July 8, 2021

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, July 15, 2021, 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, July 15, 2021, in the Kaweah Health Lifestyle Fitness Center Conference Room, 5105 W. Cypress Avenue, Visalia, CA 93277, pursuant to Health and Safety Code 32155 & 1461.

The Board of Directors of the Kaweah Delta Health Care District will meet in an open Quality Council Committee meeting at 8:00AM on Thursday, July 15, 2021, 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
Garth Gipson, Secretary/Treasurer

Cindy Moccio

Cindy Moccio
Board Clerk, Executive Assistant to CEO

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

KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS
QUALITY COUNCIL

Thursday, July 15, 2021
5105 W. Cypress Avenue
Kaweah Health Lifestyle Fitness Center Conference Room

ATTENDING: Board Members; David Francis – Committee Chair, Mike Olmos; Gary Herbst, CEO; Keri Noeske, RN, BSW, DNP, VP & 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, Chief Compliance Officer, Evelyn McEntire, Manager Quality Improvement/Interim 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
   - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Monica Manga, MD, and Professional Staff Quality Committee Chair;*
   - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – Evelyn McEntire*, RN, BSN, Interim Director of Risk Management, and Ben Cripps, Chief Compliance 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 – *Monica Manga, MD, and Professional Staff Quality Committee Chair*

3. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 — Evelyn McEntire, RN, BSN, Interim Director of Risk Management, and Ben Cripps, Chief Compliance 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. **Rapid Response Team (RRT) Quality Report**
    - 3.2. **Stroke Service Line Quality Report**
    - 3.3. **Rehabilitation Service Line Quality Report**
    - 3.4. **Hand Hygiene Quality Report**
    - 3.5. **Sepsis Quality Focus Team Report**
    - 3.6. **Catheter Associated Urinary Tract Infection (CAUTI) Quality Focus Team Report**

4. **Update: Clinical Quality Goals -** A review of current performance and actions focused on the fiscal year 2021 clinical quality goals. *Sandy Volchko, RN, DNP, Director of Quality and Patient Safety.*

5. **Safety Attitudes Questionnaire and Action Plan –** A review of Safety Culture Questionnaire results, analysis and action plans for improvement. *Sandy Volchko, RN, DNP, Director of Quality and Patient Safety.*

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

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

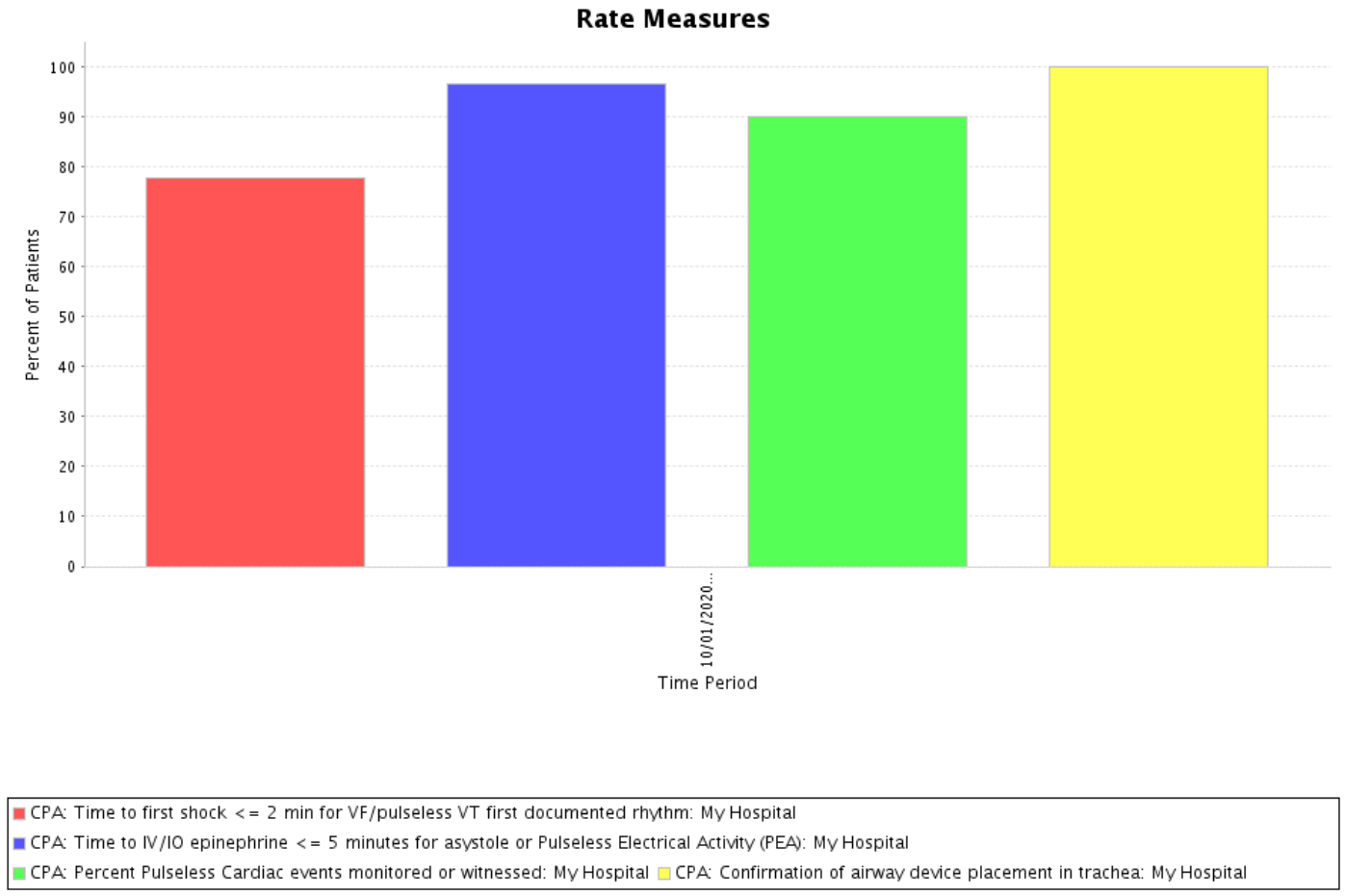
RRT/Code Blue ProStaff Report- 2021

Dr. Tang, Shannon
Cauthen and Stacey
Cajimat

GWTG Resuscitation

- 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

GWTG Recognition Measures



RRT and Resuscitation- Quality Scorecard

RRT and Resuscitation - Quality Scorecard

Measure Description	California Hospitals External Benchmark	Jan-21	Feb-21	Mar-21	Mean YTD 2021
Code Blue Data					
Total Code Blues		27	30	17	25
Total COVID-19 Positive Code Blues		17	14	0	10
Code Blues per 1000 Discharges Med Surg		8	8	5	7
Code Blues per 1000 Discharges Critical Care		12	17	7	12
Percent of Codes in Critical Care	73%	59%	50%	59%	56%
Code Blue: Survival to Discharge	22%	11%	7%	18%	12%
Deaths from Cardiac Arrest		24	15	5	15
Overall Hospital Mortality per 1000 Patients		7.632	5.661	3.292	5.53
RRT Data					
RRTs per 1000 patient discharge days		131	129	109	123
RRT mortality percentage	21%	40% n-70	31% n-47	20% n-22	30%
RRTs within 24 hours of Admit from ED (percentage)	18%	20% n-30	16% n-26	29% n-29	22%
Green	Better than Target				
Yellow	Within 10% of Target				
Red	Does not meet Target				

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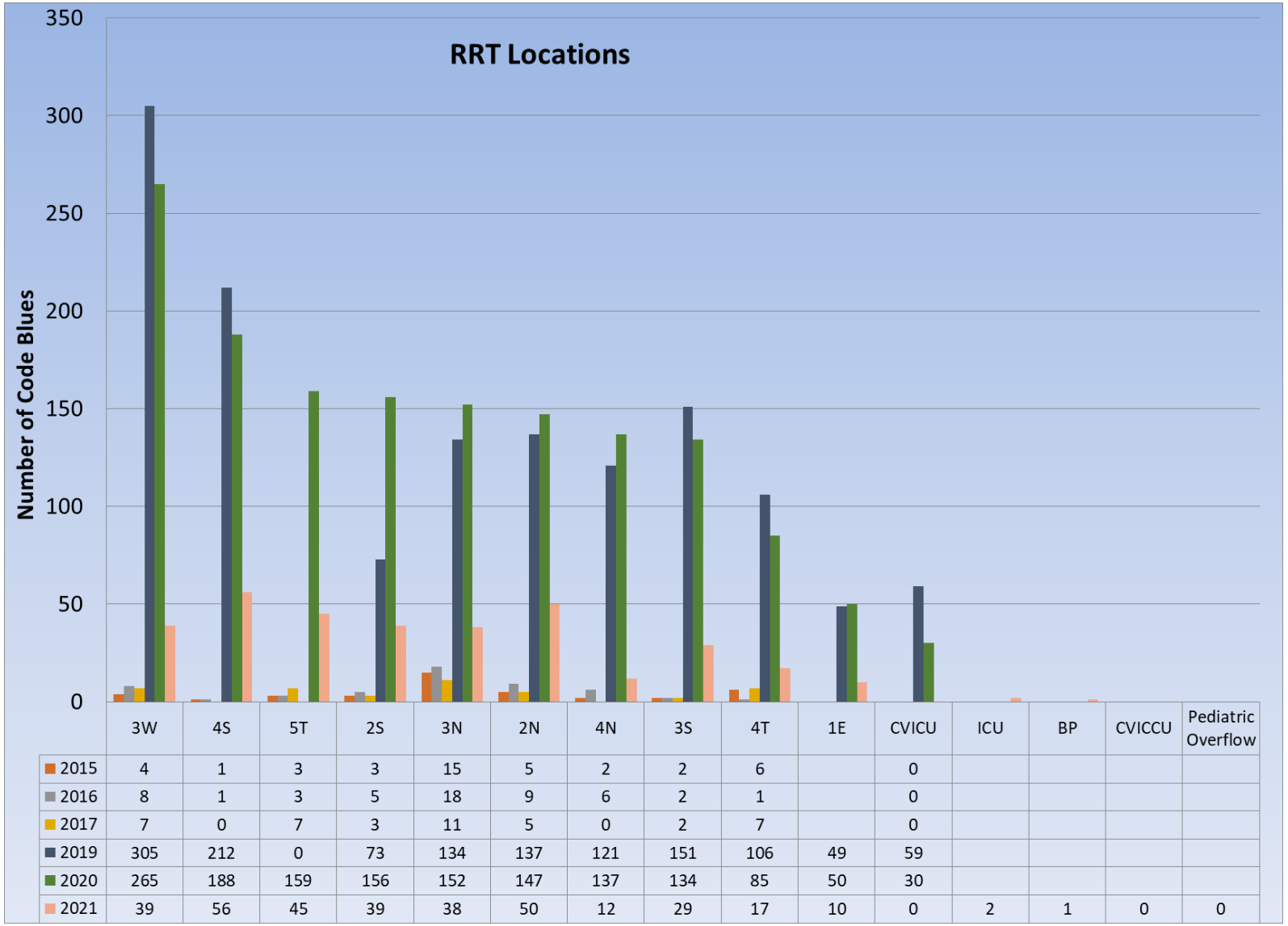
RRTs by Location



	3W	4S	5T	2S	3N	2N	4N	3S	4T	1E	CVICU	ICU	BP	CVICCU	Pediatric Overflow
2015	4	1	3	3	15	5	2	2	6		0				
2016	8	1	3	5	18	9	6	2	1		0				
2017	7	0	7	3	11	5	0	2	7		0				
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	39	56	45	39	38	50	12	29	17	10	0	2	1	0	0

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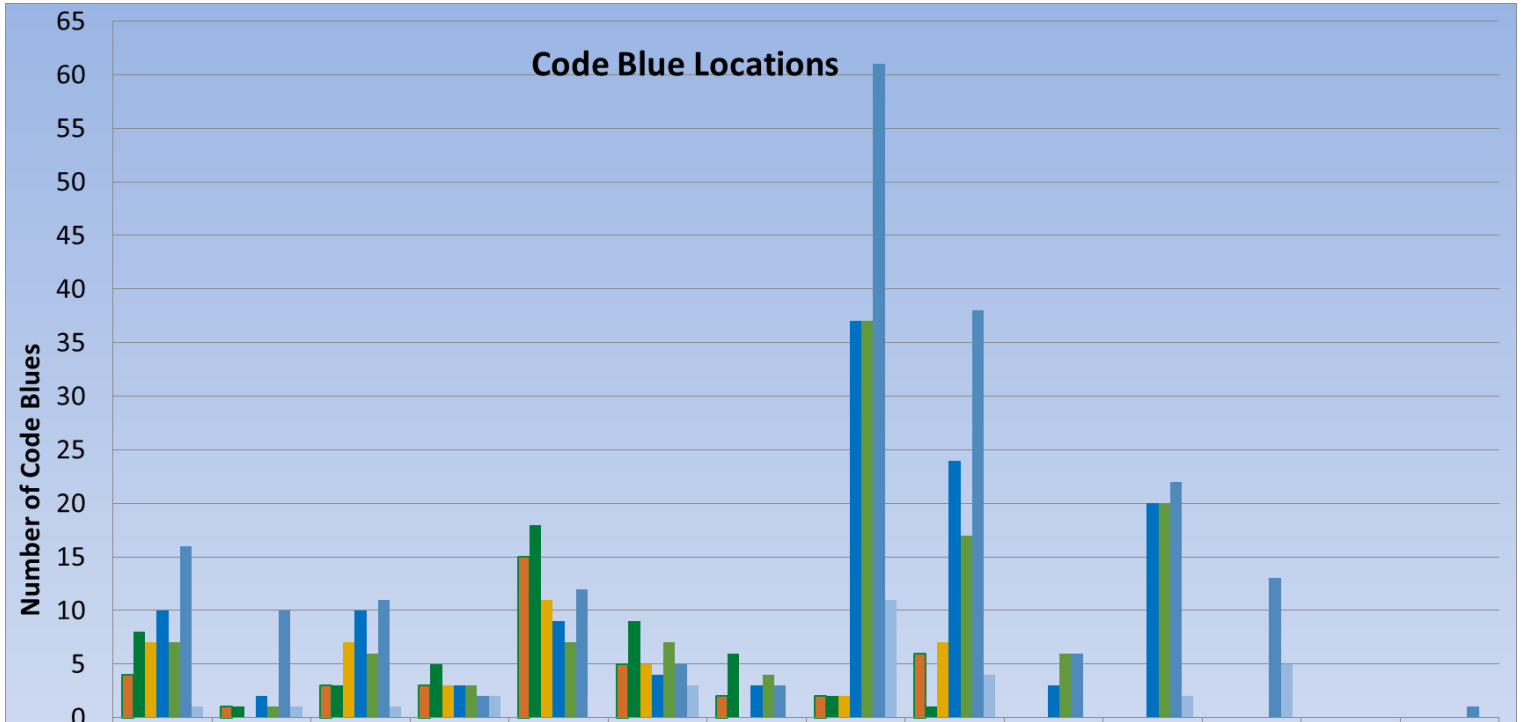
Code Blues by Location



	2N	2S	3N	3S	4N	4S	4T	ICU	CVICU	CVICCU	3W	5T	BP	Pediatric Overflow
2015	4	1	3	3	15	5	2	2	6		0			
2016	8	1	3	5	18	9	6	2	1		0			
2017	7	0	7	3	11	5	0	2	7		0			
2018 n=125	10	2	10	3	9	4	3	37	24	3	20	0	0	
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	1
2021	1	1	1	2	0	3	0	11	4	0	2	5	0	0

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Code Blues and RRTs 2021

Code Blue Summary

- Code blues in critical care setting are below the California benchmark (higher is better). The committee's goal is for code blues to occur in critical care where there are resources , monitoring, and an intensivist on the unit.
- Code blue survival to discharge benchmark not met for time period January through March due to high volume of code blue patients with covid (special cause).
- Time to first shock below benchmark (higher is better).
    - Need to revise code blue sheet to capture time of first shock.
    - Preliminary discussion about educating staff to utilize AED mode on ZOLL until arrival of Code Team.
    - All other code blue process measures are above goal.

Rapid Response Team Summary

December:

- Highest amount of RRTs per 1000 patient discharge days: 131 (Jan.)
- Highest mortality percentage: 40% (Jan.)

- Average year to date RRT mortality (30%) is above the California hospital average (21%).
- Average 2021 RRTs with 24 hours of Admit from ED are 22% (down by 2% from last report) compared to the California hospital average of 18%.

Code Blues and RRTs 2021

Analysis

- Observed a direct correlation in number of COVID patients and increase volume of code blues, RRTs, and mortality.
- Covid patients required increase oxygen support and high flow oxygen delivery systems were maximized in acute care areas. Patients with low oxygen situation in low 90s became the new normal.
- Critical care patients extended to overflow area on 3 West and intermediate critical care patients to overflow area on 2 north, thus supporting code blues occurring outside critical care unit.
- At times, RRTs are called and end of life discussion occurs leading to comfort care and a contributing factor to the percent of RRT mortalities.
- ED hold times are increased, patient's status can change while they are awaiting an admit bed. Re-evaluation of patient condition is not consistent and patients are sometimes admitted to inappropriate level of care and then RRT shortly after admit to inpatient unit.

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Next Steps

- Revise code blue form to easily capture all code blue process elements to meet GWTG standards. In-progress
- Assess teaching hospital GWTG benchmarks vs. California benchmarks. In-progress
- Create a second RRT backpack w/ emergency supplies (IO Gun, Butterfly U/S). In-progress
- Formalization of role definition of each team member of the Code team using the developed assignment sheet. In-progress
- Formalization of non-licensed staff and family activated RRT process. Pending.
- Re-instate Hi-Fidelity mock in-situ code blues. Pending
- Formalization of rounding program by RRT nurses for ICU downgrades. DONE
- Create a debrief form to debrief team members after event. DONE
    - Develop reporting structure for debrief information to be protected by CA 1157 to promote staff participation and anonymity. In-progress

Next Steps: Education

- The RRT nurses are working to educate staff during the event and to circle back with staff after the event to discuss quality of care using debrief form.
- 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.
- Incorporate advanced training for the resuscitation of our special populations of patients (trauma and post-Open Heart Surgery). Use TCAR and CALS for resuscitation guidelines. Standardize training.

Questions?

Live with passion.

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

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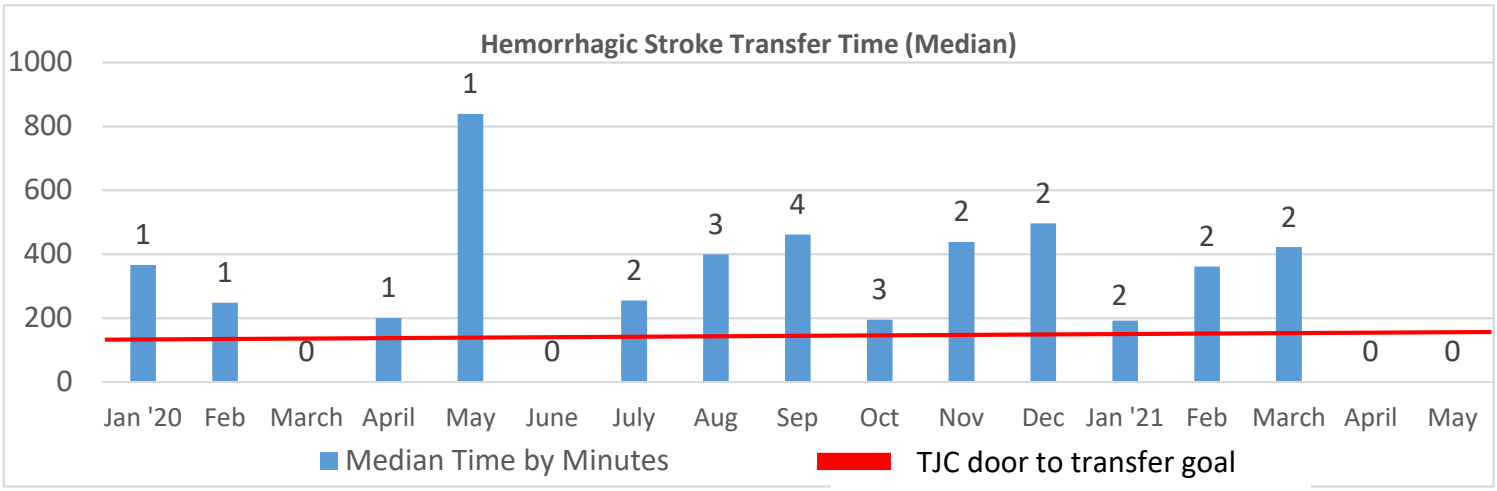
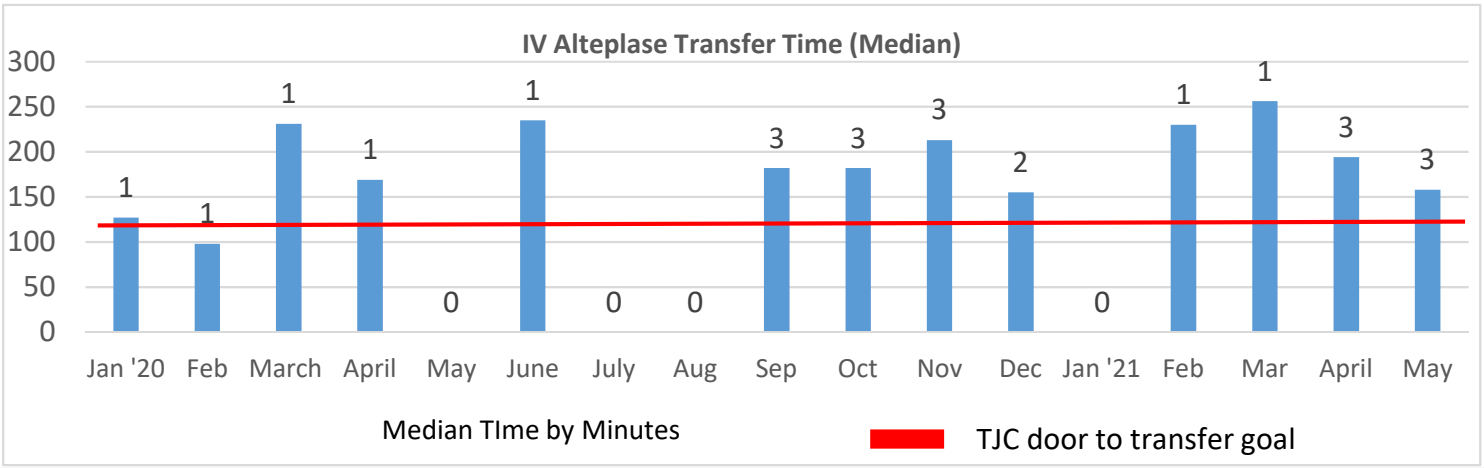
Stroke Program Dashboard 2019-2021

	Bench-marks	2019 Totals	2020 Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan'21	Feb	Mar	Apr
Grouping of Stroke Patients																		
Ischemic		*460*	39	42	38	23	28	32	31	29	34	27	24	34	34	33	32	36
Hemorrhagic		*98*	8	6	5	7	6	4	4	8	7	8	14	1	5	12	8	5
TIA (in-patient and observation)		*344*	33	44	29	24	21	13	27	20	16	24	19	11	18	18	26	19
Transfers to Higher Level of Care (Ischemic)		*27*	1	2	3	3	2	6	1	3	4	3	5	2	3	1	2	4
Transfers to Higher Level of Care (Hemorrhagic)		*17*	1	1	1	1	1	0	2	1	6	6	2	2	2	2	2	0
TOTAL NUMBER OF PATIENTS		*946*	82	95	72	58	58	55	65	61	67	68	64	50	62	66	70	64
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
% of Alteplase - Inpatient & Transfers		*13%*	20%	14%	10%	8%	7%	11%	13%	0%	11%	10%	14%	8%	3%	6%	3%	13%
% Appropriate vital sign monitoring post Alteplase	90%	*68%*	75%	75%	100%	100%	100%	75%	75%	NA	75%	88%	100%	33%	100%	100%	100%	80%
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%
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%
% 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%
% Appropriate stroke order set used (ED)	90%	*90%*	94%	92%	88%	89%	98%	90%	82%	89%	88%	80%	93%	92%	86%	88%	86%	91%
STK-1 VTE (GWTG, TJC)	85%	*99%*	100%	100%	95%	100%	91%	85%	85%	92%	96%	90%	88%	97%	89%	92%	91%	90%
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%
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%
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%
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%
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%
STK-8 Stroke Education (GWTG, TJC)	75%	*94%*	93%	97%	94%	100%	96%	88%	85%	100%	100%	100%	91%	90%	95%	97%	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%
% 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%
% Smoking Cessation (GWTG)	85%	*99%*	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%
Intensive Statin Therapy (GWTG)	75%	*90%*	94%	91%	88%	88%	97%	94%	91%	79%	93%	93%	100%	100%	90%	94%	100%	100%
% tPA Arrive by 2 Hrs; Treat by 3 Hrs. (GWTG)	85%	*96%*	100%	80%	NA	100%	100%	100%	67%	NA	100%	100%	NA	NA	NA	NA	NA	NA
% 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%
% NIHSS Reported (GWTG)	75%	*98%*	100%	93%	92%	100%	96%	94%	92%	96%	90%	100%	96%	97%	100%	100%	90%	100%
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
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
Ischemic Mortality O/E Ratio (Midas)	<1.0	*NA*	0.74	0.88	0.61	0	0	0.74	0	0.8	0.7	0.8	1.9	4	2.5	2.9	0	4.1

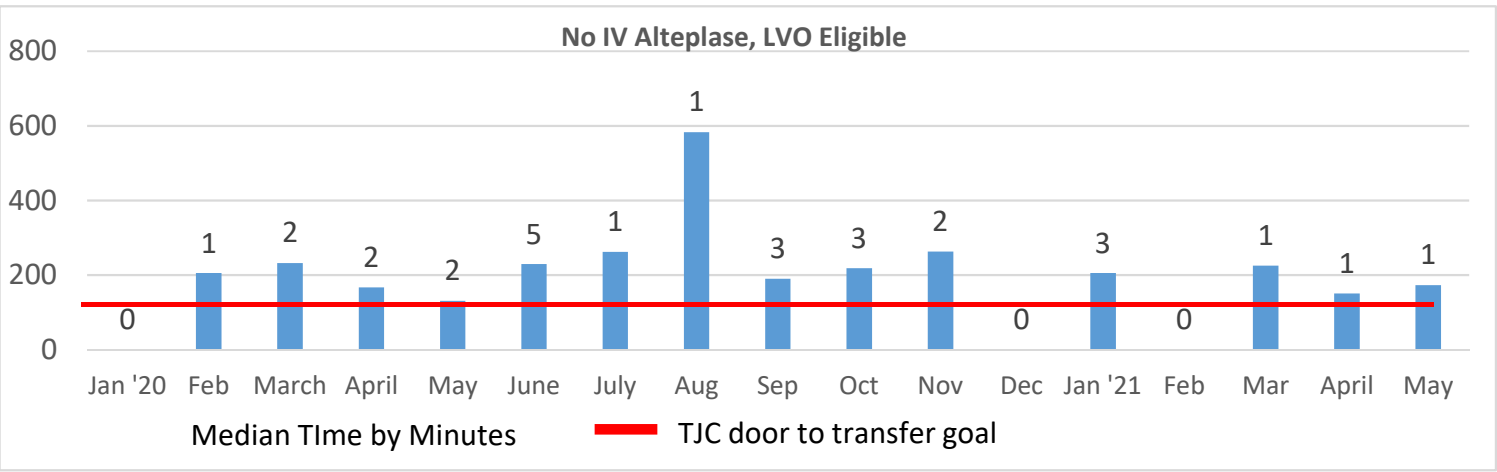
2020-2021 TRANSFERS FROM ED TO ANOTHER ACUTE CARE FACILITY
Median Time by Minutes - Goal 120 Minutes



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



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

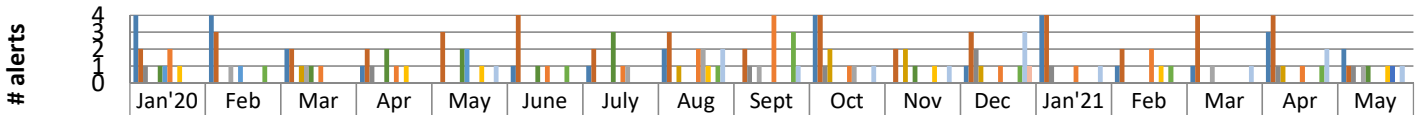


This cohort of patients have a large vessel occlusion that would be eligible for endovascular treatment and do not meet criteria for Alteplase administration. The Covid 19 pandemic has caused delays in transfer times due to the additional precautions, resources and screening needed in the recent months.

2020-2021

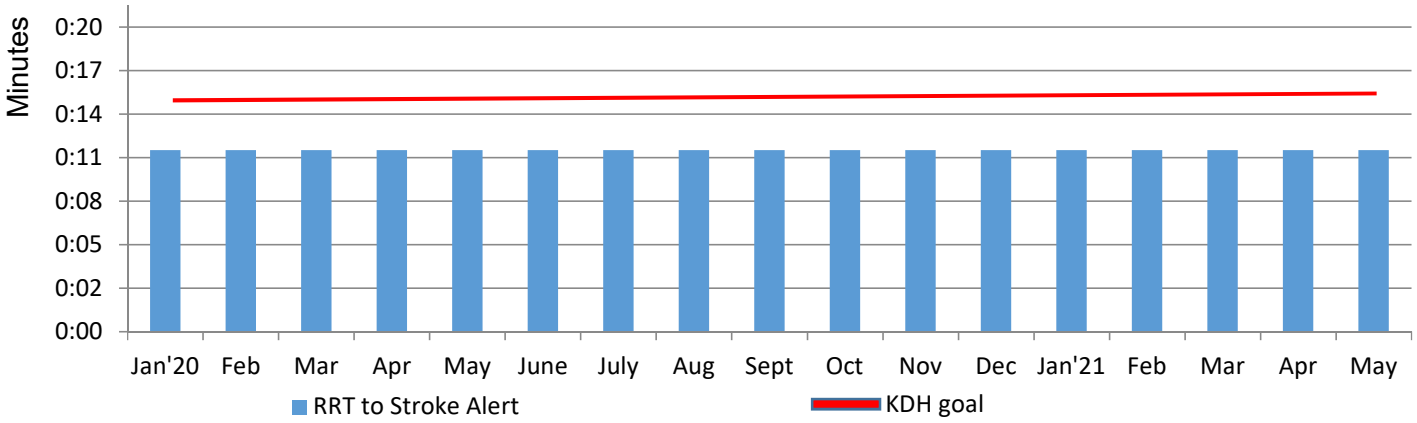
In-House Stroke Alert Dashboard

Stroke Alert Location



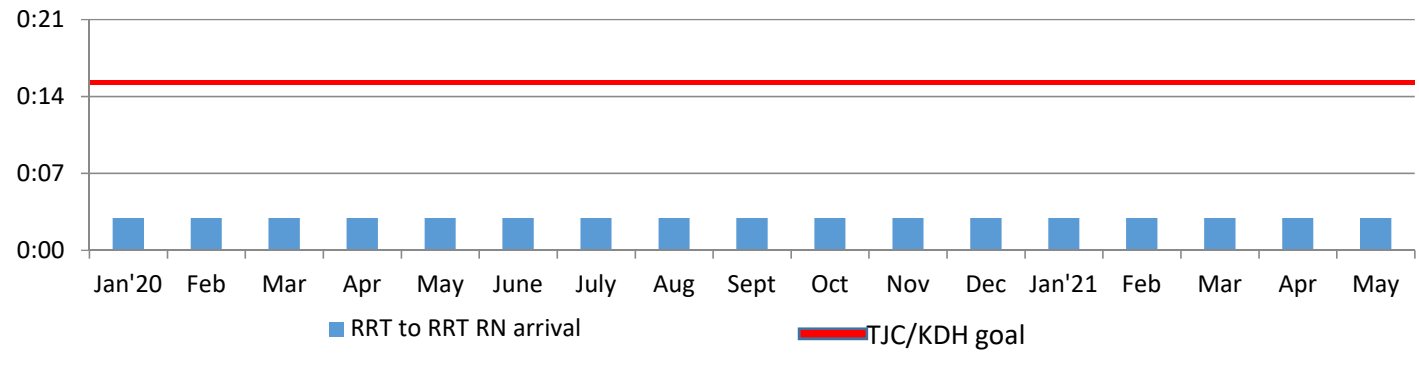
	Jan'20	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan'21	Feb	Mar	Apr	May
3W	4	4	2	1		1	1	2		5		1	4	1	1	3	2
4S	2	3	2	2	3	9	2	3	2	6	2	3	6	2	4	4	1
2S	1			1					1	1		2	1			1	1
3S			1					1		2	2	1				1	
Cath Lab		1	1						1						1		1
CVICU	1		1	2	2	1	3				1						1
ICU	1	1			2												
4N	2		1	1		1	1	2	4	1		1	1	2		1	
3N							1	2		1							
4T	1			1	1			1			1			1			1
PACU																	1
2N		1				1		1	3			1		1		1	
5T					1			2	1	1	1	3	1		1	2	1
BP												1					

RRT to Stroke Alert



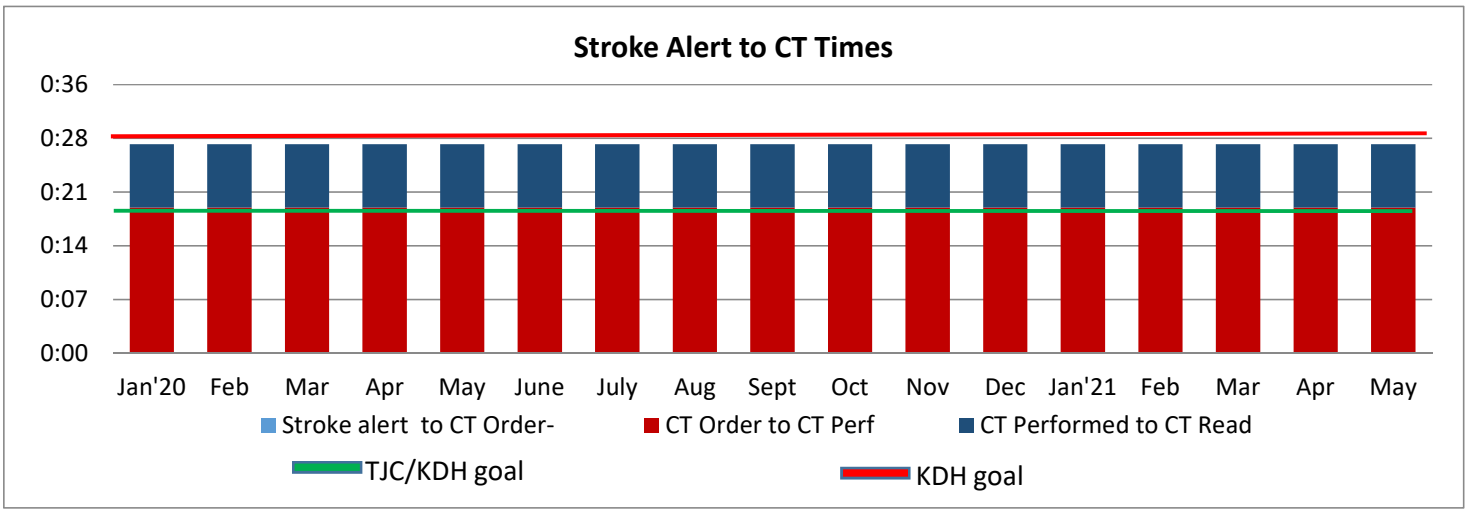
If patients exhibit any new or worsening neuro deficits while in the hospital; RNs are to call an RRT. The RRT RN will evaluate and determine if a stroke alert should be called. The goal from calling RRT to stroke alerts should be <15 minutes.

RRT to RRT RN arrival

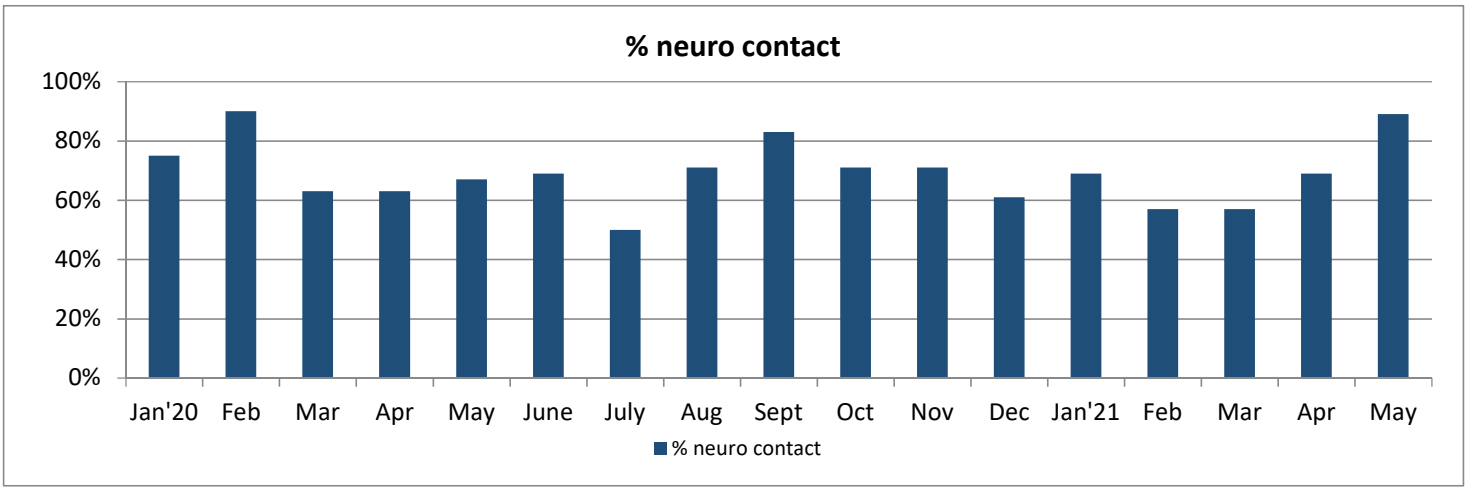


TJC expectation is that a designated provider is at the bedside within 15 minutes of stroke alert. KDH has designated the RRT RN as the provider for in-house stroke alerts.

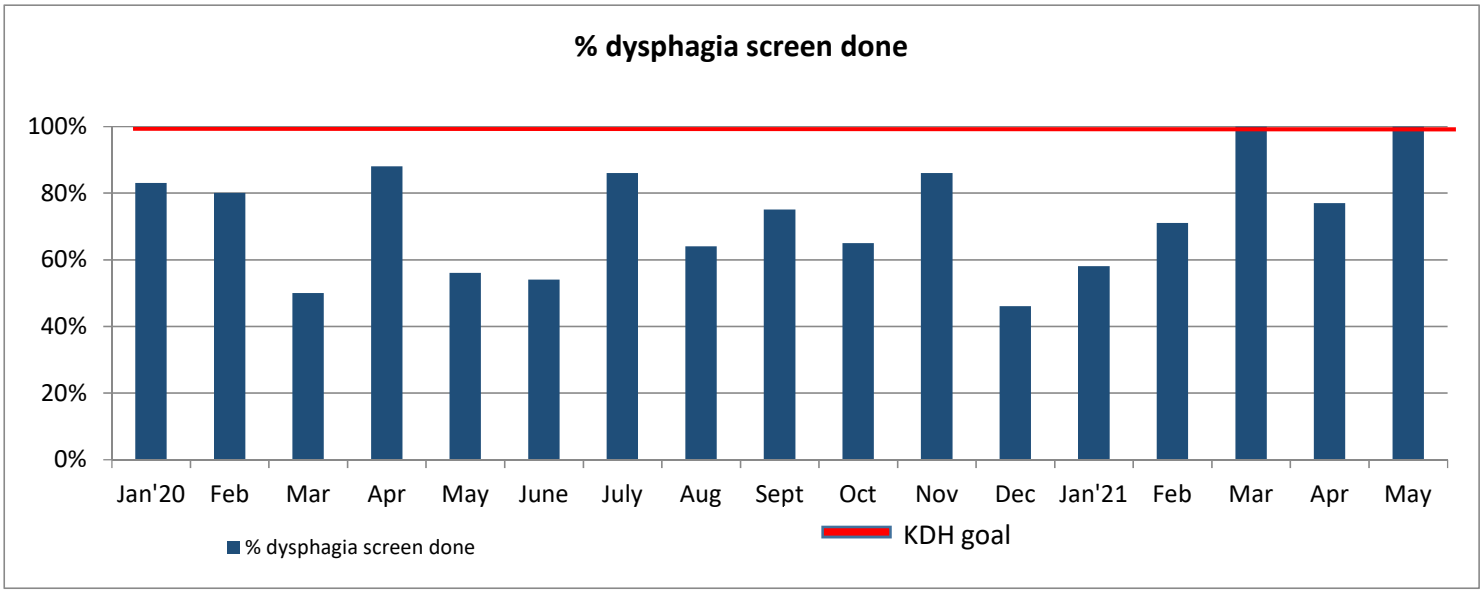
2020-2021
In-House Stroke Alert Dashboard



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



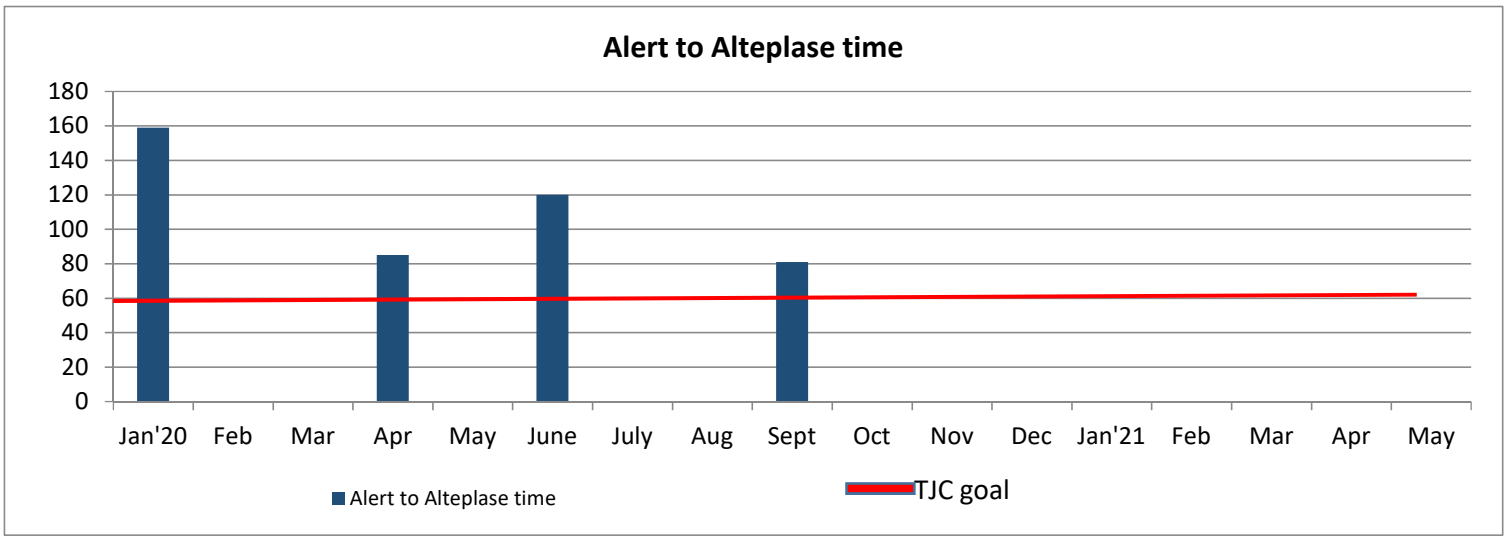
Neurology consultation should occur on all in-house stroke alerts.



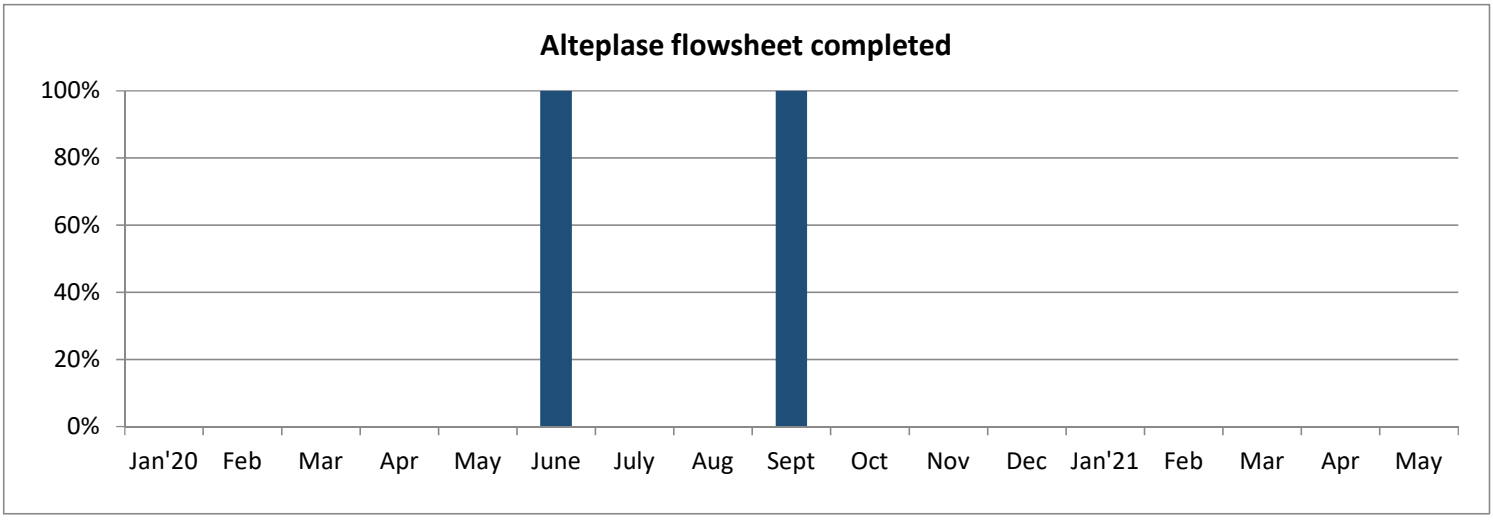
Whenever there are new or worsening neurological deficits ≥3 points, the RN should perform a dysphagia screen to evaluate the patient's ability to swallow.

2020-2021

In-House Stroke Alert Dashboard

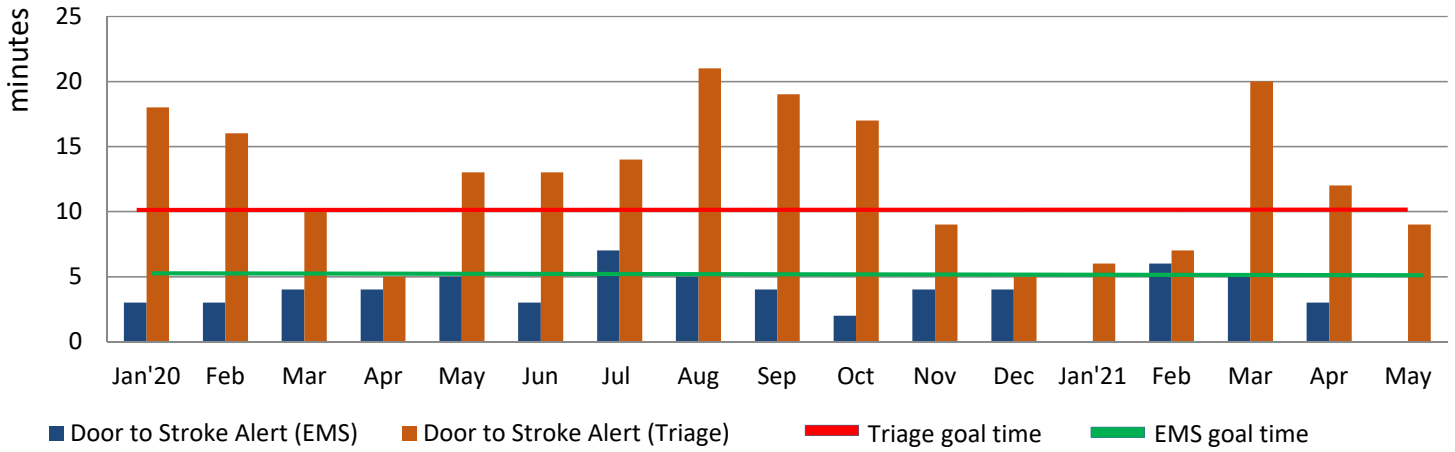


ED Patients: TJC expectation is that IV thrombolytics are given within 60 minutes to eligible patients who present for stroke care at least 50% of the time. In-House Stroke alerts: KDH expectation is that IV thrombolytics are given within 60 minutes to eligible patients who have been identified with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



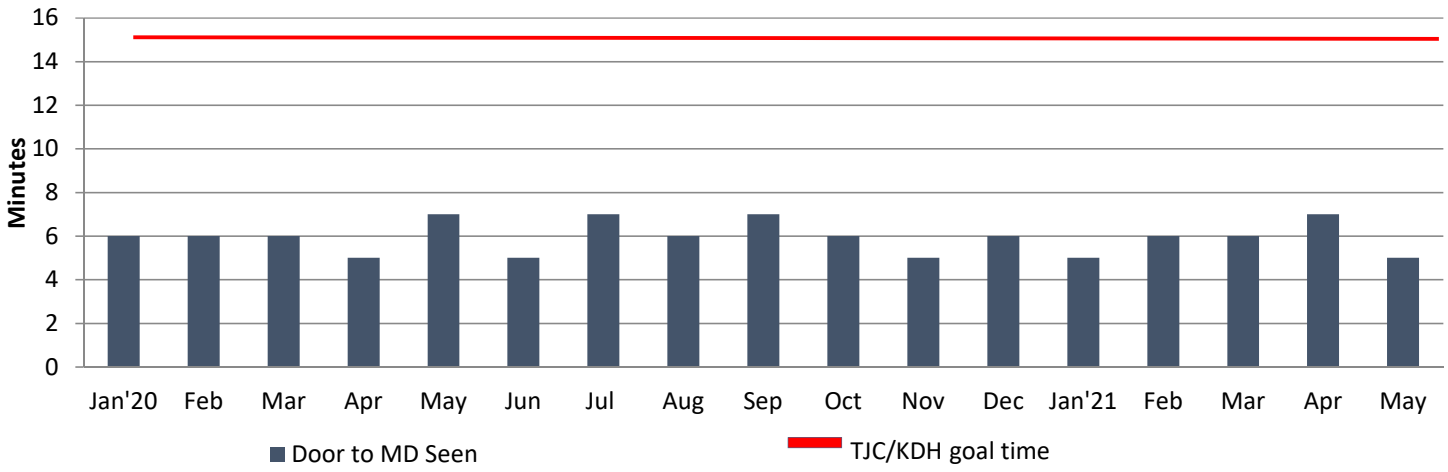
2020-2021 Stroke Alert Dashboard

Door to Stroke Alert (median times)



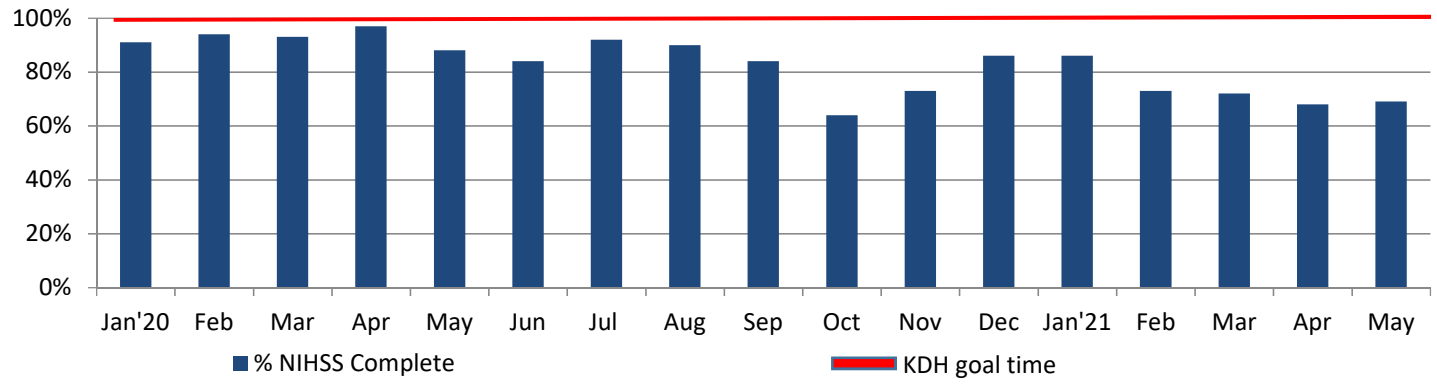
Per KDH ED Stroke Alert process; stroke alerts to be called within 5 min for EMS and 10 min for Triage. ED Stroke Alert Triage task force convened to look for opportunities for improvement March 2020.

Door to MD Seen (median time)



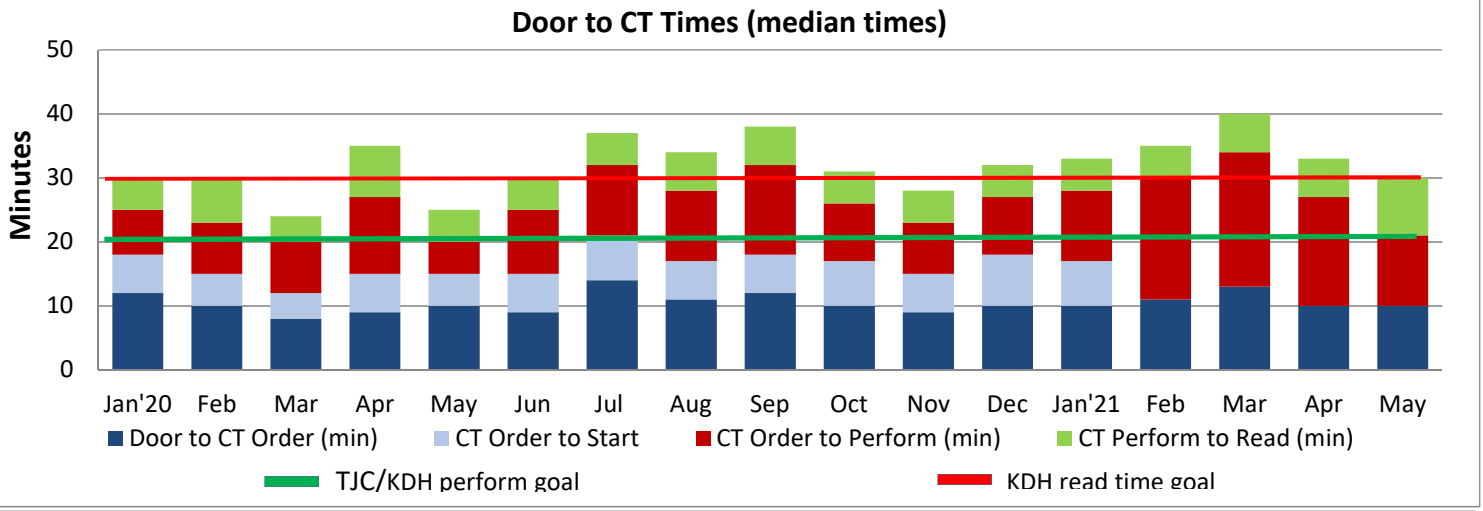
The expectation is that the physician will see the stroke alert patient within 15 minutes of arrival. Improvements made throughout the past year include: early notification from EMS, MD meets the pt at the door upon arrival, scribe documents first seen time in the record.

% NIHSS Complete

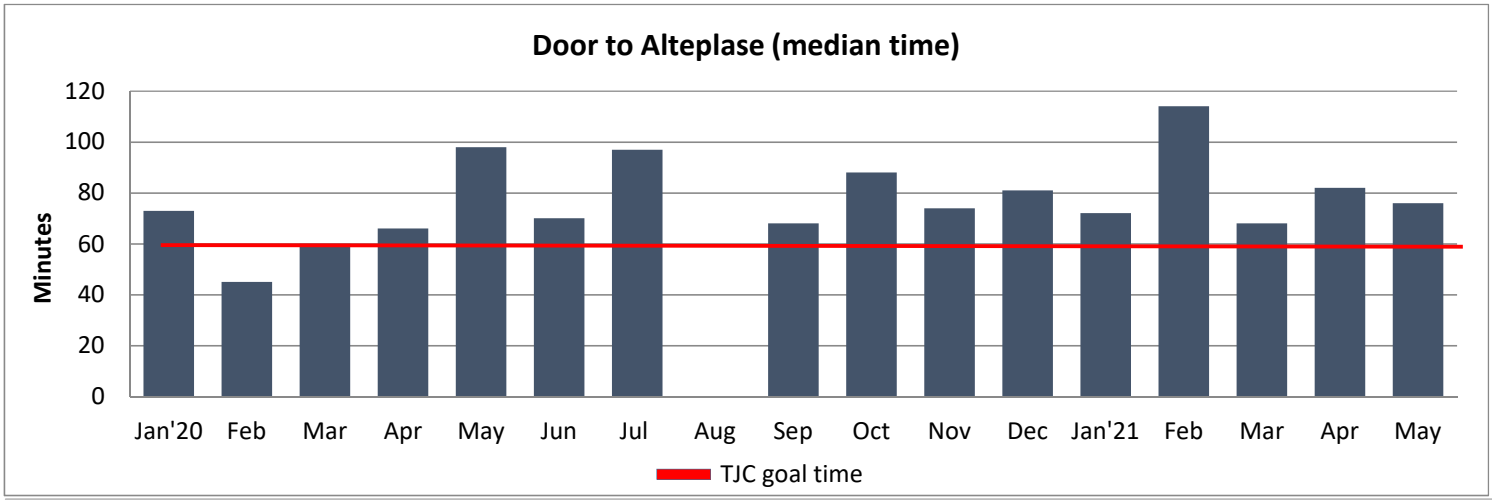


The expectation is that all stroke alert patients will have a NIHSS completed by a certified ED staff member and/or the attending physician; the primary responsible person is the attending/resident physician.

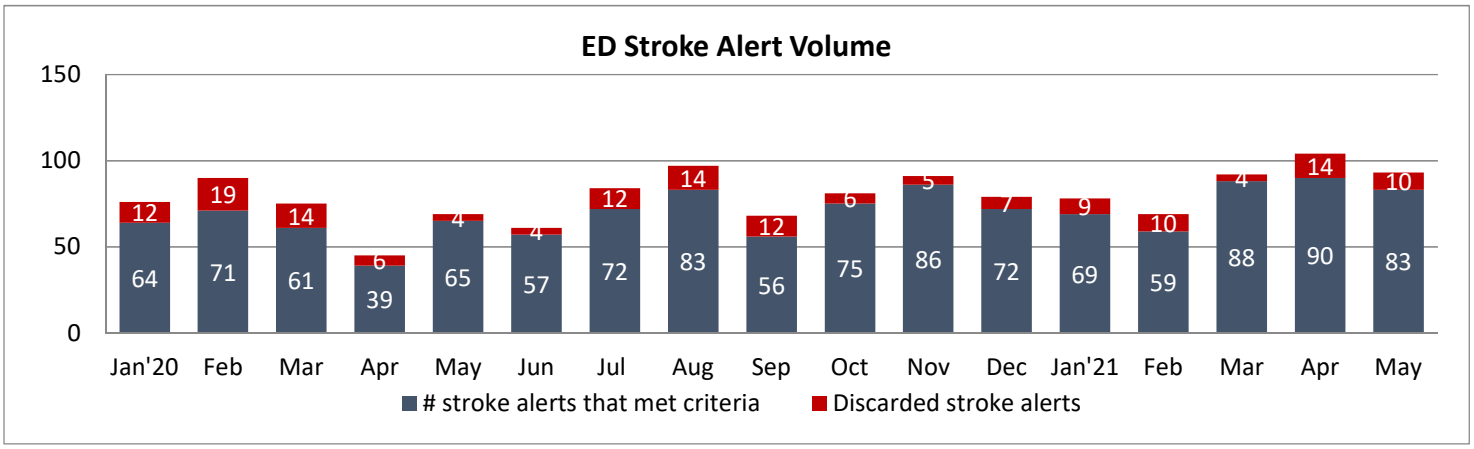
2020-2021 Stroke Alert Dashboard



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



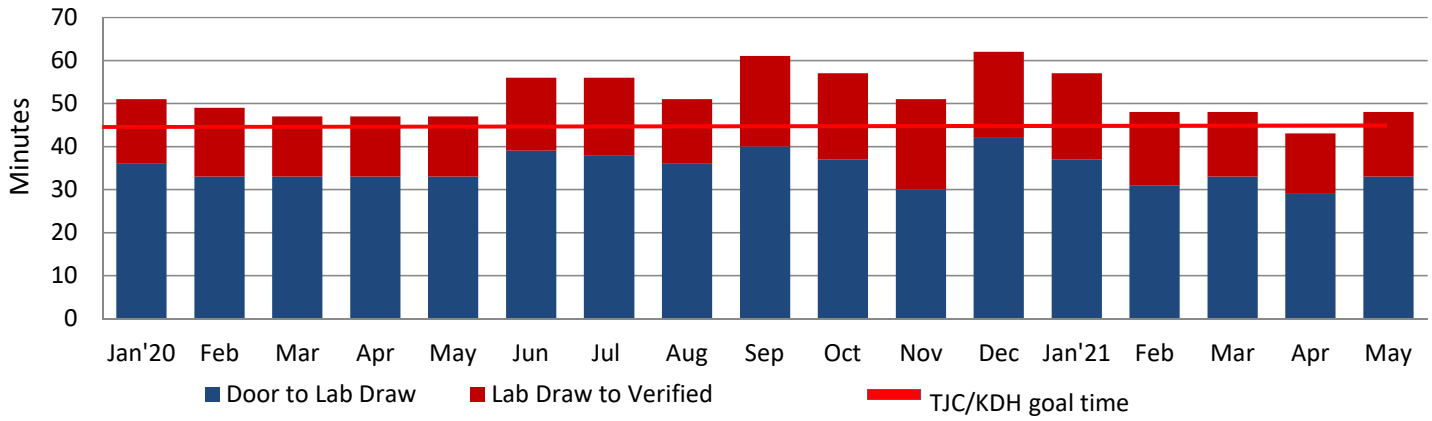
The data in this graph includes all Alteplase patients which differs from the TJC rate because exclusion criteria is not used. TJC expectation is that IV thrombolytics are given within 60 minutes to eligible patients who present for stroke care. AHA/ASA GWTG expectations were update in 2019 with new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



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

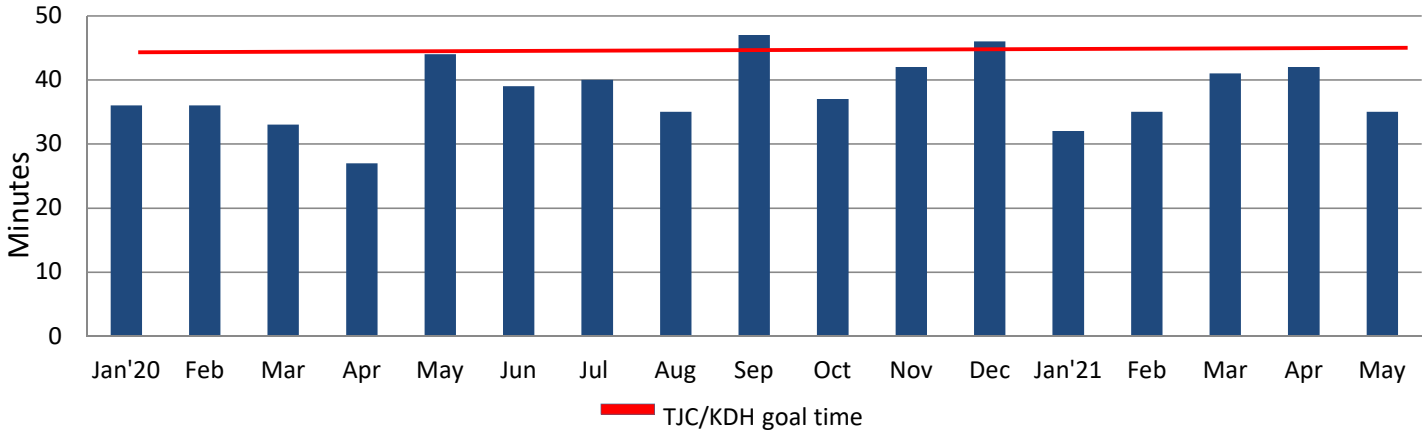
2020-2021 Stroke Alert Dashboard

Door to Lab Time (median times)



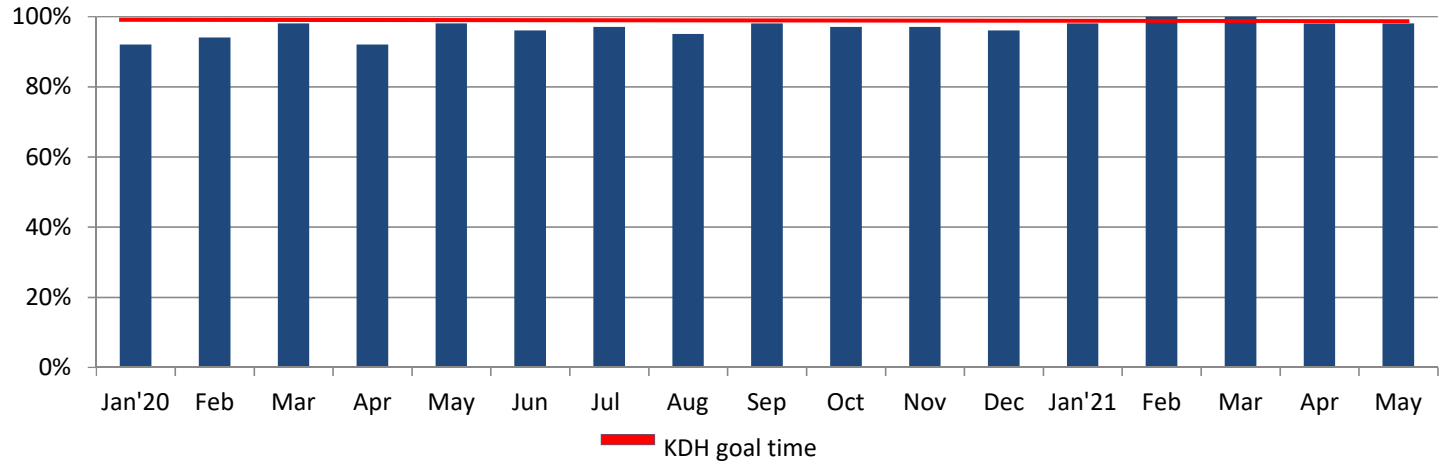
TJC expectation is that laboratory tests are completed within 45 minutes of arrival. Changes in stroke alert process has been made early 2019 to improve lab verified times. Action items taken: IV start kits in CT rooms with lab tubes, lab lable makers in both CT rooms and specimens taken immediately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

Unit/Department: Rehabilitation Services **Pro Staff Report Date:** May 2021

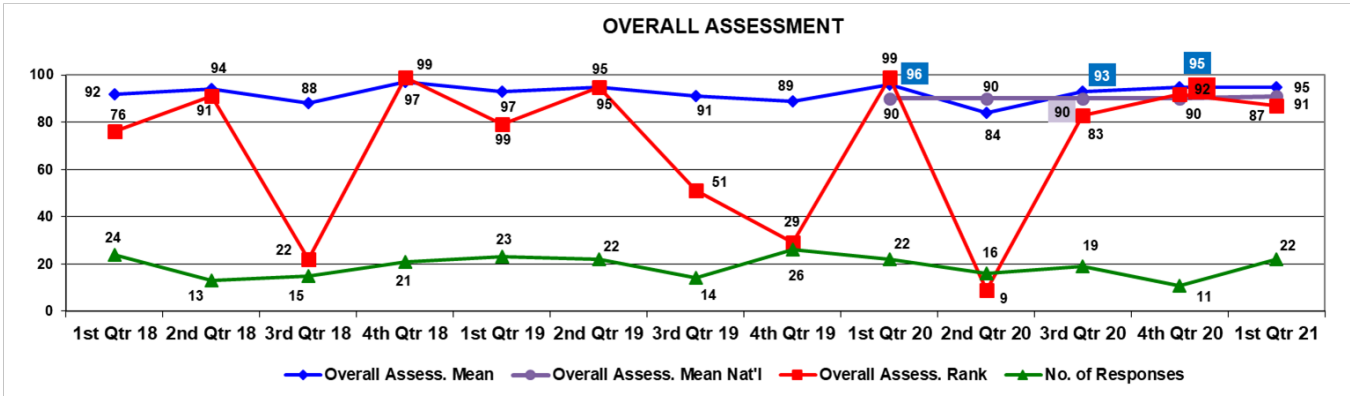
Measure Objective/Goal:

Acute rehabilitation program evaluation, including patient satisfaction, clinical quality including functional outcomes and referral review

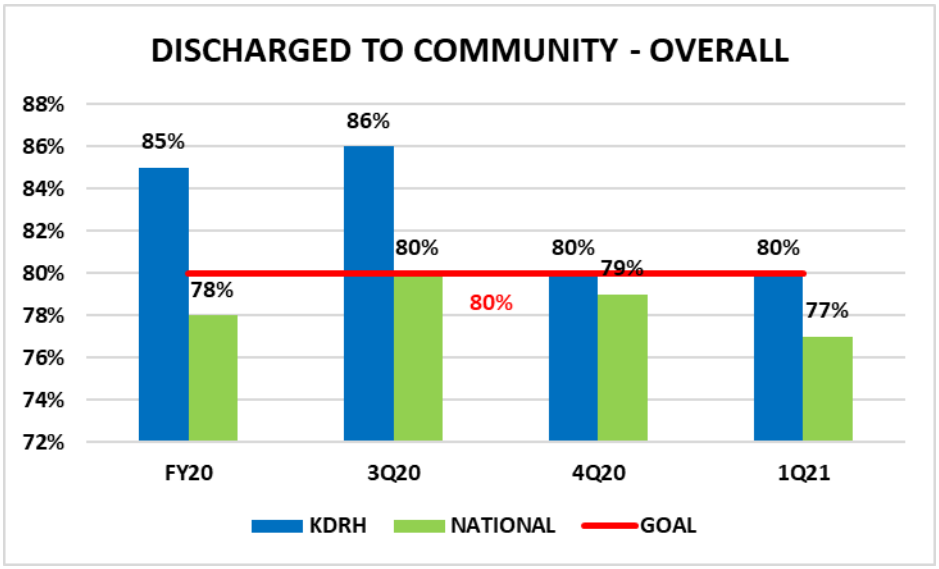
Date range of data evaluated: Rehab quarterly report, 1st quarter of 2021

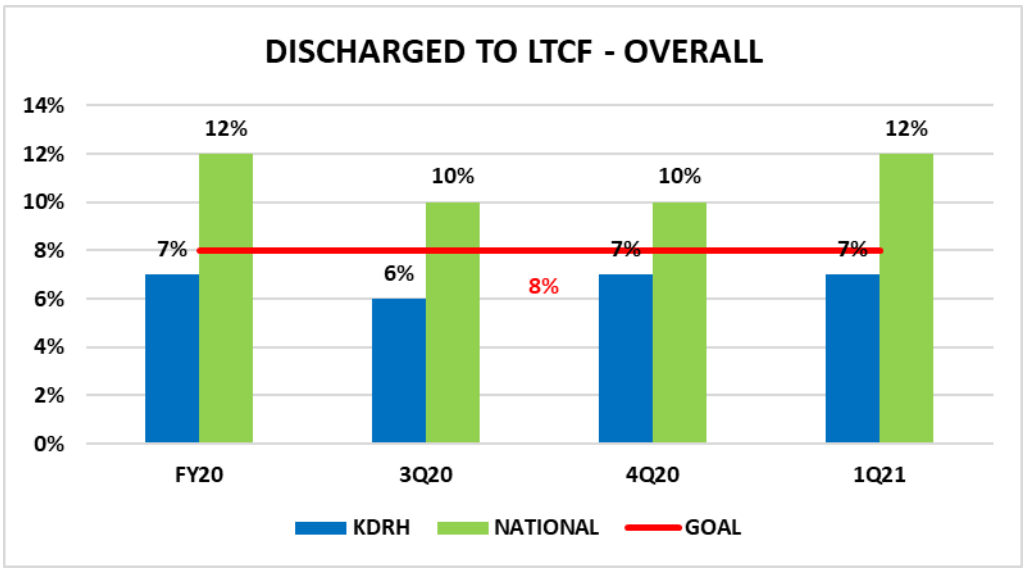
Analysis of all measures/data: (Include key findings, improvements, opportunities)

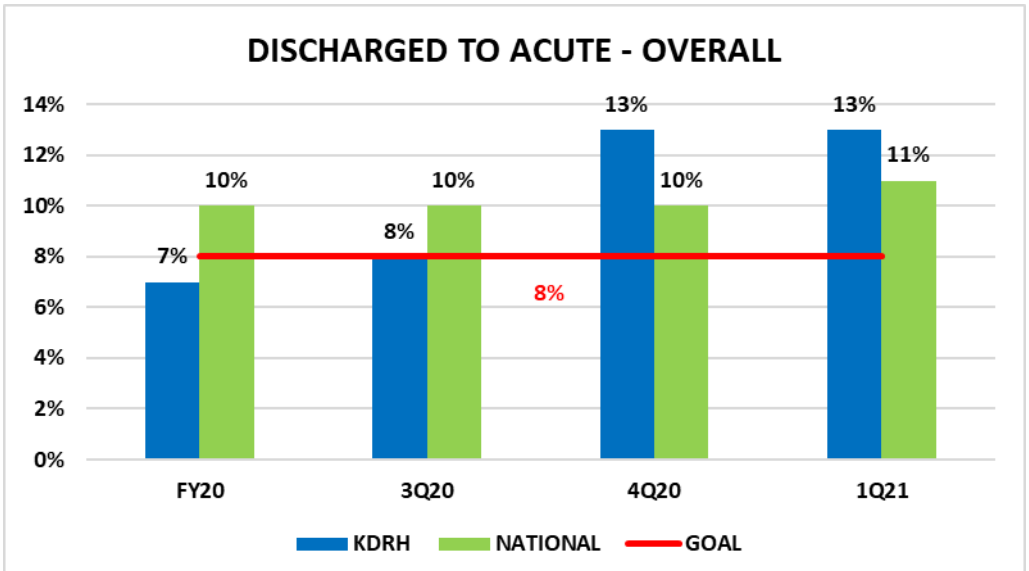
Patient satisfaction: Mean score for the overall assessment of care was 95 in the first quarter of 2021, placing the program in the 91st percentile. Scores have shown a steady positive trend over the past three quarters, after an initial dip in the early stages of the COVID pandemic.



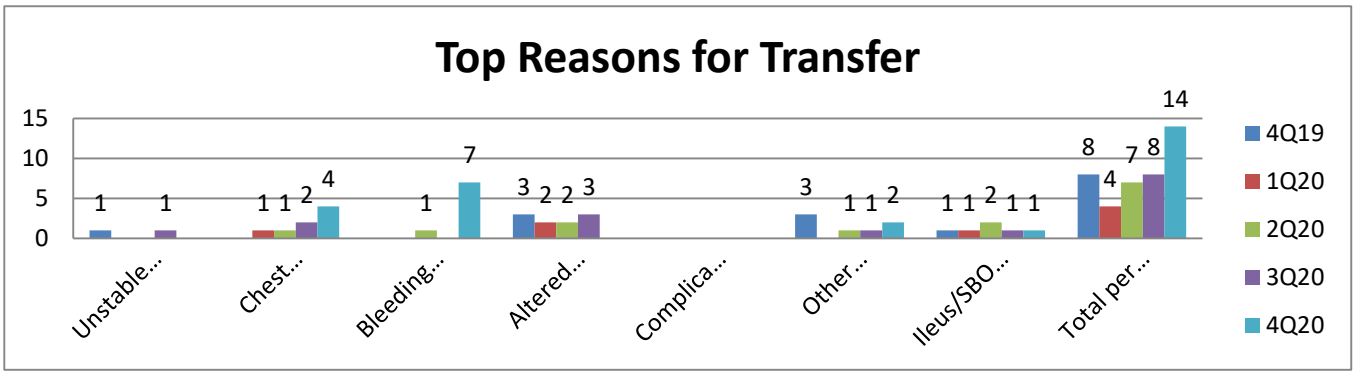
Outcomes: 80% of patients returned to community in the most recent quarter (1st quarter 2021), above national average of 77%. Skilled Nursing Facility discharges were 7% compared to national average of 12%. Acute care discharges were 13%, above the national average of 11%. Overall outcomes remain positive, with a notable increase in acute care transfers over the last two quarters – a reflection of overall higher patient acuity during the COVID pandemic – both patients recovering from COVID in the rehab setting, as well as the acceptance of patients earlier in their recovery from other conditions to alleviate pressures in the medical center during the height of the pandemic.


DISCHARGED TO COMMUNITY - OVERALL
88%
86%
84%
82%
80%
78%
76%
74%
72%
85%
78%
86%
80%
80%
79%
80%
77%
80%
FY20
3Q20
4Q20
1Q21
KDRH
NATIONAL
GOAL


DISCHARGED TO LTCF - OVERALL
14%
12%
10%
8%
6%
4%
2%
0%
7%
12%
6%
10%
7%
10%
7%
12%
8%
FY20
3Q20
4Q20
1Q21
KDRH
NATIONAL
GOAL


DISCHARGED TO ACUTE - OVERALL
14%
12%
10%
8%
6%
4%
2%
0%
7%
10%
8%
10%
13%
10%
13%
11%
8%
FY20
3Q20
4Q20
1Q21
KDRH
NATIONAL
GOAL

Transfer of Care Analysis



- Total transfers to acute were 14 for the 4th quarter of 2020. The implementation of the NIH Stroke Scale on the rehab has facilitated earlier identification and transfer of patients with evolving neurological symptoms. The other significant trend this quarter were transfers due to chest pain/shortness of breath/pneumonia – again indicative of the impact of COVID.

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

Patient satisfaction is maintaining above the 90th percentile, so initiatives in place will continue, including a survey during the patient's stay to help surface issues that can be addressed while the patient is still on site, therapists' use of a goal board to assist in patient engagement in setting and reviewing their goals, and piloting of white noise machines to assist with reducing noise complaints. Clinical outcomes continue to be strong, continue to monitor closely to confirm that recent increases in acute care transfers are reflective of the pandemic.

Measure Objective/Goal:

Nursing indicators relative to NDNQI

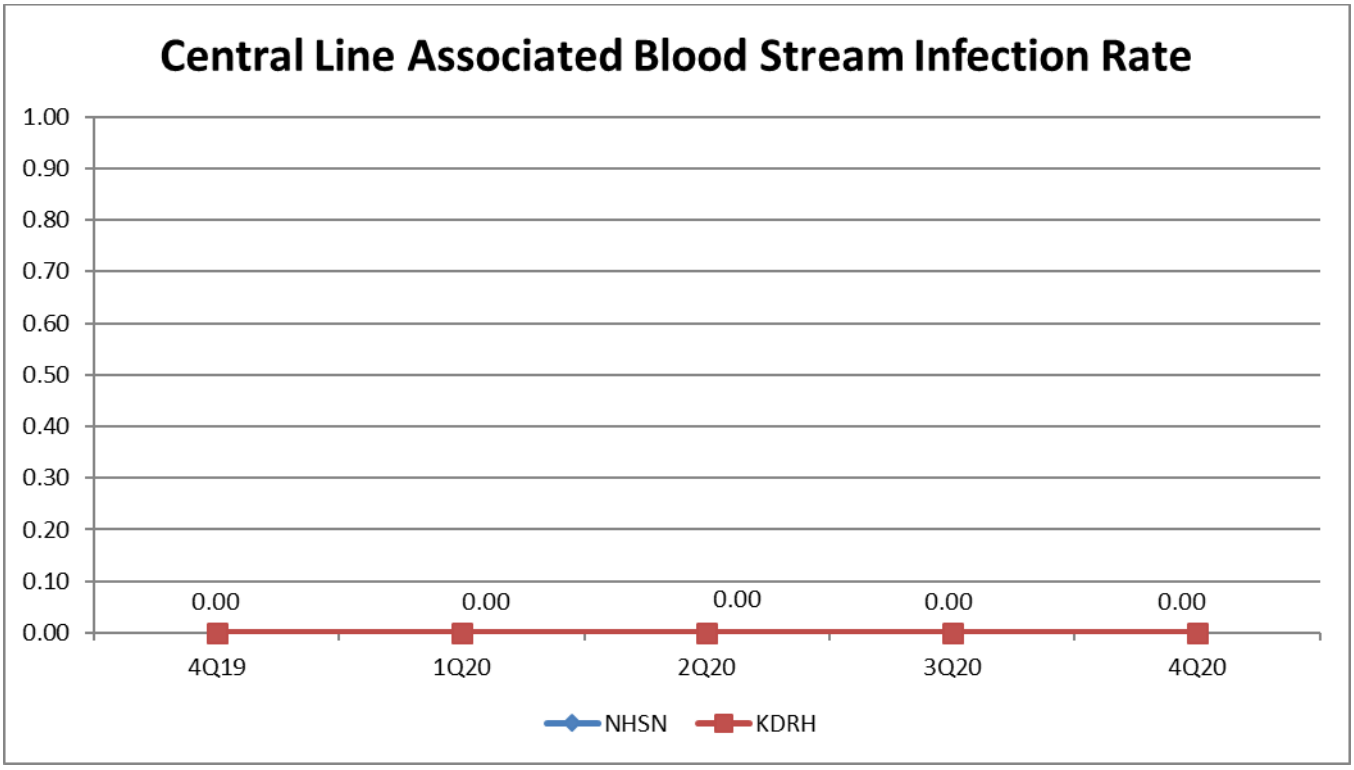
Date range of data evaluated: 4tht quarter 2020

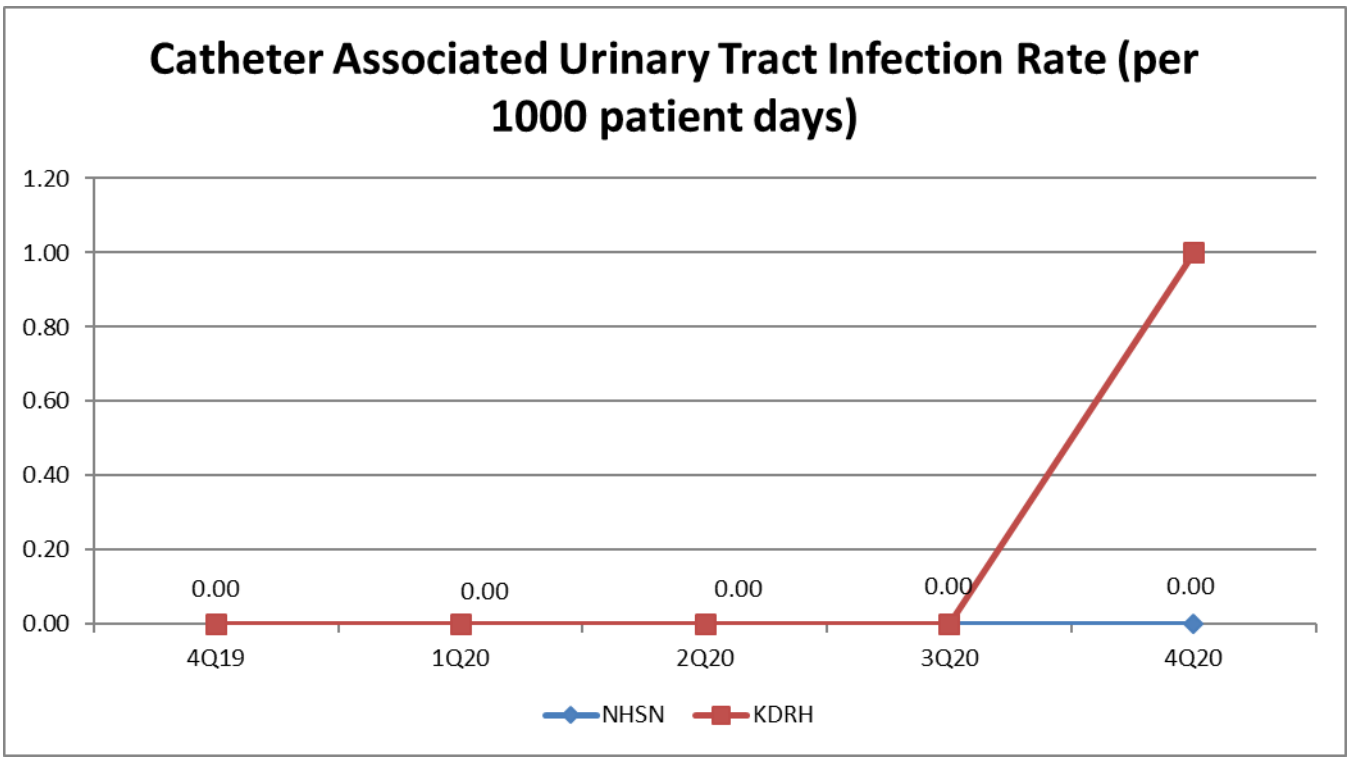
Analysis of all measures/data: (Include key findings, improvements, opportunities)

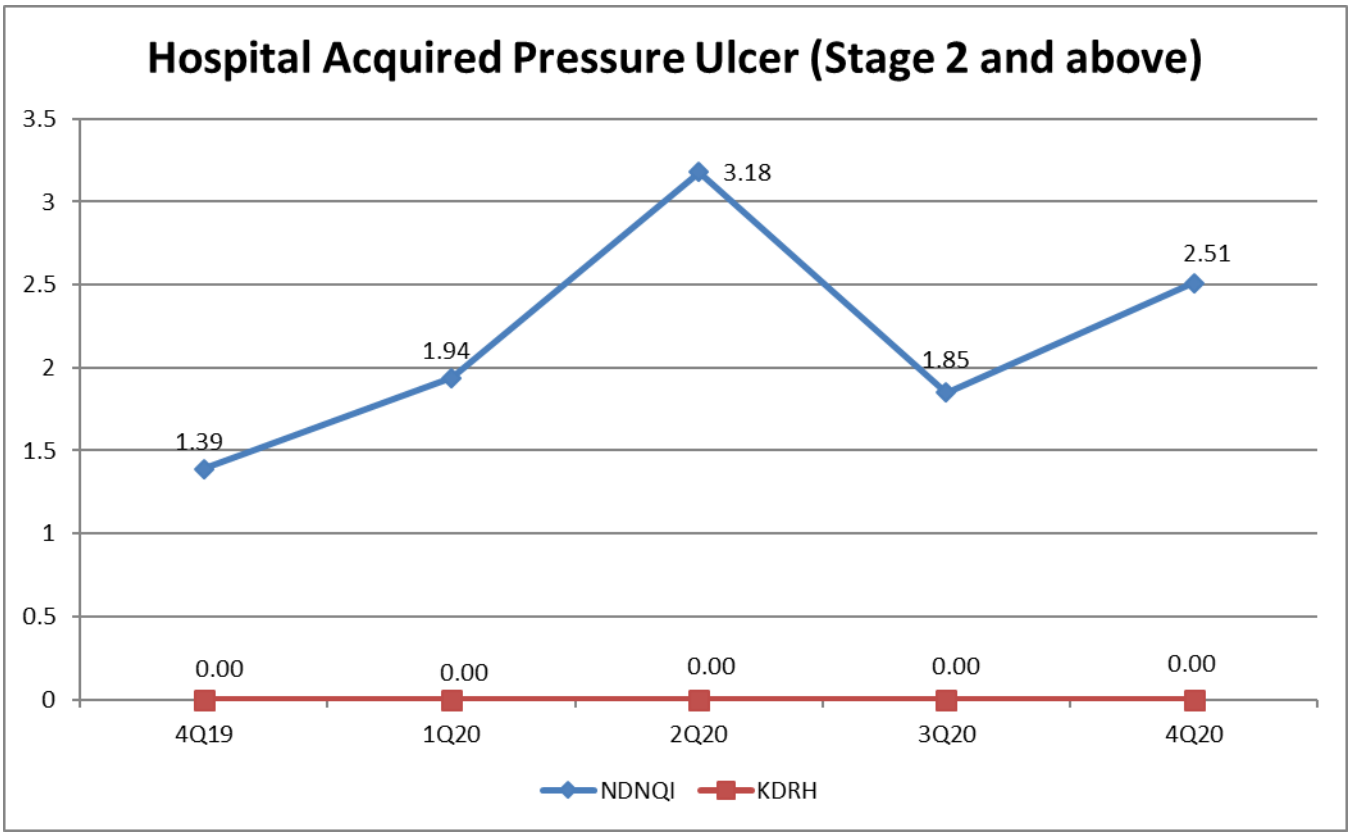
Kaweah Delta Rehab had zero incidence of central line blood stream infections or hospital acquired pressure ulcer stage II or above. There was one CAUTI. Fall rate per 1000 patient days was below NDNQI benchmarks, a total of 6 falls. There were two minor injuries (laceration and abrasion)

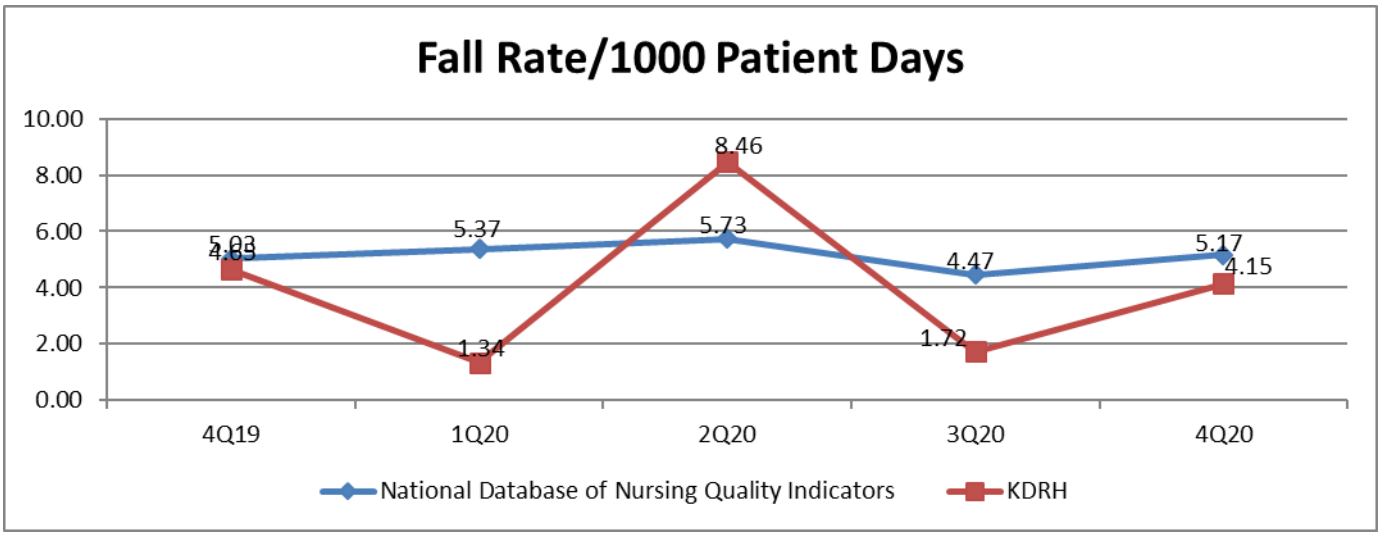
If improvement opportunities identified, provide action plan and expected resolution date:

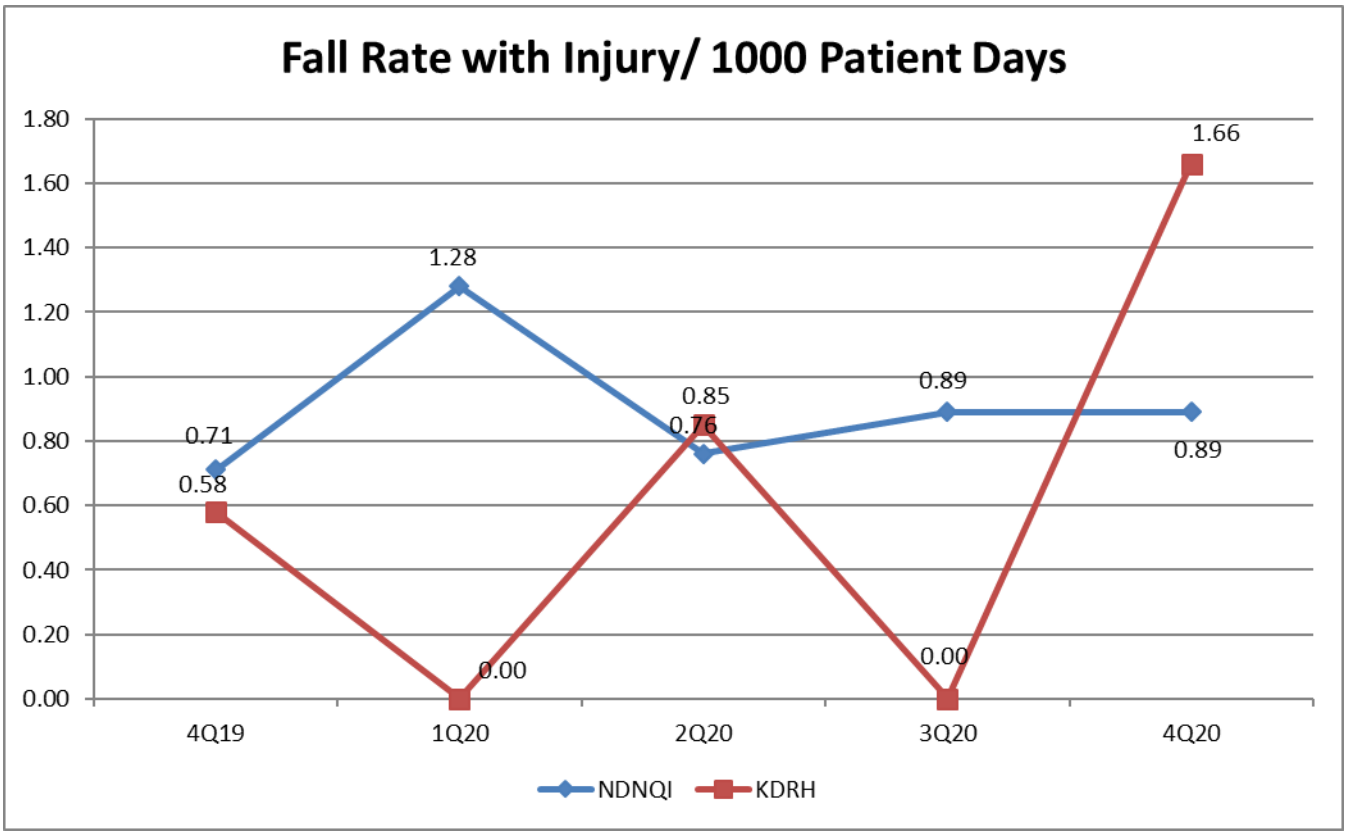
Continue existing initiatives for CAUTI with renewed focus on GEMBA rounds, peri care and bathing. Focus on validation of CNA transfer competency has helped reduce avoidable falls.


Central Line Associated Blood Stream Infection Rate
1.00
0.90
0.80
0.70
0.60
0.50
0.40
0.30
0.20
0.10
0.00
0.00
0.00
0.00
0.00
0.00
4Q19
1Q20
2Q20
3Q20
4Q20
NHSN
KDRH


Catheter Associated Urinary Tract Infection Rate (per 1000 patient days)
1.20
1.00
0.80
0.60
0.40
0.20
0.00
0.00
0.00
0.00
0.00
0.00
4Q19
1Q20
2Q20
3Q20
4Q20
NHSN
KDRH


Hospital Acquired Pressure Ulcer (Stage 2 and above)
3.5
3
2.5
2
1.5
1
0.5
0
1.39
1.94
3.18
1.85
2.51
0.00
0.00
0.00
0.00
0.00
4Q19
1Q20
2Q20
3Q20
4Q20
NDNQI
KDRH


Fall Rate/1000 Patient Days
10.00
8.00
6.00
4.00
2.00
0.00
5.03
5.37
5.73
4.47
5.17
4.83
1.34
8.46
1.72
4.15
4Q19
1Q20
2Q20
3Q20
4Q20
National Database of Nursing Quality Indicators
KDRH

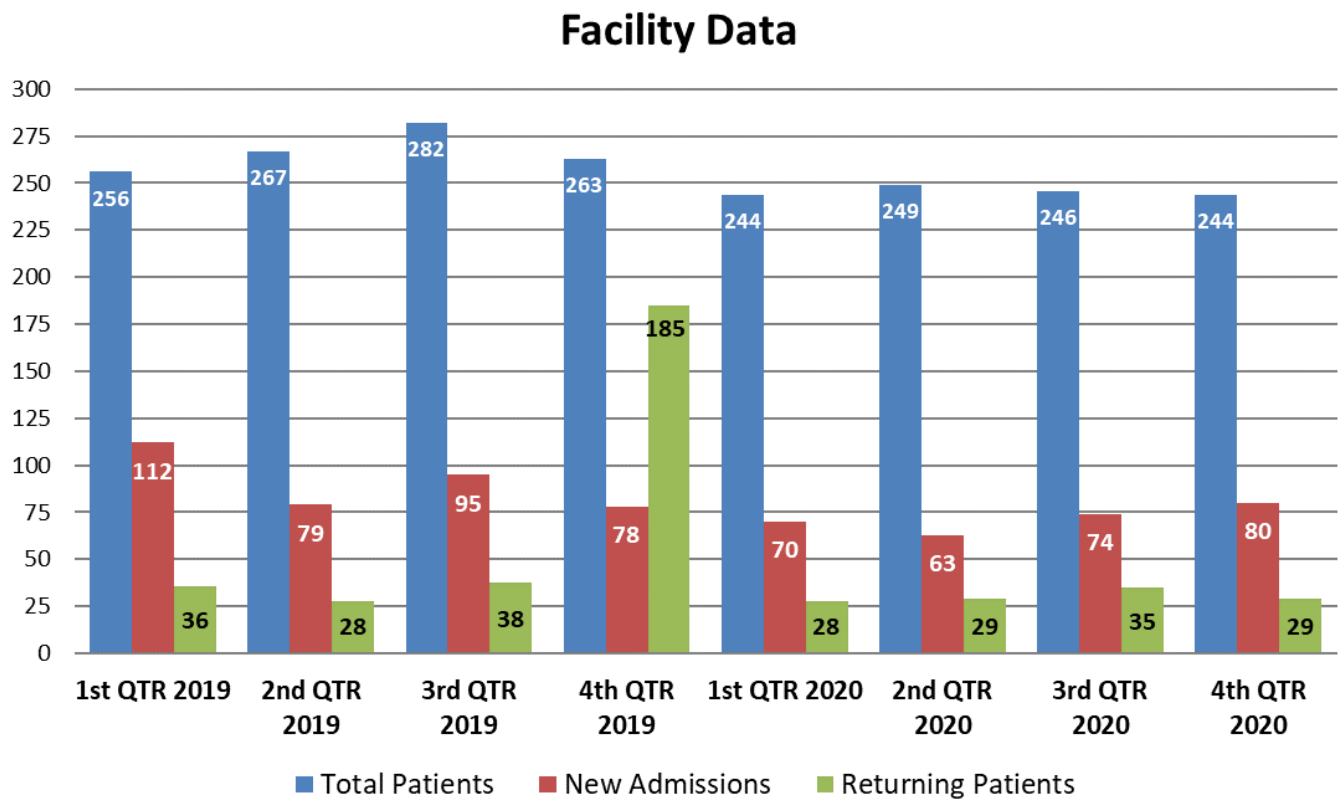


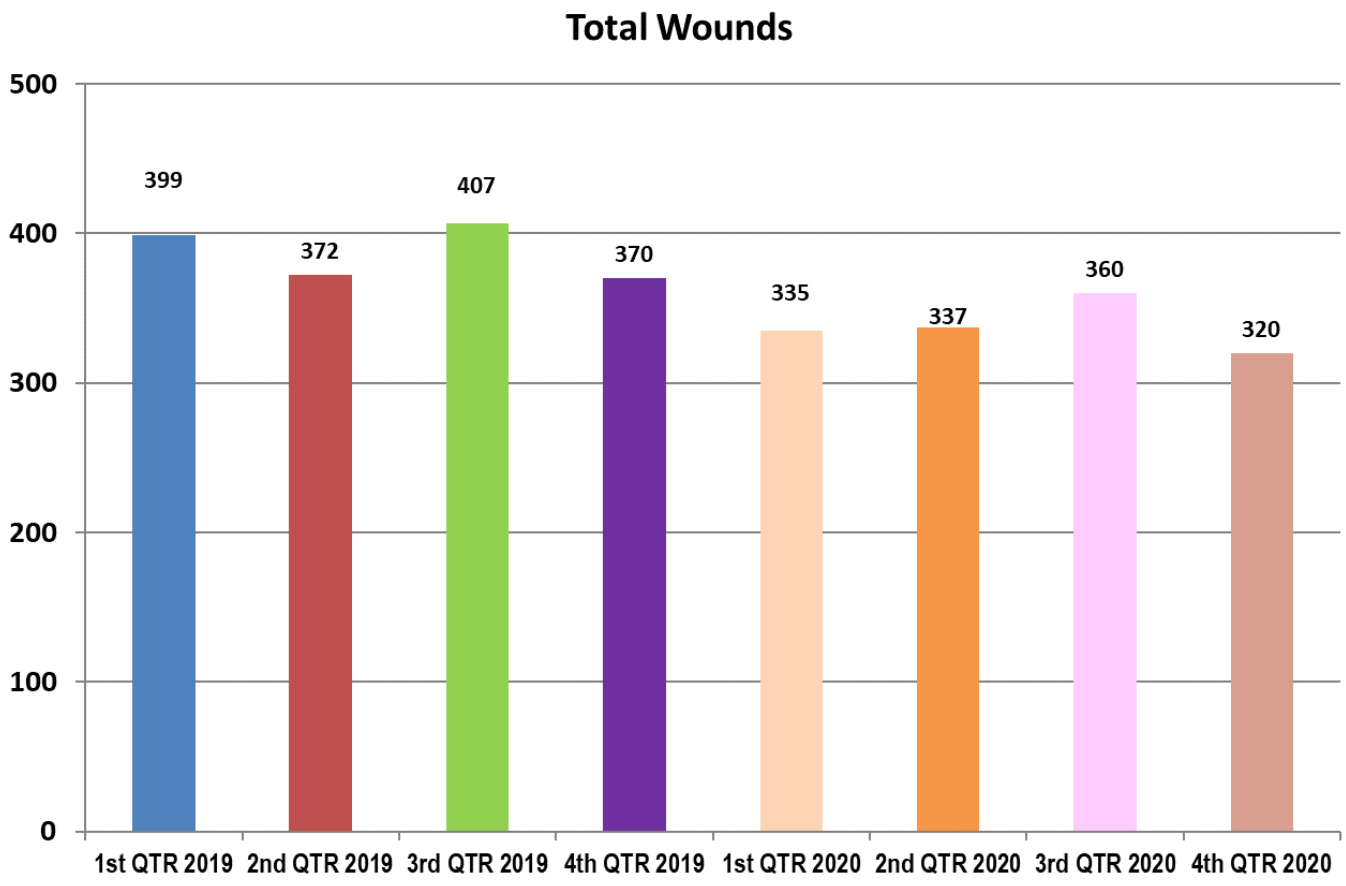
Measure Objective/Goal: Hand Hygiene compliance
Date range of data evaluated: 4th quarter 2020 through 1st quarter 2021
Analysis of all measures/data: (Include key findings, improvements, opportunities)

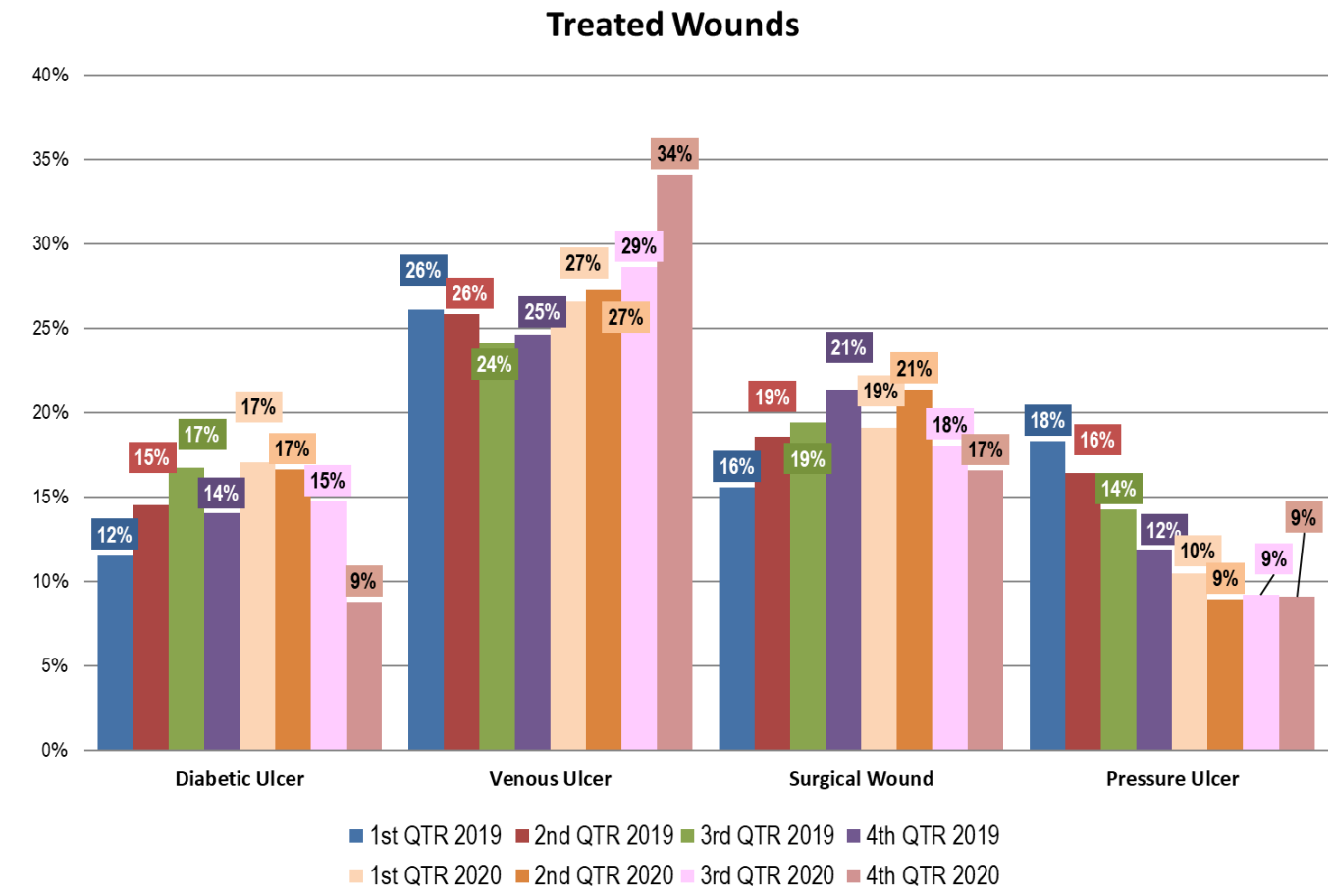
In fourth quarter 2020, 260 of 311 hand hygiene observations were compliant, for an overall compliance rate of 84%, below the target of 90%. Actions taken to improve compliance included a mandatory staff education video focused on the most common types of missed opportunities, as well as installation of additional dispensers to improve compliance. For first quarter 2021, 205 of 221 observations were compliant, for a compliance rate of 93%.

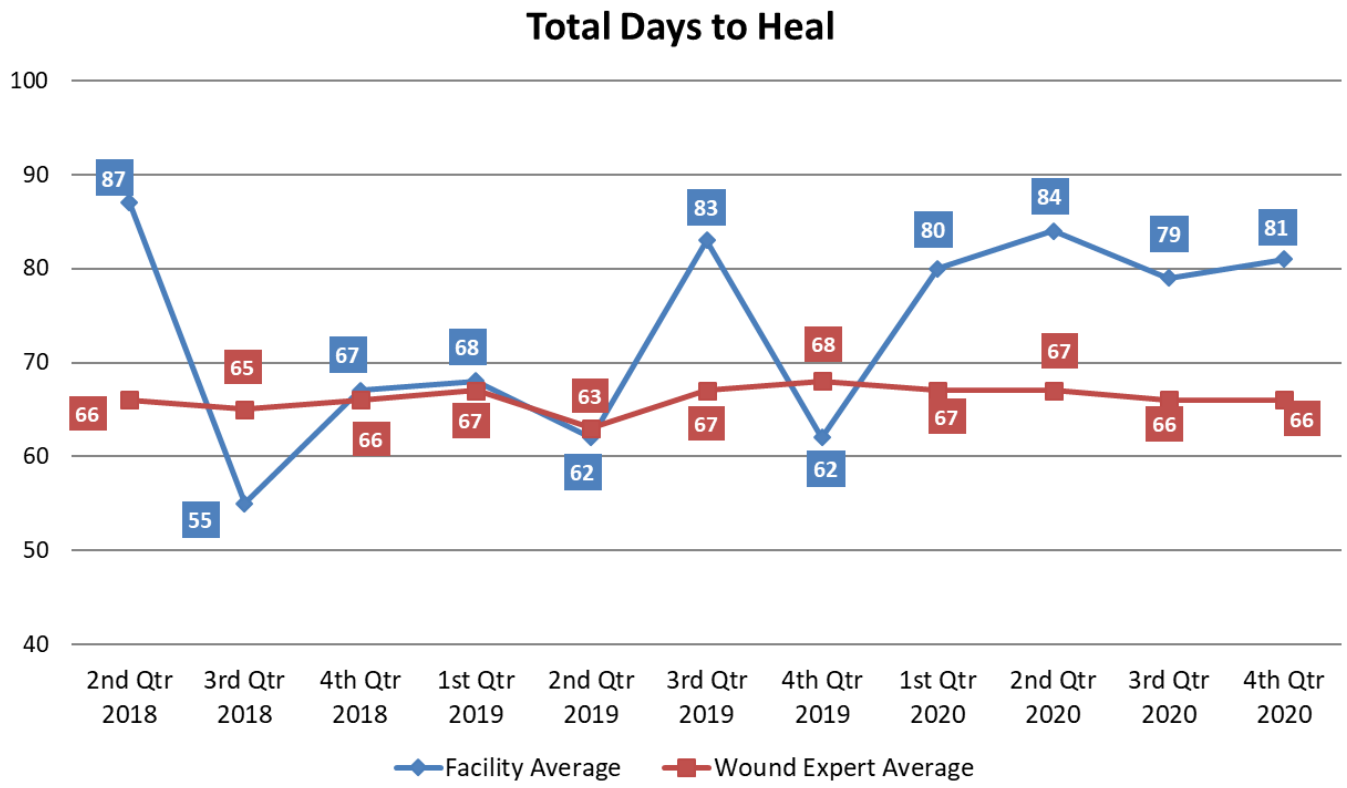
Measure Objective/Goal: Wound Center outcomes
Date range of data evaluated: 4th quarter 2020
Analysis of all measures/data: (Include key findings, improvements, opportunities)
Total number of patients and wounds treated stable with a slight increase in overall visits. Overall types of wounds being treated showed a decrease in diabetic ulcers, increase in venous ulcers and stable for surgical wounds and pressure ulcers.. The percentage of patients who successfully complete treatment dropped and discharges to another facility due to acuity increased. Discharges for not attending treatment increased over the last two quarters. Total days to heal was 81 compared to 66 benchmark in the Wound Expert database. A relatively small number of wounds were included in this quarter's results

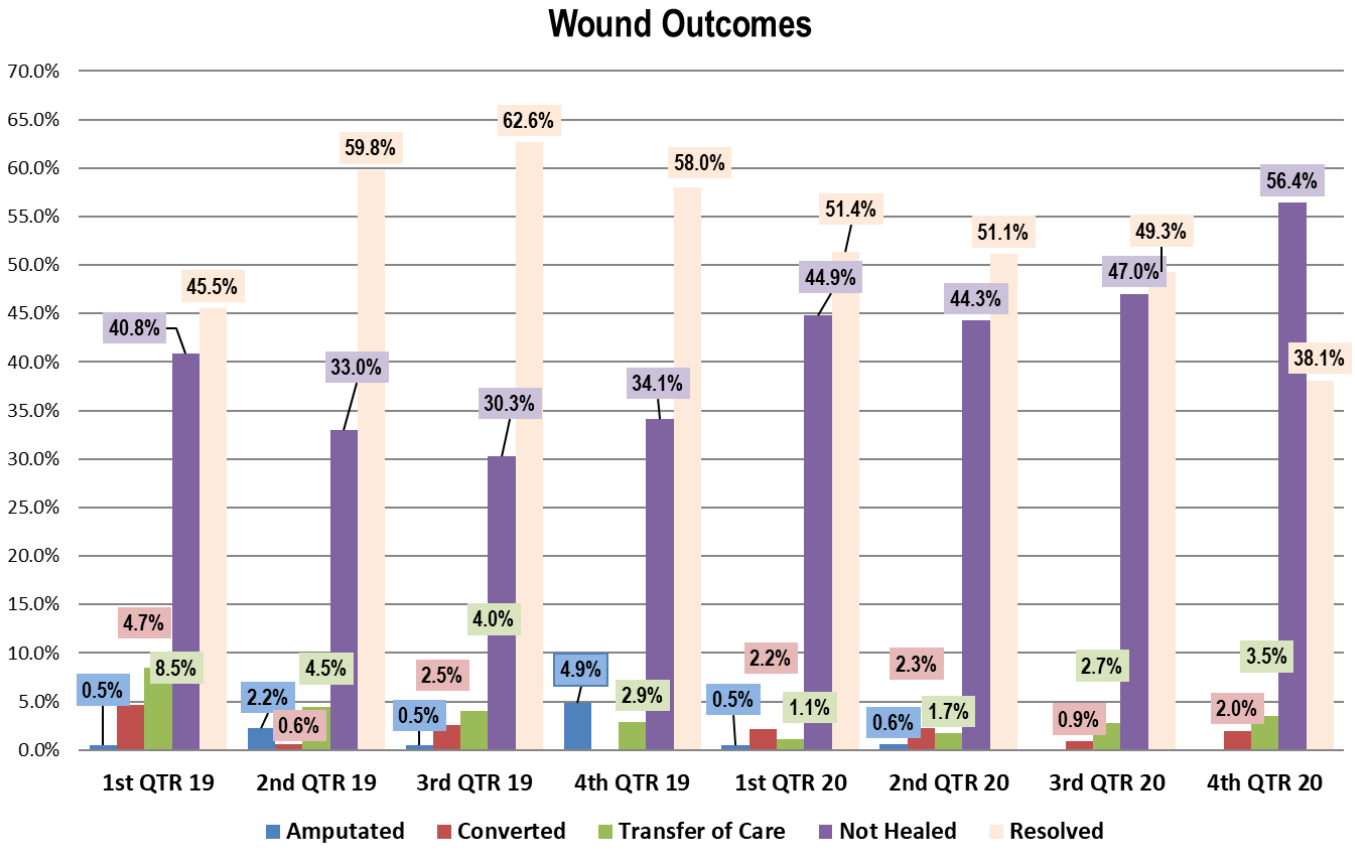
which impacted the overall averages. 6 diabetic ulcers, 50% of them over 100 days. One pressure ulcer resolved, 133 days. Some older surgical wounds resolved this quarter,leading to a significant increase in the average days to heal for that category. Venous ulcers had a significant number resolve, but average days to heal also increased for that group – closer review of those results is planned.

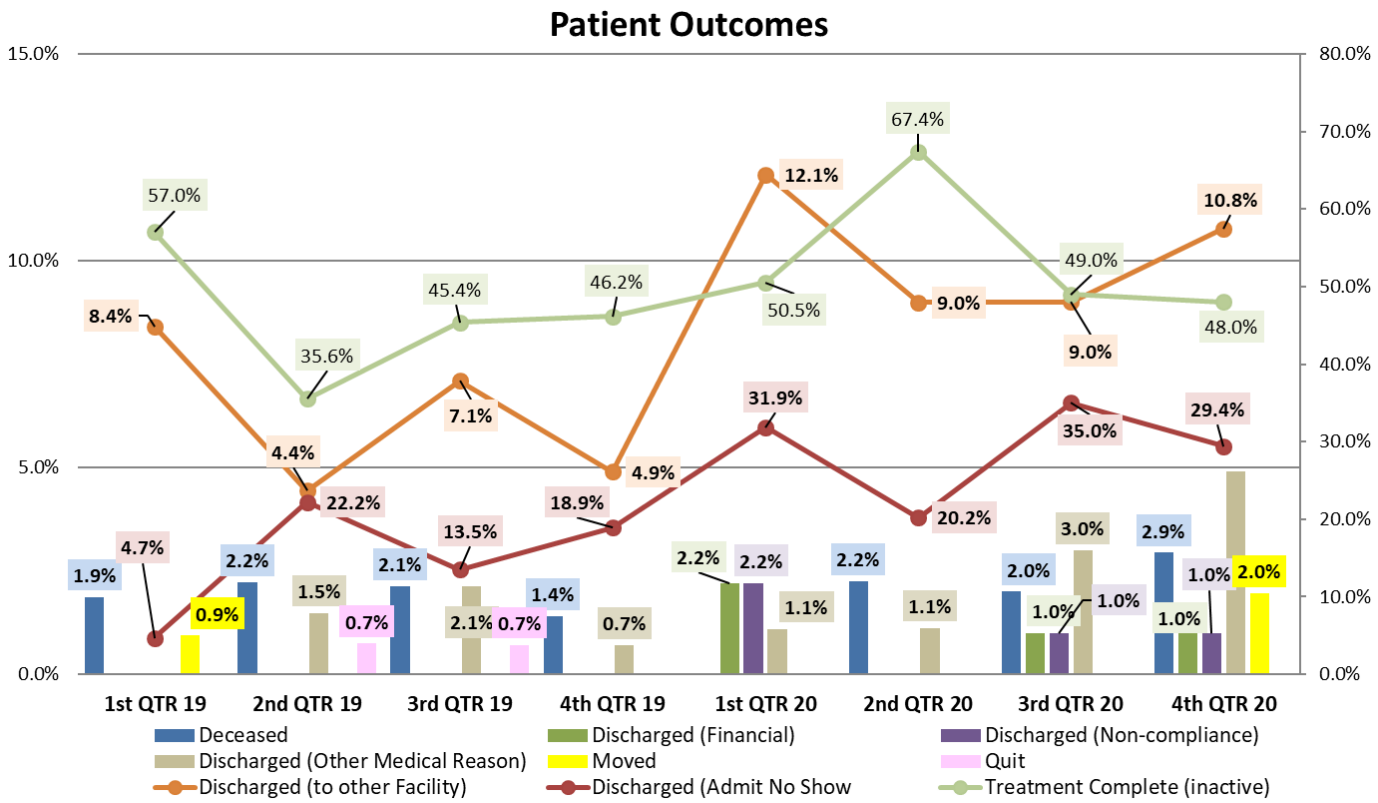



Total Wounds
500
400
300
200
100
0
399
372
407
370
335
337
360
320
1st QTR 2019
2nd QTR 2019
3rd QTR 2019
4th QTR 2019
1st QTR 2020
2nd QTR 2020
3rd QTR 2020
4th QTR 2020


Treated Wounds
40%
35%
30%
25%
20%
15%
10%
5%
0%
12%
15%
17%
14%
17%
17%
15%
9%
26%
26%
24%
25%
27%
27%
29%
34%
16%
19%
19%
21%
19%
21%
18%
17%
18%
16%
14%
12%
10%
9%
9%
9%
Diabetic Ulcer
Venous Ulcer
Surgical Wound
Pressure Ulcer
1st QTR 2019
2nd QTR 2019
3rd QTR 2019
4th QTR 2019
1st QTR 2020
2nd QTR 2020
3rd QTR 2020
4th QTR 2020


Total Days to Heal
100
90
80
70
60
50
40
87
55
67
68
62
83
62
80
84
79
81
66
65
66
67
63
67
68
67
67
66
66
2nd Qtr 2018
3rd Qtr 2018
4th Qtr 2018
1st Qtr 2019
2nd Qtr 2019
3rd Qtr 2019
4th Qtr 2019
1st Qtr 2020
2nd Qtr 2020
3rd Qtr 2020
4th Qtr 2020
Facility Average
Wound Expert Average


Wound Outcomes
70.0%
65.0%
60.0%
55.0%
50.0%
45.0%
40.0%
35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
0.5%
4.7%
8.5%
40.8%
45.5%
2.2%
0.6%
4.5%
33.0%
59.8%
0.5%
2.5%
4.0%
30.3%
62.6%
4.9%
2.9%
34.1%
58.0%
0.5%
2.2%
1.1%
44.9%
51.4%
0.6%
2.3%
1.7%
44.3%
51.1%
0.9%
2.7%
47.0%
49.3%
2.0%
3.5%
56.4%
38.1%
1st QTR 19
2nd QTR 19
3rd QTR 19
4th QTR 19
1st QTR 20
2nd QTR 20
3rd QTR 20
4th QTR 20
Amputated
Converted
Transfer of Care
Not Healed
Resolved



Submitted by Name: Lisa Harrold **Date Submitted:** November 12, 2020

Hand Hygiene Quality Report

June 2021

Hand Hygiene (HH) Dashboard

Measure Description	Benchmark/ Target	1Q21	2Q21	sparklines
OUTCOME MEASURES				
HH Overall Compliance	95%	97.2%	97.4%	
Number of HH Audits Performed	n/a	2,837,294	2,339,083	
HH Compliance - Patient Care Units	95%	97.2%	97.4%	
Number of HH Audits - Patient Care Units	n/a	2,799,635	2,338,376	
PROCESS MEASURES - Patient Care Units				
Hand Hygiene By Day/time				
HH compliance am shift	95%	97.2%	97.3%	
Number of HH Audits am shift	n/a	2,837,716	1,472,839	
HH compliance pm shift	95%	97.2%	97.6%	
Number of HH Audits pm shift	n/a	2,798,983	958,786	
HH compliance weekday	95%	97.2%	97.4%	
Number of HH audits weekday	n/a	1,696,908	1,815,546	
HH compliance weekend	95%	97.1%	97.5%	
Number of HH Audits Weekend	na/	377,443	563,866	

Data Analysis Summary:

Goal: Identify trends over time

- HH compliance rates exceed goal for past 2 quarters
- No trends noted in HH compliance on am/pm shift or weekday/ weekend

Hand Hygiene by Patient Care Unit

Hand Hygiene (HH) Dashboard

Measure Description	Benchmark/ Target	1Q21	2Q21	sparklines
Hand Hygiene By Patient Care Unit Location (*biovgil data)				
2N	95%	97.1%	97.4%	
2S	95%	98.3%	98.7%	
3N	95%	98.4%	98.2%	
3S	95%	97.6%	97.3%	
3W	95%	95.2%	96.4%	
4N	95%	98.7%	98.8%	
4S	95%	97.7%	97.6%	
4T	95%	96.7%	97.4%	
5T	95%	91.9%	92.5%	
BP	95%	98.1%	98.6%	
ICU	95%	95.6%	96.9%	
CVICU	95%	96.7%	95.4%	
ED	95%	98.1%	90.0%	
L&D	95%	97.6%	97.2%	
Mom/Baby	95%	97.5%	97.5%	
NICU	95%	99.6%	96.7%	
Peds	95%	98.2%	97.7%	
ASC/PACU	95%	100.0%	100.0%	
CCU (pre/post cath lab)	95%	99.8%	100.0%	
Mental Health	95%	96.0%	99.0%	
Acute Rehab	95%	93.4%	94.0%	

Data Analysis Summary:

Goal: Identify trends over time

- Some variation noted in hand hygiene compliance trends. 8 patient care units display a downward trend in hand hygiene, 2 patient care units are stable and consistent, and 11 patient care units demonstrate an upward trend in compliance with all but 3 of 21 patient care units exceeding the goal of 95% compliant for 1Q & 2Q 2021.
- Emergency Department and Rehab are the only non-Biovigil areas not meeting goal for 1Q 2021 & 2Q 2021.
- 2Q 2021 presented some challenges for Biovigil (1) transition to new hospital ID card for access to Biovigil badges (2) sensor batteries died earlier than expected
- Transition to new hospital ID card with Biovigil access is over 50% complete and senor batteries have been replaced throughout the downtown campus.

Hand Hygiene (HH) Dashboard

Measure Description	Benchmark/ Target	1Q21	2Q21	sparklines
Hand Hygiene by Role (>10 observations in one quarter, does not inlcude				
Nurse	95%	97.4%	97.6%	
Nurse Number of Audits	95%	1,393,627	1,227,224	
Aides	95%	97.7%	98.1%	
Aides Number of Audits	95%	15,901	15,795	
CNA	95%	96.1%	96.5%	
CNA Number of Audits	95%	682,075	521,211	
other	95%	98.3%	98.4%	
Other Number of Audits	95%	305,940	286,276	
Student	95%	98.6%	98.3%	
Student Number of Audits	95%	65,037	55,422	
Physician & Residents	95%	94.9%	97.8%	
Physician & Residents Number of Audits	95%	11,139	4,125	
EVS\HouseKeeping	95%	95.5%	95.1%	
EVS\Housekeeping Number of Audits	95%	106,185	79,809	
Respiratory	95%	97.9%	98.5%	
Respiratory Number of Audits	95%	87,691	97,921	
LVN/Tech	95%	98.5%	98.0%	
LVN/Tech Number of Audits	95%	91,824	50,593	

Hand Hygiene by Role

Data Analysis Summary:

Goal: Identify trends over time

- Audit volumes decreased from 1Q 2021 to 2Q 2021 partly due to sensor batteries needing replacement earlier than expected and partly due to transition to new hospital ID card with Biovigil access.
- Physician & Resident hand hygiene compliance improved in the 2Q 2021

BioVigil System Validation

- RN Infection Preventionist entered and exited an empty BioVigil monitored room and created HH opportunities and purposefully executed compliant and a non-compliant HH events unknown to the trained HH observer who manually recorded the observations
- All compliant and non-compliant observations recorded manually were verified in the BioVigil system retrospectively. All observations matched.

Manual Observations		
Oct. 19 2N19		
Entry		Exit
14:53:20	Compliant	14:53:33
14:53:53	Compliant	14:54:07
14:54:53	Compliant	14:55:17
14:55:55	Compliant	14:56:45
14:57:06	Compliant	14:58:36
15:01:50	no HH	15:04:26
15:06:06	Compliant	15:06:47
15:06:58	Compliant	15:07:00

BioVigil Observations					
Oct 20 , 2020 2N19					
		entry		exit	
Room 2N19	Elkin, Shawn	2020-10-19 14:52:55	Compliant	2020-10-19 14:53:08	Compliant
Room 2N19	Elkin, Shawn	2020-10-19 14:53:27	Compliant	2020-10-19 14:53:43	Compliant
Room 2N19	Elkin, Shawn	2020-10-19 14:54:23	Compliant	2020-10-19 14:54:43	Compliant
Room 2N19	Elkin, Shawn	2020-10-19 14:55:31	Compliant	2020-10-19 14:56:08	Compliant
Room 2N19	Elkin, Shawn	2020-10-19 14:56:40	Compliant	2020-10-19 14:57:50	Compliant
Room 2N19	Elkin, Shawn	2020-10-19 15:01:24	Non-compliant	2020-10-19 15:02:39	Compliant
Room 2N19	Elkin, Shawn	2020-10-19 15:05:41	Compliant	2020-10-19 15:06:24	Compliant
Room 2N19	Elkin, Shawn	2020-10-19 15:06:30	Compliant	2020-10-19 15:06:37	Compliant

Environmental Services

Hand Hygiene Supply Audits Jan-June 2021

Ensuring HH supplies are available when needed for safe patient care

Audited Items	Jan-Mar 2021 n=150	Apr-June 2021 n=485
Soap dispenser refilled	100%	83.9%
Sanitizer refilled	99.3%	82.3%
Paper towel dispenser refilled	98.0%	98.0%

All observations where performed by leaders and resolved in the moment.

Hand Hygiene

Current Strategies – Hand Hygiene Program

- New hire orientation
  - Instructions on how to perform HH
  - Setting the expectation – Gary Herbst CEO “DUDE” video
  - Hand hygiene competency for new employees
- Quarterly audits and trending of HH supply processes (refill of soap, paper towels, sanitizer) by EVS
- BioVigil electronic HH reminder system in place; manual observations completed in patient care areas where BioVigil is not present
- Hand Hygiene compliance data disseminated to leadership for action; ready to use power points and written materials easily accessible to all staff and leaders for QI work
- Ad Hoc HH Campaigns

  Examples:
  - DUDE VP/CEO videos, contests, Hand Hygiene Safety Champion Award monthly
  - Sanitizer handout (IP week)

Sepsis Quality Focus Team

ProStaff Report – May 2021

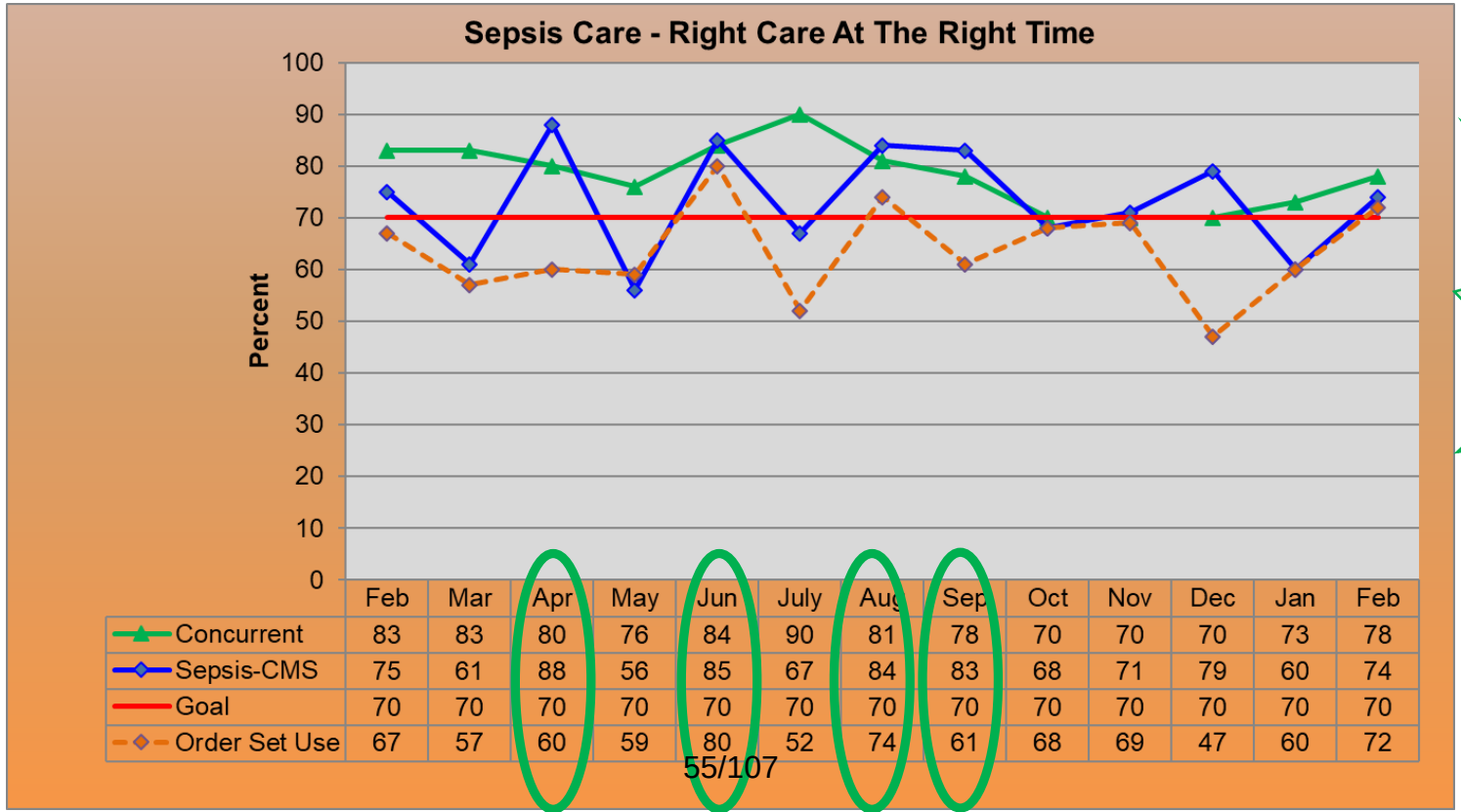
Dr. Tom Gray, Q&PS Medical Director &
Evelyn McEntire, QI Manager

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.

	Dec 20 – Feb 21 (Higher is Better)	FYTD %	FY21 Goal	FY20	Last 6 Months FY20
SEP-1 (% Bundle Compliance)	**71%**	73%	≥ 70%	67%	69%

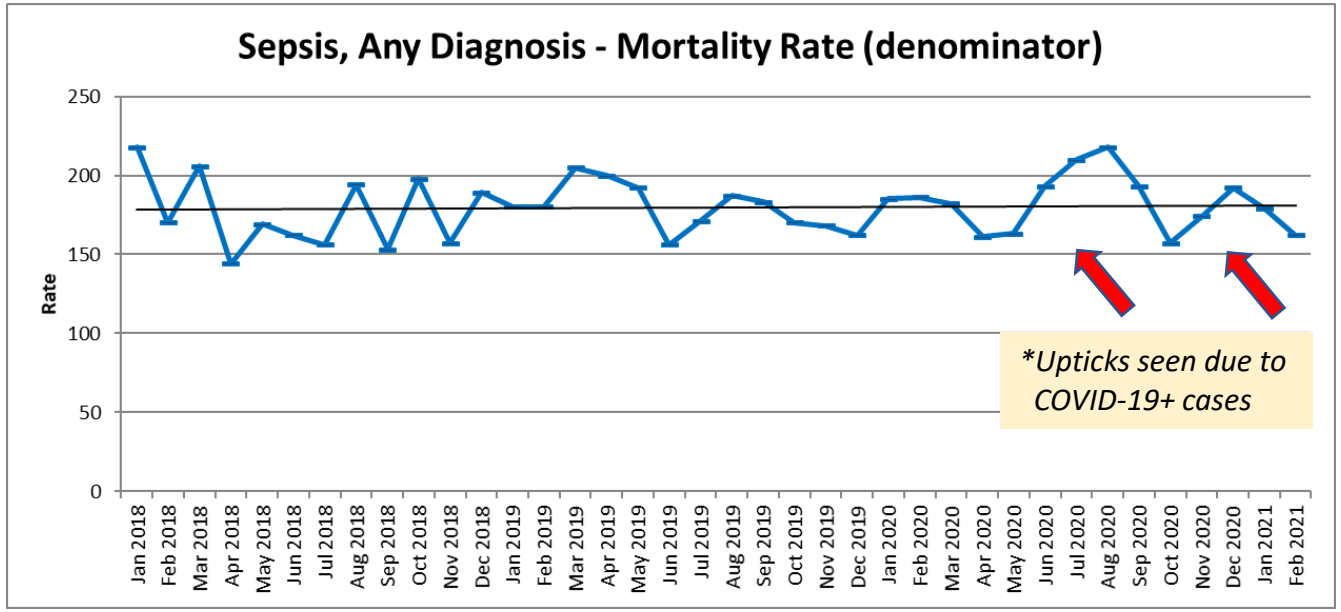


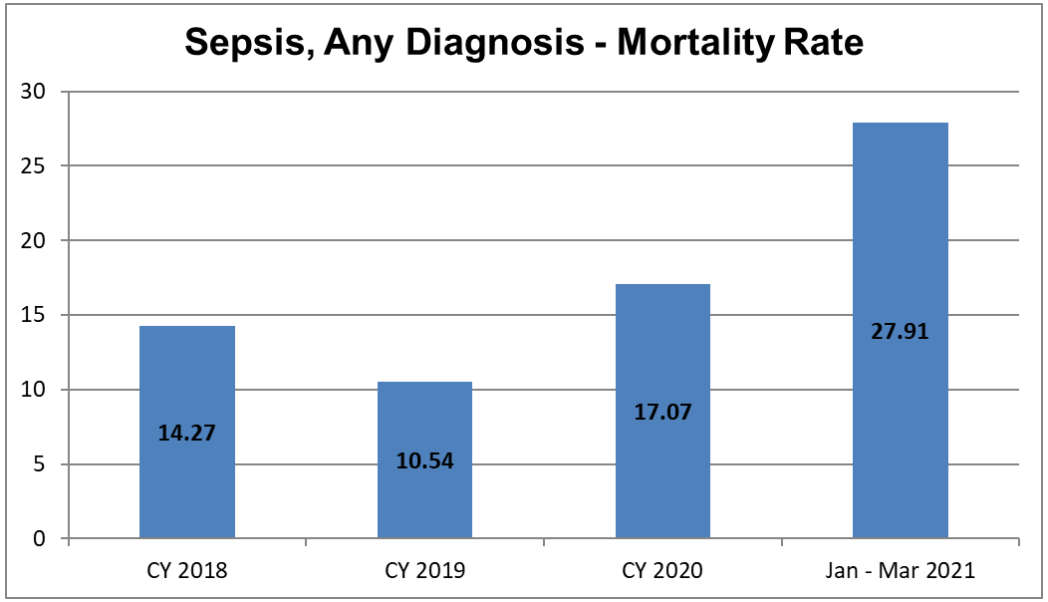
	Feb	Mar	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Concurrent	83	83	80	76	84	90	81	78	70	70	70	73	78
Sepsis-CMS	75	61	88	56	85	67	84	83	68	71	79	60	74
Goal	70	70	70	70	70	70	70	70	70	70	70	70	70
Order Set Use	67	57	60	59	80	52	74	61	68	69	47	60	72

KDMC is in the **TOP DECILE** in the nation for CMS sepsis bundle compliance for multiple months!

Reducing Mortality & Saving Lives

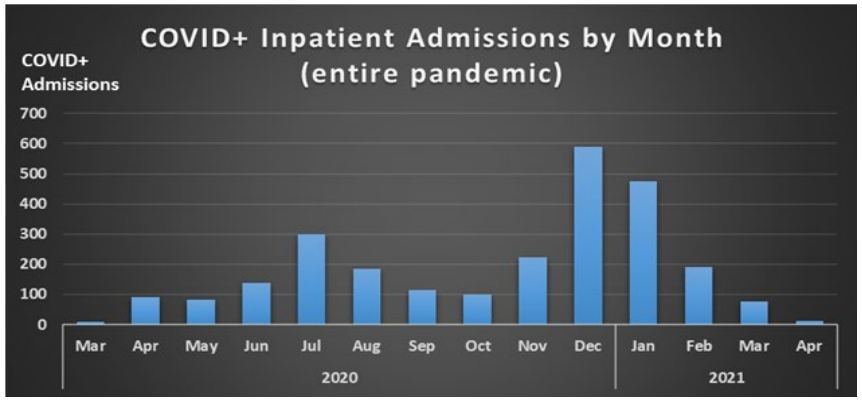
This data *includes* patients with COVID-19+ diagnoses; however, CMS SEP-1 bundle data does not.

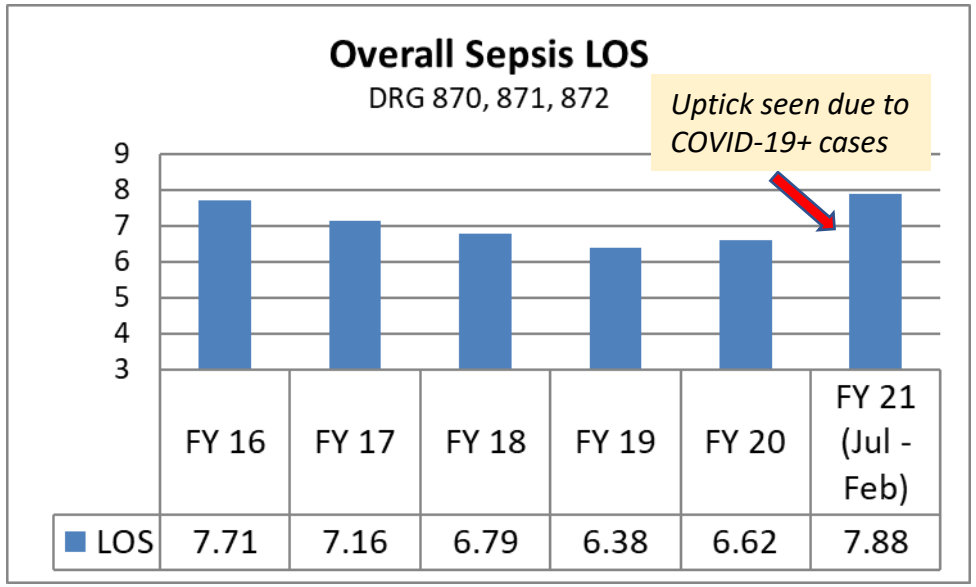


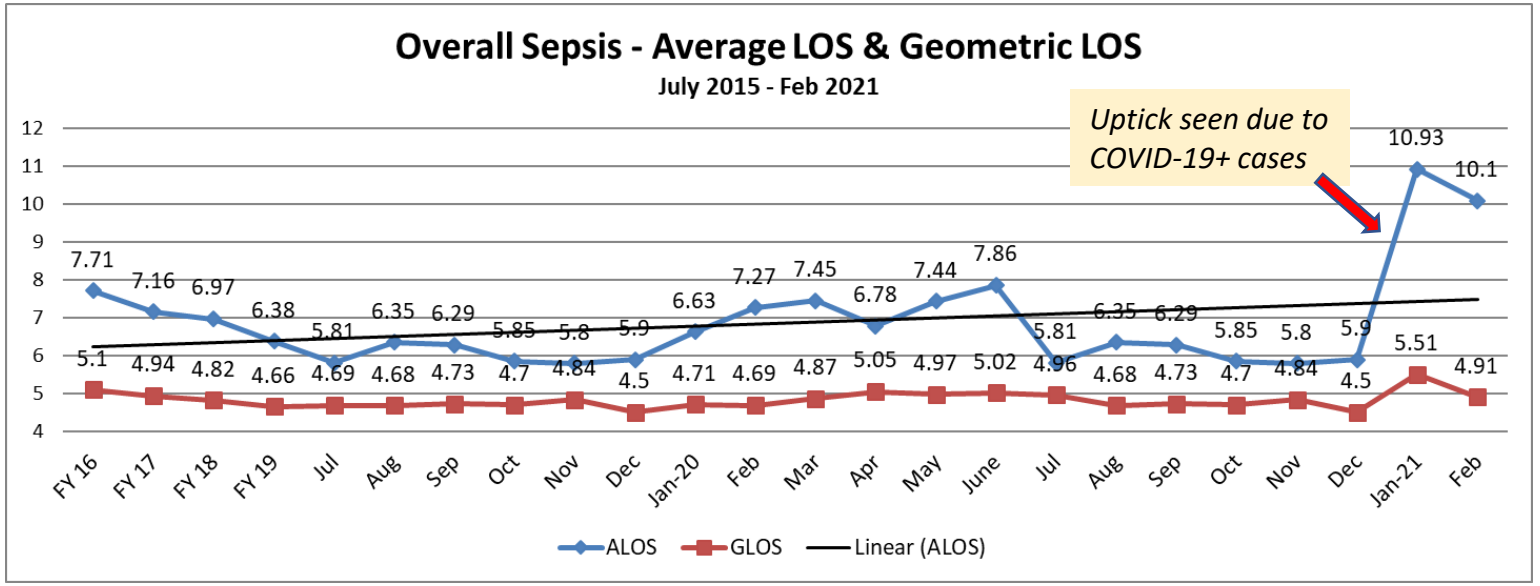


Overall Sepsis Length of Stay (LOS)

This data *includes* patients with COVID-19+ diagnoses; however, CMS SEP-1 bundle data does not.

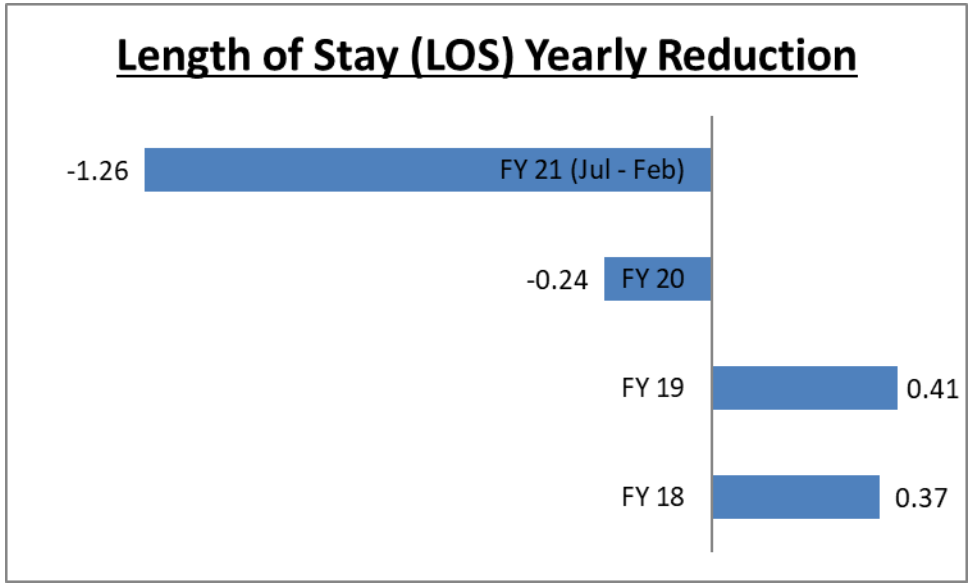


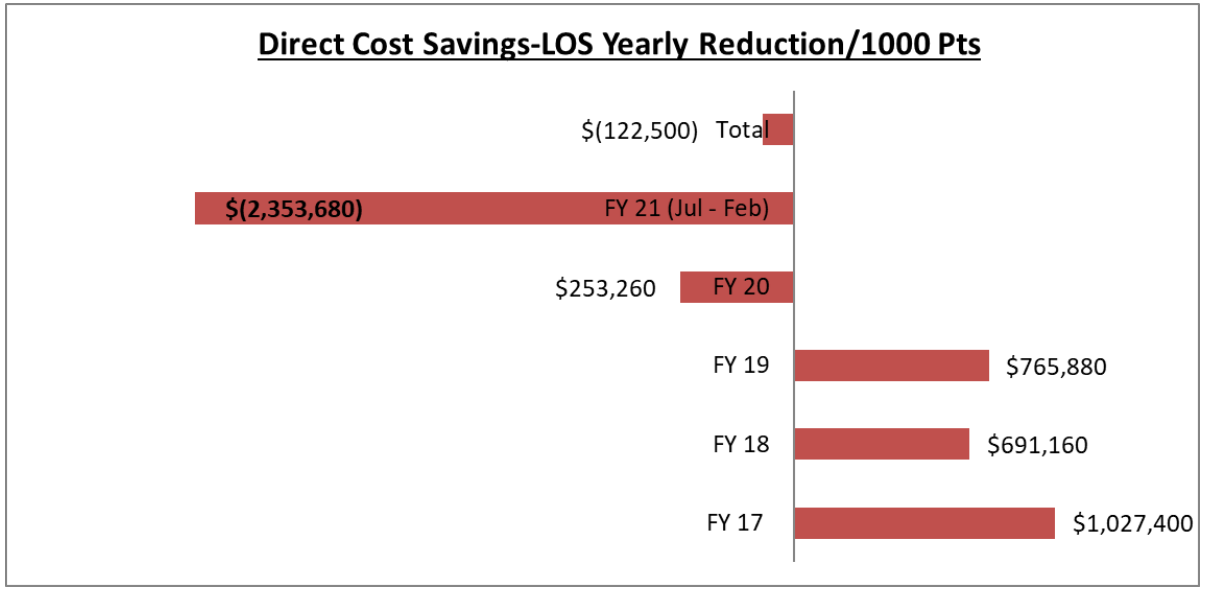




Overall Sepsis LOS Reduction & Savings

*This data includes COVID-19+ cases; however, CMS SEP-1 data does not.

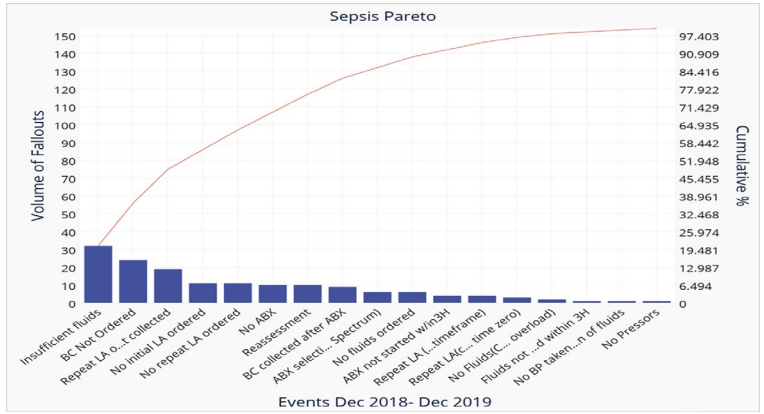




FY20 continued to show a LOS reduction through March; however, we have seen upticks in LOS for septic patients related to COVID-19 infections from April 2020 – February 2021.

2020-21 Sepsis Kaizen Update

80/20 Rule



Top Fallouts

Fall Out	Total	Cumulative Total	%	Cumulative %
Insufficient Fluids	32	32	20.78	20.78
BC Not Ordered	24	56	15.58	36.36
Repeat LA Not Collected	19	75	12.34	48.70
No Initial LA Ordered	11	86	7.14	55.84
No Repeat LA Ordered	11	97	7.14	62.99
No Abx	10	107	6.49	75.47
Reassessment	10	117	6.49	75.47
BC Collected after Abx	9	126	5.84	81.82

Prioritized QI Strategies

ED Pro	2. ED - Build and utilize SEP-1A "Catch Up" order set so all bundle components can be ordered (not "grayed out")	x	4.0	x	5.0	x	5.0	x	5.0	**500.0**
CC/INPT RN	notification"; provide prompts for critical thinking and order set initiation, and title it differently to eliminate confusion	x	2.0	x	4.0	x	4.0	x	5.0	**160.0**
ED Pro &	11. Build dot phrase - If it's not Sepsis, document it	x	4	x	2	x	4	x	5	**160.0**
ED Pro/ ED GME	9. Schedule ED and GME regular education/awareness of bundle, and order set usage	x	2	x	4	x	4	x	4	**128.0**
ED Pro	1. Improve ED provider notification by Sepsis Coordinator when attempting to avoid fallouts concurrently	x	4.0	x	2.0	x	4.0	x	3.5	**112.0**
ED/CC RN	20. Hand off sheet/pathway checklist (concerns about paper lost); can checklist be triggered electronically for RN when order set is used? This way checklist is available electronically, and can be available to print anywhere in patients Sepsis hospitalization course regardless of location. Similar to existing workflow with MRI safety form, belonging forms "ad hoc" forms. Ideally it populate, and reminder to complete.	x	3	x	2	x	4	x	4	**96.0**
CC/INPT RN	7. Mandatory for RN to fill out "provider notification form" after sepsis alert fires – alerts suppressed for 48hrs, so RNs do not receive multiple alerts. THIS IS DEPENDENT ON #6 Investigate what happens if you bypass the alert one time it appears very difficult to get it back – further education/awareness of where to find alert.	x	4.5	x	3.0	x	2.0	x	3.0	**81.0**
CC/INPT RN	10. (Q&P/S) obtain safety summit compliance rates to validate if new staff are getting instructions upon hire of requirements	x	4	x	3	x	2	x	3	**72.0**
ED Pro	16. Reflex alert, when Abx ordered (specific list of Abx) provider gets alert "do you want BC"	x	4	x	4	x	4	x	1	**64.0**
ED/CC/ HOS pro	15. > 126ml/hr option added to ED AND INPATIENT ADULT SEPSIS order sets	x	4	x	3	x	2	x	2	**48.0**
ED RN	with ED and Lab and ISS/Bridge to determine if there is a process where the actual time the labs were drawn (via generic label) can be used when "real" label is printed after provider order is obtained	x	1	x	2	x	5	x	4	**40.0**
CC/INPT RN	5. Evaluate workflow in Cerner r/t sepsis alerts & notification (long term) (Sepsis Q&P/S team). Potentially alerts can fire to cell phones.	x	1.0	x	2.0	x	4.0	x	4.0	**32.0**
ED/CC/ HOS Pro	19. Add to ED AND INPATIENT order set Reflex LA order when previous LA >2	x	2	x	4	x	4	x	1	**32.0**
CC/HOS Pro	3. Admit to CC/3W Orders: Short list of orders... if this not done... for each piece of bundle, this is like a continuation of initial sepsis orders or active "hold" orders to keep the ball rolling.	x	1.5	x	4.0	x	1.0	x	3.5	**21.0**
ED/CC/ HOS Pro	17. Dot phrase for when Abx are urgent and BC cannot be drawn beforehand, so provider documentation is in EMR (..sepsisbc)	x	4	x	3	x	1	x	1	**12.0**
CC/INPT RN	8. Evaluate what clin Ed provides to new RNs about sepsis alerts and how to respond? Ideally hands on training upon hire, look at alerted patient and walk through documentation.	x	1	x	4	x	2	x	1	**8.0**
CC/HOS Pro	22. Standardized documentation of attending reassessment (Dr. Malli's phrase)	x	3	x	2	x	1	x	1	**6.0**
ED RN	13. ED Techs input height and weight in EMR; RN input for BIBA patients HOLD dependent on #14	x	2	x	1	x	1	x	1	**2.0**
ED RN	14. IBW automated in fluid order when height and weight are documented	x	2	x	1	x	1	x	1	**2.0**
CC/INPT RN	4. Evaluate criteria of firing an alert (Q&P/S	x	1.0	x	1.0	x	1.0	x	1.0	**1.0**

- ✓ Over 20 QI strategies identified
  - Ten (10) strategies have been completed and implemented
  - Five (5) strategies are in development and nearing completion – **NO LONGER ON HOLD due to COVID-19 surge**
    - Mandatory RN Education - Annual (New Hire RN Education was implemented 3/29/21!)
    - Provider Notification Form – Currently revising with Clinical Leaders and ISS
    - Antibiotic reflex alert – 'Do you want blood cultures?'
  - Five (5) strategies in parking lot
- ✓ **CMS compliance is in the top decile multiple months in 2020!**

2020-21 Sepsis Summary & Actions

Summary

Concurrent SEP-1 CMS compliance remains at or above goal in each of the last 12 months and ***above top decile in the nation*** in 4 of the last 12 months! Sepsis Coordinator involvement continues to be a driving force for perfect and timely care of our sepsis patients.

Successes as a result of Kaizen work:

- Improved CMS bundle compliance leading to top decile performance in the nation
- Improved provider documentation and use of sepsis order sets
- Improved sepsis 3-hour bundle compliance (lactate management, blood culture orders, antibiotic administration)
- Improved sepsis 6-hour bundle compliance (repeat lactic acid lab, fluid resuscitation, and reassessment by provider)

Actions

Continued work by Kaizen group *(**PROGRESS HAS BEEN REINSTATED** following the impacts of the COVID-19 surge):*

- Increased use of sepsis order sets
- Administer IV fluid resuscitation within expected timeframe
- Ongoing sepsis education to nursing, providers, and GME residents
- Nursing documentation – Mandatory Provider Notification form *to be completed following COVID-19 surge*
- Antibiotic reflex order currently on hold until COVID vaccine distribution and tracking build is complete

SEP-1 Measure Change (effective January 1, 2021)

NEW EXCLUSION: Hypotensive readings (SBP < 90 and MAP < 65) obtained during dialysis procedures will no longer be used to define initial hypotension, persistent hypotension, or septic shock

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

Unit/Department: CAUTI QFT **ProStaff/QIC Report Date:** 4/13/2021

Measure Objective/Goal:

- Goal for FY21 ≤ 0.727 (CMS 50th percentile); Current SIR = 0.84
- Pre KAIZEN baseline SIR is 1.557
- Estimated annual number not to exceed to achieve goal= 13. Current actual number of CAUTI = 9

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 (7/2020 – 2/2021)

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	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
OUTCOME MEASURES													
Number of CAUTI	0	0	1	3	1	3	0	1	1	1	2	0	
FYTD SIR	≤ 0.727							0.78			1.04		
PROCESS MEASURES IUC Gemba Rounds													
% of pts with appropriate cleanliness	99%	98%	99%	98%	95%	97%	96%	98%		98%	99%	99%	98%
% of IUCs with order & valid rationale	100%	90%	93%	92%	93%	92%	92%	93%		94%	95%	93%	94%
% of IUCs where removal was attempted	n/a	8%	5%	6%	7%	0%	9%	9%		6%	2%	3%	7%
% of pts where alternatives have been attempted	n/a	15%	12%	12%	10%	8%	14%	12%		12%	6%	9%	10%
# of Pt Catheter days rounded on	n/a	616	720	948	877	1037	1098	1145		1047	1046	900*	931*
% of IUCs removed because of Gemba Round	n/a	7%	6%	3%	4%	2%	4%	6%		6%	4%	6%	6%
# of IUCs removed because of Gemba Round	n/a	46	42	33	35	22	46	74		64	40	50	52
*volume reduced due to reduced Gemba on weekends					Better than Target			Jan-Jul: Within 10% of Target As of Aug: Within 5% of Target			Does not meet Target		

FY 20 Total Catheter Days rounded on = 7204

94% with order and valid rationale

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

348 catheters removed as a result of the Gemba

Opportunities:

- Appropriate indications for IUC, using alternatives to IUC
- Continued order optimization for ease of use
- Learning from Fallouts

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

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

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

CAUTI QI Strategy	Status
1. Embed IUC insert power plan in existing Powerplans where the insert IUC order exists GOAL – Improve IUC order appropriateness and bundle compliance with increased use of Powerplan which contains needed IUC maintenance elements	On track to compete by May 2021
2. Place all IUC order resources on eCoach GOAL- Increase IUC appropriateness/ prompt removal, bundle compliance (improving ease of access for providers and nursing staff)	Begin Jan 2021
3. 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
4. Create change IUC task at 30 days following documented insertion GOAL- trigger nursing staff to change chronically retained IUC	12/23/20
5. 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
6. 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
7. Powerchart changes- IUC dynamic group for POA include on arrival from OR/ED, other GOAL- capture device list for lines already in place	Pending Cerner action
8. Add 3-way catheter as trigger to device list GOAL- accurate collection of device count	Pending Cerner action
9. Create alert when patient has IUC in place and documented loose stools GOAL- inspire intervention to prevent risk of CAUTI with loose stool and IUC	Continue to test and tweak
10. CAUTI Case Reviews Lessons Learned GOAL – Reduce CAUTI by ensuring identified opportunities are addressed globally	Occurs monthly at QFT
11. Evaluate reasons for IUC insertion orders GOAL – Reduce IUC utilization/appropriate indications for IUC	Partial completion 3/22/21, on-going data analysis and action
12. Safety Summit (CAUTI education for new hires) relaunch post-COVID GOAL – Improve/sustain RN bundle compliance	3/22/21
13. Rapid Cycle Post Gemba Rounds GOAL – reduce IUC utilization, verify completion of follow up	On-going
14. Handoff Gemba evaluation	Go live 1/27/21 pending outcome evaluation
15. Bladder training order and education	In development
16. Bathing Prioritization (in collaboration with CLABSI Committee) GOAL – Improve bathing/peri-care of IUC patients	10/2020
17. Add 'restricted use' to the urine culture only orderable GOAL- reduce use of culture only order in defined populations without accompanying UA	7/2020
18. 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

CAUTI QI Strategy	Status
19. Develop provider update/education related to current CAUTI status and how to order IUC/Culturing awareness GOAL- create awareness	9/2020
20. Changes to discontinue IUC orderable- alerts RN to dc the insert IUC Powerplan and related maintain order GOAL- assist with order clean up	8/2020
21. Changes to the discontinue order- alert will prompt the provider to order retention management order GOAL- provides orders for nursing to manage post IUC DC retention	Solution in testing phase, expected go live April
22. 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
23. Develop Urine Culture only powerplan to replace single orderable. 24. GOAL- Reduce CAUTI events related to culture ordering by guiding intentional use of this risky order	2/23/21
25. Culture of Culturing committee for urine specimens	2/2021
26. Adding sticker to IUC	4/2021
27. Electronic scoring tool for candida- agenda item for culture of culturing meeting	2/2021
28. Thoughtful pause- primary RN confers with charge nurse prior to specimen collection for algorithm use	2/23/21
29. Convert to 14 Fr as standard IUC size	Pending literature review
30. Resident notification of near misses	Design under review
31. Notification to provider of CAUTI	Design under review
32. Primofit & Medline External Male Catheter Product Trial	VAC approval 4/2021

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

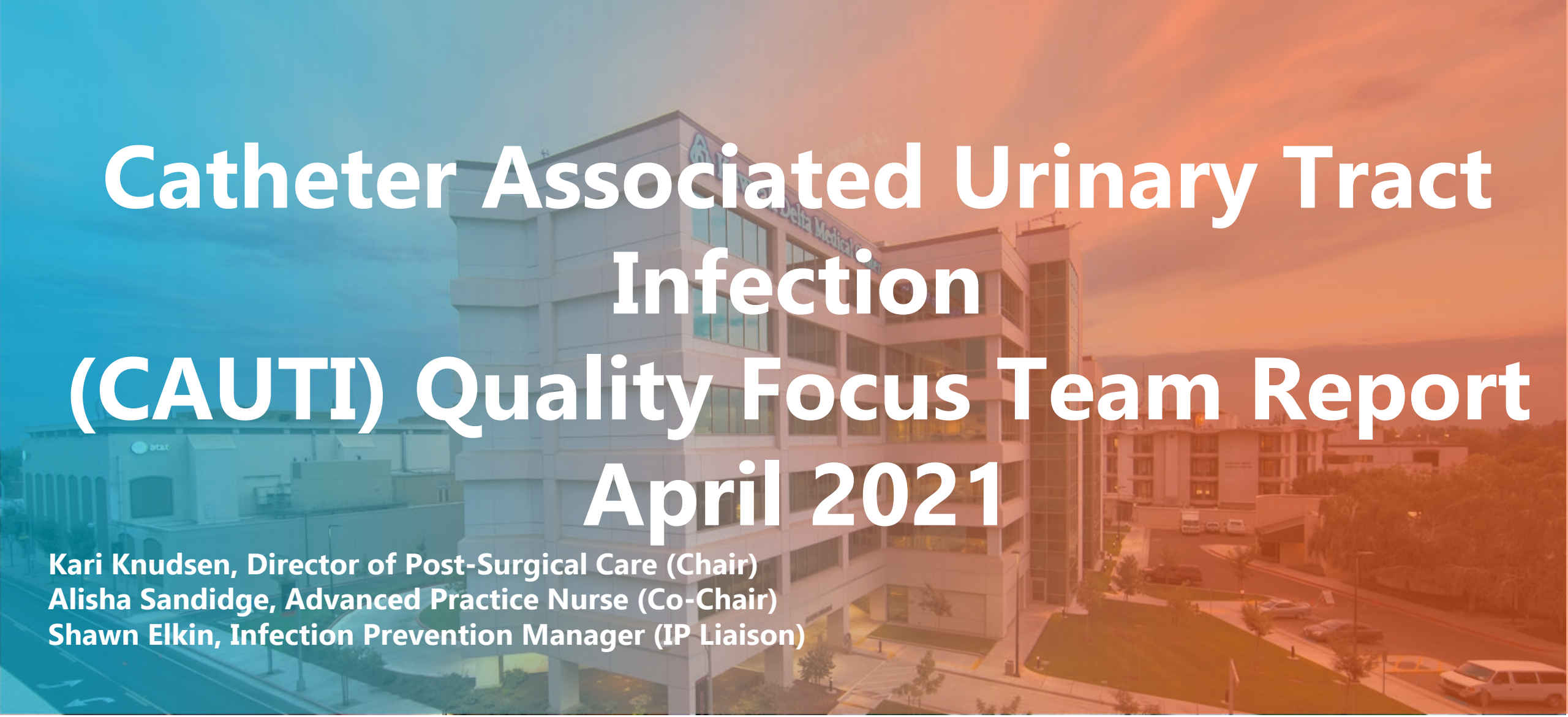
Next Steps/Recommendations/Outcomes:

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

A. Continue to maintain Kaizen initiatives: Daily IUC Gemba rounds, data collection, dissemination and QI strategy development.
B. Continue to monitor CAUTI events, effective 10/2020 events are reviewed with unit leadership at the HAI review meeting, unit leadership to create quality improvement plan and implement at the unit level. The QFT monitors those QI opportunities for global implementation
C. Continued electronic order optimization for IUC processes, as indicated by in-process QI strategies listed in action plan
D. Continue focus on retention management workflow as indicated by in-process QI strategies listed in action plan.
E. Address culturing practices in Culture of Culturing committee with medical staff partnership

Submitted by Name: Kari Knudsen **Date Submitted:** 4/5/2021

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 April 2021

Kari Knudsen, Director of Post-Surgical Care (Chair)
Alisha Sandidge, Advanced Practice Nurse (Co-Chair)
Shawn Elkin, Infection Prevention Manager (IP Liaison)

Kaweah Delta

CAUTI- FY21 Goals

Lower is Better	July 2020	Aug 2020	Sept 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Estimated Annual Number Not to Exceed to Achieve Goal*	FYTD SIR** (number of actual divided by number expected)	FY21 Goal	FY20
CAUTI Catheter Associated Urinary Tract Infection	3	0	1	1	1	2	0	1	13	0.84	≤0.727	1.12

*based on FY20 NHSN predicted values
**Standardized Infection Ratio – Number of actual infections Kaweah had divided by the number of infections CMS predicts Kaweah should have

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

Post KAIZEN-Gemba Data

CAUTI Committee Dashboard													
Measure Description	Benchmark/ Target	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
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Number of CAUTI	0	0	1	3	1	3	0	1	1	1	2	0	
FYTD SIR	≤ 0.727							0.78			1.04		
PROCESS MEASURES IUC Gemba Rounds													
% of pts with appropriate cleanliness	99%	98%	99%	98%	95%	97%	96%	98%		98%	99%	99%	98%
% of IUCs with order & valid rationale	100%	90%	93%	92%	93%	92%	92%	93%		94%	95%	93%	94%
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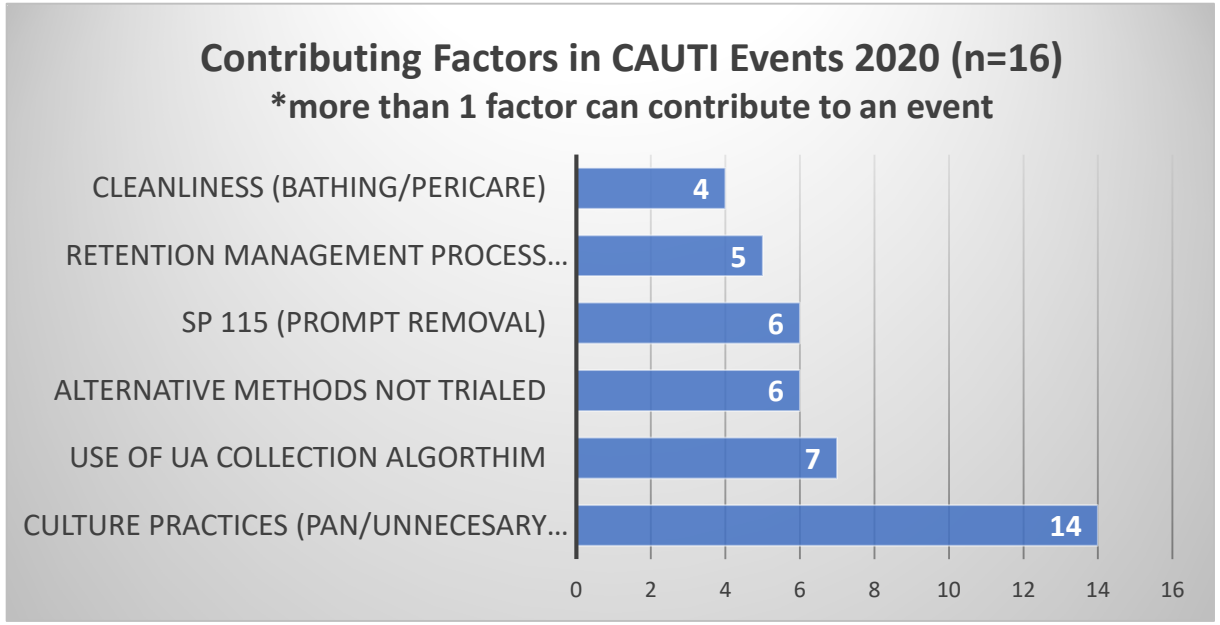
% of IUCs removed because of Gemba Round	n/a	7%	6%	3%	4%	2%	4%	6%		6%	4%	6%	6%
# of IUCs removed because of Gemba Round	n/a	46	42	33	35	22	46	74		64	40	50	52
*volume reduced due to reduced Gemba on weekends					Better than Target			Jan-Jul: Within 10% of Target As of Aug: Within 5% of Target			Does not meet Target		

Total Catheter days rounded on = 7204
98% of patients with daily bath and peri-care each shift
94% have order and valid rationale
348 catheters removed as a result of the Gemba

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

CAUTI QFT - Plans for Improvement

CAUTI QI Strategy	Status
1. Embed IUC insert power plan in existing Powerplans where the insert IUC order exists GOAL – Improve IUC order appropriateness and bundle compliance with increased use of Powerplan which contains needed IUC maintenance elements	On track to compete by May 2021
2. Place all IUC order resources on eCoach GOAL- Increase IUC appropriateness/ prompt removal, bundle compliance (improving ease of access for providers and nursing staff)	Begin Jan 2021
3. 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
4. Create change IUC task at 30 days following documented insertion GOAL- trigger nursing staff to change chronically retained IUC	12/23/20
5. 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
6. 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
7. Powerchart changes- IUC dynamic group for POA include on arrival from OR/ED, other GOAL- capture device list for lines already in place	Pending Cerner action
8. Add 3-way catheter as trigger to device list GOAL- accurate collection of device count	Pending Cerner action
9. Create alert when patient has IUC in place and documented loose stools GOAL- inspire intervention to prevent risk of CAUTI with loose stool and IUC	Continue to test and tweak
10. CAUTI Case Reviews Lessons Learned GOAL – Reduce CAUTI by ensuring identified opportunities are addressed globally	Occurs monthly at QFT
11. Evaluate reasons for IUC insertion orders GOAL – Reduce IUC utilization/appropriate indications for IUC	Partial completion 3/22/21, on-going data analysis and action
12. Safety Summit (CAUTI education for new hires) relaunch post-COVID GOAL – Improve/sustain RN bundle compliance	3/22/21
13. Rapid Cycle Post Gemba Rounds GOAL – reduce IUC utilization, verify completion of follow up	On-going
14. Handoff Gemba evaluation	Go live 1/27/21 pending outcome evaluation
15. Bladder training order and education	In development
16. Bathing Prioritization (in collaboration with CLABSI Committee) GOAL – Improve bathing/peri-care of IUC patients	10/2020
17. Add 'restricted use' to the urine culture only orderable GOAL- reduce use of culture only order in defined populations without accompanying UA	7/2020
18. 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

CAUTI QI Strategy	Status
19. Develop provider update/education related to current CAUTI status and how to order IUC/Culturing awareness GOAL- create awareness	9/2020
20. Changes to discontinue IUC orderable- alerts RN to dc the insert IUC Powerplan and related maintain order GOAL- assist with order clean up	8/2020
21. Changes to the discontinue order- alert will prompt the provider to order retention management order GOAL- provides orders for nursing to manage post IUC DC retention	Solution in testing phase, expected go live April
22. 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
23. Develop Urine Culture only powerplan to replace single orderable. 24. GOAL- Reduce CAUTI events related to culture ordering by guiding intentional use of this risky order	2/23/21
25. Culture of Culturing committee for urine specimens	2/2021
26. Adding sticker to IUC	4/2021
27. Electronic scoring tool for candida- agenda item for culture of culturing meeting	2/2021
28. Thoughtful pause- primary RN confers with charge nurse prior to specimen collection for algorithm use	2/23/21
29. Convert to 14 Fr as standard IUC size	Pending literature review
30. Resident notification of near misses	Design under review
31. Notification to provider of CAUTI	Design under review
32. Primofit & Medline External Male Catheter Product Trial	VAC approval 4/2021

Clinical Quality Goal Update

July 2021

FY 21 Clinical Quality Goals

	Jul 20 -Apr 21 Higher is Better	FY21 Goal	FY20	Last 6 Months FY20
SEP-1 (% Bundle Compliance)	75%	≥ 70%	67%	69%

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

Our Mission

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

Our Vision

To be your world-class healthcare choice, for life

Lower is Better	July 2020	Aug 2020	Sept 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Estimated Annual Number Not to Exceed to Achieve Goal*	FYTD SIR** (number of actual divided by number expected)	FY21/ FY22 Goal	FY20
CAUTI Catheter Associated Urinary Tract Infection	1	0	1	1	1	1	0	1	0	3	1	18	0.537	≤0.727 ≤0.676	1.12
CLABSI Central Line Associated Blood Stream Infection	2	1	1	0	1	2	1	2	0	0	1	15	0.743	≤0.633 ≤0.596	1.2
MRSA Methicillin-Resistant Staphylococcus Aureus	1	3	2	2	1	1	2	2	1	2	0	5-6	3.033	≤0.748 ≤0.727	1.02

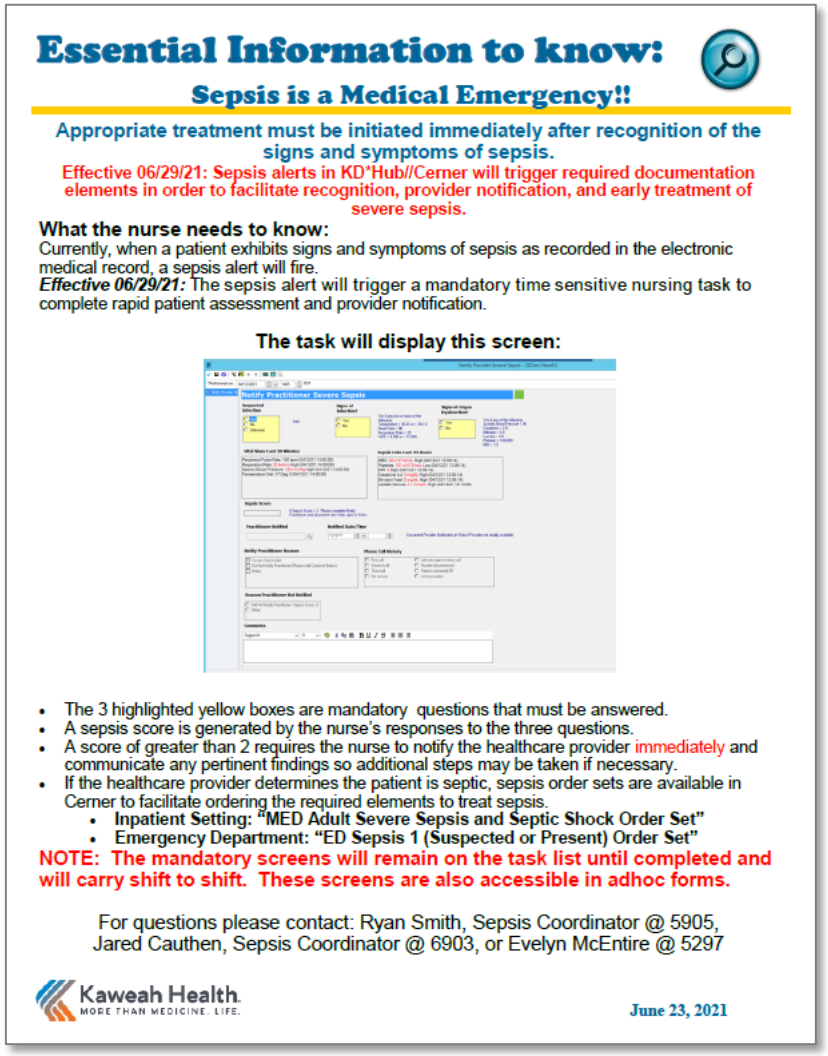
*based on FYTD21 NHSN predicted

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

Key Strategies

Sepsis

- Sepsis required physician notification of sepsis alert - results in timely best practice intervention, “the bundle” COMPLETE, GO LIVE 6/29/21!
- NEXT - sepsis handoff checklist, which is used to identify any remaining CMS SEP-1 elements needed for the treatment of patients suffering from severe sepsis.
  - Checklist used as a handoff from nurse to nurse, and identifies the remaining elements needed to fulfill SEP-1 requirements.
  - Ideal for instances when a patient transitions from the ED to their respective inpatient bed, or upon transitioning from a previous inpatient location to a new inpatient location (e.g., patients transitioning to a higher level of care).



Essential Information to know:

Sepsis is a Medical Emergency!!

Appropriate treatment must be initiated immediately after recognition of the signs and symptoms of sepsis.

Effective 06/29/21: Sepsis alerts in KD*Hub//Cerner will trigger required documentation elements in order to facilitate recognition, provider notification, and early treatment of severe sepsis.

What the nurse needs to know:

Currently, when a patient exhibits signs and symptoms of sepsis as recorded in the electronic medical record, a sepsis alert will fire.

Effective 06/29/21: The sepsis alert will trigger a mandatory time sensitive nursing task to complete rapid patient assessment and provider notification.

The task will display this screen:

- The 3 highlighted yellow boxes are mandatory questions that must be answered.
- A sepsis score is generated by the nurse’s responses to the three questions.
- A score of greater than 2 requires the nurse to notify the healthcare provider immediately and communicate any pertinent findings so additional steps may be taken if necessary.
- If the healthcare provider determines the patient is septic, sepsis order sets are available in Cerner to facilitate ordering the required elements to treat sepsis.
  - **Inpatient Setting: “MED Adult Severe Sepsis and Septic Shock Order Set”**
  - **Emergency Department: “ED Sepsis 1 (Suspected or Present) Order Set”**

NOTE: The mandatory screens will remain on the task list until completed and will carry shift to shift. These screens are also accessible in adhoc forms.

For questions please contact: Ryan Smith, Sepsis Coordinator @ 5905, Jared Cauthen, Sepsis Coordinator @ 6903, or Evelyn McEntire @ 5297

Kaweah Health MORE THAN MEDICINE. LIFE.

June 23, 2021

Key Strategies

CAUTI & CLABSI

- Gemba's! And trialing handoff process using Gemba elements
- Task force for retention management
- Letter to providers who were involved with a CAUTI event, going to physician leaders for approval
- EMR changes to improve catheter appropriateness, adherence to bundle elements and to manage retention
- New alternatives to catheter products trials
- Including peripheral IVs to critical care gemba (evaluating "just in case lines" and care practices)
- Evaluating new midline dressing kits (current kits missing necessary items)
- Education on CAUTI & CLABSI prevention for all residents completed and on annual schedule!

Key Strategies

Suggested interventions to reduce MRSA Bloodstream infection

- Screening and testing appropriate high risk MRSA colonization populations
- Ensuring communication about test results are shared with nursing and providers
- Using the Fever Algorithm Tool
- Blood culture order alert change to every 72 hours
- Blood culture decision-tree
- CRBSI Protocol for Catheter Salvage
- Chlorhexidine Gluconate bathing
- Targeted MRSA nares decolonization using Mupirocin (Bactroban)
- Honing MRSA nares decolonization to patients at risk for healthcare associated pneumonia, open soft tissue injuries, and patients with central lines (especially in the internal/external jugular site)

Action Plan Status July 2021

Culture of Culturing

1. Get sputum cultures in ICU when respiratory infection suspected rather than BC **COMPLETE**
2. Display previous culture results when ordering new culture **COMPLETE**
3. Remove the pre checked order on the ICU admission order set which order BC for temp >38.5. Review all order sets for embedded pre-checked orders **COMPLETE, reviewing RRT orders**
4. Providers to attend HAI meeting to help identify barriers and challenges to HAIs/cultures **ONGOING, NOW A CME!**
5. Extending serial blood culture Alert (for when BC are ordered after BC orders have been placed within 24 hrs) **COMPLETE**
6. Fever workup training for providers, residents and nursing **IN PROCESS**
7. Color coding of temperatures in EMR **COMPLETE**
8. Evaluating EMR functionality for fever work ups (ie. alerts for ordering cultures based off 1 abnormal temp, axillary temp) **IN PROCESS**
9. Evaluating CRBSI process with medical staff stakeholders (sequencing of blood cultures by lab for patients who have a central line that is necessary and an infectious process that needs evaluation)

SUMMARY

- Educating providers and RNs on culturing the right thing at the right time for the right reasons and soliciting feedback on the barriers
- Using the EMR as a tool to aid in culturing practices:
  - Removing pre-checked orders to elicit a thoughtful pause
  - Using an alert to avoid unnecessary cultures (over 200 avoided over a 2 week period!)
  - Evaluating functionality in culture ordering practices based on fever
- Evaluating a process where lab takes care of culturing timing for patients who have a central line

Questions?

Live with passion.

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

Kaweah Health

Safety Attitudes Questionnaire (SAQ)

Quality Council

July 15, 2021

SAQ and Regulatory Requirements

- Organizations are REQUIRED to provide latest SAQ survey results to The Joint Commission upon entrance
- Surveyors will be tracing safety culture as part of the hospital survey

Table 2. Sample Questions for Assessing Safety Culture

For Leadership	For Staff
How do you assess the culture of safety in your organization? What instrument are you using?	Have you ever completed a safety culture survey? Have you seen the results of a safety culture survey? Does your supervisor discuss the results?
Do you include safety culture improvement goals in performance expectations for leaders? What about middle management?	Is there a formal mechanism for reporting intimidating behavior? Would you feel comfortable reporting intimidating behavior?
Do you have internal or external benchmarks?	When an error occurs, do you have confidence that your leadership will take an appropriate look at how the system or process is accountable versus an individual?
What quality improvement projects have you conducted to improve your scores on safety culture?	What process do you have in place for reporting "close calls/near misses" or an error that occurred but did not reach the patient?

What is the SAQ?

Scientifically validated tool that measures safety culture in healthcare

7 domains (33 questions + 9 custom just culture questions = 42)

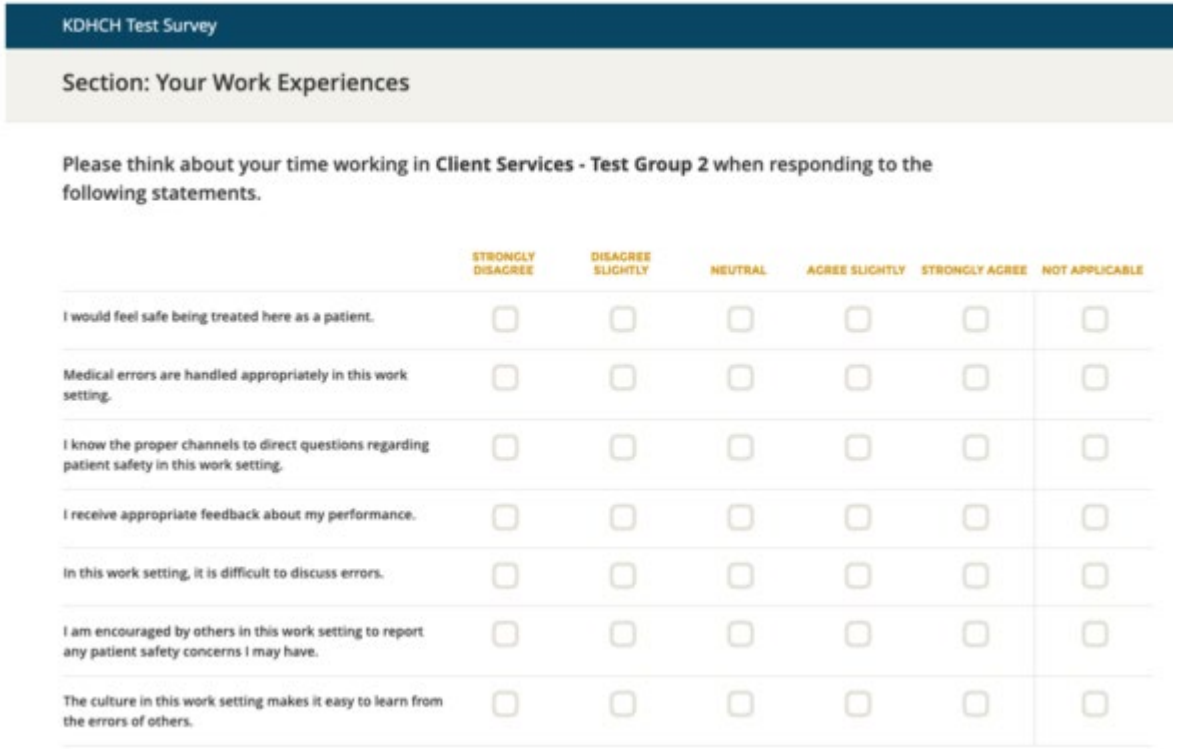
- Safety Climate
- Teamwork Climate
- Working Conditions
- Job Satisfaction
- Stress Recognition
- Perceptions of Local Management
- Perceptions of Senior Management
- 9 custom questions were added in 2018 related to Just Culture, these questions are NOT included in the overall SAQ results

What changed in the 2021 Survey from the 2018 Survey?

- Added 3 locations – EVS, Security Services and Food & Nutrition
- Added 2 additional custom questions focused on Just Culture:
  - Nurses/staff support a culture of patient safety in this work setting.
  - Physicians support a culture of patient safety in this work setting.
- 2 questions in the teamwork climate category changed:
  - Nurse input is well received in this work setting CHANGED TO: My input is well received in this work setting
  - The physicians and nurses here work together as a well coordinated team; CHANGED TO: People in this work setting work together as a well coordinated team.
  - An analysis was conduced by Pascal Metrics and it was determined that you cannot trend at the domain level or those specific items when changing from one domain to the other. Therefore we cannot compare Teamwork Climate domain scores to our past survey results

How does the SAQ measure safety culture?

- Percent of positive response
- Respondents answered a D or a E (agree or strongly agree) on a 5 point Likert scale
- Results are distributed at the question and domain (category) level
- Results are calculated based on the % of respondents who answered positively (4 or 5 on the Likert scale)
- *Domain Score is the mean of the domain questions, each item contributes equally to the domain score and the domain score represents how, on average, someone felt about this specific domain.



KDHCH Test Survey

Section: Your Work Experiences

Please think about your time working in **Client Services - Test Group 2** when responding to the following statements.

	STRONGLY DISAGREE	DISAGREE SLIGHTLY	NEUTRAL	AGREE SLIGHTLY	STRONGLY AGREE	NOT APPLICABLE
I would feel safe being treated here as a patient.	☐	☐	☐	☐	☐	☐
Medical errors are handled appropriately in this work setting.	☐	☐	☐	☐	☐	☐
I know the proper channels to direct questions regarding patient safety in this work setting.	☐	☐	☐	☐	☐	☐
I receive appropriate feedback about my performance.	☐	☐	☐	☐	☐	☐
In this work setting, it is difficult to discuss errors.	☐	☐	☐	☐	☐	☐
I am encouraged by others in this work setting to report any patient safety concerns I may have.	☐	☐	☐	☐	☐	☐
The culture in this work setting makes it easy to learn from the errors of others.	☐	☐	☐	☐	☐	☐

How do staff know who are local and senior leaders?

- There are several questions in the SAQ that staff are asked to answer in relation to local and senior leadership.
- Staff are provided definitions of each group before they start the survey

> Senior management refers to the group of individuals that are the key decision makers at your facility, such as executives and vice presidents.
>
> Local management refers to the individual(s) that provides direct supervision in the work area listed above (Manager and Director).

Safety Culture Survey Data is a Starting Point

- Survey data “asks” as many questions as it “answers”!
- It is like a lab result or a fever – from just one value, you can’t diagnose a patient or decide on a treatment plan, but it tells you ‘where’ to start looking.
- The results provide a great starting point for a conversation with your staff – what’s working, what could be better?

Interpreting SAQ Results

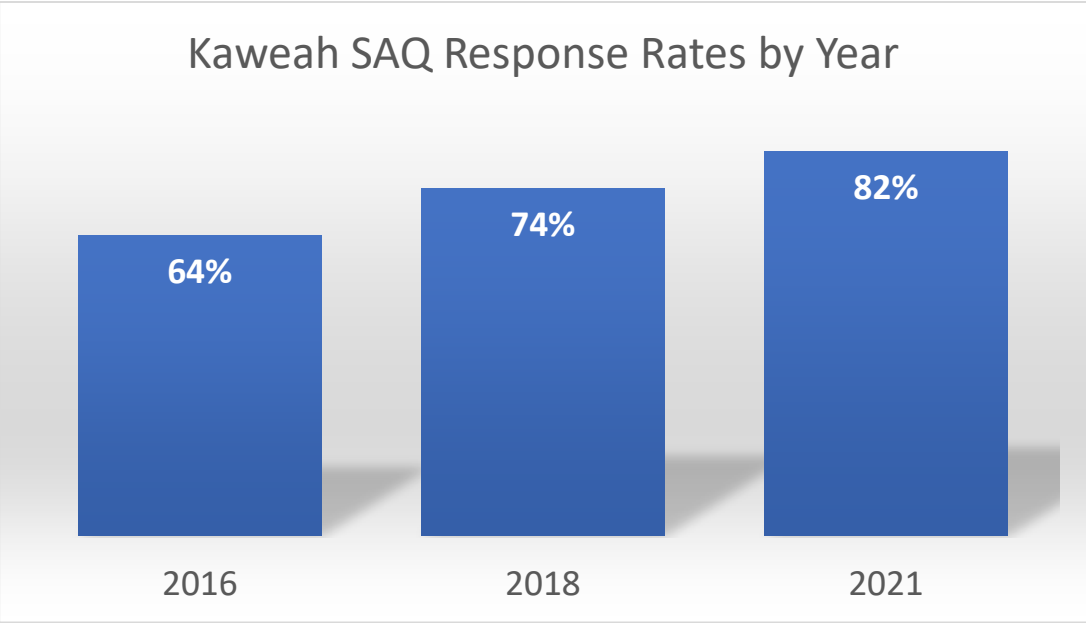
1. Level of Positive Response:

- Category or individual questions that are <60% positive response = Risk zone
  - The majority of respondents DO NOT feel positive about that category or question
- Category or individual questions that are >80% positive response = target zone
  - The majority of respondents DO feel positive about that category or question, culture is embedded and likely to sustain

2. Interpreting Results Through Pascal Metrics Benchmarking:

- Benchmarks (industry medians) are from Pascal Metrics Clients surveyed between January 1, 2019 and December 31, 2020. Due to COVID there was a decline in the number of hospitals that surveyed in 2020.
- The comparative database represents data from:
  - 11 health system clients that use domains from the SAQ
  - Approximately 100 U.S. based facilities and 8 international facilities
  - Within those facilities, there are a range of health care settings represented - hospitals, outpatient centers, medical practices, home health, hospice, long term care, etc.
  - There were over 5900 individual respondent groups in the comparative database.

SAQ Response Rates



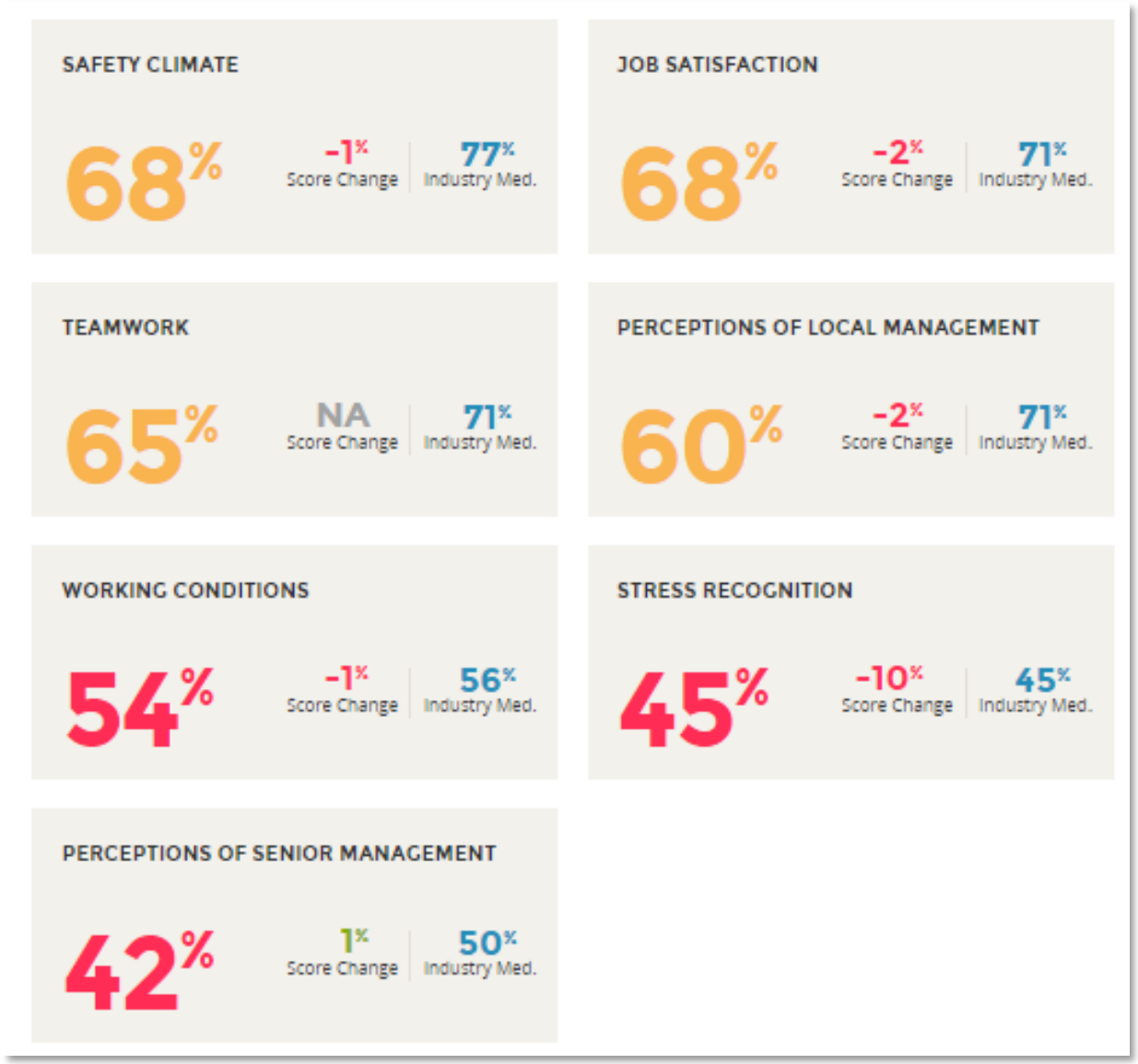
2021 Response Rates:

- Organization: 3020 surveys sent, 2475 were returned (82%)
- Medical staff: 354 surveys sent, 164 surveys returned (46%); increase from 2018 response rate of 17% (25/148)
- Newly added areas in 2021:
  - Environmental Services
  - Food and Nutrition Services
  - Security Services

2021 SAQ Kaweah Scorecard

Summary:

- 6/7 SAQ domains are below industry median; 1 is the same
- 5/7 SAQ domains decreased from 2018 results; 1 increased; 1 is n/a due to change in questions



2021 SAQ Kaweah Scorecard

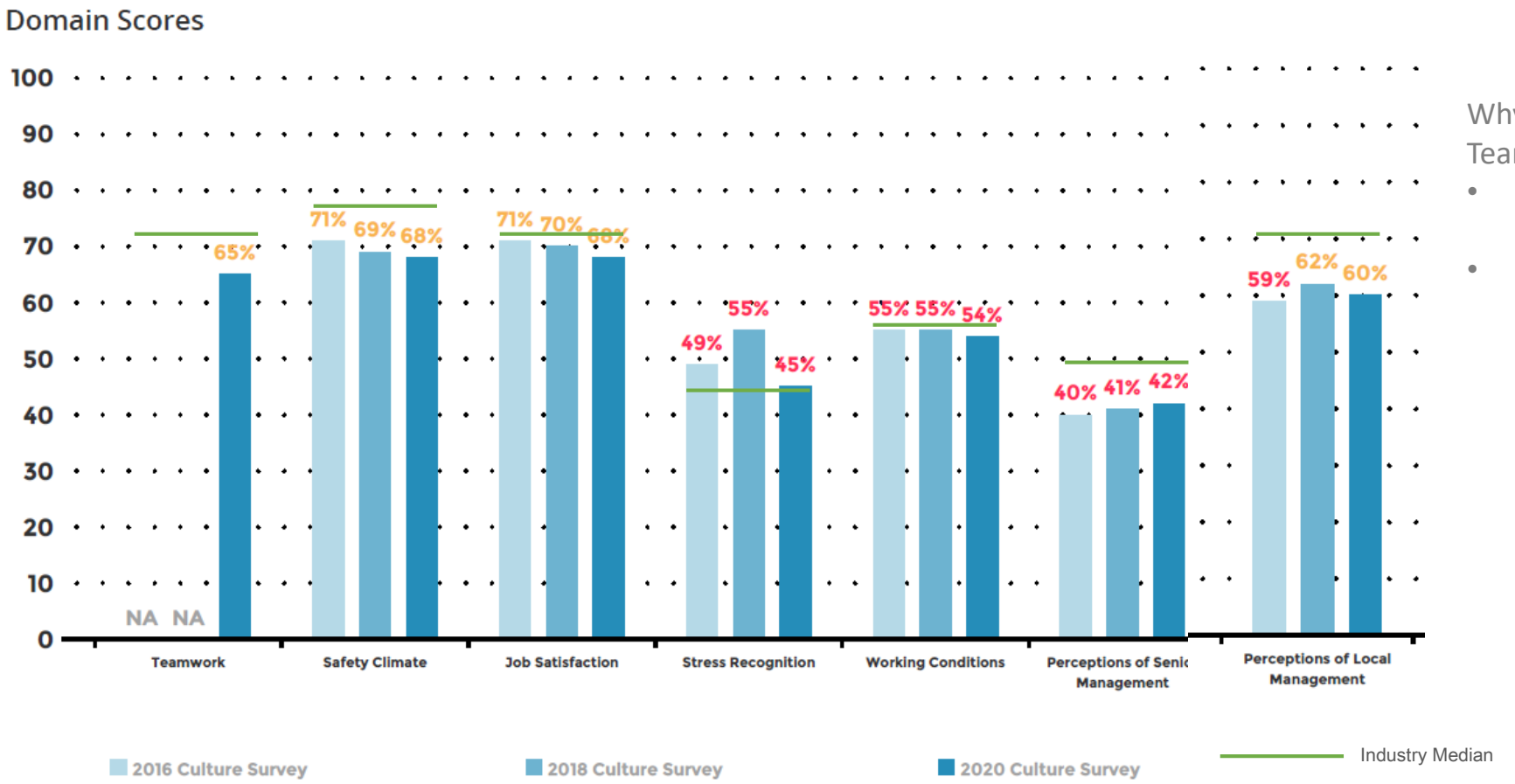
	TOP 3 ITEMS	% FAVORABLE
-1 since 2018 (Median=95%)	I know the proper channels to direct questions regarding patient safety in this work setting.	89%
-2 since 2018 (median= 92%)	I like my job.	87%
-1 since 2018 (Median= 88%)	I am encouraged by others in this work setting to report any patient safety concerns I may have.	84%

	LOWEST 3 ITEMS	% FAVORABLE
0 since 2018 (Median=43%)	The staffing levels in this work setting are sufficient to handle the number of patients.	36%
-9 since 2018 (median=42%)	Fatigue impairs my performance during emergency situations (e.g., emergency resuscitation, seizure).	48%
+1 since 2018 (Median=50%)	Problem personnel are dealt with constructively by our senior management.	56%

Red =below median; Green = above median

Largest negative distance from the median	Distance from median (change since 2018)
Local management doesn't knowingly compromise the safety of patients.	-16 (-1)
Senior management doesn't knowingly compromise patient safety	-10 (-1)
I would feel safe being treated here as a patient	-10 (-2)
This work setting is a good place to work.	-8 (-3)
My input is well received in this work setting.	-7 (n/a)
The staffing levels in this work setting are sufficient to handle the number of patients	-7 (+1)
Disagreements in this work setting are resolved appropriately (i.e., not who is right, but what is best for the patient).	-7 (n/a)
I receive appropriate feedback about my performance.	-7 (-2)
I am proud to work in this work setting.	-7 (-2)
Trainees in my discipline are adequately supervised.	-7 (0)

SAQ - Trending by Domain



Why is there no historical data in Teamwork Category?

- 2 Questions in the Teamwork Climate category changed
- An analysis was conducted by Pascal Metrics and it was determined that you cannot trend at the domain level or those specific questions when changing from one domain to the other. Therefore we cannot compare Teamwork Climate domain scores to our past survey results

Questions ≥ 80% Positive Response

Domain	Question
Teamwork Climate	It's easy for personnel here to ask questions when there is something that they do not understand
Safety Climate	I know the proper channels to direct questions regarding patient safety in this work setting
	I am encouraged by others in this work setting to report any patient safety concerns I may have
	Medical errors are handled appropriately in this work setting
Job Satisfaction	I like my job
	I am proud to work in this work setting
Custom - Just Culture	When I see others doing something unsafe for patients, I speak up
	Nurses/staff support a culture of patient safety in this work setting
	When staff make clinical errors, we focus on learning rather than blaming
	The unit manager supports and leads a culture of patient safety in my work setting

SAQ by Role

- 9 roles in 2021 had <60% positive response in all 7 SAQ categories in comparison to 5 in 2018
- Majority of roles with <60% response in at least 5/7 SAQ categories in the tech/aide/support role
- Registered Nurse is the highest volume role (n=687) with <60% positive response in 5/7 SAQ categories
- ROLES FROM 2018 WHO NO LONGER HAVE <60% POSITIVE RESPONSE IN AT LEAST 5/7 CATEGORIES:
  - Lab Aide
  - Telemonitor tech
  - Administrative Assistant
  - Cardiac Sonographer
  - RN Nurse Practitioner
  - Biomedical Technician
  - Laboratory Technician
  - Speech Pathologist

2018 Roles with <60% positive response in ALL 7 safety culture categories:

Role	n (response rate)
Lab Aide	10 (77%)
Phlebotomist	15 (39%)
Sterile Processing Tech	18 (78%)
Surgical Team Assistant	13 (81%)
Tele monitor tech	16 (89%)

2018 Roles with <60% positive response in 6/7 safety culture categories:

Role	n (response rate)
Administrative Assistant	9 (100%)
ASW/MFTI	8 (89%)
Cardiac Sonographer	14 (93%)
Licensed Psych Tech	19 (95%)
Patient Transport Aide	23 (82%)
RN Nurse Practitioner	14 (74%)
Biomedical Technician	7 (78%)

2018 Roles with <60% positive response in 5/7 safety culture categories:

Role	n (response rate)
Laboratory Technician	12 (80%)
Speech Pathologist	6 (100%)
Unit Secretary	29 (74%)

2021 Roles with <60% positive response in ALL 7 safety culture categories:

Role	n (response rate)
Cardiovascular Services	7 (27%)
Critcal Care Pulmonary & Adult Hosp Med	24 (42%)
ED Tech I	12 (52%)
LCSW/LMFT	13 (93%)
Nutrition Host	13 (81%)
OB/GYN	13 (54%)
Patient Transport Aide	22 (96%)
RN -First Assist	7 (88%)
Security Officer (driving)	29 (83%)
SP Tech I Non-Certified	8 (89%)
Surgery	13 (34%)
Surgical Team Assistant	20 (80%)
Ultrasound Tech-Registered	8 (73%)

2021 Roles with <60% positive response in 6/7 safety culture categories:

Role	n (response rate)
Care Coordination Specialist	5 (100%)
ED Tech II	7 (78%)
Environmental Services Aide	81 (85%)
Licensed Psych Tech	8 (67%)
Mental Health Worker	6 (100%)
Phlebotomist I	10 (77%)
SP Tech Certified	5 (63%)
Surgical Tech	30 (83%)

2021 Roles with <60% positive response in 5/7 safety culture categories:

Role	n (response rate)
ASW/ MFT	8 (80%)
Certified Hemodialysis Tech	10 (63%)
Imaging Office Specialist	5 (83%)
Medical Assistant	49 (82%)
Patient Access Specialist	32 (89%)
Registered Nurse	687 (79%)
Unit Secretary	19 (70%)

SAQ by Role

- The number of roles who had at least 80% positive response in at least 4/7 SAQ categories increased by 5 in 2021 compared to 2018
- Lab Aide and Administrative Assistant roles moved from the lowest SAQ scores on 2018 to the highest in 2021
- Manager is the highest volume (n 56) role with 6/7 SAQ categories >80% response

2018 Roles with >80% positive response in 6/7 safety culture categories:

Role	n (response rate)
Assistant Nurse Manager	10 (71%)
Chaplain	6 (86%)
Patient Care Pharmacy Tech	6 (100%)

2021 Roles with >80% positive response in 6/7 safety culture categories:

Role	n (response rate)
Lab Aide I	5 (83%)
Manager	56 (93%)
Occupational Therapists III	5 (100%)

2018 Roles with >80% positive response in 5/7 safety culture categories:

Role	n (response rate)
Polysomnotechnologist-Reg	8 (100%)
Interpretor	15 (94%)
Laboratory Section Chief	6 (86%)
Licenced Vocational Nurse	76 (82%)

2021 Roles with >80% positive response in 5/7 safety culture categories:

Role	n (response rate)
Executive Team	10 (100%)
Imaging Technologist	9 (100%)
Director	29 (97%)
Radiation Therapists	6 (100%)
EVS Floor Tech	5 (85%)
Nuclear Med Tech	5 (100%)
Patient Care Pharmacy Tech	5 (100%)
Administrative Assistant	5 (100%)

2018 Roles with >80% positive response in 4/7 safety culture categories:

Role	n (response rate)
Interpretor	15 (94%)
Occupational Therapist	21 (91%)
Physical Therapist	40 (89%)
Ultrasound Techologist	5 (45%)

2021 Roles with >80% positive response in 4/7 safety culture categories:

Role	n (response rate)
Laboratory Section Chief	6 (100%)
Occupational Therapists	9 (82%)
OP Registration/Cust Svc Rep	6 (100%)
Physical Therapist	10 (100%)
Physical Therapist II	12 (100%)

Questions Less than 60% Positive Response

Domain	Question	Analysis (solicited during staff debrief sessions)	Action Plan
Job Satisfaction	Morale in this work setting is high	• **Analyze results with employee engagement survey results (July 2021);** SAQ administered in Dec 2020 to Feb 2021, **SAQ results could be associated with timing of survey during COVID-19 surge**	• Leadership Team and BOD meeting 7/26/21 to review results; action plan pending.
Stress Recognition	I am more likely to make errors in tense or hostile situations	• Significant increase in SAQ Stress Recognition domain score from 2016 to 2018 ~~SAQ~~ due to mandatory training for all staff in SAQ departments/units approximately 4 months before 2018 SAQ administered; Training was embedded in new hire orientation only ongoing • Overall 10 point drop in the 2021 Stress Recognition domain score from the 2018 survey, but above the industry median. • Pascal Metrics (industry expert) indicates improvement strategies are focused on education	• Include the stress recognition module into mandatory annual testing rotation scheduled in advance of the SAQ • Evaluate pulse survey or use module post test to evaluate progress
Stress Recognition	Fatigue impairs my performance during emergency situations (e.g., emergency resuscitation, seizure)		

Questions Less than 60% Positive Response

Domain	Question	Analysis (solicited during staff debrief sessions)	Action Plan
Working Conditions	Problem personnel are dealt with constructively by our senior management	• Results analyzed from highest to lowest by work setting and disseminated to VP	• Employee relations class, help deal with problem personnel • Identify lowest scoring employees, workgroups sent to VP and leaders • Planning for FY22 leaders to submit worksheets to VP for employees ≤ 2.50 on annual evaluation or believed to be under-performing leaders to by August 31, 2021
Custom - Just Culture	The event reporting system is easy to use	Feedback solicited during SAQ staff debrief sessions which revealed the following insight: • Staff commented on the difficulty of selecting category type and several mandatory fields. The requirement to select a category was removed approximately 1.5 years ago, as well as XX were removed. Many staff not aware of changes. Staff who were commented on other event forms that continue to be long (ie. falls and adverse drug events). • Staff commented they do not submit events because they don't know if anyone reads them or does anything with them • Some commented that the event reporting process feels punitive and unaware that events can be submitted anonymously	• Targeted education through staff meetings (lowest score, high risk processes/care) by Dec 31, 2021. Education objectives to include: Importance of reporting and why, what and how to report, and just culture review • Stakeholder review and revision of falls and adverse drug event reporting forms completion target date • Implementing staff email thank you and acknowledgement of receipt of event report and communication of review by METER. Completion target August 1, 2021 • Pulse survey to be administered 1Q 2022

Questions Less than 60% Positive Response

Domain	Question	Analysis	Action Plan
Perceptions of Senior Management	The staffing levels in this work setting are sufficient to handle the number of patients	• Analyze results with employee engagement survey results (July 2021); SAQ results could be associated with timing of survey during COVID-19 surge. • Results analyzed from highest to lowest by work setting and disseminated to VP	• Conduct pulse survey • Budget planning included leader sign off • Recruiting events • Hiring in anticipation turnover, shift bonuses • Student RN interns, travelers • Improving efficiency for staff, for example, reducing documentation time
Perceptions of Local Management	Problem personnel are dealt with constructively by our local management	• Analyze results with employee engagement survey results; SAQ results could be associated with timing of survey during COVID-19 surge. • Results analyzed from highest to lowest by work setting and disseminated to VP	• Employee relations class, help deal with problem personnel • Identify lowest scoring employees, workgroups sent to VP and leaders • Planning for FY22 leaders to submit worksheets to VP for employees ≤ 2.50 on annual evaluation or believed to be under-performing leaders to by August 31, 2021

SAFETY ATTITUDES QUESTIONNAIRE TIMELINE

MARCH 2021
Result reports disseminated to leadership

JUNE 2021
Action plans developed and received by 6/18/21

JULY - OCT 2021
SAQ role debriefs completed by 9/20/21, action plan developed QIC by 10/15/21

AUG 2021
Leaders submit worksheets to VP for employees ≤ 2.88 on annual evaluation or believed to be under-performing

1Q 2022
Pulse Survey Administered

Stress Recognition Annual training completed; Safety culture action plan by role completed

APR – MAY 2021
Unit/Department results debriefed with staff

Leader TeamSTEPPS training

Just culture staff awareness campaign

JULY 2021
Results and action plan reported to Board of Directors

JULY- DEC 2021
Event reporting and just culture education to targeted units/depts. Revisions to select event reporting forms and acknowledgements

4Q 2021
Staff TeamSTEPPS simulation training offered ongoing

2Q 2022
Action plan update and survey results reported to Board of Directors

OUTSTANDING HEALTH OUTCOMES

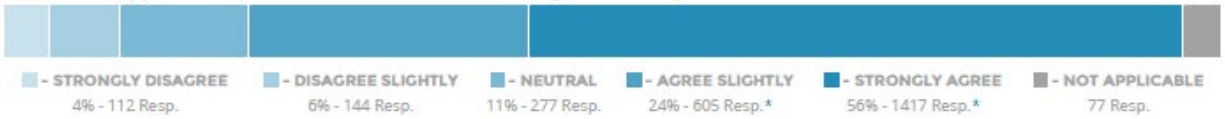
Safety Culture – Organizational Initiatives – 2021/22

Just Culture Steering Committee	Team Training	Recognitions
• Plan for Just Culture expanded staff awareness campaign 2021-2022 to include: - GME Just Review lessons learned published - Adding JC video to compass - Evaluate training of new medical staff leaders and charge nurses - Encorporating JC into annual testing - Leadership survey - Pulse survey for staff to gage effectiveness • 2021 Ongoing manager training to Just Culture and the Marx Algorithm	TeamSETPPS Leadership (Medical Team Training) • 38 Kaweah leaders participated in training May & June 2021. • Evaluation indicated the training accomplished goals: participants felt it was useful to their role/work, and learning occurred • >60 medical team tools implemented in 38 Kaweah locations/departments TeamSTEPPS Staff • All new hires in patient care roles complete CUS (I am concerned, uncomfortable, this is a safety situation) training; achieved training goals (>90% correct response rate) from 2017-2020 (2020 n=698). Post test indicates 100% correct response rate for each question. 100% of staff indicate ability to use CUS during a patient safety situation • Broad dissemination of “Say it again, Sam” (aka 2 challenge rule) TeamSTEPPS tool, approved by Patient Safety Committee for 3Q 2021 • 4Q 2021 Staff version of TeamSTEPPs simulation training go live	• 12 Good Catch awards (staff and providers) in 2021 • Hero of the Year awarded in 2021 • Sepsis Heroes awarded monthly (providers and RNs who provide best practice care to septic patients • Safety Star – awarded monthly for exceptional hand hygiene compliance as noted in the BioVigil system

Kaweah SAQ 2021
Detailed Survey Report

TEAMWORK - Quality of teamwork & collaboration in workgroup.

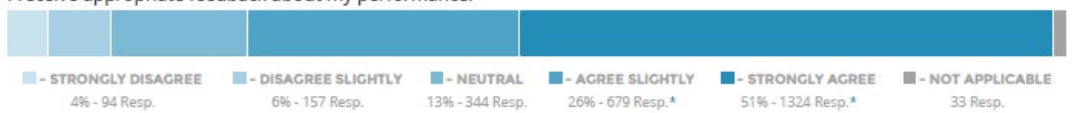
ITEM	% FAVORABLE	ORG. SCORE*	INDUSTRY MED.
DOMAIN OVERALL	65%	65%	71%
It is easy for personnel here to ask questions when there is something that they do not understand.	83%	83%	88%
I have the support I need from others in this work setting to care for patients.	79%	79%	83%
People in this work setting work together as a well coordinated team.	78%	78%	83%
My input is well received in this work setting.	71%	71%	78%
In this work setting, it is difficult to speak up if I perceive a problem with patient care.	68%	68%	73%
Disagreements in this work setting are resolved appropriately (i.e., not who is right, but what is best for the patient).	68%	68%	75%

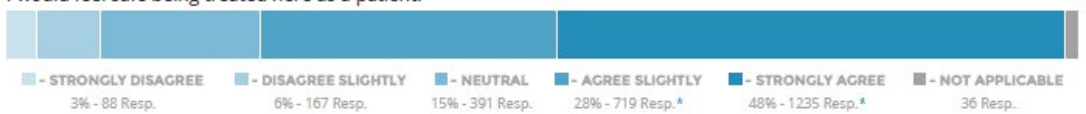


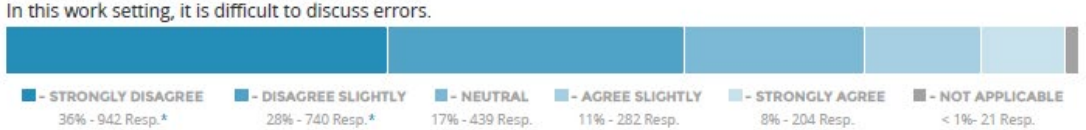
* - Used to calculate % Favorable * - Organization Score for Kaweah Delta Health Care District with no filters applied

Safety Climate - Perceived level of commitment to & focus on patient safety.

ITEM	% FAVORABLE	ORG. SCORE*	INDUSTRY MED.
DOMAIN OVERALL	68% -1	68%	77%
I know the proper channels to direct questions regarding patient safety in this work setting.	89% -1	89%	95%
I am encouraged by others in this work setting to report any patient safety concerns I may have.	84% -1	84%	88%
Medical errors are handled appropriately in this work setting.	80% -1	80%	85%
I receive appropriate feedback about my performance.	77% -2	77%	84%
I would feel safe being treated here as a patient.	75% -2	75%	85%
The culture in this work setting makes it easy to learn from the errors of others.	72% 0	72%	76%
In this work setting, it is difficult to discuss errors.	65% +1	65%	71%







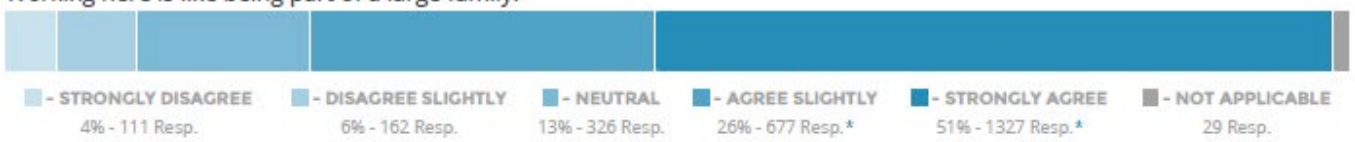
* - Used to calculate % Favorable * - Organization Score for Kaweah Delta Health Care District with no filters applied

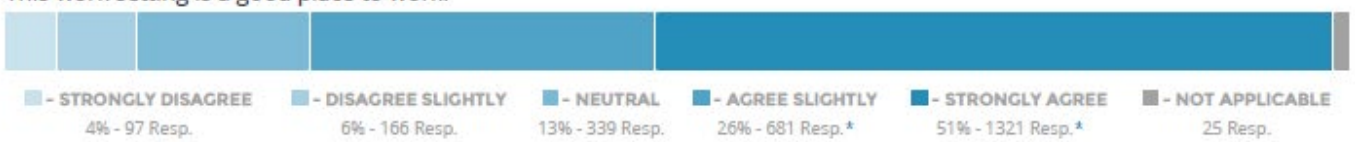
Kaweah Health

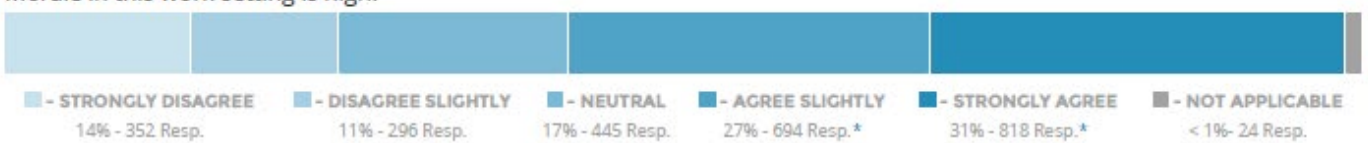
Kaweah Health

Job Satisfaction – Employees' general feelings of positivity regarding their work expe

ITEM	% FAVORABLE	ORG. SCORE*	INDUSTRY MED.
DOMAIN OVERALL	68% -2	68%	71%
I like my job.	87% -2	87%	92%
I am proud to work in this work setting.	83% -2	83%	90%
Working here is like being part of a large family.	77% -3	77%	79%
This work setting is a good place to work.	77% -3	77%	85%
Morale in this work setting is high.	58% -3	58%	61%



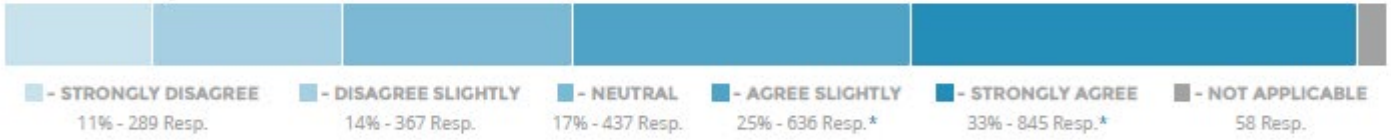


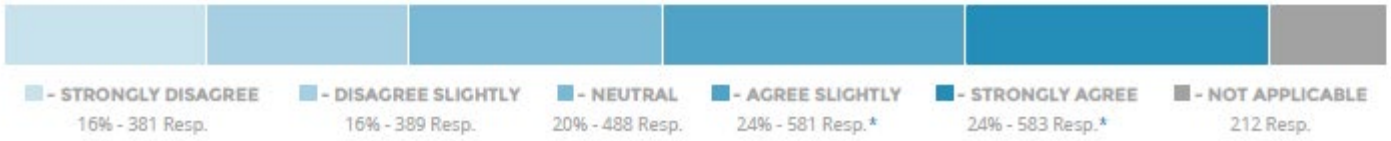


* - Used to calculate % Favorable * - Organization Score for Kaweah Delta Health Care District with no filters applied

Stress Recognition – Recognition of how stressors impact performance.

ITEM	% FAVORABLE	ORG. SCORE*	INDUSTRY MED.
DOMAIN OVERALL	45% -10	45%	45%
I am less effective at work when fatigued.	68% -5	68%	71%
When my workload becomes excessive my performance is impaired.	63% -4	63%	63%
I am more likely to make errors in tense or hostile situations.	58% -8	58%	64%
Fatigue impairs my performance during emergency situations (e.g., emergency resuscitation, seizure).	48% -9	48%	42%





* - Used to calculate % Favorable * - Organization Score for Kaweah Delta Health Care District with no filters applied

Working Conditions – Perceptions of the quality of their work environment.

ITEM	% FAVORABLE	ORG. SCORE*	INDUSTRY MED.
DOMAIN OVERALL	54% -1	54%	56%
All the necessary information for diagnostic and therapeutic decisions is routinely available to me.	72% -1	72%	77%
Trainees in my discipline are adequately supervised.	72% 0	72%	79%
This organization does a good job of training new personnel.	65% -2	65%	70%
Problem personnel are dealt with constructively by our senior management.	56% +1	56%	50%

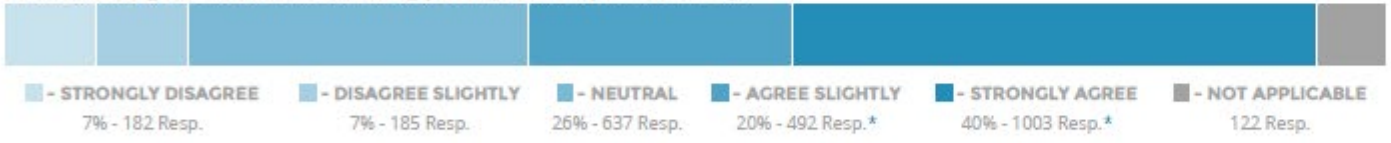
* - Used to calculate % Favorable * - Organization Score for Kaweah Delta Health Care District with no filters applied

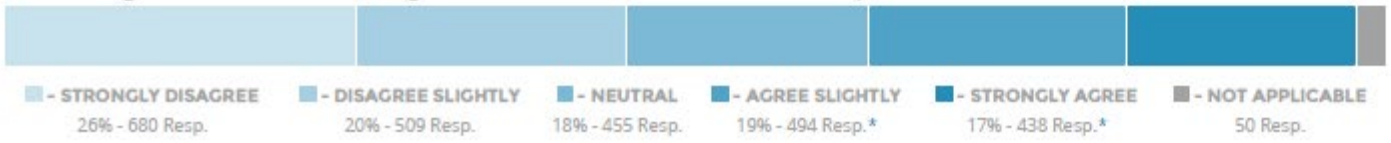
Kaweah Health

Kaweah Health

Perceptions of Senior Management– Perceptions of the support & competence of senior management.

ITEM	% FAVORABLE	ORG. SCORE*	INDUSTRY MED.
DOMAIN OVERALL	42% +1	42%	50%
I get adequate, timely info about events that might affect my work from senior management.	63% -1	63%	67%
Senior management supports my daily efforts.	60% 0	60%	64%
Senior management doesn't knowingly compromise patient safety.	60% -1	60%	70%
The staffing levels in this work setting are sufficient to handle the number of patients.	36% 0	36%	43%

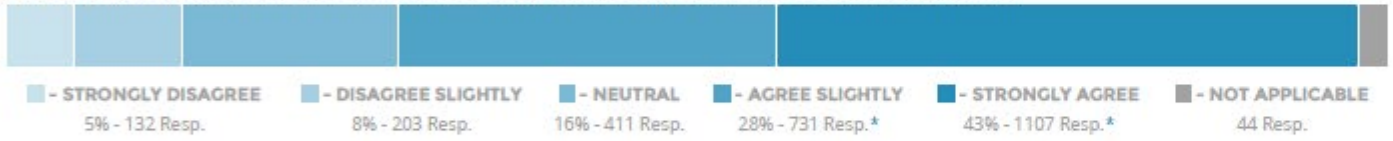




* - Used to calculate % Favorable * - Organization Score for Kaweah Delta Health Care District with no filters applied

Perceptions of Local Management – Perceptions of the support and competence of local-level management.

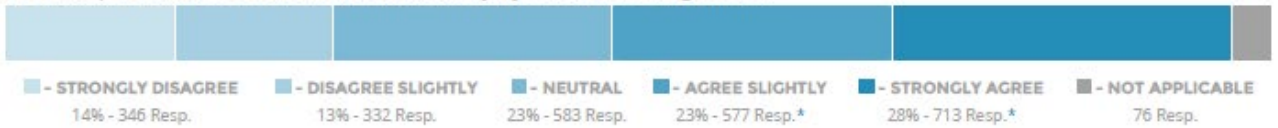
ITEM	% FAVORABLE	ORG. SCORE*	INDUSTRY MED.
DOMAIN OVERALL	60% -2	60%	71%
Local management supports my daily efforts.	74% +1	74%	79%
I get adequate, timely info about events that might affect my work from local management.	71% -1	71%	76%
Local management doesn't knowingly compromise the safety of patients.	68% -1	68%	84%

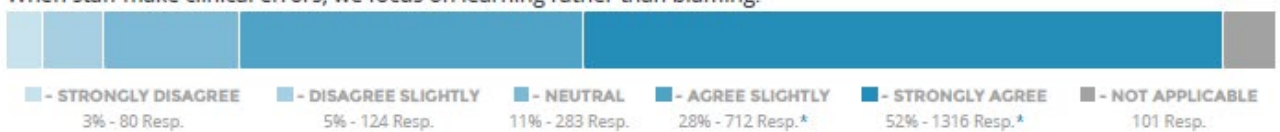


* - Used to calculate % Favorable * - Organization Score for Kaweah Delta Health Care District with no filters applied

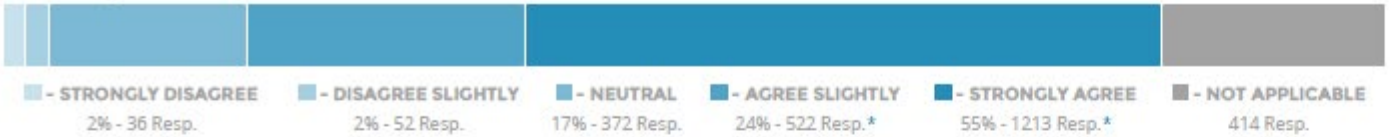
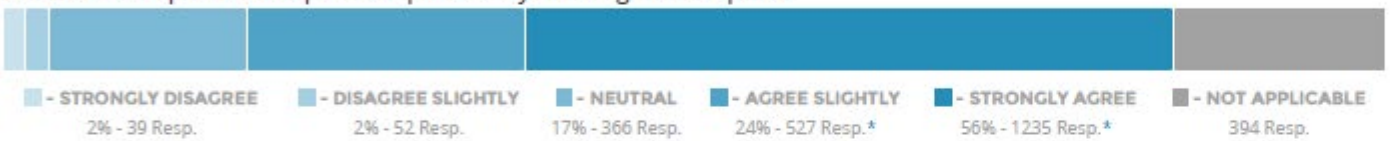
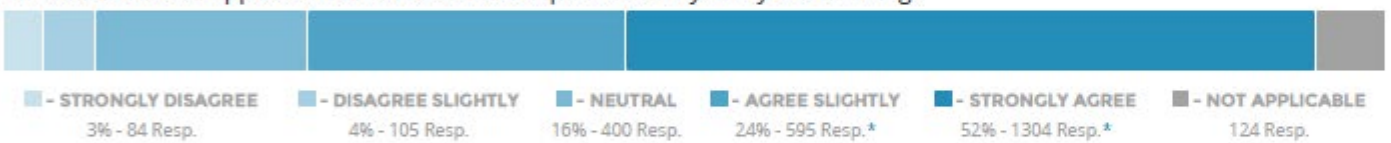
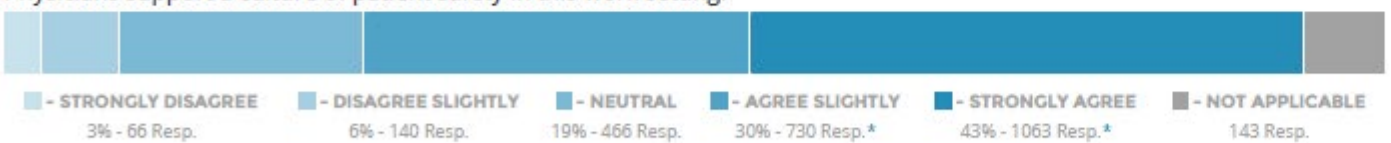
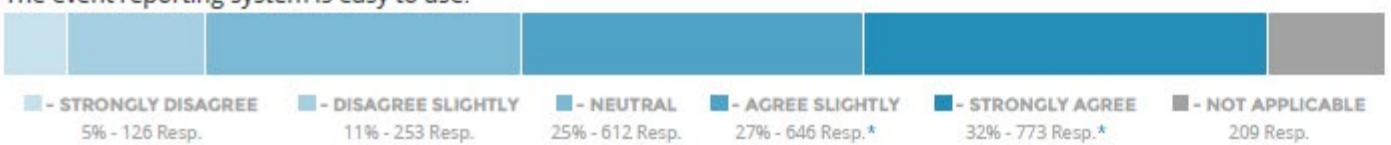
STANDALONE ITEMS (SAQ)

ITEM	% FAVORABLE	ORG. SCORE*	INDUSTRY MED.
DOMAIN OVERALL	NA	NA	NA
Problem personnel are dealt with constructively by our local management.	51% +2	51%	56%
DOMAIN OVERALL	NA	NA	NA
When I see others doing something unsafe for patients, I speak up.	95% +1	95%	NA
Nurses/staff support a culture of patient safety in this work setting.	85%	85%	NA
When staff make clinical errors, we focus on learning rather than blaming.	81% +1	81%	NA
The unit manager supports and leads a culture of patient safety in my work setting.	81% -2	81%	NA





* - Used to calculate % Favorable * - Organization Score for Kaweah Delta Health Care District with no filters applied

ITEM	% FAVORABLE	ORG. SCORE*	INDUSTRY MED.
I enter reports about events in which I was involved.  	79% -1	79%	NA
I make the hospital a safer place for patients by entering event reports.  	79% -1	79%	NA
The unit Director supports and leads a culture of patient safety in my work setting.  	76% -3	76%	NA
Physicians support a culture of patient safety in this work setting.  	73%	73%	NA
The event reporting system is easy to use.  	59% 0	59%	NA

Kaweah Health

Questions?