June 9, 2023

NOTICE

The Board of Directors of the Kaweah Delta Health Care District will meet in a Quality Council Committee meeting at 7:30AM on Thursday, June 15, 2023, in the Kaweah Health Lifestyle Fitness Center Conference Room, 5105 W. Cypress Avenue, Visalia, CA 93277.

The Board of Directors of the Kaweah Delta Health Care District will meet in a Closed Quality Council Committee at 7:31AM on Thursday, June 15, 2023, in the Kaweah Health Lifestyle Fitness Center Conference Room, 5105 W. Cypress Avenue, Visalia, CA 93277, pursuant to Health and Safety Code 32155 & 1461.

The Board of Directors of the Kaweah Delta Health Care District will meet in an open Quality Council Committee meeting at 8:00AM on Thursday, June 15, 2023, in the Kaweah Health Lifestyle Fitness center Conference Room, 5105 W. Cypress Avenue, Visalia, CA 93277.

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

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

KAWEAH DELTA HEALTH CARE DISTRICT
Michael Olmos, Secretary/Treasurer

Cindy Moccio

Cindy Moccio
Board Clerk, Executive Assistant to CEO

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

KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS
QUALITY COUNCIL

Thursday, June 15, 2023
5105 W. Cypress Avenue
Kaweah Health Lifestyle Fitness Center Conference Room

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

OPEN MEETING – 7:30AM

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

CLOSED MEETING – 7:31AM

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

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

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

OPEN MEETING – 8:00AM

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

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

3. **Written Quality Reports –** A review of key quality metrics and actions associated with the following improvement initiatives:
   - 3.1. Infection Prevention Quarterly Dashboard
   - 3.2. Hand Hygiene Report
   - 3.3. Diversion Prevention Committee Report
   - 3.4. Subacute Quality Report

4. **Nursing Workforce Study –** A review of the nursing work force, staffing, and improvement plans. *Emma Camarena DNP, RN, ACCNS-AG, CCRN, Director of Nursing Practice*

5. **Clinical Quality Goals Update-** A review of current performance and actions focused on the clinical quality goals for Sepsis, and Healthcare Acquired Infections. *Sandy Volchko, RN, DNP, Director of Quality and Patient Safety.*

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.

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2022							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
I. Environmental Surveillance							
A. **Sterilization and High Level Disinfection Quality Control**							
Goal <2% of Immediate Use Sterilization		1.93%	2.49%	2.07%	1.74%		**1st QTR:** The quarter average was just below 2%. IUSS during the month of March was very high and related to Cardiac Surgery. The instruments involved in the increase of IUSS are retractors and forceps. There is work underway to address processing times to shore-up the IUSS activity. **2nd QTR:** IUSS activity continues to be higher than goal. **3rd QTR:** IUSS activity is improving, almost meeting goal. 7 events are due to instrument turnaround time; 8 events are due to instruments not being available; 2 events due to a contaminated instrument during surgery ; and 1 event in which the instrument was not available due to turnaround time. **4th QTR:** There were a total of 46 IUSS events out of 2,633 procedures performed (both general and cardiac surgeries). IUSS generally performed for orthopedic line surgeries. Common trends (holder & bipolar forcep x 4 events; hip retractors x 2 events; several other retractors x 4 events, accounts for 22% of the IUSS events this quarter).
B. Dialysis Water/Dialysate Quality Control (AAMI RD52:2004) (% of machines that did not exceed limits)							
Acute Dialysis (Inpatient) RO Water [Target: <200cfu] [Action: > or = 50cfu] Endotoxin [Target: <2EU] [Action: > or = 1EU]		0%	0%	0%	0%		**1st QTR:** 51 Acute Dialysis RO Outlet samples and 6 Dialysis Machine samples were tested for bacterial & endotoxin counts and all results were within acceptable parameters. **2nd QTR:** 51 Acute Dialysis RO outlet samples and 6 Dialysis Machine samples were tested for bacterial & endotoxin counts and all results were within acceptable parameters. **3rd QTR:** 51 Acute Dialysis RO outlet samples and 5 Dialysis Machine samples were tested for bacterial & endotoxin counts and all results were within acceptable parameters. **4th QTR:** 51 Acute Dialysis RO outlet samples and 2 Dialysis Machine samples were tested for bacterial & endotoxin counts and all results were within acceptable parameters.

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2022							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
Outpatient Dialysis RO Water [Target: <200cfu] [Action: > or = 50cfu] Endotoxin [Target: <2EU] [Action: > or = 1EU]		0%	0%	0%	0%		**1st QTR:** 6 Outpatient Dialysis RO Outlet samples and 7 Dialysis Machine samples were tested for bacterial & endotoxin counts and all results were within acceptable parameters. **2nd QTR:** 7 Outpatient Dialysis RO Outlet samples and 8 Dialysis Machine samples were tested for bacterial endotoxin counts and all results were within acceptable parameters. **3rd QTR:** 6 Outpatient Dialysis RO Outlet samples and 6 Dialysis Machine samples were tested for bacterial endotoxin counts and all results were within acceptable parameters. **4th QTR:** 6 Outpatient Dialysis RO Outlet samples and 6 Dialysis Machine sample were tested for bacterial endotoxin counts and all results were within acceptable parameters.
C. Environmental Cleaning (ATP testing surfaces)							
Pass/Fail based on a threshold of ATP score of <200. Multiple high-touch surfaces tested each month.	Goal 100%	69%	83.4%	80.3%	65.49%		**1st QTR:** A total of 589 samples were tested, 406 passed on first sweep, 182 failed. For all failed results the room was re-cleaned. **2nd QTR:** A total of 339 samples were tested with 283 passing on first sweep, 59 failed. For all failed results the room was re-cleaned. Areas tested include (CVICU, MB, ICU, 4N, 5T, 3S, CVOR, OR, Main OR, OBOR, Cath Lab, 2E, 2N, 3N, 4S, BP, and PEDS.). Surfaces with greatest fallout are: Room sink, Rest Room sink, OR Table, Bedside Telephone. **3rd QTR:** A total of 418 samples were tested (79 or 23% increase from 2nd QTR), and 336 samples passed on first sweep, 82 failed. For all failed results the room was re-cleaned. Areas tested include (4T, 4S, ICU, 3N, 3S, 2E, 5T, 2S, 3W, Peds, Cath Lab, CVOR, CVICU, Main OR, 4N, BP, MB, OR). Sufaces with greatest fallout are: Overbed table, Calllight Button, Room Doorknob, Room Chair. EVS Leadership is working on streamlining and standardizing ATP testing to 30 specimens for each location. **4th QTR** A total of 648 samples were tested (35% increase from 3rd QTR), and 425 samples passed on first sweep, 223 failed. For all failed results the room was re-cleaned. Surfaces with greatest fallout are: Overbed/Bedside table, Room doorknob, Call button, Bedrails, and chair. EVS Leadership is working on refining sampling process to ensure timely sampling in advance of any potential recontamination of a clean surface to be tested.
II. Antimicrobial Stewardship Measures							

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2022							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
# of antibiotic IV to PO conversion		257	271	182	173	883	**1st QTR:** There were a total of 257 IV to PO conversion ABS interventions. The majority occurred CVICU and 3S. **2nd QTR:** There were a total of 271 IV to PO conversion ABS interventions. The majority occurred CVICU and ICU. The least occured in the ED. **3rd QTR:** There were a total of 182 IV to PO conversion ABS intervention. The majority occurred in CVICU, 3W and 1E/ED. **4th QTR:** There were a total of 173 IV to PO conversion ABS interventions. The majority occurred in CVICU and ICU.
Average Days of Therapy per 1,000 patient days - Fluoroquinolones		Not available	Not available	Not available	Not available		**1st QTR:** This information is unavailable for 1st QTR. It will be presented at next IP Committee meeting. **2nd QTR:** This information is unavailable for 2nd QTR. It will be presented at next IP Committee meeting. **3rd QTR:** This information is unavailable for 3 QTR. A new ID Pharmacist has started and 2nd/3rd QTR information should be available by 4th QTR. **4th QTR:**
Average Days of Therapy per 1,000 patient days - Carbapenems		Not available	Not available	Not available	Not available		**1st QTR:** This information is unavailable for 1st QTR. It will be presented at next IP Committee meeting. **2nd QTR:** This information is unavailable for 2nd QTR. It will be presented at next IP Committee meeting. **3rd QTR:** This information is unavailable for 3 QTR. A new ID Pharmacist has started and 2nd/3rd QTR information should be available by 4th QTR. **4th QTR:**
III. Employee Health							
A. Needlestick Injuries							

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2022							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
Number of sharps/needle stick reports		11	15	NA	19		**1st QTR:** 6 events involved GME Residents. 5 RNs account for the remaining needlestick events. There were 5 events related to a needle with safety mechanism, 3 events related to an insulin syringe with safety mechanism, and 2 events involving sutures. **2nd QTR:** 8 events with the majority involving RNs (5) followed by LVNs (1) and Aides (1). Most needle sticks occur when engaging the needle safety mechanism with 3 of the devices involved in events being insuling syringes with a safety mechanism. There were additional events reported for 2nd QTR (3rd QTR data not yet available). An additional 7 sharps exposures occurred involving primarily needles with a safety mechanism, insulin syringes and sutures. This events are chiefly distributed among nurses and GME Residents. GME Residents account for the greatest number of sharps exposure during 2nd QTR. **3rd QTR:** Date not available yet. Late report - there were 18 needlestick/sharps events, most associated with needle-safety and suture usage. The greatest majority of sharps exposures were related to Lab personnel with (5) events, followed by GME residents with (3) events. **4th QTR**: 19 events with GME residents incurring the greatest volume of needlesticks (8), with 3 events involving suture and 2 events with a scape, and 1 event with a guide wire. The remaining events were primarily associated with Registered Nurses (7) involving syringes. Thereafter, are isolated events involving an LVN (1), EVS worker (1), Aide (1) and phlebotomy tech (1).
B. Blood/Body Fluid Exposures							
Number of blood/body fluid exposures		3	0	NA	NA		**1st QTR:** 1 event with blood to eye from IV pigtail. 1 event blood to eye with drawing lab specimen. 1 event involving IV fluid/blood present during disconnecting the IV. **2nd QTR:** No splash events reported. **3rd QTR:** Data not available yet. **4th QTR:** Data not available.
IV. Healthcare Associated Infection Measures							
I. Overall Surgical Site Infections (SSI)	**IR/SIR**						**SSIs calculated internally though standard incidence rate and externally through Standardized Infection Ratio (SIR) from National Health and Safety Network (NHSN).**
A. #Total Procedure Count		764	918	999	522		**Cumulative Ct:** 3,203
B. Total Infection Count *[note: SSI events can be identified up to 90 days from the last day of the month in each quarter and only DIP and Organ Spc SSI are reported in NSHN]*		5	5	10	7	27	**1st QTR:** 5 **Predicted:** 11.627 **2nd QTR:** 5 **Predicted:** 12.993 **3rd QTR:** 10 **Predicted:** 12.933 **4th QTR:** 7 **Predicted:** 8.252

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2022							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
C. Incidence Rate (IR) [# of total SSI infections/# total procedures x 100]	Internal 0.70 Goal	0.654	0.54	1	1		**1st QTR:** Better than State benchmark. **2nd QTR:** Better than State benchmark. **3rd QTR:** No different than State benchmark. **4th QTR:** No different than State benchmark.
D. SIR Confidence Interval (CI-KDHCD predicted range, based on risks)		0.158, 0.953	0.141, 0.853	0.393, 1.378	0.371, 1.878		**1st QTR:** With 95% confidence the SSI event incidence rate appropriately reflects the population. **2nd QTR:** With 95% confidence the SSI event incidence rate appropriately reflects the population. **3rd QTR:** With 95% confidence the SSI event incidence rate appropriately reflects the population. **4th QTR:** With 95% confidence the SSI event incidence rate appropriately reflects the population.
E. Standardized Infection Ratio (SIR)	NHSN	0.43	0.385	0.773	0.848		**1st QTR:** There were 1 CSEC, 1 KPRO, 1 SB, 2 XLAP SSI events. All events were superficial incision primary events. Continuing to monitor SSI events for particular trends. **2nd QTR:** There were 2 APPY, 2 COLO, 2 CSEC, 1 GAST, 2 KPRO, 1 SB SSI events in total. There 5 events of deep SSI events, amongst the total the following were deep SSI events 2 APPY, 2 CSEC, 1 KPRO. Findings for deep SSI events include: excessive entry/exit during surgery, clean closure procedure not performed, pre-op antibiotic administration not documented (uncertain if it occured), documentation to support PATOS or infection present at start of surgery. **3rd QTR:** There were 2 COLO, 1 CBGB, 1 CSEC, 1 KPRO, 1 HYST, 2 HER, 1 FX, 1 SB **4th QTR:** There were 3 COLO, 2 APPY, 2 FUSN, 1 HYST, 1 FX *two cases met SIP criteria and don't count in NHSN for reporting purposes
V. Specific Surgical Review	**SIR**						
A. Colon Surgery (COLO) CMS/VBP							
1. #Total Procedure Count		28	37	28	31		**Cumulative Ct:** 124
2. Total Infection Count		0 [0]	0 [0]	2 [0]	3 [1]	5 [1]	**1st QTR:** 0 **Predicted:** 1.983/**CMS** 0 **Predicted:** 0.874 **2nd QTR:** 0 **Predicted:** 2.186/**CMS** 0 **Predicted:** 1.206 **3rd QTR:** 2 **Predicted:** 1.797 /**CMS** 0 **Predicted:** 0.909 **4th QTR:** 3 **Predicted:** 1.838 /**CMS** 1 **Predicted:** 0.976
3. SIR CI (KDHCD predicted range, based on risks)		, 1.511	, 1.370	0.187, 3.678	0.415, 4.442		**1st QTR:** With 95% confidence the absence of COLO SSI events appropriately reflects the population. **2nd QTR:** With 95% confidence the absence of COLO SSI events appropriately reflects the population. **3rd QTR:** With 95% confidence that absence of COLO SSI events appropriately reflects the population. **4th QTR:** With 95% confidence that absence of COLO SSI events appropriately reflects the population.

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2022							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
4. SIR (Standardized Infection Ration) total Value Based Purchasing (VBP) SIR = [ ]	VBP Goal <0.717	0.00	0	1.113	1.532		**1st QTR:** No COLO SSI events. **2nd QTR:** No COLO SSI events. **3rd QTR:** 2 COLO SSI events, both involve substitution of Cefotetan to Cefoxitan pre-op prophylactic antibiotic treatment. Hair removal in the O.R. was true for one case. Surgeon left 50 minutes prior to closure in the second case - patient had many comorbidities. **4th QTR:** 3 COLO SSI events. One event due to no clean closure. 2 events due to incision dehiscence and pooring healing wounds.
B. Cesarean Section (CSEC)							
1. #Total Procedure Count		230	220	279	139		**Cumulative Ct:** 868
2. Total Infection Count		1	2	1	0	4	**1st QTR:** 1 **Predicted:** 2.064 **2nd QTR:** 2 **Predicted:** 2.022 **3rd QTR:** 1 **Predicted:** 2.433 **4th QTR:** 0 **Predicted:** 1.336
3. SIR CI (KDHCD predicted range, based on risks)		0.024, 2.390	0.166, 3.268	0.021, 2.027	, 2.242		**1st QTR:** With 95% confidence the 1 CSEC event is representative of the population of CSEC procedures performed. **2nd QTR:** With 95% confidence the 1 CSEC event is representative of the population of CSEC procedures performed. **3rd QTR:** With 95% confidence the 1 CSEC event is representative of the population of CSEC procedures performed. **4th QTR:** With 95% confidence the 1 CSEC event is representative of the population of CSEC procedures performed.
4. SIR (Standardized Infection Ration) total	Goal SIR <1.00	0.49	0.989	0.411	0.00		**1st QTR:** There was 1 superficial Cesarean section SSI event 3 days post-op. Pre-op antibiotics not documented. **2nd QTR:** Both CSEC events were deep. One involved a patient with peripartum fever and infection 14 days post-op. The second event involved a procedure in which pre-op antibiotics were not documented making difficult to ascertain whether antibiotics were administered. **3rd QTR:** There was 1 superficial Cesarean section SSI event 9 days post-op involving a patient with a large pannus. Opsite was placed over incision site. Patient would have likely benefited from a Provena dressing over incision site instead. **4th QTR:** There were no CSEC SSI events.
C. Spinal Fusion (FUSN)							
1. #Total Procedure Count		44	62	67	51		**Cumulative Ct:** 224
2. Total Infection Count		0	0	0	2	2	**1st QTR:** 0 **Predicted:** 0.792 **2nd QTR:**0 **Predicted:** 1.133 **3rd QTR:** 0 **Predicted:** 0.917 **4th QTR:** 2 **Predicted:** 0.953

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2022

		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
3. SIR CI (KDHCD predicted range, based on risks)		NA	NA	NA	NA		**1st QTR:** With 95% confidence the absence of FUSN SSI events appropriately reflects the population. **2nd QTR:** NA **3rd QTR:** NA **4th QTR:** NA
4. SIR (Standardized Infection Ration) total	Goal SIR <1.00	0.00	0	0	0.953		**1st QTR:** No Spinal Fusion surgical site infections reported. **2nd QTR:** No Spinal Fusion surgical site infections reported. **3rd QTR:** No Spinal Fusion surgical site infections reported. **4th QTR:** There were 2 Spinal Fusion surgical site infections. One developed a deep infection caused by E. cloacae 11 days post-op. The second developed a superficial infection caused by P. aeruginosa 23 days post-op. Infection noted at Kaweah Rehab.
D. Hysterectomy (HYST) CMS/VBP							
1. #Total Procedure Count		14	15	15	10		**Cumulative Ct:** 54
2. Total Infection Count		0 [0]	0 [0]	1 [1]	0 [0]	1	**1st QTR:** 0 **Predicted:** 0.298/**CMS** 0 **Predicted:** 0.108 **2nd QTR:** 0 **Predicted:** 0.275 **/CMS** 0**Predicted:** 0.126 **3rd QTR:** 1 **Predicted:** 0.298/**CMS** 1 **Predicted:** 0.136 **4th QTR:** 0 **Predicted:** 0.225/**CMS** 0 **Predicted:** 0.089
3. SIR CI (KDHCD predicted range, based on risks)		NA	NA	NA	NA		**1st QTR:** With 95% confidence the absence of HYST SSI events appropriately reflects the population. **2nd QTR:** NA **3rd QTR:** NA **4th QTR:** NA
4. SIR (Standardized Infection Ration) total Value Based Purchasing (VBP) SIR = [ ]	VBP Goal <0.738	0.00	0	3.36	0		**1st QTR:** There were no Abdominal Hysterectomy surgical site infection. **2nd QTR:** There were no Abdominal Hysterectomy surgical site infection. **3rd QTR:** There was one deep Abdominal Hysterectomy surgical site infection 5 days post-op. Very minimal operative documentation. Uncertain whether clean-closure performed. **4th QTR:** There were no Abdominal Hysterectomy surgical site infection.
VI. Ventilator Associated Events (VAE)	**SIR**						
A. Ventilator Device Use SUR (standardized utilization ratio)		1.83	1.221	0.823	1.858		**1st QTR:** 1,080 **Predicted:** 591.467 **2nd QTR:** 901 **Predicted:** 350.600 **3rd QTR:** 3,052 **Predicted:** 3,707.978 **4th QTR:** 805 **Predicted:** 486.015
B. Total VAEs ICU (NHSN Reportable)	Includes IVAC Plus						

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2022							
		Q1	**Q2**	**Q3**	**Q4**	**AVG. or TOTAL YTD**	**SUMMARY / ACTION**
1. SIR Total VAE CI (KDHCD predicted range, based on risks)		0.006, 1.587	, 0.886	0.300, 2.278	,0.471		**1st QTR:** With 95% confidence the VAE event appropriately reflects the population of patients on a ventilator. **2nd QTR:** With 95% confidence the VAE event appropriately reflects the population of patients on a ventilator. **3rd QTR:** With 95% confidence the VAE event appropriately reflects the population of patients on a ventilator. **4th QTR:** With 95% confidence the VAE event appropriately reflects the population of patients on a ventilator.
2. Total VAEs SIR	<1.0	**0.32**	**0**	**0.944**	**0**		**1st QTR:** Less than predicted number of events. **2nd QTR:** Less than predicted number of events. **3rd QTR:** Slightly less than predicted number of events. **4th QTR:** Less than predicted number of events.
C. Total IVAC Plus -ICU		**1**	**0**	**3**	**0**	**4**	**1st QTR:** Patient had a IVAC event after 5 days of ventilation. **2nd QTR:** No IVAC events. **3rd QTR:** There were 3 IVAC(+) events. **4th QTR:** No IVAC events.
1. Total IVAC Plus CI (KDHCD predicted range, based on risks)		0.016, 1.557	, 2.387	0.486, 5.195	,1.269		**1st QTR:** With 95% confidence the VAE event appropriately reflects the population of patients on a ventilator. **2nd QTR:** Less than predicted number of events. **3rd QTR:** With 95% confidence the VAE event appropriately reflects the population of patients on a ventilator. **4th QTR:** With 95% confidence the VAE event appropriately reflects the population of patients on a ventilator.
2. Total IVAC *Plus* ICU SIR		**0.117**	**0**	**1.909**	**0**		**1st QTR:** Less than predicted number of events. **2nd QTR:** Less than predicted number of events. **3rd QTR:** Greater than predicted number of events. **4th QTR:** Less than predicted number of events.
1. Process Measures							
% of patients with head of bed >30 dregrees per visual inspection.	**Goal = 100%**	**84.7%**	**79.5%**	**93.8%**	**Not performed**		**1st QTR:** 50 of 59 rounds demonstrated a patient with the head of bed at or beyond 30 degrees elevation on visual inspection. **2nd QTR:** 35 responses out of 44 responses. VAE prevention committee is meeting with Respiratory to determine ways in which to increase auditing and compliance. **3rd QTR:** 15 of 16 rounds demonstrated a patient whose head of bed was at >30 degrees. (low sample) **4th QTR:** Limited resources prevented audits during this time.

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2022

		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
% Sedation Vacation	Goal = 100%	92.3%	38.6%	100.0%	Not performed		**1st QTR:** 24 of 26 rounds demonstrated a patient who received a sedation vacation while on the ventilator. **2nd QTR:** 17 responses out of 44 responses. VAE prevention committee is meeting with Respiratory to determine ways in which to increase auditing and improve sedation vacation and mobility efforts. **3rd QTR:** 5 of 5 rounds demonstrated a patient who received a sedation vacation. (very low sample) **4th QTR:** Limited resources prevented audits during this time.
% Oral Care Provided (per visual inspection)	Goal = 100%	93.8%	100.0%	100.0%	Not performed		**1st QTR:** 60 of 64 rounds demontrated a patient who received oral care based on visual inspection of the mouth. **2nd QTR:** 44 responses out of 44 responses. **3rd QTR:** 17 of 17 rounds demonstrated a patient who received oral care based on visual inspection of the mouth. (low sample) **4th QTR:** Limited resources prevented audits during this time.
% CHG Bath within last 24 hours	Goal = 100%	95.3%	100.0%	NA	Not performed		**1st QTR:** 61 or 64 rounds demonstrated a patient who received a CHG bath within the last 24 hours prior to the round. **2nd QTR:** 43 responses out of 43 responses. **3rd QTR:** CHG bathing information no longer monitored as part of the VAP prevention bundle. **4th QTR:** Limited resources prevented audits during this time.
% Vent Tubing Position Appropriately (drain away from patient - visual inspection)	Goal = 100%	90.6%	95.5%	100.0%	Not performed		**1st QTR:** 58 or 64 rounds demonstrated a patient with ventilator tubing positioned appropriately (draining away from the patient's airway). **2nd QTR:** 42 responses out of 44 responses. **3rd QTR:** 17 of 17 rounds demonstrated a patient with ventilator tubing positioned appropriately (draining away from the patient's airway). (low sample) **4th QTR:** Limited resources prevented audits during this time.
VII. Central Line Associated Blood Stream Infections (CLABSI) CMS/VBP	**NHSN SIR**						
A. Total number of Central Line Days (CLD)		4284	3795	2,848	4,121		**Cumulative Ct:** 15,048
B. Central Line Device Use SUR (standardized utilization ratio)		0.736	0.718	0.668	0.751		**1st QTR:** 4284 CLD **Predicted:** 5819.971 **2nd QTR:** 3795 CLD **Predicted:** 5,284.516 **3rd QTR:** 2,848 CLD **Predicted:** 4,265.645 **4th QTR:** 4,121 CLD **Predicted:** 5,484.254
C. Total Infection Count Valule Based Purchasing (VBP) # events = [ ]		3 [0]	5 [3]	3 [2]	5 [3]	16	**1st QTR:** 3 **Predicted:** 4.213/**CMS:** 0 **Predicted:** 2.558 **2nd QTR:** 5 **Predicted:** 3.726/**CMS:** 3 **Predicted:** 2.257 **3rd QTR:** 3 **Predicted:** 2.816/**CMS:** 2 **Predicted:** 2.502 **4th QTR:** 5 **Predicted:** 4.052/**CMS:** 3 **Predicted:** 2.559
D. SIR Confidence Interval		0.181, 1.938	0.492, 2.974	0.271, 2.899	0.452, 2.735		**1st QTR:** Worst than national benchmark. **2nd QTR:** Worst than national benchmark. **3rd QTR:** Worst than national benchmark. **4th QTR:** Worst than national benchmark

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2022							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
E. SIR (Standardized Infection Ratio) total Value Based Purchasing (VBP) SIR = [ ]	≤ 0.589 excluding COVID population	0.712	1.342	1.065	1.234		**1st QTR:** January event due to limited patient bathing and pan-culture practices. February events due to extended Femoral access, limited patient bathing, poor assessment of surgical site; Another extended Femoral access, poor adherance to hand hygiene practice. **2nd QTR:** Events related to source control (i.e. osteomyelitis and endocarditis), family manipulating the patient's vascular line, patient scratching and pinching skin at vascular line insertion site, femoral line access in a patient that it was inappropriate for, and poor hand hygiene practice amongst healthcare workers. **3rd QTR:** First event involved a dislodged port and late orders for cultures. Second event was likely due to respiratory secretions contaminating the insertion site. Last case would have benefited from prophylactic Diflucan to avoid Candidemia. **4th QTR:** (Event-1) Femoral access, blood culturing practices, poor hand hygiene compliance, Candidemia. (Event-2) High risk for Candidemia and translocation of GI bacteria, culturing practices, hand hygiene compliance, Candidemia. (Event-3) Source control, MRSA treatment increased risk of fungal infection, Osteomyelitis in spine due to MRSA, poor hand hygiene compliance, Candidemia. (Event-4) Poor hand hygiene compliance, non-compliant patient pulling out lines, central line used for dialysis, night-shift driving requests for blood cultures. (Event-5) Serial blood cultures for a non-MDRO gram neg organism, persistent positive blood cultures from beginning of admission, late identification of septicemia-5 days post admission, source control-osteomyelitis of lumbar spine.
F. Process Measures							
% of patients with a bath within 24 hours	Goal 100%	96.0%	89.5%	87.1%	95.0%		**1st QTR:** 1,642 responses out of 1,703 rounds. **2nd QTR:** 1,281 responses out 1,432 responses. **3rd QTR:** 2,596 responses out of 2,979 rounds. **4th QTR:** 1,838 responses out of 1,928 rounds.
% of central lines inserted with a valid rationale	Goal 100%	97.0%	96.8%	95.8%	96.0%		**1st QTR:** 1,046 responses out of 1,703 rounds. **2nd QTR:** 822 responses out of 849 responses. **3rd QTR:** 1,517 responses out of 1,584 rounds. **4th QTR:** 2,157 responses out of 2,250 rounds.
% of central line dressings clean, dry and intact	Goal 100%	98.0%	98.5%	97.1%	97.0%		**1st QTR:** 1,042 responses out of 1,703 rounds. **2nd QTR:** 836 responses out of 849 responses. **3rd QTR:** 1,542 responses out of 1,588 rounds. **4th QTR:** 2,190 responses out of 2,250 rounds.
% of central line dressing changes no > than 7 days	Goal 100%	98.0%	91.6%	97.2%	98.0%		**1st QTR:** 1,048 responses out of 1,703 rounds. **2nd QTR:** 772 responses out of 843 responses. **3rd QTR:** 1,543 responses out of 1,588 rounds. **4th QTR:** 1,953 responses out of 1,995 rounds.

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		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
% of patients with properly placed CHG patch	**Goal 100%**	**98.0%**	**90.4%**	**51.9%**	**97.0%**		**1st QTR:** 541 responses out of 552 rounds. **2nd QTR:** 481 responses out 532 responses. **3rd QTR:** 824 responses out of 1,588 rounds. **4th QTR:** 1,038 responses out of 1,070 rounds.
% of patients with appropriate & complete documentation	**Goal 100%**	**95.0%**	**90.9%**	**95.0%**	**94.0%**		**1st QTR:** 1,250 responses out of 1,333 rounds. **2nd QTR:** 768 responses out of 845 responses. **3rd QTR:** 1,507 responses out of 1,587 rounds. **4th QTR:** 2,100 responses out of 2,223 rounds.
# of central line days rounded on		2,871	844	1,584	2,223		**1st QTR:** Approximately, 957 central lines rounds a month. **2nd QTR:** Approximately, 488 central lines rounds a month. **3rd QTR:** Approximately 528 central line rounds a month. **4th QTR:** Approximately 741 central line rounds a month.
Skilled Nursing/Acute Rehab % of central dressing clean/dry/intact	**Goal 100%**	**95.9%**	**99.0%**	**98.3%**	**100.0%**		**1st QTR:** 47 of 49 central dressing were clean, dry and intact. **2nd QTR:** 190 respones out of 192 responses. **3rd QTR:** 119 responses out of 121 rounds. **4th QTR:** 118 responses out of 118 rounds.
Skilled Nursing/Acute Rehab % of central line dressings changed no > 7 days	**Goal 100%**	**NA**	**98.2%**	**98.3%**	**99.2%**		**1st QTR:** There were no reports provided for this metric. **2nd QTR:** 167 responses out of 170 responses. **3rd QTR:** 119 responses out of 121 rounds. **4th QTR:** 118 responses out of 119 rounds.
VIII. Catheter Associated Urinary Tract Infections (CAUTI) CMS/VBP	**NHSN SIR**						
A. Total number of Catheter Device Days (CDD)		4713	3494	3052	4,435		**Cumulative Ct:** 15,694
B. Catheter Device Days SUR (Standardized Utilization Ratio)		**0.915**	**0.751**	**0.823**	**0.928**		**1st QTR:** 4713 CDD **Predicted:** 5150.948 CDD **2nd QTR**: 3494 CDD **Predicted:** 4650.527 CDD **3rd QTR**: 3052 CDD **Predicted**: 5,943.111 CDD **4th QTR:** 4435 CDD **Predicted:** 5484.254 CDD
C. Total Infection Count Value Based Purchasing (VBP) # of events = [ ]		**8** **[5]**	**3** **[3]**	**4** **[4]**	**6** **[2]**	21	**1st QTR:** 8 **Predicted:** 6.115/**CMS:** 5 **Predicted:** 3.240 **2nd QTR:** 3 **Predicted:** 4.549/**CMS:** 3 **Predicted:** 2.089 **3rd QTR:** 4 **Predicted:** 3.970/**CMS:** 4 **Predicted:** 3.216 **4th QTR:** 6 **Predicted:** 5.783 **/CMS:** 2 **Predicted:** 3.218
D. SIR Confidence Interval		0.608, 2.484	0.168, 1.795	0.395, 3.00	0.421, 2.158		**1st QTR:** Worst than national benchmark. **2nd QTR:** Worst than national benchmark. **3rd QTR:** Worst than national benchmark. **4th QTR**: Worst than national benchmark.

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		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
E. SIR (Standardized Infection Ratio) total Value Based Purchasing (VBP) SIR = [ ]	≤ 0.650 excluding COVID population	1.308	0.66	1.244	1.038		**1st QTR:** January events: pan-culturing practices, poor hand hygiene compliance, specimen collection practices, minimal patient bathing. February events: one fever impetus for ordering cultures, pan-culturing practices, specimen collection practices, questionnable indication for indwelling urinary catheter, antimicrobial stewardship, minimal patient bathing. **2nd QTR:** Events related to: single fever as an impetus to culture, peri-care not provided, culture-of-culturing, pan-culturing, and unnecessary cultures. **3rd QTR:** First event may be due to catheter insertion practices. Second event could have been prevented with better hand hygiene compliance, also uncertain why Q1hr. I&Os (rationale for catheter) really was needed considering the patient was on a Med/Surg unit. Third event due to inappropriate culturing practices and inappropriate rationale for indwelling urinary catheter. Fourth case due to insufficient patient bathing and patient pulling on his catheter. **4th QTR:** [Event-1] No rationale provided for indwelling urinary catheter, poor hand hygiene compliance, urine culture sought when patient's death was imminent. [Event-2] Protocol for Bladder Management, urinary retention not followed, missing pericare, pan-culturing activities, poor hand hygiene compliance [Event-3] Pan-culturing activities, not following antimicrobial stewardship, not attempting alternatives to an indwelling urinary catheter [Event-4] Pan-culturing practices, late detection of septicemia, poor patient compliance, poor hand hygiene compliance, not attempting alternative to an indwelling urinary catheter
							[Event-5] Ordering cultures in response to a single elevated temperature reading, pan-culturing practices, likely stool contaminants identified in urine culture, poor hand hygiene compliance [Event-6] Pan-culturing practices, poor hand hygiene compliance.
F. Process Measures							
% of patients with appropriate cleanliness (a minimum of peri-care in the last 12 hours)	Goal 99%	99.0%	96.9%	96.3%	99.0%		**1st QTR:** 1,991 responses out of 2,126 rounds. **2nd QTR:** 751 responses out 775 responses. **3rd QTR:** 1735 responses out of 1803 rounds. **4th QTR:** 1,798 responses out of 1,808 rounds.
% of IUCs with order and valid rationale	Goal 100%	96.0%	95.8%	94.9%	93.0%		**1st QTR:** 1,171 responses out of 1,240 rounds. **2nd QTR:** 738 responses out 770 responses. **3rd QTR:** 1,714 responses out of 1,807 rounds. **4th QTR:** 2,016 responses out of 2,175 rounds.
% of IUCs where removal was attempted		6.3%	1.8%	4.4%	5.0%		**1st QTR:** 56 responses out of 890 rounds. **2nd QTR:** 14 responses out 770 responses. **3rd QTR:** 80 responses out of 1,804 rounds. **4th QTR:** 66 responses out of 1,346 rounds.

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2022

		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
% of patients where alternatives have been attempted		10.4%	6.7%	7.6%	6.0%		**1st QTR:** 129 responses out of 1,235 rounds. **2nd QTR:** 52 responses out 773 responses. **3rd QTR:** 137 responses out of 1,799 rounds. **4th QTR:** 92 responses out of 1,482 rounds.
% of IUCs removed because of unit "GEMBA" rounds		5.2%	4.4%	3.0%	2.0%		**1st QTR:** 64 responses out of 1,237 rounds. **2nd QTR:** 28 responses out of 770 responses. **3rd QTR:** 76 responses out 1,782 rounds. **4th QTR:** 41 responses out of 2,175 responses.
# of IUCs removed because of unit "GEMBA" rounds		64	28	76	41		**1st QTR:** Approximately, 21 indwelling urinary catheters a month were removed as a results of Gemba rounds. **2nd QTR:** Approximately, 9 indwelling urinary catheters a month were removed as a result of Gemba rounds. **3rd QTR:** Approximately, 25 indwelling urinary catheters a month were removed as a result of Gemba rounds. **4th QTR:** Approximately, 41 indwelling urinary catheters a month were removed as a result of Gemba rounds.
# of Indwelling Urinary Catheter days rounded on		2,607	764	1,803	2,175		**1st QTR:** Approximately, 869 rounds on indwelling urinary catheters a month. **2nd QTR:** Approximately, 255 rounds on indwelling urinary catheters a month. **3rd QTR:** Approximately, 601 rounds on indwelling urinary catheters a month. **4th QTR:** Approximately, 725 rounds on indwelling urinary catheter a month.
Skilled Nursing/Acute Rehab % of complete baths performed within 24 hours *(Modification to this measure to start 2022 1st QTR - % of completed baths performed within 48 hours for patients with central lines)*	**Goal 100%**	95.6%	98.1%	98.7%	96.6%		**1st QTR:** 87 of 91 complete baths were performed within 24 hours. **2nd QTR:** 305 responses out of 311 responses. **3rd QTR:** 77 responses out of 78 rounds. **4th QTR:** 226 responses out 234 rounds.
Skilled Nursing/Acute Rehab % of peri care performed within in a 12 hour shift	**Goal 100%**	98.1%	97.9%	94.9%	94.2%		**1st QTR:** 53 of 54 pericare actions were completed and documented within the 12 hour shift. **2nd QTR:** 185 responses out of 189 responses. **3rd QTR:** 74 responses out of 78 rounds. **4th QTR:** 162 responses out of 172 rounds.
IX. Catheter Associated Urinary Tract Infections **Long Term Care/Rehabilitation**	**Goal = 0**						
Short Stay (# of Infections/ Incidence Rate)		0	0	0	0	0	**1st QTR:** There were no CAUTI events. **2nd QTR:** There were no CAUTI events. **3rd QTR:** There were no CAUTI events. **4th QTR:** There were no CAUTI events.
Transitional Care (# of Infections/ Incidence Rate)		0	1	0		1	**1st QTR:** There were no CAUTI events. **2nd QTR:** There was 1 Symptomatic Catheter Associated Urinary Tract Infection events with a foley catheter in place. The CAUTI rate = 2.571 **3rd QTR:** There were no CAUTI events. **4th QTR:** Transitional Care unit has been closed permanently.

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2022							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
Subacute (# of Infections/ Incidence Rate)		0	0	0	0	0	**1st QTR:** There were no CAUTI events. **2nd QTR:** There were no CAUTI events. **3rd QTR:** There were no CAUTI events. **4th QTR:** There were no CAUTI events.
Acute Rehabilitiation (# of Infections/ Incidence Rate)		0	0	0	0	0	**1st QTR:** There were no CAUTI events. **2nd QTR:** There were no CAUTI events. **3rd QTR:** There were no CAUTI events. **4th QTR:** There were no CAUTI events.
X. LTC Symptomatic Urinary Tract Infections	**Goal = 0**						
Short Stay (# of Infections/ Incidence Rate)		2	1	1	1	5	**1st QTR:** There were 2 Symptomatic Urinary Tract Infection events without a foley catheter in place. 1 occurred during February the other during March. The SUTI rate = 0.464. **2nd QTR:** There was 1 Symptomatic Urinary Tract Infection event without a foley catheter in place. The SUTI rate = 0.241 **3rd QTR:** There was 1 Symptomatic Urinary Tract Infection event without a foley catheter in place. SUTI rate = 0.58 **4th QTR:** There was 1 Symptomatic Urinary Tract Infection event without a foley catheter in place. SUTI rate = 0.31.
Transitional Care (# of Infections/ Incidence Rate)		0	0	2		2	**1st QTR:** There were no SUTI events. **2nd QTR:** There were no SUTI events. **3rd QTR:** There were 2 SUTI events. SUTI rate = 2.03. **4th QTR:** Transitional Care unit has been closed permanently.
Subacute (# of Infections/ Incidence Rate)		0	0	0	0	0	**1st QTR:** There were no SUTI events. **2nd QTR:** There were no SUTI events. **3rd QTR:** There were no SUTI events. **4th QTR:** There were no SUTI events.
XI. Clostridium *difficile* Infection (CDI) CMS/VBP	**SIR**						
A. Total Infection Count	All units	9	8	10	16	33	**1st QTR:** 9 **Predicted:** 18.253 **2nd QTR:** 8 **Predicted:** 17.250 **3rd QTR:** 10 **Predicted:** 18.158 **4th QTR:** 16 **Predicted:** 17.181
B. SIR CI (KDHCD predicted range, based on risks)		0.240, 0.905	0.215, 0.881	0.280, 0.982	0.551, 1.480		**1st QTR:** Better than National benchmark. **2nd QTR:** Better than National benchmark. **3rd QTR:** Better than National benchmark. **4th QTR:** Worse than National benchmark.

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2022							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
C. SIR (Standardized Infection Ratio) total Value Based Purchasing (VBP) SIR = [ ]	VBP Goal <0.520	0.493	0.464	0.551	0.931		**1st QTR:** Infection Prevention is reminding nursing and providers about the C-difficile algorithm. Stools are being collected later during the patient's stay when while receiving a bowel regimen or on Lactulose. **2nd QTR:** Infection Prevention continues to remind nursing and providers about the C-difficile algorithm. Information was also shared at GME orientation with new Residents. **3rd QTR:** Infection Prevention is closely monitoring the upward trend in the HO CDIFF rate. There has been a couple of months without an Antimicrobial Stewardship Pharmacist. A new hire has been approved and waiting for this Antimicrobial Stewardship Pharmacist to start - history demonstrates this position has been integral in reducing and sustaining a reduction in C. difficile rates. **4th QTR:** The longstanding gains in control of C. difficile rates are gradually slipping away. Inappropriate orders for C. difficile testing at the source of increased rates (e.g. an order that was not fulfilled for 3 days because the patient didn't have a stool for this time duration, or a patient receiving a bowel regimen resulting in diarrhea and subsequent orders for C. difficile testing). The Antimicrobial Stewardship and Infection Prevention Programs will be working on initiatives to regain ground and to identify true instances of C. difficile infection.
XII. Hand Hygiene	**95%**						
A. Total Hand Hygiene Observations (combination of manual and electronic hand hygiene surveillance)		2,277,368	2,535,346	3,223,855	2,646,388	10,682,957	**1st QTR:** BioVigil electronic hand hygiene surveillance system was installed at South and West campuses. Go-Live with nearly systemwide surviellance occurred on 3/26/2022. The only areas were manual hand hygiene compliance rates are gathered on clinics and Mental Health. **2nd QTR:** BioVigil electronic hand hygiene surveilance system is gathering information throughout the majority of Kaweah Health. **3rd QTR:** BioVigil electronic hand hygiene surveillance system gathered a significant amount of hand hygiene opportunities. **4th QTR:** A moderate drop in overall hand hygiene opportunities noted this quarter.

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2022							
		Q1	**Q2**	**Q3**	**Q4**	**AVG. or TOTAL YTD**	**SUMMARY / ACTION**
B. All units Percentage of Hand Hygiene compliance based on observations/opportunities (>200 observations/ month/unit)		97.1%	97.3%	96.4%	96.5%		**1st QTR:** Overall hand hygiene compliance is remains above the 95% threashold. Work is underway to ensure there is compliance all healthcare workers using BioVigil where it is available. There are currently 3,656 users on the system. **2nd QTR:** Now there are 4,147 registered users on BioVigil. A total of 2,466,892 hand hygiene opportunities were performed appropriately. **3rd QTR:** A total of 3,110,649 hand hygiene opportunities were performed appropriately. **4th QTR:** A total of 2,553,235 hand hygiene opportunities were performed appropriately.
C. Percentage of Hand Hygiene compliance performed during "Day Shift"		97.0%	97.6%	96.8%	96.6%		**1st QTR:** Day shift and night shift have equal compliance rates. Will continue to encourage hand hygiene compliance. **2nd QTR:** 1,330,634 HHOs performed appropriately out of 1,363,355 opportunities. **3rd QTR:** Out of a total of 1,788,594 hand hygiene opportunites 1,731,359 HHOs were performed appropriately. **4th QTR:** Out of 1,027,825 hand hygiene opportunities, 992,879 HHOs were performed appropriately.
D. Percentage of Hand Hygiene compliance performed during "Night Shift"		97.0%	97.3%	97.0%	96.7%		**1st QTR:** Night shift and day shift have equal compliance rates. Will continue to encourage hand hygiene compliance. **2nd QTR:** 745,837 HHOs performed out of 766,533 opportunities. **3rd QTR:** Out of a total of 1,027,825 hand hygiene opportunities, 996,990 HHOs were performed appropriately. **4th QTR:** Out of a total of 884,531 hand hygiene opportunities, 855,341 HHOs were performed appropriately.
XIII. VRE (HAI) Blood-Hospital Onset (HO)							
A. Total Infection Count		0	1	0	1	2	**1st QTR:** 0 **Predicted:** 0 **2nd QTR:** 1 **Predicted:** 0 **3rd QTR:** 0 **Predicted:** 0 **4th QTR:** 1 **Predicted:** 0
B. Prevalence Rate (x100)		0	0.024	0	0.016		**1st QTR:** Better than National benchmark. **2nd QTR:** Better than National benchmark **3rd QTR:** Better than National benchmark **4th QTR:** Better than National benchmark
C. Number Admissions		4,244	4,158	6,464	6,426		**Cumulative Ct:** 21,292
XIV. MRSA (HAI) Blood CMS/VBP	**SIR**						
A. Total Infection Count (IP Facility-wide)		2	2	2	2	8	**1st QTR:** 2 **Predicted:** 1.247 **2nd QTR:** 2 **Predicted:**1.123 **3rd QTR:** 2 **Predicted:** 1.187 **4th QTR:** 2 **Predicted:** 1.685

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2022							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
B. SIR CI (KDHCD predicted range, based on risks)		0.269, 5.297	0.679, 7.268	0.282, 5.565	0.199, 3.922		**1st QTR:** Worst than National benchmark. **2nd QTR:** Worst than National benchmark. **3rd QTR:** Worst than National benchmark. **4th QTR:** Worst than National benchmark.
C. SIR (Standardized Infection Ration) total Value Based Purchasing (VBP) SIR = [ ]	**≤ 0.726 excluding COVID population**	**1.603**	**1.78**	**1.684**	**1.187**		**1st QTR:** 2 HO MRSA BSI events. **2nd QTR:** 2 HO MRSA BSI events. Related to source control (osteomyelitis/endocarditis) and positive test results that exceed 14 days post admission. Note, there was 1 additional HO MRSA reported during May 2022, but this was not actually an event the case involved MSSA and not MRSA (Lab corrected this information). **3rd QTR:** 2 HO MRSA BSI events. Both events were related to serial blood cultures obtained across different nursing units. Both events involve patients with MRSA in bloodstream present-on-admission. Per NHSN criteria these events shouldn't impact the hospital SIR as positive cultures didn't exceed 14 days repeat-infection-period. IP Manager is contacting the State CDPH HAI Program to determine why hospital SIR is being effected when it should not. **4th QTR:** [Event-1] late detection of MRSA BSI [Event-2] Source control - serial positive MRSA blood cultures exceeding 14 day repeat infection window period, Endocarditis ruled-out, osteomyelitis of spinous process suspected source of infection.
XV. MDRO LABID - Long Term Care							
Short Stay (# of Infections/ Incidence Rate)		**0**	**0**	**0**	**0**	0	**1st QTR:** There were no MDRO reported. **2nd QTR:** Gap analysis performed and risk assessment updated. Contact isolation fallouts noted with patients requiring isolation. In response, staff were inserviced and audits performed specifically for: isolation order, signage, caddie on door, PPE utilization and shift handoff. Improvements noted with audits for: signage, caddies, and PPE. Still working on orders and shift handoff. **3rd QTR:** There were no MDRO reported. **4th QTR:** There were no MDRO reported.
Transitional Care (# of Infections/ Incidence Rate)		**1**	**0**	**0**		1	**1st QTR:** There was 1 Clostridium difficile infection event involving a patient transferred from Kaweah Health downtown campus to Transitional Care. Patient received antimicrobial therapy for an extended period of time. **2nd QTR:** There were no MDRO reported. Enhanced Standard Precautions staff education completed and new Powerform due for go-live during August. **3rd QTR:** There were no MDRO reported. **4th QTR:** There was 1 C. difficile infection in skilled nursing over the entire 2022 calendar year. Transitional Care unit has been closed permanently.

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2022							
		Q1	**Q2**	**Q3**	**Q4**	**AVG. or TOTAL YTD**	**SUMMARY / ACTION**
Subacute (# of Infections/ Incidence Rate)		0	0	0	0	0	**1st QTR:** There were no MDRO reported. **2nd QTR:** There were no MDRO reported. Enhanced Standard Precautions staff education completed and new Powerform due for go-live during August. **3rd QTR:** There were no MDRO reported. **4th QTR:** There were no MDRO reported.
XVI. Influenza Rates (Year 2020-2021)	**NHSN**						
A. All Healthcare Workers		87.0%					**1st QTR:** Total number of healthcare personnel having worked at least 1 day at Kaweah Health during Oct. 1, 2021 through March 30, 2022 = 5,142 with 4,470 receiving influenza vaccine rate. LIP =87% (475), Employees-only = 86% (3,434), Students/Volunteers = 96% (561).
XVII. COVID-19 Vaccination Rates (Year 2020-2021)							
A. All Healthcare Workers with a completed series of COVID-19 vaccinations.		4,805	4,875	3,951	3,519		**1st QTR:** There were 702 COVID-19 vaccines administered to employees. Of a total 5,907 employees, 4,805 employees are completed the series of COVID-19 vaccinations as of March 31st, 2022. This demonstrates an 81.3% complete vaccination rate. **2nd QTR:** Of 5,979 employees 4,875 have completed their series of COVID-19 vaccinations as of June 30, 2022. This demonstrates an 81.5% complete vaccination rate. **3rd QTR:** Of a total 4,727 employees 3,951 employees were vaccinated for COVID-19 (last week of 3rd QTR), accounting for 83.6% vaccination rate. Of the 3,951 employee vaccinated there were 2,662 "Up-To-Date" with vaccinations accounting for 56.3% of employees being "Up-to-Date". **4th QTR:** Of 5,123 employees, 4,151 (81%) received at least one COVID vaccine, and 3,519 (69%) are up-to-date or fully vaccinated against COVID.

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Prepared by: Shawn Elkin, Infection Prevention Manager

Biannual Hand Hygiene Report

Quality Council

12/15/2022

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Hand Hygiene (HH) Monitoring

- 4th QTR 2019 - BioVigil electronic hand hygiene was initially piloted on 4N and ICU (total of 50 beds).
- 1st QTR 2021 – BioVigil added to total of 428 beds in all downtown patient care areas, excluding procedural areas and ED.
- 1st QTR 2022 - BioVigil added to total of 245 more beds to include, ED, ASC, Dialysis Clinic, Endoscopy, CVU, Infusion Center, Rehab, and TCS/Subacute.
- Once again during 1st QTR 2022 – BioVigil added to total of 25 beds – ED Zone 5 and 1 additional bed in Dialysis Clinic.

Hand Hygiene Monitoring

- Only Mental Health and the Rural Clinics are not covered by the BioVigil electronic hand hygiene surveillance system.
- Rural Health Clinics uses NRC to monitor hand hygiene compliance through the eyes of the patient. Patients are asked by electronic survey if they observed their healthcare worker perform hand hygiene.
- Mental Health performs its own hand hygiene audits monthly, a minimum of 200 observations a month.

Hand Hygiene Monitoring

- Hand Hygiene data is analyzed by location, role and shift.

Hand Hygiene Outcome Measures

Hand hygiene compliance is trending toward almost all units but achieving goal of ≥95% .

All branches of leadership and staff receive scheduled hand hygiene compliance reports.

Units not achieving ≥95% hand hygiene compliance submit corrective action plans within their QAPI reports submitted to the Quality Improvement Committee (QIC)

Measure Description	Benchmark /Target	2019Q4	2020Q1	2020Q2	2020Q3	2020Q4	2021Q1	2021Q2	2021Q3	2021Q4	2022Q1	2022Q2	2022Q3	sparklines
OUTCOME MEASURES														
HH Overall Compliance	95%	98.97	98.98	98.91	98.16	97.61	97.17	97.42	97.23	97.25	97.11	97.28	96.43	
Number of HH Audits Performed	n/a	86,487	552,670	312,205	1,798,574	3,320,010	2,794,940	2,343,324	2,317,980	2,446,234	2,277,805	2,535,346	3,224,539	
HH Overall Compliance - Patient Care Areas	95%	98.97	98.98	98.91	98.16	97.61	97.17	97.42	97.23	97.25	97.14	97.45	96.91	
Number of HH Audits Performed - Patient Care Areas	n/a	86,487	552,670	312,205	1,798,574	3,320,010	2,794,940	2,343,324	2,317,980	2,446,234	2,220,755	2,129,888	2,814,903	

Hand Hygiene Process Measures

There is very little difference observed between days, evenings, weekdays and weekends.

There are 39% more HH observations during AM shift compared to PM shift. Both shifts have an average compliance rate of 97%.

There are 28% more HH observations during weekdays compared to weekends. Weekends demonstrate .01% greater HH compliance compared to weekdays on average, 97.78% versus 97.77%.

Measure Description	Benchmark /Target	2019Q4	2020Q1	2020Q2	2020Q3	2020Q4	2021Q1	2021Q2	2021Q3	2021Q4	2022Q1	2022Q2	2022Q3	sparklines
Hand Hygiene By Day/time														
HH Overall Compliance - AM Shift	95%	99.17	99.16	98.83	98.14	97.48	97.24	97.33	97.10	97.16	97.19	97.57	96.85	
Number of HH Audits Performed - AM Shift	n/a	49,649	320,577	182,697	1,112,948	2,045,788	1,724,773	1,430,330	1,441,623	1,523,544	1,406,447	1,363,355	1,787,095	
HH Overall Compliance - PM Shift	95%	98.69	98.72	99.03	98.20	97.82	97.05	97.58	97.43	97.40	97.06	97.25	97.02	
Number of HH Audits Performed - PM Shift	n/a	36,838	232,093	129,508	685,626	1,274,222	1,070,167	912,994	876,357	922,690	814,308	766,533	1,027,808	
HH Overall Compliance - Weekdays	95%	98.94	98.99	98.90	98.17	97.65	97.21	97.39	97.22	97.21	97.10	97.47	96.94	
Number of HH Audits Performed - Weekdays	n/a	61,728	417,725	239,942	1,354,547	2,509,237	2,129,002	1,790,145	1,773,710	1,856,204	1,683,359	1,605,552	2,159,895	
HH Overall Compliance - Weekends	95%	99.05	98.94	98.96	98.13	97.49	97.03	97.53	97.26	97.39	97.27	97.39	96.94	
Number of HH Audits Performed - Weekends	n/a	24,759	134,945	72,263	444,027	810,773	665,938	553,179	544,270	590,030	537,396	524,336	655,008	

Hand Hygiene Process Measures

During 3rd quarter 2022, all units are performing at 95% or greater hand hygiene compliance with few exceptions.

CVICU and CVICCU have undergone recent leadership changes. Expectations related to hand hygiene compliance is being shared. It is projected that 4th quarter rates will show improvement.

Measure Description	Benchmark /Target	2019Q4	2020Q1	2020Q2	2020Q3	2020Q4	2021Q1	2021Q2	2021Q3	2021Q4	2022Q1	2022Q2	2022Q3	sparklines
Hand Hygiene By Patient Care Unit Location (*biovgil data)														
2AcequiaCVC - HH Compliance	95%	88.00	94.00	88.00	99.00	100.00	100.00	100.00	100.00	93.00	95.00	96.70	95.09	
2AcequiaCVC - HH Audits Performed	n/a	41	52	25	198	21	404	502	302	530	10,844	53,371	42,565	
2EastLabor&Delivery - HH Compliance	95%	86.00	80.00	65.00	97.24	97.33	97.64	97.51	97.24	97.97	97.82	97.55	96.69	
2EastLabor&Delivery - HH Audits Performed	n/a	80	76	46	70,276	148,020	129,732	131,498	149,119	145,080	129,564	88,627	103,004	
2NorthMedTele - HH Compliance	95%	79.00	61.00	81.00	97.23	96.92	97.36	97.62	97.26	97.09	96.29	96.57	96.22	
2NorthMedTele - HH Audits Performed	n/a	82	127	110	140,554	234,410	221,218	167,286	199,907	269,698	264,047	189,213	301,432	
2SouthObservation - HH Compliance	95%	89.00	50.00	83.00	98.43	98.08	98.02	98.51	97.82	98.31	98.16	98.29	97.13	
2SouthObservation - HH Audits Performed	n/a	28	90	102	67,987	157,102	133,157	131,810	108,888	138,197	162,681	131,994	198,290	
2WestICU - HH Compliance	95%	98.50	98.44	97.12	96.90	97.34	96.33	97.37	96.93	97.45	97.98	97.47	97.21	
2WestICU - HH Audits Performed	n/a	33,348	203,637	29,058	108,729	144,031	95,348	123,559	113,931	138,509	121,395	86,007	105,906	
3AcequiaCVICU - HH Compliance	95%	100.00	90.40	NULL	97.69	97.43	96.91	96.07	93.35	95.40	95.68	94.91	94.94	
3AcequiaCVICU - HH Audits Performed	n/a	122	63	NULL	91,774	157,004	120,389	131,750	136,066	119,300	100,240	99,668	124,011	
3AcequiaMotherBaby - HH Compliance	95%	99.00	99.00	100.00	98.18	97.74	97.81	97.93	97.03	97.79	97.92	97.84	97.68	
3AcequiaMotherBaby - HH Audits Performed	n/a	152	152	66	81,760	145,315	122,579	101,757	97,097	103,873	98,568	73,338	116,440	
3EastPediatrics - HH Compliance	95%	96.00	90.90	100.00	98.76	98.30	98.13	98.17	98.00	97.35	97.35	97.75	97.57	
3EastPediatrics - HH Audits Performed	n/a	51	33	18	5,498	21,187	14,734	22,950	24,640	25,754	21,844	15,880	22,493	
3EastPostSurgery - HH Compliance	95%	98.00	NULL	NULL	97.85	98.21	98.18	98.46	99.04	98.93	98.79	99.19	98.98	
3EastPostSurgery - HH Audits Performed	n/a	40	NULL	NULL	36,195	86,475	77,833	66,474	58,299	53,267	49,782	37,488	58,909	
3NorthMedSurg - HH Compliance	95%	84.00	80.00	75.00	98.69	98.38	98.23	98.25	98.32	98.31	98.19	97.96	97.92	
3NorthMedSurg - HH Audits Performed	n/a	64	105	63	157,106	306,844	271,518	208,799	187,554	201,745	176,546	169,860	224,382	
3SouthOncology - HH Compliance	95%	76.00	81.00	85.00	98.59	97.98	97.76	97.66	96.82	96.86	96.72	96.22	95.25	
3SouthOncology - HH Audits Performed	n/a	71	84	67	170,917	357,067	328,071	268,062	216,920	238,207	248,334	170,462	225,962	
3WestICCU - HH Compliance	95%	98.00	89.00	100.00	96.99	97.02	95.59	96.72	96.33	94.34	95.52	96.23	96.31	
3WestICCU - HH Audits Performed	n/a	63	71	61	84,081	157,893	131,983	114,691	124,755	131,411	135,100	100,603	148,535	
4AcequiaMedicalTelemetry - HH Compliance	95%	97.00	100.00	100.00	98.60	97.91	97.40	97.80	97.30	97.14	97.24	97.47	97.32	
4AcequiaMedicalTelemetry - HH Audits Performed	n/a	32	70	17	103,470	251,186	187,526	149,809	121,763	91,726	69,421	47,450	70,296	
4NorthRenalMedSurg - HH Compliance	95%	99.26	99.29	99.10	98.77	98.17	98.06	98.01	97.67	97.58	97.16	97.63	97.15	
4NorthRenalMedSurg - HH Audits Performed	n/a	53,139	349,033	283,147	335,897	379,797	348,343	316,657	330,358	302,329	262,742	232,306	315,661	
4SouthOrthoNeuroMedSurg - HH Compliance	95%	97.00	66.00	31.00	98.84	98.03	97.43	97.18	98.28	98.02	96.97	97.30	96.64	
4SouthOrthoNeuroMedSurg - HH Audits Performed	n/a	113	32	13	149,209	292,764	243,596	103,355	178,163	194,597	137,594	127,900	124,886	
5AcequiaCVICCU - HH Compliance	95%	NULL	NULL	NULL	97.30	95.25	93.47	93.84	95.38	94.19	94.83	94.90	92.55	
5AcequiaCVICCU - HH Audits Performed	n/a	NULL	NULL	NULL	127,579	351,393	302,510	203,322	139,949	148,872	121,624	116,897	139,306	

Hand Hygiene Process Measures

Majority of the locations listed here were recently added to the BioVigil electronic hand hygiene surveillance system during March 2022.

Infusion had some logistical issues related to use of BioVigil that the vendor addressed during late 3rd quarter 2022.

Emergency Department has improved hand hygiene over time. The layout and function of the ED presents challenges and there is a learning curve on how BioVigil is appropriately used in this environment. Hand hygiene compliance is hovering around 90%. With continued experience and training this rate of compliance will meet goal.

Measure Description	Benchmark /Target	2019Q4	2020Q1	2020Q2	2020Q3	2020Q4	2021Q1	2021Q2	2021Q3	2021Q4	2022Q1	2022Q2	2022Q3	sparklines
Hand Hygiene By Patient Care Unit Location (*biovgil data)														
6AcequiaNICU - HH Compliance	95%	89.00	74.00	85.00	99.14	99.51	99.38	99.59	99.47	99.47	99.59	99.63	99.41	
6AcequiaNICU - HH Audits Performed	n/a	90	90	89	67,542	129,522	66,403	101,545	130,571	143,669	107,434	82,183	143,019	
ASC - HH Compliance	95%	98.00	100.00	48.00	83.00	75.00	100.00	100.00	100.00	77.00	98.60	98.82	97.40	
ASC - HH Audits Performed	n/a	114	131	118	65	91	552	628	512	60	5,358	35,699	34,630	
Emergency Department - HH Compliance	95%	61.00	72.00	52.00	47.00	NULL	92.00	90.00	90.00	63.00	88.00	94.74	90.01	
Emergency Department - HH Audits Performed	n/a	66	68	140	155	NULL	636	207	647	252	31,244	200,632	213,664	
Endoscopy - HH Compliance	95%	100.00	92.00	100.00	100.00	100.00	100.00	0.00	0.00	0.00	99.42	99.19	97.44	
Endoscopy - HH Audits Performed	n/a	29	24	12	27	30	10	0	0	0	3,116	19,680	21,279	
Infusion - HH Compliance	95%	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	98.21	97.87	94.44	
Infusion - HH Audits Performed	n/a	30	36	20	30	30	30	40	30	20	2,293	10,399	12,958	
SouthCampusSubAcuteCare - HH Compliance	95%	100.00	71.40	100.00	100.00	100.00	97.00	0.00	100.00	100.00	98.55	99.19	98.15	
SouthCampusSubAcuteCare - HH Audits Performed	n/a	102	84	47	93	101	124	0	86	64	4,471	143,717	158,928	
SouthCampusTCS - HH Compliance	95%	100.00	50.00	100.00	100.00	97.00	100.00	100.00	0.00	0.00	99.42	99.47	99.40	
SouthCampusTCS - HH Audits Performed	n/a	30	10	42	88	66	90	60	0	0	4,495	82,780	93,993	
WestCampusAcuteCareRehab/ShortStay - HH Compliance	95%	100.00	89.00	88.00	93.00	NULL	93.00	94.00	94.00	94.00	97.04	98.43	97.99	
WestCampusAcuteCareRehab/ShortStay - HH Audits Performed	n/a	30	71	82	75	NULL	639	634	1,050	659	5,074	133,515	139,450	
WestCampusDialysis - HH Compliance	95%	100.00	97.00	100.00	100.00	100.00	100.00	100.00	96.00	95.00	97.33	97.98	96.77	
WestCampusDialysis - HH Audits Performed	n/a	93	87	90	102	82	90	130	142	40	5,250	75,823	74,945	
WestCampusWoundCare - HH Compliance	95%	NULL	NULL	NULL	NULL	NULL	NULL	NULL	NULL	NULL	95.90	98.50	97.60	
WestCampusWoundCare - HH Audits Performed	n/a	NULL	NULL	NULL	NULL	NULL	NULL	NULL	NULL	NULL	658	9,854	9,595	

Hand Hygiene By Role

Physician hand hygiene, although very low in volume, is improving for those that use BioVigil. Infection Prevention met with the hospitalists group during 3rd quarter 2022 and encouraged greater use of BioVigil, there was a lot of interest expressed.

The shear volume of hand hygiene opportunities is shared between CNAs and RNs followed by all others excluding (MDs, RTs, Students, LVNs, EVS, and Aides).

Hand Hygiene by Role (>10 observations in one quarter, does not inlcude biovigil)														
Aide - HH Compliance	95%	94.00	NULL	85.00	98.50	98.68	97.78	98.30	98.34	97.72	97.85	98.16	96.59	
Aide - HH Audits Performed	n/a	678	NULL	542	9,201	19,202	15,794	15,254	15,415	16,515	17,855	24,146	32,951	
C.N.A. - HH Compliance	95%	99.53	99.19	99.44	97.95	96.77	96.09	96.53	95.84	95.94	96.40	96.84	96.00	
C.N.A. - HH Audits Performed	n/a	15,486	102,302	69,129	415,866	831,386	684,279	522,495	489,887	572,524	532,047	558,962	711,701	
EVS - HH Compliance	95%	97.58	97.41	82.00	97.45	96.60	95.53	95.09	92.70	95.81	95.49	95.86	96.38	
EVS - HH Audits Performed	n/a	1,732	6,613	562	90,866	138,281	106,399	79,822	40,426	34,340	81,413	105,847	140,698	
LVN/Tech - HH Compliance	95%	91.00	99.62	99.49	98.80	98.04	98.50	97.33	97.70	97.80	97.34	97.57	96.46	
LVN/Tech - HH Audits Performed	n/a	161	11,837	17,672	58,774	120,366	102,193	88,326	105,878	129,757	136,711	215,381	295,512	
Nurse - HH Compliance	95%	98.86	98.92	98.60	98.10	97.85	97.41	97.61	97.64	97.56	97.26	97.15	96.17	
Nurse - HH Audits Performed	n/a	65,915	414,014	217,313	1,011,075	1,797,130	1,399,290	1,176,981	1,279,551	1,322,449	1,153,755	1,254,547	1,600,737	
Other - HH Compliance	95%	99.22	99.36	99.82	98.75	98.53	98.13	98.36	98.01	98.31	98.02	98.58	98.17	
Other - HH Audits Performed	n/a	3,217	16,689	8,528	162,090	302,052	322,758	303,172	265,952	264,691	260,518	280,419	349,028	
Physician - HH Compliance	95%	98.54	97.53	92.80	92.00	95.22	94.88	97.78	90.60	98.61	95.72	98.35	98.99	
Physician - HH Audits Performed	n/a	137	1,215	780	1,256	11,727	10,866	3,825	234	72	187	363	693	
Respiratory - HH Compliance	95%	90.00	NULL	91.00	98.30	98.17	97.86	98.37	97.61	97.14	97.80	98.45	97.90	
Respiratory - HH Audits Performed	n/a	396	NULL	282	45,719	82,248	88,040	97,902	86,616	70,921	66,678	72,302	61,923	
Student - HH Compliance	95%	91.00	NULL	100.00	99.41	99.11	98.57	98.28	97.78	98.27	97.57	97.79	96.13	
Student - HH Audits Performed	n/a	32	NULL	11	7,464	17,618	65,321	55,547	34,021	34,965	28,641	23,379	31,296	

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Kaweah Health

<u>Unit/Department</u>: Kaweah Health – Diversion Prevention Committee

<u>ProStaff/QIC Report Date</u>: 6/1/2023

<u>Measure Objective/Goal:</u>

The Diversion Prevention Committee Goals include:

- Develop an organizational program to build awareness of and response to behaviors suspicious for drug diversion.
- Build a culture within the organization of attention to drug diversion prevention.
- Implement education with orientation and annual training related to awareness of and response to drug diversion for all staff and providers.
- Ensure continued awareness and knowledge of diversion prevention strategies at all levels of the healthcare team including non-patient care areas.
- Develop a Leadership training program to provide enhanced skills for detecting and preventing diversion activities.
- Ensure accountability for action items related to routine audits and medication related reports by department leaders.
- Use of technology and automation to ensure audits and reporting are routine and applicable.
- Communicate noted trends identified through Pharmacy audits such as Bluesight, Pyxis overrides, etc. or the occurrence reporting system to department leaders.
- Monitor all active audits outlined in the CMS diversion plan of correction until compliance is met and audits are closed.

The Diversion Prevention Committees Measures of Success include:

- All existing District staff will complete the appropriate MAT training module regarding diversion prevention topics with at least 90% compliance each quarter.
- All new hire District staff will complete orientation education regarding diversion prevention topics with at least 90% compliance each quarter.
- Committee members to verify efficacy of ongoing diversion prevention education by conducting 15 or more interviews each of varied District staff, residents, and medical staff each quarter with at least 90% answering 4/4 questions correctly.
- Provide education to the Leadership group at least once per quarter to provide enhanced knowledge and skills for detecting and preventing diversion activities.
- Monthly review of audit dashboard reveals improvements in audit outcomes.

<u>Date range of data evaluated:</u> January-March 2023

The Diversion Prevention Committee was formed in April 2021 in response to a recognized need for education and monitoring after two unrelated diversion events were identified within the organization. The initial goals are to increase awareness of the risk of diversion in the health care setting and increase knowledge of the signs and symptoms of diversion.

From January-March 2023 the following goals were achieved:

Diversion Prevention Awareness Mandatory Education (Ongoing):

- Diversion Prevention Strategies Education and Monitoring (ongoing) – All Employees:
    - **No new data** - July – October 2022: 92% of existing District staff and providers (varied roles of District staff, residents, and medical staff) answered 4/4 questions correctly during 148 interviews conducted by DPC members.
      Goal: At least 90% compliance this quarter.
    - **Goal Met**- April 2023 - 97% of hospital staff completed the Mandatory Annual Training-Diversion Prevention Module, due April 26th.
- Leadership Awareness Education (ongoing):
    - **Goal Met** - March 2023: Shannon Cauthen developed “Strange Education” that was approved by DPC on March 28th. Education was sent out to Patient Care Leaders to share with their teams.
    - **Goal Met** – March 2023: Education sent out to all Patient Care Leaders about how to investigate for possible diversion and expectations for responding to Bluesight variances and investigations (including, but not limited to, IRIS). Additionally, Bluesight CBL was assigned to all nurse managers by the med safety specialist.

Pharmacy-Related Monitoring:

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

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

All goals met this quarter. No new Pharmacy-related trends or concerns noted this quarter.

<u>If improvement opportunities identified, provide action plan and expected resolution date:</u>

The purpose of the Diversion Prevention Committee is to identify opportunities and create action items on an ongoing basis.

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

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

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

Next Steps/Recommendations/Outcomes:

Continue to monitor the effectiveness of the education through staff, provider and leader interviews by Committee members.

Create additional education as needed based on interviews, audits and occurrence reports.

Continue to monitor potential diversion-related events and increase surveillance by organizational staff and providers.

Modify existing goals within the Diversion Prevention Committee to meet the identified needs and opportunities for growth within the organization.

Incorporate Substance Abuse awareness and actions into the scope of the committee to support our teams.

Submitted by:
Shannon Cauthen, Co-Chair – Director of Critical Care Services
Evelyn McEntire, Co-Chair – Director of Risk Management

Date Submitted:
June 5th, 2023

Sub Acute, TCS, and Short Stay Specific Data Collection Summarization

Professional Staff Quality Committee

Unit/Department: Sub Acute, TCS, and SS Rehab **Report Date: October 2022**

Measure Objective/Goal:

1. Falls (internal data),
2. Pressure Injuries (internal data)
3. Psychoactive medication use (MDS/Casper)

Date range of data evaluated:

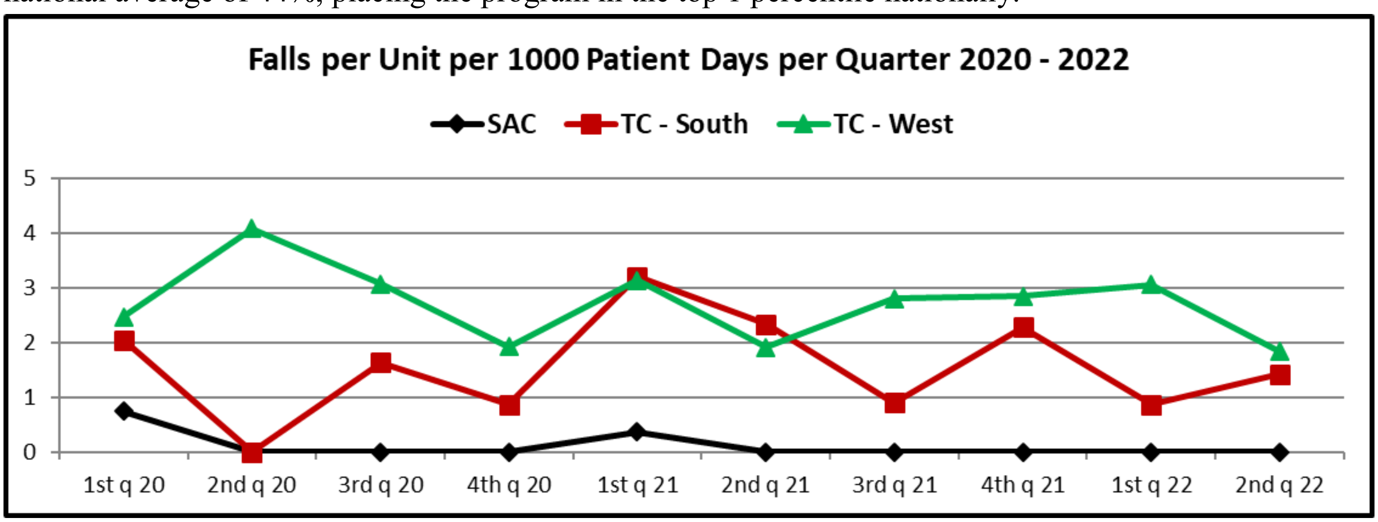
All categories are from the Report Period: 10/01/2021 – 3/31/2022. Comparison group: Casper Report from 4/25/2022 for period 08/01/2021-1/31/2022, and 1st quarter 2022 through 2nd quarter 2022, internal data.

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

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

Measure Objective/Goal: Falls

The rate of falls per 1000/pt. days in Q1 and Q2 of 2022 is 0.83, lower than 2021 at 1.22. Facility observed percent for falls for long stay patients in the most current CASPER report is 0%, remaining well below national average of 44%, placing the program in the top 1 percentile nationally.



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

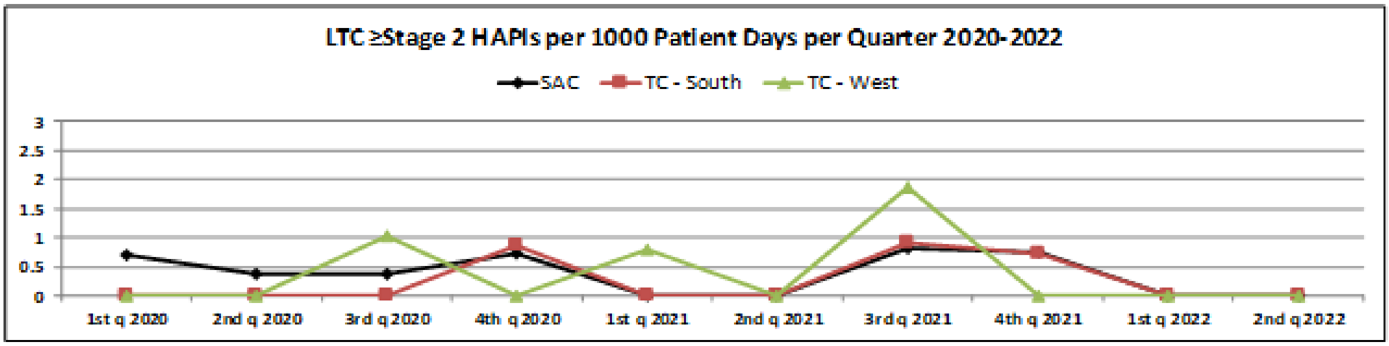
Staff continues to participate in, and has a high rate of compliance with, district-wide initiatives for fall prevention. The skilled nursing units have many mobile patients and a "no restraint" environment. Falls occur most commonly with our short-stay population, all of whom are involved with therapy programs to enhance functional mobility. We will continue fully participation in the Kaweah Health prevention protocols. The recent increase in falls on the units prompted several interventions, these include increased orientation transfer competency for new staff.

Measure Objective/Goal: Pressure Injuries

a. Incidence of new or worsening pressure ulcers for short stay patients (which would also include Sub Acute patients with a length of stay under 100 days) as reported on the Casper report is 0.8%, well below the national average of 2.8%.

b. Patients at High risk for Pressure Ulcers (Long Stay residents, defined as high risk, who have Stage II-IV pressure ulcers) is 11.1%. This is a increase from 7.4% in the last report, with a national average of 9.3% and a state average of 9.1%. This puts us at the 67^{th} percentile, worse than previous 46^{th} percentile. The definition for this long-stay quality measure asks if a wound is present, not if acquired in the facility. This is particularly challenging in a program that preferentially admits cases with pressure ulcers for ongoing treatment. The measure triggers a flag until the wound completely heals (and through the 6 month report period). Very large wounds that have healed down to very small, chronic wounds will continue to trigger this measure. Thus, it is common to see a delay in improvement on the CASPER report, while seeing improvement more immediately in our internal data.

c. Overall, the total wound rate for the three SNF units rate per 1000/pt. days for Q1 and Q2 2022 was 0. This is an increase from last year 2020 at 0.46. All three SNF units participate in Kaweah Health Clinical Skin Institute when pressure injuries are discovered on the unit. Staff capture skin injuries during routine assessments and preventative measures are implemented early leading to better patient outcomes.



2. **<u>If improvement opportunities identified, provide action plan and expected resolution date:</u>**
   a. We will continue to work within the high standards of the District, with close management of our fragile, chronic wound cases, collaborating closely with the Kaweah Health wound nurses and utilizing the standardized treatment sets available to us.

   b. UBC teams for South Campus nursing are reviewing clinical cases using a Peer review methodology to assess for and remediate practice concerns.

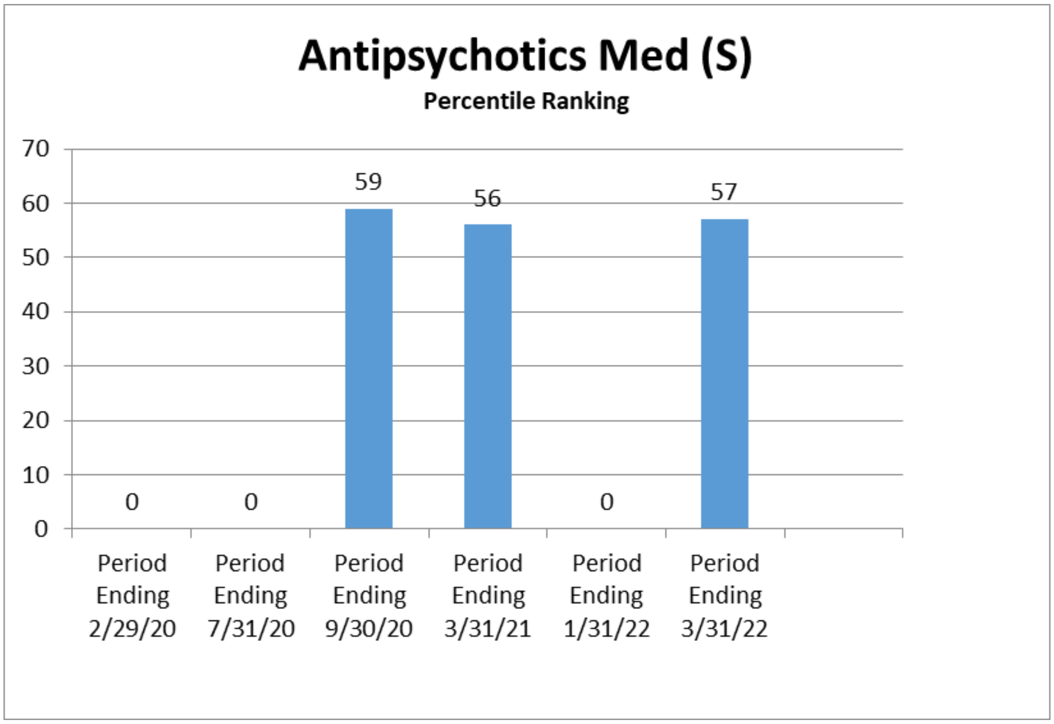
<u>Measure Objective/Goal: Psychoactive medication use:</u>

<u>Definitions/Assumptions:</u>

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

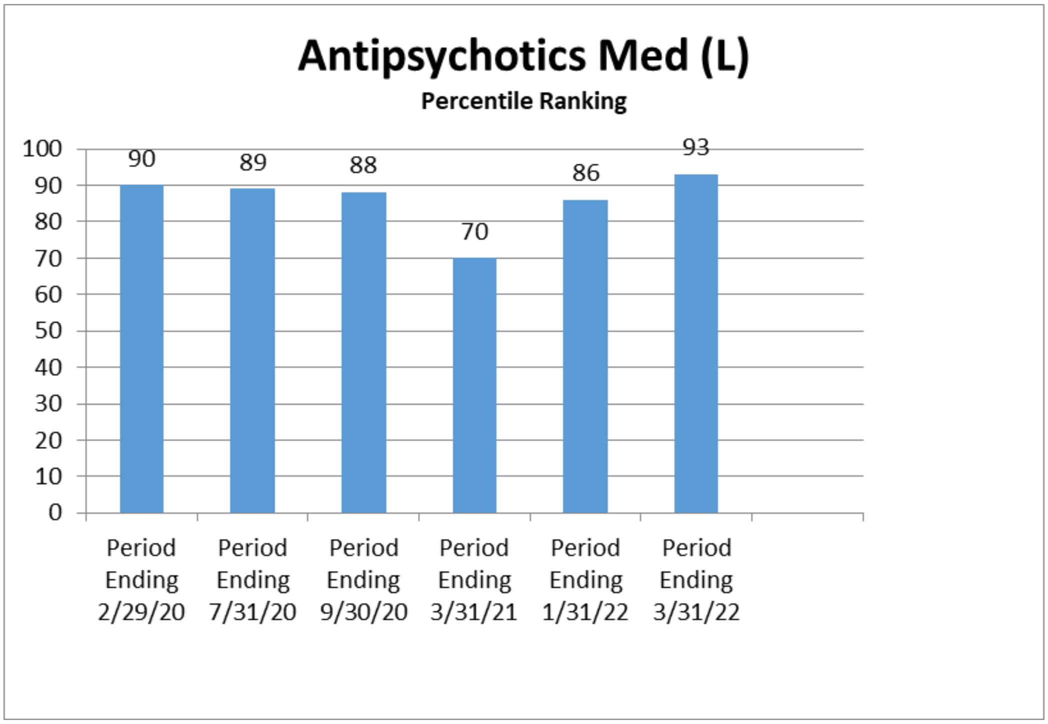
Increased use of medications in the antipsychotic drug-class for management of depression is also moving our results in these measures. Antianxiety and hypnotic medication use is not reported as a quality measure for the short-stay population. The data is collected through the MDS, but is not included in the measures that make up our quality ranking. All values are expressed in percentile rankings.

<u>Short Stay residents (<100 days).</u> Antipsychotic medication use for short stay patients is below national average, which measures only cases with newly prescribed antipsychotics. The facility four quarter percent for short stay patients who begin a new anti-psychotic during their stay is 0.7%, putting us at the 57th percentile (lower is better). The comparison national average is 1.9%.

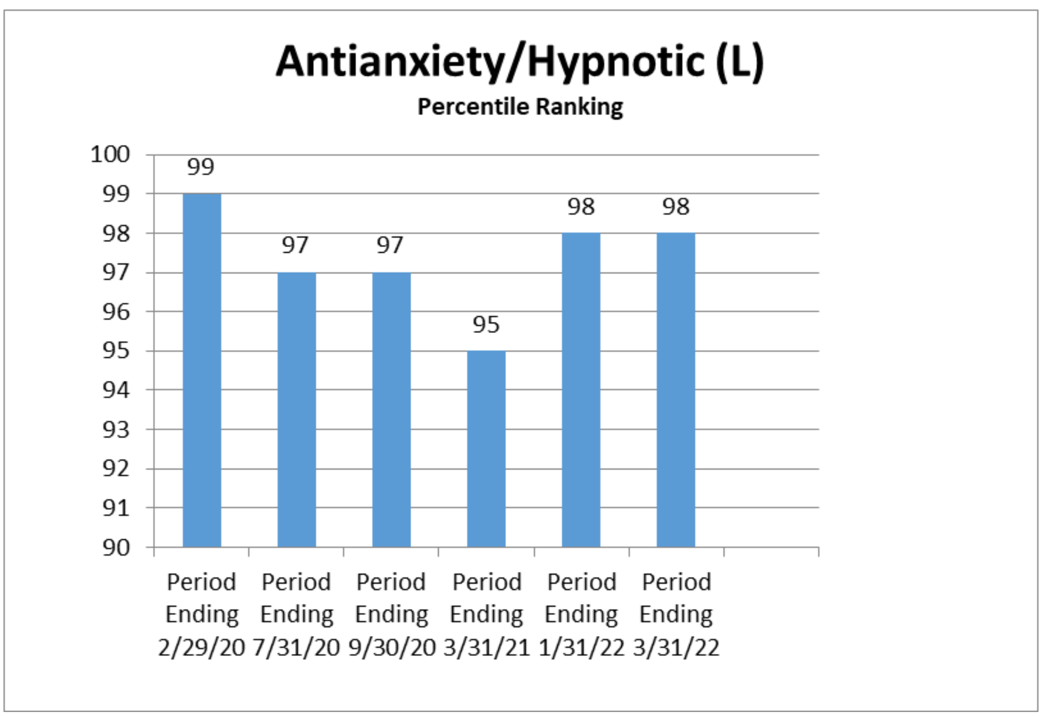


Long Stay residents. The facility percent for antipsychotic use in long stay residents is 29.6%. This puts us at the 93rd percentile (lower is better). The national average is 14.6%. Unlike the short stay measure, which only includes newly prescribed antipsychotics, the long-stay measure includes all patients on the medication for any portion of the time (even if it was a home medication). Included in this measure are medications like quetiapine, used for depression or for ventilator management cases. This is another instance where our target client group for long-term care (our Sub Acute program) is the primary driver of our performance.

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



<u>Long Stay residents.</u> Antianxiety/Hypnotic Medication use for long stay residents has remained high at the 98th percentile same as the percentile the previous year. Our utilization rate is 50%, but national rates remain at 19.5%. There are no exclusions for medical diagnosis for this measure.



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

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

Although we struggle in this measure, in the past three years of CMS surveys (including the last annual survey in July 2022) there have been no findings around inappropriate use of psychotropic medications in any of our programs.

<u>Submitted by Name:</u>	**<u>Date Submitted:</u>**
Molly Niederreiter	October 2022

Nursing Workforce: 2022 Safe Practice & Risk Assessment

Emma Camarena, DNP, RN, ACCNS-AG
Director of Nursing Practice

Foundation for the Role of Nurses

How can I provide for this right thing to be always done?

(Nightingale, 1918)

Nurse Work Environment

- Facilitate or constrain nursing practice
- Linked to patient outcomes
- Characterized by
  - Safe staffing
  - Communication & team work
  - Competent managers
  - Supportive senior leadership

(Carthon et al. 2019)

Adequate Nurse Staffing

Contributes to improved patient outcomes and to the health of the work environment

- Delivering safe, quality care in all practice settings:
  - Surveillance
  - Time with patients
  - Early detection
- Ever-present challenge: managing the balance of mission and margin
  - Improving population health and patient, staff and clinician satisfaction
  - Operations and cost of healthcare

(Carthon et al., 2019; Costa & Yakusheva, 2016, American Nurses Association, 2020)

High Patient Workloads

Nurses consistently report patient safety concerns

- Information falling through the cracks
- Miscommunication
- Delayed or missed care
- Risk of adverse event

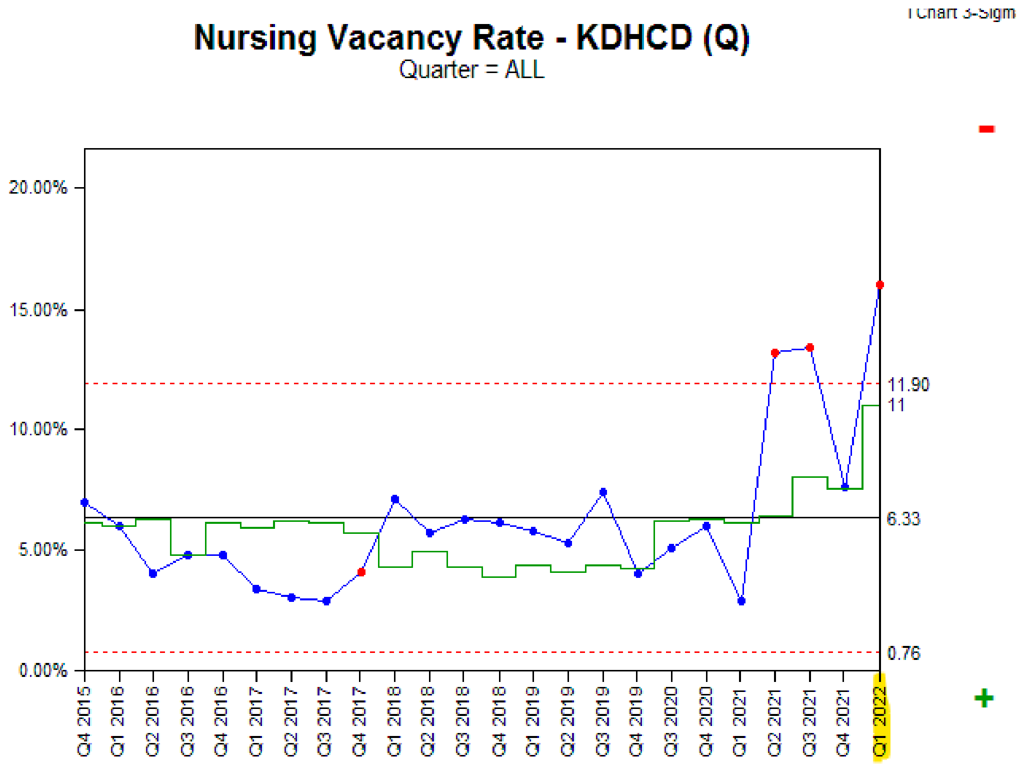
(Carthon et al., 2019)

High Patient Workloads

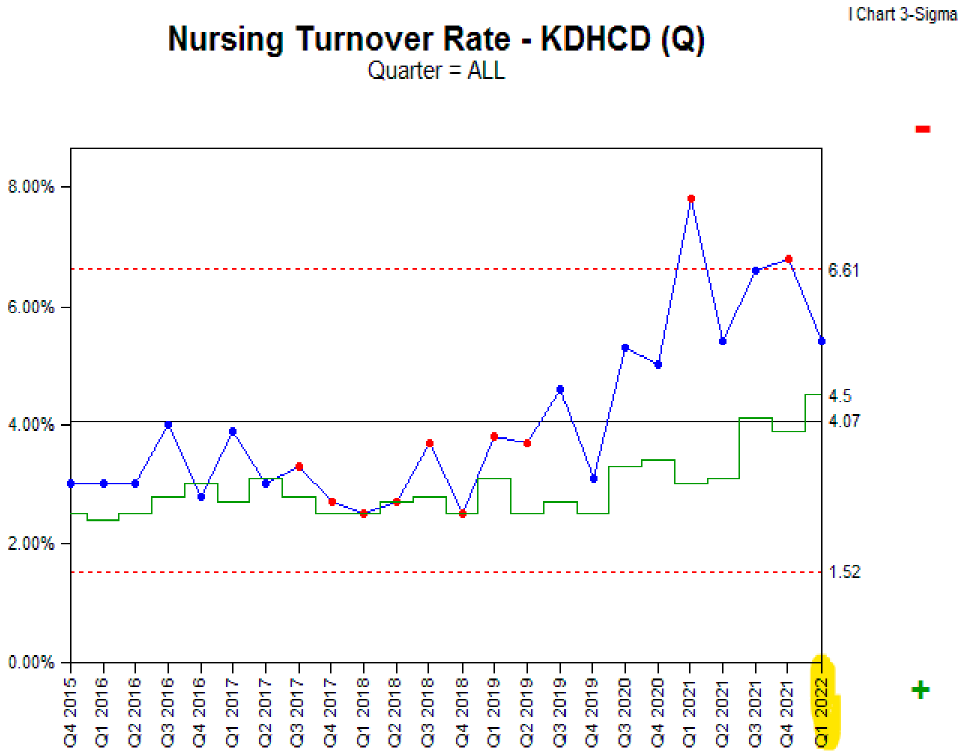
- Increased likelihood of adverse nurse outcomes
  - Burnout
  - Job dissatisfaction
  - Intent to leave

(Shin, Park, & Bae, 2018)

Vacancy and Turnover Rate



	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022
KDHCD	2.90%	13.20%	13.40%	7.60%	16.00%
Target	6.10%	6.40%	8.00%	7.50%	11.00%



	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022
KDHCD	7.80%	5.40%	6.60%	6.80%	5.40%
Target	3.00%	3.10%	4.10%	3.90%	4.50%

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Clinical Nurse Burnout

Recent survey: COVID-19 Two Year Impact Assessment Survey
Goal: identify the continued impact on America's nurses

- 75% of nurses reported feeling stress, frustrated and exhausted
- 60% of nurses reported feeling burned out

Age related statistics: younger nurses more affected

- All nurses: 30% not emotionally healthy
- Nurses under 25: 46% not emotionally healthy
- Nurses 55 and older: 19% not emotionally healthy
- 66% of nurses under 35 reported feeling anxious compared to 35% of nurses 55 or older

Nurses considering leaving their positions:

- 2021: 40%
- 2022: 52%

Cost

- $65,000 average cost to replace one nurse
- RN turnover costs: ↑ 1% = $337,000 per year

American Nurses Foundation (2022). American Nurses Foundation COVID 19 Two-Year Impact Assessment.
Ruggiero, J. & Vanek, F. (2019). *Engaging Leaders by Prioritizing Their Wellbeing and Resillency.* Presentation at the annual AONE Conference, San Diego, California
Holm, C. (2019). *Attributes in Leaders Most Desired by Clinical Nurses.* . Presentation at the annual AONE Conference, San Diego, California

Continued Impact of the Pandemic

Fear of RN shortages

- RNs leaving due to high stress of working during the pandemic
- Education programs in 2020-2021 academic year :
  - Schools deferred starting new programs
  - Education programs: reduced new enrollments
  - Students deferred admission: not willing to engage in remote learning
- Nationwide, hospitals and other healthcare settings report lower staffing ratios, more overtime and use of contract nurses to fill staffing gaps.
- RNs retiring aged 55 to 64 years old doubled from 2018 to 2022:
  - 2018: 11.4%
  - 2022: 22.5%

(Spetz, J., Chu, L., Blash, L. (2022). Forecasts of the Registered Nurse Workforce in California. Phillip R. Lee Institute for Health Policy Studies. https://healthypolicy.ucsf.edu

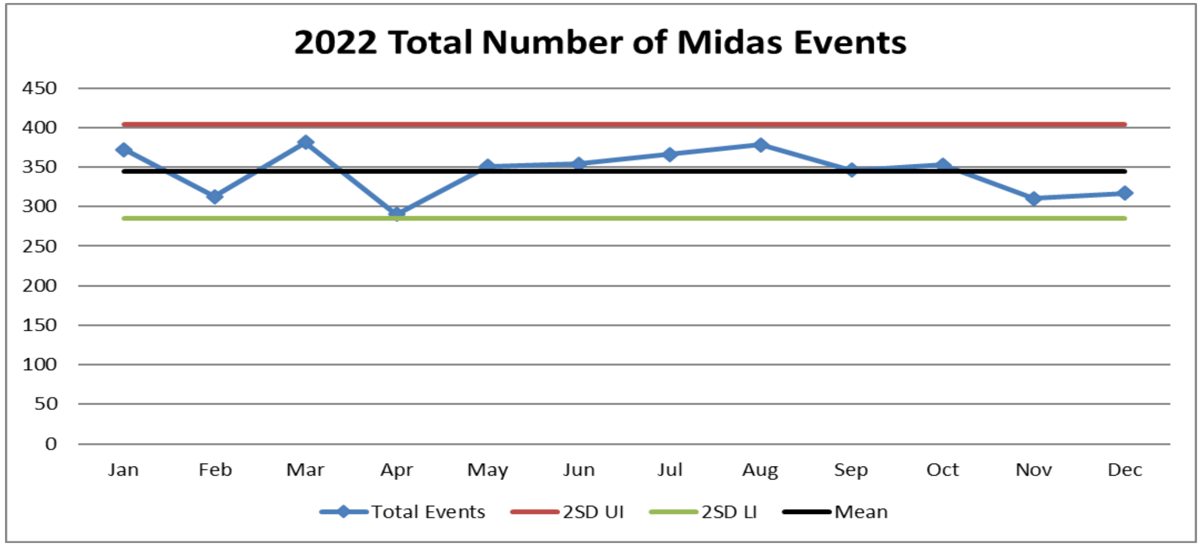
2022 Adverse Events and Staffing at KHMC

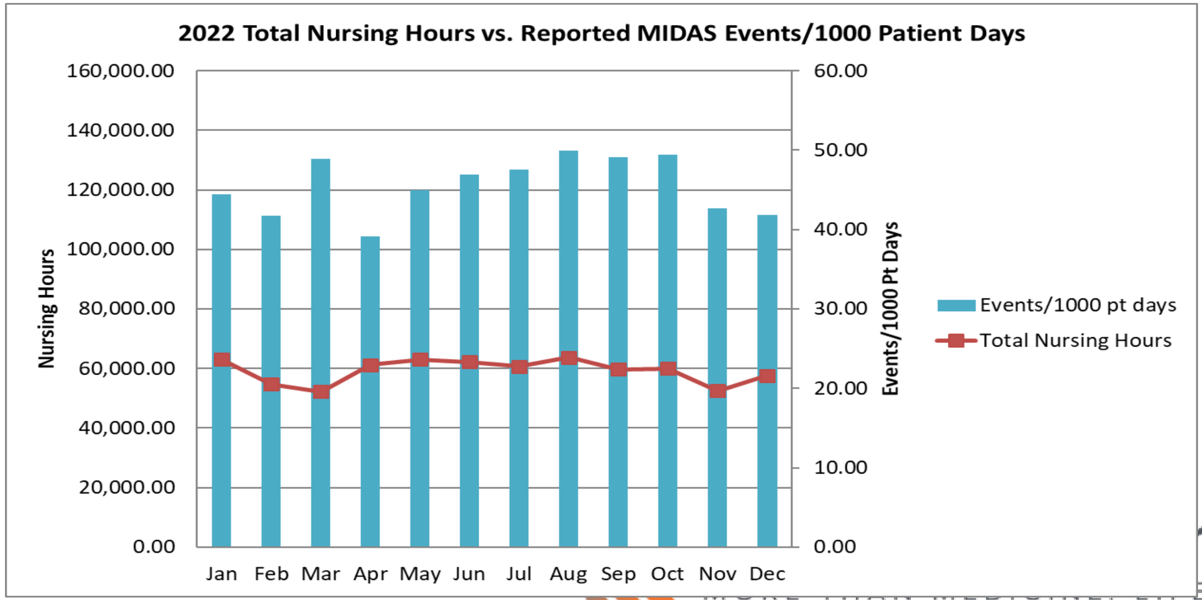
- A total of 11 Focus Reviews/Root Cause Analyses were conducted
  - **36% of the Events Were Related to Staffing or Lack There Of**
    - Novice staff – Enhanced orientation and education; Returned to in-person settings
    - Minimally staffed – Active recruitment to fill open positions; Job fairs; Contract labor
    - Unusually high volume of traveler/contracted nursing staff due to pandemic – Increased recruitment and retention of employees resulting in decreased contract labor
    - Enhanced Code Triage activation plan
  - **91% of the Events Were Related To Communication**
    - Team Communication Tool - CUS Training (New Hire and Annually)
    - Continued Handoff Communication Quality Focus Team
    - Ongoing enhancement of Just Culture throughout the organization to increase likelihood of staff/leaders in communicating safety concerns
    - Enhanced electronic documentation in the EMR for various clinical roles
    - Developed multiple PowerForms within EMR for consistent care across the continuum
    - Implemented a formal Fall Prevention program in ED and 1E areas
    - Enhanced documentation and communication of the outpatient imaging patient EMR across the continuum of diagnostics through procedure completion
    - Reinforced proper consent/timeout elements and processes in the outpatient setting
    - Instituted formal process for battery changes in remote telemetry monitors

2022 Adverse Events and Staffing at KHMC

Analysis

- No special cause outlier identified
- Looking at the 2022 total nursing hours v. reported Midas events/1000 days, there does not appear to be a trend related to nursing hours and Midas events.

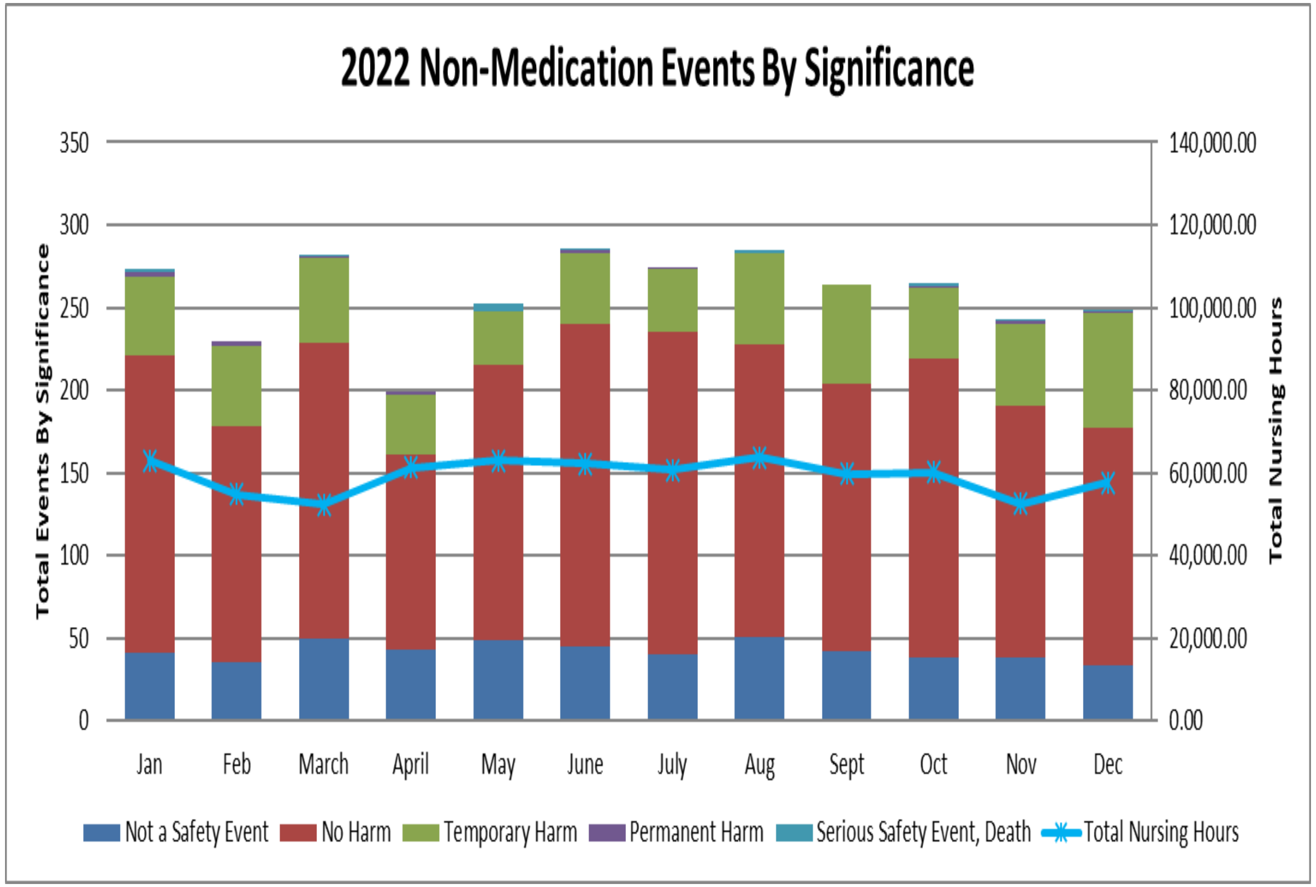




2022 Adverse Events and Staffing at KHMC

Analysis

There is a correlation between nursing hours and non-medication events for CY 2022. As the pandemic and KH staff stabilized, the majority of events were listed as “not a safety event” or “no harm”.

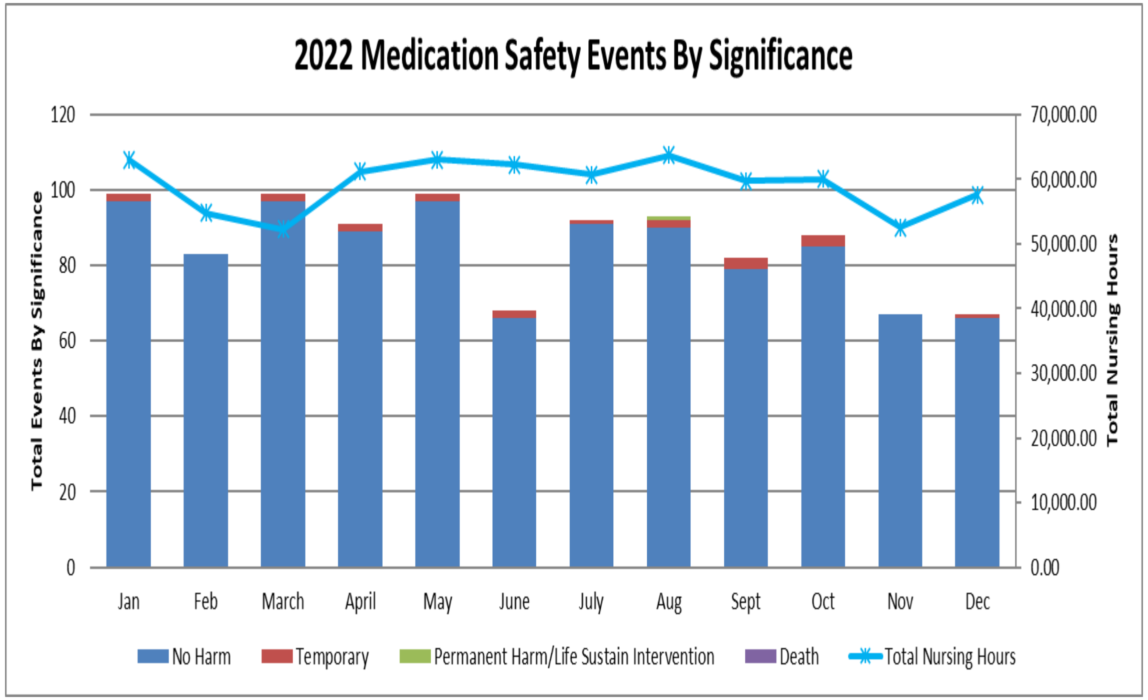


2022 Adverse Events and Staffing at KHMC

Analysis

There does appear to be a correlation between nursing hours and medication safety events. Considerations for reports of higher medication safety event reporting were due to increased events reported by BlueSight to track controlled substance events and reports of expired narcotic infusions. With the current tracked and reported events there continue to be very few harm events.

CY 2022, BCMA use was at or above the benchmark of 95%. BCMA helps staff recognize potential errors and allows staff to correct the error in the moment leading to less patient harm. Our medication safety team (Pharmacist and RN) work with staff to identify medications that cannot be scanned in an effort to improve the number of medications that can be scanned using BCMA to improve patient safety.



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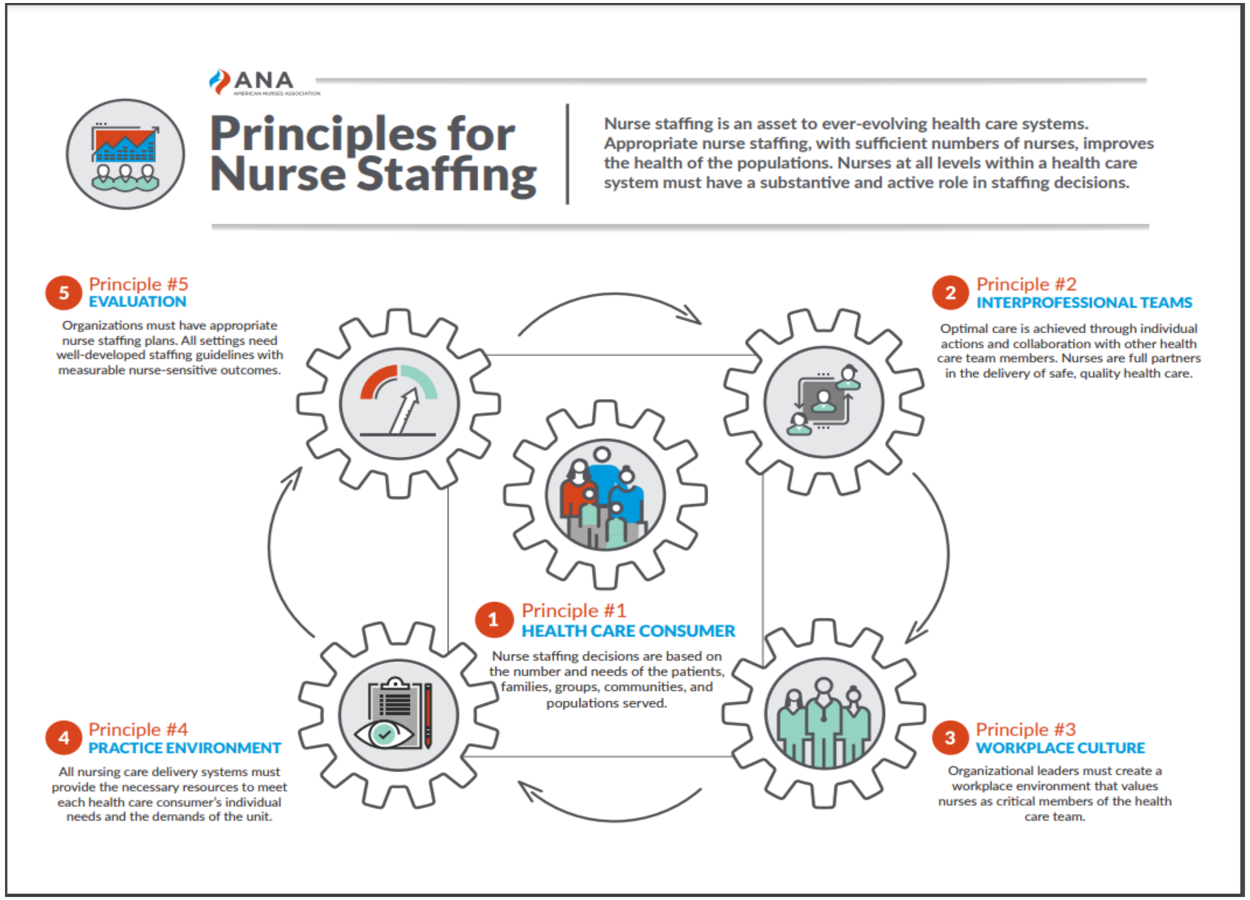
Principles for Nurse Staffing
(American Nurses Association)



https://www.nursingworld.org/practice-policy/nurse-staffing/staffing-principles/

KH Applies Principals for Nurse Staffing to Mitigate Adverse Events

1. Staffing decisions based on census *and* acuity
    - Level of care: ICU, telemetry, frequency of care
2. All nurses are providers of optimal care.
    - Optimal care is achieved through individual actions and collaboration with the healthcare team
        - Rounds (i.e. Interdisciplinary, Discharge, Gemba)
        - Team Nursing (RN-LVN)
        - Culture of Safety Survey
3. Protected time to participate in safety culture initiatives
    - Comprehensive Unit-Based Safety Program
    - HAI prevention teams
    - Quality Focus teams

KH Applies Principals for Nurse Staffing to Mitigate Adverse Events

4. Practice Environment
   - Shared governance structure (UBC, NPC, PPC)
   - Sentinel Event and Adverse event reporting (includes staff role in event)
   - Staff training and competency (initial and yearly)
   - Technology (Safe pumps, BCMA)
5. Evaluation
   - Committee review of submitted sentinel events and adverse event reporting
   - Customer and nurse satisfaction
   - Costs

https://www.nursingworld.org/practice-policy/nurse-staffing/staffing-principles/

KHMC Staff Assignment Guidelines

- ***Level of overall nursing experience*** (i.e., novice to expert)
  - Consider the experience level of the RNs at all times, all shifts
  - Consider reassigning/redistributing pts in an effort to balance workload
- ***Resources for mentoring, precepting, addressing skill development needs of nurses***
  - New hires assigned to Mentor RN as resource in addition to Charge RN
  - Preceptor training for med-surg, critical care, ED and maternal-child
  - Team Nursing (LVN orientation and education)
- ***Specific needs of population served***
  - MH.60.02 Person to Room Assignment Planning in a Dynamic Context
  - Reassess assignments throughout the day
  - Modify assignments as driven by unit activity & patient acuity.
  - PC. 205 Staffing & Scheduling, PC.180 Patient Placement Guidelines, Critical Care/Telemetry Units admission guidelines
  - Added Team Nursing on med/surg units

https://www.nursingworld.org/~4a51bc/globalassets/practiceandpolicy/nurse-staffing/staffing-principles-infographic.pdf

Kaweah Health

Nursing Education

- In 2011, The Institute of Medicine in its landmark report on The Future of Nursing called for increasing the number of baccalaureate-prepared nurses in the workforce to at least 80% to enhance patient safety. The current nursing workforce falls short of this recommendations with only 65.2% of registered nurses prepared at the baccalaureate or graduate degree level according to the latest workforce survey conducted by the National Council of State Boards of Nursing.

American Association of Colleges of Nursing (2022). Fact Sheet: Nursing Shortage

Nursing Education

- 2022 National Workforce Survey (USA):
  - RNs in workforce with BSN or greater: exceeded 70% (71.7%)
  - RNs entering workforce with BSN or entry-level MSN: 51.5%
- Kaweah Health BSN prepared bedside RNs: 43%
  - Current Strategies:
    - KH partnership with Unitek School of Nursing (BSN program)
    - Priority acceptance to nursing programs (Unitek)
    - Education assistance (HR.49)

A BSN prepares nurses to practice the full scope of responsibilities across all healthcare settings

American Association of Colleges of Nursing (2023). https://www.aacnnursing.org/news-data/fact-sheets/impact-of-education-on-nursing-practice

The pursuit of healthiness

Kaweah Health
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Outstanding Health Outcomes Update

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

June 2023

FY23 Clinical Quality Goals

Our Mission

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

Our Vision

To be your world-class healthcare choice, for life

	July 22 -Mar 23 Higher is Better	FY23 Goal	FY22	FY22 Goal
SEP-1 (% Bundle Compliance)	75%	≥ 77%	76%	≥ 75%

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 2022	Aug 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	June 2023	Estimated Annual Number Not to Exceed to Achieve Goal*	FYTD SIR** (number of actual/ number expected)	FY23 Goal (VBP 2024; National Mean 2019)	FY22 FY21 FY20
CAUTI Catheter Associated Urinary Tract Infection Excluding COVID INCLUDING COVID-19 PATIENTS	1 0	1 0	2 0	0 1	2 0	3 0	0 0	0 0	0 0	1 0			14 (23 predicted over 12 months)	0.54 0.596 Including COVID	≤0.650	1.092 0.54 1.12
CLABSI Central Line Associated Blood Stream Infection Excluding COVID INCLUDING COVID-19 PATIENTS	2 1	0 0	0 0	1 0	1 0	2 1	1 0	1 0	1 0	2 0			10 (17 predicted over 12 months)	0.88 1.034 Including COVID	≤0.589	1.132 0.75 1.20
MRSA Methicillin-Resistant Staphylococcus Aureus Excluding COVID INCLUDING COVID-19 PATIENTS	2 0	0 0	0 0	0 0	0 0	2 0	0 1	0 0	0 0	0 0			5 (8 predicted over 12 months	0.54 0.676 Including COVID	≤0.726	1.585 2.78 1.02

*based on July 2021-June 2022 NHSN predicted

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