September 12, 2024

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, September 19, 2024, in the Kaweah Health Lifestyle Fitness Center Conference Room, 5105 W. Cypress Avenue, Visalia, CA 93277.

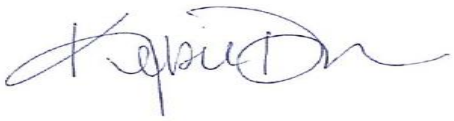
The Board of Directors of the Kaweah Delta Health Care District will meet in a Closed Quality Council Committee at 7:31AM on September 19, 2024, 2024, in the Kaweah Health Lifestyle Fitness Center Conference Room, 5105 W. Cypress Avenue, Visalia, CA 93277, pursuant to Health and Safety Code 32155 & 1461.

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, September 19, 2024, 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
David Francis, Secretary/Treasurer



Kelsie Davis
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, September 19, 2024
5105 W. Cypress Avenue
Kaweah Health Lifestyle Fitness Center Conference Room

ATTENDING: Board Members: Michael Olmos (Chair), Dean Levitan, MD; Gary Herbst, CEO; Keri Noeske, Chief Nursing Officer; Tom Gray CMO/CQO; Julianne Randolph, OD, Vice Chief of Staff and Quality Committee Chair; LaMar Mack, MD, Quality and Patient Safety Medical Director; Sandy Volchko, Director of Quality and Patient Safety; Ben Cripps, Chief Compliance and Risk Management Officer; Evelyn McEntire, Director of Risk Management; and Kyndra Licon, Recording.

OPEN MEETING – 7:30AM

1. **Call to order** – *Mike Olmos, 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 (Kelsie Davis 559-624-2330) or kedavis@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 – *Julianne Randolph, DO, Vice Chief of Staff and 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** – *Mike Olmos, Committee Chair*

CLOSED MEETING – 7:31AM

1. **Call to order** – *Mike Olmos, Committee Chair*

2. **Approval of August Quality Council Closed Session Minutes –** Mike Olmos, Committee Chair; Dean Levitan, Board Member
3. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Julianne Randolph, DO, Vice Chief of Staff and Quality Committee Chair*
4. **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.*
5. **Adjourn Closed Meeting** – *Mike Olmos, Committee Chair*

OPEN MEETING – 8:00AM

1. **Call to order** – *Mike Olmos, 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. **Approval of August Quality Council Open Session Minutes –** Mike Olmos, Committee Chair; Dean Levitan, Board Member
4. **Written Quality Reports –** A review of key quality metrics and actions associated with the following improvement initiatives:

    4.1. **Best Practice Quality Report**
    4.2. **Fall Prevention Quality Report**
    4.3. **Environment of Care Quality Report**
    4.4. **Maternal Child Health Quality Report**

5. **Rapid Response Team Code Blue Quality Report–** A review of key process and outcome measures related to rapid response and code blue processes. *Shannon Cauthen, MSN, RN, CCRN-K, NE-BC, Director of Critical Care Services*
6. **Hospital Acquired Pressure Injury Quality Report –** A review of performance and action plans associated with the prevention of pressure injuries. *Emma Camarena, DNP, RN, ACCNS-AG, CCRN, Director of Nursing Practice.*
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** – *Mike Olmos, 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.

Agenda item intentionally omitted

OPEN Quality Council Committee
Thursday, August 15, 2024
The Lifestyle Center Conference Room

Attending: Board Members: Mike Olmos (Chair) & Dr. Dean Levitan; Dr. Paul Stefanacci, CMO/CQO; Sandy Volchko, Director of Quality & Patient Safety; Jag Batth, Chief Operating Officer; Ryan Gates, Chief Population Health Officer; Shawn Elkin, Infection Prevention Manager; Cheryl Smit, Stroke Program Manager; Molly Niederreiter, Director of Rehabilitation & Skill Services; Kyndra Licon, Program Coordinator – Recording.

Mike Olmos called to order at 7:30 am.

Approval of Closed Session Agenda: Dean Levitan made a motion to approve the closed agenda, there were no objections.

Mike Olmos adjourned the meeting at 8:30 am.

Mike Olmos called to order at 8:15 am.

3. **Approval of July Quality Council Open Session Minutes –** Mike Olmos, Committee Chair; Dean Levitan, Board Member.
    - Approval of July Quality Council Open Session Minutes by Dean Levitan and Mike Olmos.
4. **Written Quality Reports –** A review of key quality metrics and actions associated with the following improvement initiatives: Reviewed with no discussion.

    4.1 Stroke Committee Quality Report
    4.2 Rehabilitation Quality Report

5. **Emergency Department Quality Report –** A review of key quality performances and action plans related to the care process in the Emergency Department. Keri Noeske, Chief Nursing Officer.
    - The key components are ED length of Stay. The goal is to improve the ED length of stay for discharged patients to 214 minutes or less. We will keep this as a goal but anticipate high volumes. In FY24 the ED cared for over 85,000 patients in 96,000 visits; record numbers for our facility. Staffing challenges played a part in the length of stay for both providers and clinical staff. Plan to improve patient flow by utilizing intake space near triage for low acuity ED patients pending discharge due to nursing treatments. Also, Implement a split flow front-end model to move low acuity patients to Zone 6/Fast Track. Planning for this to go into effect September 1st from 11 am to 9 pm. Will be staffed with one Advanced Practice Provider and two nurses. However, this will not work when there is a nurse/medical staff staffing challenge.
    - ED Left during treatment. The goal is to decrease the percentage of patients who left during treatment to under 3%. Related to the time waiting to be seen. Patients who leave during treatment have been assessed by the provider but have not stayed for the duration of treatment and to receive the results of their tests and treatments. Improvement opportunities: improve patient flow to ensure patients are being tracked for treatment by nursing staff. Continue to decrease turnaround time and validate appropriate use of imaging tests and procedures in the ED setting. Communicate with the patients about progress and updates while waiting for treatments, procedures, or results.

- ED Patient Experience – the goal is to achieve a patient feedback score greater than 4. This next year we switch to NRC survey. A new set of questions is being evaluated with a thorough and empathetic approach to ensure comprehensive care. The focus in the ED is going to be based on the feedback from these surveys. Janice is doing a daily audit on connecting with patients on receiving care. How do you clean in the ED? The ED department has 3 EVS workers and they go around cleaning the rooms after every patient and clean the waiting room every hour. How do patients receive these surveys? Text, email and phone call. What percentage of patients respond? We are getting feedback but we just started surveying people in July, so we don't have the exact number. We get a high volume of feedback in other areas so I would assume we would get a high volume, especially in the ED. The committee question was why do we only contact selective patients, what is our obligation? The regulatory obligation is to screen and tell patients their plan of care and act on it. There is no timeframe we give and there are only so many resources we have for limited care.
- ED Blood Culture Contamination – goal to achieve a blood culture contamination rate of less than 3%. We experienced an increase in that contamination rate of over 3% due to a reallocation of the resource designated to perform blood culture draws. Improvement and opportunities identified. Discussion on how you find a contamination in blood culture.
- ED Sepsis Order Set Compliance – the goal is to achieve Sepsis order set compliance greater than 80%. The ED team is very attentive to the diagnosis of sepsis and implementation of the best practice order set for the patients to ensure the best outcomes. Improvement opportunities is to review the bundle compliance fallouts, focus on ensuring all interventions are implemented for consistent treatment. Continue to educate and monitor success with the order set compliance.

6. **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.*
    - End of fiscal year results. Last month Gary requested to add FY24 Percentage National ranking. In terms of sep1 we have not finished our fiscal year, will report more next month. In our current fiscal year to date for Sepsis 1 Bundle we are at 75% of patients receiving the bundle. For sepsis mortality the lower percentile rankings are better, this is how our Midas system reports. We are 80th percentile, the bottom 20% for sepsis mortality. The percentage ranking lower is better for the HAIs. CLABSI ended the year we are bottom 28% of the country. CAUTI met our goal in the top 30% of the country. We are in lower percentile rankings for line utilization due to our high utilization rates.
    - High-level summary of strategies – work to increase execution of one-hour bundle in ED is what drives mortality down in sepsis. Janice Nini is familiar and knowledgeable with code sepsis in the ED, planning meetings in process. CHG bathing not only addresses CLABSI it addresses all infections, the approval of CHG bathing by CNAs as a non-medication is an important step. Education is ready to go to execute this. We have been having conversations with patient access to identify screen and treat patients with MRSA. For line utilization, one of the key strategies is if the timeline is still set for moving those multidisciplinary rounds to CVICU and 3W and 5T. Standardized procedure

for nurses to remove folic catheters is currently on hold as project leader evaluates other improvement strategies, perhaps targeting areas/units that have high utilization rates.

7. **Adjourn Open Meeting** – *Mike Olmos, Committee Chair*

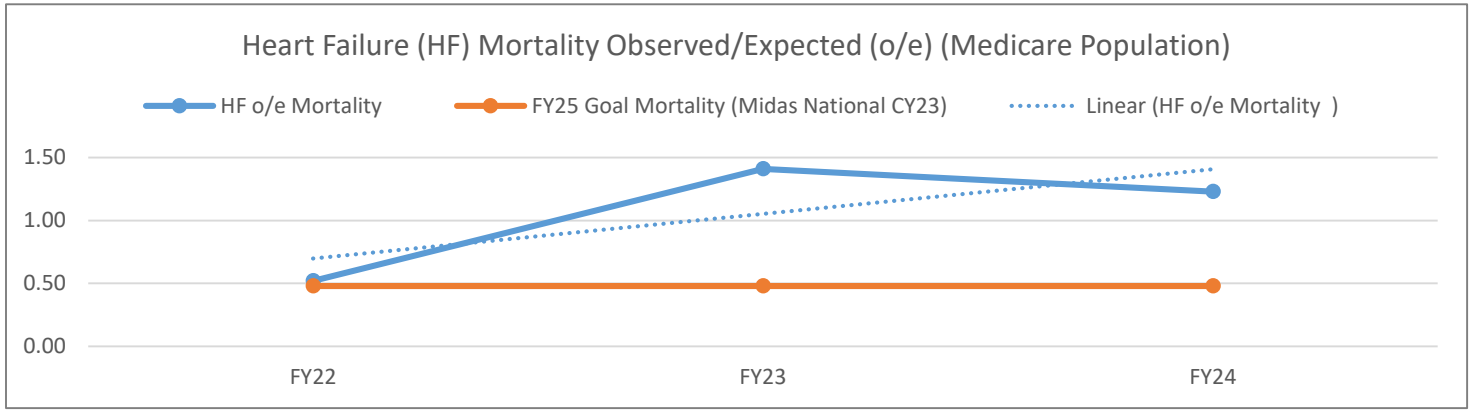
Mike Olmos adjourned the meeting at 8:56 am.

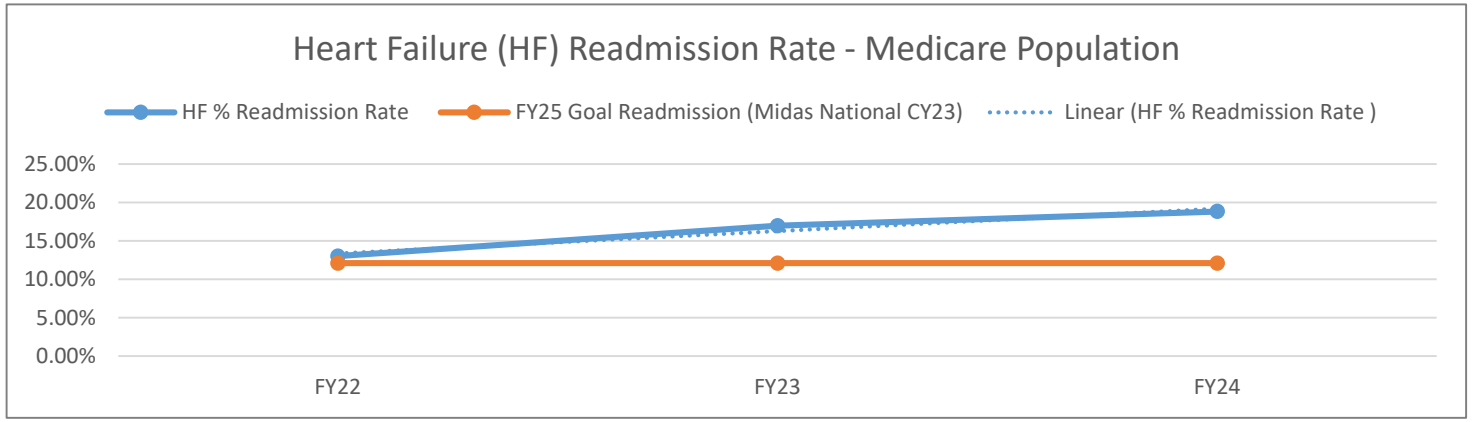
Committee minutes were approved for distribution to the Board by the Committee Chair on

Outstanding Health Outcomes (OHO)
QUALITY & PATIENT SAFETY PRIORITY

Mortality & Readmission Reduction
Heart Failure (HF), Chronic Obstructive Pulmonary Disease (COPD) & Pneumonia (PN)
August 2024

OHO FY25 Plan: Mortality & Readmission Reduction
Heart Failure – Historical Baseline





FY25 GOAL

(CMS population)

Decrease HF Hospital Readmissions to < 12.10

Decrease HF Mortality Rates to < 0.48

FY25 PLAN – Mortality & Readmissions

Heart Failure

High Level Action Plan

- Identify HF patients with an EF ≤ 40%
  - EMR identification of ejection fraction
- Provide Guideline Directed Medical Therapy at discharge

  % of Patients Prescribed each of Four Medications at Discharge

  Baseline data 1/2/24-4/29/24 and n = 5
  - 60% ACE/ARB/ARNI
  - 100% Beta Blocker
  - 0% SGLT2i
  - 0% MRA
  - Goal = 100%

OHO Update: Mortality & Readmission Reduction Heart Failure- FY25

The last data point did not meet goal because:

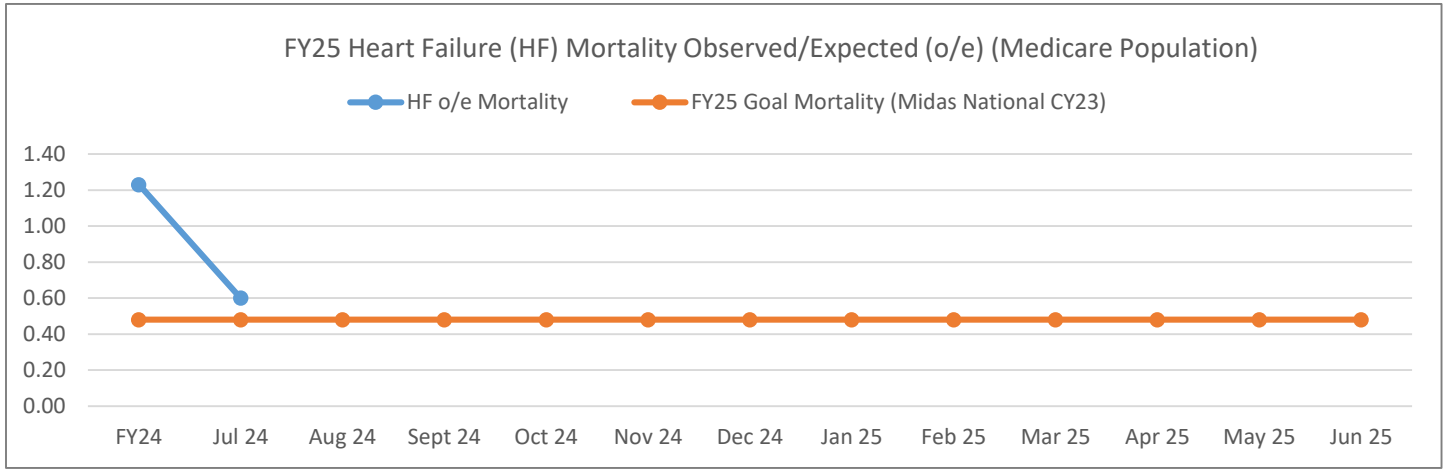
- Evidenced-based medications are not being prescribed upon discharge
  - According to the American College of Cardiology (ACC) and American Heart Association (AHA), patients with heart failure with reduced ejection fraction (HFrEF) should be treated with a combination of four medications: Angiotensin receptor/neprilysin inhibitors (ARNI), Beta blockers, Mineralocorticoid receptor antagonists (MRAs), and Sodium-glucose cotransporter-2 inhibitors (SGLT2i). These medications are sometimes called the "fantastic four". Some of these medications can help strengthen the heart muscle, lower blood pressure, and treat the heart muscle.

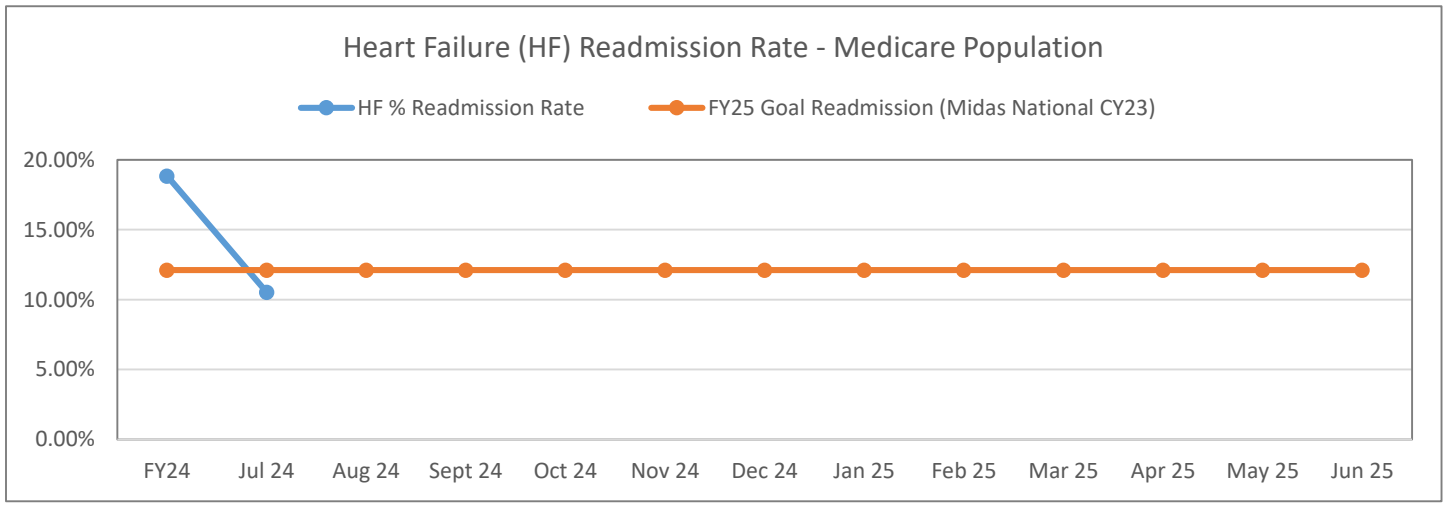
Targeted Opportunities (What specifically is causing the fallouts?)

1. SGLT2i medication is not on Kaweah Health formulary.
2. Insurance companies not covering ARNI (Entresto) despite strongest evidence that it impacts patient outcomes
3. There are medical contraindications for why certain patients can't take these medications – need better info on how often these contraindications are happening

CURRENT IMPROVEMENT ACTIVITIES	EXPECTED COMPLETION DATE	BARRIERS
Work with P&T to get SGLT2i on formulary so it can be ordered for patients as inpatients	Being reviewed at the Oct. P & T	None
Develop workflow in Cerner (mirrors Stroke patient discharge workflow which successfully ensures stroke patients are discharge on correct medications) which uses a discharge power form to remind providers to prescribe the evidenced based medications, or if contraindication to select the contraindication from a list (measures can be accurate and exclude patients with contraindications)	TBD	none

OHO Update: Mortality & Readmission Reduction Heart Failure – FY25





FY25 GOAL (CMS population)
Decrease HF Hospital Readmissions to < 12.10
Decrease HF Mortality Rates to < 0.48

FY25 PLAN – Mortality & Readmissions

Heart Failure

High Level Action Plan

- Identify HF patients with an EF ≤ 40%
  - EMR identification of ejection fraction
  - Completed 6/2024
- Provide Guideline Directed Medical Therapy at discharge
  - Baseline data established September 2024, updates to be provided in next report

% of Patients Prescribed each of Four Medications at Discharge

Baseline data

ACE/ARB/ARNI

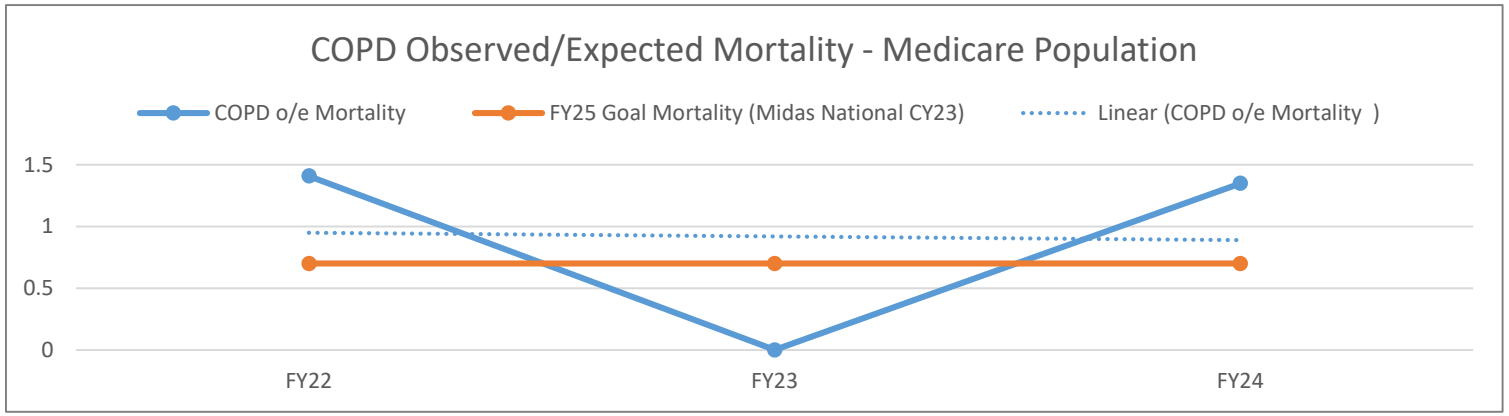
Beta Blocker

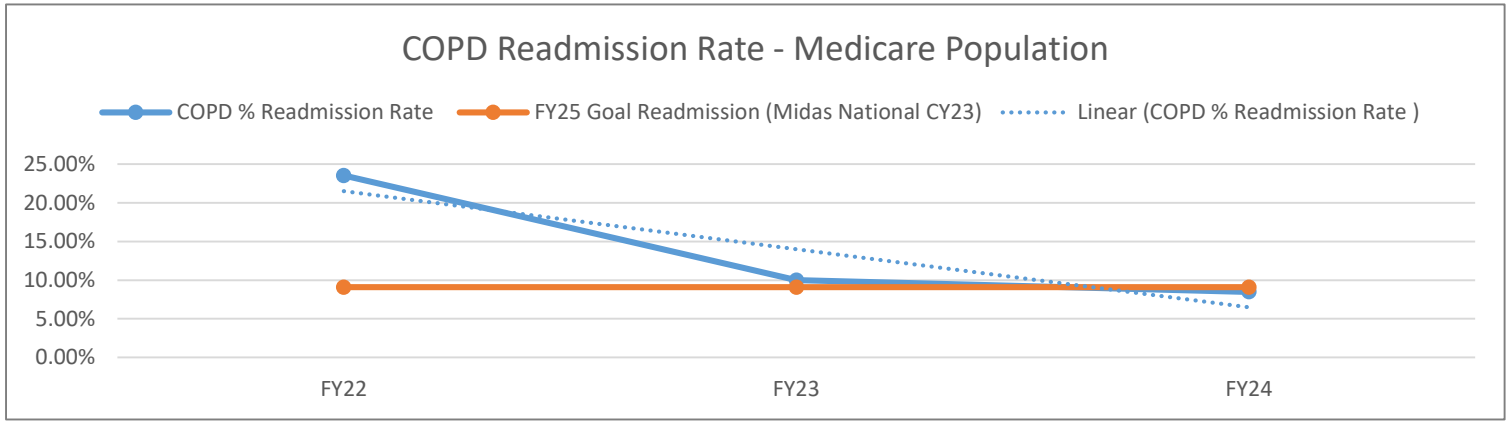
SGLT2i

MRA

Goal = 100%

OHO FY25 Plan: Mortality & Readmission Reduction
COPD - Historical Baseline





FY25 GOAL

(CMS population)
Decrease COPD Hospital Readmissions to < 9.09
Decrease COPD Mortality Rates to < 0.70

FY25 PLAN – Mortality & Readmissions

COPD

High Level Action Plan

- Provide Evidence Based steroid treatment while hospitalized - Prednisone 40mg PO daily x 5 days
  - Baseline Data – 50% of patients prescribed Prednisone during hospitalization (n=4)
  - Goal = 100%
- Provide Guideline Directed Medical Therapy at discharge - LAMA/LABA inhaler
  - Baseline Data – 50% of patients prescribed LAMA/LABA upon discharge (n=4)
  - Goal = 100%

OHO Monthly Update: Mortality & Readmission Reduction COPD – FY25

The last data point did not meet goal because:

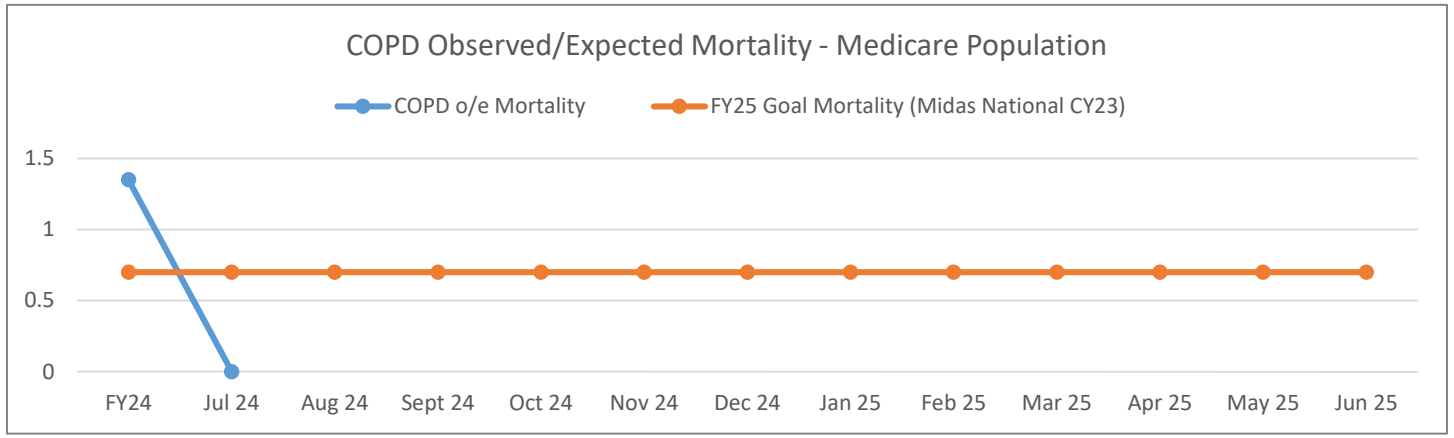
- Patients not being discharged on the evidenced-based meds that affect patient outcomes
  - Cost of inhalers – some patients revert to Advair at home because it is very inexpensive, (but not a recommended medication) compared to LAMA/LABA inhalers
- Using IV solumedrol rather than PO prednisone – high dose steroids can actually cause patient harm

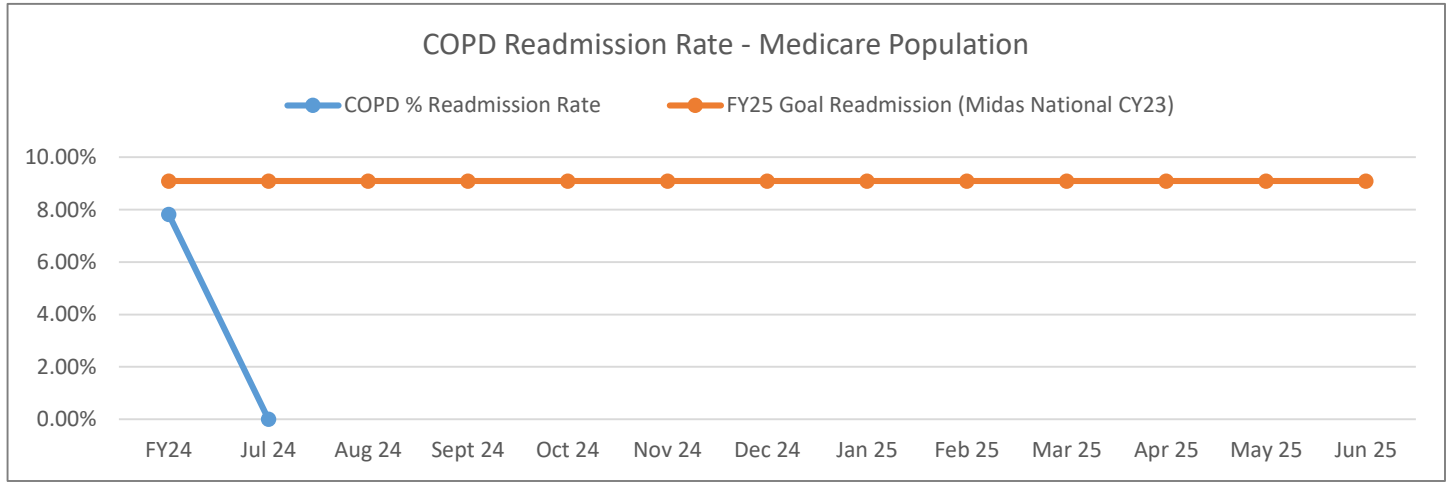
Targeted Opportunities (What specifically is causing the fallouts?)

1. Because of limited pulmonology, the decision of discharge medications fall more to discharging hospitalists. Hospitalists prescribe nebulizers for COPD inpatients, not inhalers that are used in the outpatient setting. Therefore they have understandably less knowledge on what insurance companies cover which inhalers supplied by community pharmacies
2. Provider "inertia" in using IV solumedrol – i.e. physicians have always done this and continue to do it

CURRENT IMPROVEMENT ACTIVITIES	EXPECTED COMPLETION DATE	BARRIERS
Preselected prednisone on power form	11/1/2024	none
Distribute a list to hospitalists which indicates which inhalers are covered by which insurance companies so they can order upon discharge. KH Retail Pharmacy Meds to Beds program can be used while a list is being put together	TBD	none

OHO Monthly Update: Mortality & Readmission Reduction COPD – FY25





FY25 GOAL (CMS population)
Decrease COPD Hospital Readmissions to < 9.09
Decrease COPD Mortality Rates to < 0.70

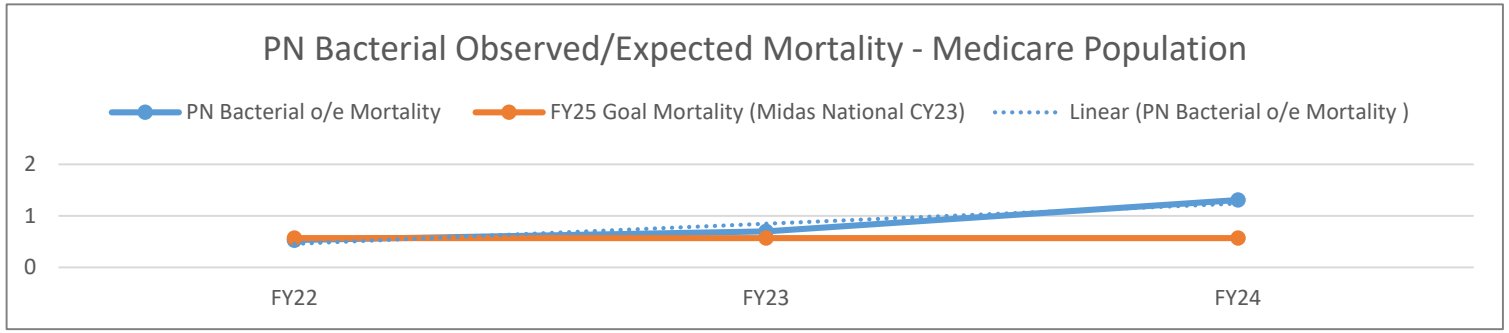
FY25 PLAN – Mortality & Readmissions

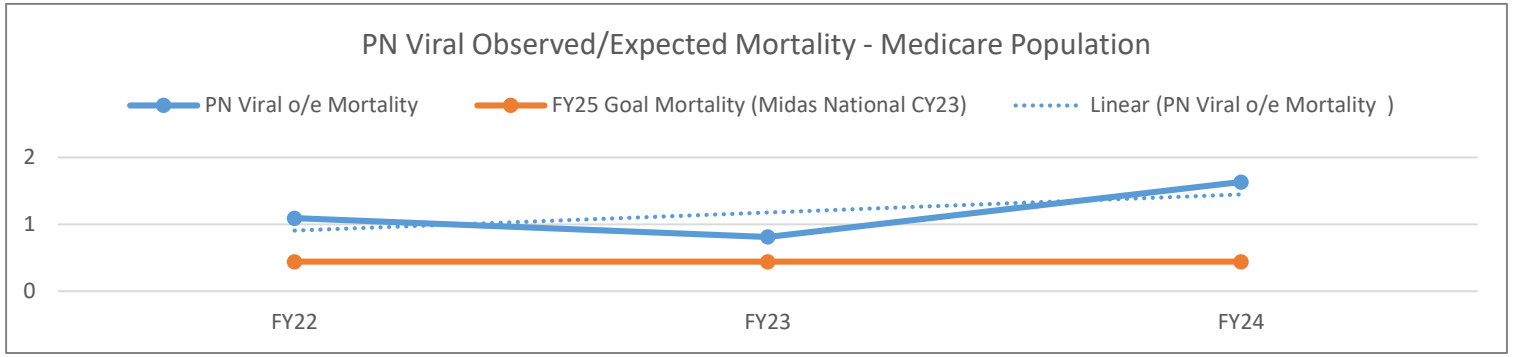
COPD

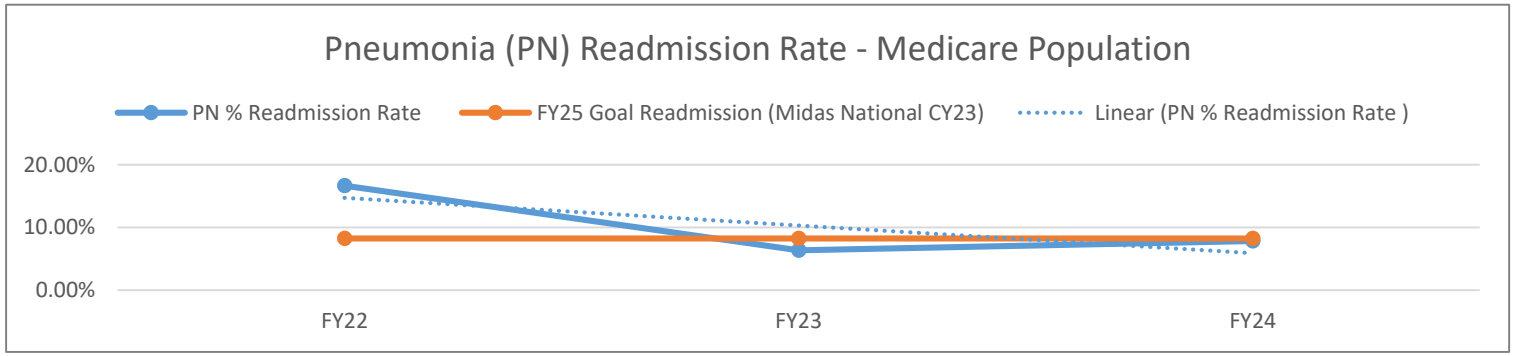
High Level Action Plan

- Provide Evidence Based steroid treatment while hospitalized - Prednisone 40mg PO daily x 5 days
  - Status: Baseline data established September 2024, updates to be provided in next report
- Provide Guideline Directed Medical Therapy at discharge - LAMA/LABA inhaler
  - Baseline data established September 2024, updates to be provided in next report

OHO FY25 Plan: Mortality & Readmission Reduction Pneumonia (PN) - Historical Baseline







FY25 PLAN – Mortality & Readmissions

Pneumonia

High Level Action Plan

- Utilize Evidence-based order set for patients admitted with Community Acquired Pneumonia
  - Baseline Data – 50% of bacterial PN patients, and 71% of viral PN pt's with order set in place (n=13)
  - Goal = 100%
- Order the appropriate antibiotics upon admission for patients with Community Acquired Pneumonia
  - Utilize preferred empirical antibiotic treatment, data pending

FY25 GOAL (CMS population)

Decrease PN Viral/Bacterial Hospital Readmissions to <8.24

Decrease PN Bacterial Mortality Rates to < 0.57

Decrease PN Viral Mortality Rates to < 0.43

OHO Monthly Update: Mortality & Readmission Reduction Pneumonia – FY25

The last data point did not meet goal because:

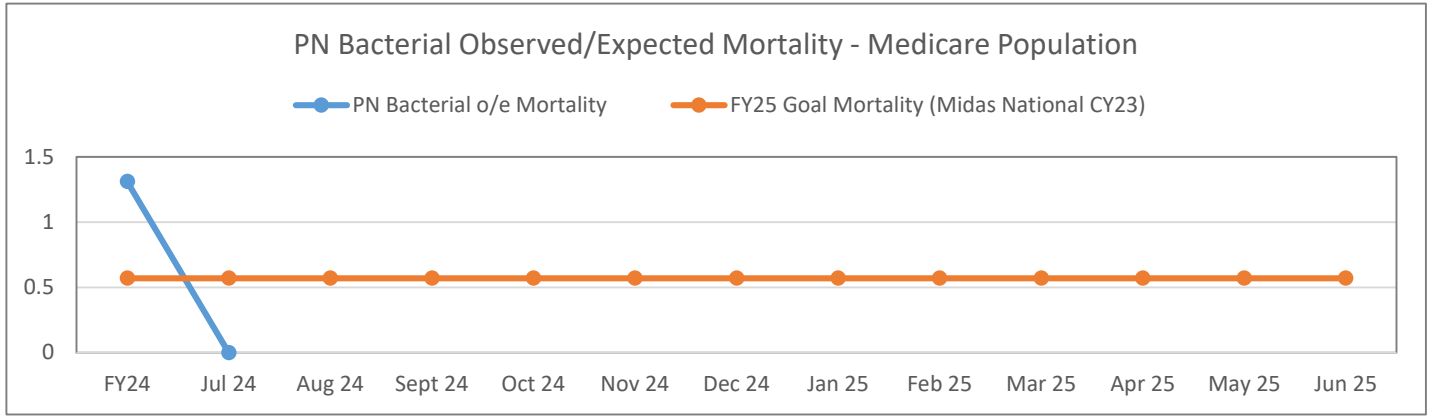
- Community Acquired Order Set not being used
- PN patients not on the correct evidenced based antibiotic (Abx) type

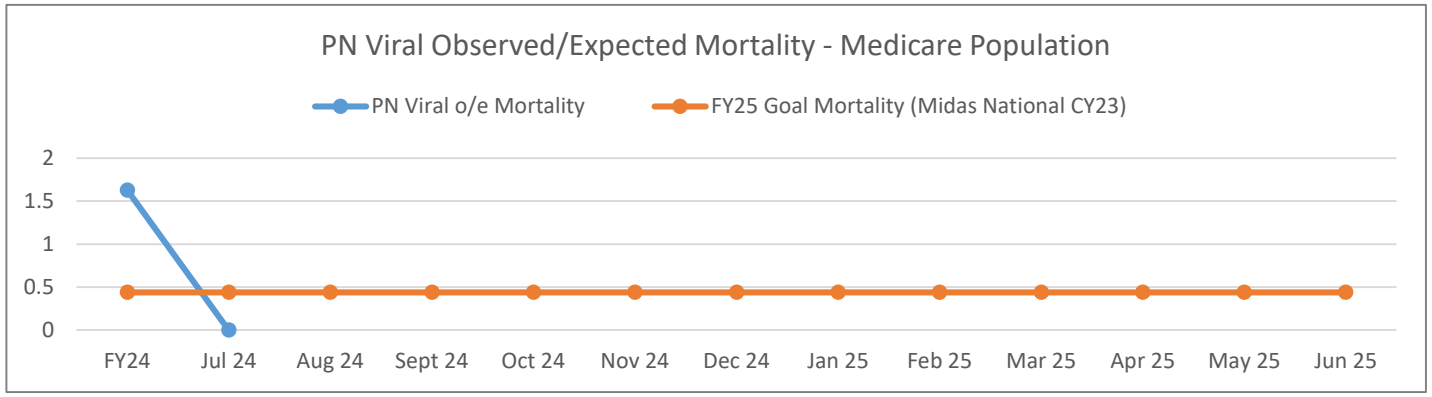
Targeted Opportunities (What specifically is causing the fallouts?)

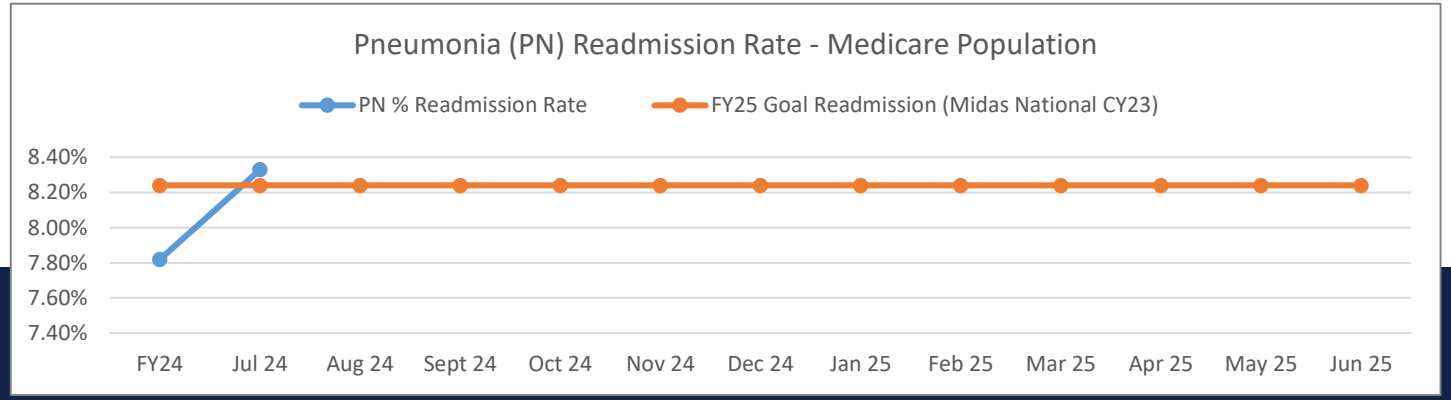
1. Abx Stewardship
2. PN order set not being used when there is a competing diagnosis

CURRENT IMPROVEMENT ACTIVITIES	EXPECTED COMPLETION DATE	BARRIERS
Dr. Tedaldi attends monthly Hospitalist meeting to encourage utilization of admission power plans.	On going	None

OHO Monthly Update: Mortality & Readmission Reduction Pneumonia – FY25







FY25 PLAN – Mortality & Readmissions

Pneumonia

High Level Action Plan

- Utilize Evidence-based order set for patients admitted with Community Acquired Pneumonia
  - Med Pneumonia Admission Order Set, Status: Baseline data established September 2024, updates to be provided in next report
- Order the appropriate antibiotics upon admission for patients with Community Acquired Pneumonia
  - Utilize preferred empirical antibiotic treatment, data pending

FY25 GOAL (CMS population)

Decrease PN Viral/Bacterial Hospital Readmissions to <8.24

Decrease PN Bacterial Mortality Rates to < 0.57

Decrease PN Viral Mortality Rates to < 0.43

Thank you

Live with passion.

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

Kaweah Health

Unit/Department Specific Data Collection Summarization

Quality Committee Report

UNIT/DEPARTMENT: **Fall Prevention Committee** REPORT DATE: **April 2024**

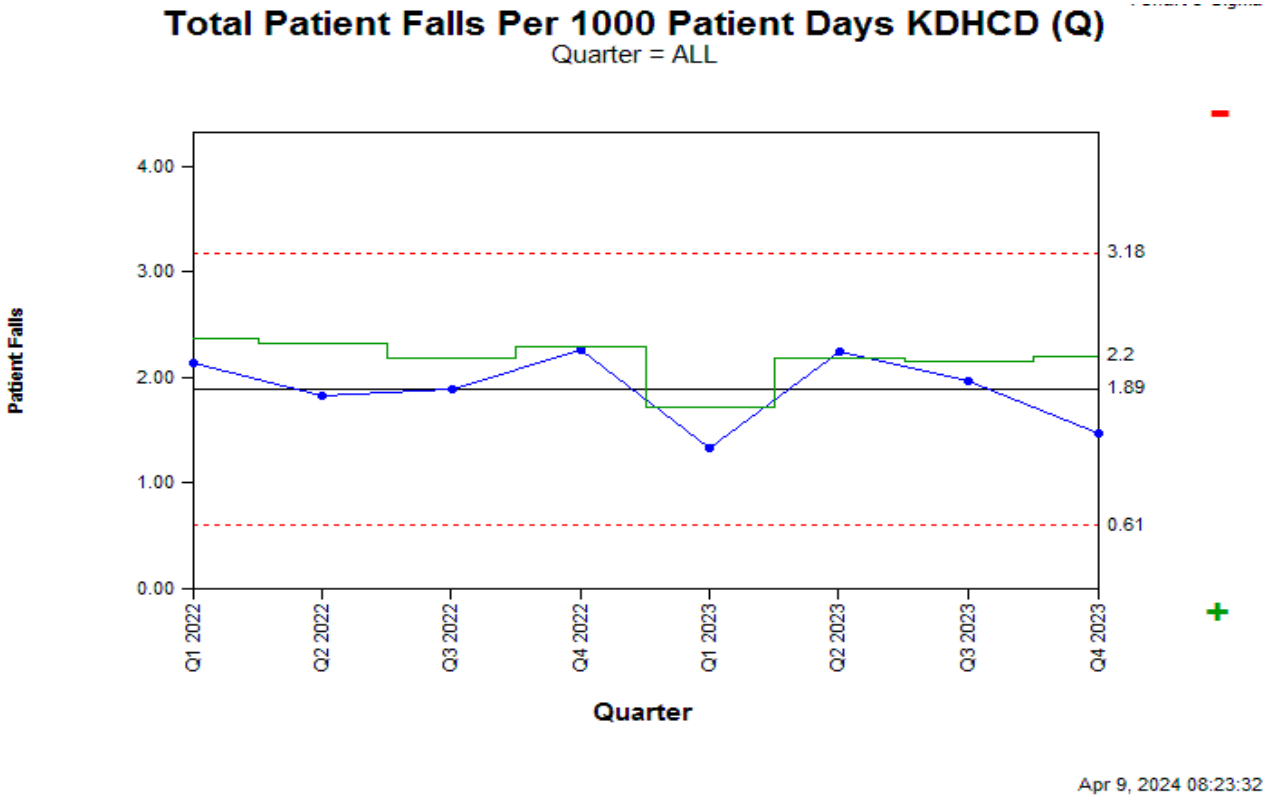
Kaweah Health Nursing Unit Falls Data, Benchmarked Nationally:

The National Database of Nursing Quality Indicators® (NDNQI®) provides a national database of more than 2,000 U.S. hospitals that features nursing-sensitive outcome measures used to monitor relationships between quality indicators and outcomes. Participating Kaweah Health nursing units include 2North, 2South, 3North, 3South, 3West, 4North, 4South, 4Tower, Broderick Pavilion, ICU, CV-ICU, CV-ICCU (5Tower), Mental Health, Pediatrics, and Acute Rehab.

INDICATOR #1 **Total Patient Falls per 1000 Patient Days**

GOAL **Outperform national target metric and/or reduce fall rate by 10%**

DATE RANGE **Q4 2023**



	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Q1 2023	Q2 2023	Q3 2023	Q4 2023
Patient Falls	2.14	1.82	1.89	2.26	1.32	2.25	1.97	1.47
Target	2.37	2.32	2.18	2.29	1.72	2.18	2.15	2.20

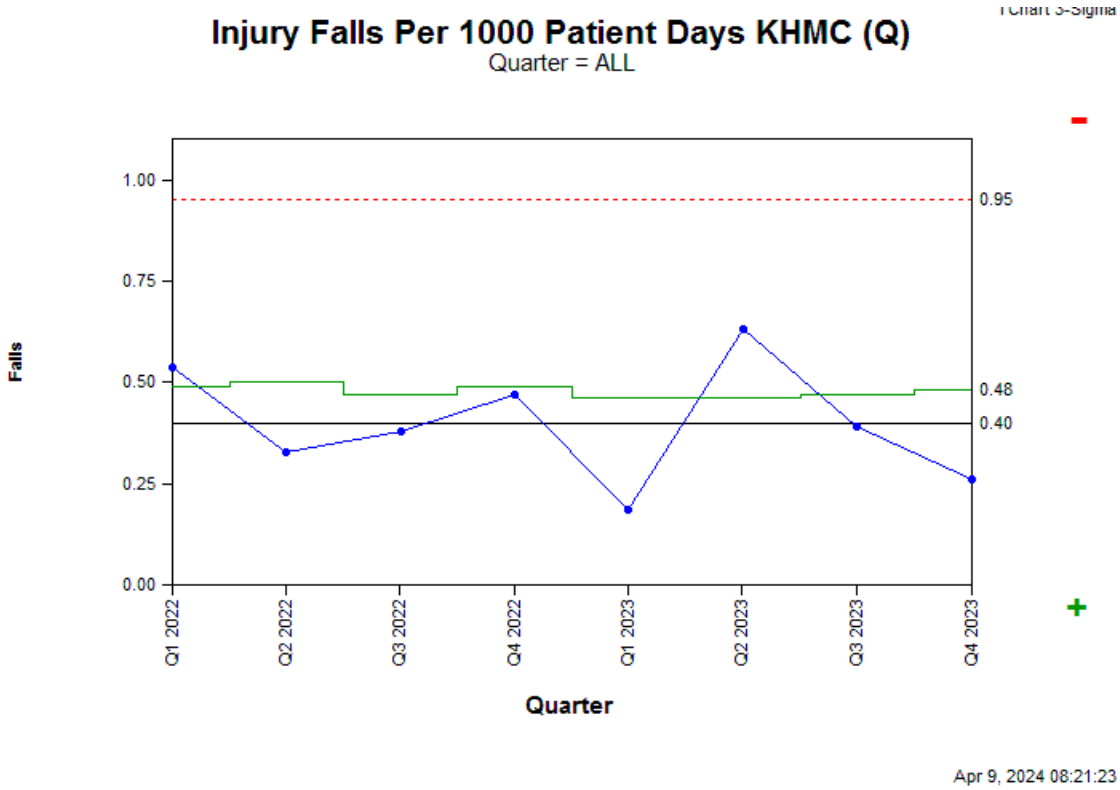
ANALYSIS OF MEASURE/DATA (Include key findings, improvements, opportunities)

✓ **Goal met: Q4 2023 outperformed the national target metric. Improvement from previous quarter to below the target of 2.20, a decrease of more than 25% from Q3 to Q4 2023**

INDICATOR #2 **Injury Falls per 1000 Patient Days**

GOAL **Outperform national target metric and/or reduce injury fall rate by 10%**

DATE RANGE **Q4 2023**



	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Q1 2023	Q2 2023	Q3 2023	Q4 2023
Falls	0.53	0.33	0.38	0.47	0.18	0.63	0.39	0.26
Target	0.49	0.50	0.47	0.49	0.46	0.46	0.47	0.48

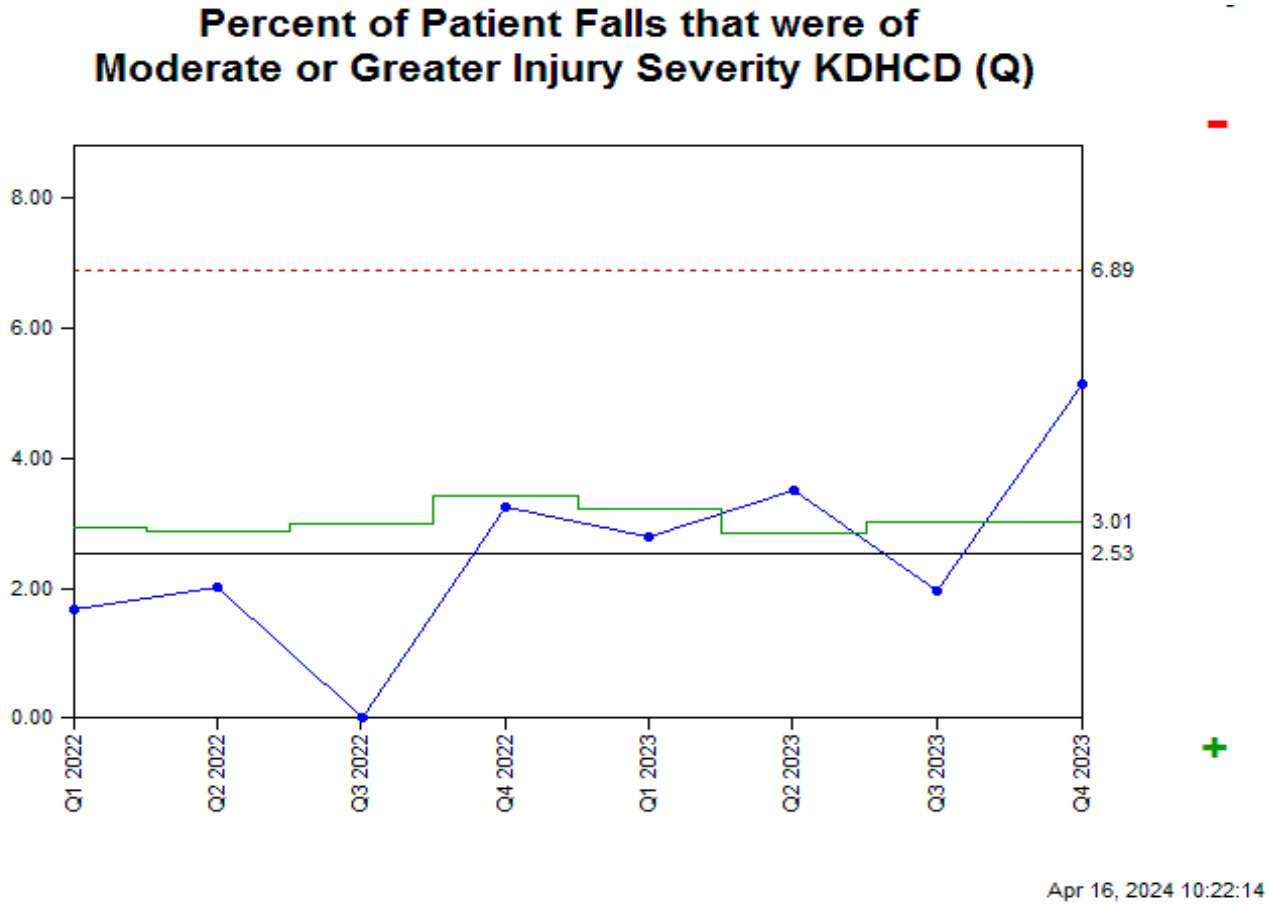
ANALYSIS OF MEASURE/DATA (Include key findings, improvements, opportunities)

- ✓ **Goal met: Q4 2023, outperformed the national target metric. Improvement from previous quarter to below the target of 0.48, a decrease of more than 33% from Q3 to Q4, 2023**

INDICATOR #3 **Percent of Patient Falls that were of Moderate of Greater Injury Severity**

GOAL **Outperform national target metric and/or reduce injury fall rate by 10%**

DATE RANGE **Q4 2023**



	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Q1 2023	Q2 2023	Q3 2023	Q4 2023
KDHCD	1.67	2.00	0.00	3.23	2.78	3.51	1.96	5.13
Target	2.93	2.88	2.99	3.42	3.21	2.83	3.01	3.01

ANALYSIS OF MEASURE/DATA (Include key findings, improvements, opportunities)

∅ **Goal not met: This is a new indicator for this report. For CY 2022, KH outperformed this target metric, but in Q2 and Q4 of 2023, we did not meet the target metric with Q4 2023 at the highest rate for 2022 and 2023.**

- **Opportunities for improvement: discovered through Falls University an increase of family members helping patients out of bed without notifying staff. We need to increase education to family members and patients to call for help when they need to get out of bed.**

Unit/Department Specific Data Collection Summarization

Quality Committee Report

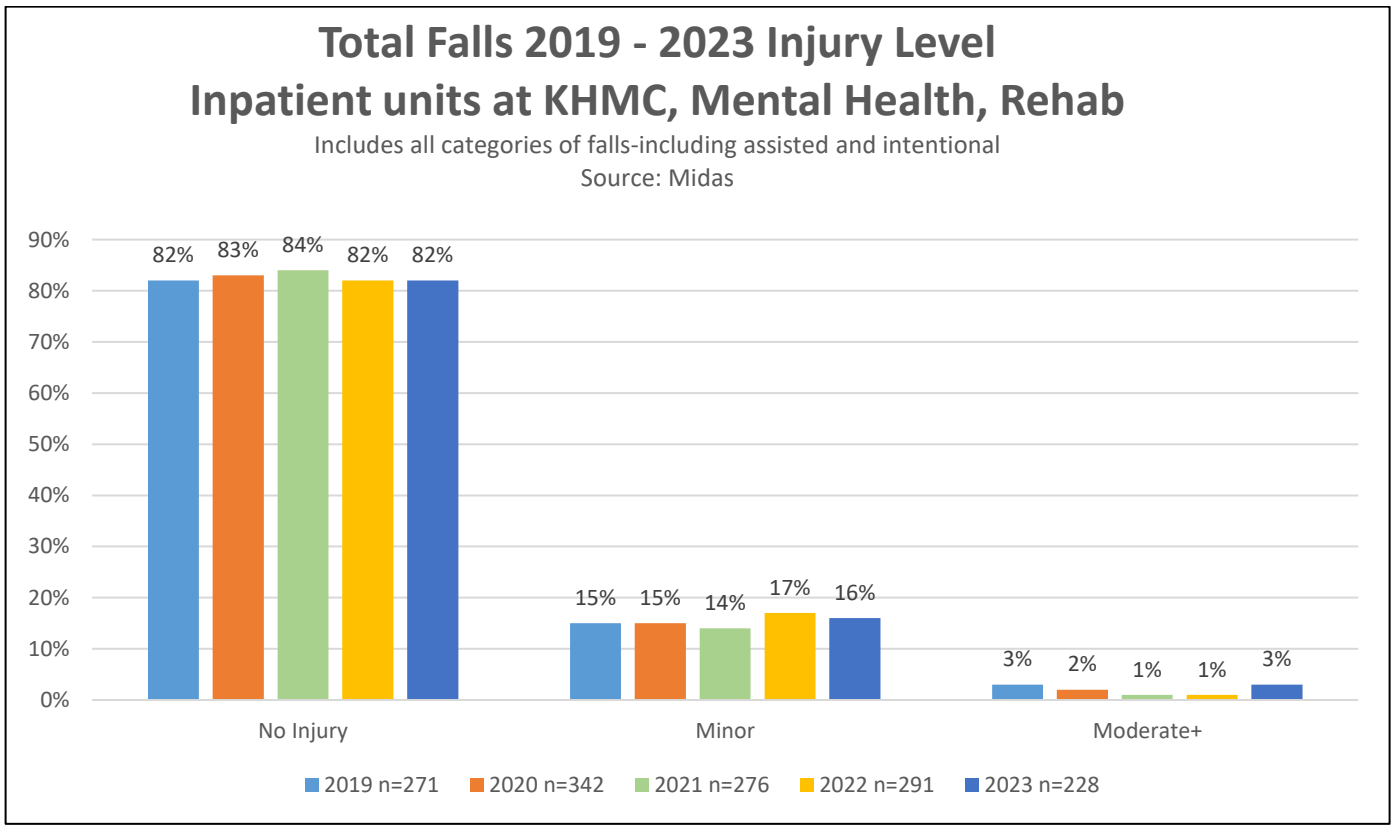
INDICATOR #4 **Total Falls – Injury Level**

GOAL **100% injury falls classified either no injury or minor injury**

DATE RANGE **CY 2019-2023**

NDNQI Defined Injury Levels

- *None* — *Resulted in no signs or symptoms of injury as determined by post-fall evaluation (which may include x-ray or CT scan)*
- *Minor* — *Resulted in application of ice or dressing, cleaning of a wound, limb elevation, topical medication, pain, bruise or abrasion*
- *Moderate* — *Resulted in suturing, application of steri-strips or skin glue, splinting, or muscle/joint strain*
- *Major* — *Resulted in surgery, casting, traction, required consultation for neurological (e.g., basilar skull fracture, small subdural hematoma) or internal injury (e.g., rib fracture, small liver laceration), or patients with any type of fracture regardless of treatment, or patients who have coagulopathy who receive blood products as a result of a fall*
- *Death* — *The patient died as a result of injuries sustained form the fall (not from physiologic events causing the fall)*



ANALYSIS OF MEASURE/DATA (Include key findings, improvements, opportunities)

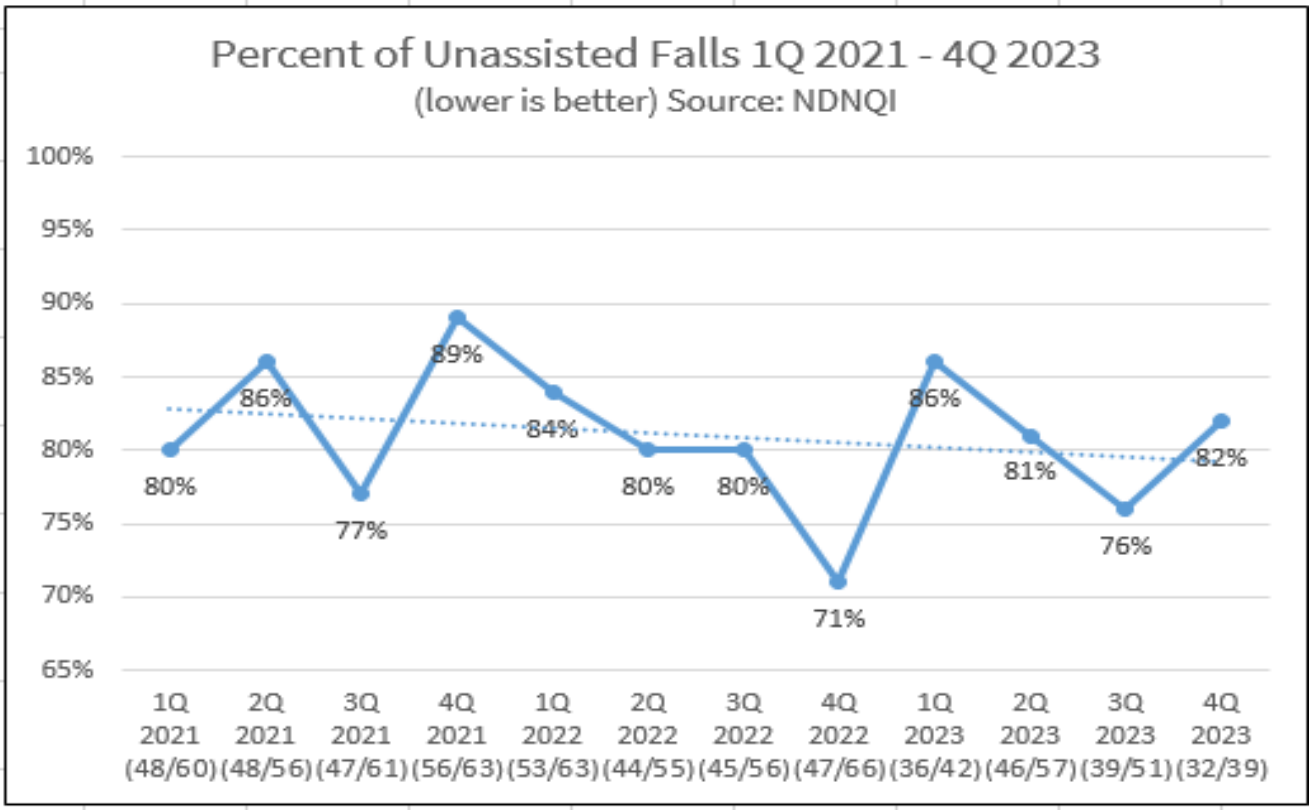
- ∅ **Goal not met: The total percentage of falls with no injuries in 2023 was unchanged from 2022 (82%) with minor injury level falls decreasing from 17% to 16%, the moderate + injury level increased to 3% in 2023 from 1% in 2021 and 2022.**

- **Opportunities for improvement: Continue to monitor patient falls, review falls at Falls University and send out take-aways for information. Provide ongoing education to staff related to fall prevention. Returning to pre-COVID fall awareness using yellow socks. Yellow socks have become the standard sock for all patients.**

INDICATOR #5 **Unassisted Falls**

GOAL **Reduce unassisted falls by 10%**

DATE RANGE **Q4 2023**

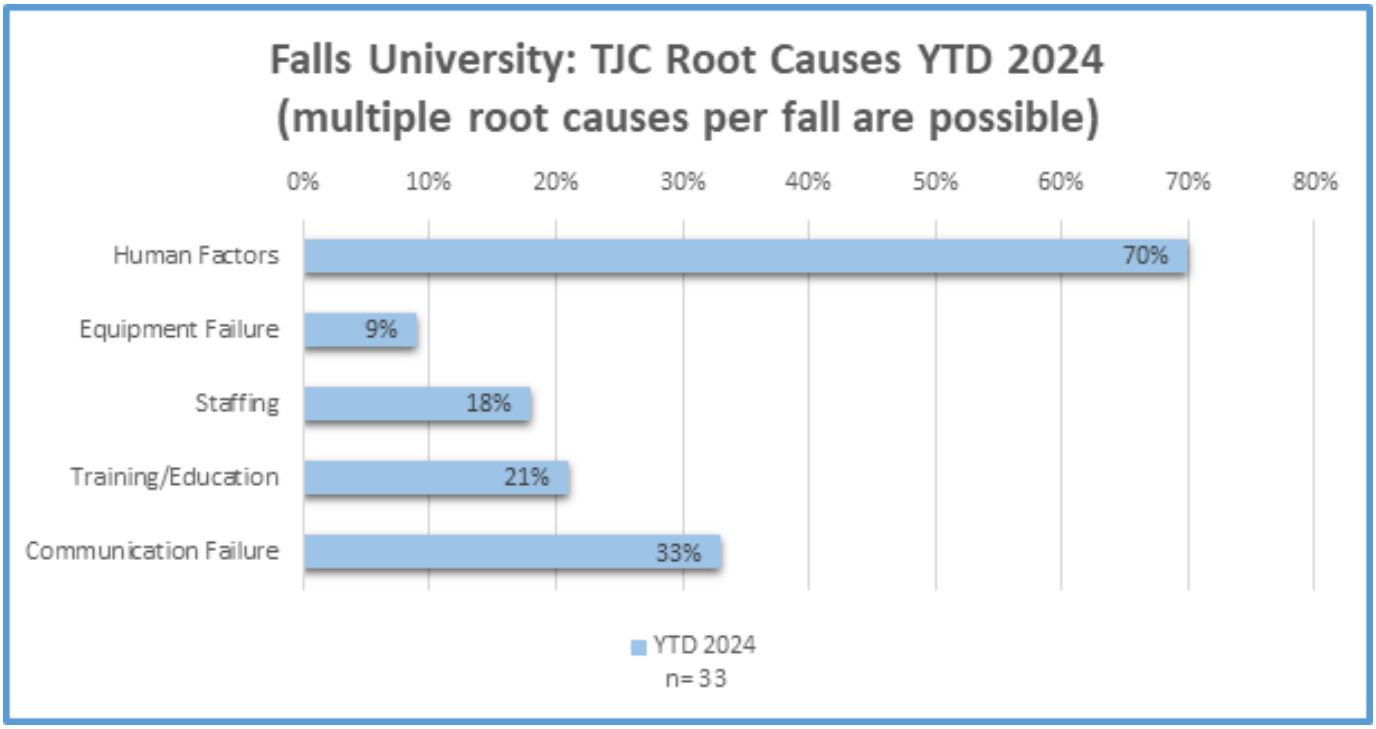


ANALYSIS OF MEASURE/DATA (Include key findings, improvements, opportunities)

∅ **Goal not met: Unassisted falls increased from 3Q 2023 to 4Q 2023 (>21%)**
<u>NOTE</u>: Percent of unassisted falls at KH includes inpatient units, Mental Health and Rehab. Overall unassisted falls in 2023 appeared to be moving in the desired direction from the first quarter to Q3 of 2023 but there was an uptick for Q4. We will continue to work through the Falls Prevention committee and Falls University to support staff in their efforts to decrease falls and improve patient outcomes.

IMPROVEMENT OPPORTUNITIES / ACTION PLANS / NEXT STEPS, RECOMMENDATIONS, OUTCOMES:

- **Falls Prevention Committee meeting monthly**
- ***Falls University continues* to meet biweekly with units who report falls in the occurrence reporting system. Real-time discussion of events and opportunities for utilization of prevention strategies is shared with staff.**
    - **Utilize The Joint Commission's framework for Root Cause Analysis to explore impact of performance, resources, knowledge/skill-set, and communication on patient outcome (see attribution information below)**



    - **Email communication to nurses at all levels includes key "Take-Aways" from Falls University event review**
    - **Managers to include takeaways in their weekly updates disseminated to staff**
    - **Report recommendations/actions to QComm meetings using the SBAR tool.**
    - **Human factors (62%) continues to be the number one root cause. We continue to encourage staff to pause prior to leaving the patients room to ensure all safety precautions are in place (SPLAT the room).**

- **<u>Work in Progress</u> (WIP) – summary of collaborative efforts led by Emma Camarena, Director of Nursing Practice, Kari Moreno, Nurse Manger and Cindy Vander Schuur in partnership with quality, clinical informatics and nursing leaders:**
    - **Post-Fall electronic charting**

- **Stakeholders made final edits based on input from various departments/divisions to ensure global applicability and post-fall electronic charting is in use.**
- **Optimize post-fall iPOC to include alerts/task prompts to drive interventions**
- **Developing a workflow for LVNs and LPTs to assist in the post falls interventions and documentation**

- **Prevention and Intervention Strategies**
  - **Partner with unit staff and leaders, clinical educators, quality and patient safety partners to educate staff on the importance of ensuring room safety using the SPLAT acronym addressing frequently cited human factors (e.g., alarms, slip/trip hazards) as root causes for falls.**
  - **Falls committee Participation in Patient Safety Awareness Week campaign to provide falls prevention information to staff.**
- **Documentation**
  - **Working with MCH to complete iView documentation into PowerForm to improve workflow and standardize information capture. MCH staff utilize a different falls tool to document falls in mothers and Peds**
  - **Documentation optimization of IPOCS with Chartis to begin in April**
  - ***Critical chart open alerts notifying staff their patient had a fall in the last 72 hours***
- **Policy**
  - **Policy was revised to reflect updated prevention, intervention, workflow, and documentation per WIP listed above**
- **Education and Training**
  - ***New Falls CBL related to practice, workflow and documentation changes impacted by all WIP listed above***
  - ***All hospital staff need foundational falls prevention education. Escalated education for nursing. Revision of falls education in progress for all patient care staff***
  - ***Review rehab education and discuss ways to include into yearly education.***

Unit/Department Specific Data Collection Summarization

Quality Committee Report

SUBMITTED BY:

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

Cindy Vander Schuur, BSN, RN
Quality and Patient Safety

Kari Moreno, MSN, CMSRN, DSD
Acute Rehabilitation Nurse Manager
DON-Skilled Nursing

DATE SUBMITTED: **April 22, 2024**

Environment of Care
1st Quarter Report
Jan 1, 2024 through March 31, 2024
Presented by

Maribel Aguilar, Safety Officer
maaguila@kaweahhealth.org
559-624-2381

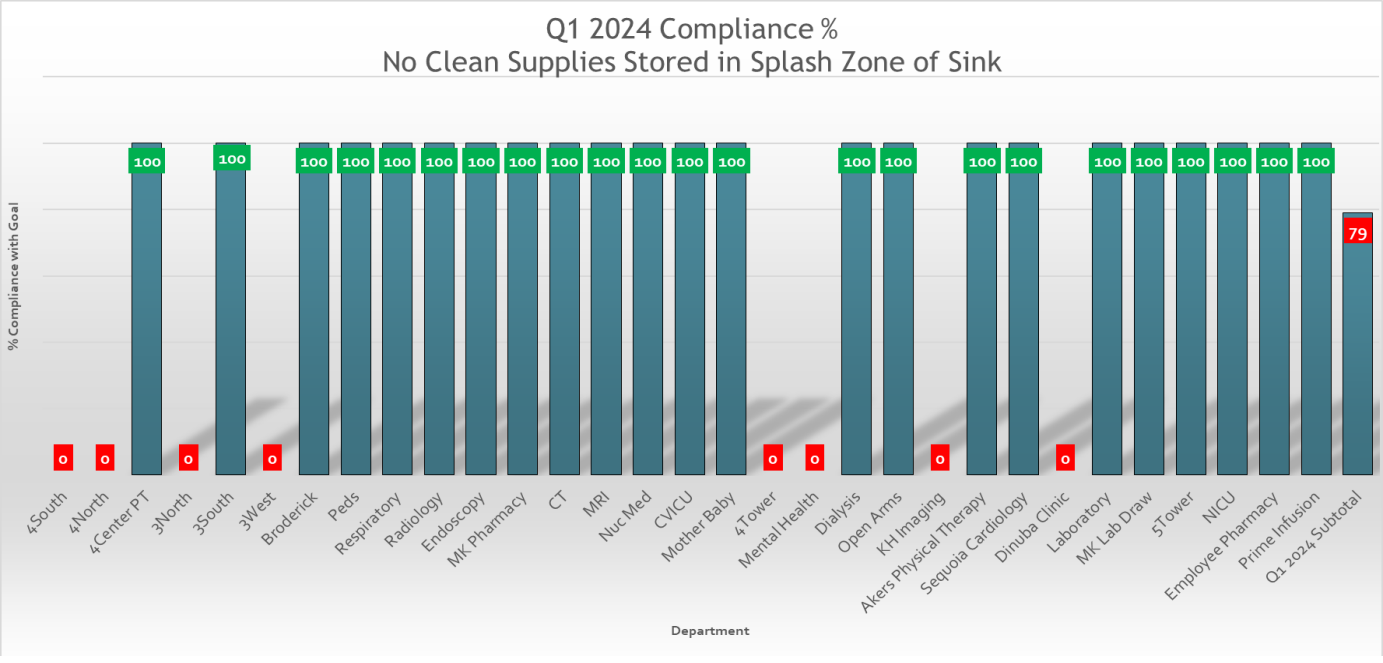
INFECTION PREVENTION

First Quarter 2024

Performance Standards: Weekly EOC Hazard Rounds 2024 Infection Prevention Goal: Will audit for presence of medical supplies, devices and/or medication within 3 feet on either side of sinks present in patient care areas, including outpatient care clinical settings. If present, the audit result is considered a fallout. If not present, the audit result is considered a success.

Goal: 100% compliance (no fallouts)
Minimum Performance Level: 95% compliance rate

Evaluation:
Q1 2024 Compliance Rate: **79%. Minimum performance was not met**
35 departments were surveyed for Q1 2024.
8 departments were observed out of compliance with medical supplies, devices and/or medication stored within 3 feet on either side of sinks.



Plan for Improvement:
Methods to mitigate these events from occurring:

1. Eliminate clutter/storage of supplies, devices, medication within 3 feet on either side of a patient care sink.
2. Install an approved hard plastic barrier that prevents water exposure to medical supplies, devices and/or medication that are present within 3 feet on either side of patient care sinks.
3. "Tip-of-the-day" and "One-Page-Wonder" distributed in advance of audits and each time a fallout is observed.

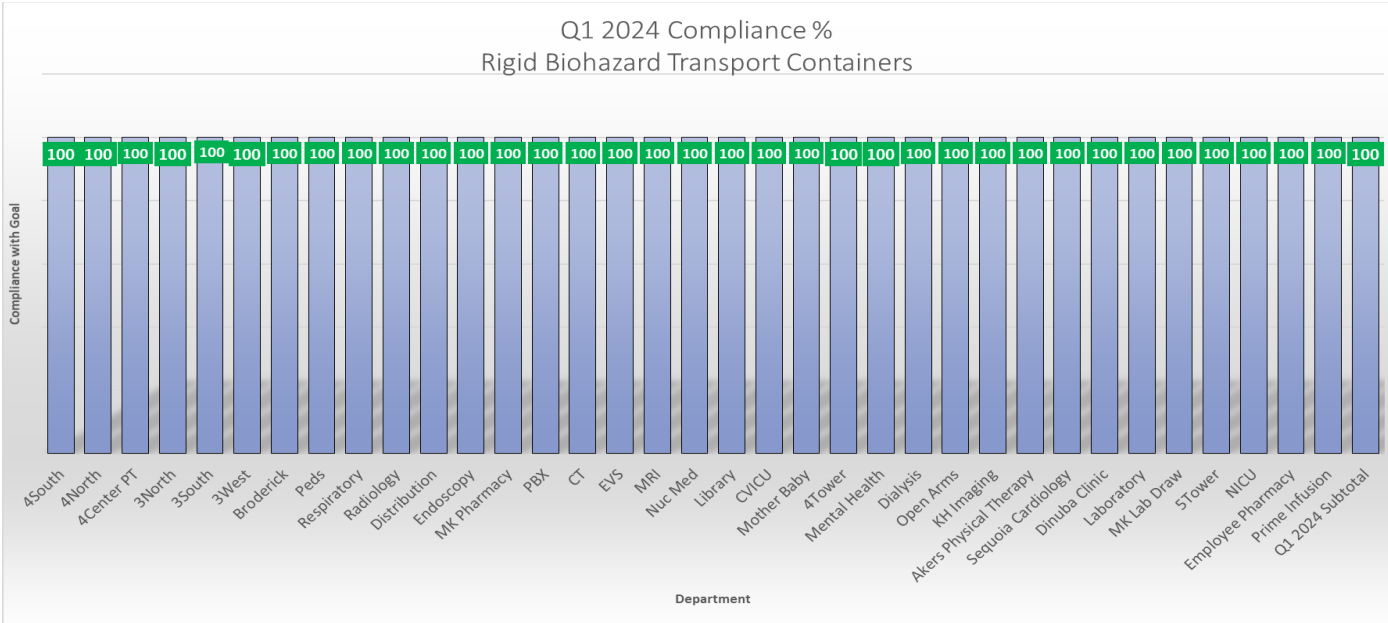
INFECTION PREVENTION

First Quarter 2024

Performance Standards: Will audit for 3 specific observations related to rigid biohazard instrument transport containers:
(1) Whether used instrumentation/scopes are placed in a rigid biohazard instrument transport container.
(2) Whether enzymatic/wetting solution is present along all surfaces of used instrumentation/scopes and that enzymatic/wetting solution has not dried out.
(3) That the rigid biohazard instrument transport container is secured "locked" when in use.

Goal: 100% compliance rate. No fallouts
Minimum Performance Level: 95% compliance rate

Evaluation:
Q1 2024 Compliance Rate: **100%**
35 departments were surveyed for Q1 2024.
All areas observed were compliant with rigid biohazard instrument transport container elements.



Plan for Improvement:
Methods to mitigate these events from occurring:

1. Appropriate use of rigid biohazard instrument transport container by staff in department observed.
2. "Tip-of-the-day" and "One-Page-Wonder" information sheet (available in existing policy) distributed in advance of audits and each time a fallout is observed.

RISK MANAGEMENT

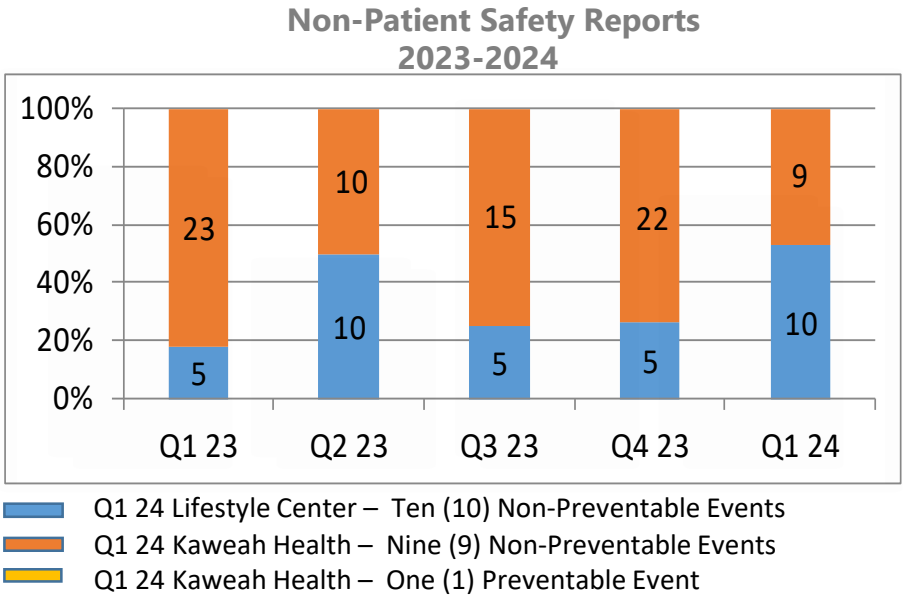
First Quarter 2024

Performance Standard: Reports of preventable non-patient safety related events in a KDHCD facility.

Goal: Will decrease by two (2) events or more when compared to 2023
Minimum Performance Level: Report non-patient safety related events within 7 days

Evaluation:
In 1st Qtr. 2024, We identified one (1) preventable safety event which required medical intervention.

Goal was met for 1st Qtr.



LIFE SAFETY - SAFETY

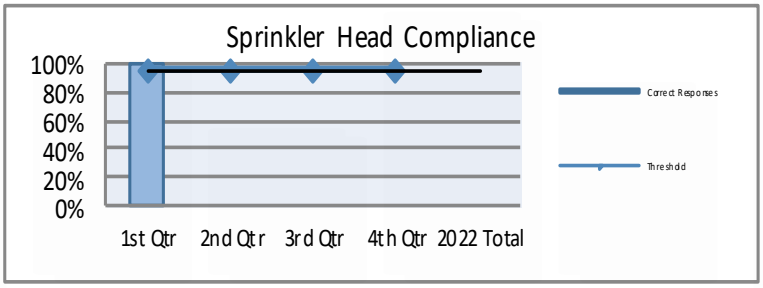
First Quarter 2024

Performance Standard: During hazardous surveillance rounding, sprinkler heads will be monitored for damage, corrosion, foreign material, and paint.

Goal: 100% compliance
Minimum Performance Level: 95% compliance rate

Evaluation:
Thirty-eight departments were surveyed in the 1st quarter. No sprinkler heads were found with damage, corrosion, foreign material or paint, which resulted in a 100% compliance rate.

95% minimum performance level **was met** for this quarter.



Plan for Improvement:
In each department visited there were no compliance issue with sprinkler heads. Will continue to monitor during rounding.

UTILITIES MANAGEMENT

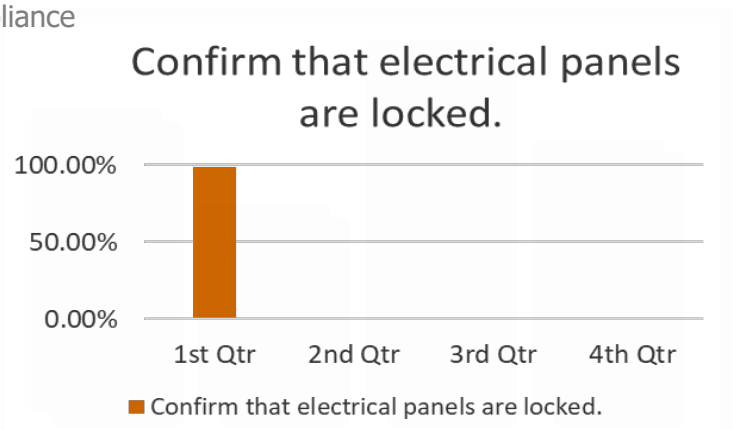
First Quarter 2024

Performance Standard: Inspections will be performed during EOC rounds to confirm that electrical panels are locked.

Goal: 100% Compliance
Minimum Performance Level: 100% Compliance

Evaluation:
47 Areas were surveyed in the 1st quarter. Two electrical panels were found unlocked, this resulted in 95.75% compliance rate.

Minimum Performance Level was **not met** during this quarter.



Plan for Improvement:
We are searching for a universal surface mount panel lock that is keyless and self latching.

UTILITIES MANAGEMENT

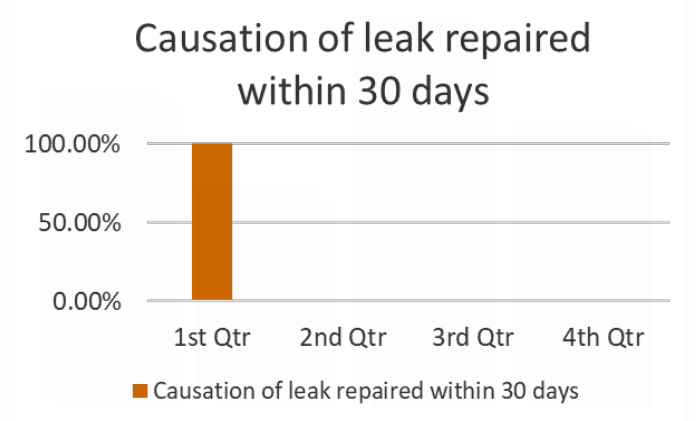
First Quarter 2024

Performance Standard: Inspections will be performed during EOC rounds to identify any ceiling tiles that are damaged/stained. The expectation is staff that work in the area have placed a Facilities Maintenance work order and the Goal is to correction of causation within30 days of work order being placed.

Goal: 100% Compliance
Minimum Performance Level : 100% Compliance

Evaluation:
47 Areas were surveyed in the 1st quarter. Six stained ceiling tiles were documented and the correction of causation was repaired within 30 days of work order being placed. All departments were compliant, this resulted in 100% compliance rate.

Minimum Performance Level **was met** during this quarter.



Plan for Improvement:
All areas surveyed in the 1st Quarter were compliant.

SECURITY SERVICES

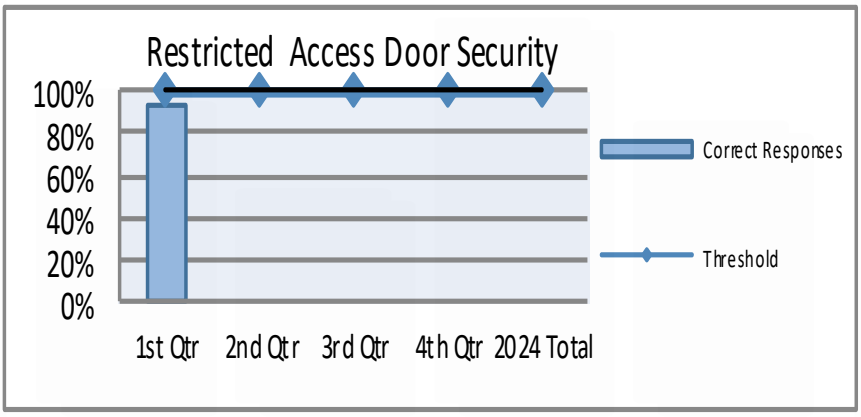
First Quarter 2024

Performance Standard: During hazardous surveillance rounding, units will be evaluated for authorized personnel doors/exit only door accessibility to the public.

Goal: 100% compliance with doors not accessible to the public
Minimum Performance Level: 100% compliance with doors not accessible to the public

Evaluation:
Forty-three departments were surveyed in the 1st quarter. In departments surveyed three authorized personnel only doors were found accessible to the public, which resulted in a 93% compliance rate.

100% minimum performance level **was not met** for this quarter.



Detailed Plan for Improvement:
Security staff will follow up with Department Leadership of areas with restricted accesses found unsecure to identify causes and partner to identify solutions. Explore addition of signage to restricted access doors where appropriate.

ENVIRONMENTAL SERVICES (EVS)

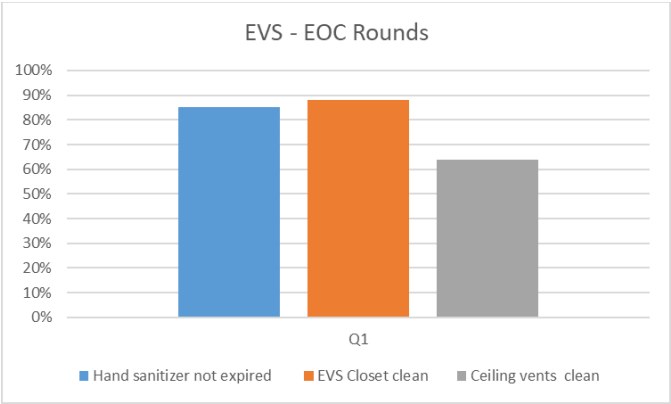
First Quarter 2024

Performance Standard: During EOC rounds, as applicable, the following is evaluated: hand sanitizer not expired; EVS closets are clean; ceiling vents are clean.

Goal: 100% Compliance
Minimum Performance Level: 95% Compliance

Evaluation:
1. Hand Sanitizer not expired: 17/20 = 85%
2. EVS Closets clean: 14/16 = 88%
3. Ceiling vents clean: 14/22 = 64%

Minimum Performance Level **was not met** during this quarter.



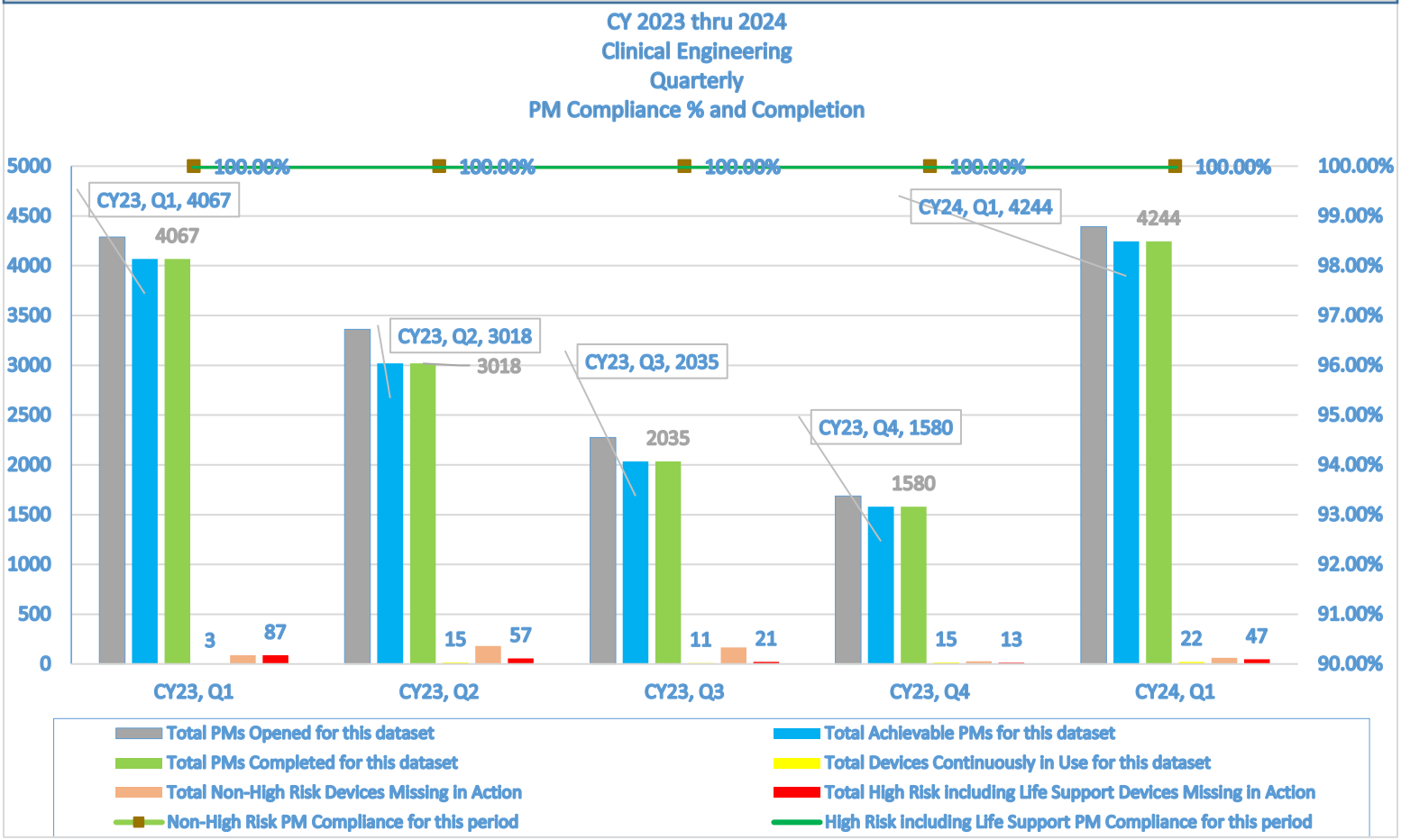
Detailed Plan for Improvement:
- Director re-educated EVS Managers on completing EOC rounding logs in a standardized manner (completed by 5/1/24). Electronic system (RLDatix) that will be implemented by Safety department will help optimize data gathering and reporting.
- EVS Leadership to proactively monitor areas routinely while completing departmental rounds (ongoing).
- EVS Managers to coach staff in non-compliant areas and also recognize compliance as appropriate.

EOC Component: Medical Equipment Preventive Maintenance (PM) Compliance

Performance Standard: **Maintain a 100% compliance rate on non-high risk and high risk Medical Equipment**
Performance Standard: **<2% Total of High Risk Devices to be Missing for Preventative Maintenance per quarter**

Evaluation:
For the reporting quarter, CY 2024, Q1 (Jan-Mar), Medical Device count available to receive Preventive Maintenance is 4244 and all of those devices received Preventive Maintenance. All Medical Devices this Quarter received PM or were marked as In Use or Missing in Action (MIA) as defined by TJC.

PM Compliance for Non-High Risk Devices is 100% and **meets** the 100% Compliance Goal.
PM Compliance for High Risk Including Life Support Devices is 100% and **meets** the 100% Compliance Goal.
Performance Improvement Goal: Total High Risk Devices MIA count is 47 for the Quarter. Total HRiLS MIA devices as % of total HRiLS inventory is 01.02%. Goal met.



Calendar Year 2024	Quarter 1			Q1 Total
Category	Jan-24	Feb-24	Mar-24	CY24, Q1
Total PMs Opened for this dataset	968	1403	2020	**4391**
Total Administrative Closures for this dataset	3	9	5	**17**
Total Devices Continuously in Use for this dataset	2	12	8	**22**
Total Non-High Risk Devices Missing in Action	37	23	1	**61**
Total High Risk including Life Support Devices Missing in Action	1	17	29	**47**
Total Achievable PMs for this dataset	925	1342	1977	**4244**
Total PMs Completed for this dataset	925	1342	1977	**4244**
Total PMs Not Completed	0	0	0	**0**
Total PM Compliance	100.00%	100.00%	100.00%	**100.00%**
Non-High Risk PM Compliance for this period	100.00%	100.00%	100.00%	**100.00%**
High Risk Including Life Support PM Compliance For this period	100.00%	100.00%	100.00%	**100.00%**

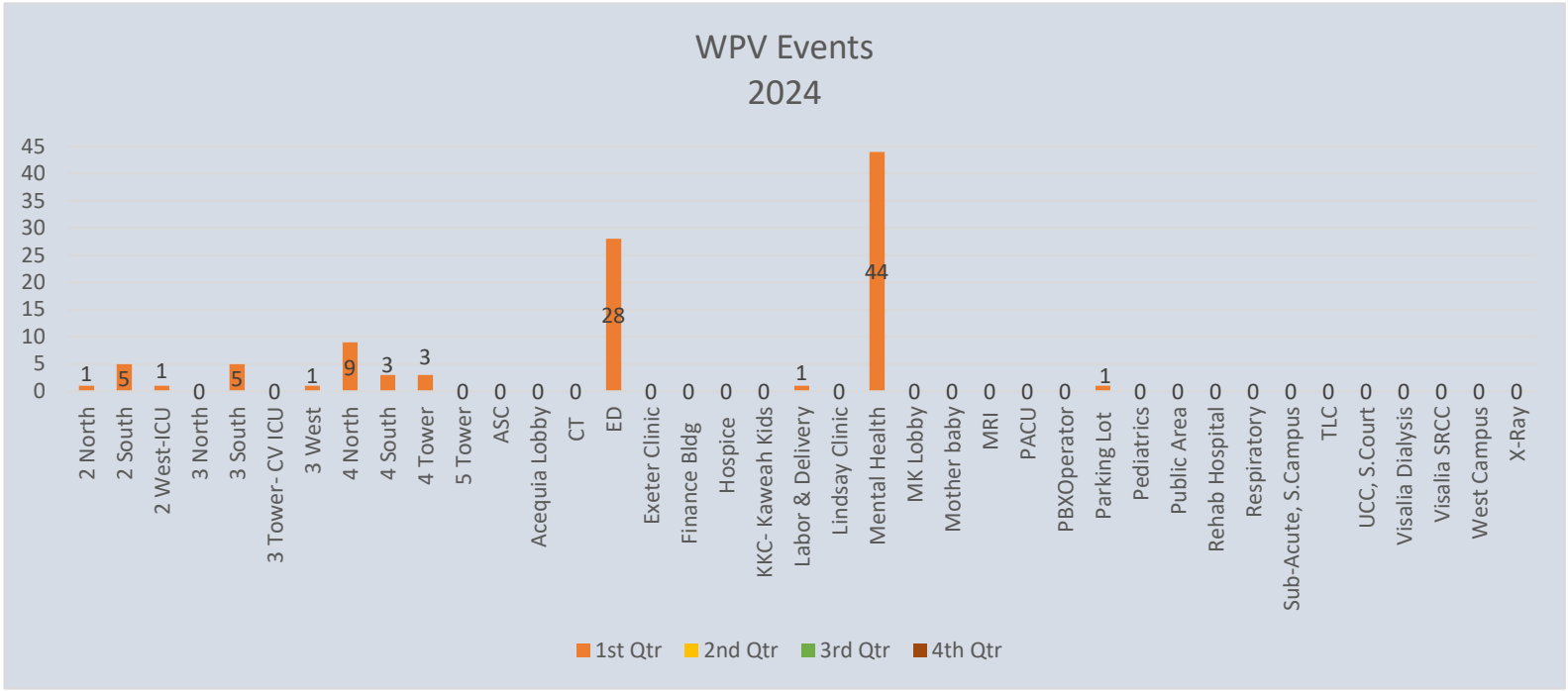
Plan for Improvement:
The 47 High Risk medical devices missing in action for planned maintenance in the first quarter are assigned to a Clinical Engineering technician who will work directly with the owning department's manager during the second quarter of 2024 to locate the MIA equipment. A monthly report is provided to EOC Committee for these specific devices remaining "MIA". If a device continues as not located at the end of the next quarter (2Q, 2024), a device status change "Retired-Missing in Action" in the inventory will take effect for that device.

Workplace Violence
Safety Department
2024, 1st Quarter

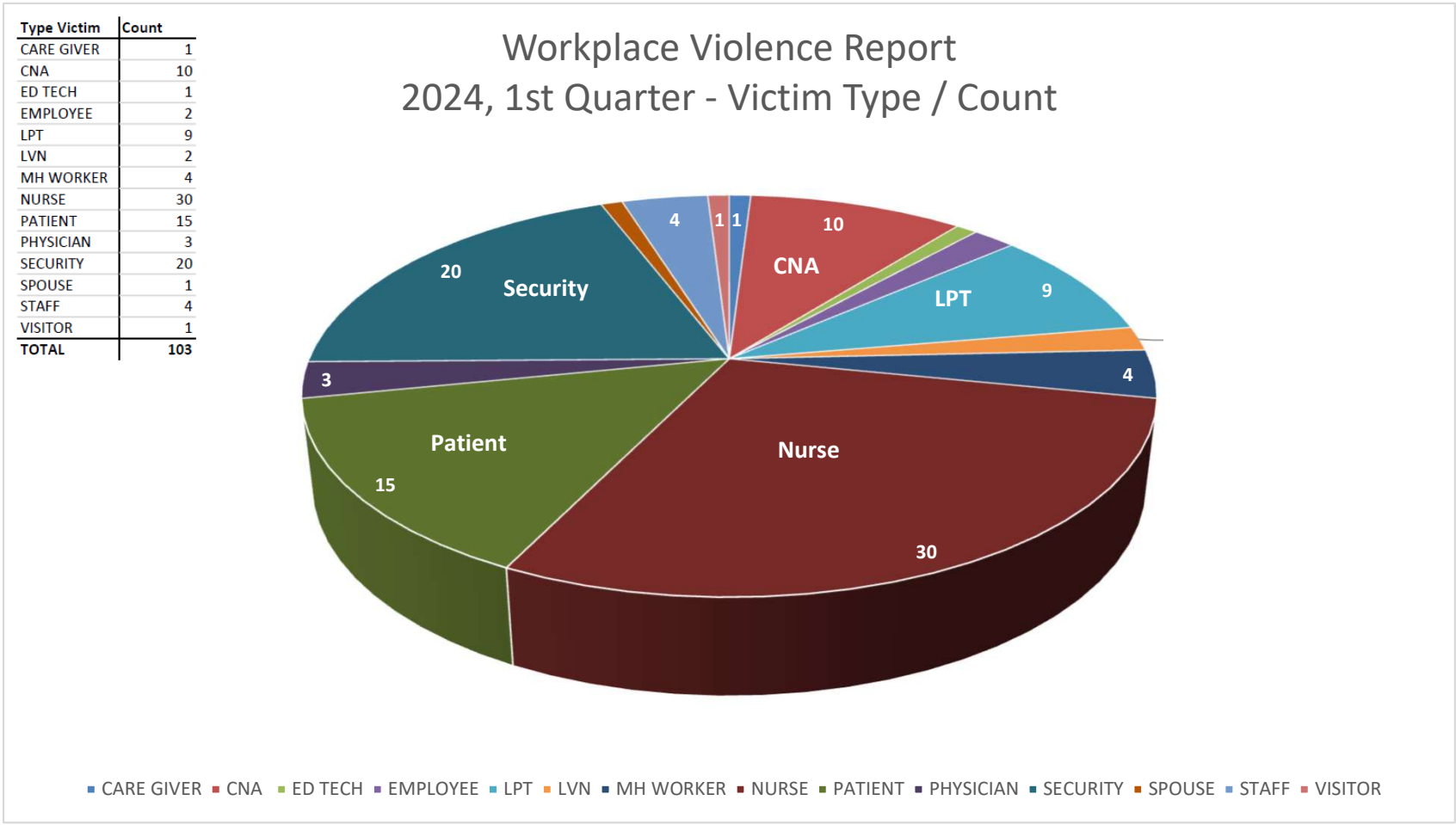
Kaweah Health
Safety Department
Workplace Violence Report
2022-2024 TD

Year/Qtr	2 North	2 South	2 West-ICU	3 North	3 South	3 Tower-CV ICU	3 West	4 North	4 South	4 Tower	5 Tower	ASC	Acequia Lobby	CT	ED	Exeter Clinic	Finance Bldg	Hospice	KKC	Labor & Delivery	Lindsay Clinic
2022, Q1	5	1	1	9	3	0	2	3	1	2	1	0	0	0	48	0	0	1	1	0	0
2022, Q2	0	4	0	5	2	0	0	0	3	1	0	0	0	0	40	0	0	0	0	0	0
2022, Q3	0	1	2	13	2	0	4	5	2	7	6	2	0	0	25	0	0	0	0	0	0
2022, Q4	5	3	0	10	9	0	2	2	3	2	3	0	0	0	38	0	0	0	0	4	0
Total 2022	**10**	**9**	**3**	**37**	**16**	**0**	**8**	**10**	**9**	**12**	**10**	**2**	**0**	**0**	**151**	**0**	**0**	**1**	**1**	**4**	**0**
2023, Q1	1	1	0	1	4	2	2	1	1	1	0	0	3	1	34	0	0	0	0	0	0
2023, Q2	6	0	0	3	2	2	0	1	2	2	1	0	1	0		0	0	0	0	0	0
2023, Q3	2	0	1	2	3	0	0	0	4	1	2	0	0	0	34	0	0	0	0	0	0
2023, Q4	3	1	1	4	0	1	1	8	7	7	5	0	0	0	29	0	0	0	0	1	0
Total 2023	**12**	**2**	**2**	**10**	**9**	**5**	**3**	**10**	**14**	**11**	**8**	**0**	**4**	**1**	**151**	**0**	**0**	**0**	**0**	**1**	**0**
2024, Q1	1	5	1	0	5	0	1	9	3	3	0	0	0	0	28	0	0	0	0	1	0
2024, Q2																					
2024, Q3																					
2024, Q4																					
Total 2024	**1**	**5**	**1**	**0**	**5**	**0**	**1**	**9**	**3**	**3**	**0**	**0**	**0**	**0**	**28**	**0**	**0**	**0**	**0**	**1**	**0**

Year/Qtr	Mental Health	MK Lobby	Mother-baby	MRI	PACU	PBX-Operator	Parking Lot	Pediatrics	Public Area	Rehab Hospital	Respiratory	Sub-Acute, S. Campus	TLC	UCC, S. Court	Visalia Dialysis	Visalia SRCC	West Campus	X-Ray	Total
2022, Q1	19	0	0	0	0	0	0	1	0	0	0	2	2	1	0	0	0	0	103
2022, Q2	17	0	0	0	0	0	1	0	0	0	0	2	0	0	0	0	0	0	75
2022, Q3	36	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	2	0	108
2022, Q4	12	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	0	0	95
Total 2022	**84**	**0**	**0**	**0**	**0**	**0**	**2**	**1**	**0**	**0**	**0**	**4**	**2**	**1**	**1**	**1**	**2**	**0**	**381**
2023, Q1	39	0	0	0	0	1	1	0	0	0	0	0	1	1	0	0	0	0	95
2023, Q2	35	0	1	2	0	1	0	0	0	2	0	0	0	0	0	0	0	0	115
2023, Q3	100	0	0	0	0	0	3	0	0	0	0	0	0	0	0	0	0	0	152
2023, Q4	39	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	109
Total 2023	**213**	**1**	**1**	**2**	**0**	**2**	**5**	**0**	**0**	**2**	**0**	**0**	**1**	**1**	**0**	**0**	**0**	**0**	**471**
2024, Q1	44	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	103
2024, Q2																			0
2024, Q3																			0
2024, Q4																			0
Total 2024	**44**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**103**


WPV Events
2024
45
40
35
30
25
20
15
10
5
0
2 North 1
2 South 5
2 West-ICU 1
3 North 0
3 South 5
3 Tower- CV ICU 0
3 West 1
4 North 9
4 South 3
4 Tower 3
5 Tower 0
ASC 0
Acequia Lobby 0
CT 0
ED 28
Exeter Clinic 0
Finance Bldg 0
Hospice 0
KKC- Kaweah Kids 0
Labor & Delivery 1
Lindsay Clinic 0
Mental Health 44
MK Lobby 0
Mother baby 0
MRI 0
PACU 0
PBXOperator 0
Parking Lot 1
Pediatrics 0
Public Area 0
Rehab Hospital 0
Respiratory 0
Sub-Acute, S.Campus 0
TLC 0
UCC, S.Court 0
Visalia Dialysis 0
Visalia SRCC 0
West Campus 0
X-Ray 0
1st Qtr
2nd Qtr
3rd Qtr
4th Qtr

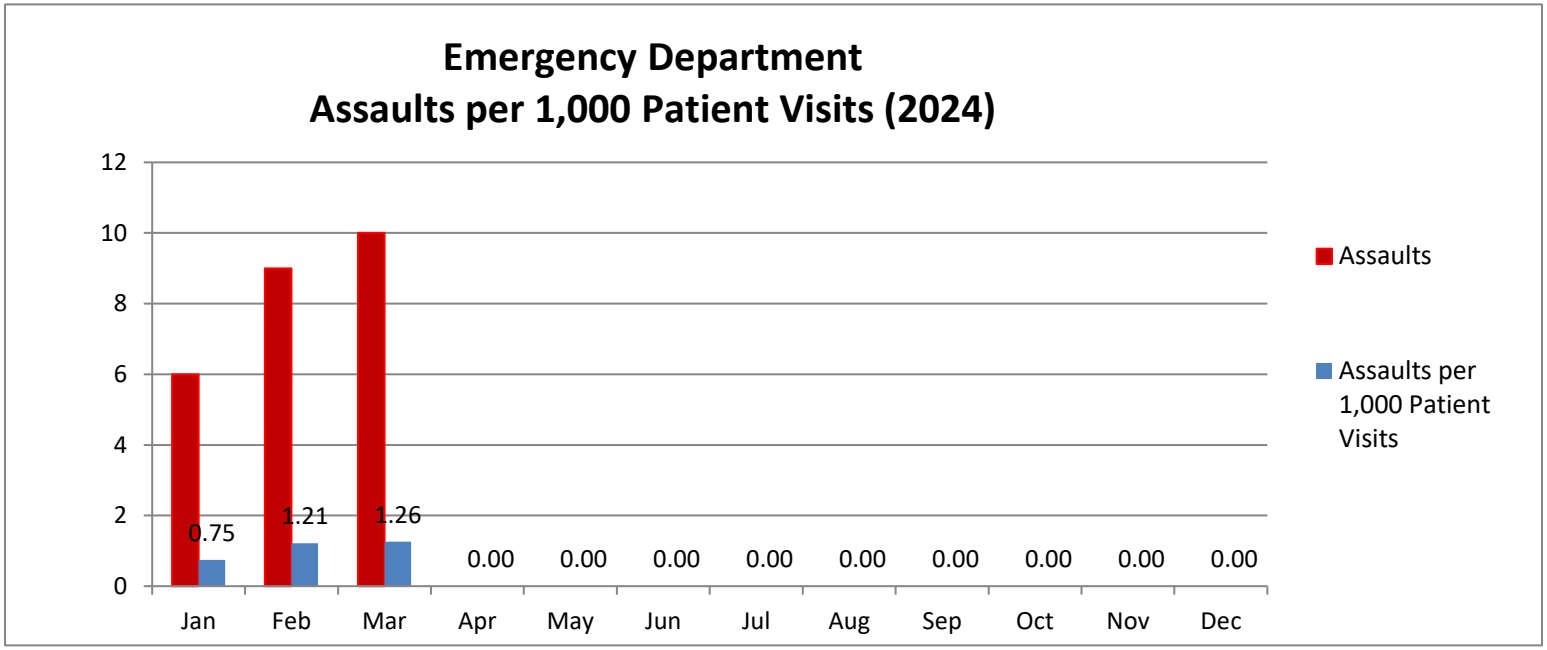
Type Victim	Count
CARE GIVER	1
CNA	10
ED TECH	1
EMPLOYEE	2
LPT	9
LVN	2
MH WORKER	4
NURSE	30
PATIENT	15
PHYSICIAN	3
SECURITY	20
SPOUSE	1
STAFF	4
VISITOR	1
TOTAL	**103**



Kaweah Health Security Services
Emergency Department, Assaults per 1,000 Patient Visits
Year 2024, Qtr01

EMERGENCY DEPARTMENT

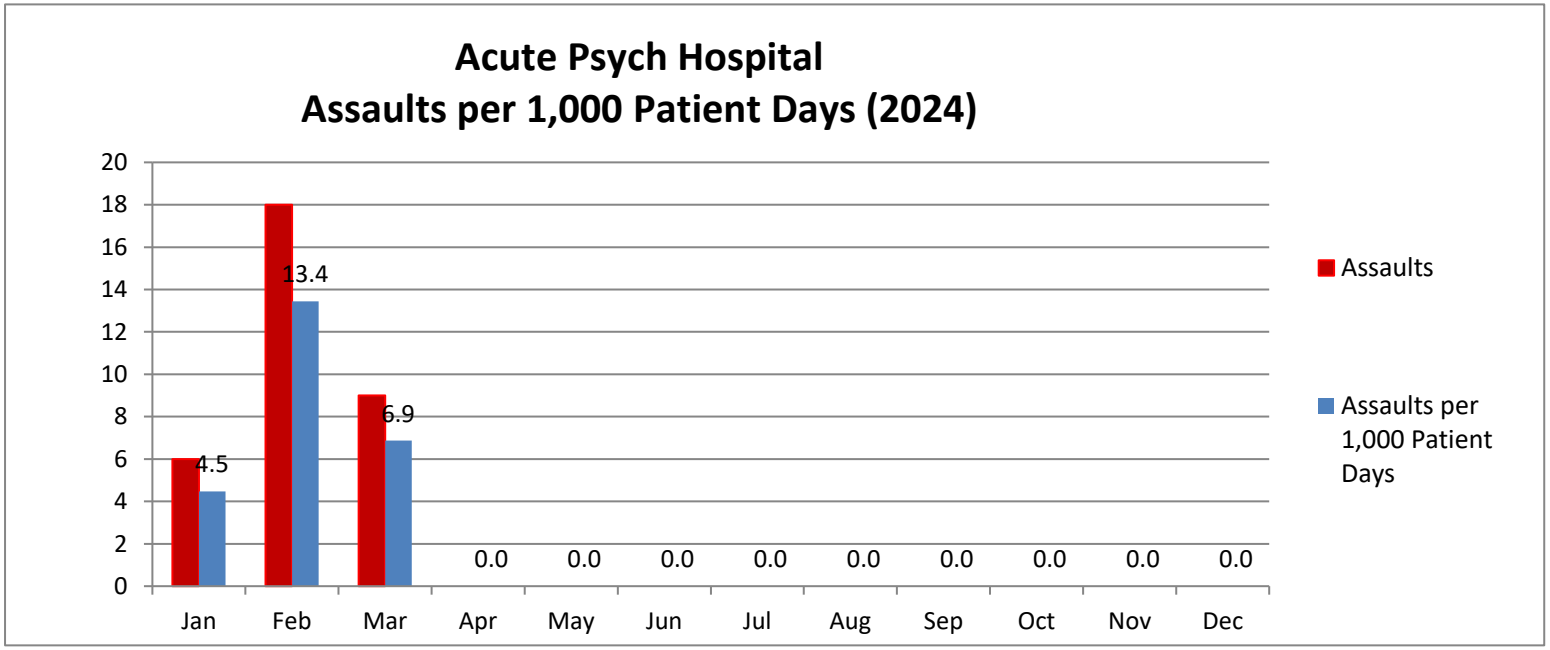
YR 2024	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Patient Days	8,035	7,430	7,921	7,856								
Assaults	6	9	10									
Assaults per 1,000 Patient Visits	0.75	1.21	1.26	0.00	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!



Kaweah Health Security Services
Mental Health Hospital, Assaults per 1,000 Patient Days
Year 2024, Qtr01

MENTAL HEALTH

YR 2024	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Patient Days	1,340	1,339	1,311	1,358								
Assaults	6	18	9									
Assaults per 1,000 Patient Days	4.5	13.4	6.9	0.0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!



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Maternal Child Health FY2024 Quality Improvement Dashboard

LABOR AND DELIVERY	Goal	2023	July 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	June 2024	FYTD
Early Elective Deliveries: PC-01	0%	3.8%	1.7%	4.3%	2.0%	9.0%	5.1%	4.1%	4.3%	8.1%	5.0%	6.4%	7.7%	9.1%	5.6%
Nullip Term Singleton Vertex : PC-02	23.6%	25.9%	26.5%	21.4%	30.0%	21.8%	24.8%	28.3%	23.0%	32.0%	24.5%	29.2%	29.1%	27.4%	26.5%
RASS Compliance	100%	88%	89.98%	91%	93%	91%	91%	91.62%	98.72%	99.12%	99.40%	100%	100%	100%	95.40%
Dermatome Compliance	100%	89%	95.25%	89.66%	93%	91%	91%	91.62%	98.98%	99.12%	99.40%	100%	100%	100%	95.75%
Severe Unexpected Complications in Term Newborns: PC-06.1	5%	9.80%	8.88%	5.60%	8.90%	9.30%	9.30%	3.10%	9%	3.6%	9.8%	0%	3.3%	3%	6.15%
*Bar Code Medication Administration	95%	N/A	97%	97.4%	97.7%	96.8%	97.6%	97%	96.5%	97.59%	97.46%	97.3%	97.59%	96.86%	97%
*Scheduled Inductions Not Delay	95%	N/A	92.9%	76.0%	84%	83%	76.0%	87.3%	81.8%	71.21%	86.84%	78.6%	82.43%	72.41%	81%
BIOVIGIL Compliance	95%	97.2%	97.7%	96.4%	97%	96%	96.0%	96.8%	98.9%	97.3%	97.0%	97.3%	96.5%	96.1%	97.0%

MOTHER-BABY	Goal	2023	July 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	June 2024	FYTD
Exclusive Breastmilk: PC-05	52.4%	64.1%	54.2%	66.7%	61.0%	62.6%	60.3%	55.0%	58.9%	53.7%	60.8%	61.6%	52.1%	63.7%	59.2%
Latch Assessment Compliance	100%	74%	60%	60%	70%	72%	52%	66%	74%	84%	82%	86%	86%	84%	73%
RASS Compliance	100%	N/A	20%	30%	70%	90%	50%	96%	90%	100%	100%	100%	100%	100%	79%
Early Catheter Removal	100%	N/A	80%	80%	80%	93%	80%	80%	80%	90%	90%	92%	86%	92%	85%
*Bar Code Medication Administration	95%	N/A	99%	99%	98.9%	98.3%	98.6%	98%	98.9%	98.5%	98.05%	98.82%	98.5%	98.6%	99%
BIOVIGIL Compliance	95%	97.5%	97.6%	97.9%	98.2%	97.4%	97.0%	97.5%	97.1%	97.0%	97.4%	97.0%	97.2%	97.0%	97.3%

NEONATAL-NICU	Goal	2023	July 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	June 2024	FYTD
CLABSI per 1000 Patient Days	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
VAP per 1000 Patient Days	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Any Breastmilk for NICU Babies	100%	N/A	85.9%	93.5%	95.1%	97.6%	98%	83%	97%	90%	97.80%	100%	97%	98%	94%
*Bar Code Medication Administration	95%	N/A	99.3%	98.8%	99.2%	99.2%	99.5%	99%	99.4%	99.42%	99.17%	99%	99%	99%	99%
BIOVIGIL Compliance	95%	99.5%	99.5%	99.3%	99.1%	99.0%	99.1%	99.2%	100%	99.4%	99.4%	99.6%	99.5%	99.5%	99.3%

PEDIATRICS	Goal	2023	July 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	June 2024	FYTD
PEWS Compliance	90%	98%	100%	100.0%	98%	100%	100.0%	100%	97.9%	100.00%	100.00%	91.6%	93.30%	95.8%	98.1%
Patient Falls per 1000 Patient Days	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0.08333
Ambulation	90%	N/A	55%	20%	25%	15%	20%	5%	28%	53%	78%	65%	83%	83%	44.2%
Child Life Activities	90%	N/A	30%	8%	8%	10%	15%	11%	44%	67%	67%	89%	87%	93%	44.1%
CLABSI per 1000 Patient Days	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
*Bar Code Medication Administration	95%	N/A	97.60%	100%	99%	98.60%	98%	99%	98.61%	97.0%	97.90%	98.91%	99.54%	99.90%	98%
*Alaris Pump IV Fluids	95%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	94.9%	96.30%	91.38%	94.52%	89.78%	95.6%
BIOVIGIL Compliance	95%	97.5%	97.5%	98.1%	98%	97.5%	98.2%	97.6%	98.6%	97.0%	98.3%	98.2%	97.9%	98.3%	97.9%

>10% above goal/benchmark	Within 10% of goal/benchmark	Outperforming/meeting goal/benchmark

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Labor and Delivery FY2024 Quality Improvement Dashboard

LABOR AND DELIVERY	Goal	2023	July 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	June 2024	FYTD
Early Elective Deliveries: PC-01	0%	3.8%	1.7%	4.3%	2.0%	9.0%	5.1%	4.1%	4.3%	8.1%	5.0%	6.4%	7.7%	9.1%	5.6%
Nullip Term Singleton Vertex : PC-02	23.6%	25.9%	26.5%	21.4%	30.0%	21.8%	24.8%	28.3%	23.0%	32.0%	24.5%	29.2%	29.1%	27.4%	26.5%
RASS Compliance	100%	88%	89.98%	91%	93%	91%	91%	91.62%	98.72%	99.12%	99.40%	100%	100%	100%	95.40%
Dermatome Compliance	100%	89%	95.25%	89.66%	93%	91%	91%	91.62%	98.98%	99.12%	99.40%	100%	100%	100%	95.75%
Severe Unexpected Complications in Term Newborns: PC-06.1	5%	9.80%	8.88%	5.60%	8.90%	9.30%	9.30%	3.10%	9%	3.6%	9.8%	0%	3.3%	3%	6.15%
*Bar Code Medication Administration	95%	N/A	97%	97.4%	97.7%	96.8%	97.6%	97%	96.5%	97.59%	97.46%	97.3%	97.59%	96.86%	97%
*Scheduled Inductions Not Delay	95%	N/A	92.9%	76.0%	84%	83%	76.0%	87.3%	81.8%	71.21%	86.84%	78.6%	82.43%	72.41%	81%
BIOVIGIL Compliance	95%	97.2%	97.7%	96.4%	97%	96%	96.0%	96.8%	98.9%	97.3%	97.0%	97.3%	96.5%	96.1%	97.0%

>10% above goal/benchmark	Within 10% of goal/benchmark	Outperforming/meeting goal/benchmark

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Mother Baby FY2024 Quality Improvement Dashboard

MOTHER-BABY	Goal	2023	July 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	June 2024	FYTD
Exclusive Breastmilk: PC-05	52.4%	64.1%	54.2%	66.7%	61.0%	62.6%	60.3%	55.0%	58.9%	53.7%	60.8%	61.6%	52.1%	63.7%	59.2%
Latch Assessment Compliance	100%	74%	60%	60%	70%	72%	52%	66%	74%	84%	82%	86%	86%	84%	73%
RASS Compliance	100%	N/A	20%	30%	70%	90%	50%	96%	90%	100%	100%	100%	100%	100%	79%
Early Catheter Removal	100%	N/A	80%	80%	80%	93%	80%	80%	80%	90%	90%	92%	86%	92%	85%
*Bar Code Medication Administration	95%	N/A	99%	99%	98.9%	98.3%	98.6%	98%	98.9%	98.5%	98.05%	98.82%	98.5%	98.6%	99%
BIOVIGIL Compliance	95%	97.5%	97.6%	97.9%	98.2%	97.4%	97.0%	97.5%	97.1%	97.0%	97.4%	97.0%	97.2%	97.0%	97.3%

>10% above goal/benchmark	Within 10% of goal/benchmark	Outperforming/meeting goal/benchmark

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Neonatal -NICU FY2024 Quality Improvement Dashboard

NEONATAL-NICU	Goal	2023	July 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	June 2024	FYTD
CLABSI per 1000 Patient Days	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
VAP per 1000 Patient Days	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Any Breastmilk for NICU Babies	100%	N/A	85.9%	93.5%	95.1%	97.6%	98%	83%	97%	90%	97.80%	100%	97%	98%	94%
*Bar Code Medication Administration	95%	N/A	99.3%	98.8%	99.2%	99.2%	99.5%	99%	99.4%	99.42%	99.17%	99%	99%	99%	99%
BIOVIGIL Compliance	95%	99.5%	99.5%	99.3%	99.1%	99.0%	99.1%	99.2%	100%	99.4%	99.4%	99.6%	99.5%	99.5%	99.3%

>10% above goal/benchmark	Within 10% of goal/benchmark	Outperforming/meeting goal/benchmark

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Pediatrics FY2024 Quality Improvement Dashboard

PEDIATRICS	Goal	2023	July 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	June 2024	FYTD
PEWS Compliance	90%	98%	100%	100.0%	98%	100%	100.0%	100%	97.9%	100.00%	100.00%	91.6%	93.30%	95.8%	98.1%
Patient Falls per 1000 Patient Days	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0.08333
Ambulation	90%	N/A	55%	20%	25%	15%	20%	5%	28%	53%	78%	65%	83%	83%	44.2%
Child Life Activities	90%	N/A	30%	8%	8%	10%	15%	11%	44%	67%	67%	89%	87%	93%	44.1%
CLABSI per 1000 Patient Days	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
*Bar Code Medication Administration	95%	N/A	97.60%	100%	99%	98.60%	98%	99%	98.61%	97.0%	97.90%	98.91%	99.54%	99.90%	98%
*Alaris Pump IV Fluids	95%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	94.9%	96.30%	91.38%	94.52%	89.78%	95.6%
BIOVIGIL Compliance	95%	97.5%	97.5%	98.1%	98%	97.5%	98.2%	97.6%	98.6%	97.0%	98.3%	98.2%	97.9%	98.3%	97.9%

>10% above goal/benchmark	Within 10% of goal/benchmark	Outperforming/meeting goal/benchmark

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LABOR AND DELIVERY

Early Elective Deliveries: PC-01

Patient Outcomes: PC-02

RASS Compliance

Dermatome Compliance

Severe Unexpected Complications in Term Newborns: PC-06.1

Pitocin Use for Labor Induction/Augmentation

Pitocin Increase Compliance

Hand Hygiene Compliance

MOTHER-BABY

Exclusive Breastmilk: PC-05

Latch Scores

RASS Compliance

Early Catheter Removal

Completion of Whiteboards

Hand Hygiene Compliance

NEONATAL-NICU

CLABSI per 1000 Patient Days

VAP per 1000 Patient Days

NICU Babies Receiving Any Breastmilk

Hand Hygiene Compliance

PEDIATRICS

PEWS Compliance

Patient Falls per 1000 Patient Days

Ambulation

Child Life Activities

CLABSI per 1000 Patient Days

Hand Hygiene Compliance

Maternal Child Health Quality Improvement Definitions

Numerator: Patients with an induction or cesarean procedure prior to labor.
Denominator: Patients with 37/38 week deliveries, EXCLUDES those with:
- a condition justifying an elective delivery (per Joint Commission).
- a history of prior stillbirth IF induction or cesarean performed in current delivery.

Numerator: Cases delivered by cesarean.

Denominator: All deliveries that are Nulliparous, Term, Singleton, or and Vertex. EXCLUDES the below deliveries:
- Mulitples
- Breach
- Preterm
- With Placenta Previa
- With History of Prior Live Birth

Numerator: Number of opportunities documented
Denominator: Number of opportunities

Numerator: Number of opportunities documented
Denominator: Number of opportunities

Numerator: Newborns with severe complications, EXCLUDES those with:
- Congenital malformations.
- Fetal conditions.
- Exposure to maternal drug use.

Denominator: Liveborn single term newborns 2500 grams or over in birth weight.

Numerator: # of patients whose Pitocin was increased every 30 minutes as appropriate
Denominator: # of patients with Pitocin Labor Induction/Augmentation orders

Numerator: Compliance of hand hygiene opportunities.
Denominator: Total number of hand hygiene opportunities.

Numerator: Newborns who were fed breast milk only since birth.
Denominator: Single term liveborn newborns discharged alive from the hospital.

Numerator: Newborns who were fed breast milk only since birth.
Denominator: Single term liveborn newborns discharged alive from the hospital.

Numerator: Latch assessments completed and documented at least once per staff shift.
Denominator: Patients who are exclusive breastfeeding.

Numerator: Number of opportunities documented
Denominator: Number of opportunities

Numerator: # of elective c-section cases who have foley catheter removed within 12 hours after delivery.
Denominator: Total number of elective cesareans births.

Numerator: Patient whiteboards completed and updated when necessary throughout staff shift.
Denominator: Total number of whiteboard completion opportunities.

Numerator: Compliance of hand hygiene opportunities.
Denominator: Total number of hand hygiene opportunities.

Numerator: Total number of days with central line-associated bloodstream infections.
Denominator: Total number of patient days.

Numerator: Total number of days with Ventilator-Associated Pneumonia.
Denominator: Total number of patient days.

Numerator: Total babies who received any breastmilk.
Denominator: Babies admitted into the NICU. EXCLUDES:

- Babies with exclusive formula preference from their mother.
- Observation admissions with less than 4 hours in NICU.
- Transfers out of the NICU before first feeding.
- Expiration prior to first feeding.

Numerator: Compliance of hand hygiene opportunities.
Denominator: Total number of hand hygiene opportunities.

Numerator: Total number of patients who had Pediatric Early Warning Scores documented.
Denominator: Total number of patients.

Numerator: Total number of patient falls.
Denominator: Total number of patient days.

Numerator: Total number of completed opportunities for patient ambulation.
Denominator: Total number of patient ambulation opportunities. Excluding patients less than 18 months old.

Numerator: Total number of completed opportunities for patient life activities.
Denominator: Total number of patient life activity opportunities. Excluding patient less than 3 months old.

Numerator: Total number of days with central line-associated bloodstream infections.
Denominator: Total number of patient days.

Numerator: Compliance of hand hygiene opportunities.
Denominator: Total number of hand hygiene opportunities.

Labor and Delivery Early Elective Delivery

Goal: The goal is to have zero early elective deliveries.	**Med Staff Champion: Dr. Betre/Banks**	**Subject Experts: Laura Robertson**	**Time Period: Jan 2024 – Jun 2024**
Team Leader: Laura Robertson	**Team members: All OB Providers**		**Revision (date): 07/16/24**
PI Liaison:			**Revision #: 1**

PLAN (DEFINE/MEASURE/ANALYZE)

Background/Problem Statement:
Patients with an induction or cesarean procedure prior to labor including patients with 37/38 week deliveries, excluding those with a condition justifying an elective delivery (per The Joint Commission) or a history of prior stillbirth IF induction or cesarean performed in current delivery.

Current Condition: YTD 5.0%
2023 Total = 5.0%
Jan – Mar 2024 = 5.8%
Apr = 6.4%
May – Jun 2024 = (not available, California Maternal Quality Care Collaborative operates about 8 weeks behind)

Target / Goal: 0%

Problem Analysis / Root Cause, Gap:

1. There is no stop gap when a provider calls to schedule an early elective delivery.
2. There are issues with diagnostic coding.

DO

Countermeasure / Action Plan / Solutions:
01/23/24 – 3rd meeting. Discussed scheduling a meeting with Maternal Fetal Medicine as they recommend early elective deliveries for obesity, hypertension, etc.
02/20/24 – reviewed specific cases with requests to have individual providers review their documentation, noted issue with diagnostic coding may be causing fallouts
04/16/24 – review of quality improvement data (all of MCH)
05/21/24 – reviewed specific cases, continue to see issues with coding, information to be provided at the next OB Committee meeting
07/16/24 – review of quality improvement data (all of MCH)

CHECK

Results / Metrics:
We will continue to monitor compliance.

ACT / ADJUST

Follow-Up / Sustainability:
Working to correct potential issues with coding.
Working to establish checks and balances with scheduling to ensure proper diagnosis for early deliveries.
We will continue to monitor for compliance.

Kaweah Health

Labor and Delivery Nullip Term Singleton Vertex: PC-02

Goal: The goal is to have ≤23.6% cesarean deliveries for this population.	**Med Staff Champion: Dr. Betre/Banks**	**Subject Experts: Laura Robertson**	**Time Period: Jan 2024 – Jun 2024**
Team Leader: Laura Robertson	**Team members: All OB Providers**		**Revision (date): 07/16/24**
PI Liaison:			**Revision #: 1**

PLAN (DEFINE/MEASURE/ANALYZE)

Background/Problem Statement:
Working to reduce the cesarean section rate for the lowest risk patient population, the nulliparous term singleton vertex patient.

Current Condition: FYTD 26.2%
2023 Total = 25.9%
Jan – Mar 2024 = 26.5%
Apr = 29.2%
May – Jun 2024 = (not available, California Maternal Quality Care Collaborative operates about 8 weeks behind)

Target / Goal: To have a ≤23.6% cesarean delivery rate for this patient population.

Problem Analysis / Root Cause, Gap:

1. Most common reason for fallout is Induced Labor (25.1%)
2. Staff need further education on appropriate induction process and communication with providers.

DO

Countermeasure / Action Plan / Solutions:
02/20/24 – reviewed specific cases, evaluated commonalities between fallouts
04/16/24 – review of quality improvement data (all of MCH)
05/21/24 – reviewed specific cases, continue to see issues inductions of labor
07/16/24 – review of quality improvement data (all of MCH)

- Added a celebration board for staff to indicate when they have a successful NTSV vaginal delivery.
- Added a Labor Comfort Cart to provide more tools for the nurses to assist patients in achieving a vaginal delivery.
- Provided education on supporting vaginal births to licensed staff.

CHECK

Results / Metrics:
We will continue to monitor reports for compliance rates.

ACT / ADJUST

Follow-Up / Sustainability:
Educator continues to meet with staff to educate them on best practices and ensure they are up to date on NSTV.

Kaweah Health

Labor and Delivery RASS and Dermatome

Goal: The goal is to have 100% compliance	**Med Staff Champion: Dr. Betre/Banks**	**Subject Experts: Laura Robertson**	**Time Period: Jan 2024 – Jun 2024**
Team Leader: Laura Robertson	**Team members: All L&D RNs**		**Revision (date): 07/16/24**
PI Liaison:			**Revision #: 1**

PLAN (DEFINE/MEASURE/ANALYZE)

Background/Problem Statement:
There was a Joint Commission finding that we were not compliant with Epidural order set in documenting RASS and Dermatome assessment with an epiduralized patient. This measure looks at how many opportunities to chart RASS and Dermatomes within the order parameters when a patient has an epidural and how many were compliant. All RNs with an epiduralized patient should be charting RASS and Dermatomes per the order set.

Current Condition:
FYTD = RASS 95.40% Dermatome 95.75%
Jan – Mar 2024 = RASS 99.08% Dermatome 99.17%
Apr – Jun 2024 = RASS 100% Dermatome 100%

Target / Goal: 100%

Problem Analysis / Root Cause, Gap:

1. There was lack of understanding of appropriate charting with an epiduralized patient.

DO

Countermeasure / Action Plan / Solutions:

- Analyzed order sets and policy to ensure we were following best practice.
- Reviewed charting and worked with ISS to make charting location more visible and adding forced cells to assist with compliance
- Created charting guide to ensure expectations were clear.
- Began auditing by RN in October to ensure auditing was being done with a full understanding of the clinical picture.
- Discussions with RNs out of compliance, initiating correction as needed
- In November began celebrating RNs with 100% compliance
- Added RASS and Dermatome to the 2024 Annual Competency validation. This resulted in three months of 100% compliance and added focus to the measure.

CHECK

Results / Metrics:
We will continue to monitor compliance.

ACT / ADJUST

Follow-Up / Sustainability:

We will continue to monitor for compliance.

Labor and Delivery Scheduled Inductions Not Delayed

Goal: The goal is to have 95% of inductions started timely	**Med Staff Champion: Dr. Betre/Banks**	**Subject Experts: Laura Robertson**	**Time Period: Jan 2024 – Jun 2024**
Team Leader: Laura Robertson	**Team members: All OB Providers**		**Revision (date): 07/16/24**
PI Liaison:			**Revision #: 1**

PLAN (DEFINE/MEASURE/ANALYZE)

Background/Problem Statement:
Scheduled inductions experiencing delay in the initiation of induction medications. Resulting in prolonged patient stay and an increase in patient census.

Current Condition: FYTD 81%
2023 FYTD (July – December 2023) – 83.2%
Jan – Mar 2024 = 79.95%
Apr – Jun 2024 = 77.80%

Target / Goal: To have 95% of all induction medications started within 1 hour of admission.

Problem Analysis / Root Cause, Gap:

1. Delays due to provider not seeing patients and orders not placed in a timely manner.
2. Delays due to short staffing and high census.

DO

Countermeasure / Action Plan / Solutions:

- Staff education on initiating orders in a timely manner. Instructed to call providers right away to let them know their patient is admitted and orders are needed.
- Working with providers to have them come see induction patients in a timely manner.
- Working to increase staffing, 14 RNs hired in 2023 and 15 have started or will start in 2024.

CHECK

Results / Metrics:
We will continue to monitor compliance.

ACT / ADJUST

Follow-Up / Sustainability:
We will continue to follow-up on individual fallouts with both staff and providers.

Kaweah Health

Labor and Delivery Severe Unexpected Complications in Term Newborns: PC-06.1

Goal: The goal is to have ≤5%	**Med Staff Champion: Dr. Betre/Banks**	**Subject Experts: Laura Robertson**	**Time Period: Jan 2024 – Jun 2024**
Team Leader: Laura Robertson	**Team members: All OB Providers**		**Revision (date): 07/16/24**
PI Liaison:			**Revision #: 1**

PLAN (DEFINE/MEASURE/ANALYZE)

Background/Problem Statement:
Working to reduce the cesarean section rate for the lowest risk patient population, the nulliparous term singleton vertex patient.

Current Condition: FYTD 6.75%
2023 Total = 9.80%
Jan – Mar 2024 = 7%
Apr = 0%
May – Jun 2024 = (not available, California Maternal Quality Care Collaborative operates about 8 weeks behind)

Target / Goal: To have a ≤5% severe unexpected complications in term newborns.

Problem Analysis / Root Cause, Gap:
This measure addresses this gap and gauges adverse outcomes resulting in severe or moderate morbidity in otherwise healthy term infants without preexisting conditions. This measure also uses length of stay (LOS) modifiers to guard against over coding and under coding of diagnoses. Importantly, this metric serves as balancing measures for other maternal measures such as NTSV Cesarean rates and early elective delivery rates. The purpose of a balancing measure is to guard against any unanticipated or unintended consequences of quality improvement activities for these measures.

DO

Countermeasure / Action Plan / Solutions:
02/20/24 – reviewed specific cases, evaluated commonalities between fallouts
04/16/24 – review of quality improvement data (all of MCH)
05/21/24 – reviewed specific cases, seeing connections between these cases and inductions and NTSV cesarean sections
07/16/24 – review of quality improvement data (all of MCH)

CHECK

Results / Metrics:
We will continue to monitor reports for rates.

ACT / ADJUST

Follow-Up / Sustainability: Continue working and collaborating with our OB Improvement and MCH Quality Improvement Committee's to ensure case reviews and to identify areas of improvement.

Kaweah Health

MOTHER BABY EARLY URINARY CATHETER REMOVAL

Goal: Early Urinary Catheter Removal Compliance goal is 100%	**Med Staff Champion: Dr. Betre/Banks**	**Subject Experts: Stephanie Genetti and Cassandra Sanchez**	**Time Period: January- June 2024**
Team Leader: Stephanie Genetti	**Team members: All Staff**		**Revision (date): 07/15/2024**
PI Liaison:			**Revision #: 1**

PLAN (DEFINE/MEASURE/ANALYZE)

Background/Problem Statement: Early urinary catheter removal: % of elective scheduled C-section cases who have foley catheter removed within 12 hrs after delivery.

Current Condition: YTD 88.3%
2023 YTD 75.84%
Jan-Mar 2024 87%
Apr-Jun 2024 90%

Target / Goal: 100%

Problem Analysis / Root Cause, Gap:
Staff are not documenting the Early Catheter Removal in the correct location.

DO

Countermeasure / Action Plan / Solutions:
January-June 2024: Unit Based Council continues to audit 50 random patient charts. Findings are then reported and team is notified via meeting minutes. Staff are directed to be increasingly diligent and reminders have been added to staff huddles and weekly newsletters.
March-May 2024: Manager sent emails containing continued education power point to staff identified with "fallouts" staff were directed to respond with questions/concerns/barriers to compliance.

CHECK

Results / Metrics:
Goal was not met for either 1st or 2nd quarter of calendar year 2024.

ACT / ADJUST

Follow-Up / Sustainability:
Mother Baby leadership is auditing 100% of all elective scheduled c-sections to evaluate opportunities for improvement.

Kaweah Health

Mother Baby Bar LATCH Assessments

Goal: The goal is 100% of our patients who are exclusively breastfeeding will have a LATCH assessment documented at least once per shift.	**Med Staff Champion: Dr. Betre/Banks**	**Subject Experts: Stephanie Genetti and Cassandra Sanchez**	**Time Period: January –June 2024**
Team Leader: Stephanie Genetti	**Team members: All Staff, UBC**		**Revision (date): 07/15/2024**
PI Liaison:			**Revision #: 1**

PLAN (DEFINE/MEASURE/ANALYZE)

Background/Problem Statement:
The goal is 100% of our patients who are exclusively breastfeeding will have a LATCH assessment documented at least once per shift as required per our standards of care following California Department of Public Health Model Hospital Policy, excluding any patients that are formula feeding only.

Current Condition:
2023 YTD 69.5%
Jan-Mar 2024 80%
Apr-June 2024 85.33%

Target / Goal: 100%

DO

Countermeasure / Action Plan / Solutions:
Jan 2024: Intervention- education to staff via huddles and Unit Based Council meeting minutes continues.
February-March 2024: Lactation team working with staff to address Latch score audits (50) per month with findings reported via Unit Based Council. Repeat offenders for non-compliance addressed individually.
Apr- June 2024: Annual Competency Validation incudes nursing staff direction to provide evidence of daily work to substantiate correct scoring for accuracy and frequency of LATCH Assessment.
Ongoing: Staff now directed to remind oncoming staff during bedside report to confirm latch score is completed. Hold one another accountable and include lactation for tracking of trends. During the last hour of the shift, the LVN will audit charts and notify RN's if latch score still need to be charted. Audits identified through 2024 annual competency notes fallouts for patients who discharge early in the shift. Manager has implemented conversations with staff to address trends/gaps as a warning prior to implementing discipline.
Unit Based Council/Charge Nurse and Team Lead staff have all been included in problem solving and compliance.
July 2024: suggest case review presentation from identified "fallout" staff to present at UBC via case review format to discuss barriers to compliance.

CHECK

Results / Metrics:
Goal not met

Kaweah Health

Mother Baby Bar LATCH Assessments

	Problem Analysis / Root Cause, Gap: Staff note the patients do not call for every feeding and in turn some opportunities to assess are lost. Staff referenced further it was not clear that this was an “assessment”.		
		ACT / ADJUST	**Follow-Up / Sustainability:** We will continue to monitor for compliance. LATCH is reported monthly to all staff via UBC minutes to establish team methods for process improvement. Lactation team is also partnering for additional reinforcement and available for remediation should lack of education/competency be identified as a concern.

Kaweah Health

Mother Baby RASS Scoring

Goal: Richmond Agitation Sedation Scale must be assessed within 60 minutes of giving an oral narcotic medication.	**Med Staff Champion: Dr. Betre/Banks**	**Subject Experts: Stephanie Genetti and Cassandra Sanchez**	**Time Period: January- June 2024**
Team Leader: Stephanie Genetti	**Team members: All Licensed Staff**		**Revision (date): 07/15/2024**
PI Liaison:			**Revision #: 1**

PLAN (DEFINE/MEASURE/ANALYZE)

Background/Problem Statement:

This measure looks at compliance of the Licensed Nurse documenting the Richmond Agitation Sedation Scale (RASS) of a patient within 60 minutes of administering an oral narcotic medication. The follow up from the Licensed Nurse must be documented using the RASS scoring 100% of the time.

Current Condition: YTD 98.3%

YTD 2023 59.33%
Jan-Mar 2024: 97%
Apr-Jun 2024: 100%

Target / Goal: 100%

Problem Analysis / Root Cause, Gap:

Staff were not charting the RASS scoring assessment timely.

DO

Countermeasure / Action Plan / Solutions:

Identification of compliance through reports and auditing.
January-June 2024: Mother Baby's Unit Based Council audited 50 random charts each month and presented findings to share with the team.
Ongoing: Licensed Vocational Nurse have been effectively utilized to complete daily audits. The Licensed Vocational Nurse notifies Registered Nurse if there are any RASS scores that remain outstanding. Continued Increase in compliance and consistency have been noted. The assessment has become standard practice and staff continue to hold one another accountable. Reminders are periodically included in team huddles and weekly updates. This metric was also included in the team's 2024 Annual Competency where evidence of daily work was substantiated by approved validators to ensure accuracy and consistency. For consecutive misses from staff, Manager is implementing discipline/conversations and use of case study for additional education.

CHECK

Results / Metrics:

2nd Quarter 2024 goal was met.

Mother Baby RASS Scoring

		ACT / ADJUST	**Follow-Up / Sustainability:** We will continue to monitor and report findings via Unit Based Council minutes to the team monthly.

Neonatal Intensive Care Unit (NICU)- Breast Milk for NICU Babies

Goal: 100% of qualifying NICU patients receive any/some breast milk during their hospital admission to the NICU.	**Med Staff Champion: Dr. Dosado**	**Subject Experts: Felicia Vaughn, Daniel Castaneda, Mary Dieterle**	**Time Period: January 2024- July 2024**
Team Leader: Felicia Vaughn	**Team members: All Staff**		**Revision (date): 7/12/2024**
PI Liaison:			**Revision #:**

PLAN (DEFINE/MEASURE/ANALYZE)

Background/Problem Statement:
This measure looks at the total number of qualifying patients who receive breastmilk during any point of their NICU admission.

Exclusion Criteria:
Exclusive formula preference from mother, observation admissions with less than 4 hours in the NICU, transfers out of the NICU before the first feeding and expiration of life prior to first feeding.

Current Condition: Currently at our highest compliance rate since metric tracking began- 96.9%
July- Sept 2023 = 91.5%
Oct- Dec 2023= 92.9%
Jan- June 2024= 96.9%

Target / Goal: 100%

Problem Analysis / Root Cause, Gap:

- NICU admission challenge mothers from providing exclusive breast milk due to separation from their infant(s).

DO

Countermeasure / Action Plan / Solutions:

- Early lactation support for mothers with breastfeeding preference on admission. - Dedicated Lactation Nurse stationed in the NICU five days a week.
- Acknowledge and recognize mothers who provide expressed breast milk for their infant(s).

CHECK

Results / Metrics:

- Month of April 2024 the unit achieved 100% compliance.
- This goal is reasonable and attainable.

ACT / ADJUST

Follow-Up / Sustainability:

- Continue to support families that wish to provide breast milk for their infants.

Kaweah Health

Pediatrics Alaris Pump IV fluids

Goal: Alaris Pump Pediatric Drug library utilized 95% of the time of every Peds fluid infusion	**Med Staff Champion: Dr. Maccalli**	**Subject Experts: Danielle Grimaldi and Linda Ellison**	**Time Period: January 2024-June 2024**
Team Leader: Danielle Grimaldi	**Team members: All Staff**		**Revision (date): 7/17/2024**
PI Liaison:			**Revision #: 1**

PLAN (DEFINE/MEASURE/ANALYZE)

Background/Problem Statement:
This measure looks at how many times Pediatric drug guardrails are utilized during all Pediatric IV fluid infusions.

Current Condition: YTD 93.75 %
January-March 2024= 95.6%
April-June 2024= 91.89%

Target / Goal: 95%

Problem Analysis / Root Cause, Gap:
Continue to ensure the team is compliant by running reports and holding staff accountable to usage.

DO

Countermeasure / Action Plan / Solutions:
Identification of usage and compliance through reports. Ensure all fluids running on the Pediatric floor is utilizing Pt Fin number. This will help to delineate which Pediatric fluids are utilized outside the drug library on Peds and in the ED. Licensed staff must enter correct FIN number to help narrow down personnel administering IV fluids outside guardrails on each unit.

CHECK

Results / Metrics:
Goal met 1st quarter 2024.

ACT / ADJUST

Follow-Up / Sustainability:
We will continue to monitor for compliance. Will meet individually with nurses until compliance increases.

Kaweah Health

Child Life Activities

Goal: 90% compliance in documenting a Child Life Activity opportunity during each shift.	**Med Staff Champion: Dr. Maccalli**	**Subject Experts: Danielle Grimaldi and Linda Ellison**	**Time Period: January 2024-June 2024**
Team Leader: Danielle Grimaldi	**Team members: All Staff**		**Revision (date): 07/17/2024**
PI Liaison:			**Revision #: 1**

PLAN (DEFINE/MEASURE/ANALYZE)

Background/Problem Statement:
This measure looks at how many pediatric patients engaged in a Child Life Activity and it was documented each shift.

Current Condition: YTD 74.5 %
January-March 2024 = 59%
April-June 2024= 90%

Target / Goal: 90%

Problem Analysis / Root Cause, Gap:
This is a new quality measure for us in regards to documentation. Patients are frequently in the Play room or playing in their rooms but it is not being documented by staff. Patients are frequently sick during early admission, and we fail to document patient's inability to participate in Child Life Activities early in their disease process.

DO

Countermeasure / Action Plan / Solutions:
Added documentation checks to daily Charge Nurse duties to address in the moment.
Documentation workflow updated to increase compliance with documentation

CHECK

Results / Metrics:
Goal met 2nd quarter 2024.

ACT / ADJUST

Follow-Up / Sustainability:
We will continue to monitor for compliance. We will educate to documentation more frequently using audits as a tool.
Documentation workflow recently updated and charting compliance has improved since workflow updated.

Kaweah Health

Patient Ambulation

Goal: 90% compliance in documenting a Patient Ambulation opportunity.	**Med Staff Champion: Dr. Maccalli**	**Subject Experts: Danielle Grimaldi and Linda Ellison**	**Time Period: January 2024-June 2024**
Team Leader: Danielle Grimaldi	**Team members: All Staff**		**Revision (date): 07/17/2024**
PI Liaison:			**Revision #: 1**

PLAN (DEFINE/MEASURE/ANALYZE)

Background/Problem Statement:
This measure looks at how many pediatric patients had the opportunity to ambulate each shift.

Current Condition: YTD 65%
January-March 2024 = 53%
April-June 2024= 77%

Target / Goal: 90%

Problem Analysis / Root Cause, Gap:
This is a new quality measure for us in regards to documentation. Patients are ambulating in the room, but staff are not documenting it appropriately. Patients are frequently sick during early admission and we fail to document patient's inability to ambulate early in the disease process.

DO

Countermeasure / Action Plan / Solutions:
Added documentation checks to daily Charge Nurse duties to address in the moment. Documentation workflow updated to increase compliance with documentation.

CHECK

Results / Metrics:
Goal Not Met

ACT / ADJUST

Follow-Up / Sustainability:
We will continue to monitor for compliance. We will educate to documentation more frequently using audits as a tool. Documentation workflow recently updated and charting compliance has improved since workflow updated.

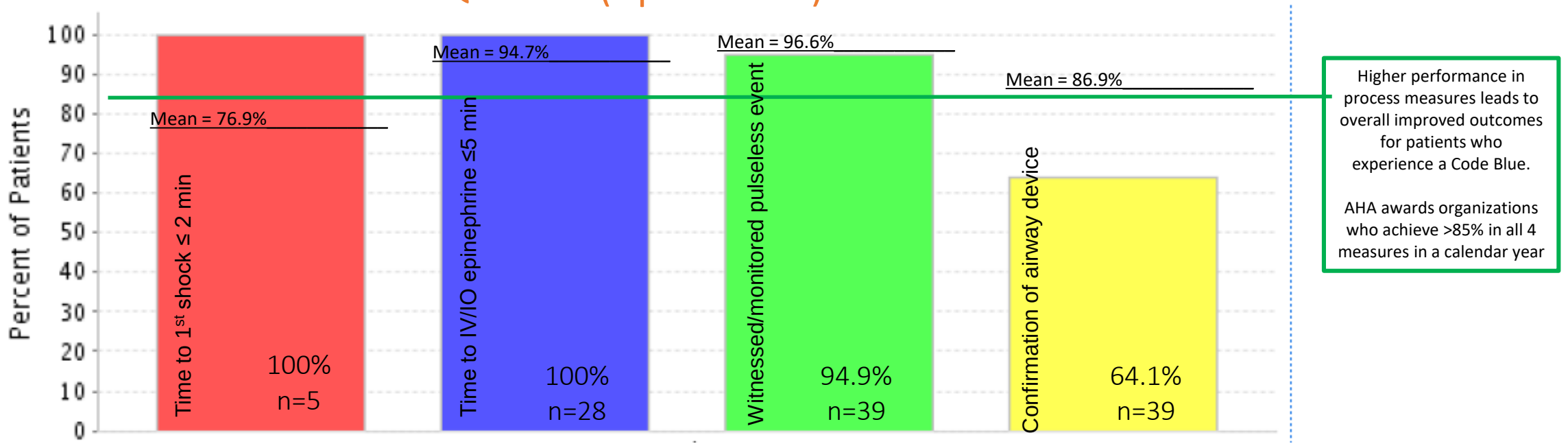
RRT/Code Blue QCOMM Report

Q2 2024

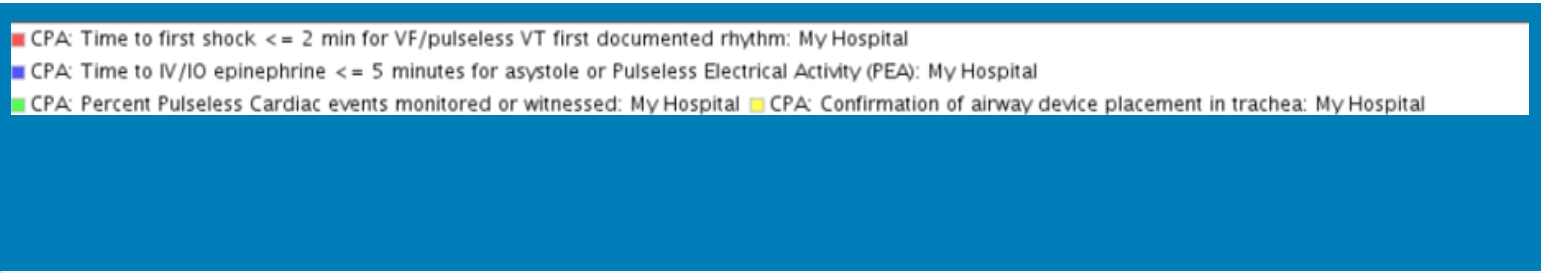
Shannon Cauthen

KH Code Blue Process Measures
Get With the Guidelines

Q2 2024 (April - June)



Mean = National mean of all hospitals that participate in AHA GWTG registry July 2023 - June 2024



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RRT and Resuscitation Scorecard

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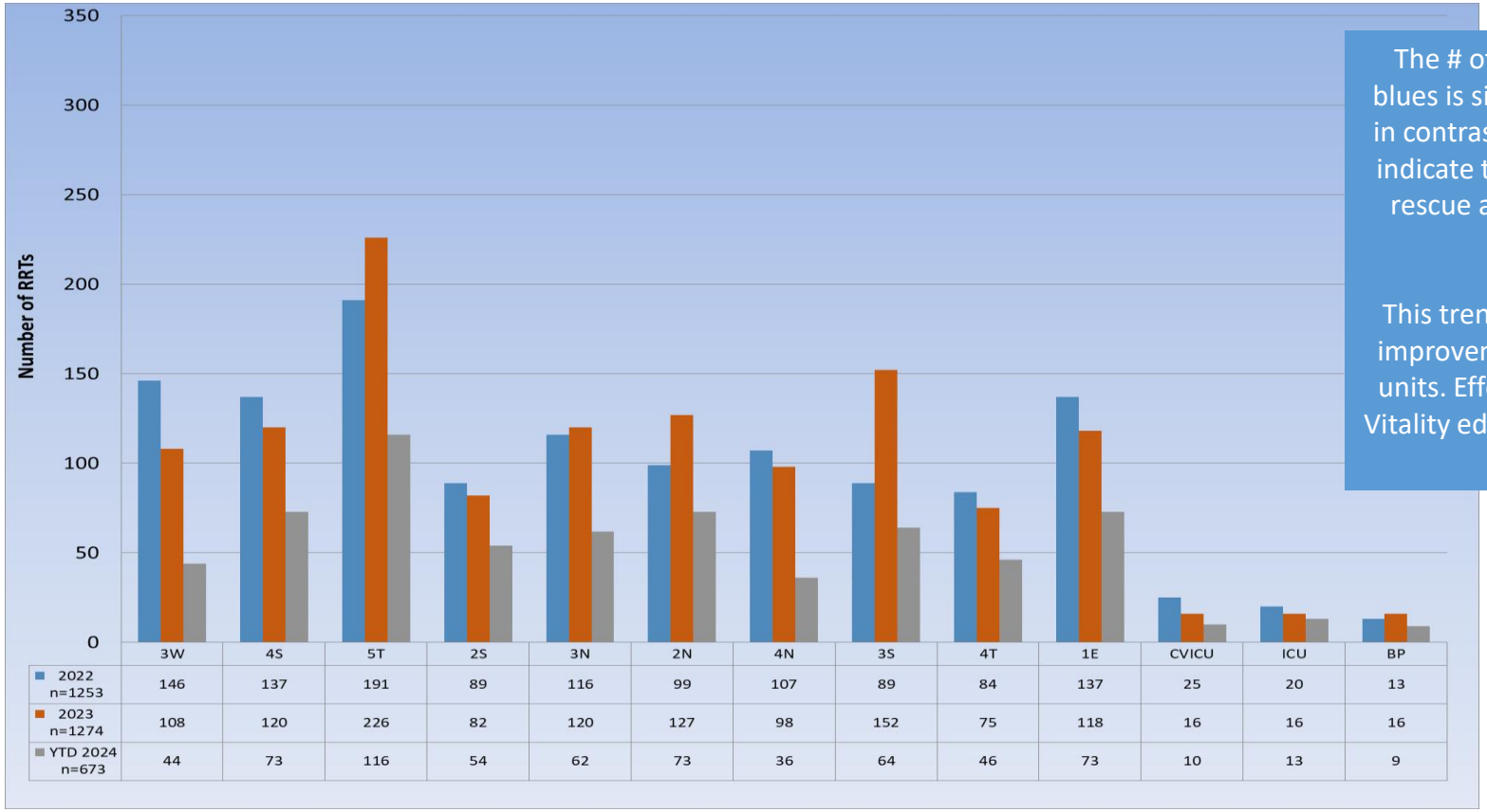
RRT & Code Blue Dashboard

Code Blue Data	All GWTG Hospitals Mean - CY 2023 (updated for 2Q24 data)	CY 2023 Baseline Mean	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Mean (Rolling 12 months)
Total Code Blues (Med/Surg/ICCU/CC)		11	7	9	9	7	11	21	13	8	12	12	9	22	12
Code Blues per 1000 Discharges Med Surg/ICCU		4	3	2	3	4	3	9	4	2	6	3	3	7	4
Code Blues per 1000 Discharges Critical Care		5	2	5	4	2	5	7	6	4	4	6	4	9	5
Percent of Codes in Critical Care	66% (↑ is better)	58%	43%	67%	56%	29%	64%	43%	62%	63%	42%	67%	56%	55%	54%
Event Survival Rates		63%	71%	44%	56%	57%	73%	67%	69%	75%	58%	50%	67%	82%	64%
Code Blue: Survival to Discharge	26% (↑ is better)	24%	14%	33%	56%	14%	9%	10%	15%	13%	25%	8%	22%	18%	20%
Deaths from Cardiac Arrest (expired during event)		4	2	5	4	3	3	7	4	2	5	6	3	4	4
Overall Hospital Mortality Rate		2.70	1.9	1.79	2.69	2.45	3.09	3.25	3.62	2.65	3.27	2.71	2.59	2.63	2.72
RRT Data			Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Mean
Total RRTS		110	125	103	87	115	119	128	148	117	119	107	120	90	115
RRTs per 1000 Patient Discharge Days		89	98	79	71	100	93	99	114	93	94	81	88	66	90
RRT Mortality	16% (↓ is better)	19%	13% n=16	17% n=17	13% n=11	23% n=25	22% n=23	24% n=28	20% n=26	12% n=13	28% n=31	20% n=21	17% n=20	17% n=15	19%
RRTs Within 24 hours of Arriving to Inpatient Unit	15% (↓ is better)	27%	26% n=32	30% n=31	25% n=22	26% n=30	23% n=27	25% n=32	20% n=30	23% n=27	13% n=16	19% n=20	23% n=28	32% n=29	24%
RRT- Med-Surg to Intermediate Critical Care Transfers	*9%	21%	22% n=27	22% n=23	20% n=17	23% n=26	13% n=16	21% n=27	18% n=26	22% n=19	19% n=23	21% n=22	20% n=24	10% n=9	19%
RRT- Med-Surg to Critical Care Transfers	*29%	9%	12% n=15	9% n=9	11% n=10	7% n=8	11% n=13	6% n=8	7% n=11	8% n=9	9% n=11	5% n=5	5% n=6	10% n=9	8%
RRT-Intermediate Critical Care to Critical Care Transfers	*33%	9%	6% n=8	9% n=9	14% n=12	12% n=14	6% n=7	9% n=12	10% n=15	3% n=4	13% n=12	5% n=5	7% n=8	6% n=5	8%

Better than Target | Does not meet Target | *Direction of goal is not being established

RRTs by Location

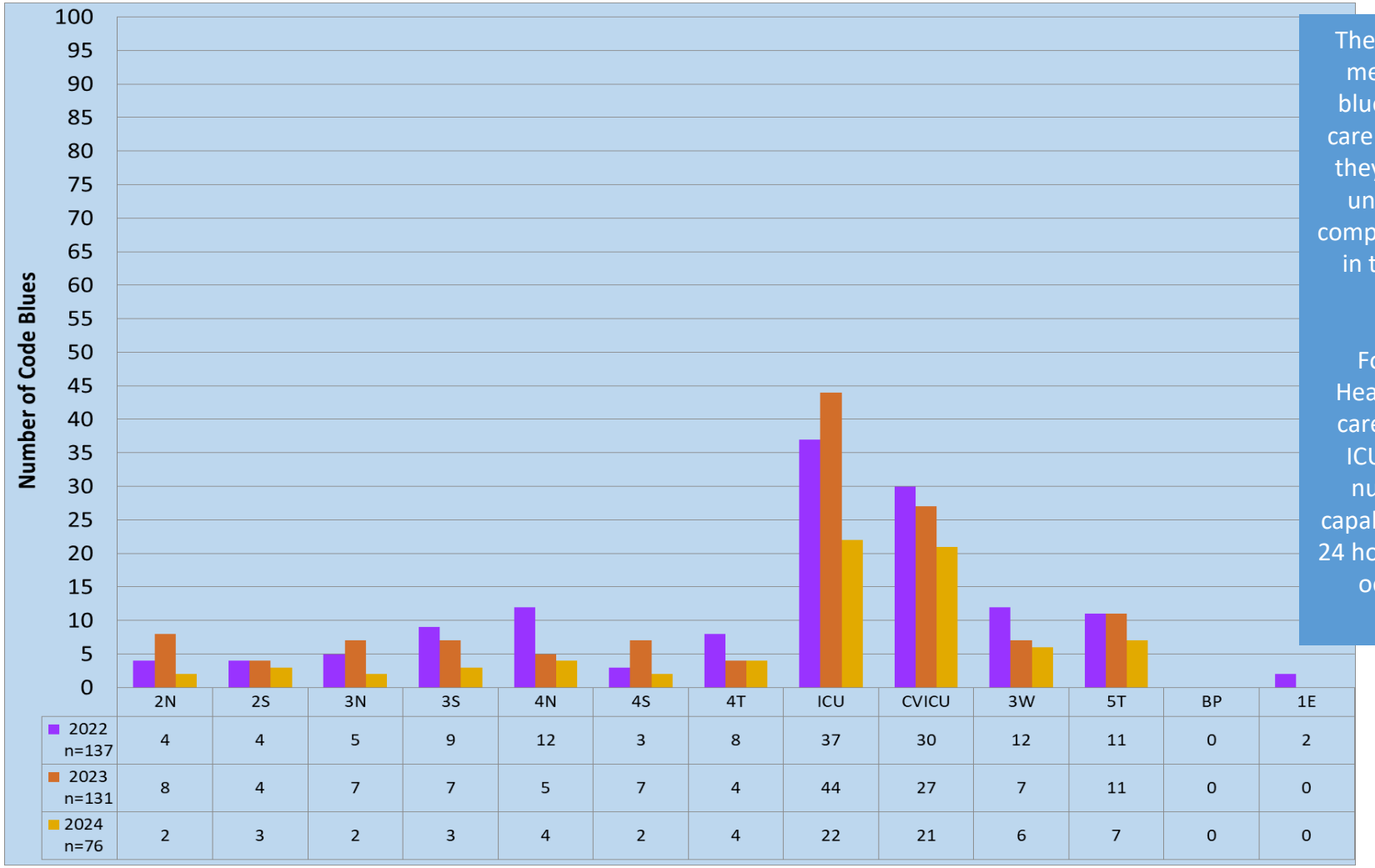


	3W	4S	5T	2S	3N	2N	4N	3S	4T	1E	CVICU	ICU	BP
2022 n=1253	146	137	191	89	116	99	107	89	84	137	25	20	13
2023 n=1274	108	120	226	82	120	127	98	152	75	118	16	16	16
YTD 2024 n=673	44	73	116	54	62	73	36	64	46	73	10	13	9

The # of RRTs contrasted with the # of code blues is significant if there are a low # of rapids in contrast to a high # of code blues. This *could* indicate that we are missing an opportunity to rescue a patient and that could lead to poor outcomes.

This trend is monitored and opportunities for improvement are addressed with the involved units. Efforts include: sim lab time, 10 Signs of Vitality education and RRT nurse participation at unit staff meetings.

Code Blues by Location



	2N	2S	3N	3S	4N	4S	4T	ICU	CVICU	3W	5T	BP	1E
2022 n=137	4	4	5	9	12	3	8	37	30	12	11	0	2
2023 n=131	8	4	7	7	5	7	4	44	27	7	11	0	0
2024 n=76	2	3	2	3	4	2	4	22	21	6	7	0	0

The American Heart Association measures our percent of code blues that occur inside a critical care unit. For reporting purposes, they only consider a critical care unit to be the ICU/CVICU. Our compliance with this measurement in the past rolling 12 months is 54%.

For the purposes of Kaweah Health, our intermediate critical cares operate very much like an ICU and include highly trained nurses, advanced monitoring capabilities and intensivist support 24 hours/day. The percent of codes occurring in the critical care division YTD is 74%.

Opportunities for Improvement

Opportunities:

- Decrease the number of RRTs within 24 hours of admission.
  - Potential Root Causes
    - Improper level of care placement upon admission

Action Plan:

- Trial of ER-STOP (Research project for DNP student)
  - Implements re-evaluation of boarded patients every 2 hours using Risk Assessment Score (MEWS)
  - Trial period: September 1st-30th

Upcoming Projects

- Sidewalk CPR at Tulare County Fair, September 13th from 1100-2000

- Re-establish RRT partners
  - Each RRT nurse partners with an inpatient unit to provide education, additional rounding and support with clinical/education needs

Celebrations!

American Heart Association.

American Heart Association. Get With The Guidelines. Resuscitation

The American Heart Association proudly recognizes

Kaweah Delta Health Care District
Visalia, CA

Get With The Guidelines® - Resuscitation GOLD

Achievement Award Hospital
Adult

The American Heart Association recognizes this hospital for its continued success in using the **Get With The Guidelines®** program.

Thank you for applying the most up-to-date evidence-based treatment guidelines to improve patient care and outcomes in the community you serve.*

Nancy Brown
Chief Executive Officer
American Heart Association

Joseph C. Wu, MD, PhD, FAHA
President
American Heart Association

*For more information, please visit Heart.org/GWTGQualityAwards.

In recognition of 2 consecutive years of cumulative compliance >85%!

The pursuit of healthiness

Kaweah Health
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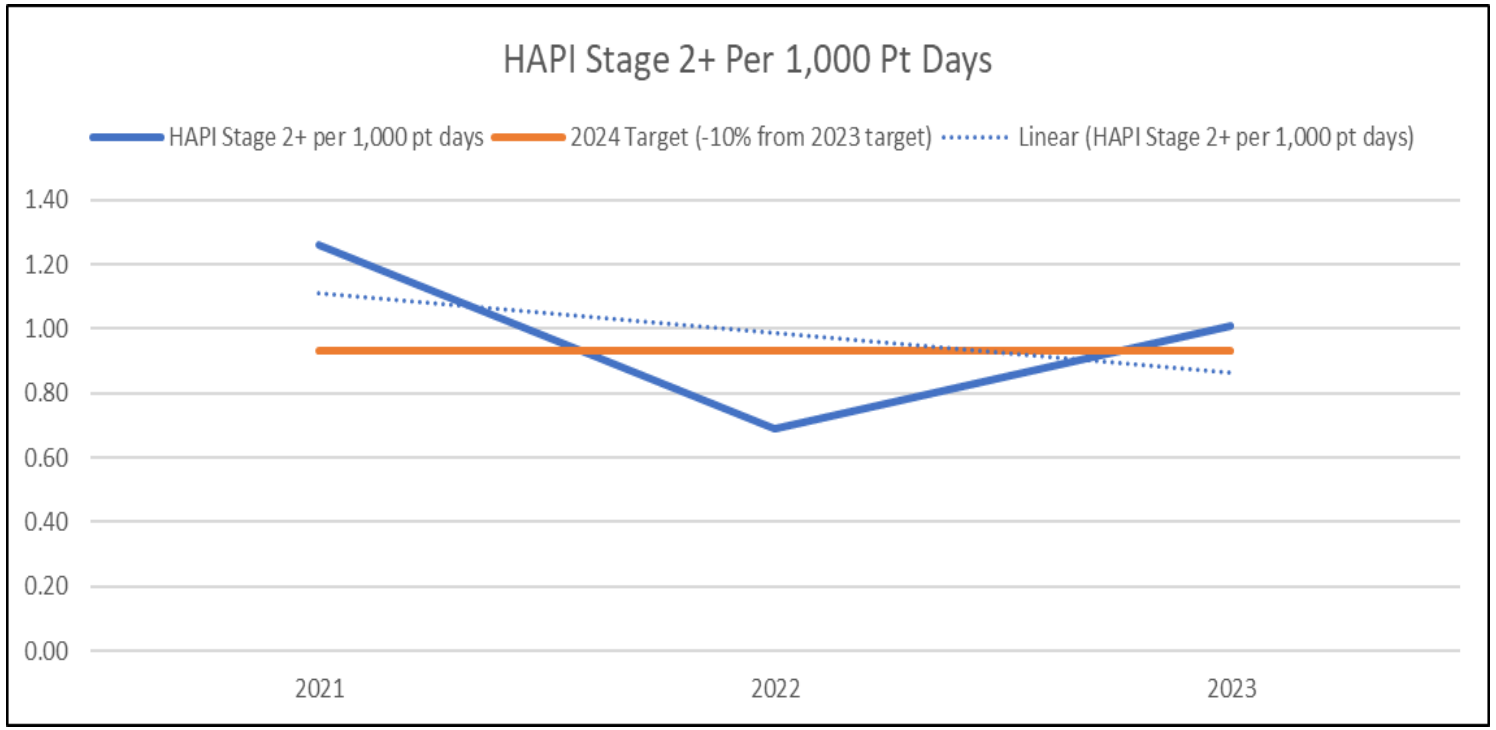
PATIENT SAFETY PRIORITY

Hospital Acquired Pressure Injury (HAPI) Reduction Initiative

Patient Safety Committee
August 2024

HAPI Reduction Annual Plan



2024 GOAL

HAPI Stage 2+ per 1,000 pt days will be reduced to 0.93. This is an internal target set by the committee based on a 10% decrease from the previous calendar year.

2024 PLAN

High Level Action Plan

- Staff performing complete skin assessments
- Care plans (IPOC) present to help drive preventative care
- Complete wound documentation complete (measurements, description of wound)
- Consistent documentation of preventative measures & basic hygiene/care
- Addressing competency/knowledge gaps: Identifying advanced HAPIs, recognizing wounds in a timely manner, and preventative interventions through required Wound Care Classes

HAPI Reduction Monthly Update

Number of Fall Outs

- In June and July, there were 18 and 10 (respectively) HAPI Stage 2+

Targeted Opportunities (based on fallouts)

1. Staff not performing complete skin assessments, no IPOC present to help drive preventative care, wound documentation incomplete (measurements, description of wound), inconsistent documentation of preventative measures
2. Basic hygiene/care not done – bathing, Intake and Output, Nutrition monitoring
3. Device associated HAPIs which accounted for 39% (31/79) HAPIs from Jan-July 2024
4. Not identifying advanced HAPIs (unstageable, Stage 3 & 4): Not recognizing wounds in a timely manner when interventions may be more effective and preventative, knowledge gap
5. Lack of availability of wound classes: lack of education provided to newly hired staff/documentation of competencies.

HAPI Reduction Monthly Update

Current Improvement Activities

1. Development of a HAPI response plan established through the HAPI (Hospital Acquired Pressure Injury) committee: patient care directors to join HAPI committee with executive sponsor to develop improvement strategies to improve targeted opportunities
    a. Initial meeting with the leadership team to discuss potential strategies (8/14/2024)
    b. Director of Nursing Practice and Advanced Practice Nurses begin research to develop a global HAPI prevention plan (8/21/2024)
    c. Review first draft global HAPI prevention plan with nursing leadership team (9/3/2024)
    d. Approve completed global HAPI prevention plan at HAPI committee (9/9/2024)
    e. Present completed global HAPI prevention plan to Patient Care Leadership (9/16/2024)
    f. Present HAPI reduction update with initiated global action plan to Patient Safety Committee (9/23/24)

- We will know these actions have been successful when (MOS):
    a. Outperform the benchmark for HAPI stage 2+ per 1000 patient days. YTD through June 1.69 Benchmark 0.93

2. Current action that will ensure care planning (IPOC) and wound documentation will be accurate and complete (include dates of completion)
    a. Emphasize IPOC development and wound documentation in wound class (Begin with Aug. 23rd class)
    b. Future state for IPOC development and more efficient documentation of interventions – project underway with Informatics team
    c. Unit leaders will perform unit based spot checks of expected documentation, remediate staff who are not compliant.

- We will know these actions have been successful when (MOS):
    - Statit report: increase in % of encounters with at risk with IPOC within 14 hours of risk identified. Current: July 28.6%

3. Current actions that will ensure patients have basic hygiene/care provided (include dates of completion)
    a. Actions established as part of global HAPI prevention plan (pending global action plan completion 9/3/24)

- We will know these actions have been successful when (MOS):
    a. Development of a measure of success will be part of the global HAPI prevention plan (9/3/2024)

HAPI Reduction Monthly Update

Current Improvement Activities (continued)

4. Current action that will address respiratory HAPI prevention (include dates of completion)
    a. Respiratory therapy (RT) included the preventative barriers/dressings on clean devices to ensure availability to the RT team for new set ups (8/15/2024)
    b. Preventative measures included a skin section during RT competency fair (8/12/2024)
    c. RT manager will conduct spot checks to ensure preventative barriers/dressings are in place, educating in the moment as needed (8/15/2024)

- We will know these actions have been successful when (MOS):
    a. Outperform the respiratory device associated HAPIs per 1000 patient days benchmark. Benchmark: 0.29 Current: YTD through June 0.40

5. Current actions that address the knowledge gap of timely advanced HAPI identification/recognition (unstageables, Stages 3 and 4) (include dates of completion)
    a. Director of Nursing Practice to attend wound class to ensure education provided emphasizes the identification and stages of HAPIs (8/28/2024) and
    b. Validate consistency of information provided by the wound RNs teaching the wound class (8/28/2024)
    c. Revise wound class curriculum based on identified needs after course observation (9/9/24)

- We will know these actions have been successful when (MOS):
    a. Validate student's knowledge of main course objectives through post-class rounding by APNs, Wound nurses and Unit leaders

6. Current actions that address nursing competency (include dates of completion)
    a. Identify staff who have completed the wound class from NetLearning and Work Day lists (8/21/2024)
    b. Email list of staff who have completed the wound class to leadership to identify staff who need to attend the wound class (8/23/2024)
    c. Prioritize class attendance based on HAPI dashboard underperforming units established through HAPI committee (9/9/2024)

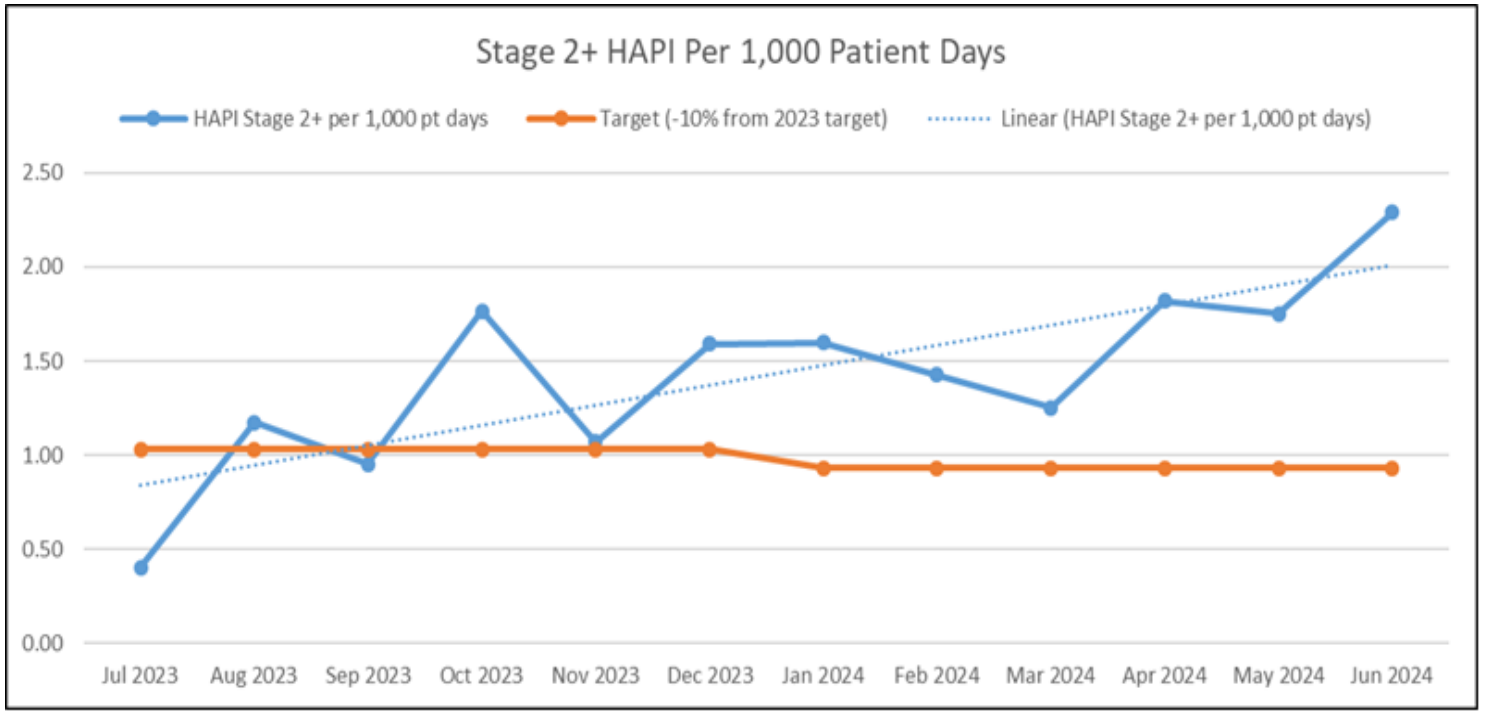
- We will know these actions have been successful when (MOS):
    a. Staff who haven't taken the wound class are registered for the wound class and completed the wound class

HAPI Reduction Monthly Update

Unit Based Initiatives Underway – to be included in global plan for all areas to implement

- Nurses seeking orders for device removal in multidisciplinary rounds.
- Using foam barriers on cervical collars.
- Managers checking for compliance with barriers on devices.
- Progressive mobility programs – critical care and medical surgical units
  - Critical Care go live with changes in October
  - Med/Surg – developing scoring methods with therapy, next update on 9/3/24
- Posting q2hour turn schedules on whiteboards for patients who are self turners, remind patient during hourly rounds.
- Second skin assessment every shift at shift report with two nurses. Check care plans and turn documentation at this time.
- Creation of a wound cart to make products more accessible during patient care.
- Increased stock of pillows on unit to facilitate heel offloading and support for turns (removing barriers for team members).
- Change turning hours to odd hours to avoid confusion of ownership at shift change.
- Charge nurses rounding, spot checking and completing audits. Finding opportunities during the shift for real-time correction.

HAPI Reduction Quarterly Update



PROGRESS ON 2024 PLAN

High Level Action Plan

- Progress will be provided for 3Q24

2024 GOAL

HAPI Stage 2+ per 1,000 pt days will be reduced to 0.93. This is an internal target set by the HAPI committee based on a 10% decrease from the previous calendar year.

Thank you

Live with passion.

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

Kaweah Health