrival. KDH's CT read time goal is 30 minutes. Starting 2019; tracking of CT start times will be included in this measurement. start time is define by the first CT images in Synapse. **Feb 2021 removed CT start time metric.

Door to Alteplase (median time)

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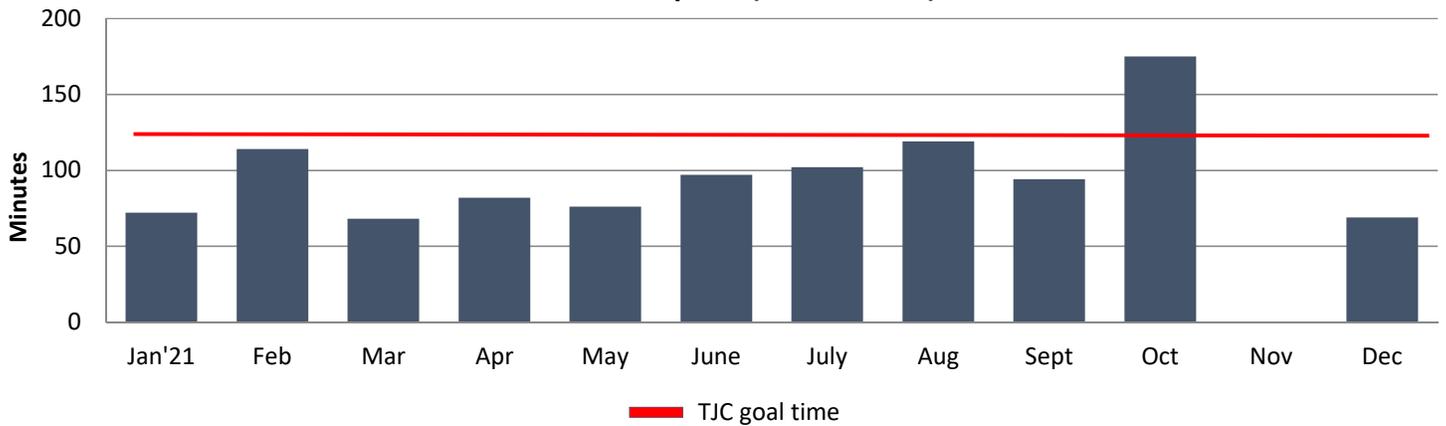
The data in this graph includes all Alteplase patients which differs from the TJC rate because exclusion criteria is not used. TJC expectation is that IV thrombolytics are given within 60 minutes to eligible patients who present for stroke care. AHA/ASA GWTG expectations were update in 2019 with new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

ED Stroke Alert Volume

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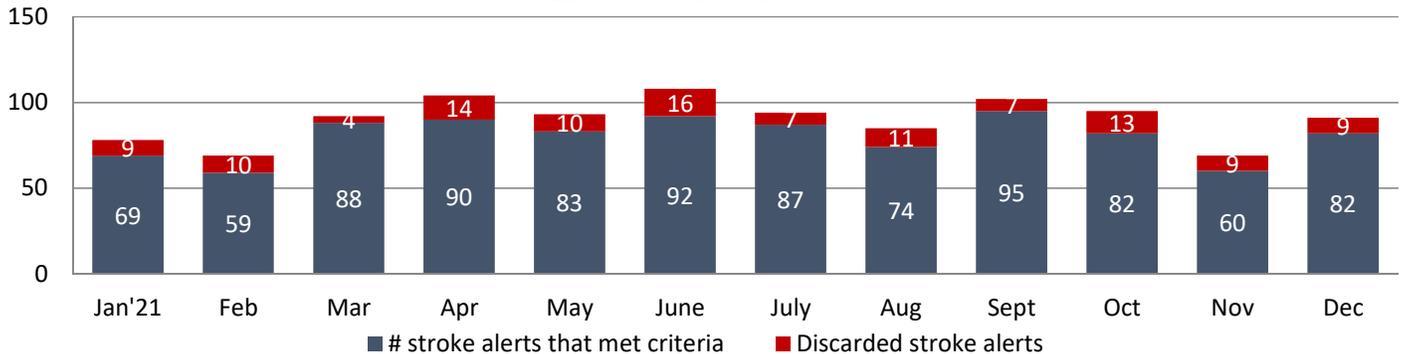
Stroke alert criteria includes: pt presenting with stroke like symptoms +FAST screen, stroke alerts called prior to arrival and up to 1 hour after arrival. Excluded cases: >1 after arrival or if stroke alert was cancelled.

2020-2021 Stroke Alert Dashboard

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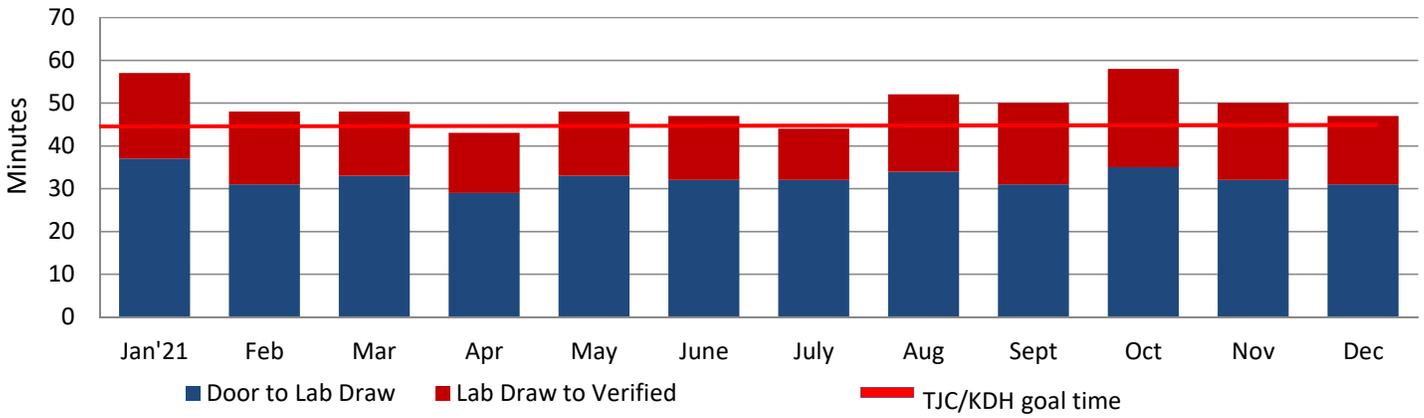
TJC expectation is that laboratory tests are completed within 45 minutes of arrival. Changes in stroke alert process has been made early 2019 to improve lab verified times. Action items taken: IV start kits in CT rooms with lab tubes, lab label makers in both CT rooms and specimens taken immediately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

Door to EKG Time (median time)
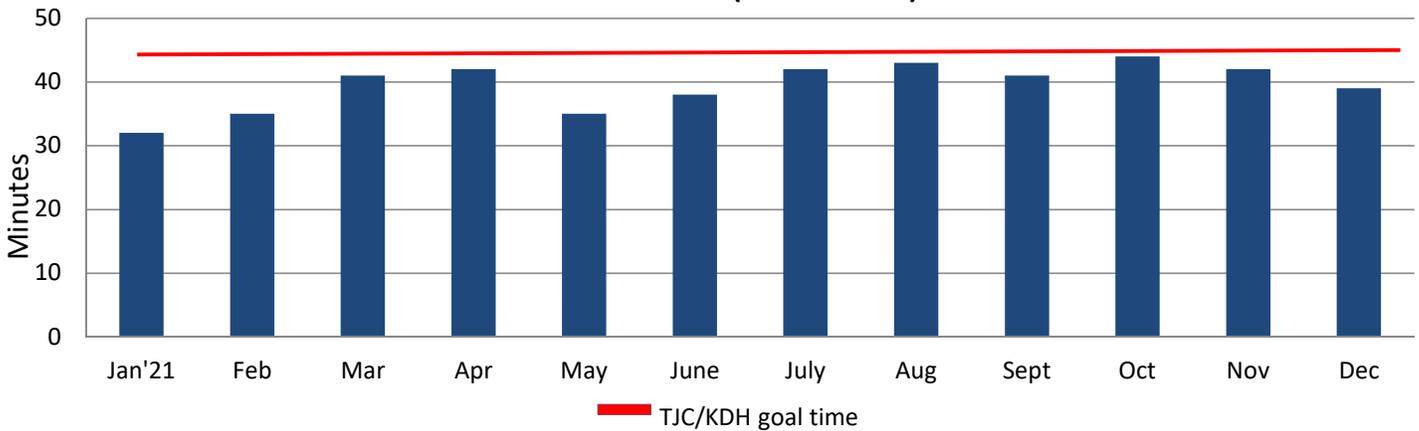
TJC expectation is that EKGs are completed within 45 minutes of arrival.

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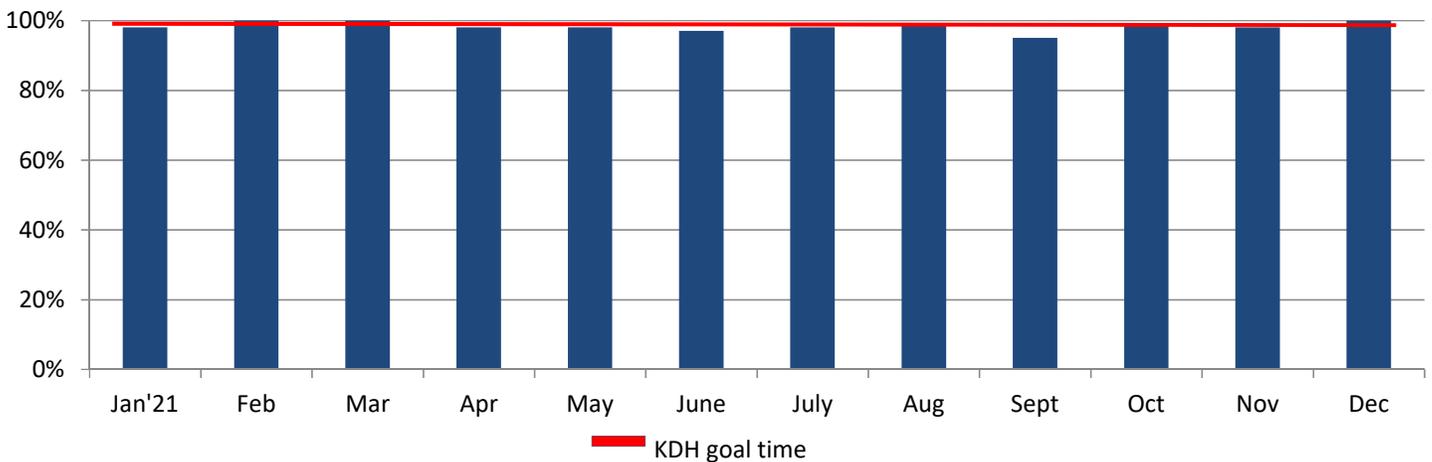
Dysphagia screening should be completed by the RN on all stroke alert patients prior to any po intake, including meds. Dysphagia screening is part of the ED stroke alert order sets. Goal is 100% compliance.

2020-2021
In-House Stroke Alert Dashboard

Stroke Alert Location

alerts

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

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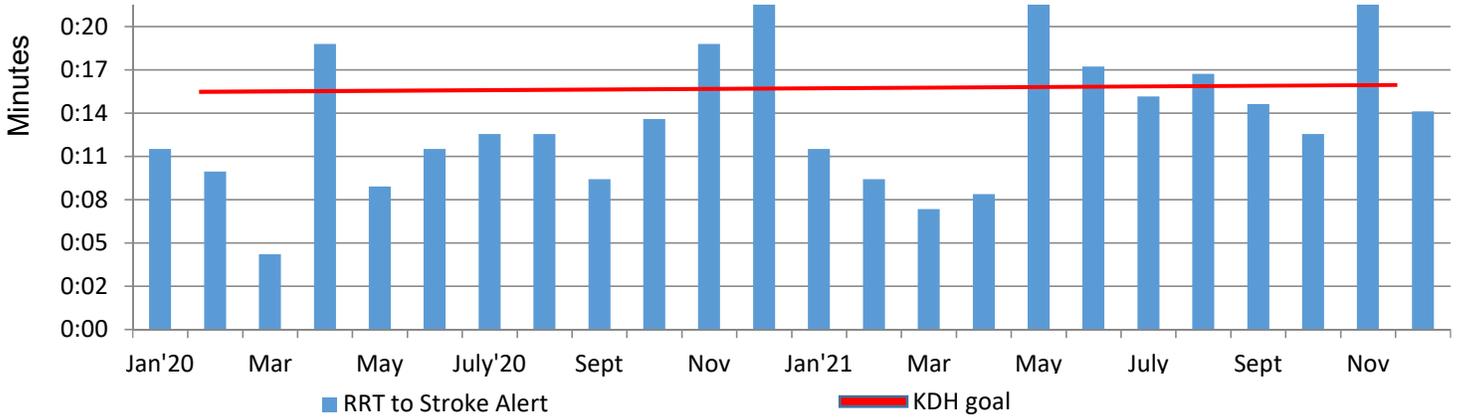
If patients exhibit any new or worsening neuro deficits while in the hospital; RNs are to call an RRT. The RRT RN will evaluate and determine if a stroke alert should be called. The goal from calling RRT to stroke alerts should be <15 minutes.

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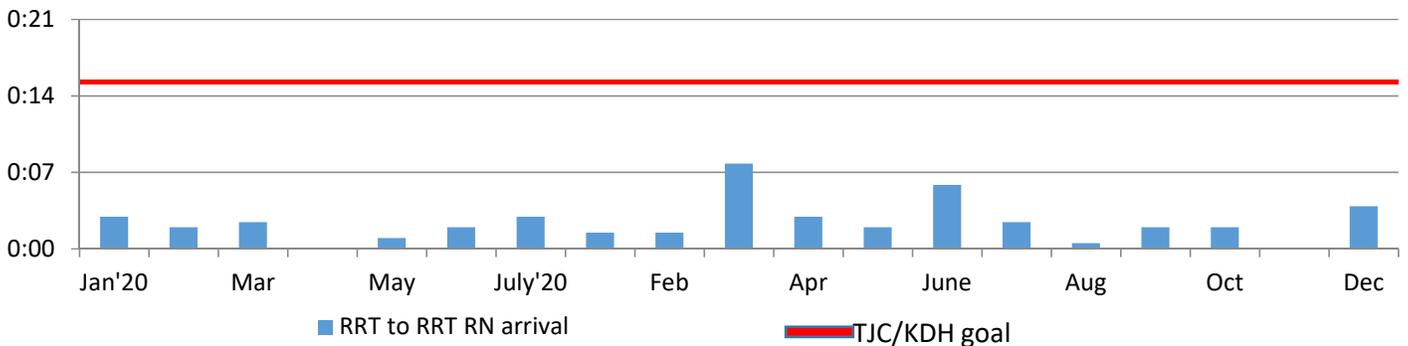
TJC expectation is that a designated provider is at the bedside within 15 minutes of stroke alert. KDH has designated the RRT RN as the provider for in-house stroke alerts.

2020-2021
In-House Stroke Alert Dashboard

Stroke Alert to CT Times

Legend: Stroke alert to CT Order- | CT Order to CT Perf | CT Performed to CT Read | TJC/KDH goal | KDH goal
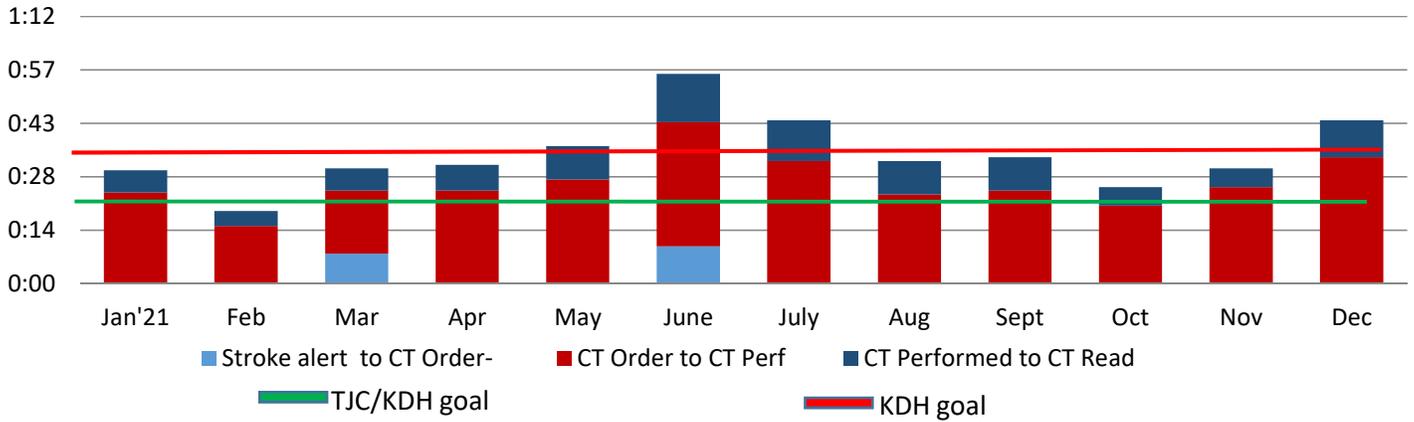
TJC expectation is that the CT will be read within 45 minutes of arrival. KDH's goal is 30 minutes **(red line).** TJC added a new metric in 2018; the expectation is that the CT will be performed within 20 minutes of alert **(green line).**

% neuro contact

Legend: ■ % neuro contact
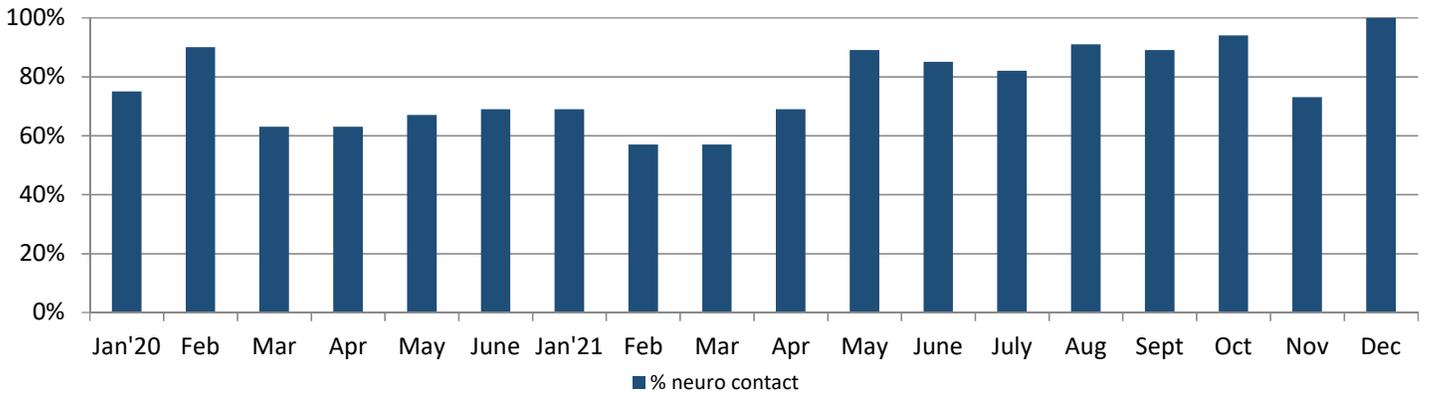
Neurology consultation should occur on all in-house stroke alerts.

% dysphagia screen done

Legend: ■ % dysphagia screen done | KDH goal
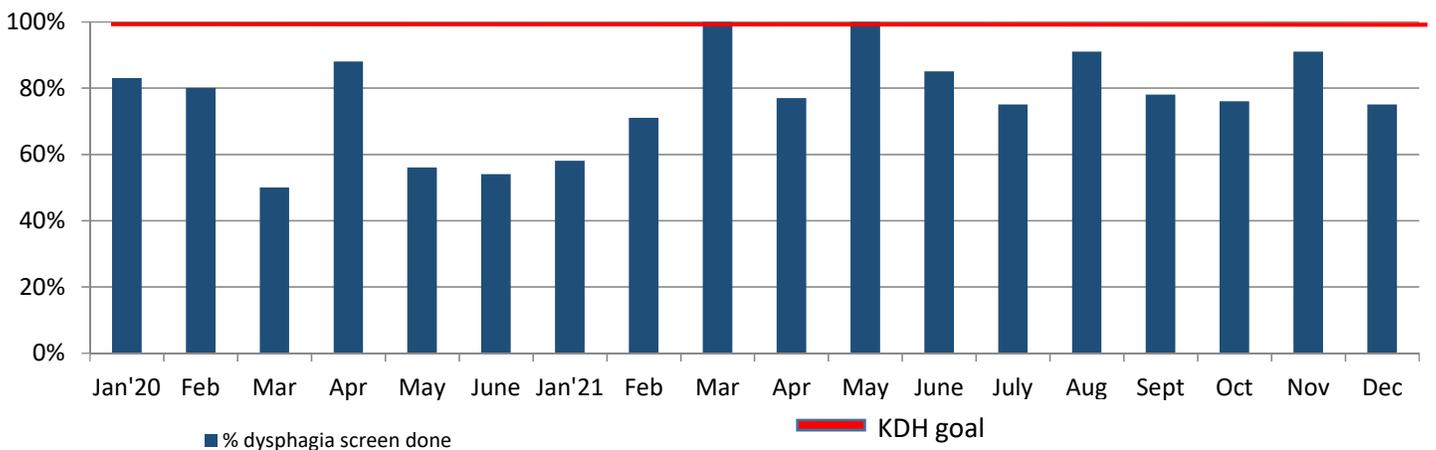
Whenever there are new or worsening neurological deficits ≥3 points, the RN should perform a dysphagia screen to evaluate the patient's ability to swallow.

80/145

2020-2021
In-House Stroke Alert Dashboard

Alert to Alteplase time

Legend: ■ Alert to Alteplase time ■■■ TJC goal
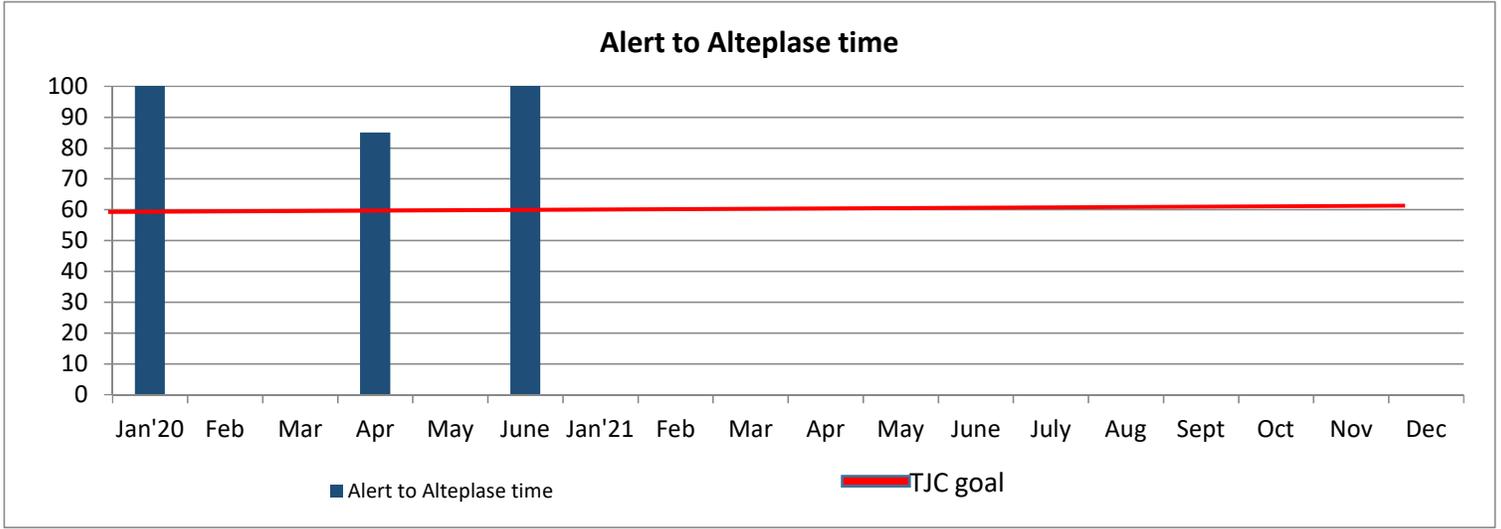
ED Patients: TJC expectation is that IV thrombolytics are given within 60 minutes to eligible patients who present for stroke care at least 50% of the time. In-House Stroke alerts: KDH expectation is that IV thrombolytics are given within 60 minutes to eligible patients who have been identified with new or worsening stroke symptoms

Alteplase flowsheet completed
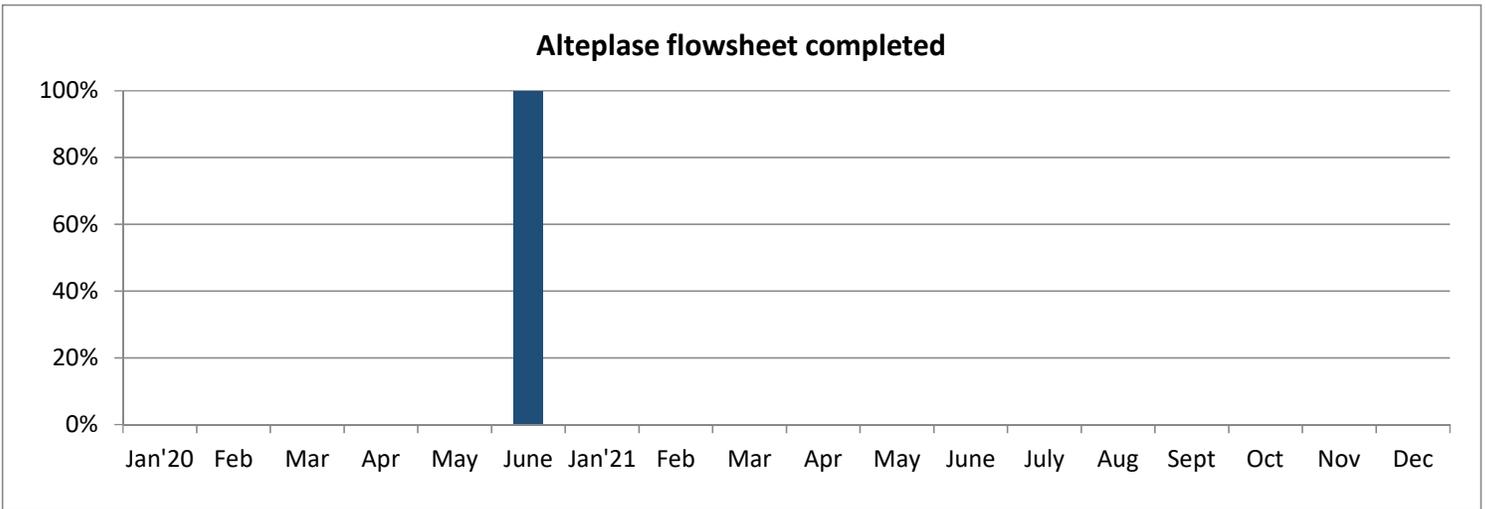
	Bench-marks	2019 Totals	2020												Jan'21	Feb	Mar	Apr	May	Jun	July	Aug
			Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec								
Grouping of Stroke Patients																						
Ischemic		460	39	42	38	23	28	32	31	29	34	27	24	34	34	33	32	36	39	37	33	38
Hemorrhagic		98	8	6	5	7	6	4	4	8	7	8	14	1	5	12	8	5	9	12	7	7
TIA (in-patient and observation)		344	33	44	29	24	21	13	27	20	16	24	19	11	18	18	26	19	20	16	19	14
Transfers to Higher Level of Care (Ischemic)		27	1	2	3	3	2	6	1	3	4	3	5	2	3	1	2	4	4	2	2	0
Transfers to Higher Level of Care (Hemorrhagic)		17	1	1	1	1	1	0	2	1	6	6	2	2	2	2	2	0	0	2	1	1
TOTAL NUMBER OF PATIENTS		946	82	95	72	58	58	55	65	61	67	68	64	50	62	66	70	64	72	69	62	60
Total # of Pts who rec'd Alteplase (Admitted/Transferred)		65	8	6	4	2	2	4	4	0	4	3	4	3	1	2	1	5	7	5	3	3
% of Alteplase - Inpatient & Transfers		13%	20%	14%	10%	8%	7%	11%	13%	0%	11%	10%	14%	8%	3%	6%	3%	13%	16%	13%	9%	8%
% Appropriate vital sign monitoring post Alteplase	90%	68%	75%	75%	100%	100%	100%	75%	75%	NA	75%	88%	100%	33%	100%	100%	100%	80%	100%	100%	100%	66%
Rate of hemorrhagic complications for Alteplase pts	0%	0%	0%	0%	0%	0%	0%	0%	0%	NA	0%	0%	0%	0%	0%	0%	0%	0%	14%	0%	33%	0%
Core Measure: OP-23 Head CT/MRI Results	72%	54%	100%	NA	0%	100%	NA	100%	0%	50%	100%	100%	100%	50%	NA	100%	100%	100%	67%	50%	67%	NA
% Appropriate stroke order set used (In-Patient)	90%	93%	95%	97%	99%	97%	96%	92%	90%	98%	91%	95%	91%	93%	93%	96%	95%	90%	88%	87%	97%	94%
% Appropriate stroke order set used (ED)	90%	90%	94%	92%	88%	89%	98%	90%	82%	89%	88%	80%	93%	92%	86%	88%	86%	91%	92%	88%	95%	83%
STK-1 VTE (GWTG, TJC)	85%	99%	100%	100%	95%	100%	91%	85%	85%	92%	96%	90%	88%	97%	89%	92%	91%	90%	95%	70%	83%	91%
STK-2 Discharged on Antithrombotic (GWTG, TJC)	85%	99%	100%	100%	100%	100%	100%	100%	97%	97%	97%	100%	100%	100%	100%	97%	100%	100%	100%	100%	100%	100%
STK-3 Anticoag for afib/aflutter ordered at Dc (GWTG, TJC)	85%	96%	100%	89%	100%	100%	100%	75%	80%	100%	100%	100%	100%	100%	100%	100%	NA	50%	100%	100%	100%	100%
STK-4 Alteplase Given within 60 min (GWTG, TJC)	75%	80%	100%	100%	100%	NA	NA	100%	100%	NA	NA	50%	NA	100%	NA	NA	NA	100%	100%	100%	NA	NA
STK-5 Early Antithrombotics by end of day 2 (GWTG, TJC)	85%	99%	92%	93%	97%	100%	96%	92%	96%	96%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
STK-6 Discharged on Statin (GWTG, TJC)	85%	98%	100%	98%	100%	100%	97%	100%	96%	100%	100%	93%	100%	100%	90%	94%	100%	100%	100%	100%	100%	97%
STK-8 Stroke Education (GWTG, TJC)	75%	94%	93%	97%	94%	100%	96%	88%	85%	100%	100%	100%	91%	90%	95%	97%	100%	100%	94%	100%	100%	100%
STK-10 Assessed for Rehab (GWTG, TJC)	75%	100%	100%	100%	100%	100%	97%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
% Dysphagia Screen prior to po intake (GWTG)	75%	94%	85%	85%	91%	90%	77%	81%	97%	97%	72%	85%	90%	90%	78%	90%	88%	71%	90%	88%	89%	94%
% Smoking Cessation (GWTG)	85%	99%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
% LDL Documented (GWTG)	75%	94%	91%	84%	96%	100%	90%	90%	91%	100%	97%	90%	92%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Intensive Statin Therapy (GWTG)	75%	90%	94%	91%	88%	88%	97%	94%	91%	79%	93%	93%	100%	100%	90%	94%	100%	100%	88%	100%	100%	97%
% tPA Arrive by 3.5 Hrs; Treat by 4.5 Hrs (GWTG)	75%	97%	100%	86%	100%	100%	100%	100%	100%	NA	100%	100%	80%	100%	100%	NA	100%	100%	100%	100%	100%	NA
% NIHSS Reported (GWTG)	75%	98%	100%	93%	92%	100%	96%	94%	92%	96%	90%	100%	96%	97%	100%	100%	90%	100%	100%	97%	95%	97%
Ischemic ALOS/GMLOS excess	<1.0	NA	1.45	1.67	2.2	0.18	0.49	1.68	0.91	0.18	1.23	0.53	3.94	3.11	1.9	2.76	3.63	0.75	1.49	2.23	1.97	2.06
Hemorrhagic ALOS/GMLOS excess	<1.0	NA	1.63	0.43	3.74	0.49	3.53	17.98	1.42	6.11	5.01	-1.66	0.62	-3.4	3.46	3.05	11.17	1.12	6.2	1.84	1.77	1.84
Ischemic Mortality ACA O/E Ratio (Midas)	<1.0	NA	0.8	0.9	0.8	0	0	1.4	0	1.1	0.8	0.5	2	2.3	1.4	1.6	0	1.4	1.3	1.4	1.3	1.1

2020-2021 TRANSFERS FROM ED TO ANOTHER ACUTE CARE FACILITY
Median Time by Minutes - Goal 120 Minutes

Hemorrhagic Stroke Transfer Time (Median)

Legend: ■ Series1 ▬ TJC door to transfer goal
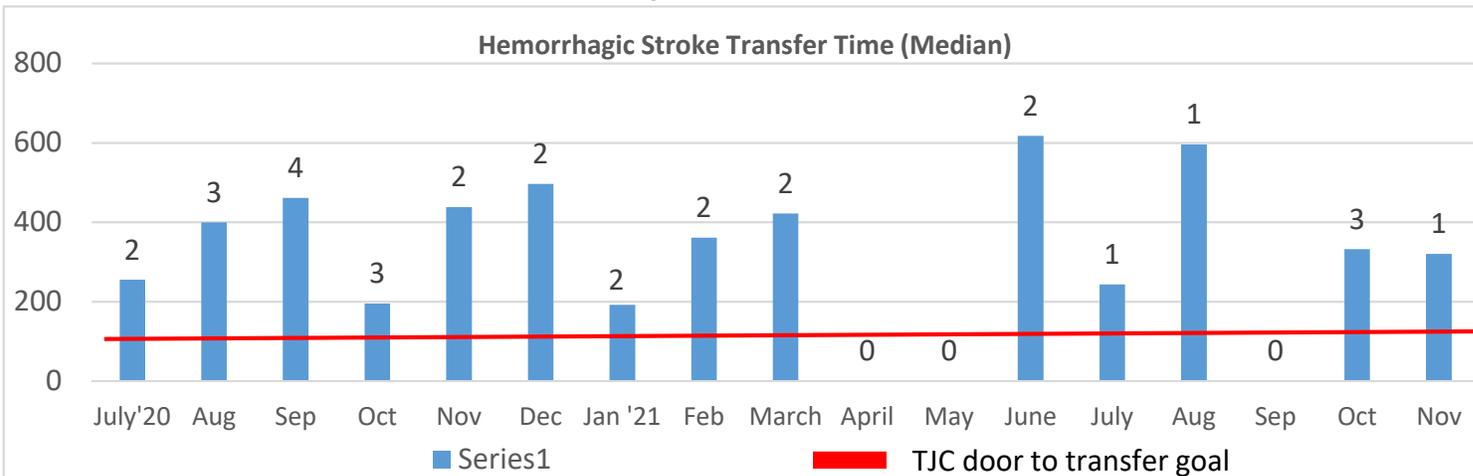
Hemorrhagic patients are transferred out for other procedures not done at KDH, specifically coiling/clipping of aneurysms or bleeds. A task force has been set up to help streamline the process, all action items are captured in PDSA document. The Covid 19 pandemic has caused delays in transfer times due to the additional precautions, resources and screening needed.

IV Alteplase Transfer Time (Median)

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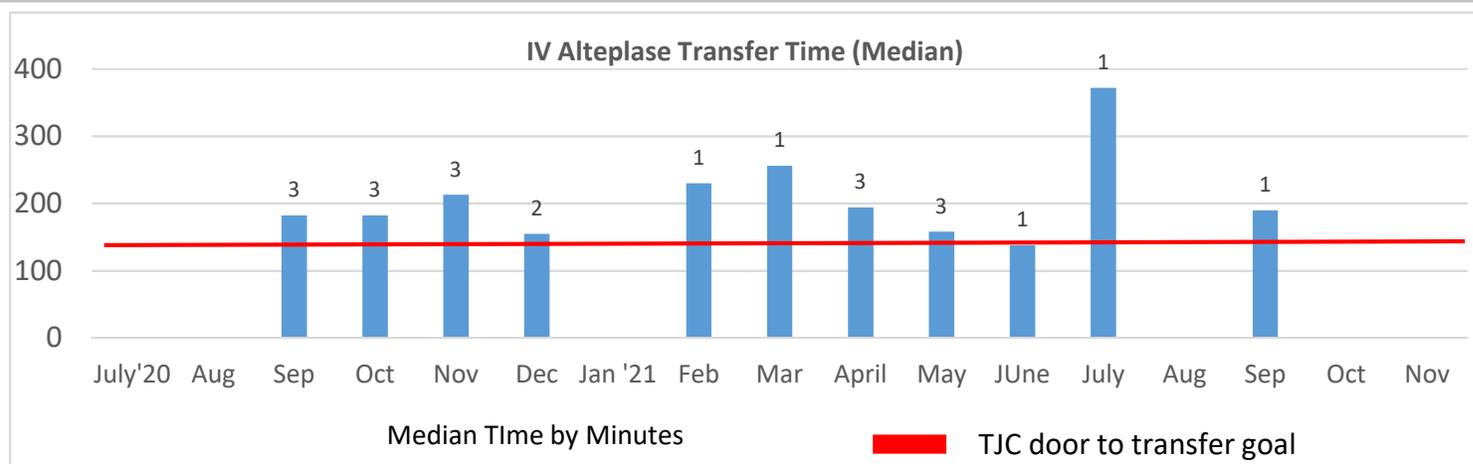
Transfers for ischemic strokes occur primarily if a large vessel occlusion is noted and would be eligible for endovascular treatment. As a result of the efforts made by the ED Stroke Alert Committee and the Transfer Process Task Force door to transfer times have improved; however the Covid 19 pandemic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

No IV Alteplase, LVO Eligible

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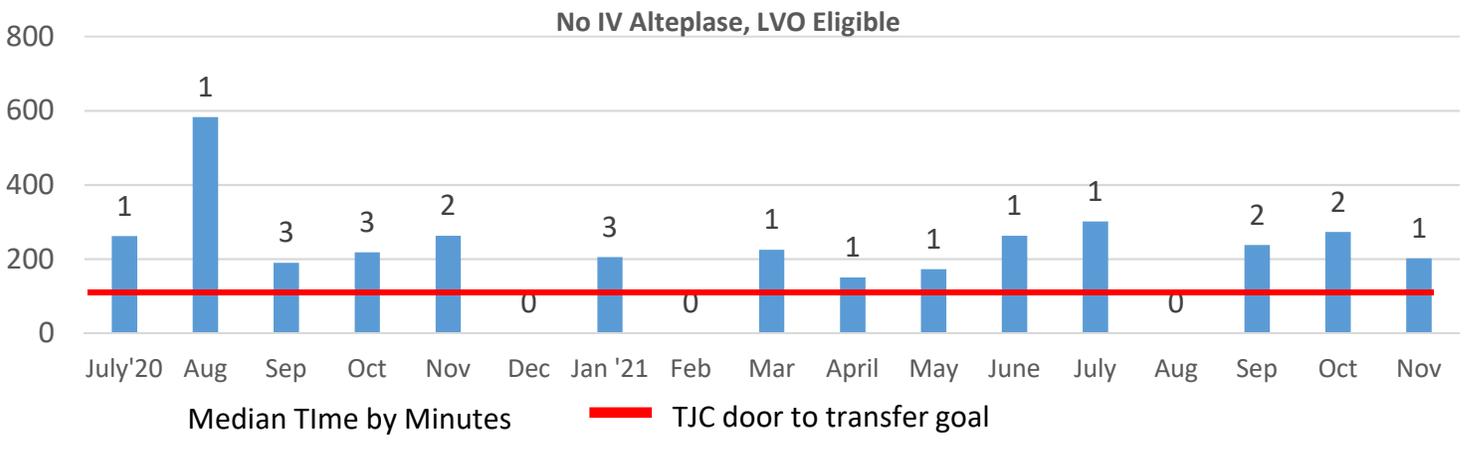
This cohort of patients have a large vessel occlusion that would be eligible for endovascular treatment and do not meet criteria for Alteplase administration. The Covid 19 pandemic has caused delays in transfer times due to the additional precautions, resources and screening needed in the recent months.

Sepsis Quality Focus Team

December 2021
Prostaff/QIC Report

SEP-1 Early Management Bundle Compliance

CA State Compliance 64% ~ National Compliance 60% ~ Top Performing Hospitals 82%

Percent of patients with sepsis that received "perfect care." Perfect care is the right treatment at the right time.

Sepsis Care - Right Care At The Right Time

New goal for FY22 = ≥75%

	Nov	Dec	21-Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sept	Oct	Nov
Concurrent	70	70	73	78	76	73	81	78	78	77	79	76	80
Sepsis-CMS	71	79	60	74	76	77	77	77	66	75	57	77	
Goal	70	70	70	70	70	70	70	70	75	75	75	75	75
Order Set Use	69	47	60	72	80	64	70	77	69	72	53	56	70

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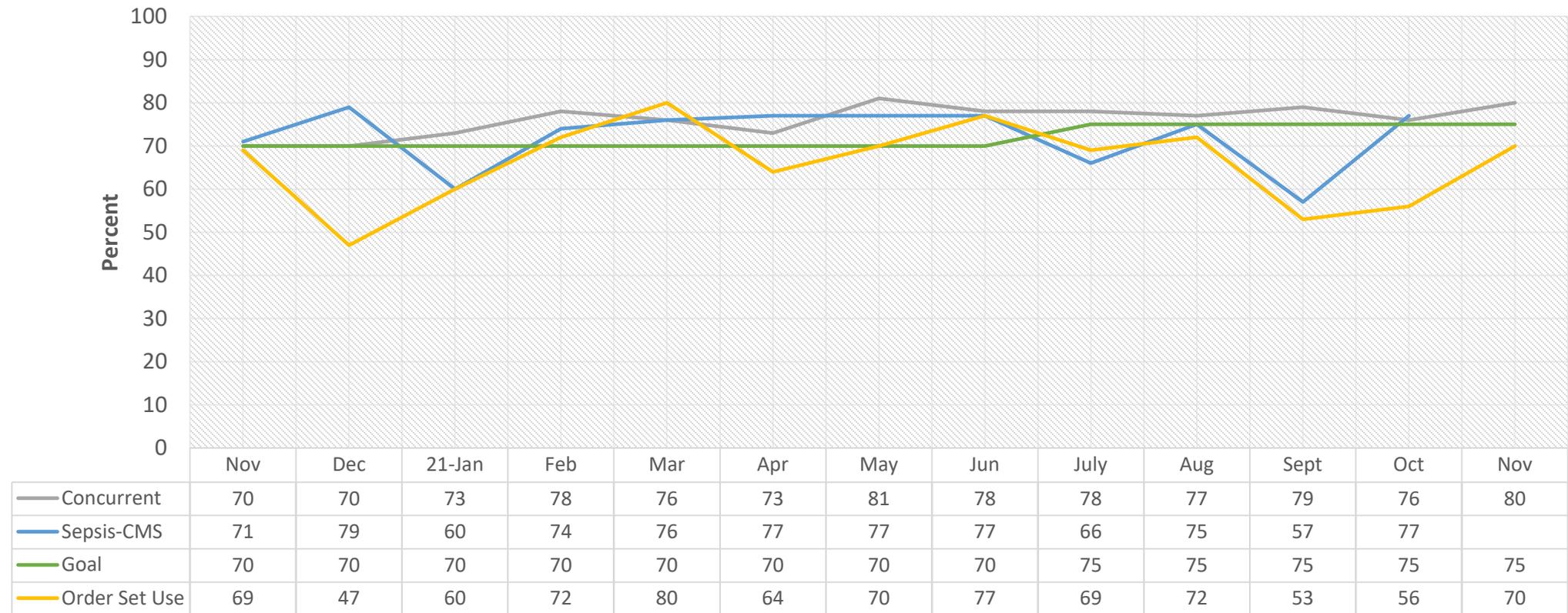
Key Strategies

Sepsis – SEP-1 is an "all or nothing" measure

Required Action	Severe Sepsis		Septic Shock	
	3-Hr Bundle	6-Hr Bundle	3-Hr Bundle	6-Hr Bundle
Initial Lactate Collection	Yes	Must be completed within 3-hrs of Severe Sepsis Presentation		
Blood Culture Collection	Yes			
Initial Antibiotic Started	Yes			
Repeat Lactate Collection (if Initial Lactate is > 2)	N/A	Yes	Completed within 6-hrs of Severe Sepsis presentation	
30 mL/kg Crystalloid Fluids Started	N/A	N/A	Yes	Completed within 3-hrs of initial hypotension and/or septic shock
Vasopressor Given (if hypotension persists)	N/A	N/A	Completed within 6-hrs of septic shock	Yes
Repeat Volume Status Assessment	N/A	N/A		Yes

July 2021

Overall Sep-1 Compliance: 66%

21/32 (10/11 fallouts occurred during Sepsis Coordinator off hours)

- Initial LA: 92%
- Abx: 88%
- BC: 93%
- Fluids: 96%
- Repeat LA: 93%
- Vasopressors: 100%
- Reassessment: 89%

August 2021

Overall Sep-1 Compliance: 75%

24/32 (7/8 fallouts occurred during Sepsis Coordinator off hours)

- Initial LA: 97%
- Abx: 94%
- BC: 97%
- Fluids: 96%
- Repeat LA: 87%
- Vasopressors: 100%
- Reassessment: 100%

September 2021

Overall Sep-1 Compliance: 57%

17/30 (12/13 fallouts occurred during Sepsis Coordinator off hours)

- Initial LA: 95%
- Abx: 80%
- BC: 88%
- Fluids: 94%
- Repeat LA: 86%
- Vasopressors: 100%
- Reassessment: 100%

October 2021

Overall Sep-1 Compliance: 77%

30/39 (6/8 fallouts occurred during Sepsis Coordinator off hours)

- Initial LA: 97%
- Abx: 92%
- BC: 97%
- Fluids: 97%
- Repeat LA: 90%
- Vasopressors: 100%
- Reassessment: 100%

- 88% (35/40) of SEP-1 fallouts occur when Sepsis Coordinators not here - Action: Sepsis required physician notification of sepsis alert - results in timely best practice intervention, "the bundle" COMPLETE, GO LIVE 6/29/21!

- Increasing CMS sampling during COIVD to generate a more statistically significant denominator

- Re-identifying root causes of SEP-1 bundle non-compliance to revise prioritized QI strategy list with stakeholders. Completion goal 12/31/21 COMPLETE

- 3 Current QI Strategies (additional actions pending root cause analysis):
  1. Provider notification process – barriers and QI work
  2. Sepsis Simulation training (EM GME)
  3. Alert optimization

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Pareto Diagram

Sepsis Reasons for SEP-1 Non-Compliance July 2020 - Aug 2021

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Bundle not ordered – Not initiating any/all strategies

Bundle not ordered – Not initiating any/all strategies

Did not know Sepsis Alert fired
- Providers don't get alert
- RN gets alert does not evaluate
  - Not required can pass and not complete Required notification.
  - Not evaluating (culture/accountability)
  - Alarm Fatigue

RN not getting alert
- Suppressed Alert
  - Back Charting
  - Creatinine >2 not recognized by Cerner
  - Doesn't suppress for all patients. Issue? Server?
  - Vital signs HR "PPR", AP, HR, MONITO HR, PPR
  - 48 degree Suppression (already went off once)

Providers not using Sepsis order sets
- Senior Resident not ordering SEP. 1 Through Intern in ED
- Intern and Senior Resident Oversight?
- Don't agree all Bundle elements (i.e. fluids) don't order

Don't know patient is Septic Patient presents in atypical fashion
- Providers don't call Sepsis Until everything else is ruled out
  - Not enough information or evidence to confirm Sepsis
- Sepsis left on differential
- Ordering a La Carte
  - Not using "Catch Up" Order Set

Sepsis Bundle Fallout

Not using order set
- Patient not fitting Sepsis picture
- Looking for other infection sources
- Go a la cart

Don't order repeat LA because it is not high but >2
- Not super concerning or urgent for patients (also if not presenting sick/bad)
- Patient isn't "super sick" found other reason for elevated LA, no need to repeat

Repeated LA not collected
- Hospitalists orders as inpatient as "routine"
  - No need to use order set because all elements done in ED
- Order in late... RN busy, not collected timely
- Insufficient vein access, cannot draw
- RN don't document in Bridge why sample can't be drawn
- IE - Inpatient missing repeat LA

Not ordering or collecting BC, UA, Repeat UA

Unaware of measure requirements
- BP normal, LA >4 Still needs fluid
- Patient should not get more fluids
  - Not auto in order set
  - Lack of knowledge

Staggering fluid resuscitation
- Provider order outside of order sets
  - See how patient responds to fluid
  - (not always HR/RF) Patient responds well after less amount so move is discharged.
- IE scanning < 1 at a time not over required time

Not aware of HR/RF exceptions

Fluids Insufficient/None

88/145

DRAFT Root Causes & Improvement Strategies

Root Cause of SEP-1 Bundle Not Fully Implemented	Data	Potential/Actual QI Strategy Action

Do not know patient is septic because the alert did not fire
• Alert suppressed for 48 hrs after initial alert
• Creatinine >2 not recognized by Cerner/in the alert algorithm
• Alert does not fire when a string of VS are documented all at one, it suppresses an abnormal VS(s) that require patient evaluation
• Alert does not fire when multiple VS (ie.HR, PPR, AP, etc) and one value is abnormal and the others are not
• Alert does not fire for providers (fires inappropriately such as when ED providers reestablishes a relationship with an in-patient to back document, or fires for triage provider after patient is in "back")
	SEPSIS ALERT EVALUATION
	Inpatient & ED Patients
	•Patients with a Sepsis alert are 0.26 times (26%) more likely to have sepsis than not (424/1619 = 0.26)
	• The odds a patient with no sepsis alert is septic is 0.01 (1%) (319/31,021)
	Sensitivity – 0.57; Specificity – 0.95
	Inpatient ONLY
	• Patients with a Sepsis alert are 0.28 times (28%) more likely to have sepsis than not (417/1470 = 0.28)
	• The odds a patient with no sepsis alert is septic is 0.03 (3%) (295/9,127)
	Sensitivity – 0.59; Specificity – 0.83
		• Improve sensitivity and specificity of alert
		  • Work with Cerner to evaluate criteria in "the cloud" can alert fire when Cr <2.0
		  • 30 hour alert "look back" on VS and labs
		• Suppress alert in ICU based on ICD10 sepsis dx
		• Alert suppression (for RNs) changed from 48 hrs to 13 hrs (per shift)
		• Optimize alert and turn on for providers
		  • Alert cannot fire when provider is no longer caring for patient (ie. alert fires for ED provider when documenting and patient has been admitted, or triage provider when pt is in "back" under care of another ED provider)

Do not know the patient is septic because the RN did not evaluate the alert and execute provider notification process • Alert fatigue, accountability	See provider notification data analysis slides	• See above for alert fatigue • This is not appear to be a knowledge deficit "6 Attributes Test" completed indicating that 4/4 RNs surveyed in different units were able to articulate the who, what, where, when, why and how of the provider notification process
Provider not using order sets for known septic patients where bundle elements are easily accessed • Resident & provider knowledge • Personal preference to go a la cart	12/21 (57%) ED SEP-1 fallouts did not use order set (July – Sept 2021)	ED simulation training FM simulation training?
Patients sepsis not recognized because they present in atypical fashion • Order bundle elements a la cart as work up is completed • Sepsis left on the differential (not using dot phrase)	n/a	Education on dot phrase

DRAFT Root Causes & Improvement Strategies

Root Cause of SEP-1 Bundle Not Fully Implemented	Data	Potential QI Strategy
Fluids (none ordered or not enough) • Pt should not get more fluids • BP is normal, LA>2, still needs fluids • Not using order set - Staggering fluid resuscitation, see how pt responds and d/c fluids before needed amount is infused (pt doesn't need more and literature support is low grade)	96% SEP-1 abstracted patients meet fluid requirements (July – Oct 2021)	Brainstorm with team

Repeat lactic acid (LA) or blood culture (BC) not ordered
• Providers don't order repeat LA because the first result was not that high and perhaps expected due to pt's comorbid conditions
• Provider orders "routine" so lab is not completed timely; there is no need to use the SEP-1 power plans since all the elements were completed in ED
• Do not know the patient is septic
   • Patient not presenting in typical fashion, looking for other sources of infection
   • No sepsis alert for providers
   • RNs not executing provider notification process consistently
   • RRT not called for abnormal VS/labs (RRT initiates bundle as indicated)
   • No one is closely identifying sepsis (no sepsis coordinator patient oversight)
	94% SEP-1 abstracted patients meet BC bundle requirements (July – Oct 2021)
	
	89% SEP-1 abstracted patients meet repeat LA bundle requirements (July – Oct 2021)
		• Reflux order for any LA
		• Provider orders repeat LA "timed" or "STAT" (provider awareness)
		
		• Optimize alert and turn on for providers (see previous section)
		• Improve the RN provider notification process
		• 3rd Sepsis Coordinator

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Data Analysis

Required Sepsis Alert Provider Notification Process

Process went live June 29, 2021 to ensure RNs and providers are aware that patient is possibly septic and may require intervention for optimal outcomes

| Sepsis alert fires in Cerner | → | RN Evaluates patient using provider notification form | → | RN notifies provider if score ≥3 | → | Provider orders SEP-1 power plan if warranted |
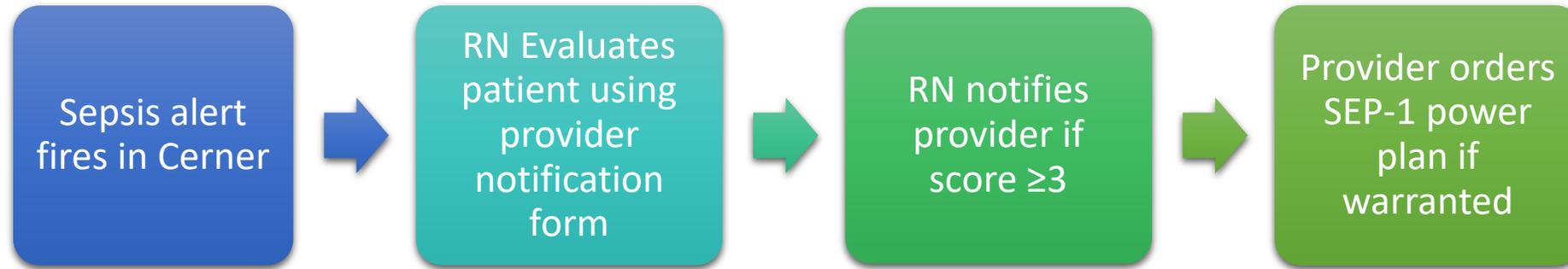
Summary July 2021- October 2021

- 38% of alerts are evaluated, of those 27% have a score ≥3 (n=374)

- **For the 374 pts with score ≥3, 77% of the time providers are notified (n=288)**

- **Of the 288 pt's who's providers are notified, 14% order a SEP power plan**

- If 27% of alerts have scores **≥3, the providers would have been notified on 595 of** 2205 alerts that were not evaluated (potentially alerts were not legitimate)

- ACTION – Evaluate alert notification process with ISS and nursing to optimize and improve

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Data Analysis

Required Provider Notification Process

| Sepsis alert fires | → | RN Evaluates patient using provider notification form | → | RN notifies provider if score ≥3 | → | Provider orders SEP-1 power plan if warranted |
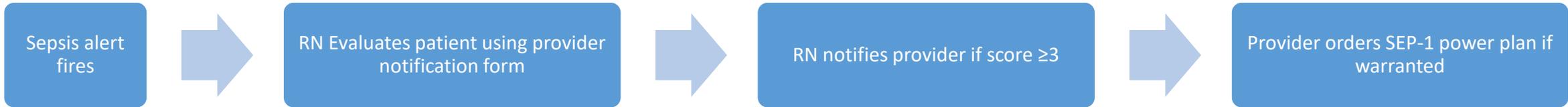
Sepsis Alert Location	# of Alerts	# of Forms w Score	% Sepsis Alerts w Form Completed
KDMC 14	79	33	42%
KDMC 15	491	229	47%
KDMC 1E	401	35	9%
KDMC 2E	6	0	0%
KDMC 2N	138	72	52%
KDMC 2S	95	60	63%
KDMC 3N	135	75	56%
KDMC 3S	163	90	55%
KDMC 3W	316	142	45%
KDMC 4N	137	78	57%
KDMC 4S	79	44	56%
KDMC BP	22	9	41%
KDMC CV	534	150	28%
KDMC ED	242	6	2%
KDMC IC	702	346	49%
KDMC MA	35	0	0%
Grand Total	**3575**	**1370**	**38%**

Form Location	# Sepsis Alerts w Score of 3	# Forms Score 3 and Provider Notified	%Sepsis Alerts w Forms Score 3 and Provider Notified
KDMC 14	6	4	67%
KDMC 15	55	46	84%
KDMC 1E	4	4	100%
KDMC 2N	14	14	100%
KDMC 2S	16	17	106%
KDMC 3N	23	23	100%
KDMC 3S	26	19	73%
KDMC 3W	31	20	65%
KDMC 4N	20	16	80%
KDMC 4S	7	6	86%
KDMC CV	43	36	84%
KDMC ED	3	1	33%
KDMC IC	126	82	65%
Grand Total	**374**	**288**	**77%**

Form Location	Count of FIIN Number	# Forms w Score 3 and Provider Notified and Plan	% Forms w Score 3 and Provider Notified that Have a Plan
KDMC 14	5	2	40%
KDMC 15	79	17	22%
KDMC 1E	15	2	13%
KDMC 2N	18	2	11%
KDMC 2S	27	6	22%
KDMC 3N	35	7	20%
KDMC 3S	37	7	19%
KDMC 3W	68	4	6%
KDMC 4N	35	4	11%
KDMC 4S	14	1	7%
KDMC CV	60	8	13%
KDMC ED	6	1	17%
KDMC IC	168	19	11%
Grand Total	**567**	**80**	**14%**

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SEP-1 Bundle Fluid Requirements Changes to CMS Guidelines

- Allows providers to infuse a lesser amount of fluid (< 30 ml/kg)

- Permits crystalloid use

- Must have a diagnosis of at least one: Stage 4 CKD, Stage 5 CKD/ESRD or HF

- Providers must document the total fluid volume to be given in lieu of 30 mL/kg

- Effective as of July 1, 2021

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Sepsis Any Diagnosis Observed/Expected Mortality

SEPSIS ANY DX 0/E MORTALITY
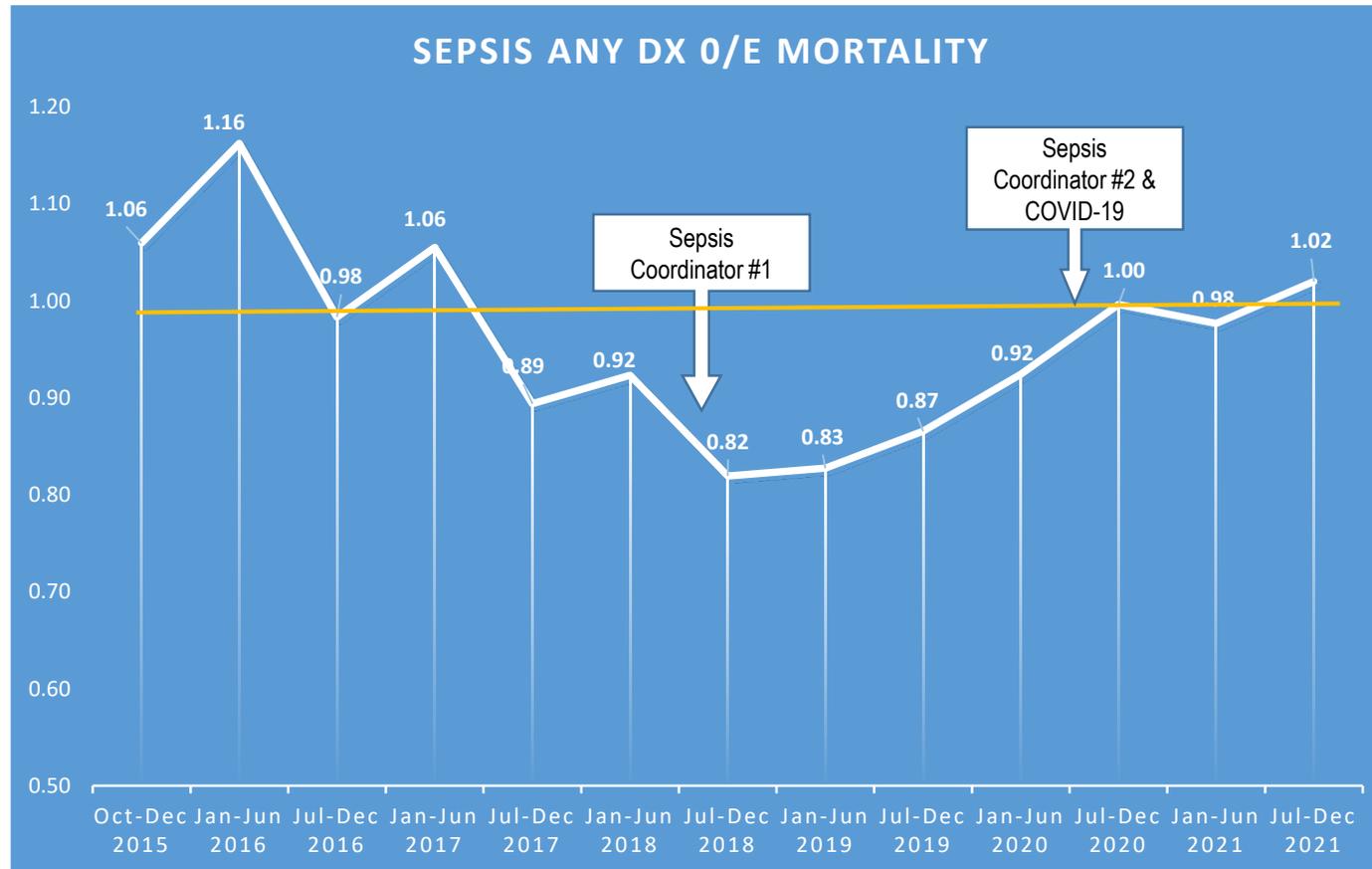
- Goal ≤ 1.0 which indicates that at least expected deaths do not exceed actual

- Significant change in how sepsis mortality is measured since o/e mortality includes septic patients with COVID-19 dx starting in 2020, but does risk adjust for COVID

- Sepsis o/e mortality is not a direct comparison pre and post pandemic

- Despite COVID-19 patient inclusion, o/e mortality remains at ≤ 1.0

Sepsis QFT Actions & Next Steps

- 3 Improvement strategies in process:
    1. Developing Emergency medicine GME Sepsis simulation training, with goal of multidisciplinary involvement
    2. Optimizing sepsis alert to reduce alert fatigue (ie. suppressing alerts for circumstances where patient is already known to be septic)
    3. Evaluate and improve the RN provider notification process for sepsis alerts

Next Steps:

- Review root causes identified with complete stakeholder group for input and additions

- Review suggested improvement strategies with complete stakeholder group, and solicit input to expand list

- Prioritize and execute improvement strategies

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Questions?

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

Unit/Department: CAUTI QFT   **ProStaff/QIC Report Date:** 1/20/2022

Measure Objective/Goal:
- Goal for FY22 ≤ 0.676 (CMS 50th percentile); **Current SIR = 1.319**
- Pre KAIZEN baseline SIR is 1.557
- SIR is as of November 2021; Actual CAUTI FY22 is 14

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

Date range of data evaluated: FYTD SIR (7/2021 – 11/2021)

Analysis of all measures/data: (Include key findings, improvements, opportunities)
(If this is not a new measure please include data from your previous reports through your current report):

CAUTI Committee Dashboard

Measure Description	Benchmark/Target	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21
OUTCOME MEASURES																				
Number of CAUTI	0	3	1	1	0	1	1	1	1	0	1	0	3	0	0	1	3	5	2	2
FYTD SIR	≤0.676					0.78**			1.04**			0.432	0.583	0.537		0.569			1.436	1.319
PROCESS MEASURES IUC Gemba																				
% of pts with appropriate cleanliness	99%	98%	95%	97%	96%	98%		98%	99%	99%	98%	99%	99%	98%		98%			95%	100%
% of IUCs with order & valid rationale	100%	92%	93%	92%	92%	93%		94%	95%	93%	94%	93%	94%	92%		94%			96%	97%
% of IUCs where removal was attempted	n/a	6%	7%	0%	9%	9%		6%	2%	3%	7%	3%	3%	4%		6%			3%	3%
% of pts where alternatives have been attempted	n/a	12%	10%	8%	14%	12%		12%	6%	9%	10%	12%	11%	8%		15%			8%	7%
# of Pt Catheter days rounded on	n/a	948	877	1037	1098	1145		1047	1046	900*	931*	926*	951*	928*		1045			1068	902
% of IUCs removed because of Gemba Round	n/a	3%	4%	2%	4%	6%		6%	4%	6%	6%	5%	5%	6%		6%			4%	5%
# of IUCs removed because of Gemba Round	n/a	33	35	22	46	74		64	40	50	52	50	43	51		43			43	49
*volume reduced due to reduced Gemba on weekends **FYTD includes cases removed in Mar 2021	Equal or Better than Target			Jan-Jul: Within 10% of Target As of Aug: Within 5% of Target			Does not meet Target													

FY 22 Total Catheter Days rounded on = 3005	**98%** of patients with daily bath and peri-care per shift
96% with order and valid rationale	**135** catheters removed as a result of the Gemba

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

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

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

CAUTI QI Strategy	Status
1. Adding sticker to IUC GOAL: Visual reminder to replace IUC prior to specimen collection after 72 hours to reduce false positives from biofilm.	12/27/21
2. Letter for providers on events (like CLABSI) GOAL: Provider awareness of HAI.	12/27/21
3. Primofit & Medline External Male Catheter Product Trial GOAL: Reliable method for male external alternative to IUC	3/1/22
4. SonoSite Bladder Scanner conversion	2/1/2022
5. On-going attempts to do in person Resident education	On-going
6. Fever Indication for Culture Task Force	On-going
7. ICU Forum	1/24/22
8. Add number of attempts for IUC insertion, Policy no more than 2 attempts.	3/1/22
9. CHG on IUC tubing * pilot ICU	1/24/22
10. Include timing of CAUTI at HAI committee, differentiate within 5 days or after to identify if likely due to insertion	1/13/22
11. Accuryn System review active drain clearance system trial	2/1/22
12. CAUTI Case Reviews Lessons Learned GOAL – Reduce CAUTI by ensuring identified opportunities are addressed globally	Monthly at QFT
13. Mandatory CBL Resident education On-going monitoring	On-going
14. Rapid Cycle Post Gemba Rounds GOAL – reduce IUC utilization, verify completion of follow up	11/23/21
15. Culture of Culturing committee for urine specimens GOAL: Variation in culturing practices is the largest contributing factor to CAUTI.	11/23/21
16. Resident Notifications of near misses and events GOAL: Resident request for awareness and learning opportunities.	11/23/21
17. Mandatory CBL Resident education On-going monitoring	On-going
18. Powerchart changes- IUC dynamic group for POA include on arrival to unit from OR/ED, other GOAL- capture device list for lines already in place	7/1/21
19. Develop orders for Adult Urinary Retention management GOAL- orders for retention management currently exist as one off options, bundling them together for ease of ordering increases use	9/2020
20. Develop Urine Culture only powerplan to replace single orderable. GOAL- Reduce CAUTI events related to culture ordering by guiding intentional use of this risky order	2/23/21
21. Bathing Prioritization (in collaboration with CLABSI Committee) GOAL – Improve bathing/peri-care of IUC patients	10/2020
22. Add 'restricted use' to the urine culture only orderable GOAL- reduce use of culture only order in defined populations without accompanying UA	7/2020
23. Develop insert IUC Powerplan to include important maintenance elements: straight cath option prior to IUC insertion, change IUC prior to specimen collection, change IUC at 30 days GOAL- Create and bundle essential orders for IUC maintenance	8/2020
24. Develop provider update/education related to current CAUTI status and how to order IUC/Culturing awareness GOAL- create awareness	9/2020
25. Changes to discontinue IUC orderable- alerts RN to dc the insert IUC Powerplan and related maintain order	8/2020

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

	GOAL- assist with order clean up	
26.	Safety Summit (CAUTI education for new hires) relaunch post-COVID GOAL – Improve/sustain RN bundle compliance	3/22/21
27.	Place all IUC order resources on eCoach GOAL- Increase IUC appropriateness/ prompt removal, bundle compliance (improving ease of access for providers and nursing staff)	1/1/2021
28.	Develop Urine Culture only Powerplan to replace single orderable. GOAL- Reduce CAUTI events related to culture ordering by guiding intentional use of this risky order	12/29/20
29.	Hide single Insert IUC orderable for downtown campus and Rehab GOAL: Improve bundle compliance by driving use of the insert IUC Powerplan which contains needed maintenance elements	10/2020
30.	Kaizen strategy: evaluate option for time clock for line info GOAL- Improve prompt removal, visual reminder of how long the line has been in place	11/2020
31.	Add 3-way catheter as trigger to device list GOAL- accurate collection of device count	4/22/21
32.	Changes to the discontinue order- alert will prompt the provider to order retention management order. Single orderable done, Powerplan additions in progress. GOAL- provides orders for nursing to manage post IUC DC retention	10/1/21
33.	Thoughtful pause= primary RN confers with charge nurse prior to specimen collection for algorithm use GOAL: Reduce unnecessary urine cultures	3/22/21
34.	Medline urology assessment of current practices and care of IUCs GOAL: Evaluate CAUTI reduction program for improvement opportunities.	5/25/21

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

Next Steps/Recommendations/Outcomes:

A. Continue to maintain Kaizen initiatives: Daily IUC Gemba rounds, data collection, and dissemination and QI strategy development.

B. Continue to monitor CAUTI events, reviewed with unit leadership at the HAI review meeting, unit leadership creates quality improvement plan and implements at the unit level. The QFT monitors QI opportunities for global implementation

C. Standard Urology Product Line Conversion go live February 2022 with education and maintained support by Medline.

D. Address culturing practices in newly revised Fever as an Indication for Culture Taskforce with medical staff partnership

E. ICU HAI Forum on 1/24/2022 to inspire and synthesize sustainable prevention practices for CAUTI and CLABSI.

Submitted by Name: Kari Knudsen   **Date Submitted:** 12/31/2021

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

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

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

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CAUTI-FY22 Goals

Lower is Better	July 2021	Aug 2021	Sept 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	June 2022	Estimated Annual Number Not to Exceed to Achieve Goal*	FYTD SIR** (number of actual/ number expected)	FY22 Goal	FY21 FY20
CAUTI Catheter Associated Urinary Tract Infection	**1**	**3**	**5**	**2**	**2**								20	**1.319**	≤0.676	0.54 1.12

*based on FY21 NHSN predicted values
**Standardized Infection Ratio- Number of action infection Kaweah had divided by the number of infections CMS predicts Kaweah should have

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Kaizen Root Cause

Analysis:

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

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

Kaizen improvement strategies focused on addressing the top 4 root causes

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

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

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Contributing Factors in CAUTI Events 2020 (n=16)
***more than 1 factor can contribute to an event**

Factor	Value
CLEANLINESS (BATHING/PERICARE)	4
RETENTION MANAGEMENT PROCESS...	5
SP 115 (PROMPT REMOVAL)	6
ALTERNATIVE METHODS NOT TRIALED	6
USE OF UA COLLECTION ALGORTHIM	7
CULTURE PRACTICES (PAN/UNNECESARY...	14

BACKGROUND

- Multidisciplinary team reviews CAUTI events and counts contributing factors to events based on CDC evidenced-based guidelines
- Top 3 contributing factors to CAUTI events culturing practices, use of UA algorithm and alternative methods not tried

2020 Key Strategies
- Daily line rounds to ensure best practices are consistent (bathing, peri-care), and line necessity.
- Specimen collection practices and necessity
- Culturing – addressing pan culturing practices
- Culturing – optimization of orders for line placement, maintenance of line and retention management

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Post KAIZEN-Gemba Data

FY22

Total Catheter days rounded on = 3005

98% of patients with daily bath and peri-care each shift

96% have order and valid rationale

135 catheters removed as a result of the Gemba

CAUTI Committee Dashboard

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CAUTI QFT– Plans for Improvement

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Green items are completed; Yellow are in progress

Current State

CAUTI Contributing Factors July 2021-November 2021
N=18

Factor	Value
Not changed due to supply shortage	6
Cleanliness (bathing/pericare)	11
Retention management process (straight cath)	0
SP 115 (prompt removal)	4
Alternative methods not trialed	6
Use of UA Collection algorthim	4
Culture Practices (pan/unnecesary cultures)	13

- Multidisciplinary team reviews CAUTI events and counts contributing factors to events based on CDC evidenced-based guidelines
- All current initiatives continue, on 9/24/21 a modified Kaizen narrowed work on root causes for this FY
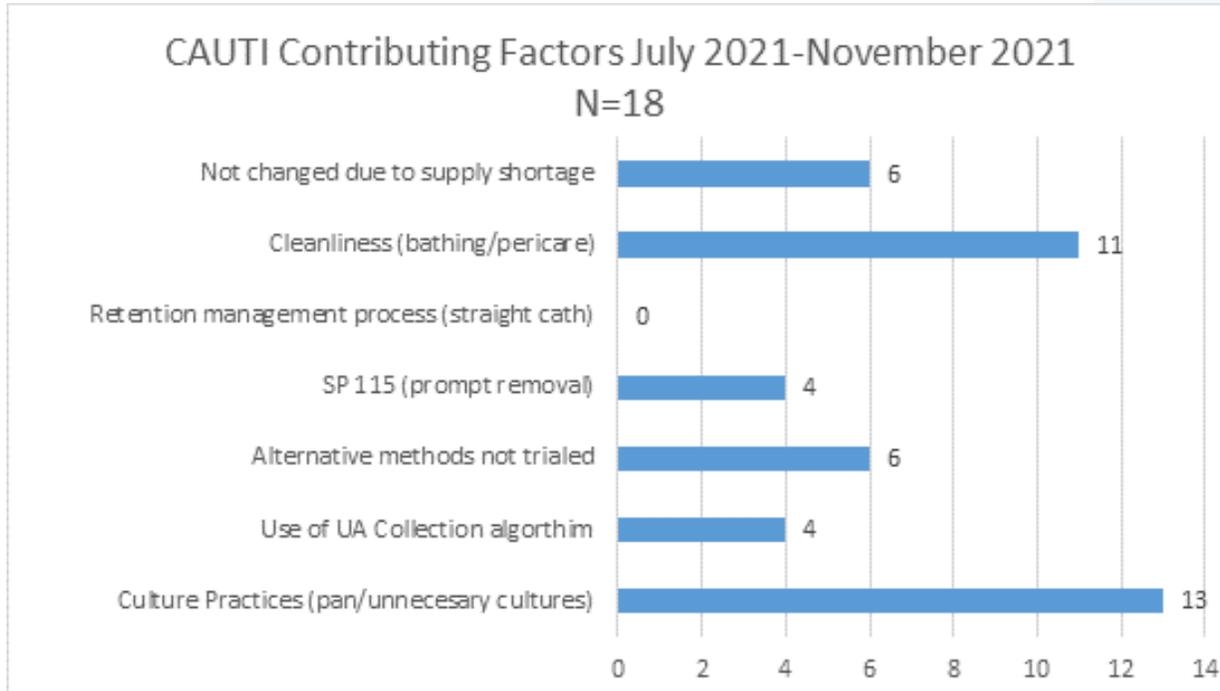
2021 Key Contributors
- IUC tray supply availability affects sterile insertion; prevents changing IUC prior to specimen collection
- FY 22: 54% CAUTI events a second culture was ordered within 24 hours of urine culture = pan culturing
- Single episode of fever or leukocytosis precipitated the urine culture in 38.2% of events (2021 thru Oct)
- Surge documentation in effect during this time frame skews the data; unknown if bathing performed and not documented or not done

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Clinical Quality Goal Update

January 2022

Kaweah Health
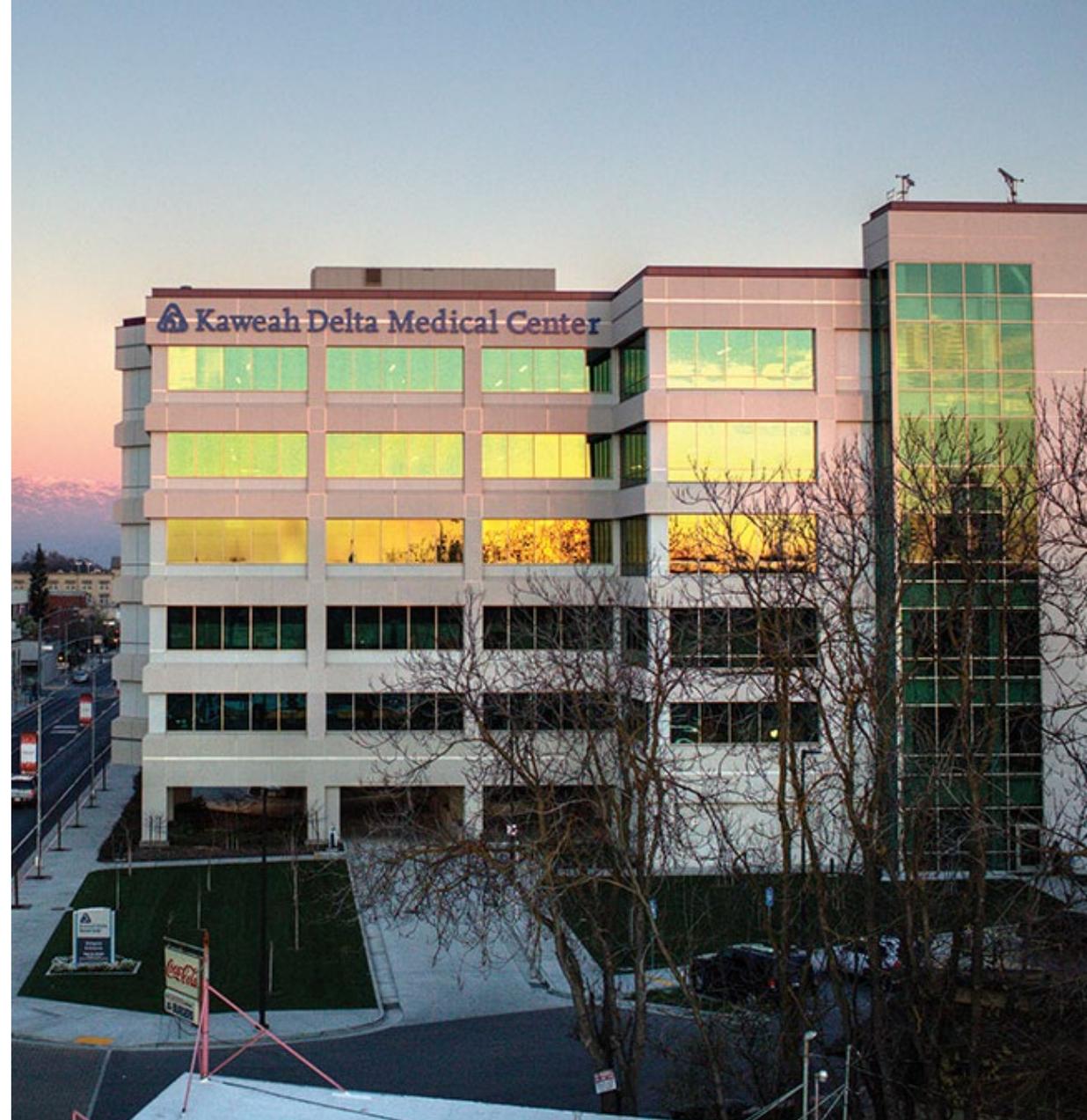
FY22 Clinical Quality Goals

Our Mission

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

Our Vision

To be your world-class healthcare choice, for life

	July-Nov 2021 Higher is Better	**FY22 Goal**	**FY21**	**FY21 Goal**
SEP-1 (% Bundle Compliance)	**73%**	≥ 75%	74%	≥ 70%

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

Lower is Better	July 2021	Aug 2021	Sept 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	June 2022	Estimated Annual Number Not to Exceed to Achieve Goal*	FYTD SIR** (number of actual/ number expected)	FY22 Goal	FY21 FY20
CAUTI Catheter Associated Urinary Tract Infection COVID-19 PATIENTS	**1** 0	**3** 1	**5** 5	**2** 0	**2** 1	**1** 0							24 (12 predicted over 6 months)	**1.177**	≤0.676	0.54 1.12
CLABSI Central Line Associated Blood Stream Infection COVID-19 PATIENTS	**0** 0	**4** 3	**3** 3	**3** 0	**1** 1	**1** 0							19 (9.5 predicted over 6 months)	**1.261**	≤0.596	0.75 1.20
MRSA Methicillin-Resistant Staphylococcus Aureus	**2**	**0**	**1**	**3**	**0**	**2**							7 (3.6 predicted over 6 months	**2.293**	≤0.727	2.78 1.02

*based on July-Dec 2021 NHSN predicted
**Standardized Infection Ratio is the number of patients who acquired one of these infections while in the hospital divided by the number of patients who were expected.

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Questions?

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

Board of Directors

Quality Council

Medical Staff Executive Committee (MEC)

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

Department Quality Reports

- Patient Care Operational Medical Staff - Service Line

Organizational Quality Committees

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

Quality Focus Teams

- Sepsis
- Skin/Wound
- Handoff Communication

Patient Throughput

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

Patient Safety Committee

- CUSP Teams — ED / Mom/Baby / NICU / 3S / OR
- Root Cause Analysis/Focus Review Teams
- Quality-Risk Committee
- Just Culture Steering Committee
- FMEA Team Proactive Risk Assessment
- METER

111/145

Annual Review of Quality (AP.41) and Patient Safety Plan (AP.175)
2022 Quality and Patient Safety Initiatives & Quality Focus Team (QFT) Review

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

Just Culture Steering	Patient Safety Subcommittee, Org Committee	☒ High Risk ☒ Problem Prone ☒ High Volume	• Key strategy in organization safety culture improvement action plan • National Quality Forum (NQF) safe practice included in Leapfrog Safety Grade	• Just Culture measures included in the Safety Attitudes Questionnaire (SAQ)	Manager of Organizational Development
Medication Safety	Org Oversight Committee; includes Medication Reconciliation Outstanding Health Outcomes (OHO) Strategic Initiative	☒ High Risk ☒ Problem Prone ☒ High Volume	• Oversees the Medication Error Reduction Program (MERP) per CA state requirements • Oversees Nursing Medication Safety Task Force QI work • Medication Reconciliation (inpatient) (Outstanding Health Outcome Strategic Measure). TJC National Patient Safety Goal (NPSG)	• Several measures monitored as determined annually by the committee through the MERP and Adverse Drug Event (ADE) committee work. Examples include antidote administration rates, bar code medication administration rates, reducing ADEs. • Medication Reconciliation measures include: Home medication list review of high risk patients; Complete initial home medication review within 24 hrs of admission	Director of Pharmacy
Adverse Drug Event (ADE) Committee	Org Sub-Committee Medication Safety	☒ High Risk ☒ Problem Prone ☒ High Volume	• Reviews, tracks and trends and resolves (or escalates) adverse drug event Midas reports	• ADE volume and tracked trends as reported to Medication Safety Committee	Medication Safety Coordinator
Team Rounding	OHO Strategic Initiative	☒ High Risk ☒ Problem Prone ☒ High Volume	• Identified by Strategic planning group as a contributing factor to increased LOS, and decreased teamwork climate	• TBD by team	VP of Medical Education
Sepsis QFT	OHO Strategic Initiative Quality Focus Team (QFT)	☒ High Risk ☒ Problem Prone ☒ High Volume	• Established QFT since 2016 • High volume diagnosis, high mortality rates nationally (problem prone) • Centers for Medicare and Medicaid Services (CMS) SEP-1 bundle compliance publically reported on CMS care compare website	• SEP-1 Bundle compliance • LOS • Mortality	Medical Director of Quality & Patient Safety; Director of Quality and Patient Safety

Annual Review of Quality (AP.41) and Patient Safety Plan (AP.175)
2022 Quality and Patient Safety Initiatives & Quality Focus Team (QFT) Review

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

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

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

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

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

Patient Throughput	Org Committee	☒ High Risk
		☒ Problem Prone
		☒ High Volume
			• Steering committee that oversees work of 4 sub-groups:
			• Throughput & Patient Progression
			  o Care Mgmt roles & responsibilities
			  o Discharge planning & timely discharge
			  o Multidisciplinary huddles
			• Throughput & Patient Progression
			  o Long Stay Committee
			• Demand Mgmt
			  o ED to Inpatient admission process
			• Capacity Mgmt
			  o Patient Placement Infrastructure
			• Project work will include a proactive risk assessment (FMEA) to be reviewed by Patient Safety Committee
				• Various throughput measures included time to provider, time from door to admit, time from admit to arrival on unit.
				• Several processes measures reported through each sub-group
					Executive Team

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

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Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	Date Approved: 05/25/2021
Approvers: Board of Directors (Administration)	
Quality Improvement Plan	

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

I. Purpose

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

II. Scope

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

III. Structure and Accountability

Board of Directors

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

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

Quality Council

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

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

Medical Staff

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

Quality Improvement Committee (QIC)

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

The QIC shall have primary responsibility for the following functions:

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

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

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

outcomes, quality of care and patient safety. The QIC is responsible to establish organizational Quality Focus Teams who:

    a.   Are focused on enterprise-wide high priority, high risk, problem prone QI issues

    b.   May require elevation, escalation and focus from senior leadership

    c.   Have an executive team sponsor

    d.   Are chaired by a Director or Vice President

    e.   May have higher frequency of meetings as necessary to focus work and create sense of urgency.

    f.   Report quarterly into the QAPI program

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

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

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

Medical Executive Committee

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

Nursing Practice Improvement Council

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

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

Graduate Medical Education

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

a)   Collaboration between Quality and Patient Safety Department, Risk Management, and GME Quality Subcommittee

b)   GME participation in Quality Improvement Committee and Patient Safety Committee

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

Methodologies:

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

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

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

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

·   **<u>Plan:</u>**

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

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

- **Do:**

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

- **Check:**

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

- **Act:**

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

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

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

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

IV. Confidentiality

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

V. Annual Evaluation

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

VI. Attachments

Components of the Quality Improvement and Patient Safety Plan:

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

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Approvers: Board of Directors (Administration), Cindy Moccio (Board Clerk/Exec Assist-CEO)	

Patient Safety Plan

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

I. Purpose

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

II. Scope

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

III. Structure and Accountability

A. Board of Directors

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

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

B. Quality Council

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

C. Patient Safety Committee

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

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

1. The Patient Safety Officer is the Chief Quality Officer

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

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

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

D. Medication Safety Quality Focus Team

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

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

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

IV. Organization and Function

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

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

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

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

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

5. Graduate Medical Education

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

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

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

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

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

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

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

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

E. A proactive component of the program includes the selection at least every 18 months of a high risk or error prone process for proactive risk assessment such as a Failure Modes Effects Analysis (FMEA), ongoing measurement and periodic analysis. The selected process and approach to be taken will be approved by the Patient Safety Committee and Quality Council.

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

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

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

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

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

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

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

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

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

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

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

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

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

V. Evaluation and Approval

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

VI. Confidentiality

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

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

"These guidelines, procedures, or policies herein do not represent the only medically or legally acceptable approach, but rather are presented with the recognition that acceptable approaches exist. Deviations under appropriate circumstances do not represent a breach of a medical standard of care. New knowledge, new techniques, clinical or research data, clinical experience, or clinical or bio-ethical circumstances may provide sound reasons for alternative approaches, even though they are not described in the document."

Rehabilitation Quality Report

January 2022

Acronyms

CARF - Commission on Accreditation of Rehabilitation Facilities
CAUTI - Catheter Associated Urinary Tract Infection
CLABSI - Central Line Associated Blood Stream Infection
HAPI – Hospital Acquired Pressure Injury
LOC – Level of consciousness
NDNQI - The National Database of Nursing Quality Indicators
NHSN - National Healthcare Safety Network
SNF – skilled nursing facility
SBO – Small bowel obstruction
SOB – Shortness of breath

More than medicine. Life.

Kaweah Health

Rehabilitation Hospital

Established May 1994

- CARF Accreditation
- 45 bed
- Budgeted census 18
- Physical, Occupational and Speech Therapy
- 3 hours per day
- Specific criteria for admission
  - Diagnosis and medical necessity
  - Discharge plan

More than medicine. Life.

Kaweah Health

Patient Satisfaction

Overall Assessment
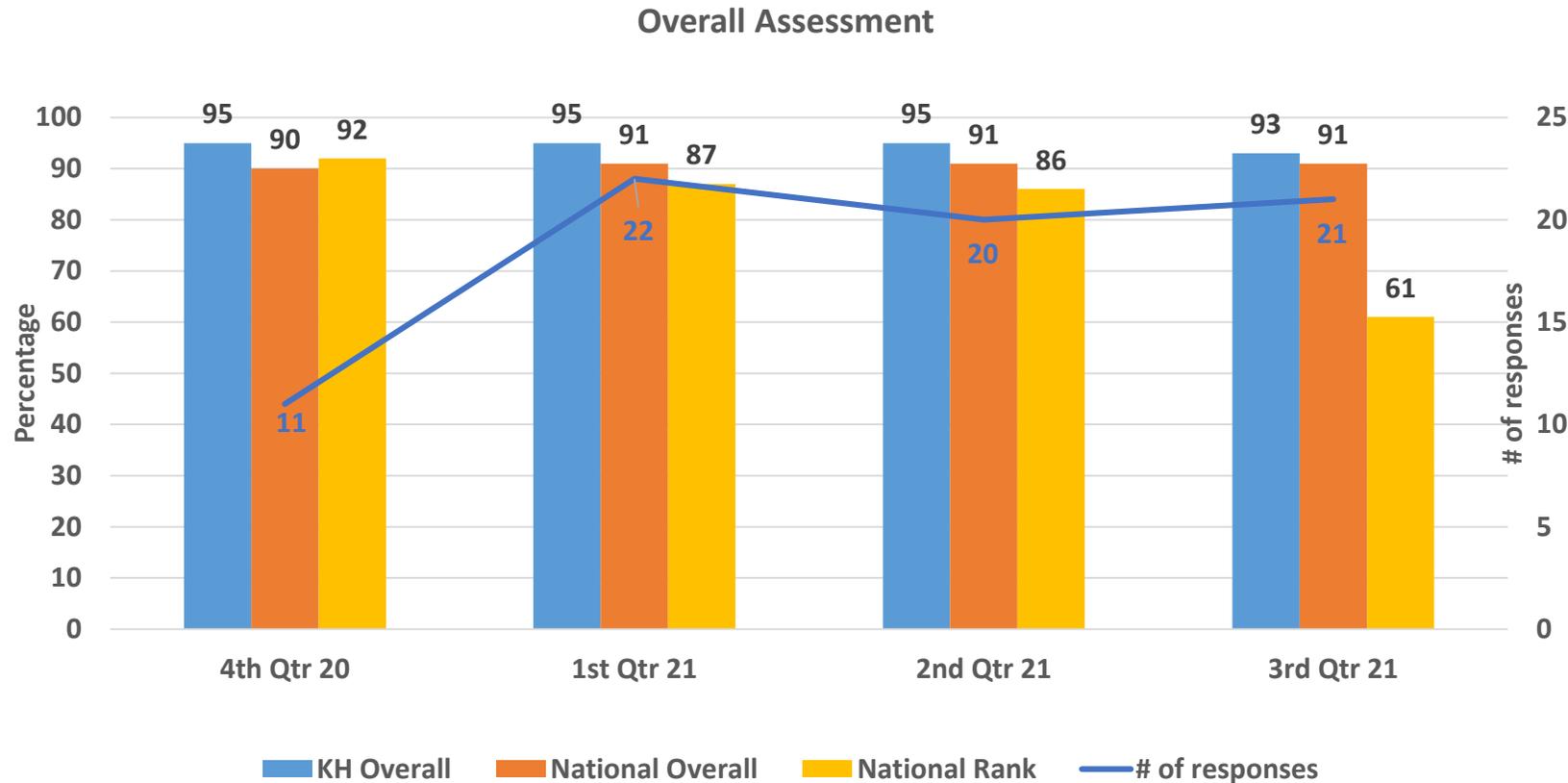
- Press Ganey
- 40 questions
- Patient Satisfaction Committee
  - Staff driven
  - Develop action plans

More than medicine. Life.

Kaweah Health
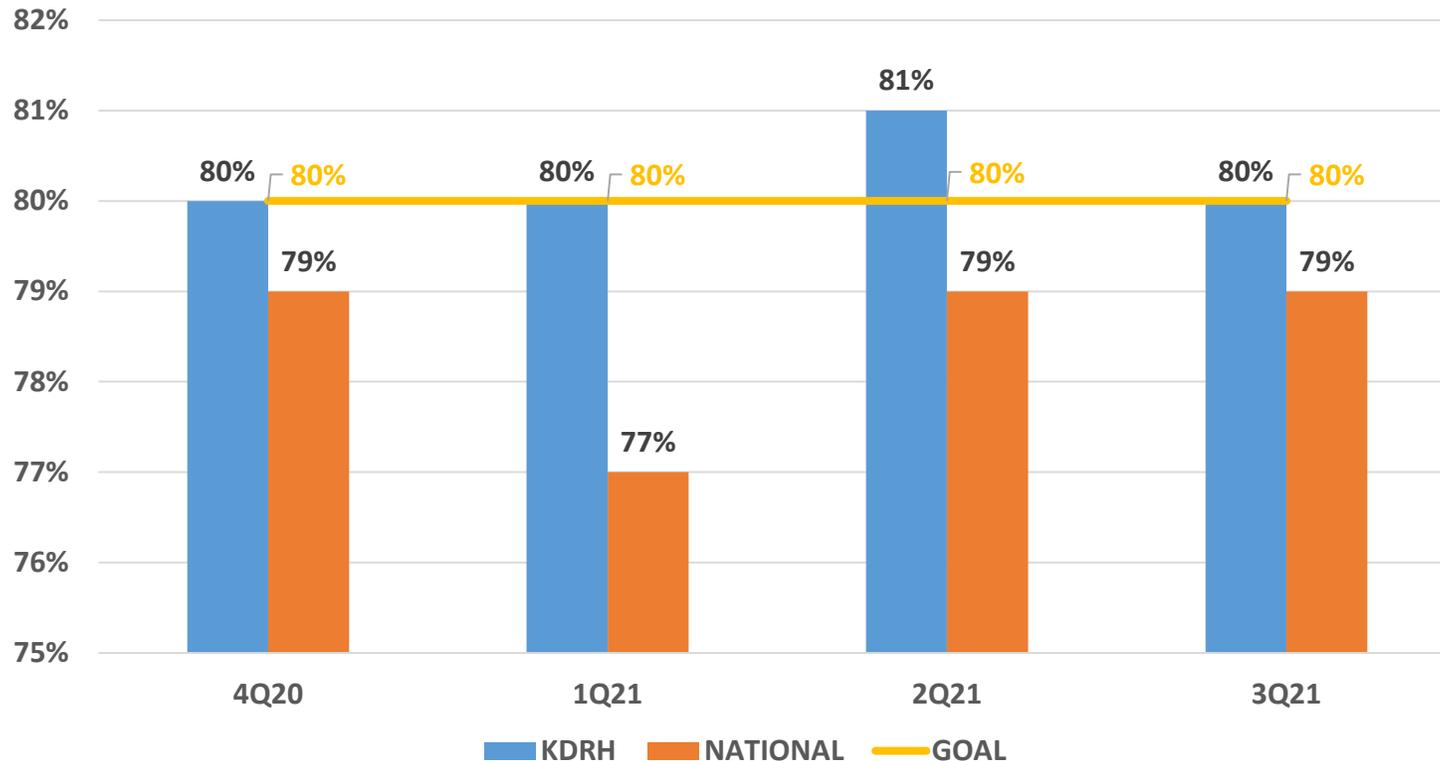
Discharge to Long Term

OVERALL
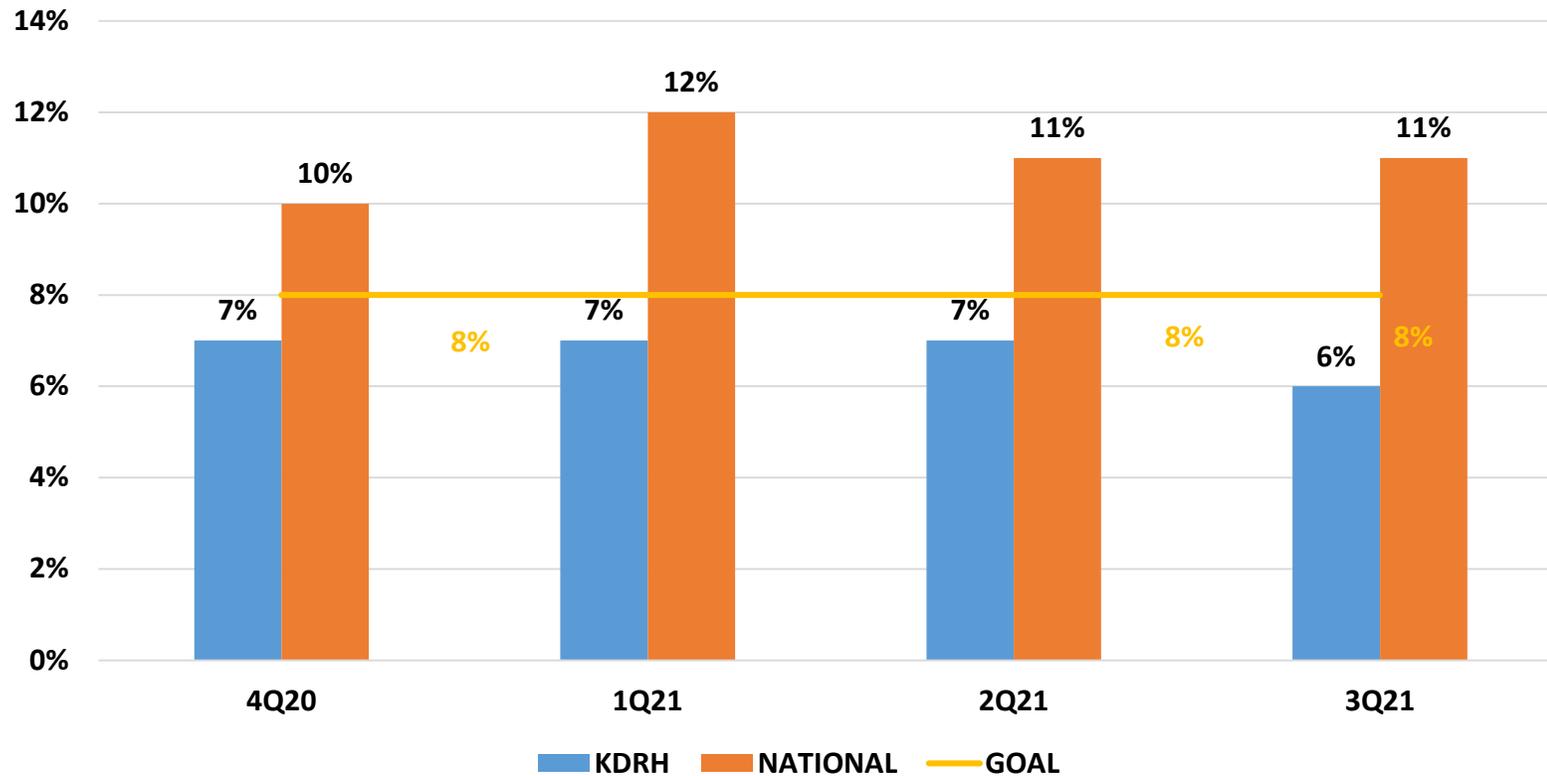
- SNF instead of home
- Lower is better
- Meeting Goal
- Better than the Nation

Discharge to Acute

OVERALL
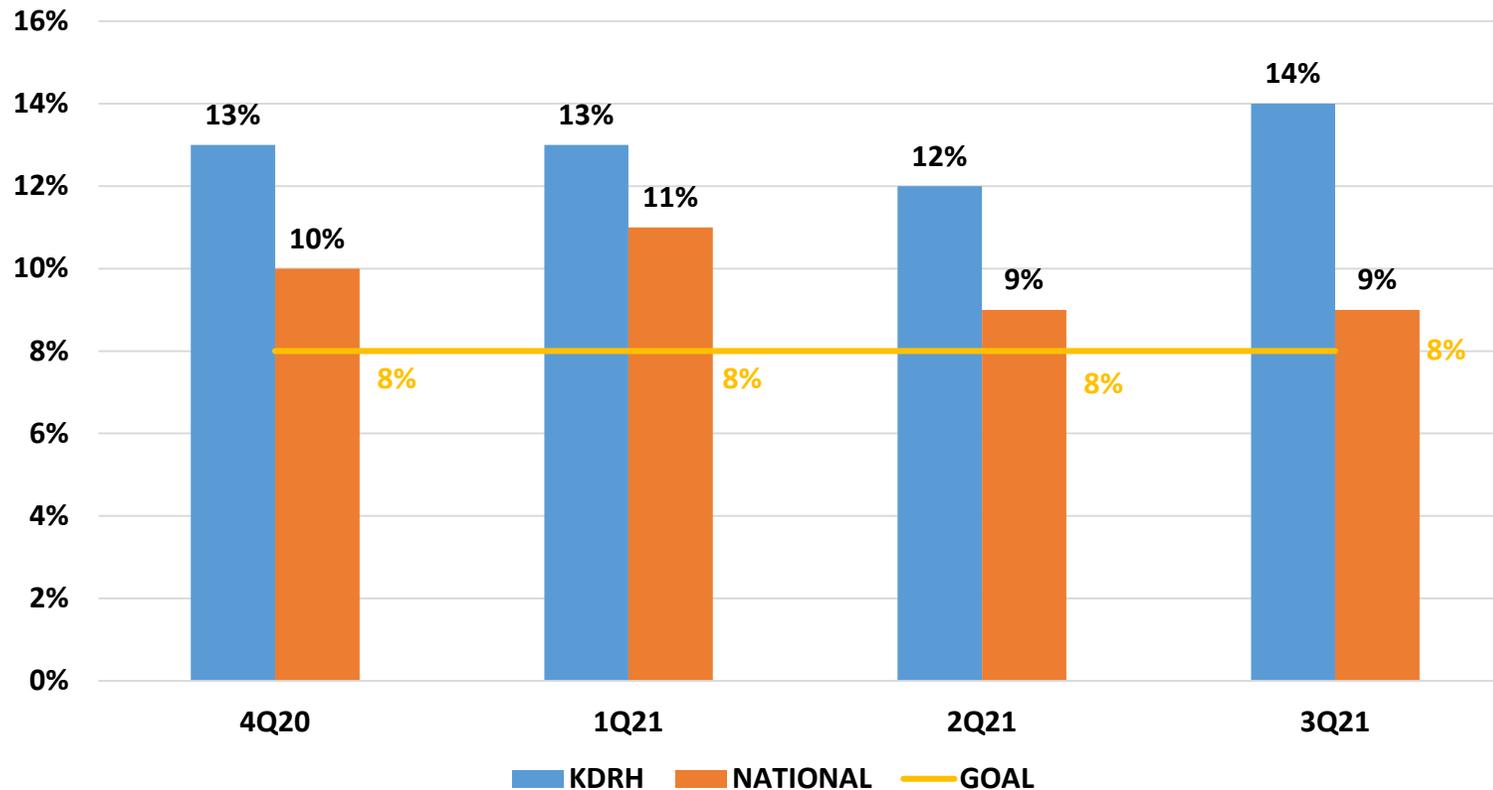
- Lower is better
- Not meeting Goal
- Worse than the Nation
  - Decreased onset days
  - Increased complexity
  - Medical Center census

Reasons for Transfer

Top Reasons for Transfer

More than medicine. Life.
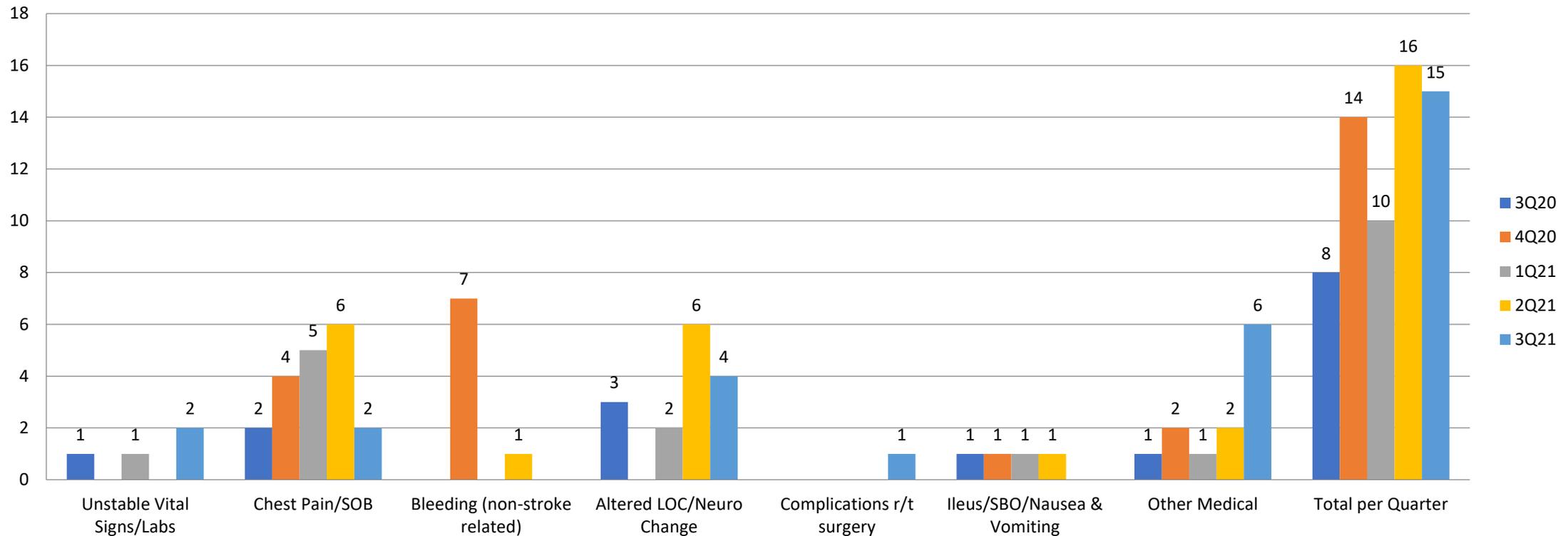
Kaweah Health

Quality Indicators

January 2022

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Kaweah Health
MORE THAN MEDICINE. LIFE.

CLABSI

Central Line Associated Blood Stream Infection Rate
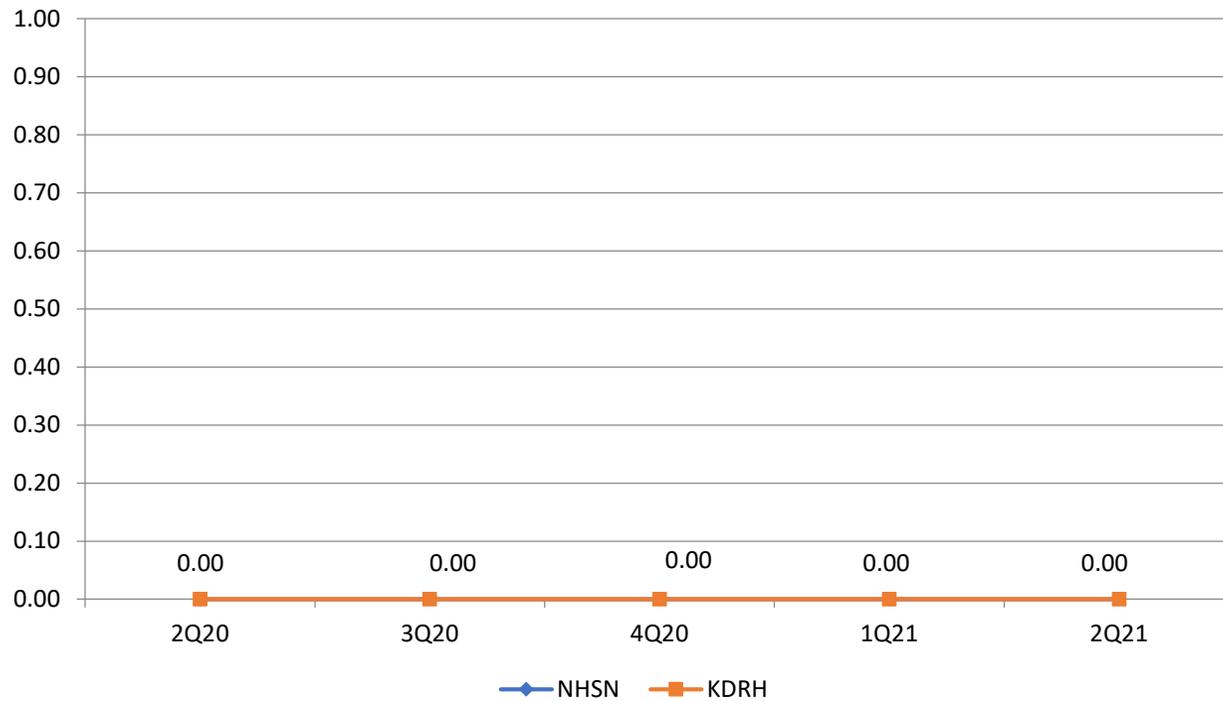
- Low # of central lines on Rehab unit

More than medicine. Life.

Kaweah Health

CAUTI

Catheter Associated Urinary Tract Infection Rate (per 1000 patient days)
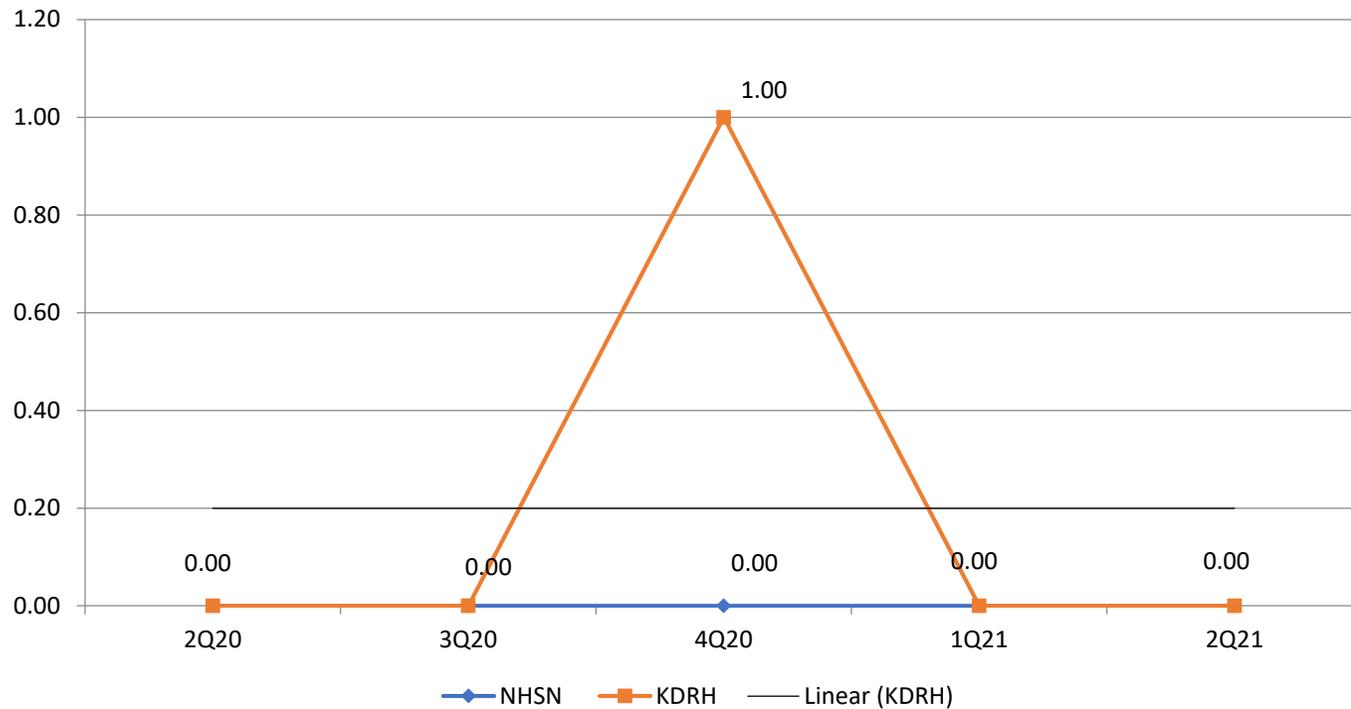
- Each CAUTI is reviewed with Infection Prevention and committee.

More than medicine. Life.

Kaweah Health

FALL RATE

Fall Rate/1000 Patient Days
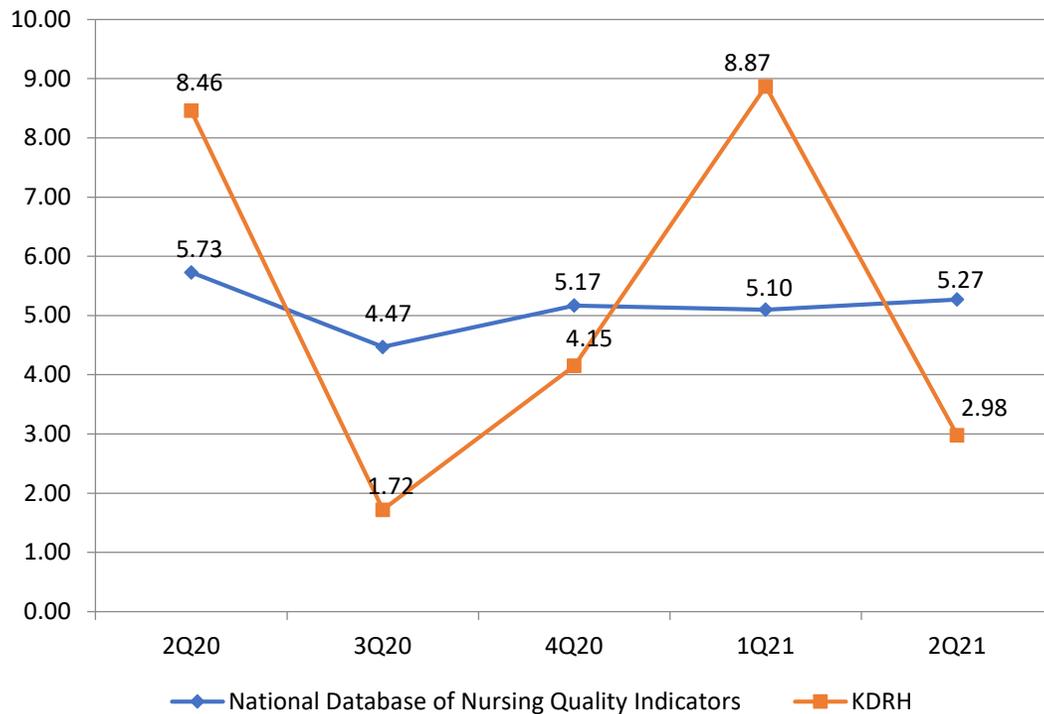
Fall Rate with Injury/ 1000 Patient Days
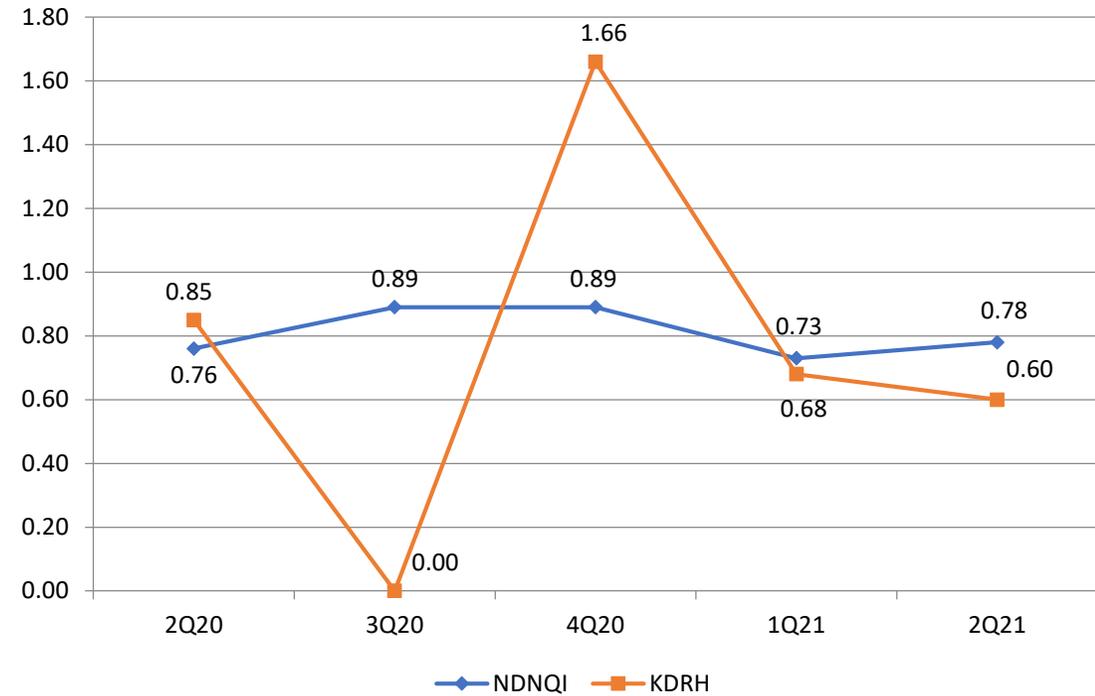
* National Standard is Acute Hospital Quality Indicator

SafeGait

1ˢᵗ of its kind in California

- Improved Patient Outcomes and Function
- Safer Patient Handling
- Dynamic Fall Protection and Fall Recovery
- Reduces Length of Hospital Stay
- Patient Specific Data to Show Progress

HAPI

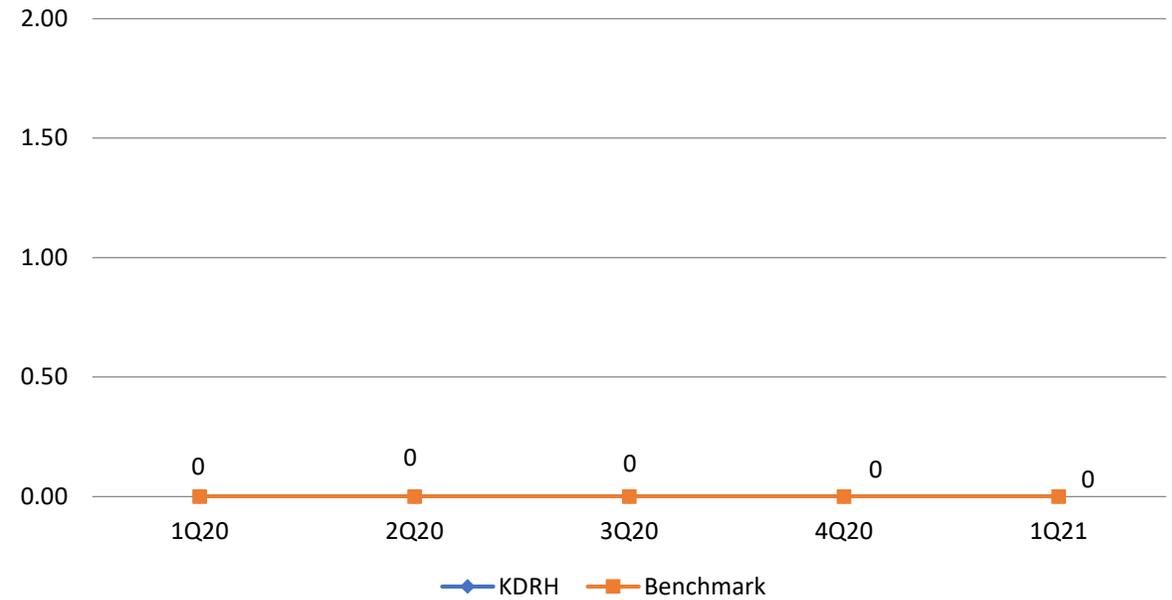**Hospital Acquired Pressure Injury (Stage 2 and above)**

- No pressure injuries