November 11, 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, November 18, 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, November 18, 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, November 18, 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, November 18, 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, Vice President & CNO; Monica Manga, MD, Chief of Staff; Daniel Hightower, MD, Professional Staff Quality Committee Chair; Tom Gray, MD, Quality and Patient Safety Medical Director; Sandy Volchko DNP, RN CLSSBB, Director of Quality and Patient Safety; Ben Cripps, Vice President, Chief Compliance and Risk Management Officer; Evelyn McEntire, Director of Risk Management; and Rita Pena, 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 – *Daniel Hightower, MD, and Professional Staff Quality Committee Chair*
   - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Evelyn McEntire, RN, BSN, Director of Risk Management and Ben Cripps, Vice President & Chief Compliance and Risk Officer.*
4. **Adjourn Open Meeting** – *David Francis, Committee Chair*

CLOSED MEETING – 7:01AM

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

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

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

OPEN MEETING – 8:00AM

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

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

3. **Written Quality Reports –** A review of key quality metrics and actions associated with the following improvement initiatives:
   - 3.1. **Length of Stay Quality Improvement Report**
   - 3.2. **Central Line Associated Bloodstream Infection (CLABSI) Quality Focus Team Report**
   - 3.3. **Safety Culture Quality Improvement Update: Safety Attitudes Questionnaire by Role**

4. **Healthgrades 2022 Quality Ratings Report and Leapfrog Safety Score Review–** A review of Healthgrades ratings based on population specific mortality and complications rates from 2018-2020 and the fall 2021 Leapfrog Safety Grade and associated indicators. *Sandy Volchko, RN, DNP, Director of Quality and Patient Safety*.

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

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.

KAWEAH DELTA HEALTH CARE DISTRICT

BOARD QUALITY COUNCIL COMMITTEE

THURSDAY NOVEMBER 18, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

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KDHCD - BOARD QUALITY COUNCIL COMMITTEE

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Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

Unit/Department: Resource Effectiveness Committee ProStaff/QIC Report Date: 11/9/21

Deferred from June 2021. Interdisciplinary team focused on operational changes related to COVID operations, hospital surge, increased occupancy and decreased staffing challenges.

Measure Objective/Goal: Decrease organizational length of stay

	FY2019	FY2020	FY2021	FY2022 YTD
Actual LOS	4.91	4.99	5.89	6.25
Expected LOS	3.84	3.98	4.21	4.30
Opportunity Days	1.08	1.02	1.67	1.95

Figure 1: Length of Stay comparison over fiscal years. Actual length of stay compared to expected and potential opportunity days for improvement.

Date range of data evaluated:

July 2018 through September 2021, monthly length of stay averages for all adult patients. Excludes Pediatrics, Obstetrics, Mental Health and Post-acute patients.

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):

The Resource Effectiveness Committee (REC) reconvened in July 2021 after a year hiatus due to COVID operational responses. FY 2022 goals discussed and modified to align with our FY 2022 Efficacy and Efficiency goals as outlined in the strategic plan. With continued length of stay, throughput and staffing challenges in clinical and non-clinical patient care roles, an assessment of opportunities was completed to evaluate and make recommendations for our Emergency Department flow and throughput the patient continuum of care. Recommendations were made that will directly affect a majority of the areas we currently are reviewing within the REC and it was determined that this committee will be utilized to monitor and implement recommended changes and practices from the analysis moving forward.

Fourteen distinct projects were identified (Figures 2-4) to support improvements to organizational efficiency. Success with these projects will demonstrate improved length of stay, shorter Emergency Department boarding time, increased capacity for inpatient surgery admissions and greater availability of inpatient beds to accept patients needing higher level of care transfer in the region.

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

⑥ Key Patient Throughput Solutions (1 of 3)

	Impact			Effort			Priority		
	H High	M Medium	L Low	H High	M Medium	L Low	H High	M Medium	L Low

#	Solution	Description	Impact	Effort	Priority
1	**Throughput and Patient Progression**				
1.A	Care Management Roles & Responsibilities	Clarify workflows / accountabilities of the care management team (inclusive of Case Management, Social Work, Utilization Management, Nurses, Residents, and Providers); ensure all activities are integrated into the broader care team to promote patient throughput, staff efficiency, and denial reductions	H	H	H
1.B	Discharge Planning & Timely Discharge	Develop process for identifying and documenting anticipated date of discharge (ADD) on admission; integrate ADD into Cerner for all care team members and collaborating services to prioritize patient throughput accordingly; incorporate discharge time into multidisciplinary huddles; develop standard patient / family communication	H	M	H
1.C	Hospitalist Deployment & Scheduling	Optimize hospitalist-to-hospitalist handover to minimize patient progression delays on switch day; evaluate opportunities to streamline rounds, stagger switch days, and further cohort hospitalist patients across Kaweah Health as appropriate	M	H	M
1.D	Multidisciplinary Huddles	Transform daily huddles to pro-actively manage day-to-day throughput and increase institutional awareness of throughput needs; implement targeting scripting for all participants to streamline huddle time and drive decision-making	H	M	H
1.E	Long Stay Committee	Implement Long Stay Committee structure to review barriers to safe discharge for patients with LOS > 5 days; develop standardized report outs and escalation pathways; incorporate leadership from Care Management, Finance, Medical Staff, Population Health, Managed Care, among others	H	L	H
1.F	Post-Acute Network	Evaluate need for post-acute network; assess current post-acute transition processes (including to Kaweah Health rehab and skilled nursing) and implement streamlined processes where possible; review current contracts for authorization turnaround times, educate Case Management, and develop tracking and escalation process	M	H	M

Figure 2: Descriptions of projects related to patient flow, throughput and discharge improvements.

⑥ Key Patient Throughput Solutions (2 of 3)

	Impact			Effort			Priority		
	H High	M Medium	L Low	H High	M Medium	L Low	H High	M Medium	L Low

#	Solution	Description	Impact	Effort	Priority
2	**Demand Management**				
2.A	ED to Inpatient Admission Process	Develop admission guidelines by service to streamline service identification; optimize hospitalist identification and admission process; identify opportunities for parallel processes in ED admission process (i.e., hospitalist acceptance patient transport request, nurse-to-nurse handover, etc.)	M	H	M
2.B	Observation Program	Develop observation admission criteria, order sets / protocols based on top 5-10 diagnoses, communication / education strategy to interdisciplinary team and collaborating services (e.g., Cardiology, Radiology, etc.); evaluate possibility of re-establishing space for a dedicated observation unit; leverage Cerner tools to proactively monitor LOS of currently admitted observation patients; conduct ongoing case review and track conversion rate to inpatient	H	H	M
2.C	Transfer Center Operations	Develop clinical prioritization algorithm for transfer requests and escalation process for transfer requests not accepted due to bed availability; track and quantify financial impact of lost or cancelled transfers	L	M	L
3	**Capacity Management**				
3.A	Patient Placement Infrastructure	Realign bed supply with demand to allow for aggregation and optimal patient placement; develop patient placement matrix and prioritization algorithms	M	M	M
3.B	ED Care Model & Workflow Redesign	Streamline ED workflows to enable improved throughput / reduced LOS for treat & release patients; optimize triage processes to decrease number of patients in waiting room	M	H	M
3.C	ED RN Staffing Optimization	Align nurse, licensed vocational nurse (LVN), and licensed psychiatric technician (LVT) staffing to patient arrivals and ED census by time of day and day of week	M	M	L

Figure 3: Descriptions of projects related to management of inpatient bed demands and capacity to support inpatient bed needs.

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

6 Key Patient Throughput Solutions (3 of 3)

	Impact			Effort			Priority		
	H High	M Medium	L Low	H High	M Medium	L Low	H High	M Medium	L Low

#	Solution	Description	Impact	Effort	Priority
4	**Foundational**				
4.A	Patient Throughput Dashboard	Design and launch an all-encompassing patient throughput dashboard (including process and outcome metrics) and corresponding communication / education plan (see illustrative example on page 74); leverage available Cerner real-time patient throughput dashboards for day-to-day clinical operations	H	M	M
4.B	Physician Leadership Structure	Evaluate current physician leadership structure as it relates to supporting and driving throughput; outline physician leadership opportunities, including Chief Medical Officer role, and organizational / medical staff readiness	H	H	H
4.C	EMR & Technology Optimization	Align upcoming Cerner implementation with redesigned processes; identify other Cerner optimization opportunities related to throughput and patient progression, demand management, and capacity management	H	M	H

Figure 4: Descriptions of opportunities to create foundational changes that support increased use of real time data to inform decsions and partner with physician leadership to direct patient care.

Length of Stay Barriers

Discharge LOS committee has identified and continue work on barriers to discharge. The committee implement a focused LOS workgroup to look at patients over 30 days ALOS to discuss barriers and discharge needs. Surge numbers and staffing crisis within both bedside nursing and case management are impeding our ability to affect change in many areas. Personnel resource limitations create challenges in implementing process changes, team continues to recruit, train and identify other avenues to achieve daily outcomes to improve ability to respond to increased needs with increased census.

Length of Stay values

Challenges during the pandemic response led to lengthening of the LOS for patients rather than shortening. Patients with COVID had an average LOS of 12 days. Patients with and without COVID had delayed discharges due to limited post-acute facilities able to take patients. Post-acute services had delays in opening new cases safely due to staffing and increased demands. The hospital also experienced staffing shortage crises that led to delays in decision making around discharge for patients. Patients with COVID take more resources to complete procedures. We experienced three COVID surges in FY 2021 with a rise in LOS both times. Our health system is now facing a fourth COVID surge and LOS continues to stay elevated, as clinical staffing and case management are short-staffed. Assistance requested from the state for staffing and waivers to handle the current surge, but each time we have seen an increase in our LOS. We are actively working on creative ways to deal with these increased LOS by creating a formal discharge lounge, discussion to create a transitional care unit at TCS to house long term placement patients, earlier discharge round times and a new dashboard with discharge statistics for both physicians and nursing units to encourage transparency and improvement in discharge times. Implemented a post-acute COVID unit (CARES) at Acute Rehabilitation to support discharge of patients to post-acute care while still in isolation for COVID.

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

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

The team goals for FY22 are listed in Figure 5.

FY 22 Goals	Action Plans	Resolution Date
Reduce Average LOS – Non-COVID patients	Work on developing a transitional care unit, earlier discharge rounds to facilitate earlier discharge times	October 2021
Remove discharge placement barriers	Discharge management/LOS team meeting. New digital TRT tool implemented with CM to assist in capture barriers, Subgroups work on standardization of work.	Ongoing
Discharge Orders ready by 1000	Work with physician groups to facilitate 20% compliance with discharge orders ready by 1000 each day. Educate providers on new discharge dashboard	September 2021
Create organizational plan for ED surge response	Continue to streamline response to volume surges in the ED with rapid movement of patients within 2 hours to available beds. Improve communication of activities underway to minimize duplication or disruption of efforts	September 2021
Encourage discharge times earlier in the day	Work with units to encourage earlier discharges, work to establish formal discharge lounge	October 2021

Figure 5: Resource Effectiveness Committee FY2022 goals to improve patient throughput, efficient use of organizational resources, align with organizational strategic plan and improve overall length of stay.

Next Steps/Recommendations/Outcomes:
REC will meet again at the end of November as the steering committee for the identified throughput projects. This committee will oversee the projects and ensure that these processes are given priority to affect change. Leadership is committed to design and implementation of the identified opportunity projects in Figures 2-4. Leadership is also committed to ongoing sustainability through monitoring, auditing changes and making changes to improve success.

Submitted by Name: Rebekah Foster, Director of Care Management

Date Submitted: 11/9/21

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

Central Line Blood Stream Infection (CLABSI) Quality Focus Team Report November 2021

Amy Baker, Director of Renal Services (Chair)
Emma Camarena, Advanced Practice Nurse (Co-Chair)
Shawn Elkin, infection Prevention Manager (IP Liaison)

CLABSI Quality Focus Team and Kaizen Event Background

Background: Patients are acquiring CLABSIs at rates that exceed national benchmarks. The CLABSI SIR from July 2019 to December 2019 was 1.47 with a goal (CMS 50th percentile) of ≤ 0.784; the number of CLABSIs was higher than expected (9 observed, 6 expected). CLABSIs 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 length of stay.

Current State (Kaizen Event) Review -

- Days between CLABSI from 4/2018 to 4/2020 is 18.74.
- CLABSIs are associated with both insertion practices and maintenance practices
- CLABSIs have not increased because we have more central lines or insert them under emergent circumstances
- We do not have consistency with best practices in CLABSI prevention
- No standard MD training on CLABSI prevention training
- The "Vital Few" are:
  - Central Line site: IJ or Femoral
  - Bath not received
  - Line necessity was not addressed
  - Hemodialysis
  - Expired peripheral IV
- CLABSIs are not isolated to one unit or unit type
- The weekly HAI audit (for best practices) has not helped consistency in bundle practices or reduced CLABSI

Analysis:

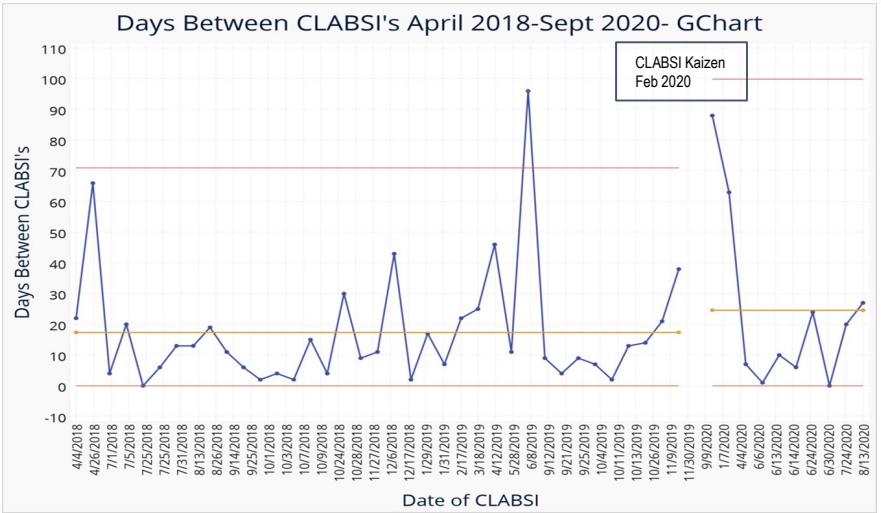
Identified Root Causes (in order from most significant to least):

1. Line Necessity
2. Bundle Practice
3. Education
4. Cultures
5. Central Line Insertion
6. Bathing
7. Leadership Standard Work
8. Documentation
9. Human Factors

Kaizen improvement strategies focused on addressing the top 4 root causes

Action Plan: Goal CLABSI SIR ≤0.633 (new) and Mean Days Between CLABSI > 40.5

Improvement Strategy	Who?	When?
Line Necessity –Implementation of interventions delayed due to COVID-19 pandemic	Emma C. Joetta D.	March 31, 2020 (TPN orders 7/2020)
Bundle Practice-Implementation of interventions delayed due to COVID-19 pandemic	Amy Baker	March 31, 2020
Education-Implementation of interventions delayed due to COVID-19 pandemic priorities	Eileen P. Enri S.	March 31, 2020 (Comp Fair 6/20)
Blood Cultures: The Culture of Culturing	Dr. Gray & Shawn Elkin	
Leadership Standard Work	Mary Laufer	
Improve location and par of central line supplies • Include in manager communication plan; • Include in RN & CNA education that they need to follow up with CN or manager that PAR level needs to be adjusted; also talk to manager & central distribution	Kaizen Team Education Team	
Email Take-Always after CLABSI committee review of events	Amy Baker	
Insertion: New site = New kit to be included with MD/resident education with Dr. LeDonne—Conference cancelled due to COVID-19 pandemic.	Dr. Gray Shawn Elkin	



Results Report

BASELINE DATA
July-Dec 2019
SIR = 1.47
Goal = ≤0.784

Mean days between CLABSIs 4/2018 to 1/2020 = 17
Goal > 40.5

Update: Sept 2020
April – June 2020
SIR = 1.63
Goal = ≤0.633

Mean days between CLABSI 1/2020 to 9/2020 = 24.6

Post Kaizen- Gemba Data

CLABSI Committee Dashboard

Measure Description	Benchmark/ Target	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
OUTCOME MEASURES																
Number of CLABSI	0	0	5	2	1	2	0	1	2	1	2	0	0	1	1	0
FYTD SIR	≤0.596		1.63			1.28*			1.2*			0.933				0.000
PROCESS MEASURES CL Gemba																
% of pts with bath within 24 hrs	99%	78%	80%	84%	88%	88%		95%	96%	96%	96%	96%	97%	93%		97%
% of CL with valid rationale order	100%	93%	97%	96%	95%	96%		98%	98%	97%	99%	98%	98%	98%		99%
% of CL dressings clean, dry and intact	100%	92%	95%	91%	92%	95%		97%	95%	94%	97%	95%	95%	97%		97%
% of CL that had drsg change no > than 7 days	100%	90%	90%	89%	96%	98%		98%	98%	99%	99%	99%	99%	98%		98%
% of patients with proper placed gardiva patch	100%	81%	93%	90%	89%	92%		93%	94%	94%	93%	95%	94%	94%		96%
% of CL pts with app & complete documentation	100%	81%	86%	86%	87%	87%		92%	91%	93%	95%	90%	91%	94%		94%
# of Pt Central Line days rounded on	n/a	1050	1315	1194	1087	1372		1084	1194	1067	1010	1179	1198	968		1092

*SIR manually calculated

Better than Target

Jan-Jul: Within 10% of Target
As of Aug: Within 5% of Target

Does not meet Target

Total Number of Patient Central Line Days Rounded on = 14,810

Continued focus in areas on CLABSI reduction – prioritizing the initiatives.

Improvements from first 3 months of Gemba vs last 3 months:

- Bath within 24 hrs: 81% to 95%
- CL with order: 95% to 99%
- Dressing Clean: 92% to 97%
- Dressing change: 90% to 98%
- Gardiva Patch: 88% to 96%
- Complete documentation: 83% to 94%

Clabsi QFT- Plans for Improvement

- Subcommittees have formed to help reduce different aspects of CLABSI
  - Culture of Culturing Committee- work on reduce number of pan culturing and discuss TPN utilization related to CLABSI's.
  - HAI Review Committee- Review each CLABSI case to identify learning opportunities, barriers and identify root causes.
  - MRSA Subcommittee- Now turning into a QFT! Trail will begin on 4N and ICU to treat positive Nasal MRSA patients.
  - Peripheral IV Subcommittee- provide guidelines around peripheral IV usage for critical care and medical surgical level of care.

In addition to subcommittees the CLABSI QFT has been

- Reviewing unit specific action plans to address CLABSI's- focusing on Critical Care Areas due to high volume of CLABSI's
- Working on Power Plan to create ease of use and understanding- Consolidating power plans to use include all types of central lines
- Update policy with Lippincott links so staff can see video's of central line dressing change

End of Fiscal Year Performance

Lower is Better	July 2021	Aug 2021	Sept 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	June 2022	Estimated Annual Number Not to Exceed to Achieve Goal*	FYTD SIR** (number of actual/ number expected)	FY22 Goal	FY21 FY20
CAUTI Catheter Associated Urinary Tract Infection	1	3	4										20	**1.649**	≤0.676	0.54 1.12
CLABSI Central Line Associated Blood Stream Infection	0	4	3										16	**1.573**	≤0.596	0.75 1.20
MRSA Methicillin-Resistant Staphylococcus Aureus	2	0	1										6	**1.767**	≤0.727	2.78 1.02

*based on FY21 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.

QUESTIONS?

Safety Attitudes Questionnaire (SAQ)
Role Debrief Summary
October 2021

SAQ 2020/2021 by Role Data Summary

- 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)
Sterile Processing Tech	18 (78%)
Surgical Team Assistant	13 (81%)
Tele monitor tech	16 (89%)

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

Role	n (response rate)
ED Tech I	12 (52%)
LCSW/LMFT	13 (93%)
Nutrition Host	13 (81%)
Patient Transport Aide	22 (96%)
RN -First Assist	7 (88%)
Security Officer (driving)	29 (83%)
SP Tech I Non-Certified	8 (89%)
Surgical Team Assistant	20 (80%)
Ultrasound Tech-Registered	8 (73%)

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%)

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%)

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 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	1111

SAQ by Role Debrief Summary

- 10 roles were debriefed on their role specific SAQ results, completed by 9/30/21. The remaining roles were also individual departments who already debriefed SAQ results, or too large (Registered Nurse). All debrief notes follow the summary.
- Roles debriefed separate from their home unit/dept:
    - Emergency Department Licensed Psych Techs
    - Mental Healthcare Workers
    - Care Coordinator Specialist
    - Dialysis Tech
    - ED Tech
    - Imaging Office Specialist
    - Patient Access Specialist
    - Phlebotomist
    - Ultrasound
    - Unit Secretary
    - Surgical Technicians
    - Surgical Team Assistant
    - RN 1st Assistant
- Targeted role debriefs deferred: Medical Assistants and Patient Access Specialist at Rural Health Clinics and Urgent cares due to surge
- Debriefs attended by at least one leader, all debrief notes shared with all role leaders
- Role debriefs mainly assisted in the identification of role specific safety culture issues (ie. training, leader knowledge of roles).
- Some debriefs indicate a hierarchical gradient (differences in power between medical team members) that could result in decreased safety culture.
- Some debriefs indicate that some roles feel other roles do not understand their job responsibilities, which can lead to feelings of disrespect.
- B. Green, R.S. Oeppen, D.W. Smith and P.A. Brennan (2017)[1] recommends team communication tools such as the TeamSTEPPS® tool "CUS" and "2 challenge rule" to flatten hierarchical gradients. "CUS" (I am concerned, uncomfortable, this is a safety issue), tool is required upon hire and is included in annual mandatory training. It is reinforced ad hoc through unit level leadership.

Suggested Actions for Discussion:

1. Local leadership evaluate role & unit/department specific concerns; corrective action plan
2. Continue to reinforce "CUS" through the organization, and broadly introduce, spread and reinforce the 2 Challenge Rule (Kaweah Health terms this tool: "Say it again, Sam".
3. Consider addressing hierarchy issues broadly with leadership

[1]B. Green, R.S. Oeppen, D.W. Smith and P.A. Brennan (2017). Challenging hierarchy in healthcare teams – ways to flatten gradients to improve teamwork and patient care . British Journal of Oral and Maxillofacial Surgery, 2017-06-01, Volume 55, Issue 5, Pages 449-453, Copyright © 2017 The British Association of Oral and Maxillofacial Surgeons. Retrieved 10/12/21 from https://www.clinicalkey.com/#!/content/playContent/1-s2.0-S026643561730061X?returnurl=https:%2F%2Flinkinghub.elsevier.com%2Fretrieve%2Fpii%2FS026643561730061X%3Fshowall%3Dtrue&referrer=https:%2F%2Fpubmed.ncbi.nlm.nih.gov%2F

Safety Attitudes Questionnaire (SAQ)
Role Debrief Summary
November 2021

SAQ 2020/2021 by Role Data Summary

- 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)
Sterile Processing Tech	18 (78%)
Surgical Team Assistant	13 (81%)
Tele monitor tech	16 (89%)

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

Role	n (response rate)
ED Tech I	12 (52%)
LCSW/LMFT	13 (93%)
Nutrition Host	13 (81%)
Patient Transport Aide	22 (96%)
RN -First Assist	7 (88%)
Security Officer (driving)	29 (83%)
SP Tech I Non-Certified	8 (89%)
Surgical Team Assistant	20 (80%)
Ultrasound Tech-Registered	8 (73%)

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%)

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%)

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 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	1111

SAQ by Role Debrief Summary

- 10 roles were debriefed on their role specific SAQ results, completed by 9/30/21. The remaining roles were also individual departments who already debriefed SAQ results, or too large (Registered Nurse). All debrief notes follow the summary.
- Roles debriefed separate from their home unit/dept:
    - Emergency Department Licensed Psych Techs
    - Mental Healthcare Workers
    - Care Coordinator Specialist
    - Dialysis Tech
    - ED Tech
    - Imaging Office Specialist
    - Patient Access Specialist
    - Phlebotomist
    - Ultrasound
    - Unit Secretary
    - Surgical Technicians
    - Surgical Team Assistant
    - RN 1st Assistant
- Targeted role debriefs deferred: Medical Assistants and Patient Access Specialist at Rural Health Clinics and Urgent cares due to surge
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- B. Green, R.S. Oeppen, D.W. Smith and P.A. Brennan (2017)[1] recommends team communication tools such as the TeamSTEPPS® tool "CUS" and "2 challenge rule" to flatten hierarchical gradients. "CUS" (I am concerned, uncomfortable, this is a safety issue), tool is required upon hire and is included in annual mandatory training. It is reinforced ad hoc through unit level leadership.

Action Plan:

1. Local leadership evaluate role & unit/department specific concerns; corrective action plan
2. Continue to reinforce TeamSTEPPS® tool "CUS" through the organization, and broadly introduce, spread and reinforce the TeamSTEPPS® 2 Challenge Rule (Kaweah Health terms this tool: "Say it again, Sam".)
3. Developing plan to incorporate job shadowing in RN orientation to gain a better understanding of ancillary roles (ie. telemonitors, lab, and transporters).

[1]B. Green, R.S. Oeppen, D.W. Smith and P.A. Brennan (2017). Challenging hierarchy in healthcare teams – ways to flatten gradients to improve teamwork and patient care . British Journal of Oral and Maxillofacial Surgery, 2017-06-01, Volume 55, Issue 5, Pages 449-453, Copyright © 2017 The British Association of Oral and Maxillofacial Surgeons. Retrieved 10/12/21 from https://www.clinicalkey.com/#!/content/playContent/1-s2.0-S026643561730061X?returnurl=https:%2F%2Flinkinghub.elsevier.com%2Fretrieve%2Fpii%2FS026643561730061X%3Fshowall%3Dtrue&referrer=https:%2F%2Fpubmed.ncbi.nlm.nih.gov%2F

November 2021

Fall Ratings Review Healthgrades & Leapfrog Safety Grade

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

Acronyms

- Pts - Patients
- C. Diff – Clostridium difficile
- SSI – Surgical Site Infection
- MRSA – Methicillin-Resistant Staphylococcus Aureus
- CLABSI – Central Line-Associated Bloodstream Infection
- CAUTI – Catheter-Associated Urinary Tract Infections
- PSI – Patient Safety Indicator
- HAC – Healthcare Acquired Condition
- HAI – Healthcare Acquired Infection
- H-COMP – Consumer Assessment of Healthcare Providers and Systems Composite Score
- HCAHPS – Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- MEDPAR – Medicare Provider Analysis and Review (contains records for 100% of Medicare beneficiaries who use hospital inpatient services. The records are stripped of most data elements that will permit identification of beneficiaries)
- GI – Gastrointestinal
- CMS – Centers for Medicare and Medicaid Services

Healthgrades Ratings Report

Fall 2021

Healthgrades Methodolgy

Healthgrades® 2022 Clinical Outcomes Methodology

- *Independently analyze each short-term acute care hospital in the country: ~4,500 hospitals*
- ***Hospitals may not opt-in or opt-out***
- *3-years of Medicare patient data (2018-2020)**
- *Risk-Adjusted statistical model considers patient acuity, driving a predicted value*
- *Star ratings determined by actual performance vs. predicted performance*

★★★★★ Outcomes **better** than expected ~ 15%

★★★ Outcomes **as expected** ~ 70%

★ Outcomes **worse** than expected ~ 15%

Mortality Rates

Did patients die during or after their care?

Complication Rates

Did patients experience unexpected issues during their hospital stay?

*All pts with a diagnosis of COVID-19 from Jan 1- Sept. 30, 2020 removed from analysis

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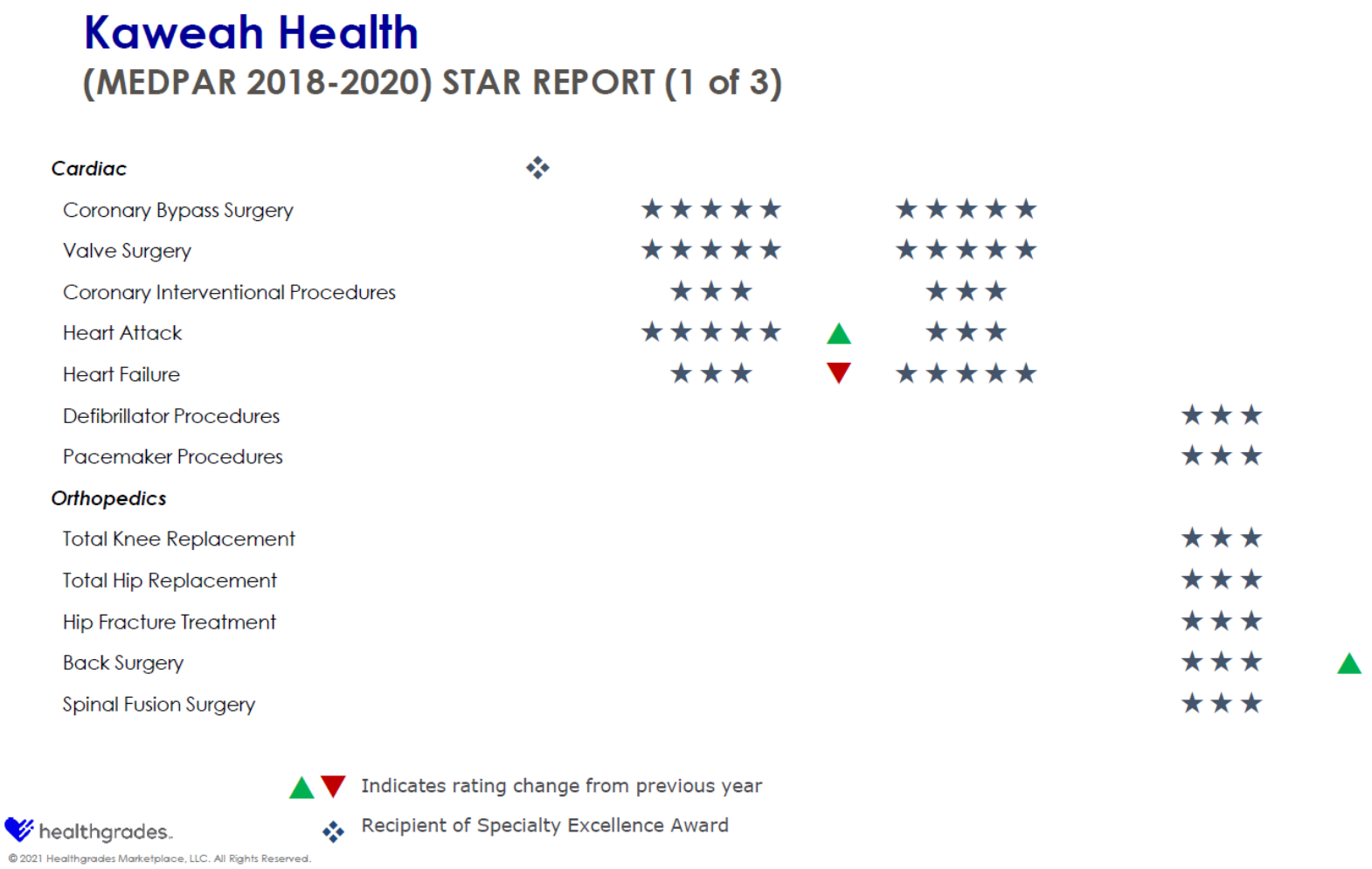
Kaweah Healthgrades



Kaweah Healthgrades

Kaweah Health
(MEDPAR 2018-2020) STAR REPORT (2 of 3)

2022 Medpar Ratings		Mortality Inhospital	Mortality Inhospital + 30	Complications	
Neurosciences					
Cranial Neurosurgery		★★★	★★★		
Stroke	❖	★★★★★	★★★★★		
Pulmonary	❖				
Chronic Obstructive Pulmonary Disease		★★★★★	★★★		
Pneumonia		★★★★★	★★★★★		
Vascular					
Repair of Abdominal Aorta				★★★	
Carotid Procedures				★★★	
Peripheral Vascular Bypass				★★★	
Prostate Surgery					
Prostate Removal Surgery				★	▼

▲▼ Indicates rating change from previous year

❖ Recipient of Specialty Excellence Award

healthgrades.

Kaweah Healthgrades

Kaweah Health

(MEDPAR 2018-2020) STAR REPORT (3 of 3)

2022 Medpar Ratings	Mortality Inhospital	Mortality Inhospital + 30	Complications
Gastrointestinal			
Upper Gastrointestinal Surgeries	★★★	★★★	
Colorectal Surgeries	★★★	★★★	
GI Bleed	★★★★★ ▲	★★★	
Bowel Obstruction	★★★	★★★	
Pancreatitis	★★★	★★★	
Gallbladder Removal Surgery			★★★ ▼
Critical Care ❖			
Sepsis	★★★★★	★★★★★	
Pulmonary Embolism	★★★	★★★	
Respiratory Failure	★★★★★	★★★★★	
Diabetic Emergencies			★★★

▲▼ Indicates rating change from previous year

❖ Recipient of Specialty Excellence Award

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Kaweah Achievements

Cardiac

Recipient of the Healthgrades Cardiac Surgery Excellence Award™ for 6 Years in a Row (2017-2022)
Named Among the Top 5% in the Nation for Cardiac Surgery for 5 Years in a Row (2018-2022)
Named Among the Top 10% in the Nation for Cardiac Surgery for 6 Years in a Row (2017-2022)
Five-Star Recipient for Coronary Bypass Surgery for 6 Years in a Row (2017-2022)
Five-Star Recipient for Valve Surgery for 2 Years in a Row (2021-2022)
Five-Star Recipient for Treatment of Heart Attack in 2022
Five-Star Recipient for Treatment of Heart Failure for 2 Years in a Row (2021-2022)

Neurosciences

Recipient of the Healthgrades Stroke Care Excellence Award™ for 4 Years in a Row (2019-2022)
Named Among the Top 10% in the Nation for Treatment of Stroke for 4 Years in a Row (2019-2022)
Five-Star Recipient for Treatment of Stroke for 8 Years in a Row (2015-2022)

Pulmonary

Recipient of the Healthgrades Pulmonary Care Excellence Award™ for 9 Years in a Row (2014-2022)
Named Among the Top 5% in the Nation for Overall Pulmonary Services for 2 Years in a Row (2021-2022)
Named Among the Top 10% in the Nation for Overall Pulmonary Services for 9 Years in a Row (2014-2022)
Five-Star Recipient for Treatment of Chronic Obstructive Pulmonary Disease for 2 Years in a Row (2021-2022)
Five-Star Recipient for Treatment of Pneumonia for 9 Years in a Row (2014-2022)

Gastrointestinal

Five-Star Recipient for Treatment of GI Bleed in 2022

Critical Care

Recipient of the Healthgrades Critical Care Excellence Award™ for 3 Years in a Row (2020-2022)
Named Among the Top 5% in the Nation for Critical Care for 2 Years in a Row (2021-2022)
Named Among the Top 10% in the Nation for Critical Care for 3 Years in a Row (2020-2022)
Five-Star Recipient for Treatment of Sepsis for 10 Years in a Row (2013-2022)
Five-Star Recipient for Treatment of Respiratory Failure for 4 Years in a Row (2019-2022)

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Kaweah Achievements

Kaweah Healthgrades

Summary and follow up:

- Improvements: 3 to 5 stars in Heart Attack and GI Bleed In-hospital Mortality, 1 to 3 star Back Surgery Complications
- Decrease: 5 to 3 star Heart Failure In-hospital Mortality, Gallbladder Removal Surgery Complications. Prostate Removal Surgery, 3 to 1 star (8 / 85 cases, five with post op ileus resolved in 1-2 days, one transient hypotension, one post op fever) to be reviewed with Surgical Quality Medical Director
- Detailed review of each population with Healthgrades to include all stakeholders. Healthgrades reviews assist in identifying potential opportunities for continued improvement

Leapfrog Safety Grade

Fall 2021

Leapfrog Safety Grade

Released November 10, 2021

- Leapfrog Hospital Safety Grades (formerly known as Hospital Safety Scores) are assigned to over 2,700 general acute-care hospitals across the nation twice annually.
- 32 Measures included in the safety grade calculation and are taken from the Centers for Medicare & Medicaid Services (CMS) and the Leapfrog Hospital Survey. Included measures focused on:
  - Healthcare acquired infections (5)
  - Patient experience (5)
  - Safe practices such as hand hygiene program, safety culture measurement & quality improvement and bar code medication administration, computerized provider order entry, ICU physician staffing, and nurse staffing/adverse events (7)
  - Post op complications, healthcare acquired conditions (15 – PSI90 is a composite measure based on 10 different complications)
- Performance on each component is based on a z-score. This means a hospital's score is dependent on how other hospitals perform

Kaweah Health Hospital Safety Score Fall 2021 = 3.205
Letter Grade Key: A = >3.133 B= >2.964 C= >2.476 D= >2.047

Kaweah Health Past Safety Grades

Leapfrog Safety Grade

Improvement from Spring 2021 “B” to Fall 2021 “A”

Since the Spring 2021 Score Kaweah Health has achieved:

- Reductions in 4 of the 5 Healthcare Acquired Infections included in the grade calculation (CAUTI, CLABSI, SSI, C. Diff).
- Continued strong execution of 7 organizational safe practices such as a comprehensive hand hygiene program, safety culture measurement and improvement, bar code medication administration, ICU physician staffing, etc).
- Better than national rates in post-operative complications and healthcare acquired conditions
- Improvements in 2/5 patient experience measures (staff responsiveness and discharge communication)

Changes in the Fall 2021 Leapfrog Safety Grade Measures/Calculations:

1) Points available for the Org Hand Hygiene Program were increased from 60 to 100, and
2) Replaced 5 individual PSI measures (post op complications) with the 1 PSI 90 composite measure (8 PSIs used to calculate 1 measure).

Leapfrog Safety Grade

Data Date Ranges:

Safe Practices/Leapfrog Survey – June 2021

HCAHPS (CMS)- 01/01/2019–12/31/2019

HACs (CMS) - 07/01/2017–06/30/2019

HAIs (CMS) - 04/01/2019–12/31/2019 and 07/01/2020– 9/30/2020

PSIs (CMS) - 07/01/2018–12/31/2019

	Leapfrog Safety Grade Measure	Kaweah Health Fall 2021 Scores	Kaweah Health Spring 2021 Scores	Mean Fall 2021	Mean Spring 2021	Final Weight
Process/Structural Measures Higher is better	Computerized Physician Order Entry (CPOE) (Leapfrog Survey)	100	100	85.77	82.19	5.9%
	Bar Code Medication Administration (BCMA) (Leapfrog Survey)	100	100	83.25	81.76	5.8%
	ICU Physician Staffing (IPS) (Leapfrog Survey)	100	100	62.82	60.72	7.1%
	Safe Practice 1: Culture of Leadership Structures and Systems	120.00	120	116.85	117.30	3.2%
	Safe Practice 2: Culture Measurement, Feedback, & Intervention	110.00	120	116.49	117.11	3.3%
	Safe Practice 9: Nursing Workforce	100.00	100	98.16	98.38	4.3%
	Hand Hygiene (Leapfrog Survey)	100	60	74.36	59.22	4.9%
	H-COMP-1: Nurse Communication	90	90	91.10	91.03	3.1%
	H-COMP-2: Doctor Communication	89	89	91.00	90.91	3.1%
	H-COMP-3: Staff Responsiveness	86	86	84.38	84.20	3.1%
	H-COMP-5: Communication about Medicines	77	77	77.66	77.52	3.1%
	H-COMP-6: Discharge Information	87	87	86.51	86.49	3.1%
Outcome Measures Lower is better	Foreign Object Retained (HAC)	0.065	0.065	0.02	0.02	4.3%
	Air Embolism (HAC)	0.000	0	0.0004	0.0004	2.5%
	Falls and Trauma (HAC)	0.327	0.327	0.42	0.43	4.7%
	CLABSI (HAI)	1.063	1.071	0.81	0.67	4.6%
	CAUTI (HAI)	1.124	1.627	0.75	0.72	4.5%
	SSI: Colon (HAI)	0.266	0.498	0.80	0.81	3.4%
	MRSA (HAI)	1.865	1.454	0.84	0.80	4.5%
	C. Diff. (HAI)	0.192	0.291	0.54	0.58	4.3%
	PSI 4: Death rate among surgical inpatients with serious treatable conditions	155.29	168.71	159.67	164.57	2.0%
	CMS Medicare PSI 90: Patient safety and adverse events composite	0.86	n/a	1.00	n/a	15.2%

Process Measure Domain Score:	0.159152
Outcome Measure Domain Score:	0.04632
Process/Outcome Domains - Combined Score:	0.205472
Normalized Numerical Score:	3.205472
Hospital Safety Grade (Letter Grade):	A

Leapfrog Safety Grade

Sustaining the "A"

- Continued focus on Healthcare Acquired Infections (CAUTI, CLABSI, MRSA & SSI)
  - Quality Focus Teams – multidisciplinary approach to ensure Infection Prevention best practices are evaluated, implemented and adhered to
- Diligent measurement and oversight quality improvement work in: safety culture, organizational hand hygiene program
- Steady focus on using technology that improves patient safety including bar code medication administration and computerized provider order entry
- Concentrated efforts in improving patient experience through leader rounding
- Continued work on Patient Safety Indicators through a multidisciplinary approach to case review, and quality improvement work through the Surgical Quality Improvement Committee

Questions?

Live with passion.

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

Kaweah Health

Clinical Quality Goal Update

November 2021

FY22 Clinical Quality Goals

	July-Sept 2021 Higher is Better	FY22 Goal	FY21	FY21 Goal
SEP-1 (% Bundle Compliance)	66%	≥ 75%	74%	≥ 70%

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

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

Lower is Better	July 2021	Aug 2021	Sept 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	June 2022	Estimated Annual Number Not to Exceed to Achieve Goal*	FYTD SIR** (number of actual/ number expected)	FY22 Goal	FY21 FY20
CAUTI Catheter Associated Urinary Tract Infection	1	3	4	2									20	1.436	≤0.676	0.54 1.12
CLABSI Central Line Associated Blood Stream Infection	0	4	3	3									16	1.600	≤0.596	0.75 1.20
MRSA Methicillin-Resistant Staphylococcus Aureus	2	0	1	3									6	2.571	≤0.727	2.78 1.02

*based on FY21 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 – SEP-1 is an "all or nothing" measure

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

July 2021

Overall Sep-1 Compliance: 66%

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

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

August 2021

Overall Sep-1 Compliance: 75%

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

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

September 2021

Overall Sep-1 Compliance: 57%

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

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

- Sepsis required physician notification of sepsis alert - results in timely best practice intervention, "the bundle" COMPLETE, GO LIVE 6/29/21!
- Increasing CMS sampling during COIVD to generate a more statistically significant denominator
- Re-identifying root causes of SEP-1 bundle non-compliance to revise prioritized QI strategy list with stakeholders. Completion goal 11/30/21
- Exploring alert triggers with ISS
- Exploring RRT RNs helping with sepsis alerts during coordinator off hours

Key Strategies

CAUTI & CLABSI

- "ICU Forum" January 2022, educate & inspire!
  - Goal: gather insight on challenges and solutions to applying the CLABSI and CAUTI prevention bundles to ICU/COVID patients
- Culture of Culturing
  - Data analysis on "pan culture rates" and orders for cultures when a culture was ordered within 5 days
- Kaizen Reboot for CAUTI prevention;
  - additional root causes identified and QI strategies developed focused on RN implementation of protocols and cleanliness
- CLABSI QFT
  - Peripheral IV QI - Including peripheral IVs to critical care gemba, and evaluating "just in case lines" and care practices

"Operation Catheter Insertion Kits" October 2021

Key Strategies MRSA QFT

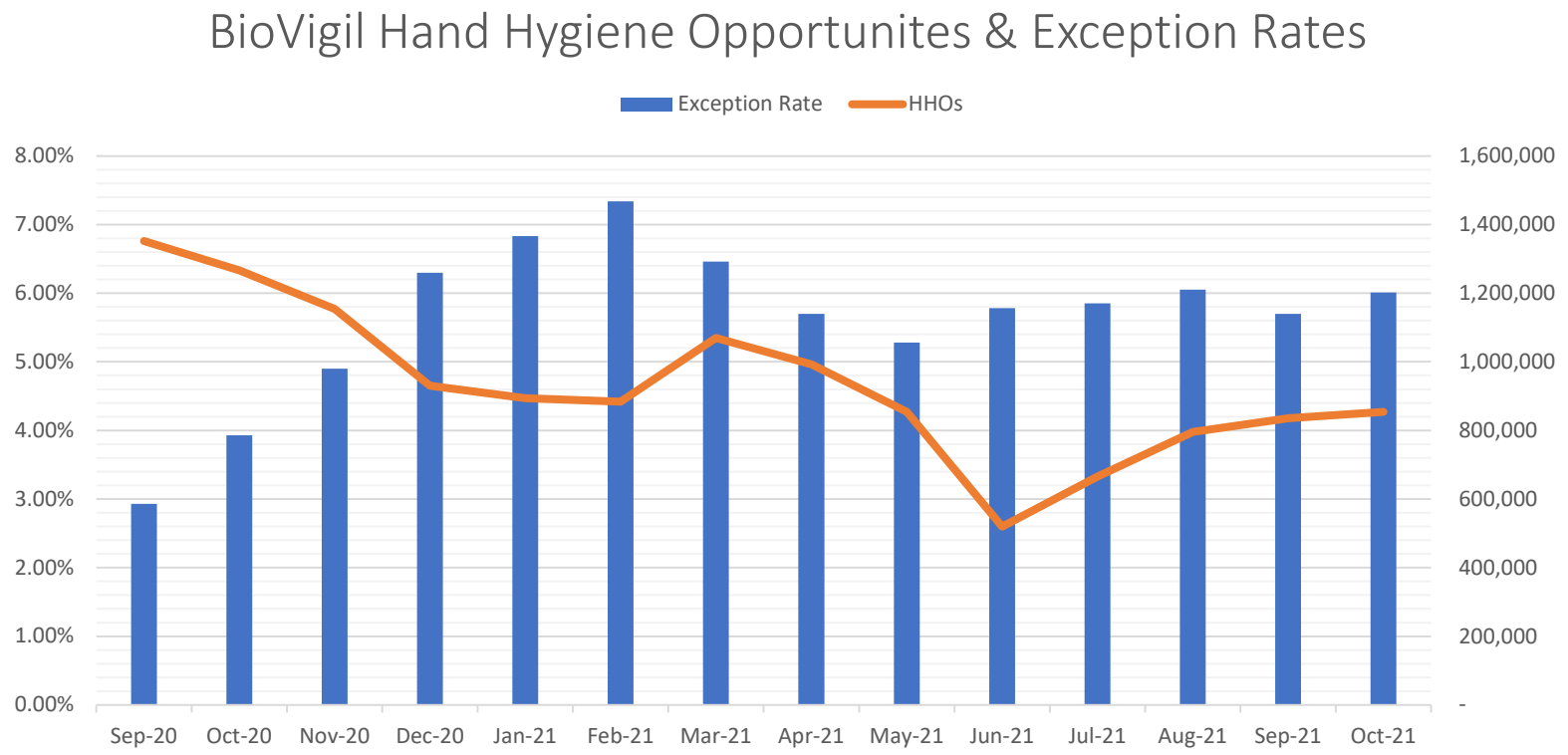
Planned Interventions to reduce MRSA Bloodstream infection

1. Hand Hygiene – BioVigil and Non-BioVigil areas, 95% compliance & use of BioVigil system

Goal: return to September 2020

High volume of HHO

Low exception rates



Key Strategies MRSA QFT

Planned Interventions to reduce MRSA Bloodstream infection

1. Hand Hygiene – BioVigil and Non-BioVigil areas, 95% compliance & use of BioVigil system
2. Decolonization Processes
   - ICU and 4N Trial with standardize procedure, goal November go live
   - Dashboards (over all and unit level) for steps of decolonization process outside trial units
3. Environment & Equipment Cleaning
   - By end of September use ATP monitoring to evaluate cleanliness/compliance with policy on patient care equipment cleaning (primarily nursing processes)
   - Ongoing efforts to address cleanliness (primarily EVS processes), prioritize units
4. Evaluating MRSA Patient Movement

Questions?

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