August 11, 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, August 17, 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, August 17, 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, August 17, 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 August 17, 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, Daniel Hightower, MD, Chief of Staff and 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, Chief of Staff 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, Chief of Staff 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. Rapid Response Team (RRT)
    - 3.2. Pain Committee
    - 3.3. Rehabilitation
    - 3.4. Central Line-associated Bloodstream Infection (CLABSI) Quality Focus Team
4. **Environment of Care Rounds Follow Up** – Review of current status of action plans submitted by Kaweah Health leaders in response to surveillance round findings. *Maribel Aguilar, Hospital Safety Officer and Shawn Elkin, MPA, BSN, RN, PHN, CIC, Manager of Infection Prevention.*
5. **Environmental Services Adenosine Triphosphate (ATP) Testing and Methicillin-Resistant Staphylococcus Aureus (MRSA) Quality Focus Team Report**– Action plan related to improve our performance and what we can expect to see in the coming quarters on the disinfection rates we are experiencing in the terminal cleaning of our patient rooms. *Tendai R. Zinyemba, MBA, MSMIS, CHESP, Director - Environmental Services, Laundry, & Patient Transport*
6. **Trauma Program Quality Report –** A review of key quality measures through the American College of Surgeons Trauma Quality Improvement Program (TQIP) registry and action plans focused on the Kaweah Health Trauma Program. *Franklin Martin, BSN, Director of Trauma Services, Dr. Fitzpatrick, MD, Medical Director Trauma Program.*
7. **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.*
8. **Adjourn Open Meeting** – *David Francis, Committee Chair*

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

KAWEAH DELTA HEALTH CARE DISTRICT

QUALITY COUNCIL - CLOSED MEETING

THURSDAY AUGUST 17, 2023

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 4-8

KDHCD - QUALITY COUNCIL - CLOSED MEETING

THURSDAY AUGUST 17, 2023

CLOSED MEETING SUPPORTING DOCUMENTS

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KDHCD - QUALITY COUNCIL - CLOSED MEETING

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KDHCD - QUALITY COUNCIL - CLOSED MEETING

THURSDAY AUGUST 17, 2023

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 4-8

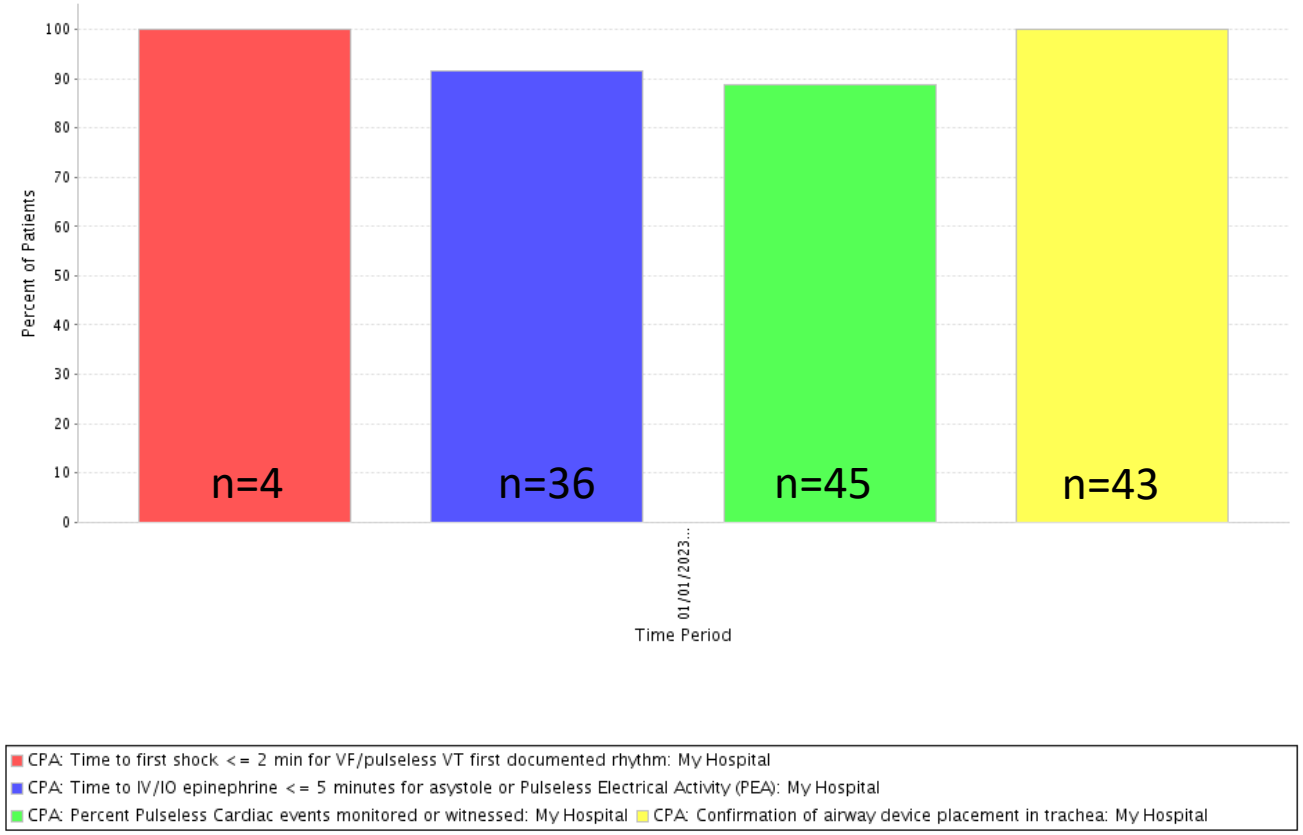
RRT/Code Blue Pro Staff Report

Q1 2023

Shannon Cauthen MSN, CCRN-K

GWTG Performance

Goal: >85%



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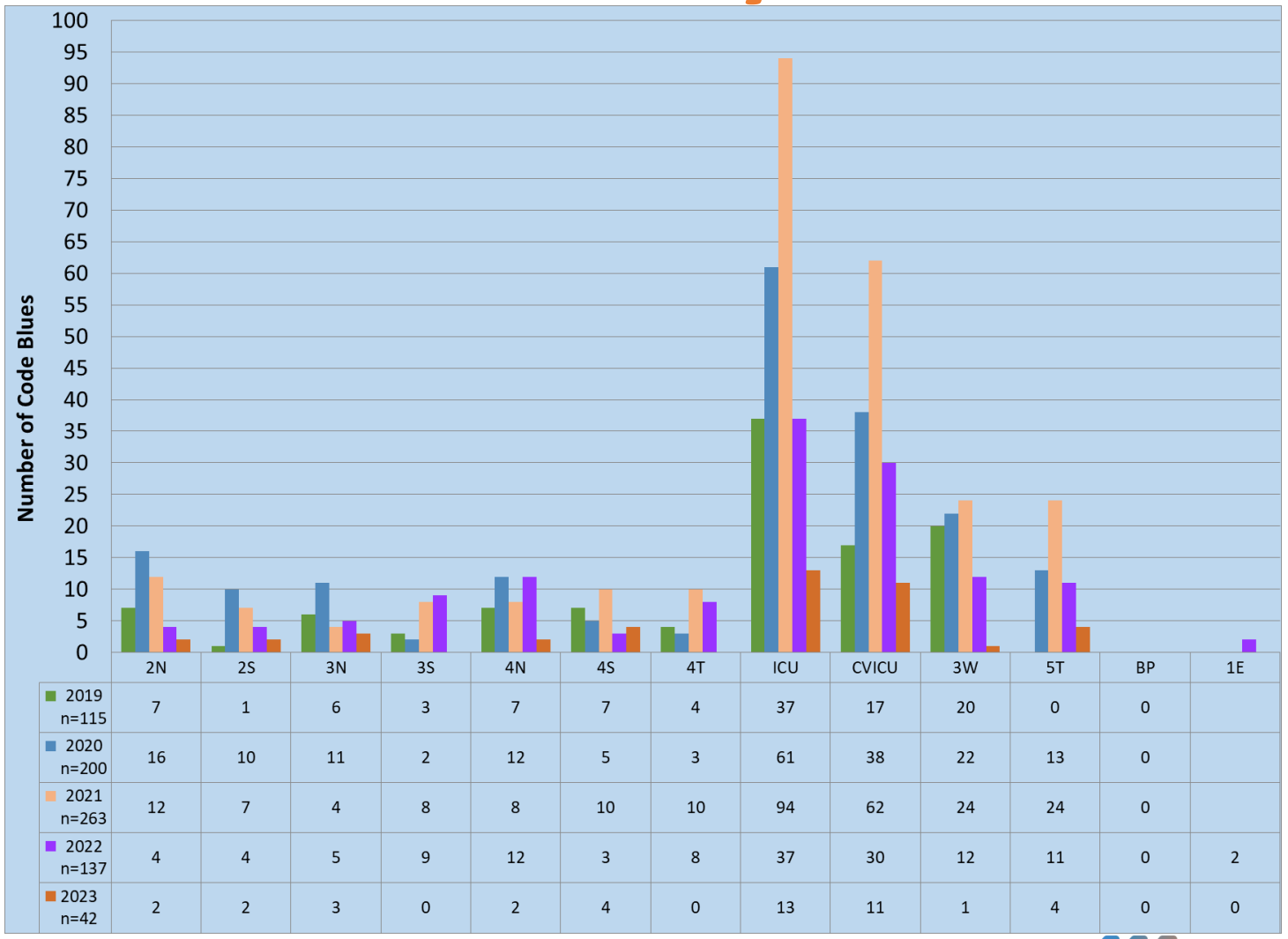
RRT and Resuscitation Scorecard

Measure Description	All GWTG Hospitals (External Benchmark)	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Mean (Rolling 12 months)
Code Blue Data														
Total Code Blues (Med/Surg/ICCU/CC)		9	9	16	7	12	7	9	9	17	14	14	13	11
Total COVID-19 Positive Code Blues		0	0	3	1	1	1	0	0	2	4	1	0	1
Code Blues per 1000 Discharges Med Surg/ICCU		5	4	3	2	2	3	5	6	8	3	4	7	4
Code Blues per 1000 Discharges Critical Care		3	3	9	4	8	3	3	2	5	8	9	3	5
Percent of Codes in Critical Care	66% (↑ is better)	44%	33%	75%	71%	83%	57%	44%	22%	38%	71%	71%	29%	53%
Event Survival Rates								56%	67%	47%	57%	71%	43%	57%
Code Blue: Survival to Discharge	20% (↑ is better)	44%	11%	19%	29%	17%	57%	22%	22%	6%	14%	0%	14%	21%
Deaths from Cardiac Arrest (expired during event)		3	5	6	3	3	0	4	3	9	8	4	8	5
Overall Hospital Mortality Rate		2.853	2.399	3.094	2.048	2.061	2.889	2.396	2.146	3.048	3.54	3.154	2.288	2.66
RRT Data														
Total RRTS		100	93	115	94	111	98	110	98	125	121	96	133	108
RRTs per 1000 Patient Discharge Days		78	71	90	72	85	86	93	83	100	98	87	100	87
RRT Mortality	21% (↓ is better)	14% n-14	19% n-18	19% n-22	20% n-19	16% n-18	14% n-14	17% n-19	21% n-21	18% n-22	22% n-27	17% n-16	17% n-22	18%
RRTs Within 24 hours of Arriving to Inpatient Unit	15% (↓ is better)	21% n-21	24% n-22	17% n-19	17% n-16	22% n-24	21% n-21	23% n-25	22% n-22	23% n-29	26% n-31	24% n-23	26% n-35	22%
RRT- Med-Surg to Intermediate Critical Care Transfers	*9%	18% n-18	14% n-13	21% n-24	19% n-18	17% n-19	20% n-20	23% n-25	15% n-15	16% n-20	14% n-17	24% n-23	23% n-30	19%
RRT- Med-Surg to Critical Care Transfers	*29%	10% n-10	6% n-6	23% n-27	3% n-3	10% n-11	9% n-9	6% n-7	14% n-14	9% n-11	9% n-11	1% n-1	10% n-13	9%
RRT-Intermediate Critical Care Transfers to Critical Care	*32%	4% n-4	6% n-6	6% n-7	6% n-6	11% n-12	5% n-5	8% n-9	4% n-4	9% n-11	10% n-12	8% n-8	9% n-12	7%

Green	Better than Target
Yellow	Within 10% of Target
Red	Does not meet Target
*	Target Goal not Being Established

Code Blues by Location

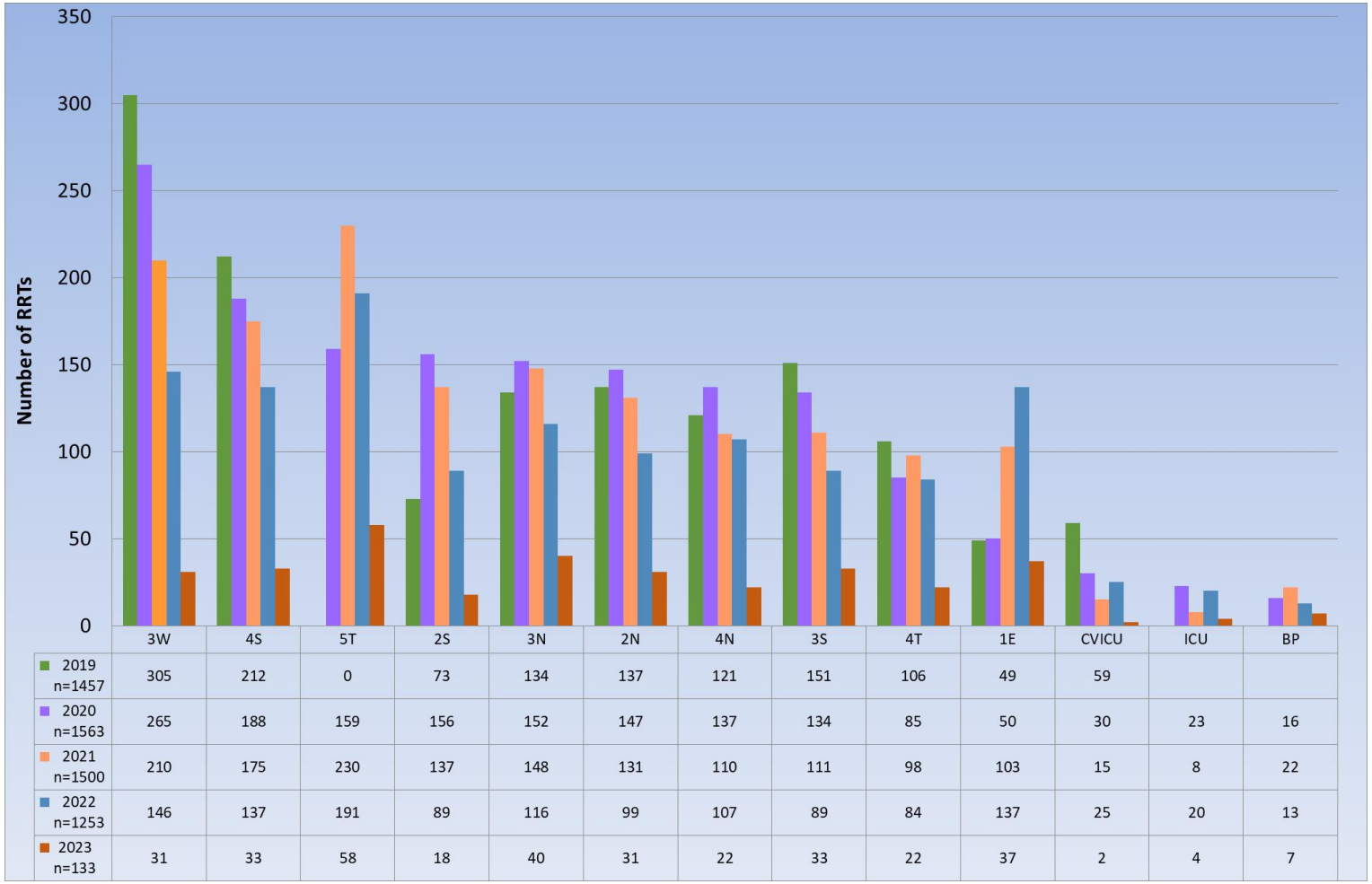


	2N	2S	3N	3S	4N	4S	4T	ICU	CVICU	3W	5T	BP	1E
2019 n=115	7	1	6	3	7	7	4	37	17	20	0	0	
2020 n=200	16	10	11	2	12	5	3	61	38	22	13	0	
2021 n=263	12	7	4	8	8	10	10	94	62	24	24	0	
2022 n=137	4	4	5	9	12	3	8	37	30	12	11	0	2
2023 n=42	2	2	3	0	2	4	0	13	11	1	4	0	0

Code Blues: The goal remains to have the majority of our codes occurring in CC (which the AHA considers the ICU/CVICU). In Q1, 57% of our Codes Occurred in ICU/CVICU.

If you include the ICCUs (which are rich in resources and advanced monitoring), 69% of our code blues occurred in CC.

RRTs by Location



	3W	4S	5T	2S	3N	2N	4N	3S	4T	1E	CVICU	ICU	BP
2019 n=1457	305	212	0	73	134	137	121	151	106	49	59		
2020 n=1563	265	188	159	156	152	147	137	134	85	50	30	23	16
2021 n=1500	210	175	230	137	148	131	110	111	98	103	15	8	22
2022 n=1253	146	137	191	89	116	99	107	89	84	137	25	20	13
2023 n=133	31	33	58	18	40	31	22	33	22	37	2	4	7

Working with ED RN for his DNP Project to decrease RRTs in first 24 hours. Will use MEWS screening tool to re-evaluate patients every 12 hours while awaiting an inpatient bed.

Projected go-live Summer 2023.

Completed Projects

- COPES Go-Live (February 2023)
- Booth at Patient Safety Fair (March 2023)
- Increased presence at staff meetings and on floors to provide education to staff (April 2023-ongoing)
- Re-implementation of Mock Mega Codes w/ Sim Lab support (April 2023)

Next Steps

- Sidewalk CPR: June 6th Downtown Visalia and Rawhide Game
- Mock Code Blues (unit-lead following COPES)
- LUCAS Go-Live (pneumatic CPR machine)

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Pain Management Committee Quality Report

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

William Brien, MD
Chief Medical Officer
Chief Quality Officer

August 2023

Pain Management at Kaweah Health

Committee Mission:

- Responsible for oversight of pain management and safe opioid prescribing
- Develop measures and monitor quality improvement (QI) activities
- Ensure our pain management standardized practices meet the highest standards
- Continually evaluate how pain is managed within our institution to ensure our procedures and protocols address the needs of our patients and empower our staff to provide excellent care.

Pain Committee membership includes Nursing, Pharmacy (Pain Service), Quality, Physician stakeholders such as Chief Medical Officer, Palliative Care, Anesthesia, Emergency Medicine, GME Residents, Medical Director of Best Practice Teams, as well as consultation with Medical Director of Quality and Patient Safety.

Pain Management at Kaweah Health

Committee Goals:

Monitor appropriate and effective pain management; oversee, prioritize and focus QI activities on:

1. Pain assessment – completed accurately (assessment of pain level with appropriate intervention)
2. Types of interventions – pharmacological (opioid vs multimodal) and non-pharmacological. Increase use of multi-modal intervention. Ensure safe prescribing practice.
3. Effectiveness –use of multimodals, right pain medication for right pain level, use of non-pharmacologic pain methods
4. Safety measures – discharge prescribing, adverse drug events related to opioids, and monitor use of naloxone in partnership with the pain service pharmacists and the Medication Safety Committee
5. Increase organizational achievement in best practices utilizing the Cal Hospital Compare Opioid Honor Roll Program measures to assess performance and progress.

Pain Management at Kaweah Health

Key Activities 2023:

- Ketamine usage
- Oral Morphine Equivalent (OME) data
- Opioid prescribing guidelines
- Enhanced patient/family education
- “Stigma training” for targeted providers
- Implementation of stigma reducing interventions
- Alternatives to opioids
- Medication Assisted Treatment
- Alternatives to Opioids for pain management
- Broadly communicate program goals and progress

KH Pain Management Committee

Pain Management & Opioid Safety Initiatives

Pain Management QI Initiative	Status	Action Plan 2023
1. Ensure opioid safety through monitoring of Adverse Drug Events (ADE) per 1,000 inpatient admission (Medicare FFS Part A claims) **Goal:** Surpass Bed Size (300+) current rate of 1.66 per 1,000 inpatient admissions (as reported by Health Services Advisory Group HSAG 1/1/22-12/31/22).	• Lower is better. 2019 = 2.29 per 1,000(17/7430); 2020 = 1.15 per 1,000 (7/6074); 2021 = 1.33 per 1,000 (7/5347); 2022 = 1.85 per 1,000 (10/5295) Goal achieved. Jan – Feb 2023 = 2.63 per 1,000 (2/759) 2023 YTD – to early to determine goal status (metric with very small numerator, only 2 months included YTD which generates an inflated rate)	• Note - Resident QI project completed May 2022 focused on evaluation of 17 patients with a reported ADE related to opioids from Dec 2020 -Aug 2021 to determine if there was a true ADE. The evaluation utilized the evidenced-based Naranjo Adverse Drug Reaction Probability Scale (a tool that standardized assessment of causality for all adverse drug reactions). Results indicated that only 35% (6/17) were true ADEs. Although the sample was small, it would be reasonable to conclude that the HSAG ADEs related to opioid rate per 1,000 is lower than reported. • eCQM team considering adding Naloxone use as an internal measure to enhance monitoring. • 2023 Goal decreased from 2.46 to 1.66 • Quality RN to do a snapshot review of potential fallouts based on patients meeting HSAGs Opioid ADE ICD-10 codes not POA criteria for committee review and action if necessary
2. Ensure opioid safety through monitoring of Adverse Drug Events collected through Pharmacy case review. Number of RRTs where Narcan was effective (Narcan is a reversal agent used to treat opioid overdoses) **Goal:** Not set as this is an overall monitoring measure. An increase would indicate a potential issue to be evaluated.	• 2021: 54 patients were administered Narcan during an RRT, 27 of them (50%) the RRT RN reported the Narcan was effective (not evaluated by pharmacy). • 2022: 36 patients were administered Narcan during an RRT, 26 of them (72%) the RRT RN reported the Narcan was effective (not evaluated by pharmacy). 2022-The number of patients administered Narcan during an RRT has decreased 33% since 2021. • Jan – June 2023: 20 patients were administered Narcan during an RRT, 7 of them (35%) were determined by pharmacy to be effective.	• Committee had identified that often the RRT RNs report of Narcan effectiveness in cases is not consistently accurate (ie. some case review revealed that patients where Narcan was effective during an RRT were not on opioids). Re-education with RRT RNs completed. Plan is to revise process to include a pharmacists case review to identify gaps timely and report actual cases where Narcan was effective (as vetted by pharmacy) as the measure • January 2023: Pharmacy began monthly review of Narcan use & effectiveness in RRT cases. Data is reported monthly and included in the Pain Committee dashboard. This results in timely identification of process issues and mitigation/resolution if committee determines necessary.

KH Pain Management Committee

Pain Management & Opioid Safety Initiatives

Pain Management QI Initiative	Status	Action Plan 2023
3. Ensure Opioid safety through discharge prescribing of opioids for < 7 days in duration Goal (internal): 9%	Lower is better % of patients with opioid prescription >7 day: • 2021: 14% • 2022: Decreased to 9.9% Improved from 2021. Within 10% of goal. • 2023: Data TBD. The denominator definition of this initiative was revised 7/2023. All patients with a prescription for an opioid at discharge will be included and we will no longer be excluding those patients with an opioid listed as a home medication. The report that pulls this data must also be revised.	• Committee selected and approved the Opioid Prescribing Engagement Network (OPEN) evidenced based guidelines for acute pain management. There is a link in Cerner and on Compass for easy accessibility. • Data analysis in progress to identify trends (ie. providers, opioid types) • May 2023: Providers receive an alert in Cerner for any inpatient, acute therapy discharge prescription of an opioid >7days. • Letter with multiple links to evidence drafted for approval by MEC to be issued to providers who prescribe opioids for >7 days duration at discharge; Letters to be issued to providers who exceed recommendations starting Sept 2023 with a cc to Peer Review Coordinators.
4. Ensure Opioid safety through discharge prescribing. CMS Measure: Safe Use of Opioids-Concurrent Prescribing (eCQM - Electronic Clinical Quality Measures). CMS Benchmark: 16% State	• Measure description - Inpatient hospitalizations for patients 18 years of age and older prescribed, or continued on, two or more opioids or an opioid and benzodiazepine concurrently at discharge • Denominator exclusions: Inpatient hospitalizations where patients have cancer that overlaps the encounter or are receiving palliative or hospice care (including comfort measures, terminal care, and dying care) during the encounter • 2021 = 18.70% (1053/5642) • This measure will be publically reported in January 2023 on CMS Care Compare. • 2022 = 20.7% (1145/5537) Goal not achieved • Jan – June 2023: 15.6% (415/2663)*see action plan 2023 YTD: Goal achieved.	• Committee selected and approved the Opioid Prescribing Engagement Network (OPEN) evidenced based guidelines for acute pain management. There is a link in Cerner and on Compass for easy accessibility • ISS has completed the eCQM build December 2022. • ISS created a detailed report from Cerner Feb 2023 • Utilizing the ISS report to review and identify trends to act on and data will be shared with the Pain Committee. *ISS has not updated to the 2023 CMS Specifications. The 2023 data is being reported using the 2022 Specifications Manual and may change once this is updated. • Letter with multiple links to evidence drafted for approval by MEC to be issued to providers who prescribe two or more opioids or an opioid and benzodiazepine concurrently at discharge; Letters to be issued to providers who exceed recommendations starting Sept 2023.

KH Pain Management Committee

Type of Pain Management Intervention, Effectiveness, & Assessment Initiatives

Pain Management QI Initiative	Status	Action Plan 2023
1. Increasing peripheral nerve block infusions (Anesthesia) **Goal:** Increase volume from 2021; reduces need for opioids	2021: 37 peripheral nerve block infusions completed by Anesthesia 2022: 26 peripheral nerve block infusions completed by Anesthesia Jan – June 2023: 7 peripheral nerve block infusions completed by Anesthesia. Volumes decreasing	• Focusing increasing nerve blocks on the amputation surgical population • Follow up with Department of Anesthesia
2. Increasing Multimodal use when opioids are prescribed in surgical opioid patient populations **Goal: 100%** ERAS patients with multimodal pain management	Data (higher is better): • 2022: 100% of ERAS elective colorectal patients with multimodal pain management: Goal achieved • 2023: Data pending	• Implement opioid prescribing guidelines as described above • Update provider Kaweah Health onboarding materials for pain management Reported through Surgical Quality Committee: • ERAS expanded to Orthopedic populations 1Q 2022 • Plan to expand ERAS to non-elective colorectal and gynecological surgical patients populations late 2023 • 2023: Data is pending hiring and onboarding a data abstractor so data can be updated
3. Right pain medication administered for level of pain reported. **Goal:** 95%	Data (higher is better): • 2022: 87% Goal not achieved • Jan – June 2023: 88% Increased from 2022. 2023 YTD Goal not achieved	• Assigned Nursing Director reports this measure and the action plan directly to the Quality Improvement Committee. • This data is shared with the Pain Pharmacists for them to utilize during Opioid Stewardship Rounds. • Related to pain management, however is now a Joint Commissions finding, the action plan to address this reported to Accreditation Committee. Fall out reports are sent to managers for follow up monthly by assigned project director

KH Pain Management Committee

Type of Pain Management Intervention & Effectiveness Initiatives

Pain Management QI Initiative	Status	Action Plan 2023
4. Review and revise patient education materials for pain management Goal: Patient and community awareness to reduce opioid use & achieve XX points on the 2024 Cal Hospital Compare (CHC) Opioid Honor Roll Program. Goal under development pending the release of the 2024 Cal Hospital compare	This is included in the Cal Hospital Compare Opioid Honor Roll program. • In 2021/2022 Kaweah Health achieved 17 points in the program. • *In 2023 Kaweah Health achieved 14 points in the program and received a Participation Certificate. The goal was to achieve ≥26 points. However, the numerical score cannot be compared to 2021/2022 as CHC changed the format of the Honor Roll with different initiatives and a different scoring grid. This was not known to the Committee when setting the 2023 goal. PENDING	• Committee reviewed patient education materials from the CDC on opioid safety. Recommended distributing to patients upon admission/discharge. Materials have been approved by the Patient Education Committee. Discussion Sept 2022 with Patient Care Nursing Managers regarding the addition of the materials to admission/discharge packets. Processes vary by unit. Discussion with ISS to link materials with any acute care, inpatient discharge prescription of an opioid. IN PROGRESS • Education materials are available in Cerner in both English and Spanish. Complete • *The Cal Hospital Compare Opioid Honor Roll scoring system changed in 2023. The 2024 Honor Roll is not available at this time. The Pain Committee will make an appropriate numerical goal when this is available. PENDING
5. Assess and address provider stigma associated with pain management for patients with Opioid Use Disorder (OUD) Goal: Reduce stigma & achieve XX points on the 2024 Cal Hospital Compare (CHC) Opioid Honor Roll Program. See* in above 2 boxes. Goal under development pending the release of the 2024 Cal Hospital compare	• In 2022-2023 two separate surveys were administered to providers who prescribe opioids. A total of 72 providers responded to these surveys. • Survey results suggest increased stigma in providers that tend to prescribe the most opiates. • Initiative (assessing stigma) included in the Cal Hospital Compare Opioid Honor Roll program. • KH Achieved 17 points in the CHC program in 2021/2022. 2023 goal was ≥26 . 2023 Cal Hospital Compare results = 14 points. Goal unable to meet do to changes in scoring methodology. See* in above 2 boxes.	• Provider education materials addressing stigma with OUD patients available. • Implement stigma reducing strategies • Plan to resurvey to evaluate effectiveness • CME presentation to be planned for 2023/2024 • Implicit Bias education required by CA state law was completed by selected APP's and providers by 12/31/21. • Implicit Bias education for all KH employees began Jan 2023

KH Pain Management Committee

Pain Management & Opioid Safety Initiatives

Data Under Development	Status	Action Plan 2023
1. Ketamine usage – reduce opioid use Goal: TBD Metrics: TBD	The current available report is being reviewed to see how data can be pulled electronically	• Dr. M. Tedaldi is leading an initiative to use oral Ketamine in the Med/Surg areas of the hospital. Currently IV Ketamine is only able to be administered in certain specific areas where a patient can be closely monitored. Dr. Tedaldi is working on this initiative with pharmacy and the medication safety team and reporting progress to the Pain Management Committee.
2. Oral Morphine Equivalent – reduce opioid use Goal: TBD Metrics: TBD	An electronic report to pull data is in development with pain service pharmacists as the subject matter experts	• OME data to be available and reported to the Pain Management Committee by end of year 2023

Questions?

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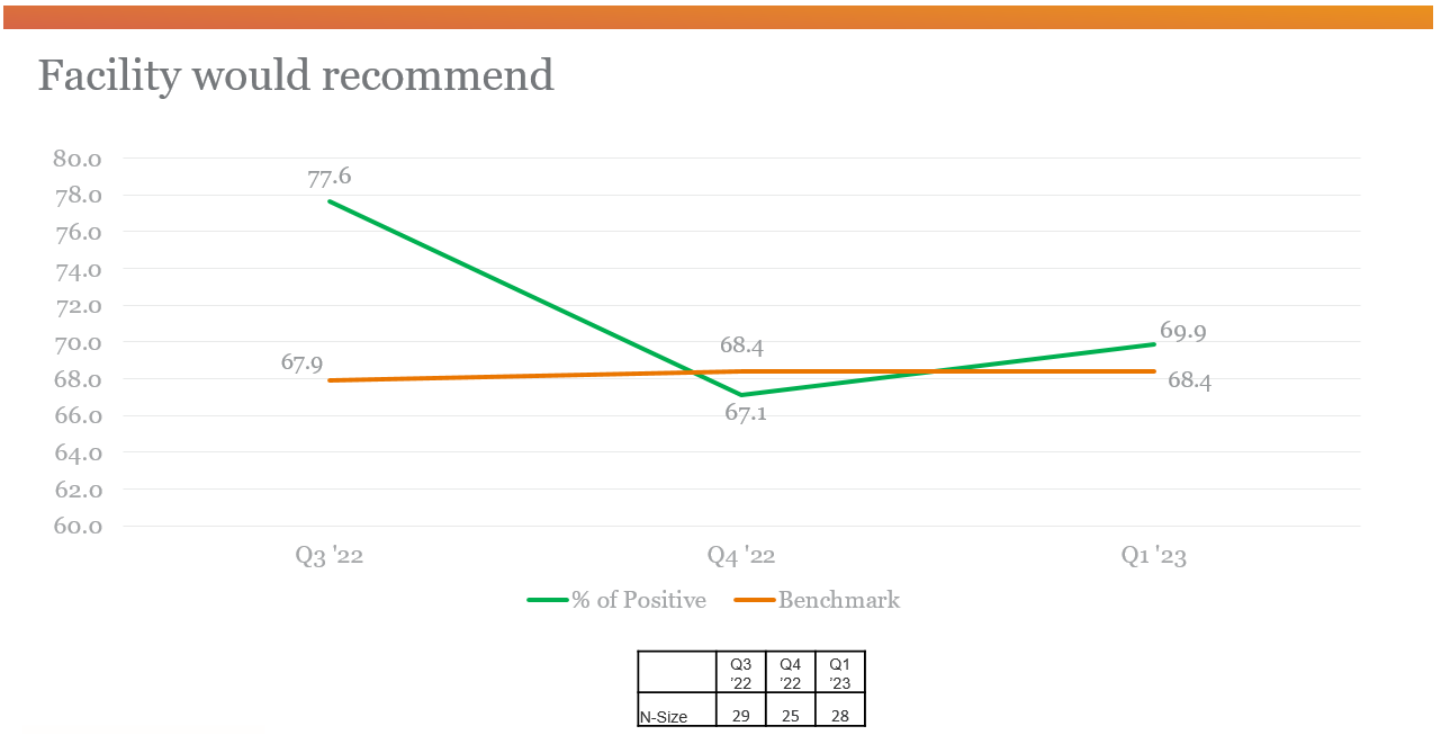
Kaweah Health

Unit/Department: Rehabilitation Services **Pro Staff Report Date:** May 2023

Measure Objective/Goal:
Acute rehabilitation program evaluation: patient satisfaction and clinical quality including functional outcomes and transfer of care.
Date range of data evaluated: Rehab quarterly report 4Q2022 and 1Q2023

Patient Satisfaction
Analysis of all measures/data: (Include key findings, improvements, opportunities)
In July 2022, the Rehab program transitioned to a new survey platform with NRC however, the surveys are very different. Press Ganey was a mailed survey of 40 questions versus NRC 12 questions via email, text or phone. We have seen a significant improvement in number of surveys collected however, we will need to have a few quarters of NRC survey responses to set goals and better understand and interpret the results. The key metric we measure is the question "would you recommend this facility" and will action plan utilizing the 4 questions which are correlated to the key metric.



	Q3 '22	Q4 '22	Q1 '23
N-Size	29	25	28

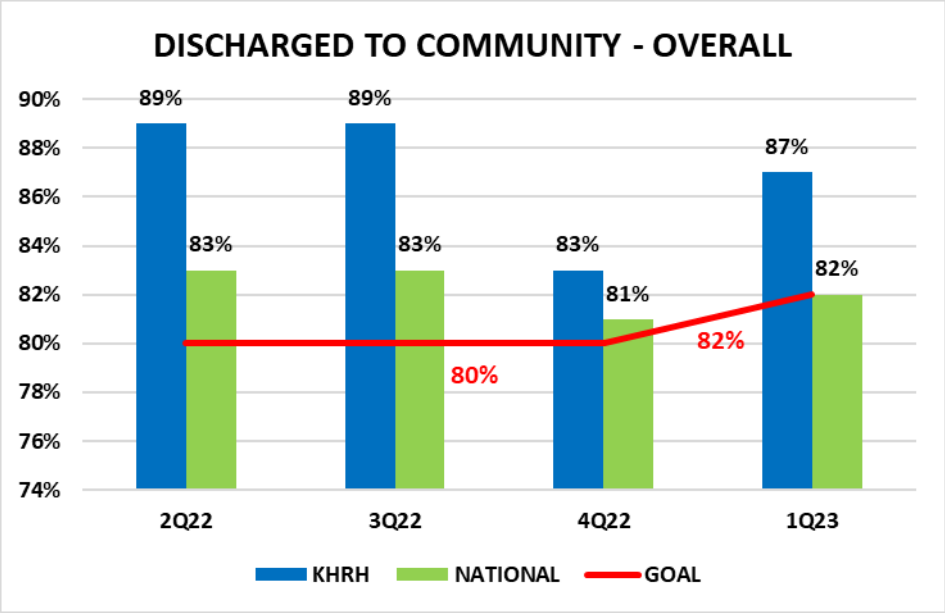
If improvement opportunities identified, provide action plan and expected resolution date:
We will need to have a few quarters of NRC survey responses to set goals and better understand and interpret the results.

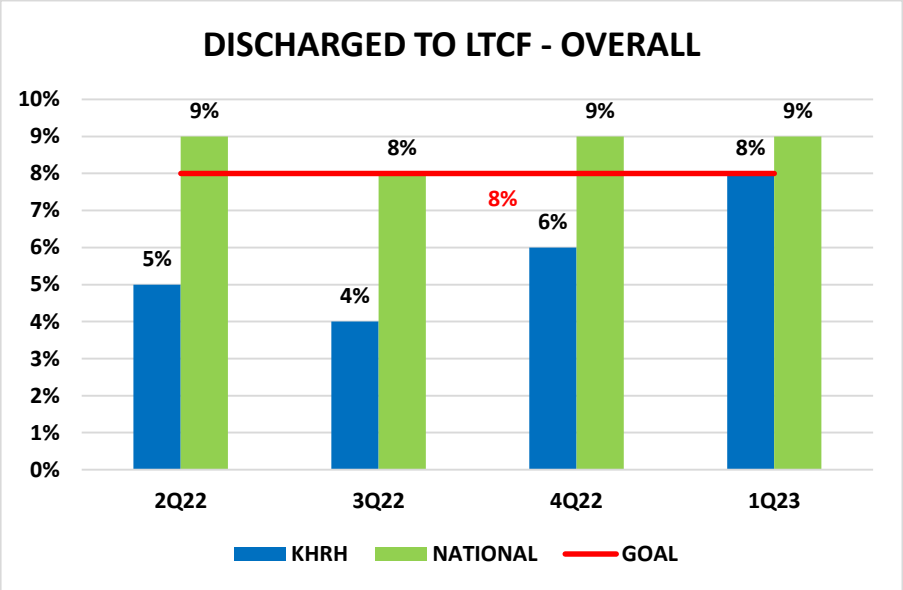
Functional Outcomes

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

Discharged to Community – (higher is better) in 4Q22/1Q23 83%/87% of KH Rehab patients returned to community, exceeding the national average of 81%/83%.

Discharge to LTCH – (lower is better) KH Rehab patients discharging to Skilled Nursing Facility in 4Q22 was 6% compared to national average of 9% and 1Q23 8% compared to 9%. This increase in patients discharging to SNF instead of home is because, in an effort to grow our program, we are being less restrictive in regards to the type of patient we accept. We are including more patients that fall outside of the traditional Rehab diagnoses but still qualify for Acute Rehab program.





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

Track the admissions that fall outside of the traditional Rehab diagnoses but still qualify for Acute Rehab program and what their discharge destination is.

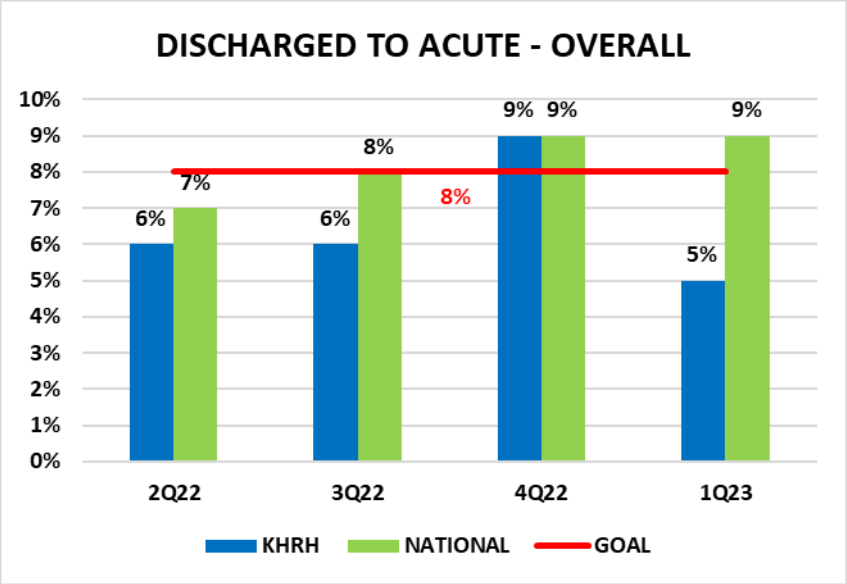
Transfer of Care

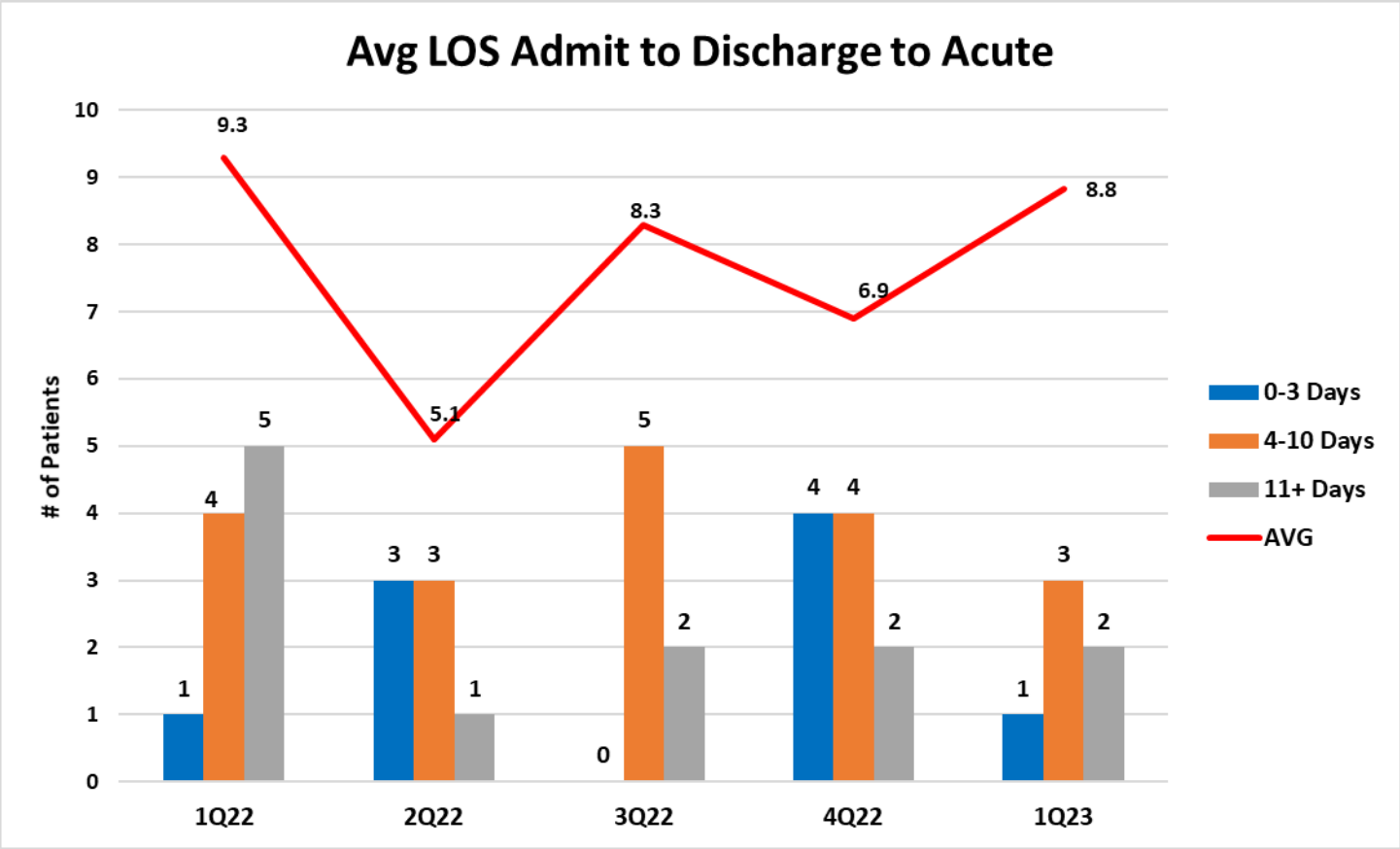
Analysis of all measures/data: (Include key findings, improvements, opportunities)

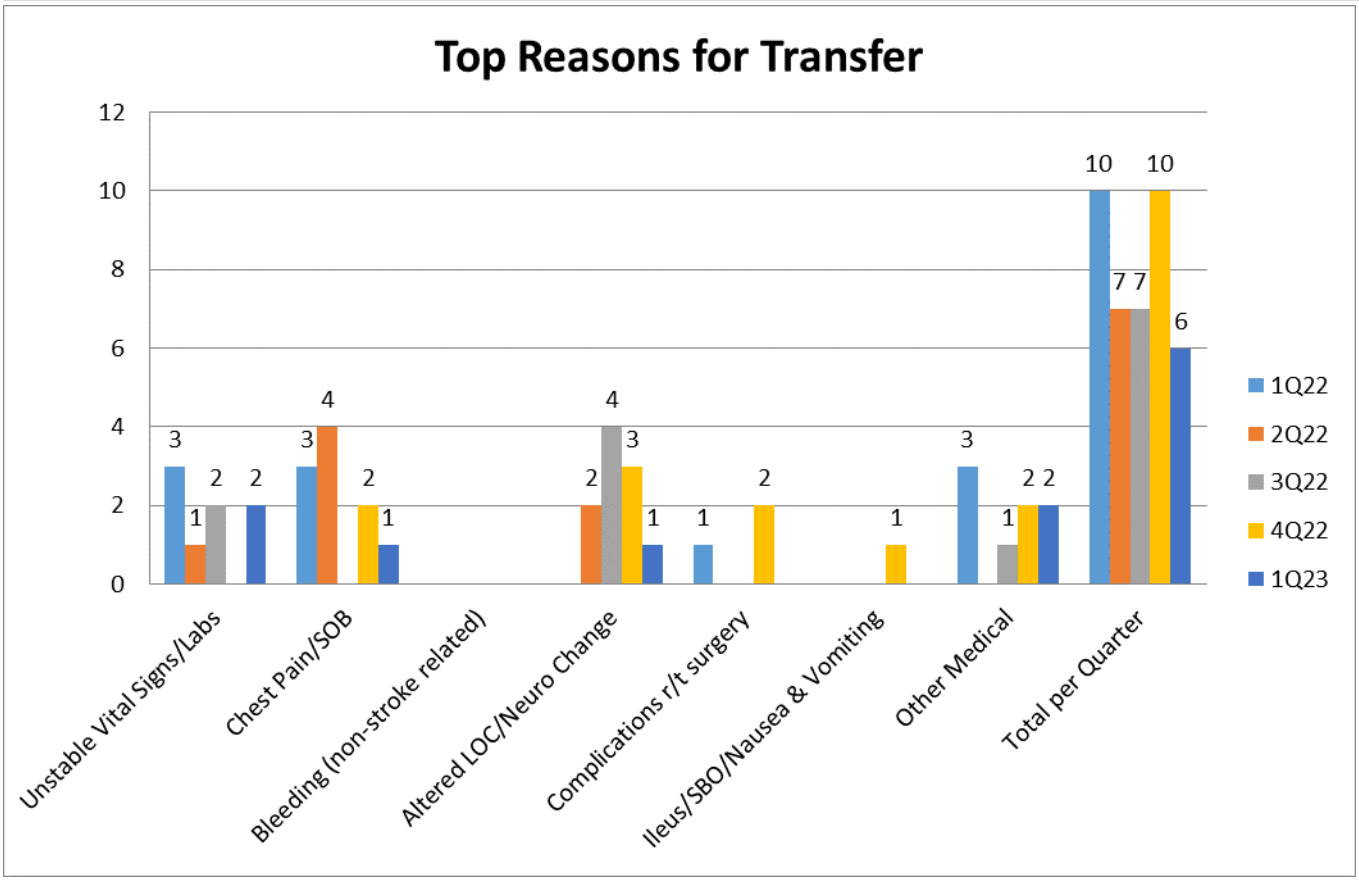
Discharged to Acute – (lower is better) In 4Q22, KH Rehab patients discharging back to the Acute Medical Center was 9%, same as the national average and 1Q23, we improved to 5% versus the nation at 9%. The Case Mix Index for KH 1.39 is now becoming closer to nation 1.42, which allows for improved comparison and as the acuity of the patient is increasing, we may end up closer to the nation in regards to transfers back to acute.

Average LOS Prior to Discharge to Acute – In 4Q22, the avg. number of days from Rehab admission to transfer to Medical Center was 6.9 days and 1Q23 8.8 days. In 4Q22, 4 patients were transferred back to acute in first 3 days but in 1Q23 there was only 1. The average LOS being at about 1 week from admission supports that the patients were appropriate at the time of admission to Acute Rehab (AR).

Top Reasons for Transfer - In 4Q22 there were 10 and 1Q23 there were 6 patients transferred back and admitted to the Acute Medical Center. In discussion with Dr Matsuo, all were appropriate transfers due to diagnosis and treatment plans except 1 that was transferred back to the ED to be taken to a non-emergent podiatric surgery. The surgery team is aware as this is not to appropriate process.





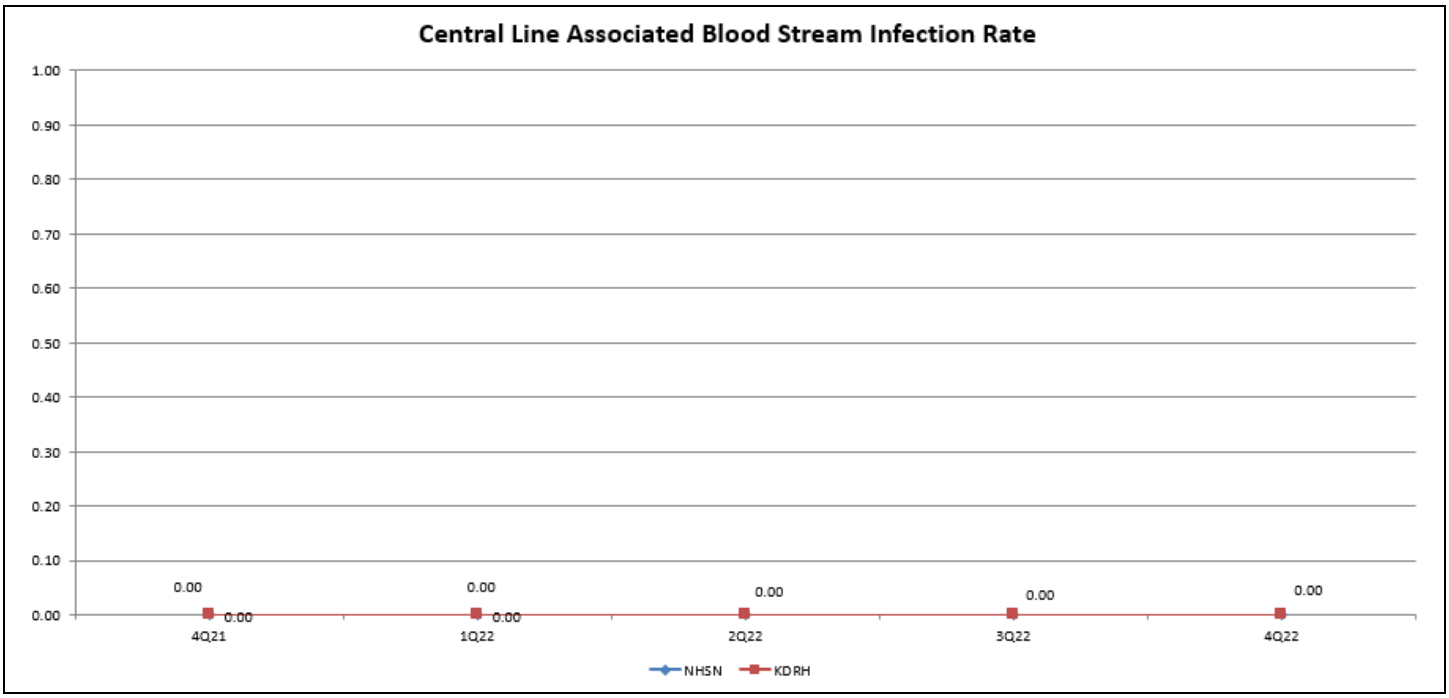


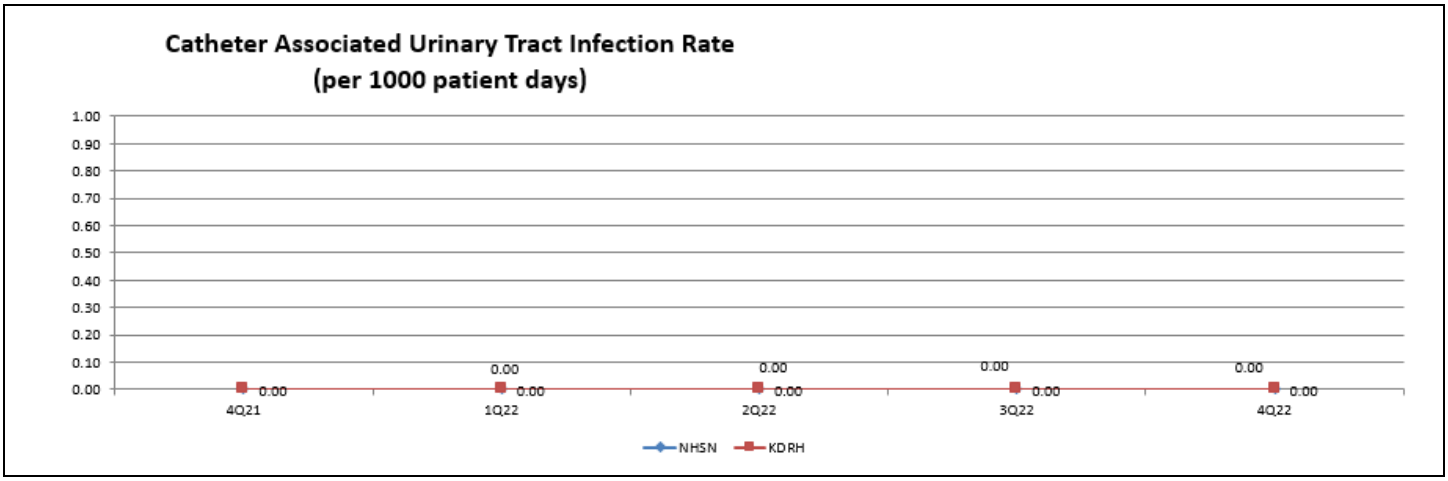
<u>If improvement opportunities identified, provide action plan and expected resolution date:</u>
Track admissions that fall outside of the traditional Rehab diagnoses but still qualify for Acute Rehab program versus traditional Acute Rehab diagnoses.

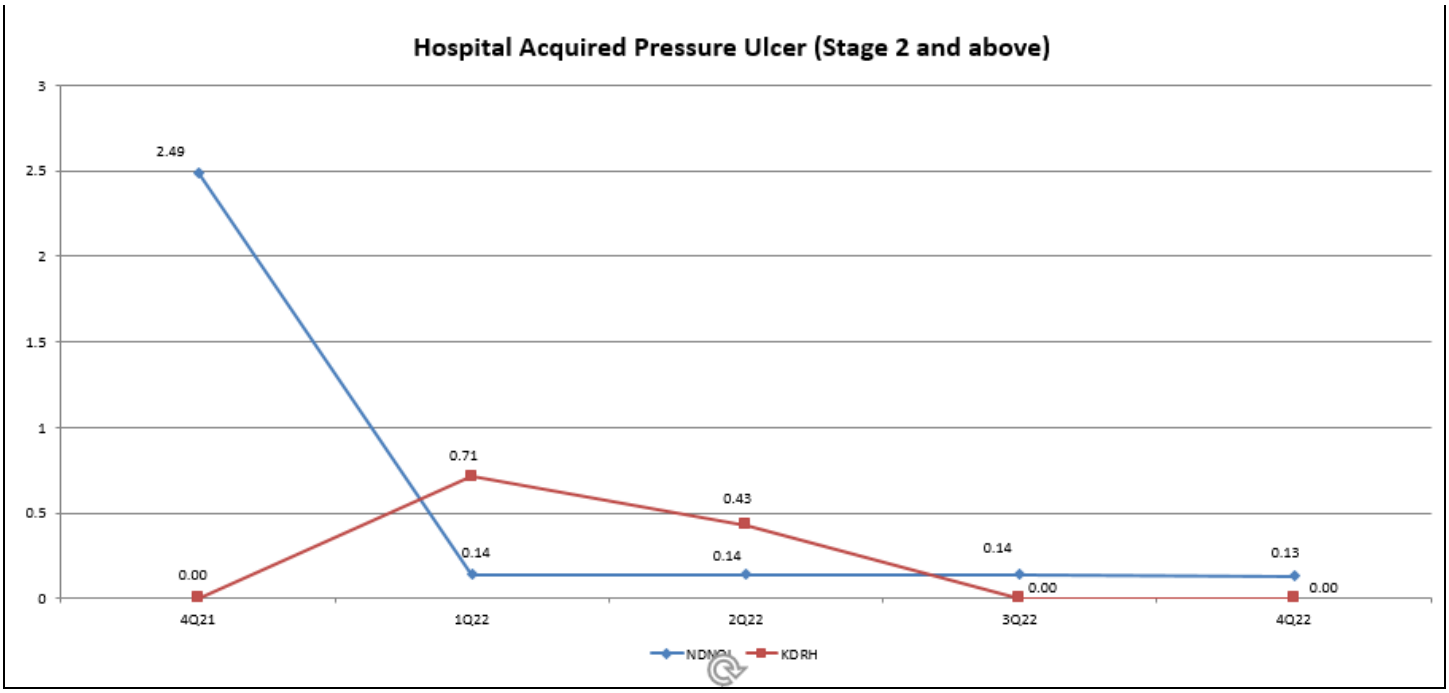
Measure Objective/Goal:
Nursing indicators relative to NDNQI

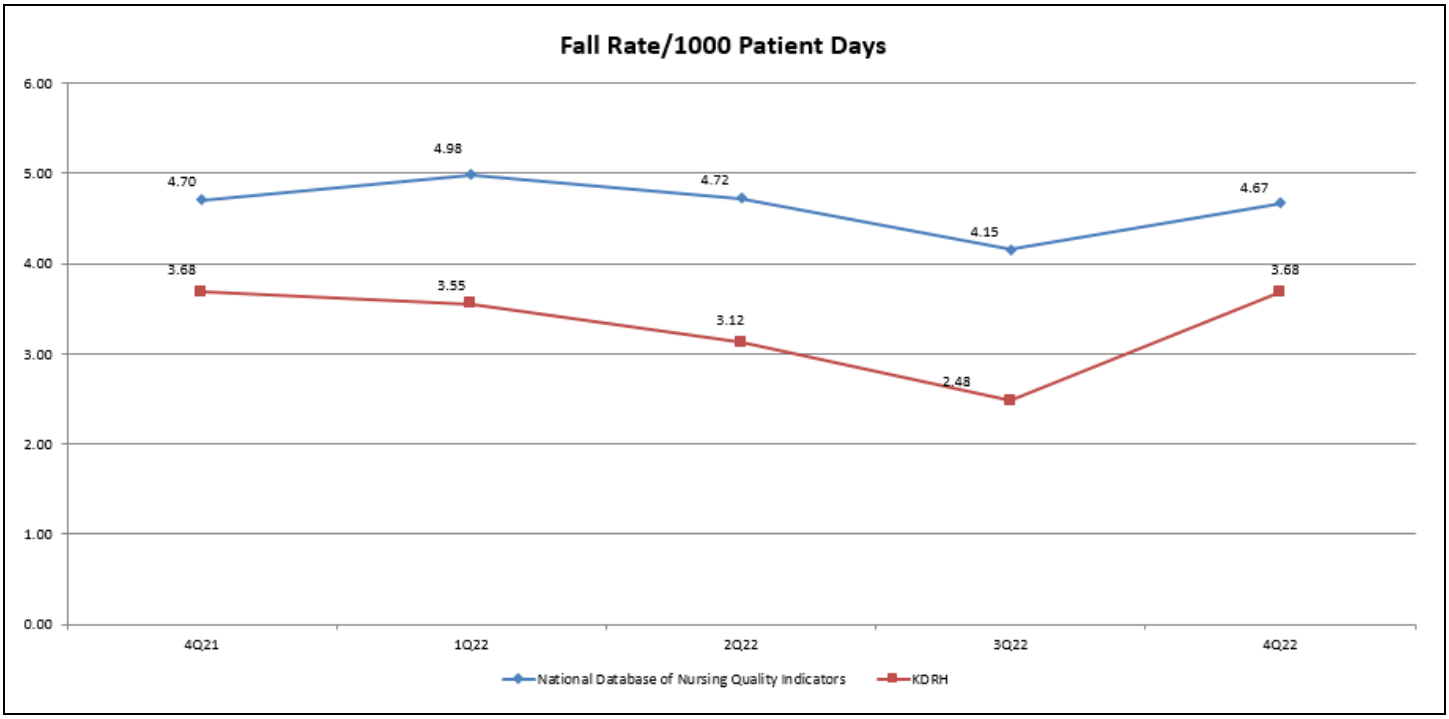
Date range of data evaluated: 3Q22 and 4Q22

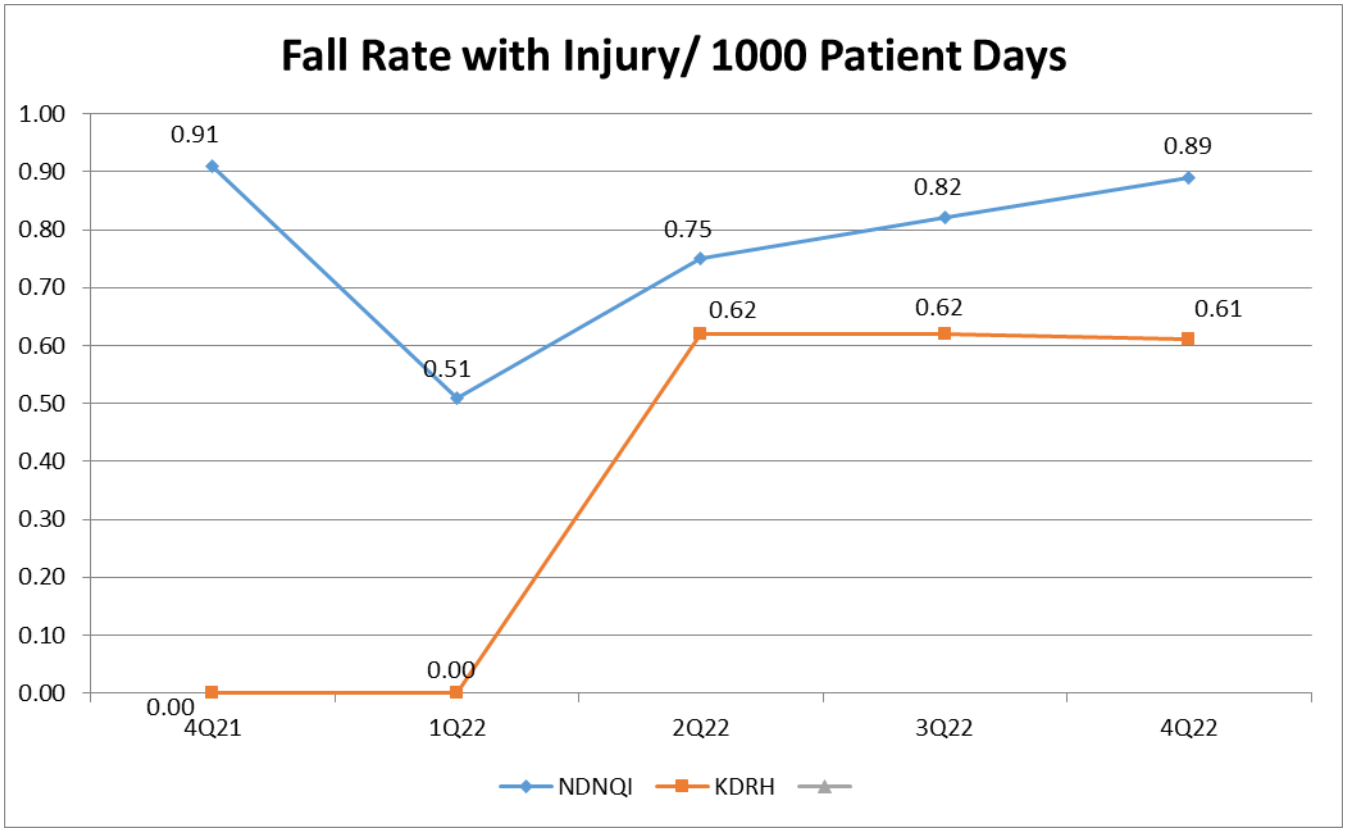
Analysis of all measures/data: (Include key findings, improvements, opportunities)
Kaweah Health Rehab had zero incidence of central line blood stream infections and CAUTI. Hospital acquired pressure ulcer stage II or above for 3Q22 and 4Q22 was 0. Fall rate per 1000 patient days and fall rate with injury/1000 patient days continue to be below NDNQI benchmarks in 3Q22 and 4Q22.




Catheter Associated Urinary Tract Infection Rate
(per 1000 patient days)
1.00
0.90
0.80
0.70
0.60
0.50
0.40
0.30
0.20
0.10
0.00
0.00
0.00
0.00
0.00
0.00
0.00
0.00
0.00
0.00
0.00
4Q21
1Q22
2Q22
3Q22
4Q22
NHSN
KDRH


Hospital Acquired Pressure Ulcer (Stage 2 and above)
3
2.5
2
1.5
1
0.5
0
2.49
0.14
0.14
0.14
0.13
0.00
0.71
0.43
0.00
0.00
4Q21
1Q22
2Q22
3Q22
4Q22
NDNQI
KDRH





If improvement opportunities identified, provide action plan and expected resolution date:
Continue existing initiatives for CAUTI with renewed focus on GEMBA rounds, peri care and bathing as well as focus on validation of CNA transfer competency has helped reduce avoidable falls. Falls University restarted; Rehab Nurse Manager is the co-chair and invites staff to participate.

Measure Objective/Goal: Hand Hygiene compliance

Date range of data evaluated: 4Q22 and 1Q23

Analysis of all measures/data: (Include key findings, improvements, opportunities)
4Q22 and 1Q23 hand hygiene in OT, PT, Rehab Nursing and Wound Clinic have all consistently exceeded KH wide goal of 95%.

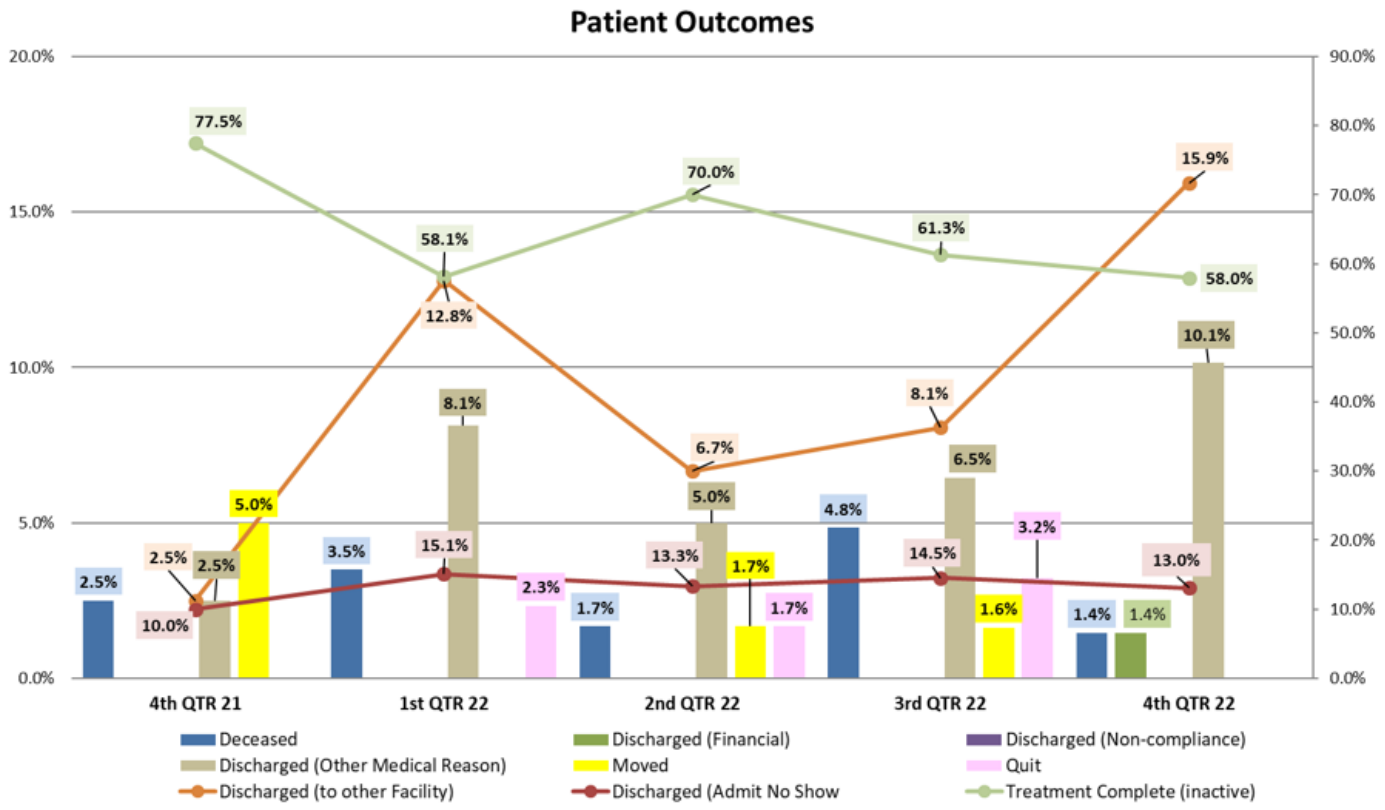
If improvement opportunities identified, provide action plan and expected resolution date:
Improve compliance with utilizing Biovigil on West campus.

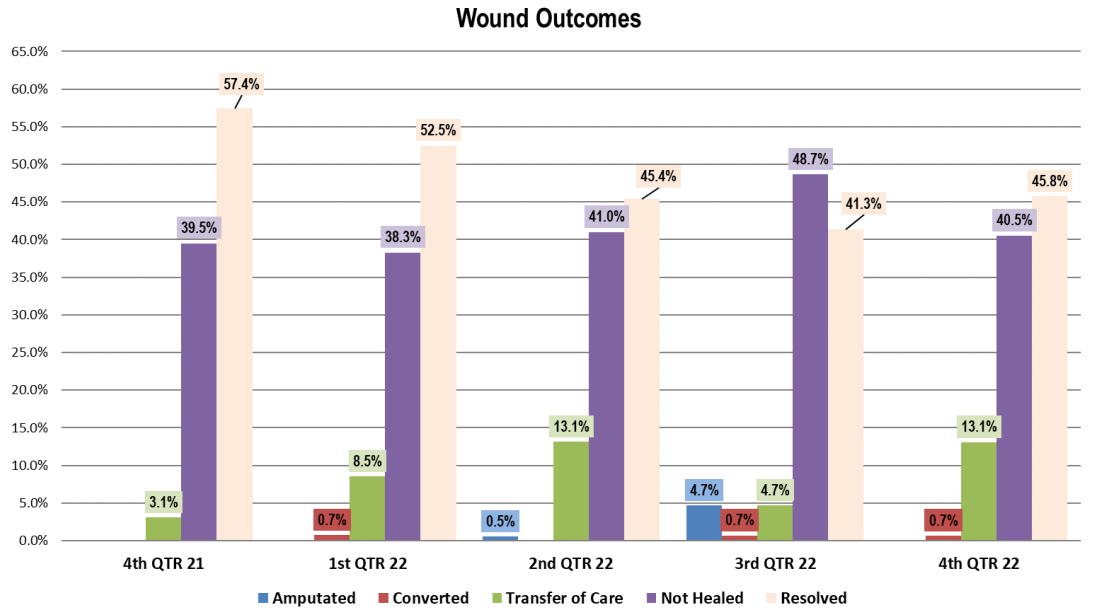
Measure Objective/Goal: Wound Center outcomes

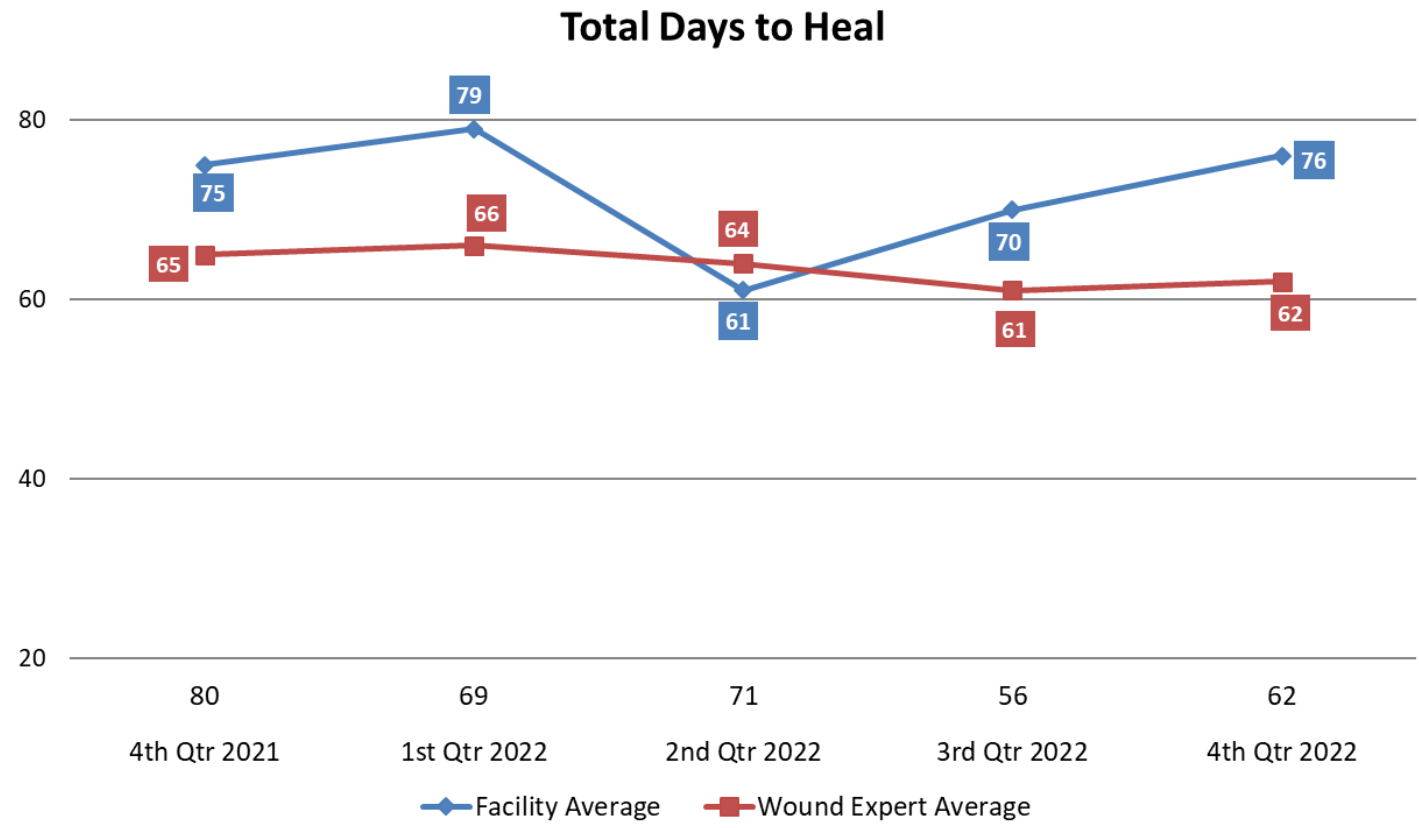
Date range of data evaluated: 3rd and 4th quarter 2022

Analysis of all measures/data: (Include key findings, improvements, opportunities)
All wound outcomes in 4Q22, 58%% of the wound center patient's complete treatment down 3.3% from 3Q22. Data for the 4th quarter of 2022, reveals we are performing 14 days over compared Wound Expert Center's average on "days to heal". We averaged 76 days compared to 62 the wound expert average. Diabetic Ulcers (9 total wound): Kaweah Wound Center Average Days to heal 131 compared to 89 with Wound Expert Facility Average, largely due to the small sample size and one patient taking over 500 days to heal. This is a significant increase from the previous 2 quarters due to a few outliers. Pressure Ulcers (4 wounds): Kaweah Wound Center Average Days to heal 41, 19 days better compared to 62 with Wound Expert Facility Average. Surgical Wounds (11 wounds): Kaweah Wound Center Average Days to heal 72 compared to 71 with Wound Expert Facility Average. Venous Stasis Ulcers (19 Wounds: Kaweah Wound Center Average Days to heal 60 outperforming Wound Expert Facility Average with 68. The number of patients at the wound center has stabilized in 3Q22 and 4Q22 due to hiring a full time FNP. We expect a continued increase in wounds and wound outcomes. HBO is now operational and we have certified providers to supervise

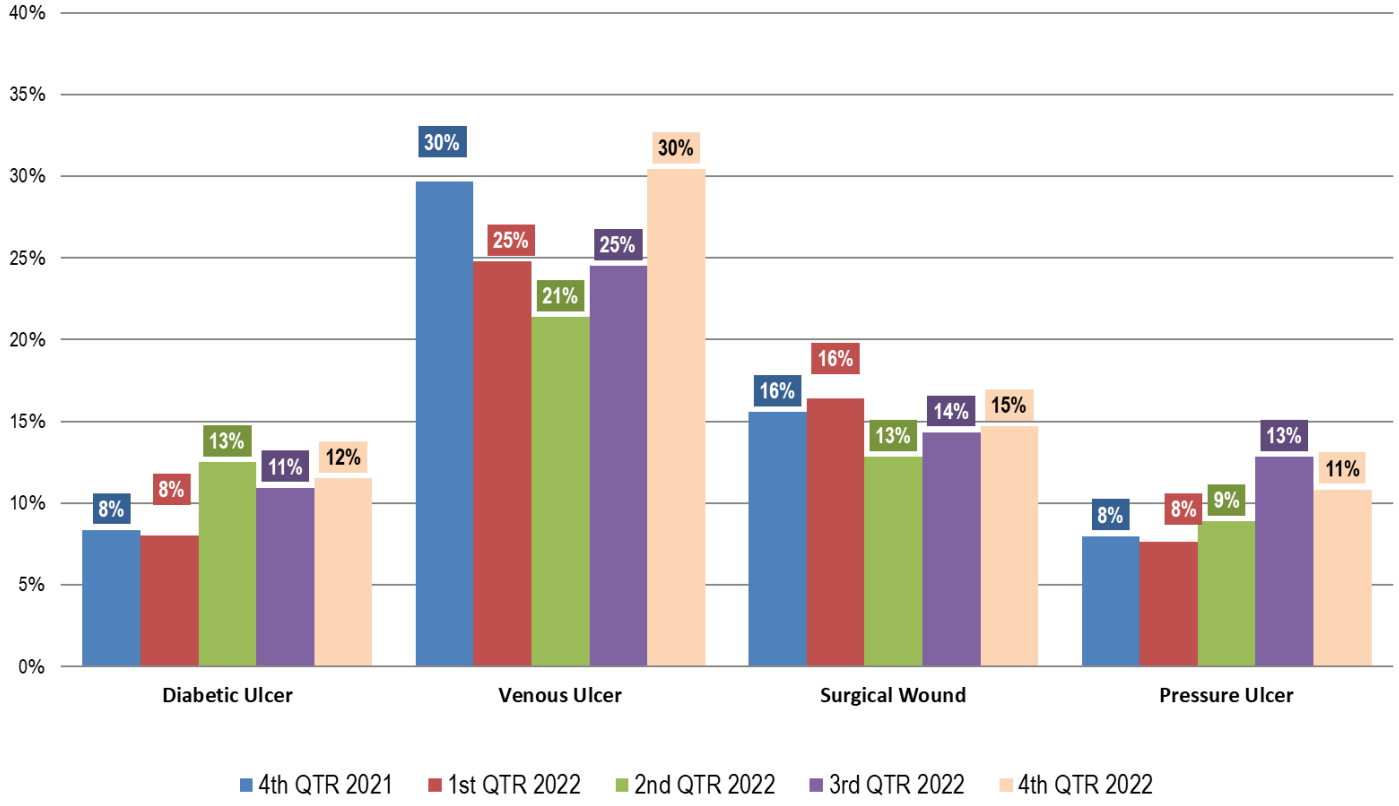
patients.


Patient Outcomes
20.0%
15.0%
10.0%
5.0%
0.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
77.5%
58.1%
70.0%
61.3%
58.0%
15.9%
12.8%
6.7%
8.1%
10.1%
8.1%
6.5%
5.0%
5.0%
4.8%
3.2%
2.5%
2.5%
2.5%
3.5%
15.1%
2.3%
1.7%
13.3%
1.7%
1.7%
14.5%
1.6%
13.0%
1.4%
1.4%
10.0%
4th QTR 21
1st QTR 22
2nd QTR 22
3rd QTR 22
4th QTR 22
Deceased
Discharged (Financial)
Discharged (Non-compliance)
Discharged (Other Medical Reason)
Moved
Quit
Discharged (to other Facility)
Discharged (Admit No Show
Treatment Complete (inactive)

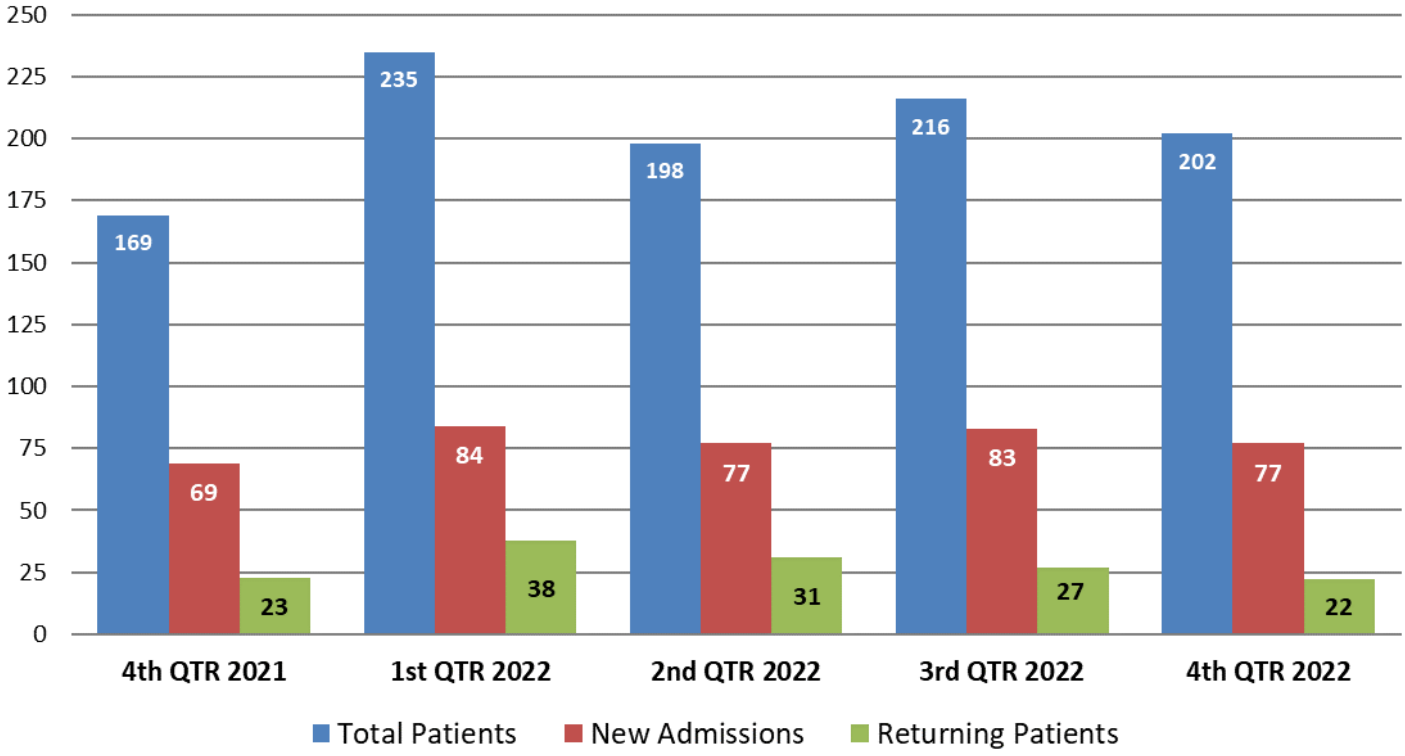

Wound Outcomes
65.0%
60.0%
55.0%
50.0%
45.0%
40.0%
35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
57.4%
52.5%
45.4%
48.7%
45.8%
39.5%
38.3%
41.0%
41.3%
40.5%
3.1%
8.5%
13.1%
4.7%
4.7%
13.1%
0.7%
0.5%
0.7%
0.7%
4th QTR 21
1st QTR 22
2nd QTR 22
3rd QTR 22
4th QTR 22
Amputated
Converted
Transfer of Care
Not Healed
Resolved

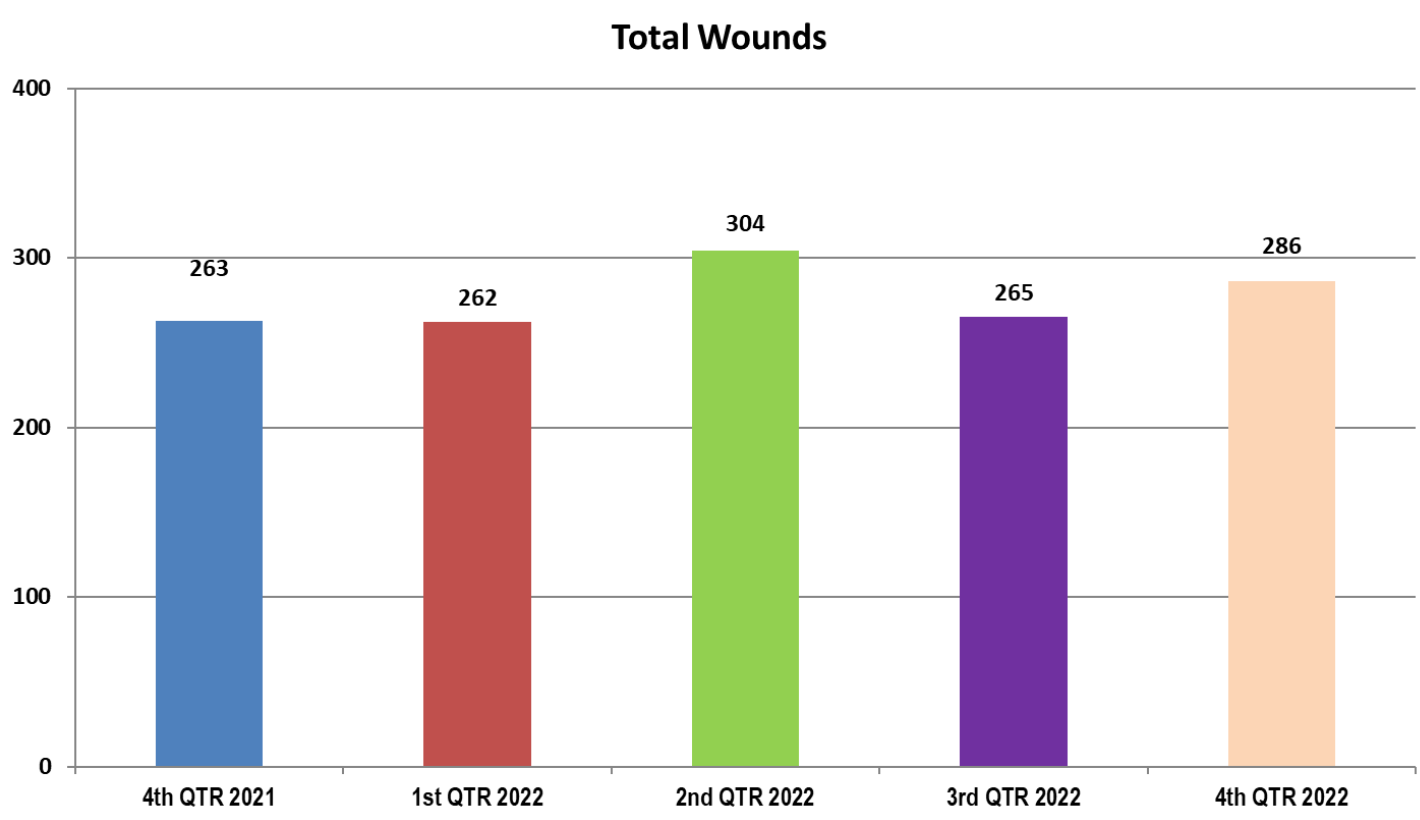

Total Days to Heal
80
60
40
20
79
75
66
65
64
61
70
61
76
62
80
69
71
56
62
4th Qtr 2021
1st Qtr 2022
2nd Qtr 2022
3rd Qtr 2022
4th Qtr 2022
Facility Average
Wound Expert Average

Treated Wounds



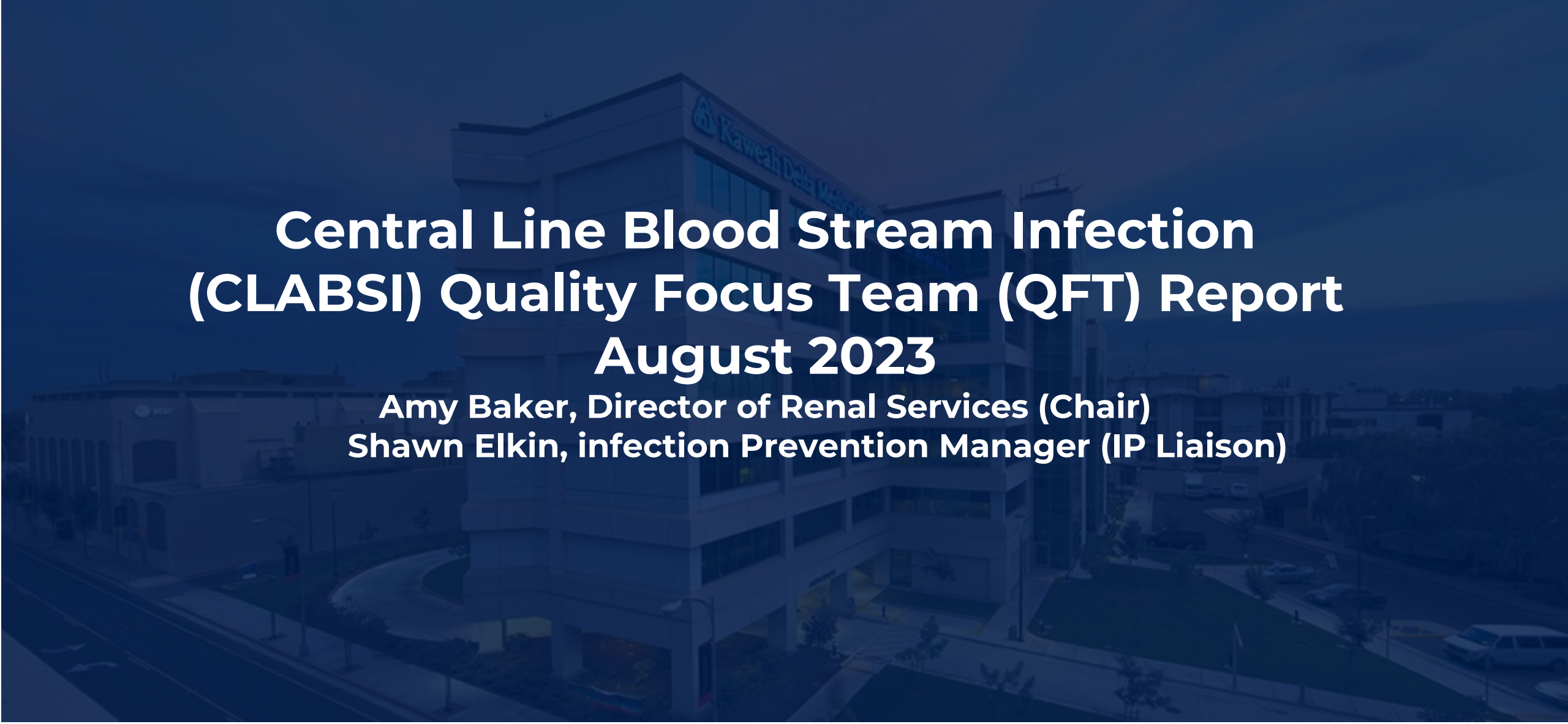
Facility Data





If improvement opportunities identified, provide action plan and expected resolution date:
1Q23 and 2Q23: Focus on how to heal venous stasis ulcers, identify treatments, which are making improvements. Implement monthly discussion of patient not healing. Focus on Documentation. Wound labeling, and identifying as well as resolving or discharging patients efficiently. Stalled wound meetings with medical director to address wounds that have not healed in 100 days. Implement dietician screenings to identify patients that need additional interventions.

Submitted by Name: Molly Niederreiter **Date Submitted:** May 18 2023



Central Line Blood Stream Infection (CLABSI) Quality Focus Team (QFT) Report August 2023

Amy Baker, Director of Renal Services (Chair)
Shawn Elkin, infection Prevention Manager (IP Liaison)

Post Kaizen- Gemba Data

- **For Fiscal Year 2022-2023 there has been 14 CLABSI events**
- **The % of central lines with a valid rationale order continues to be a problem area.**

CLABSI Committee Dashboard

Measure Description	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
OUTCOME MEASURES														
Number of CLABSI	2	2	1	2	3	0	0	1	1	3	1	1	1	2
FYTD SIR	1.09	1.12	1.07	1.13	2.26	1.14	0.802	0.792	0.784	1.026	0.99	0.98	0.97	1.03
PROCESS MEASURES CL Gemba														
% of pts with bath within 24 hrs	n/a	95%	96%	95%	95%	97%	96%	95%	95%	96%	99%	95%	90%	96%
% of CL with valid rationale order	n/a	98%	97%	96%	96%	96%	93%	99%	96%	94%	93%	89%	88%	94%
% of CL dressings clean, dry and intact	n/a	97%	96%	98%	98%	97%	96%	97%	98%	98%	96%	98%	96%	97%
% of CL that had drsg change no > than 7 days	n/a	97%	97%	92%	94%	96%	98%	98%	98%	98%	99%	89%	98%	99%
% of patients with proper placed gardiva patch	n/a	95%	95%	90%	95%	94%	94%	95%	97%	98%	93%	95%	95%	98%
% of CL pts with app & complete documentation	n/a	92%	93%	91%	91%	95%	96%	94%	94%	95%	97%	96%	97%	96%
# of Pt Central Line days rounded on		1296	1087	892	910	838	792	787	746	715	751	560	591	554

CLABSI QFT- Ongoing Meeting Objectives

- CLABSI Quality Focus Team continues to meet once a month
  - Each CLABSI case is reviewed with unit nurse manager and bedside nurses who provided care to patient
  - CLABSI's are reviewed monthly during Hospital Acquired Infection Case Reviews.
    - Nurse Manager attends to hear case review and see identified fallouts
  - Unit specific action plans are and reviewed based on any deficiencies
  - Unit RN's provide feedback from the bedside
  - Action plan is reviewed with units UBC's
- Additional projects are reviewed and implemented by CLABSI QFT

CLABSI QFT- Ongoing Meeting Objectives

- Chlorhexidine Bathing for Med/Surg level Patients
  - Practice change presented at Patient Care Leadership Meeting
  - Subcommittee needed to work out details
    - Details include:
      - Certified Nursing Assistant can perform CHG bathing
      - Does CHG need to scanned in MAR
- Reviewing peripheral IV usage, length of dwell time and education around infiltrated IV's.
- New members to CLABSI QFT include new Critical Care APN and new representative from the Clinical Education Department.

Current Fiscal Year

FY23 Clinical Quality Goals

	July 22 – May 23 Higher is Better	FY23 Goal	FY22	FY22 Goal
SEP-1 (% Bundle Compliance)	74%	≥ 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.

Our Mission

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

Our Vision

To be your world-class healthcare choice, for life

Lower is Better	July 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	2 0	0 0	14 (23 predicted over 12 months)	0.55 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	0 0	3 0	10 (17 predicted over 12 months)	0.98 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	0 0	2 1	5 (8 predicted over 12 months	0.63 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.

Questions?

Live with passion.

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

Kaweah Health

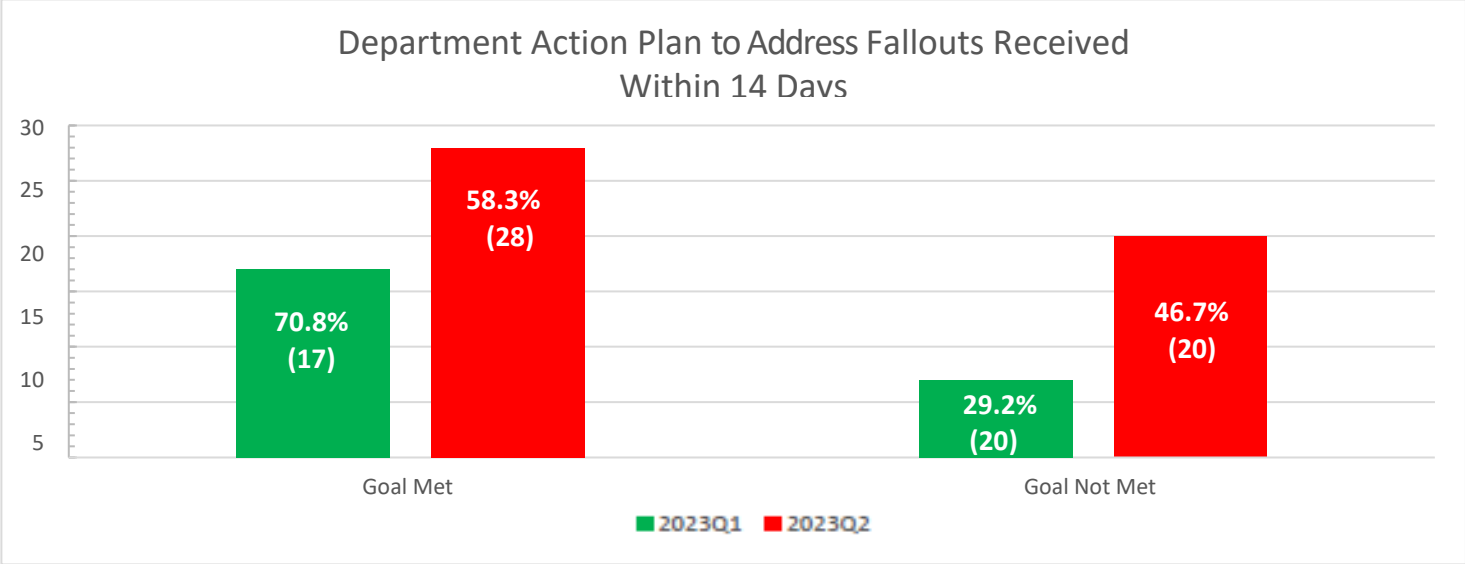
Infection Prevention Component:	**INFECTION PREVENTION COMPREHENSIVE ROUNDS**
Performance Standard:	**Comprehensive Rounds -** Action plans to correct elements out of compliance are returned by the department leader to Infection Prevention department within 14 days of report of findings to ensure safety issues are addressed in a reasonable timeframe in order to mitigate the risk of infection to patients and staff, to enhance patient safety and to optimize the environment of patient care. **Goal:** >90% compliance rate. **Minimum Performance Level:** 90% compliance rate.

Evaluation:

Action plans from department leaders within 14 days to address findings 2023 Q1&2: **62.5%**

72 departments were surveyed for 2023 Q1&2.

45 departments met the goal. 27 departments did not meet the goal.



Improvements made to process:

Rounding schedule shared with affected departments in advance.

Manager or designee is asked to attend the rounds onsite.

The rounding tool has been consolidated into one comprehensive questionnaire so managers only receive one document outlining the fallouts.

Managers are provided 14 days to return the action plan versus 7 days as was previously expected.

Reminders are submitted to the manager initially and after the 14-day mark to submit the completed action plan.

Next Steps:

Contact Director for departments with fallouts

Attend Patient Care Management (PCM) to discuss fallouts and expectations.

Kaweah Health Care District
2023 Hazardous Surveillance Schedule
Thursday's at 09:00 a.m.

Surveillance team members are from the following Departments: Safety, EVS, Infection Control, Maintenance, Security, and Clinical Engineering.

Date	Area		Date	Area
January 5			July 6	4th Floor Mineral King (4S, 4N, 4C...)
January 12	4th Floor Mineral King (4S, 4N, 4C...)		July 13	3rd Floor Mineral King (3N, 3S, 3W, 3E-BP, 3E-Peds, 3C)
January 19	3rd Floor Mineral King (3N, 3S, 3W, 3E-BP, 3E-Peds, 3C)		July 20	Respiratory, Endoscopy, Mitts Building
January 26	Distribution, Respiratory, Endoscopy, Cardiothoracic Surgery Clinic		July 27	Acequia Wing-CVICU, Mother Baby, Telemetry, CVICCU 5th Floor
February 2	Acequia Wing-CVICU, Mother Baby, Telemetry, CVICCU 5th Floor		August 3	Mental Health
February 9	AW Main Lobby, Central Logistics, Administration, Security, AW PBX		August 10	Urgent Care Flagstaff, Woodlake Clinic,
February 16	Mental Health		August 17	Visalia Dialysis, CAPD/CCPD, Open Arms House
February 23	Patient Accounting (5300 Tulare), Visalia Dialysis, CAPD/CCPD, Open Arms House		August 24	Radiology (Main Campus),Nuclear Med, CT Scan, MRI
March 2	Radiology (Main Campus),Nuclear Med, CT Scan, MRI		August 31	Sterile Processing (MK), Sterile Processing Basement (AW)
March 9	Sterile Processing (MK), Sterile Processing Basement (AW)		September 7	KD Imaging, SIC, Sequoia Oncology-SRCC
March 16	KD Imaging, SIC, Sequoia Oncology-SRCC		September 14	Laboratory
March 23	Hanford Medical Oncology, Radiation Oncology, Dinuba Clinic		September 21	The Lifestyle Center, Akers MOB
March 30	Laboratory		September 28	Warehouse-Construction Services, Patient Access Main St, Ben Maddox
April 6	Kaweah Kids, Old Finance Building, ISS, Foundation Employee Pharmacy/Prime Infusion,Hospice,		October 5	Support Services Building- All floors
April 13	Urgent Care Flagstaff, Woodlake Clinic		October 12	Hanford Medical Oncology, Radiation Oncology, Dinuba Clinic
April 20	Home Health, Private Home Care, Clinical Engineering		October 19	EEG, Sleep Lab, Willow Lab draw station Library, Food Services
April 27	EEG, Sleep Lab, Willow Lab Draw station, 202 Building All(Employee Health)		October 26	Office of Research/Grants, Population Health, Patient Family Services, 202 Building ALL
May 4	Laundry, Maintenance, EVS, Center for Mental Wellness		November 2	2nd Floor MK (2E, 2N, 2S,2C,2W-ICU) NICU-6th Floor
May 11	2nd Floor MK (2E, 2N, 2S,2C,2W-ICU) NICU-6th Floor		November 9	Rehab Lovers Lane, Specialty Clinic, Tulare Clinic, Cherry Clinic
May 18	Rehab Lovers Lane, Specialty Clinic, Tulare Clinic, Cherry Clinic		November 16	Acequia 2nd Floor (CVOR,Cath Lab, OB OR...)
May 25	Acequia Wing 2nd Floor (CVOR,Cath Lab, OB OR...).		November 23	CHC Subacute, Urgent Care, KATS
June 1	CHC Subacute, Urgent Care, KATS, Paradise House		November 30	MK Pharmacy, MK PBX, Med Staff
June 8	Surgical Services, Surgery Center, Pathology		December 7	Surgical Services, Surgery Center, Pathology
June 15	Emergency Department		December 14	Emergency Department
June 22	Rehab Hospital, Outpatient Rehab-Akers, Sequoia Cardiology-MOB		December 21	Rehab Hospital
June 29	KD Exeter Clinic, KD Lindsay		December 28	KD Exeter Clinic, KD Lindsay

Methicillin-Resistant Staphylococcus Aureus (MRSA)
Quality Focus Team Report
July 2023

Quality Focus Team Members

- *Jag Batth - Chief Operating Officer (ET)*
- *Kylie Jarrell – Admin Assistant Environmental Services, Laundry/Linen, & Patient Transport Service (Recorder)*
- *Tendai Zinyemba - Director of Environmental Services. Laundry/Linen, & Patient Transport Service (Chair)*
- *Shane Reynolds - Assistant Nurse Manager 4N (Co-Chair)*
- *Justin Ma – Infectious Disease Pharmacist*
- *Amy Baker – Director of Renal Services*
- *Sandy Volchko - Director of Quality & Patient Safety*
- *Shawn Elkin – Infection Prevention & Control Manager*
- *Joetta Denny – Infection Prevention*
- *Gloria Dickerson – Clinical Educator*
- *Johnny Mata – Respiratory Care Manager*

MRSA- FY23 Goals

Healthcare onset MRSA bloodstream infection rate that does not exceed a standardized infection ratio of 0.726 or (<0.5 cases a month/1.5 cases a quarter/6 cases a year)

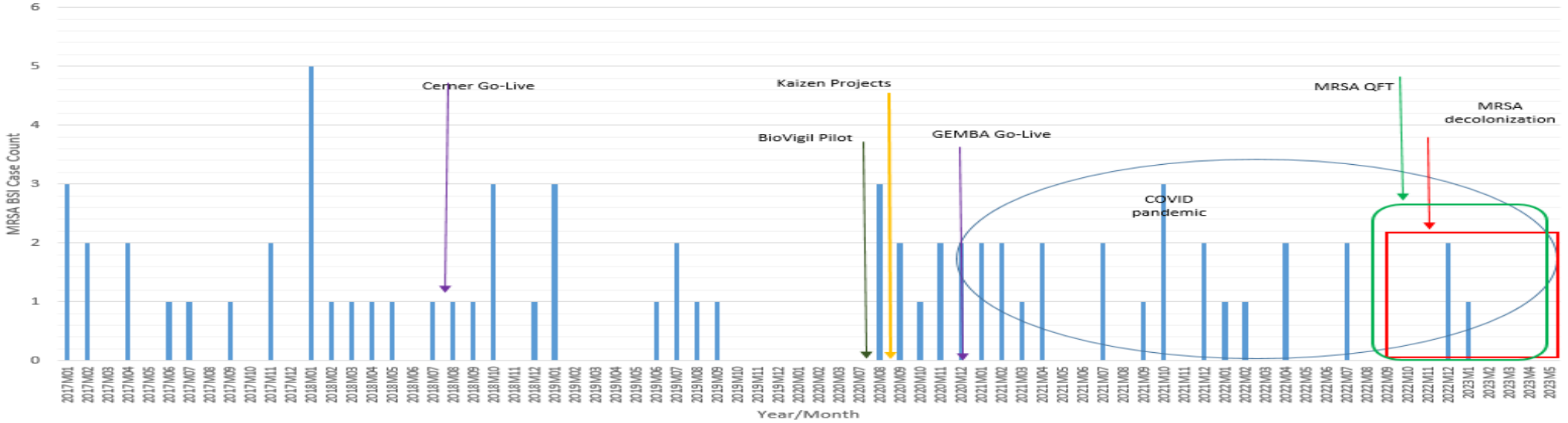
We reported 5 MRSA BSI events July 2022 – May 2023. (Only 1 was related to COVID-19 during FY)

*based on July-August 2022 NHSN predicted

**Standardized Infection Ratio (SIR) is the number of patients with a healthcare acquired infection (HAI) divided by the number of patients who were predicted to have an HAI. MRSA Bloodstream Infection is impacted by the number of inpatient days for a given time period.

Background Data – MRSA Bloodstream Infection Events

Number of MRSA Bloodstream Infection events at Kaweah Health from over calendar years 2017 through May 2023 with emphasis on implementation of MRSA Quality Focus Team and MRSA Nasal Decolonization Pilot Study.

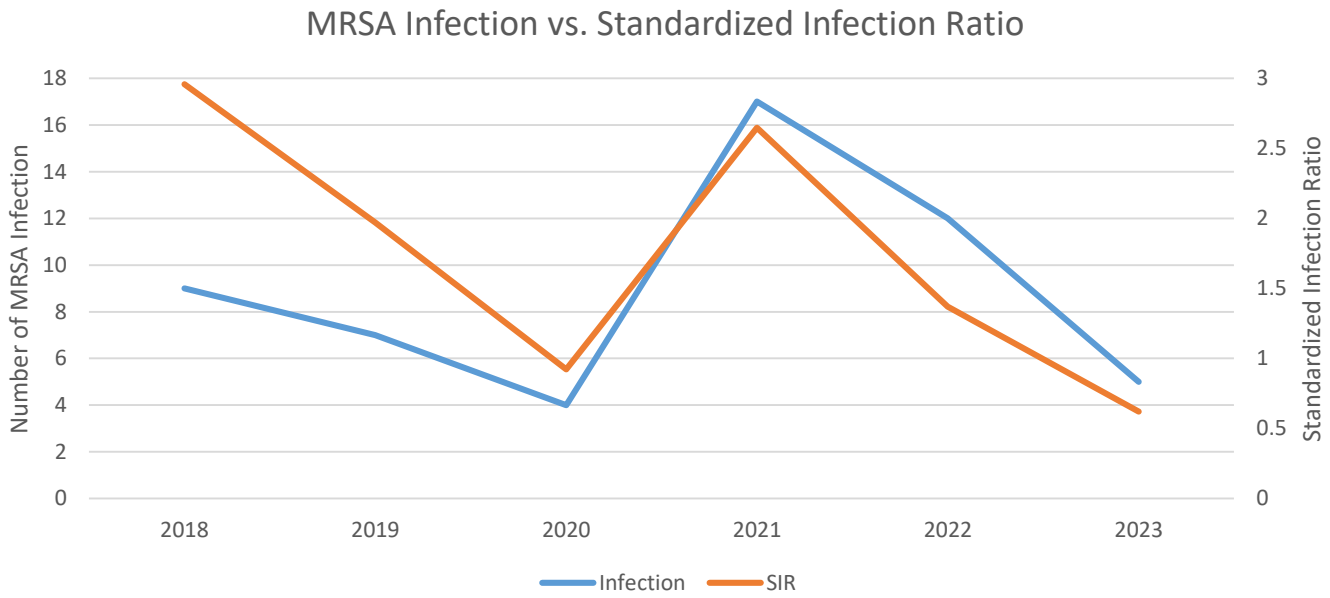


Number of MRSA BSI events dipped during November 2019 through March of 2020 in part due to the electronic hand hygiene system pilot on 4N, and ICU and the added attention given to healthcare associated infections (e.g. CLABSI/CAUTI) with Kaizen Projects and initiation of GEMBA Rounds. The increase in MRSA BSI events after March 2019 was associated with the COVID-19 pandemic, extended lengths of stays, blood culturing practices, and source control of the primary infection site. FY2023 has demonstrated a significant decrease in MRSA BSI events proximal to the time automated orders for Mupirocin decolonization treatment went live for 4N and ICU.

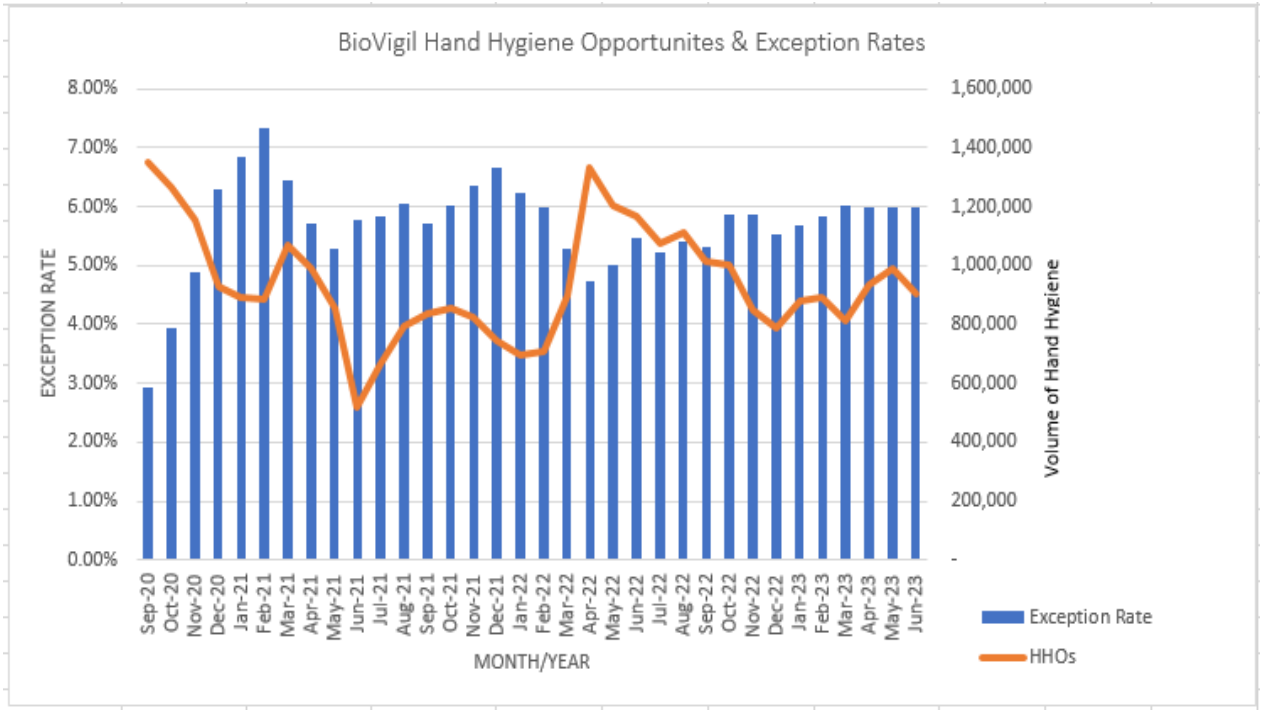
Fiscal Year	Infection	SIR
2018	9	2.958
2019	7	1.97
2020	4	0.923
2021	17	2.648
2022	12	1.371
2023	5	0.620

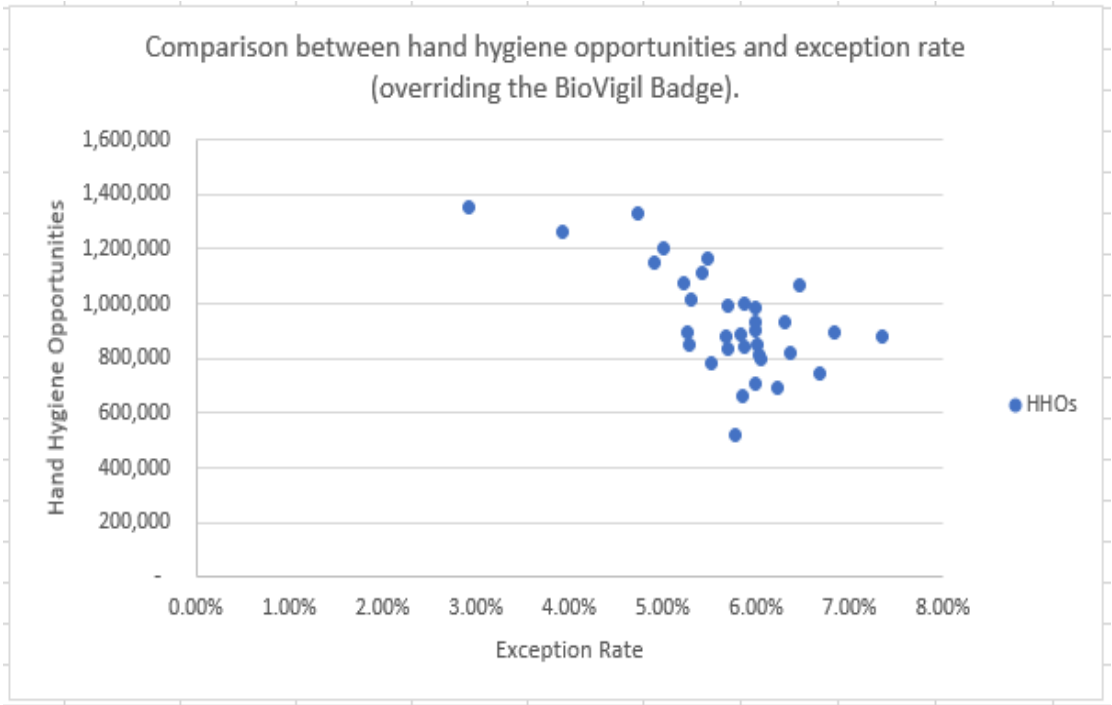
Background Data – MRSA Bloodstream Infections & Standardized Infection Ratio Trend

Fiscal Year	Infection	SIR
2018	9	2.958
2019	7	1.97
2020	4	0.923
2021	17	2.648
2022	12	1.371
2023	5	0.620



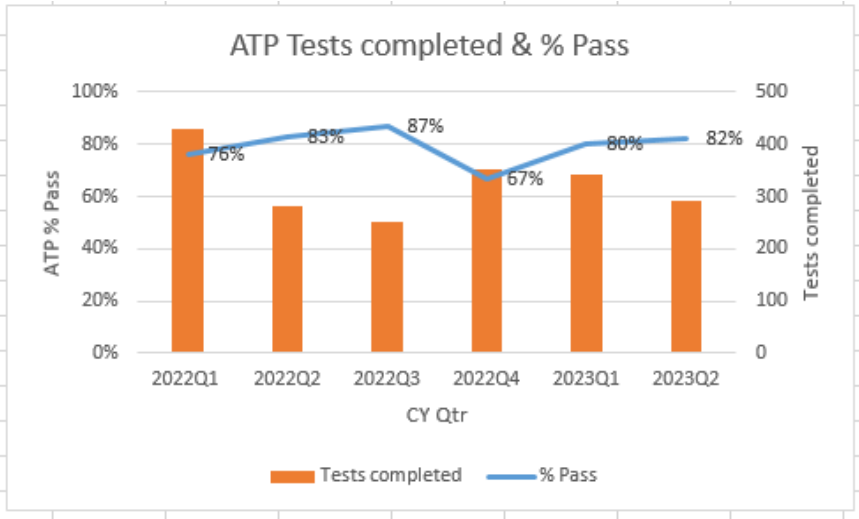
BioVigil Data - Hand Hygiene Opportunities





ATP Data

Filter: Area = '5T,Cath Lab,CVICU,CVOR,ICU,Main OR,OB OR,OR', Date Collected Between 2022-01-01 and 2023-06-30



Qtr	% Pass	Tests completed
2022Q1	76%	429
2022Q2	83%	283
2022Q3	87%	252
2022Q4	67%	351
2023Q1	80%	343
2023Q2	82%	293
Avg	79%	

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Summary Report

Filter: Area = '5T,Cath Lab,CVICU,CVOR,ICU,Main OR,OB OR,OR', Date Collected Between 2022-01-01 and 2023-06-30

Total	Pass	Marginal	Fail
2004	1575	2	427
100.0%	78.59%	0.1%	21.31%

Summary Report

Filter: Area = '5T,Cath Lab,CVICU,CVOR,ICU,Main OR,OB OR,OR', Date Collected Between 2023-04-01 and 2023-06-30

Total	Pass	Marginal	Fail
293	240	0	53
100.0%	81.91%	0%	18.09%

Rank Report By Site

Filter: Area = '5T,Cath Lab,CVICU,CVOR,ICU,Main OR,OB OR,OR', Date Collected Between 2022-01-01 and 2023-06-30

	Pass		Marginal		Fail		
Site	#	%	#	%	#	%	Total
Call Button	5	31.25%	0	0.0%	11	68.75%	16
Overbed TBL	3	33.33%	0	0.0%	6	66.67%	9
Telephone	5	45.45%	0	0.0%	6	54.55%	11
RM Sink	6	46.15%	0	0.0%	7	53.85%	13
Bedside TBL	13	50.0%	0	0.0%	13	50.0%	26
Bedrail	53	53.54%	0	0.0%	46	46.46%	99
Chair	24	63.16%	0	0.0%	14	36.84%	38
IV Pole	30	66.67%	0	0.0%	15	33.33%	45
RM Light SW	2	66.67%	0	0.0%	1	33.33%	3
RR Sink	18	72.0%	0	0.0%	7	28.0%	25
ORBedControl	102	73.91%	0	0.0%	36	26.09%	138
OR Table	216	80.3%	0	0.0%	53	19.7%	269
Miscellanous	225	80.65%	1	0.36%	53	19.0%	279
Counter	242	81.48%	0	0.0%	55	18.52%	297
Anes Cart	179	83.64%	1	0.47%	34	15.89%	214
Back Table	128	85.91%	0	0.0%	21	14.09%	149
OR Light	306	86.44%	0	0.0%	48	13.56%	354
Handrail	8	88.89%	0	0.0%	1	11.11%	9
Flush Handle	10	100.0%	0	0.0%	0	0.0%	10

ATP Data - Plan for sustainable improvement

- Determined our World-class goal to be 90% moving forward – no industry benchmark.
- Hired EVS Coordinator for standardized training – complete (Julian Medrano currently in training).
- Retraining of all EVS leaders to include certification from ATP reader manufacturer (Neogen) - 100% complete.
  - Streamlined timing and communication on conducting ATP tests.
- Annual competency validation of staff – work in progress.
- Track & trend data, to include high touch areas of focus and align needs to analyzed trend.

Root Causes Identified

Culturing Practices

- Late blood cultures eliminating present-on admission designation.
- Serial blood cultures that exceed 14-day repeat infection timeframe (RIT).
- Positive MRSA serial blood cultures that exceed 14 days are considered a new event and healthcare acquired.
- Serial positive cultures across patient room assignments.

Source Control

- Endocarditis
  (Life-threatening inflammation of the inner lining of heart chambers and valves)
- Osteomyelitis
  (*Inflammation or swelling that occurs in the bone)*
  maybe a contributing factors to seeding of the bloodstream.
- Delayed consultations, incomplete diagnostic studies, or avoidance of obtaining a specimen from the likely source of infection.
- Without addressing the primary source of infection there will be continued seeding of the bloodstream.

MRSA QFT: Key Strategies

- Automated Mupiriocin MRSA nasal decolonization treatment (house-wide go-live scheduled for 7/17/2023
- Improved utilization of the BioVigil electronic hand hygiene surveillance system
- Clinic based ‘Patient as observer’ hand hygiene program using NRC Picker Survey tool
- Do You Disinfect Every time (D.U.D.E.) Campaign
- Environmental cleaning – quality metrics Adenosine Triphosphate (ATP) monitoring
- Targeted use of Electrostatic Disinfectant Sprayer that produces an electrical charge so that disinfectant attaches to surfaces directly and indirectly facing the sprayer, ensuring thorough coverage over surfaces

MRSA QFT: Recommendations

1. Provider involvement needed to help:
    - Process to effectively order/perform blood cultures
        - Prostaff will be reviewing/approving an evidence-based decision flow map for blood culturing practices
        - Decision flow map addresses source control monitoring (i.e. endocarditis, osteomyelitis, and device related sources)
2. Double down on MRSA Key strategies shared on prior slide (Decolonization; Hand hygiene; Patient care environment cleaning & disinfection etc…)

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Trauma Department

June 2023

Summary Information

TQIP Report

- Spring 2023 Benchmark Report
  - Data dates: October 2021 – Sept 2022
- All level III Trauma centers in the United States
  - 196 TQIP centers
- 88,663 patients include in this report (All patients)
  - 2,381 Kaweah Trauma patients (2.69%)

Hospital Registry

Year	Case Volume	%Change
2020	2393	1.57%
2021	3140	31.2%
2022	3205	2.07%
2023	1271 (Jan-May)	(1.26%)

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Surgeon Response Time

TQIP Report

				Highest Activations			
		Patients	Unknown Highest Activation	Highest Activation	Time to Surgeon Arrival (minutes) [1]	Surgeon Arrival more than 30 minutes	Unknown Time to Surgeon Arrival
Cohort	Group	N	N (%)	N (%)	Median (IQR)	N (%)	N (%)
All Patients	All Hospitals	55,995	261 (0.5)	3,744 (6.7)	7 (0-20)	449 (12.0)	328 (8.8)
	Your Hospital	1,030	0 (0.0)	196 (19.0)	4 (0-10)	16 (8.2)	4 (2.0)

Hospital Monthly tracking

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Trauma Department

Trauma Tracking	Benchmark	Jan - 23	Feb - 23	Mar - 23	Apr - 23	May - 23	June - 23
Surgeon Response Time - Critical Trauma	80%	100.0%	87.5%	95.7%			
Ortho Response Time	80%						
Neuro Response Time	80%						

Surgeon Response Time

Opportunity

Surgeon Response Time to Critical Trauma Activation

- The benchmark set by the American College of Surgeons sets the benchmark at < 30 min. The on-call physician has < 30 min to arrive in the patient's room from the time of patient arrival.
- The dashboard shows an average surgeon response time is currently less than 30 min. During the reporting period, we had physician times that were outliers. Factors that played a part in their times being outside the time frame were: In surgery or lack of documentation.

Solution

Physician Outliers: Every physician that does not meet this benchmark is coached individually by **Dr. Vincent Kirkpatrick, MD.**

Documentation: We are improving the documentation by educating staff on the importance of documenting accurate times of arrival for the physicians. The staff has been instructed to keep an eye out while documenting for trauma surgeon's arrival and to place that time on the trauma flowsheet.

We have educated the providers that once they arrive in the Emergency Department they need to make sure that either the Health Unit Coordinator (HUC) or Trauma Team Lead (TTL) knows they are there to document the time.

Measures

- The measurement used to track response time is the time the Trauma Surgeon is paged to the time the surgeon arrives in the patient's room.

Next Steps

- Continue to track and trend along with coaching. We are working on additional solutions to track our neurosurgery and orthopedic surgeon response times.

TQIP Mortality

Table 2a: Risk-Adjusted Mortality by Reporting Period and Cohort

	Odds Ratio									
Cohort	Fall 2018	Spring 2019	Fall 2019	Spring 2020	Fall 2020	Spring 2021	Fall 2021	Spring 2022	Fall 2022	Spring 2023
All Patients	NA	0.80	0.68	1.13	1.11	1.29	1.38	1.54	2.08	1.36
Elderly	NA	1.27	1.04	1.17	0.97	1.34	1.50	1.73	2.17	1.31
Isolated Hip Fracture	NA	1.07	0.93	0.93	0.95	0.93	0.96	1.26	1.43	1.14

Explanation of odds ratio

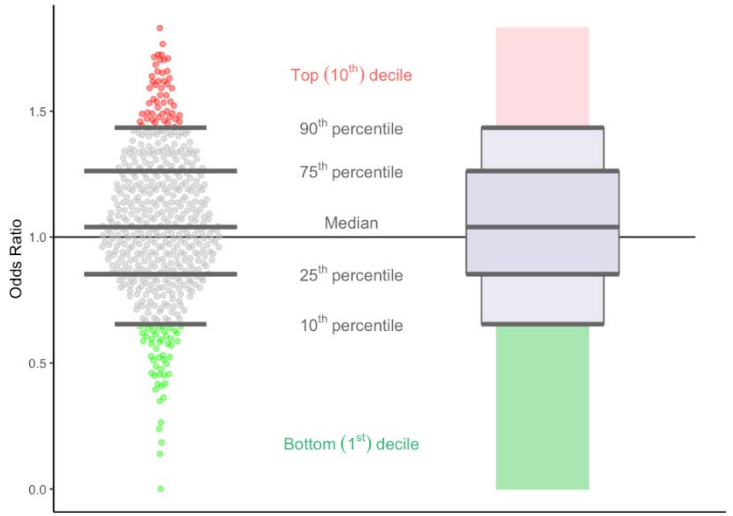
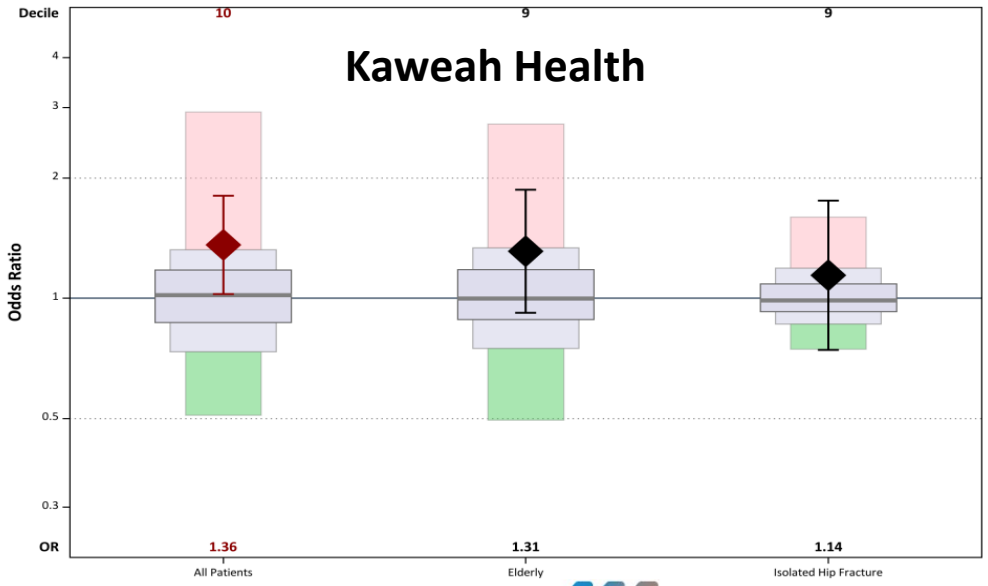


Figure 2: Risk-Adjusted Mortality by Cohort



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TQIP Mortality

Opportunity

- TQIP is the Trauma Quality Improvement Program which is part of the American College of Surgeons. They look at the mortality rate for our patients in three areas: all patients, > 65 years old, and isolated hip fractures.

- We had a great improvement since our last report. We have reviewed all previous mortality cases and added any missed coded injuries in our registry. We have also put out education and algorithms for registry staff to help them with injury coding.

Solution

- We have been reviewing all our mortalities and looking for trends. This measure continues to be developed.
- We are working with EMS to make sure they are bringing in appropriate patients. EMS agency has a policy for their staff that states which patients to bring to the facility and those that stay at the scene. When we find cases that are questionable we send them to the EMS agency for review.
- Monthly staff education with the trauma registrars.

Measures

- We will utilize the bi-annual TQIP report for our data but we will also continually review all our mortalities every month.

Next Steps

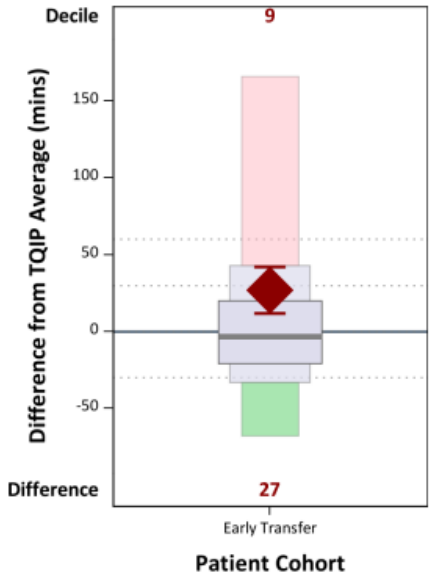
Monthly mortality reviews and follow-up with any identified educational opportunities.

Door to Transfer

Table 5: Risk-Adjusted Average Time to Transfer

	Patients	Average Time to Transfer (minutes)			Difference from TQIP Average (minutes) and 95% Confidence Interval				
Cohort	N	Observed	Expected	TQIP Average	Difference	Lower	Upper	Outlier	Decile
Early Transfer	185	151	126	142	27	12	42	High	9

Figure 5: Risk-Adjusted Average Time to Transfer



Opportunity

Transferring Trauma patients for higher level of care on average for our facility is observed to be 25 min on average longer than TQIP expects to transfer a patient.

Solution

Completed items: Early Recognition, Transfer Algorithm, and Monthly Dashboard

Transfer destination list: We have created a list of trauma centers in the state of California listing them from closest to furthest to aide the transfer center nurse in knowing who to call next.

Transfer guidelines: Transfer center leadership is finalizing transfer call center guidelines so staff understand the expectation when transferring patients.

EMR packet build: We identified that we spend a lot of time trying to figure out all the patients injuries, VS, labs, etc. Case management is working with ISS to create a document that provides all information to the transferring facility for quicker review of the case.

Measures

We measure this outcome utilizing our DI system that captures the time frames between the patient's arrival and the patient's departure. Monitoring our transfers is a requirement by the ACS, we review every transfer out of our facility.

Next Steps

Next steps are to continue to track and trend these cases for other opportunities. At this time I do not have time frames for the EMR builds but our expectation is for a great improvement in our times. We improved by 7 min from our previous TQIP report in fall of 2022.

Orthopedic Trauma Care

Table 16: Operative Fixation in Elderly Patients with Isolated Hip Fracture

	Isolated Hip Fracture	Operative Fixation	Time to Operative Fixation (hours)	Operative Fixation more than 24 Hours	Operative Fixation more than 48 Hours	Unknown Time to Operative Fixation
Group	N	N (%)	Median (IQR)	N (%)	N (%)	N (%)
All Hospitals	15,802	13,597 (86.0)	22.6 (16.68-30.68)	5,917 (43.8)	1,171 (8.7)	84 (0.6)
Your Hospital	115	103 (89.6)	27.28 (21.8-40.77)	67 (65.0)	13 (12.6)	0 (0.0)

Table 17: Operative Fixation in Patients with Femoral Shaft Fracture

	Femoral Shaft Fracture	Operative Fixation	Time to Operative Fixation (hours)	Operative Fixation more than 24 Hours	Unknown Time to Operative Fixation
Group	N	N (%)	Median (IQR)	N (%)	N (%)
All Hospitals	2,159	1,866 (86.4)	19.8 (11.5-27.75)	639 (34.4)	11 (0.6)
Your Hospital	41	35 (85.4)	17.57 (7.8-33.62)	13 (37.1)	0 (0.0)

Table 18: Operative Fixation in Patients with Open Tibia Shaft Fracture

	Open Tibia Shaft Fracture	Operative Fixation	Time to Operative Fixation (hours)	Operative Fixation more than 24 Hours	Unknown Time to Operative Fixation
Group	N	N (%)	Median (IQR)	N (%)	N (%)
All Hospitals	305	269 (88.2)	5.33 (3.3-11.67)	14 (5.2)	0 (0.0)
Your Hospital	8	7 (87.5)	18.27 (4.37-21.73)	1 (14.3)	0 (0.0)

Table 19: Operative Irrigation and Debridement in Patients with Open Tibia Shaft Fracture

	Open Tibia Shaft Fracture	Irrigation and Debridement	Time to First Irrigation and Debridement (hours)	Irrigation and Debridement more than 24 Hours	Unknown Time to Irrigation and Debridement
Group	N	N (%)	Median (IQR)	N (%)	N (%)
All Hospitals	305	275 (90.2)	5.27 (3.28-11.48)	10 (3.6)	0 (0.0)
Your Hospital	8	8 (100.0)	17.74 (6.05-21.57)	1 (12.5)	0 (0.0)

- **Time to operative fixation** is patient arrival to surgical cut time.
- These numbers are compared to all level III trauma centers.

Orthopedic Trauma Care

Opportunity

This benchmark is set by collaboration with the Trauma Department and Orthopedic surgeons utilizing best practices set by the American College of Surgeons (ACS) for isolated hip fractures, long bone fractures, and treatment for orthopedic injuries. We do a great job fixing our femur fractures but our numbers have slightly increased in isolated hip fractures, tib/fib fractures, and irrigation/debridement.

Solution

Monitoring and reporting (on going)

After the time frame was set we need to create graphs and reports to capture this data. We use this data to track monthly our time frames and report the information to the orthopedic team.

Treatment Guidelines: Our orthopedic service lines is currently working on treatment guidelines for pelvic fracture, long bone fracture, open extremity, and hip fractures.

Measures

The process for measurement is through our DI registry system and our Spring/Fall TQIP report. Our registrars extract this information and input it into our system. The registrars utilize the time the patient arrived in the emergency room to the time that patient arrived in surgery.

Next Steps

We will continue to track and trend these cases. We will continue to work with our Surgical leadership team and orthopedic service line to identify any opportunities for improvement.

We are going to pull the cases from our TQIP report to identify our opportunities for improvement.

Door to Antibiotics – Open Fractures

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Trauma Department

Trauma Tracking	Benchmark	Jan - 23	Feb - 23	Mar - 23	Apr - 23	May - 23	June - 23
Door to Antibiotics for open fractures < 1 hr.	80%	42.86% (3/7)	50% (4/8)	100% (1/1)			

Problem/Opportunity

- The goal for antibiotic administration with open fractures is set at < 1 hour. The standard is set by the American College of Surgeons Trauma Quality Improvement Program.
- As a facility, we struggle to meet these goals due to several different reasons. The areas that we have identified are knowledge deficit for staff and lack of documentation.

Solution

- **Knowledge Deficit:** We have done daily rounds with Trauma Team Leads in educating them along with education newsletters to the emergency department regarding timely antibiotic administration.
- **Documentation:** We are redesigning our trauma flow sheet. We have added a pre-populated medication list including antibiotics and also added a reminder “open fracture”. (completed)
- **Antibiotic workgroup:** We started a work group to discuss new opportunities to improve compliance. We are adding a prepopulated antibiotic list to the order set. We are also sending fallouts to pharmacy, ED leadership, and ED liaison group for review monthly and follow-up with staff involved in the care.

Measures

- We will measure success through our DI system where we will track patient arrival to antibiotic administration time frames. Success will be when 90% of the open fracture cases receive antibiotics in < 1 hour.

Next Steps

- Monitoring for compliance with new changes.

Neuro Trauma Care

Table 21: ED Intubation for Severe TBI Patients

	Severe TBI [1]	Intubation in ED [2]	Time to ED Intubation (minutes)	Unknown Time to Intubation or ED Discharge
Group	N	N (%)	Median (IQR)	N (%) [3]
All Hospitals	687	344 (51.9)	9 (5-19)	24 (5.9)
Your Hospital	39	23 (60.5)	7 (5-12)	1 (3.7)

[1] Excluding patients directly admitted to the hospital
[2] Excluding patients with unknown intubation location
[3] Among Severe TBI patients who were intubated

Table 22: Intracranial Pressure (ICP) Monitoring for Severe TBI Patients

	Severe TBI	ICP Monitoring	Time to ICP Monitoring (hours)	Unknown Time to ICP Monitoring
Group	N	N (%)	Median (IQR)	N (%)
All Hospitals	701	29 (4.1)	3.43 (2.7-12.27)	0 (0.0)
Your Hospital	39	6 (15.4)	3.48 (3.17-3.88)	0 (0.0)

- **Time to ED intubation** is captured from patient arrival to intubation
- **Time to ICP** is captured from patient arrival to cut time.

Table 23: Craniotomy

	Severe TBI	Craniotomy	Time to Craniotomy (hours)	Unknown Time to Craniotomy
Group	N	N (%)	Median (IQR)	N (%)
All Hospitals	701	95 (13.6)	2.43 (1.68-3.38)	0 (0.0)
Your Hospital	39	8 (20.5)	3.28 (2.35-14.43)	0 (0.0)

Table 24: Spinal Decompression/Stabilization for Patients with Spinal Cord Injury

	Spinal Cord Injury	Spinal Decompression/ Stabilization	Time to Spinal Decompression/ Stabilization (hours)	Time to Spinal Decompression/ Stabilization more than 24 hours	Unknown Time to Spinal Decompression/ Stabilization
Group	N	N (%)	Median (IQR)	N (%)	N (%)
All Hospitals	394	216 (54.8)	27.4 (12.93-55.87)	118 (54.9)	1 (0.5)
Your Hospital	9	3 (33.3)	35.47 (4.37-36.4)	2 (66.7)	0 (0.0)

- **Time to craniotomy** is captured from arrival to the ED to incision time.
- **Time to decompression/stabilization** is captured from arrival to the ED to incision time.

Neuro Trauma Care

Opportunity

This data is in comparison to other level III trauma centers. We have improved our time frames from for our Spinal stabilization by 4hrs but we did go up in our other areas by 1 hr.

Solution

Monitoring and reporting with Neuro

Measures

The process for measurement is through our DI registry system and our Spring/Fall TQIP report. Our registrars extract this information and input it into our system. The registrars utilize the time the patient arrived in the emergency room to the time that patient arrived in surgery.

Next Steps

We will continue to track and trend these cases. We will continue to work with our Surgical leadership team and Neuro service line to identify any opportunities for improvement.

We are going to pull the cases from our TQIP report to identify our opportunities for improvement.

Meeting with Neuro group to determine acceptable time frames so we can identify cases quicker for review.

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Outstanding Health Outcomes Update

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

August 2023

FY23 Clinical Quality Goals

	July 22 – Jun 23 Higher is Better	FY23 Goal	FY22	FY22 Goal
SEP-1 (% Bundle Compliance)	73%	≥ 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.

Our Mission

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

Our Vision

To be your world-class healthcare choice, for life

Lower is Better	July 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	2 0	0 0	14 (23 predicted over 12 months)	0.55 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	0 0	3 0	10 (17 predicted over 12 months)	0.93 1.066 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	0 0	2 1	5 (8 predicted over 12 months	0.63 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.

Questions?

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