LAC+USC Medical Center Annual Performance Improvement, Patient Safety, & Risk Assessment Evaluation July 2021- June 2022

A. Annual Summary

LAC+USC Medical Center conducts a comprehensive performance improvement and patient safety program. Through its balanced score card, each department establishes goals for each of the five pillars of the LAC+USC Strategic Priorities (Appendix A): Population Health, Value-Based Care and Technology, Quality, Safety & Patient Experience, Workforce, Fiscal Sustainability, and Community. These goals are strategically aligned with LAC+USC Medical Center's mission, vision and values and the Department of Health Services' strategic goals and priorities. The balanced score card model ensures a balanced approach to performance improvement.

B. Balanced Score Card Summary

The balanced score card uses perspectives to integrate performance goals and strategic alignment. LAC+USC Medical Center's leadership modified the traditional perspectives to align around five strategic goals. These goals loosely correlate to a traditional balanced score card approach by focusing on the customer (Population Health, Value Based Care and Technology), a learning and growth perspective (Workforce), an internal processes perspective (Quality, Safety and Patient Experience) a financial perspective (Fiscal Sustainability) and a fifth perspective (Community). Each department and service identifies specific indicators for applicable pillars as the focus for their performance improvement activities. These perspectives align with the Department of Health Services strategic goals.

LAC+USC Medical Center departments embraced the balanced score card perspective and aligned their departmental goals and strategies around the matrixes established by linking the hospital's goals with the Department of Health Services goals. The result is an integrated, organized, strategically focused structure for improving performance and quality. LAC+USC's philosophy is to set targets such that achieving goals is challenging and to modify targets to set higher goals when achievement is attained. Each department embraced this philosophy in a spirit of continuous improvement.

A summary of projects reported to QIC and organized by strategic pillar is as follows:

Population health, Value-Based Care & Technology • Improve Ophthalmology cycle time • Improve access to clinic services by providing wheelchair service to ambulatory patients • Develop transitional hemodialysis pathway to improve transitions in care • Increase use of telehealth visits in ENT • Improve cycle time in the ENT • Improve and standardize workflow for PFSW intake processes in ED • Reduce backlogs in radiology • Improve online platform communication effectiveness to improve patient safety and timely delivery of care • Development of an updated standard surgical blood order schedule • Specialty connect Telax to improve patient access to clinic staff • Improve percentage of EOSS documentation of PRN's for psychiatric patients • Improve efficiency of GI lab • Increase primary care empaneled patient enrollment onto the patient portal • Improve patient access equity and specialty care appointment standardization • Improve efficiency of phlebotomy services • Reduce unnecessary rehab therapy by improving communication with ordering providers	Quality, Safety & Patient Experience • Improve customer's satisfaction and patient relations by reducing the number of formal grievances received • Improve Hand Hygiene compliance in ED • Improve compliance with vaginal packing removal • Reduce skin injury in patients with BiPap • Improve primary team to surgical ICU team post-operative handoff process • Improve organization-wide hand hygiene rates • Decrease falls, hospital acquired pressure injuries and physical assaults on staff • Improve HCAPHS nursing, communication and discharge information • Improve patient experience with nutrition by implementing AAP recommendations for juice intake • Standardize prostate cancer treatment for low and high-risk patients • Reduce CAUTI rates • Decrease time to therapeutic ranch for adult inpatients • Reduce number of OR case cancellations due to hyper/hypo glycemia, stabilize serum glucose levels, decrease NPO time, and increase patient satisfaction • Improve call light response for patients in Burn ICU • Improve accuracy of FAST in TTA cases • Implement ICU liberation bundle • Improve patient experience on medical surgical units

	• Reduce surgical site infection risk • Improve flu vaccine status for patients • Reduce delays in cancer care with better navigation • Decrease emergency RRT/Code blue calls in PCU • Increase utilization of ouchless modalities in Peds • Standardize opioid safety • Improve barcode medication administration with respiratory therapy meds
Workforce • Improve nurse turnover rate • Implement shared governance in nursing • Improve onboarding process for volunteers	Fiscal Sustainability • Reduce no show percentage for COVID-19 testing in preparation for PFTs • Decrease use of nursing attendants with the use of TeleSitters • Improve medi-cal application disposition days • Reduce Acute Psych denied days • Reduce no shows for jail specialty clinic • Decrease ophthalmology surgical cancellation rates
Community • Improve access to specialty care services • PFAC involvement in QI project design	

Departments reported progress with these initiatives and resulting accomplishments to the Governing Body through the Quality Improvement Committee and the Medical Executive Committee. Due to COVID, some of these initiatives were paused while the hospital managed the surge in patient volume. Initiatives were fluid during the COVID period, starting and stopping as surges allowed.

C. Leadership Review and Evaluation Process

During this evaluation year, in order to build improvement capability, LAC+USC Medical Center continued the Healthcare Scholars Program and the Quality Academy. The Quality

Academy set a goal to provide education on QI principles to 250 participants by 2021. As of May 2022 (Wave 10) the Academy enrolled 317 participants. Each participant completed a PI project as part of the program and the project results are reported to the executive leadership and integrated into the organization's quality improvement program.

D. Performance Improvement Activities and Patient Safety Culture Improvement Projects

As departments worked through their individual initiatives, opportunities arose to establish some organization-wide initiatives targeted under our strategic goals. The following are examples of current multi-disciplinary performance improvement projects.

- OR Lean, which evolved into the ERAS on the Move project
- Hand Hygiene
- CAUTI/CLABSI reduction
- Team STEPPS implemented in L&D, NICU, Ped ED, PICU, Primary Care, Specialty Care, all ICUs, CCU and Cath Lab, Operating Room, Lab and Radiology, and Med/Surg. Plan for Team STEPPS in Psychiatric units in 2022-2023.
- H3 Support Team (LAC+USC second victim support) Continues to support wellness for employees
- HAPI reduction

E. Patient Family Advisor Committee (PFAC) Integration

The LAC+USC bilingual PFAC has 11 volunteer Patient Family Advisors (PFA). Over the past two and a half years these PFAs have been engaged and active in the Medical Center's QI projects by means of monthly PFAC meetings that facilitate robust discussions with department leader improvement projects and PFA membership on hospital councils to provide the patient and community lens from its direct consumer. Despite the COVID-19 pandemic, the PFAC smoothly transitioned to an online platform to ensure that the patient's unique perspective was utilized and valued in newly initiated LAC+USC projects. Since December 2019 the PFAC collaborated on 24 Medical Center projects. Examples of such projects are telehealth satisfaction, gastrointestinal (GI) lab patient experience, opioid care, family education videos, language access and inclusion signage and the LAC+USC strategic plan. The PFAC continues to grow steadily and build capacity of equitable services through the lens of the community, patient and guest. As our PFAC continues its outreach campaign, our goal is to have the ability to infuse the patient perspective throughout the Medical Center's departments and programs.

Key Metrics	2019-2020	2021	Jan-May 2022
PFA Membership	7	9	11
PFA Medical Center Committee Memberships	7	0	1
Medical Center Projects	8	11	5
Volunteer Hours	72 hours	106 hours	46 hours
PFA Interviews	12	10	4
PFA Attrition	2	1	0

F. Risk Assessment & Evaluation of Patient Safety Culture

As part of the annual evaluation, LAC+USC conducts a comprehensive risk assessment and evaluation of our patient safety culture (Appendix B).

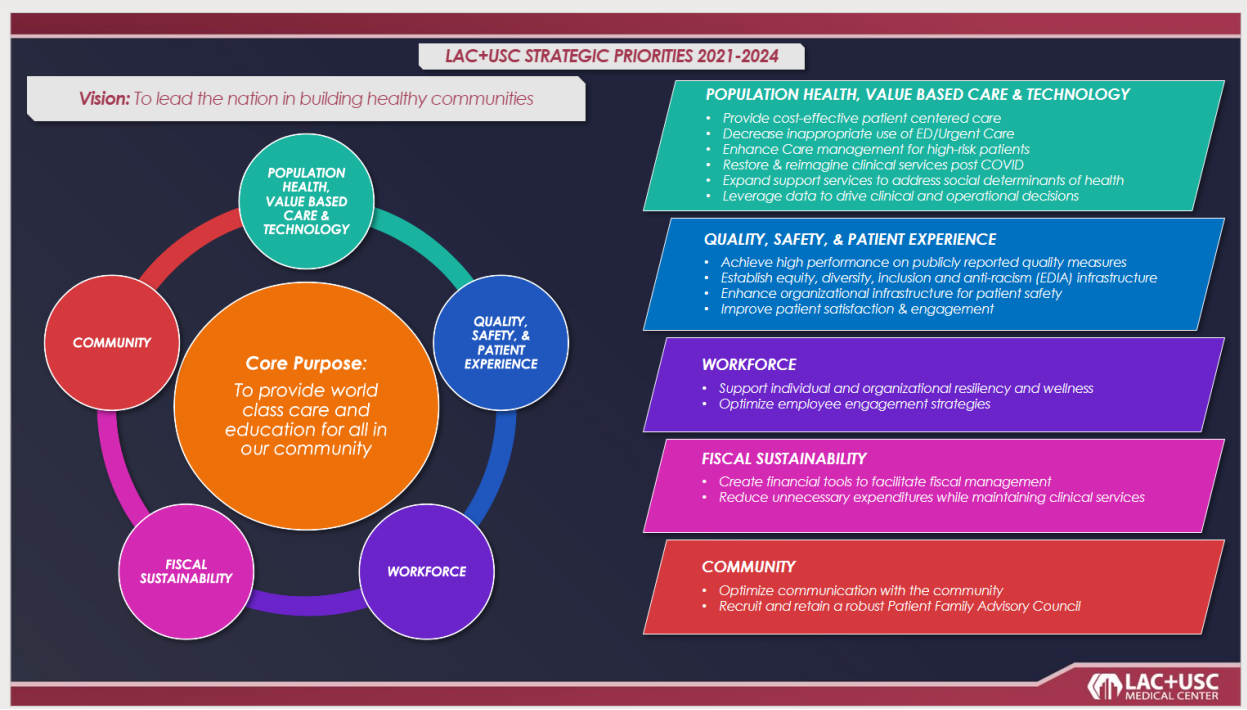
G. Goals for 2022-2023

Reflecting on a critical analysis of the current program and the risk assessment goals for 2022-2023 include the following:

- Achieve Leapfrog "A" and CMS 5-star status
    - Improve HCAHPS scores for physician and nurse communication.
    - Continue spreading Team STEPPS to improve patient safety culture.
    - Continue building improvement capability through the Quality Academy.
    - Maintain focus on hospital acquired infections, falls and pressure ulcers.
    - Continue Daily Dose.
    - Continue expansion of visual management boards and safety huddles across inpatient areas, incorporating multidisciplinary rounds.
    - Establish a wellness infrastructure
    - Conduct 2-4 organization-wide performance improvement projects consistent with organizational goals.

LAC+USC Strategic Priorities

2021-2024



LAC+USC Quality/Patient Safety Risk Assessment for FY 2021-2022

A	Review of Hazards and Risks
B	Probability and Severity of Risk Events
C	AHRQ Safety Indicators
D	Root Cause Analysis Summary
E	Deficiencies identified by California Department of Public Health
F	Staff Assaults
G	National Safety Patient Goals Dashboard
H	Mortality Index Trends
I	Risk Mitigation Planning

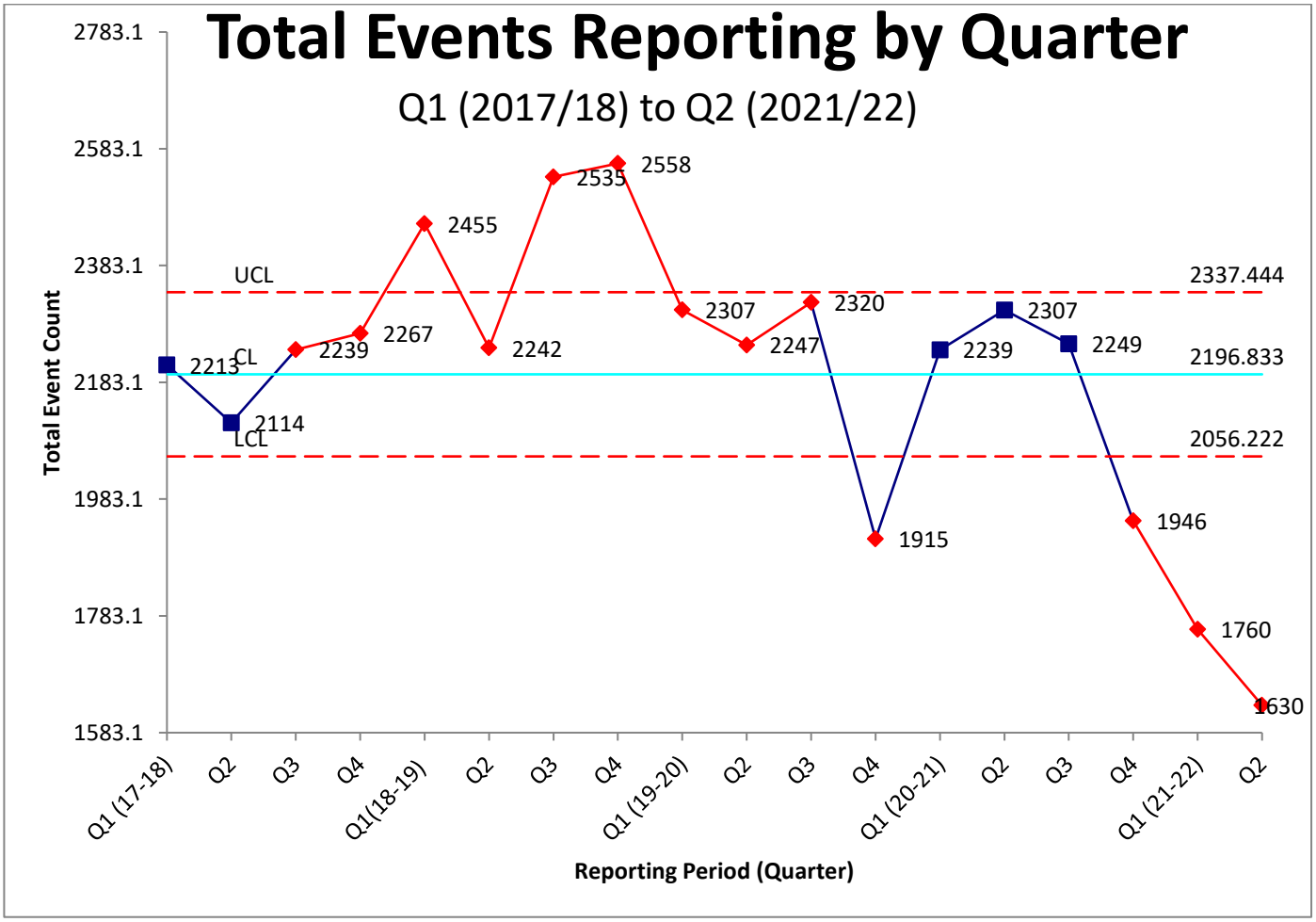
During this evaluation period, a world-wide pandemic (COVID-19) continued to have some impact on normal hospital operations and procedures. We experienced a surge in COVID -19 cases in the winter months of 2021-2022 which resolved by spring of 2022. Many of the metrics we follow were impacted by the pandemic and closures.

A. **Review of Hazards and Risks**

Risks and hazards across the organization are identified through review of reported safety intelligence events, surveillance activities related to compliance and accreditation, reviews of reported deficiencies from regulatory agency visits, and analysis of trends in routine data collected. The following sections present data related to these surveillance activities. The final section includes our analysis and risk mitigation plans.

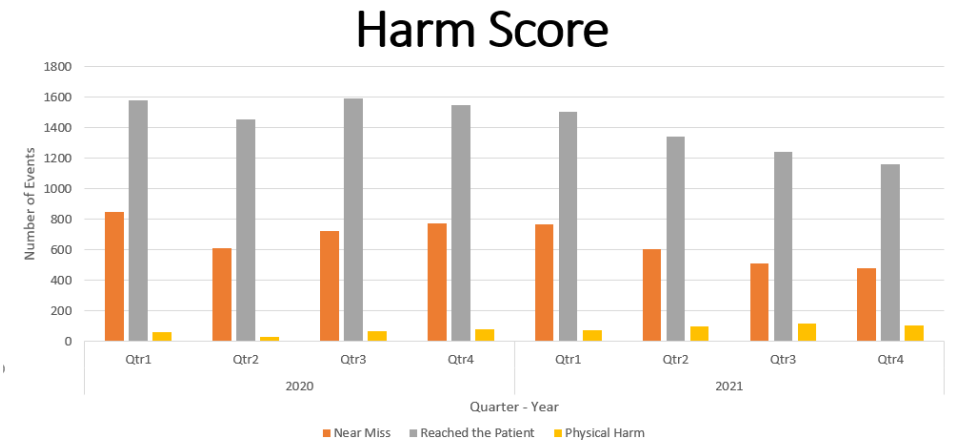
1. Total Events Reported

Staff report safety events through an automated, anonymous, event reporting system. The most frequently reported events remain pressure ulcers, with registered nurses the most frequently identified reporters, followed by lab/radiology technicians and physician residents. The top locations of events are general medical/surgical and emergency medicine. All events are reviewed by our risk management team and selected events are identified for in-depth root cause analysis based on severity scores. An average of 2280 events are reported each quarter.



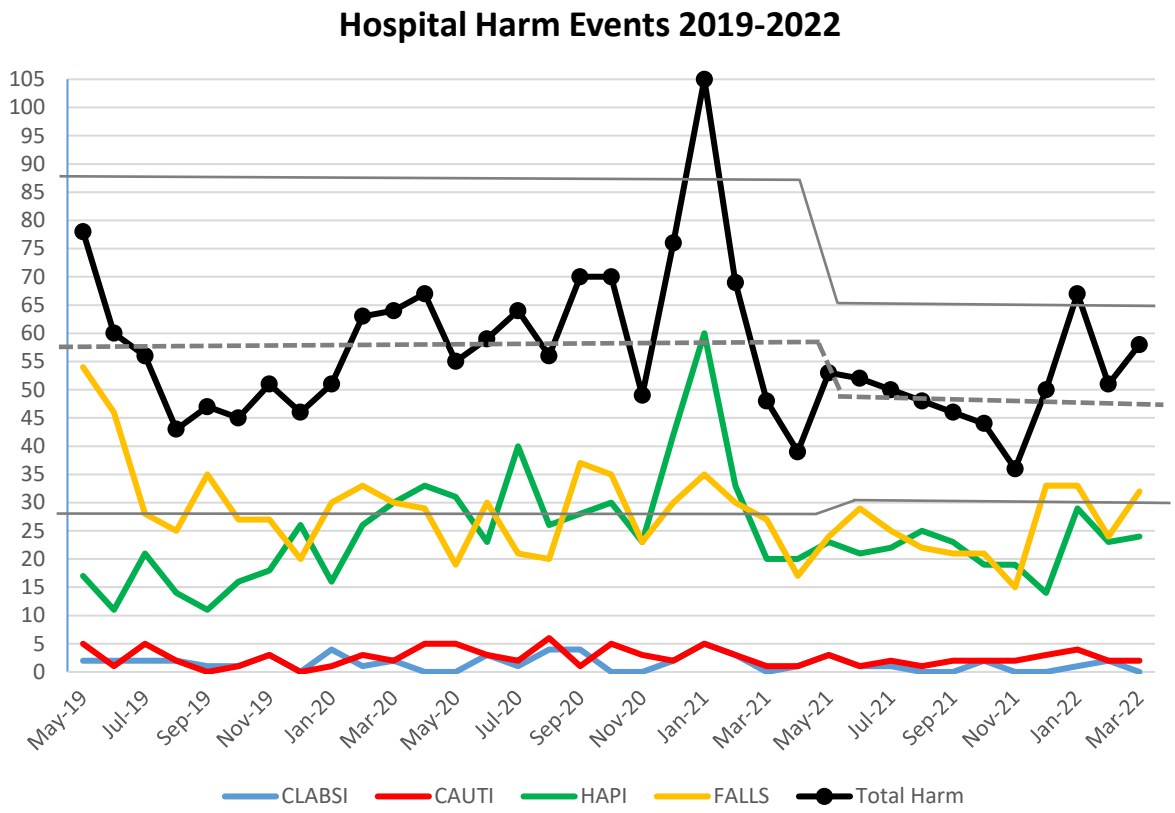
A. Harm Scores

Event Reporting



	Q1 - 2020			Q2 - 2020			Q3 - 2020			Q4 - 2020		
	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
Near Miss	268	300	277	164	221	224	216	259	245	275	263	230
Reached the Patient	537	533	510	434	511	509	521	473	598	552	525	472
Physical Harm	21	25	13	7	9	10	16	13	35	28	23	27

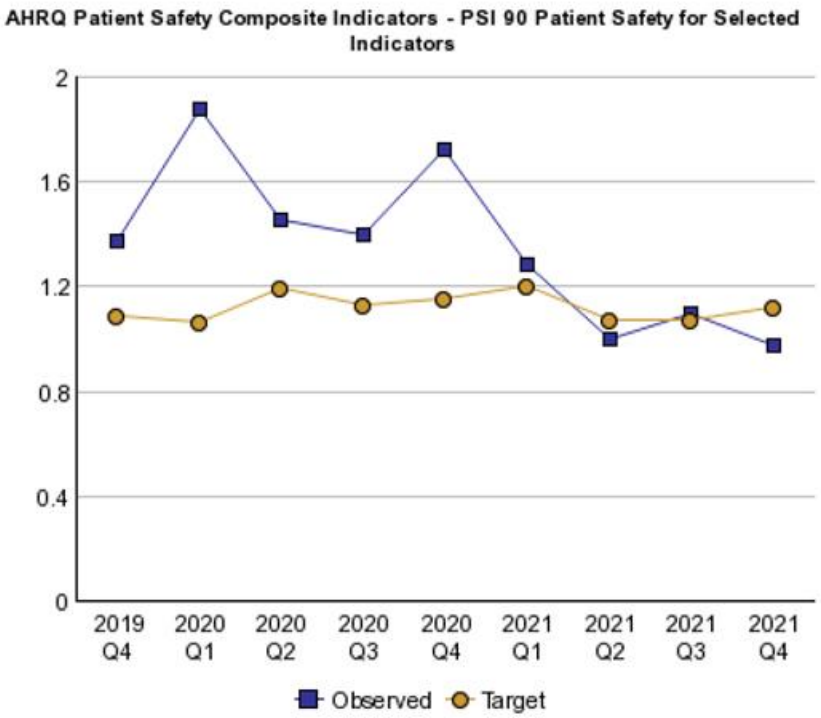
	Q1- 2021			Q2 - 2021			Q3- 2021			Q4 - 2021		
	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Near Miss	263	254	247	214	179	208	202	158	149	154	170	150
Reached the Patient	518	466	521	441	458	439	401	413	425	420	367	370
Physical Harm	26	20	22	29	26	41	40	39	37	22	52	29



B. AHRQ Safety Indicators (July 2021 to Jan2022)

PSI02 Death Rate in Low-Mortality Diagnosis Related Groups (DRGs)	1,287	0	0.000000
PSI03 Pressure Ulcer Rate	8,812	6	0.994377
PSI04 Death Rate Among Surgical Inpatients with Serious Treatable Conditions	183	44	1.407234
PSI04a Death Among Surgical Stratum A: DVT or PE	40	1	0.525042
PSI04b Death Among Surgical Stratum B: Pneumonia	51	11	2.233260
PSI04c Death Among Surgical Stratum C: Sepsis	41	14	1.556645
PSI04d Death Among Surgical Stratum D: Shock or Cardiac Arrest	32	15	1.147790
PSI04e Death Among Surgical Stratum E: GI Hemorrhage or Acute Ulcer	19	3	1.263380
PSI05 Retained Surgical Item or Unretrieved Device Fragment Count	N/A	3	N/A
PSI06 Iatrogenic Pneumothorax Rate	14,958	1	0.487533
PSI07 Central Venous Catheter-Related Blood Stream Infection Rate	9,512	2	1.244995
PSI08 In Hospital Fall with Hip Fracture Rate (AHRQ 5.0/4.5a Postoperative Hip Fracture Rate)	16,682	0	0.000000
PSI09 Postoperative Hemorrhage or Hematoma Rate	3,564	5	0.462581

PSI10 Postoperative Acute Kidney Injury Requiring Dialysis (AHRQ 5.0/4.5a: Postoperative Physiologic and Metabolic Derangement Rate)	1,347	1	1.034964
PSI11 Postoperative Respiratory Failure Rate	1,319	5	0.766883
PSI12 Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate	3,731	23	1.618975
PSI13 Postoperative Sepsis Rate	1,277	4	0.717737
PSI14 Postoperative Wound Dehiscence Rate	1,599	1	0.930055
PSI14a Postoperative Wound Dehiscence Rate Stratum 14A: Open Approach	572	1	0.955373
PSI14b Postoperative Wound Dehiscence Rate Stratum 14B: Non-Open Approach	1,027	0	0.000000
PSI15 Unrecognized Abdominopelvic Accidental Puncture/Laceration Rate (AHRQ 5.0/4.5a Accidental Puncture or Laceration Rate)	3,258	1	0.328491
PSI18 Obstetric Trauma Rate – Vaginal Delivery With Instrument	9	0	N/A
PSI19 Obstetric Trauma Rate-Vaginal Delivery Without Instrument	494	8	N/A



LAC+USC participates in a national benchmarking organization (Vizient) where clinical data from our facility is compared to other academic medical centers across several clinical indicators. This benchmarking is now showing an improvement in our comparisons for PSI 90 composite where we are now below target for the last three quarters. Efforts are ongoing

to improve our PSI composite scores. LAC+USC continues with measure surveillance to sustain ongoing measure improvement projects (Core Measures/eCQMs). LAC+USC works with DHS committee to ensure documentation capture of relevant metric information is electronically retrievable for accurate reflection of standardized care metrics compliance.

C. Root Cause Analysis Summary

In January 2021, we convened a Quality Risk and Safety (QRS) committee to better coordinate information across each of these disciplines and to develop strategies to identify opportunities across these areas to improve. The QRS committee began reviewing critical clinical events in April 2021. Critical clinical events were defined as events that have a harm score >7, reportable events, elopements, claims, multiple similar events or trends, sentinel events, events referred by hospital leadership, and grievances with alleged medical negligence. The committee determined the next step for the events whether they receive a root cause analysis lead by risk management and patient safety, a focused assessment, or if the local department or unit review, analysis, and action plan was felt to be sufficient.

From July 2021 to April 2022 the QRS committee reviewed 158 events. We did RCAs on 22 of these events, Intensive Reviews on 3 of these events, and reached out to departments for a more robust local response in 49 of these events.

D. Deficiencies Identified by California Department of Public Health

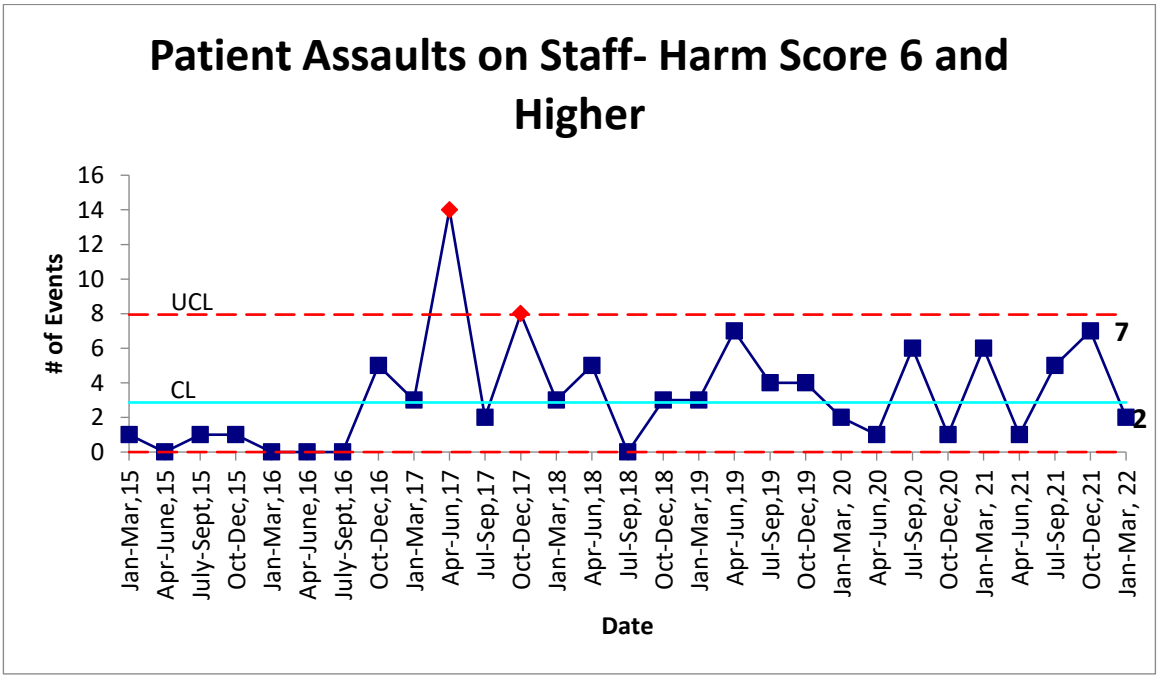
From June 2021 to April 2022, LAC+USC reported the following "Never Events" to the California Department of Public Health:

Pressure Ulcers	28
Retained foreign body	1
Alleged physical assault (patient to patient)	1
Patient complication during surgery	1

The vast majority of reported pressure ulcer cases resulted in findings of "no deficiencies", signifying all appropriate clinical actions were taken to prevent the problem. No trends are identified with CDPH reportable events

E. Workers' Compensation Workplace Violence

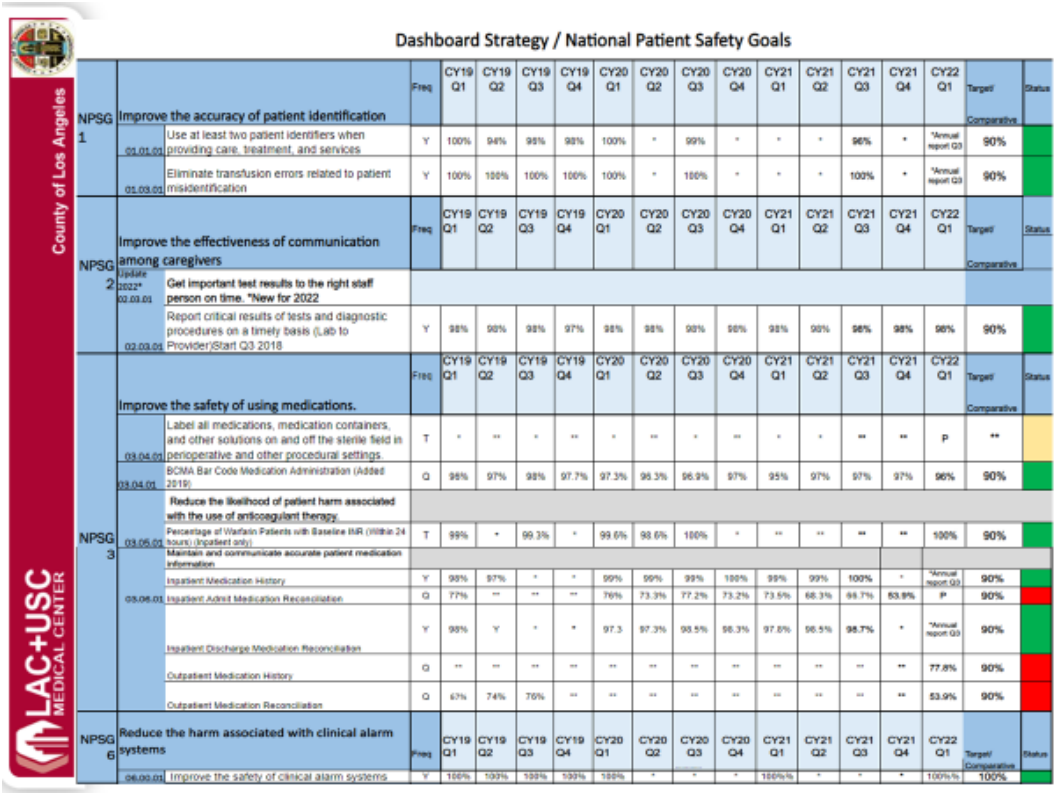
PI MEASURE	FREQUENCY	GOAL	1st Quarter 2021 JAN	FEB	MAR	2nd Quarter 2021 APR	MAY	JUN	3rd Quarter 2021 JUL	AUG	SEP	4th Quarter 2021 OCT	NOV	DEC
SAFETY MANAGEMENT														
# of Workers' Compensation Claims (Industrial Accident Injuries)	Monthly	<66/Mo	66	51	87	55	66	55	58	62	77	58	47	49
# of Cumulative Trauma Injuries	Monthly	<6/Mo	6	12	5	6	5	4	3	5	1	5	1	1
# of Needlestick/Sharps Injuries	Monthly	<9/Mo	10	6	11	7	11	12	10	10	18	16	13	18
# of Injuries from Lifting & Moving Patient	Monthly	<5/Mo	4	4	9	8	4	5	6	4	4	7	3	6
# of Workplace Violence Incidents	Monthly	<21/Mo	11	4	18	10	18	7	20	17	19	13	18	13
SECURITY MANAGEMENT														
# Grand Theft Autos	Monthly	<5	0	1	1	3	1	0	1	2	0	1	0	4
# Vehcle Burglary	Monthly	<5	0	0	0	0	1	2	0	1	0	2	0	0
# Co. Property stolen	Monthly	<5	1	0	1	1	0	0	1	0	0	0	0	0
# Crimes/Persons	Monthly	<5	3	0	4	2	3	5	2	2	7	1	1	0
# Crimes/Property	Monthly	<5	7	3	2	4	4	7	3	3	2	5	4	7



F. National Patient Safety Goals Dashboard

Data from the National Patient Safety Goals dashboard is presented quarterly at the Patient Safety Committee. Discussions at the committee include actions recommended for any area where there is a deficiency. Current areas of opportunity include inpatient adult medication reconciliation, outpatient medication history, outpatient medication reconciliation, hand hygiene, and PPE compliance. We are still in the process of determining a data collection method

for NPSG 03.04.01 labeling medications and solutions and chlorhexidine baths in the preop clinic. Below are the NPSG dashboards.



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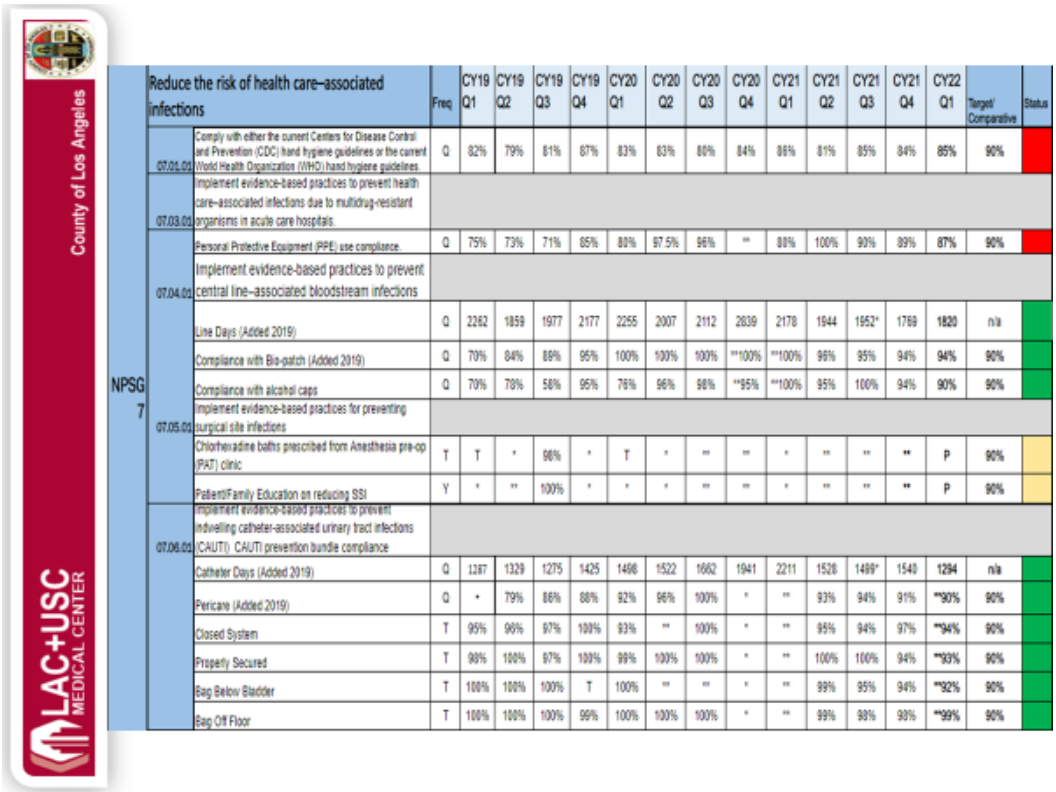
Dashboard Strategy / National Patient Safety Goals

			Freq	CY19 Q1	CY19 Q2	CY19 Q3	CY19 Q4	CY20 Q1	CY20 Q2	CY20 Q3	CY20 Q4	CY21 Q1	CY21 Q2	CY21 Q3	CY21 Q4	CY22 Q1	Target/ Comparative	Status
NPSG 1		Improve the accuracy of patient identification																
	01.01.01	Use at least two patient identifiers when providing care, treatment, and services	Y	100%	94%	95%	98%	100%	*	99%	*	*	*	96%	*	*Annual report Q3	90%	
	01.03.01	Eliminate transfusion errors related to patient misidentification	Y	100%	100%	100%	100%	100%	*	100%	*	*	*	100%	*	*Annual report Q3	90%	
NPSG 2		Improve the effectiveness of communication among caregivers	Freq	CY19 Q1	CY19 Q2	CY19 Q3	CY19 Q4	CY20 Q1	CY20 Q2	CY20 Q3	CY20 Q4	CY21 Q1	CY21 Q2	CY21 Q3	CY21 Q4	CY22 Q1	Target/ Comparative	Status
	Update 2022* 02.03.01	Get important test results to the right staff person on time. *New for 2022																
	02.03.01	Report critical results of tests and diagnostic procedures on a timely basis (Lab to Provider)Start Q3 2018	Y	98%	98%	98%	97%	98%	98%	98%	98%	98%	98%	98%	98%	98%	90%	
NPSG 3		Improve the safety of using medications.	Freq	CY19 Q1	CY19 Q2	CY19 Q3	CY19 Q4	CY20 Q1	CY20 Q2	CY20 Q3	CY20 Q4	CY21 Q1	CY21 Q2	CY21 Q3	CY21 Q4	CY22 Q1	Target/ Comparative	Status
	03.04.01	Label all medications, medication containers, and other solutions on and off the sterile field in perioperative and other procedural settings.	T	*	**	*	**	*	**	*	**	*	*	**	**	P	**	
	03.04.01	BCMA Bar Code Medication Administration (Added 2019)	Q	98%	97%	98%	97.7%	97.3%	96.3%	96.9%	97%	95%	97%	97%	97%	96%	90%	
	03.05.01	Reduce the likelihood of patient harm associated with the use of anticoagulant therapy.																
		Percentage of Warfarin Patients with Baseline INR (Within 24 hours) (Inpatient only)	T	99%	*	99.3%	*	99.6%	98.6%	100%	*	**	**	**	**	100%	90%	
	03.06.01	Maintain and communicate accurate patient medication information																
		Inpatient Medication History	Y	98%	97%	*	*	99%	99%	99%	100%	99%	99%	100%	*	*Annual report Q3	90%	
		Inpatient Admit Medication Reconciliation	Q	77%	**	**	**	76%	73.3%	77.2%	73.2%	73.5%	68.3%	68.7%	53.9%	P	90%	
		Inpatient Discharge Medication Reconciliation	Y	98%	Y	*	*	97.3	97.3%	98.5%	96.3%	97.8%	96.5%	98.7%	*	*Annual report Q3	90%	
		Outpatient Medication History	Q	**	**	**	**	**	**	**	**	**	**	**	**	77.8%	90%	
		Outpatient Medication Reconciliation	Q	63%	74%	76%	**	**	**	**	**	**	**	**	**	53.9%	90%	
NPSG 6		Reduce the harm associated with clinical alarm systems	Freq	CY19 Q1	CY19 Q2	CY19 Q3	CY19 Q4	CY20 Q1	CY20 Q2	CY20 Q3	CY20 Q4	CY21 Q1	CY21 Q2	CY21 Q3	CY21 Q4	CY22 Q1	Target/ Comparative	Status
	06.00.01	Improve the safety of clinical alarm systems	Y	100%	100%	100%	100%	100%	*	*	*	100%%	*	*	*	100%%	100%	



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			Freq	CY19 Q1	CY19 Q2	CY19 Q3	CY19 Q4	CY20 Q1	CY20 Q2	CY20 Q3	CY20 Q4	CY21 Q1	CY21 Q2	CY21 Q3	CY21 Q4	CY22 Q1	Target/ Comparative	Status
NPSG 7		Reduce the risk of health care–associated infections																
	07.01.01	Comply with either the current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines or the current World Health Organization (WHO) hand hygiene guidelines.	Q	82%	79%	81%	87%	83%	83%	88%	84%	86%	81%	85%	84%	85%	90%	
	07.03.01	Implement evidence-based practices to prevent health care–associated infections due to multidrug-resistant organisms in acute care hospitals.																
	07.04.01	Personal Protective Equipment (PPE) use compliance.	Q	75%	73%	71%	85%	83%	97.5%	96%	**	88%	100%	90%	89%	87%	90%	
		Implement evidence-based practices to prevent central line–associated bloodstream infections																
		Line Days (Added 2019)	Q	2262	1859	1977	2177	2255	2007	2112	2839	2178	1944	1952*	1769	1820	n/a	
		Compliance with Bio-patch (Added 2019)	Q	70%	84%	89%	95%	100%	100%	100%	**100%	**100%	96%	95%	94%	94%	90%	
		Compliance with alcohol caps	Q	70%	78%	58%	95%	76%	96%	98%	**95%	**100%	95%	100%	94%	90%	90%	
	07.05.01	Implement evidence-based practices for preventing surgical site infections																
		Chlorhexadine baths prescribed from Anesthesia pre-op (PAT) clinic	T	T	*	98%	*	T	*	**	**	*	**	**	**	P	90%	
		Patient/Family Education on reducing SSI	Y	*	**	100%	*	*	*	**	**	*	**	**	**	P	90%	
	07.06.01	Implement evidence-based practices to prevent indwelling catheter-associated urinary tract infections (CAUTI) CAUTI prevention bundle compliance																
		Catheter Days (Added 2019)	Q	1287	1329	1275	1425	1498	1522	1662	1941	2211	1528	1499*	1540	1294	n/a	
		Pericare (Added 2019)	Q	*	79%	86%	88%	92%	96%	100%	*	**	93%	94%	91%	**90%	90%	
		Closed System	T	95%	96%	97%	100%	93%	**	100%	*	**	95%	94%	97%	**94%	90%	
		Properly Secured	T	98%	100%	97%	100%	99%	100%	100%	*	**	100%	100%	94%	**93%	90%	
		Bag Below Bladder	T	100%	100%	100%	T	100%	**	**	*	**	99%	95%	94%	**92%	90%	
		Bag Off Floor	T	100%	100%	100%	99%	100%	100%	100%	*	**	99%	98%	98%	**99%	90%	

			Freq	CY19 Q1	CY19 Q2	CY19 Q3	CY19 Q4	CY20 Q1	CY20 Q2	CY20 Q3	CY20 Q4	CY21 Q1	CY21 Q2	CY21 Q3	CY21 Q4	CY22 Q1	Target/ Comparative	Status
NPSG 15	The hospital identifies safety risks inherent in its patient population																	
	15.01.01	Identify patients at risk for suicide.																
		Nursing suicide risk assessment upon admission	T	100%	100%	100%	100%	100%	*	100%	*	100%	*	100%	*	73%	90%	
		Nursing suicide risk assessment upon discharge	T	100%	100%	100%	100%	100%	*	100%	*	100%	*	100%	*	99%	90%	
Universal Protocol	Universal Protocol: Preventing Wrong Site, Wrong Procedure		Freq	CY19 Q1	CY19 Q2	CY19 Q3	CY19 Q4	CY20 Q1	CY20 Q2	CY20 Q3	CY20 Q4	CY21 Q1	CY21 Q2	CY21 Q3	CY21 Q4	CY22 Q1	Target/ Comparative	Status
	01.01.01	Conduct a preprocedure verification process	Y	*	*	100%	*	**	*	**	**	**	**	**	*	100%	90%	
	01.01.02	Mark the procedure site	Y	*	*	100%	*	**	*	**	**	**	**	**	*	100%	90%	
	01.01.03	A time-out is performed before the procedure	Y	*	*	100%	*	**	*	**	**	**	**	**	*	95.00%	90%	

Legend

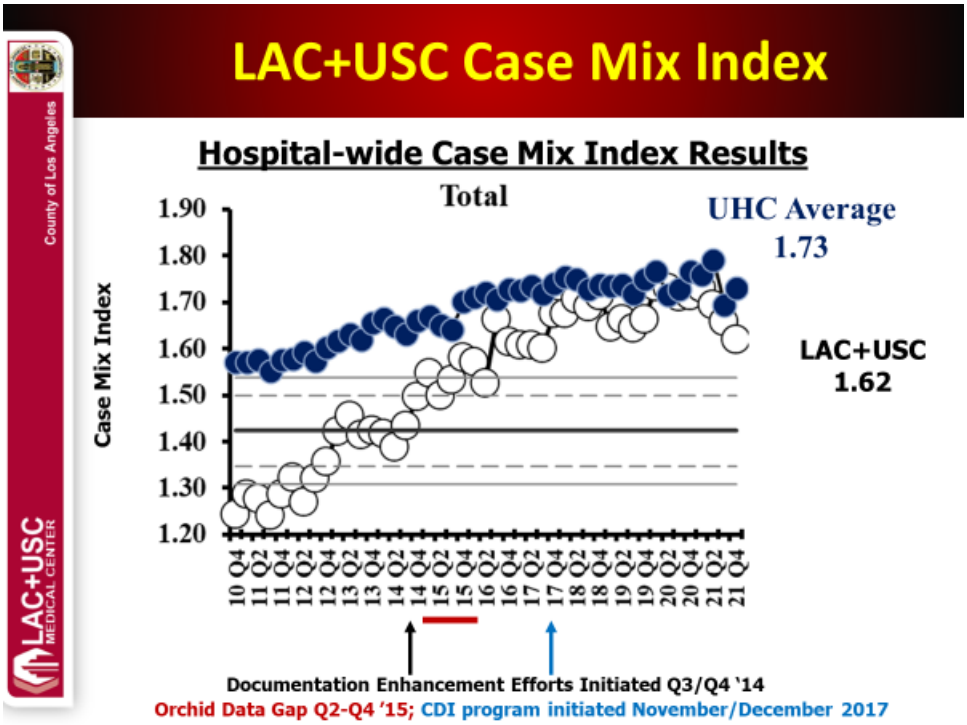
P=pending data

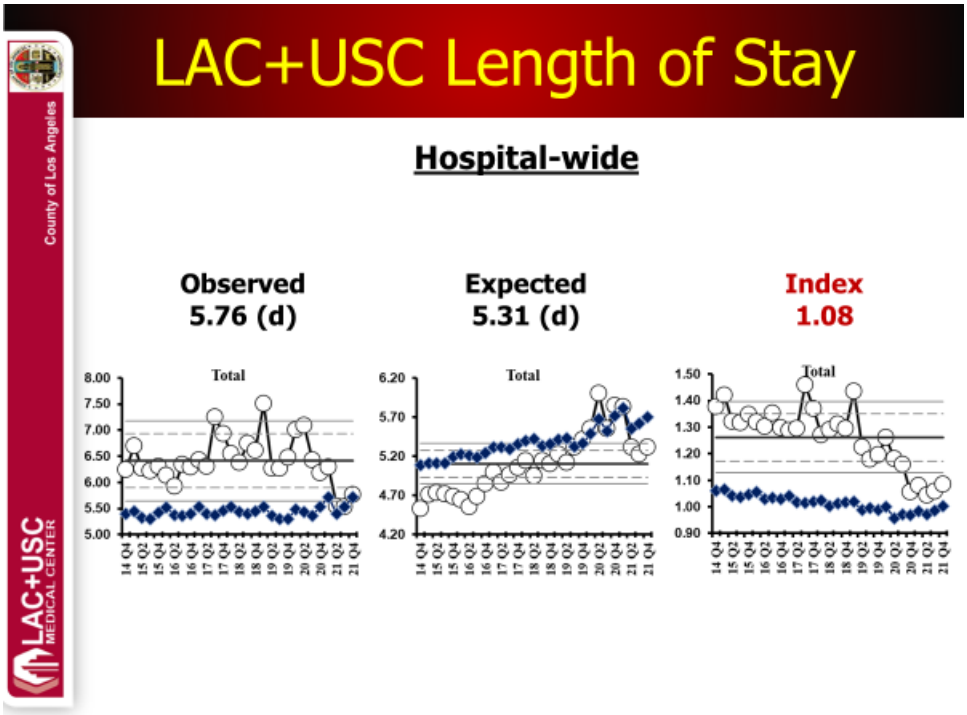
** =data not available; * Data not due this Quarter

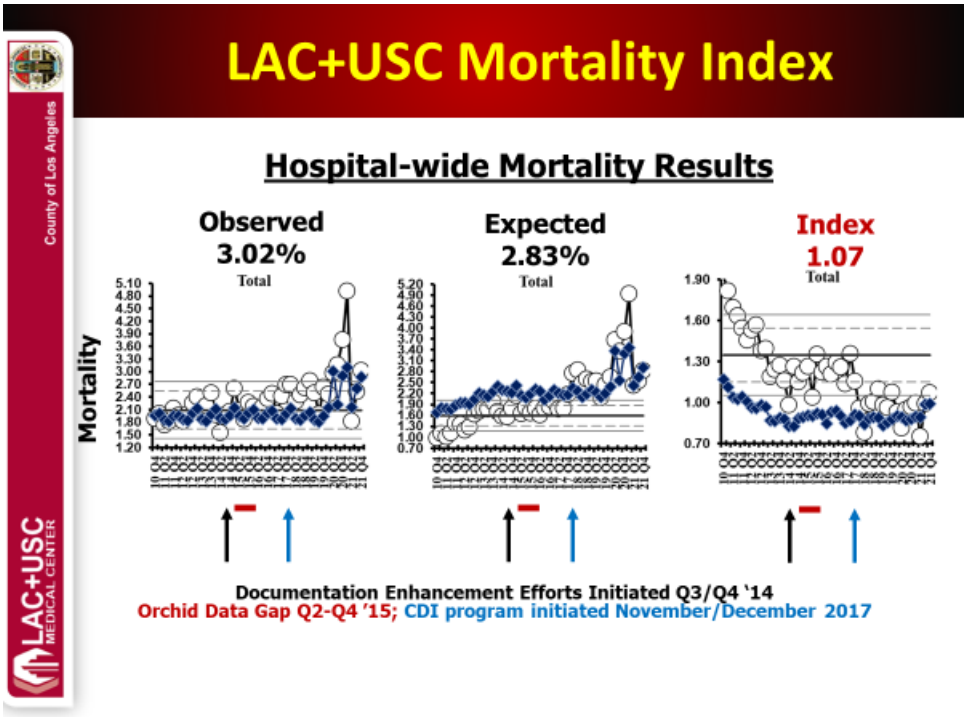
P- Pending- data Note: No audits during Apr-May 2020 & Pandemic Surges

*Due to the pandemic surges, many departments were unable to capture data in some of Q4 2020, Q1 & Q4 2021.

G. Mortality Index Trends







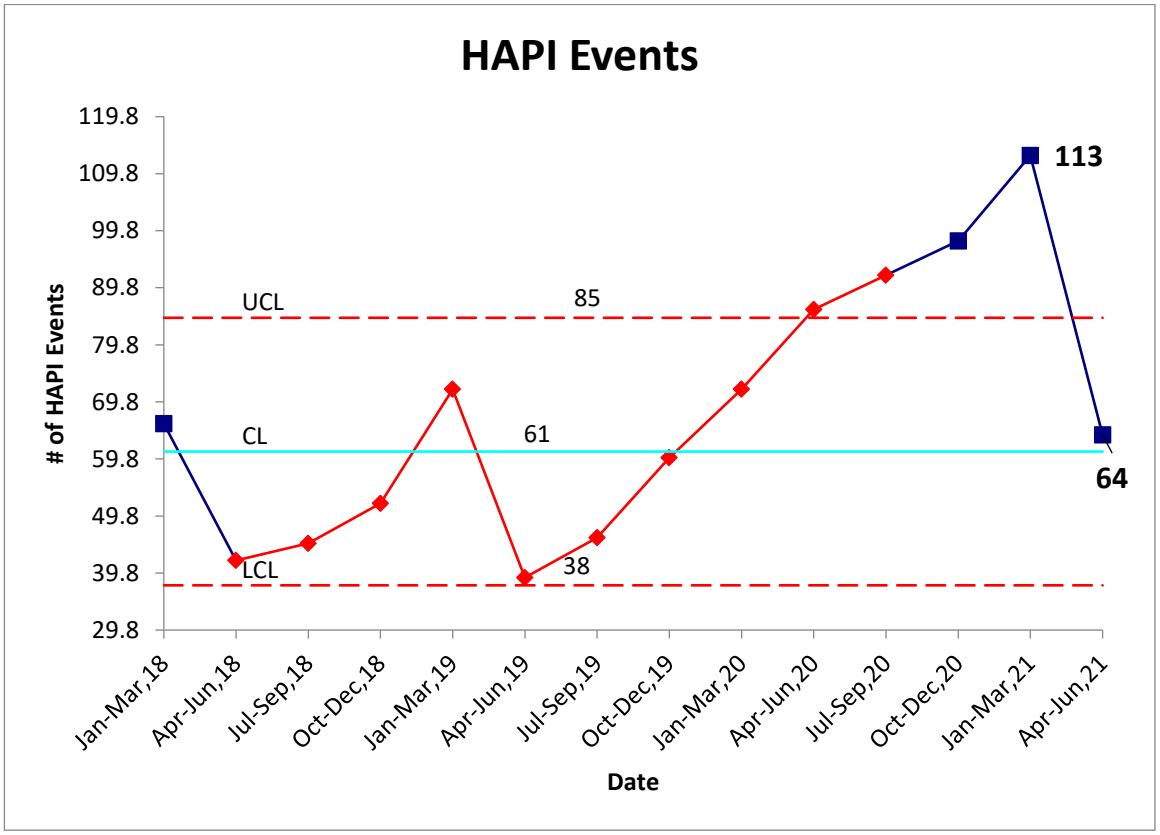
Efforts related to clinical documentation improvement continue to demonstrate improvement of our CMI, Mortality, and LOS index as benchmarked with other academic medical centers through Vizient, Inc. The CMO's office is engaged in aggressive feedback and coaching with the Department Chairs and Service Chiefs to improve both the clinical documentation and the quality of care delivered. The Mortality Index is up slightly this quarter due to decline in documentation driving a lower-than-usual Case Mix Index for some of our very complicated clinical service lines.

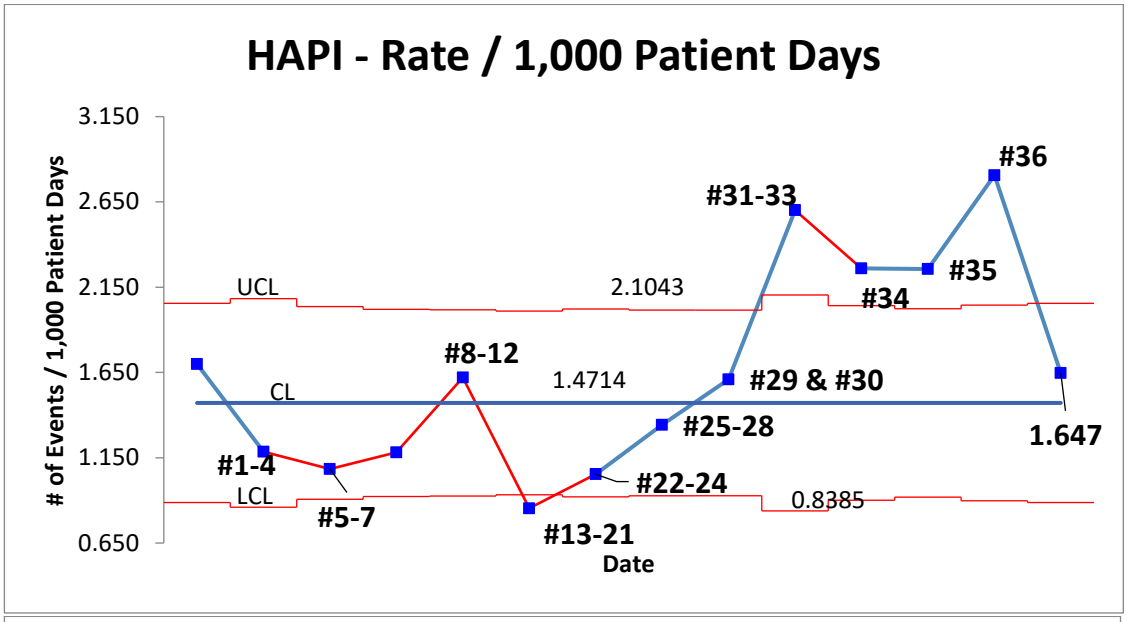
H. Quality/Patient Safety Risk Mitigation Plan

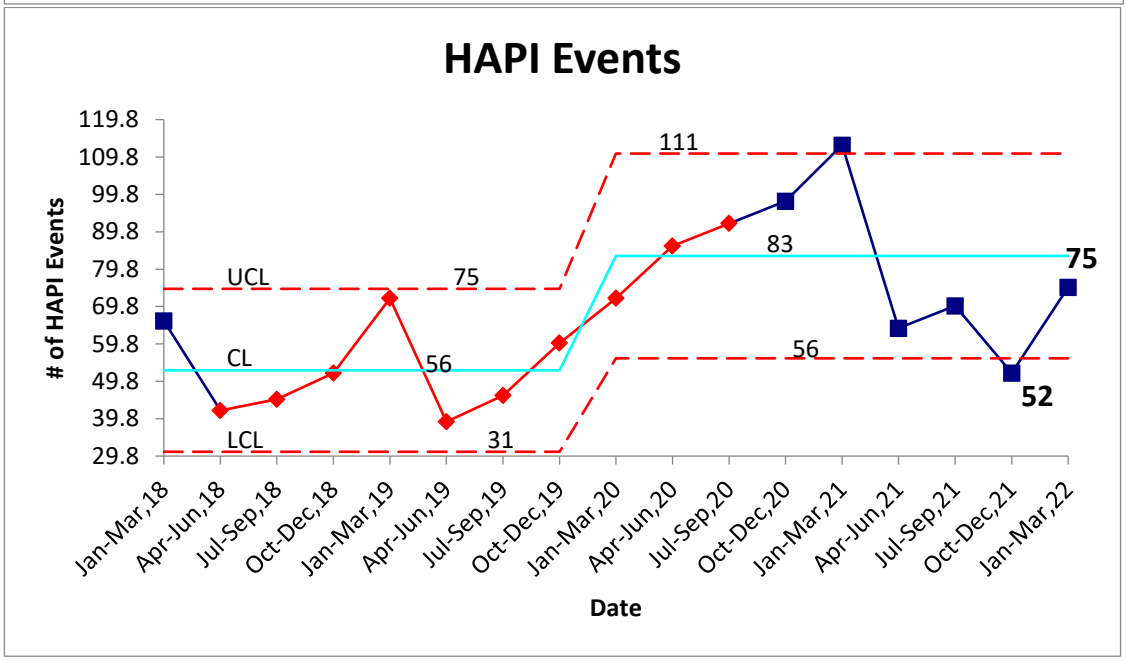
LAC+USC has identified the following risk mitigation strategies to address areas of opportunity.

1) Pressure Ulcers

- Pressure ulcers continue to be a challenging patient safety problem. Numbers increased throughout COVID due to proning and oxygenation devices. Staff continue to review each event and identify opportunities to improve.

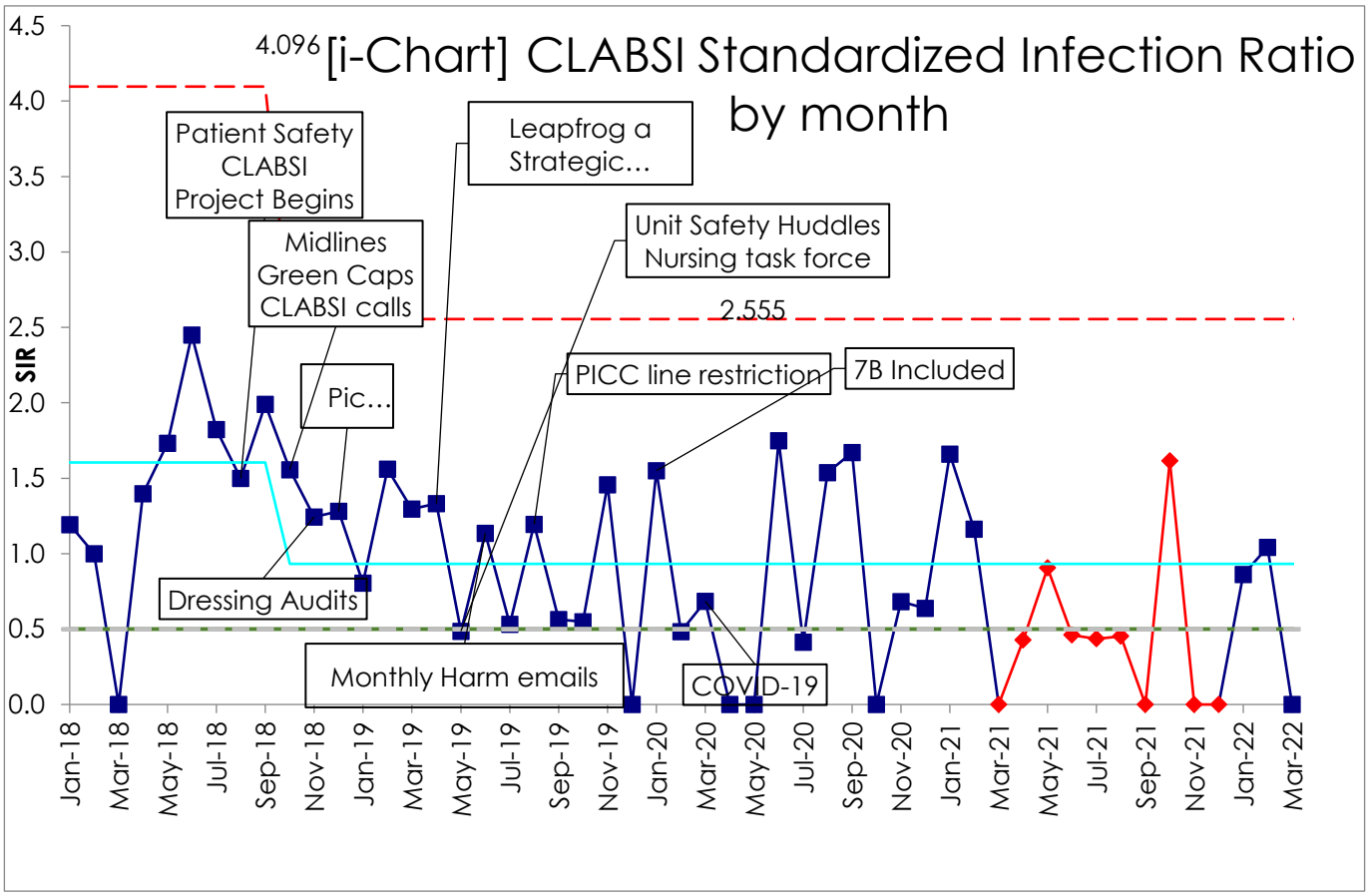






2) CAUTI/CLABSI

CLABSI and CAUTI rates have improved but remain higher than our goal SIR <0.4. We have implemented a checklist for patients with foley catheters and central lines where staff are to assess the daily need for these invasive devices and to ensure the cleanliness of them and keep up with the current CDC guidelines and LAC+USC policies. Many units have discussed these patients in their unit safety huddles or rounds, and work to decrease the overall number of foley catheters and central lines in our patients. We continue to review each event at our CLABSI and CAUTI committees respectively to search for ways to improve.


[i-Chart] CLABSI Standardized Infection Ratio by month
4.096
2.555
SIR
Patient Safety CLABSI Project Begins
Midlines Green Caps CLABSI calls
Pic…
Leapfrog a Strategic…
Unit Safety Huddles Nursing task force
PICC line restriction
7B Included
Dressing Audits
Monthly Harm emails
COVID-19
4.5
4.0
3.5
3.0
2.5
2.0
1.5
1.0
0.5
0.0
Jan-18
Mar-18
May-18
Jul-18
Sep-18
Nov-18
Jan-19
Mar-19
May-19
Jul-19
Sep-19
Nov-19
Jan-20
Mar-20
May-20
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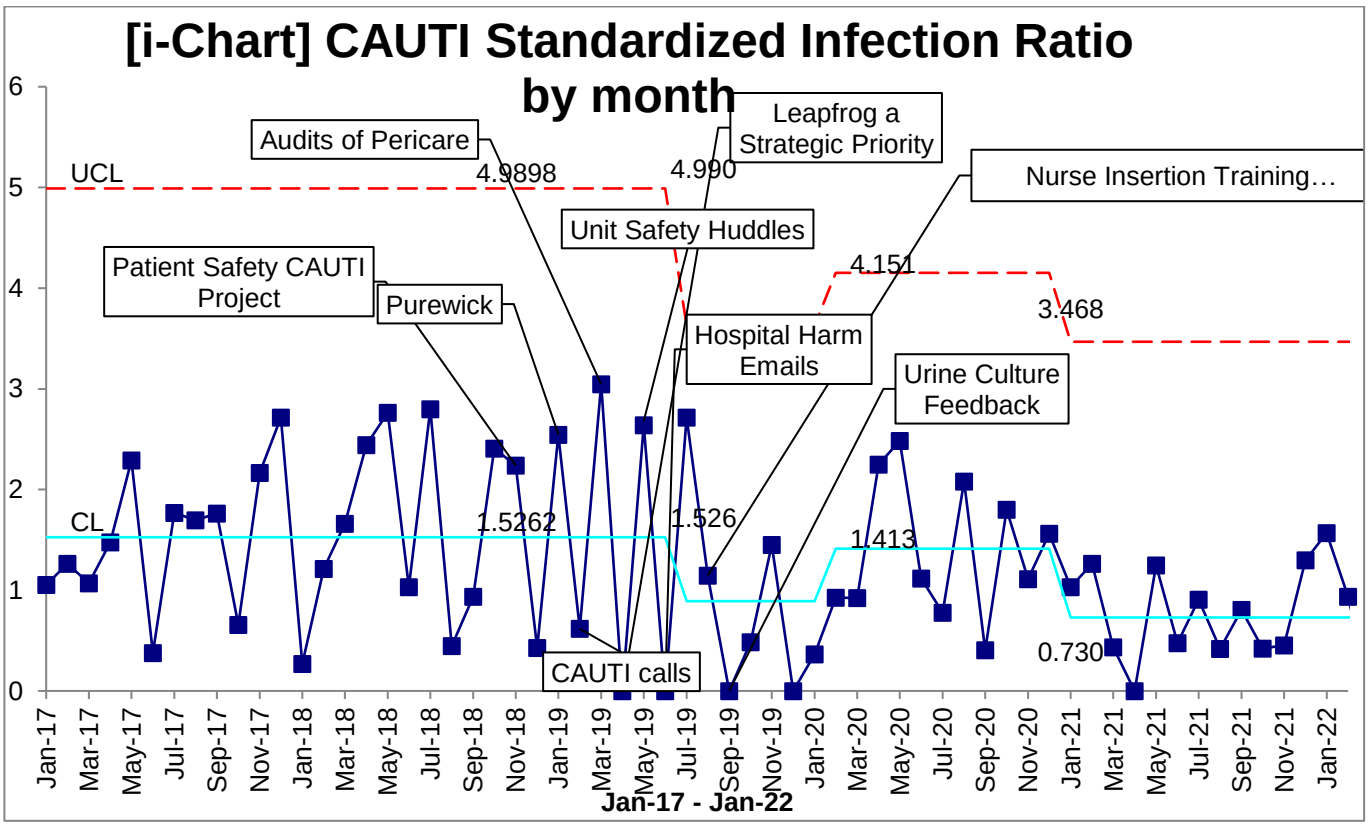
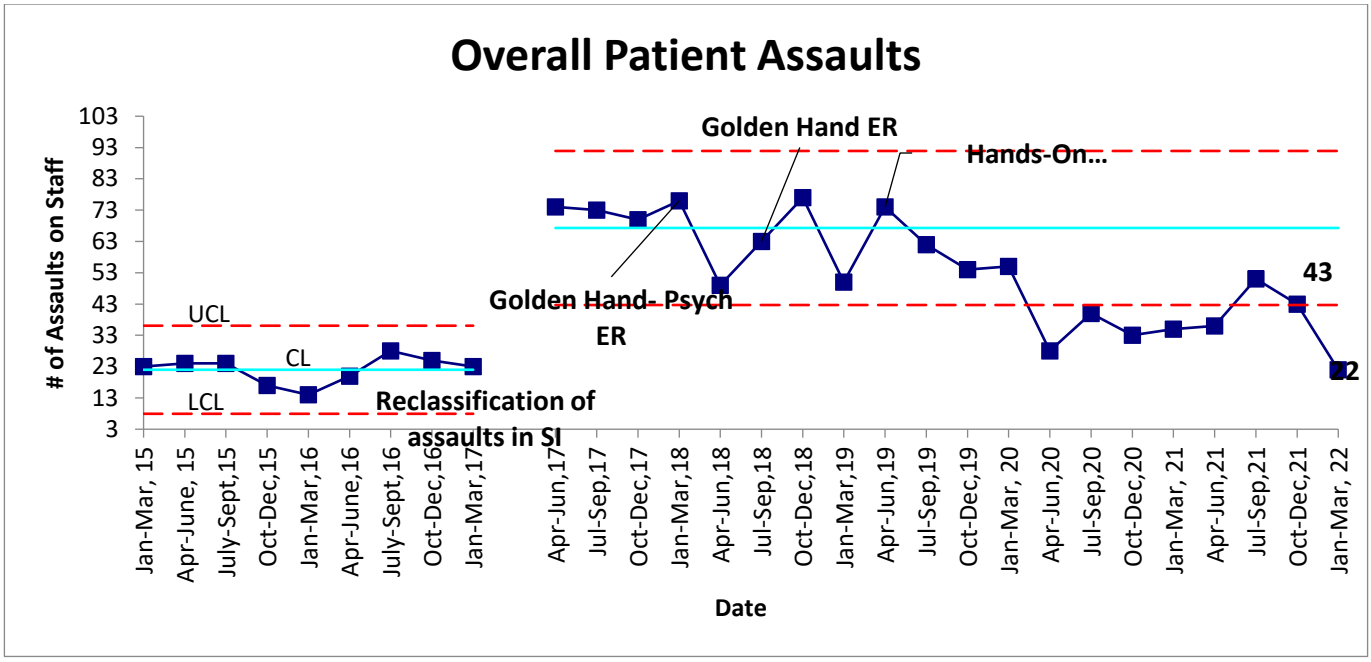
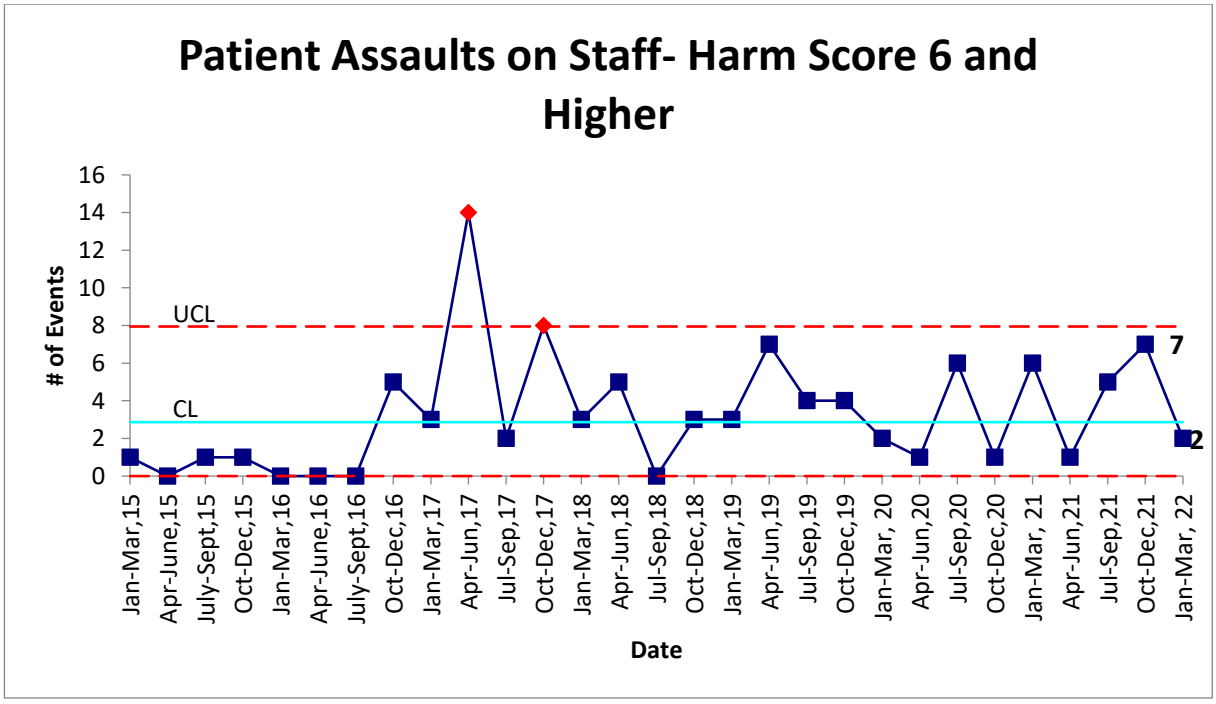
May-21
Jul-21
Sep-21
Nov-21
Jan-22
Mar-22


[i-Chart] CAUTI Standardized Infection Ratio by month
UCL
4.9898
4.990
CL
1.5262
1.526
1.413
4.151
3.468
0.730
Audits of Pericare
Leapfrog a Strategic Priority
Nurse Insertion Training…
Unit Safety Huddles
Patient Safety CAUTI Project
Purewick
Hospital Harm Emails
Urine Culture Feedback
CAUTI calls
6
5
4
3
2
1
0
Jan-17
Mar-17
May-17
Jul-17
Sep-17
Nov-17
Jan-18
Mar-18
May-18
Jul-18
Sep-18
Nov-18
Jan-19
Mar-19
May-19
Jul-19
Sep-19
Nov-19
Jan-20
Mar-20
May-20
Jul-20
Sep-20
Nov-20
Jan-21
Mar-21
May-21
Jul-21
Sep-21
Nov-21
Jan-22
Jan-17 - Jan-22

3) Patient and staff assaults

We continue to monitor our patient and staff assaults. Golden hand projects were initiated in high-risk units and the psych ED with reductions in the number of assaults. We continue to have a high number of forensic psych patients which challenge our staff.

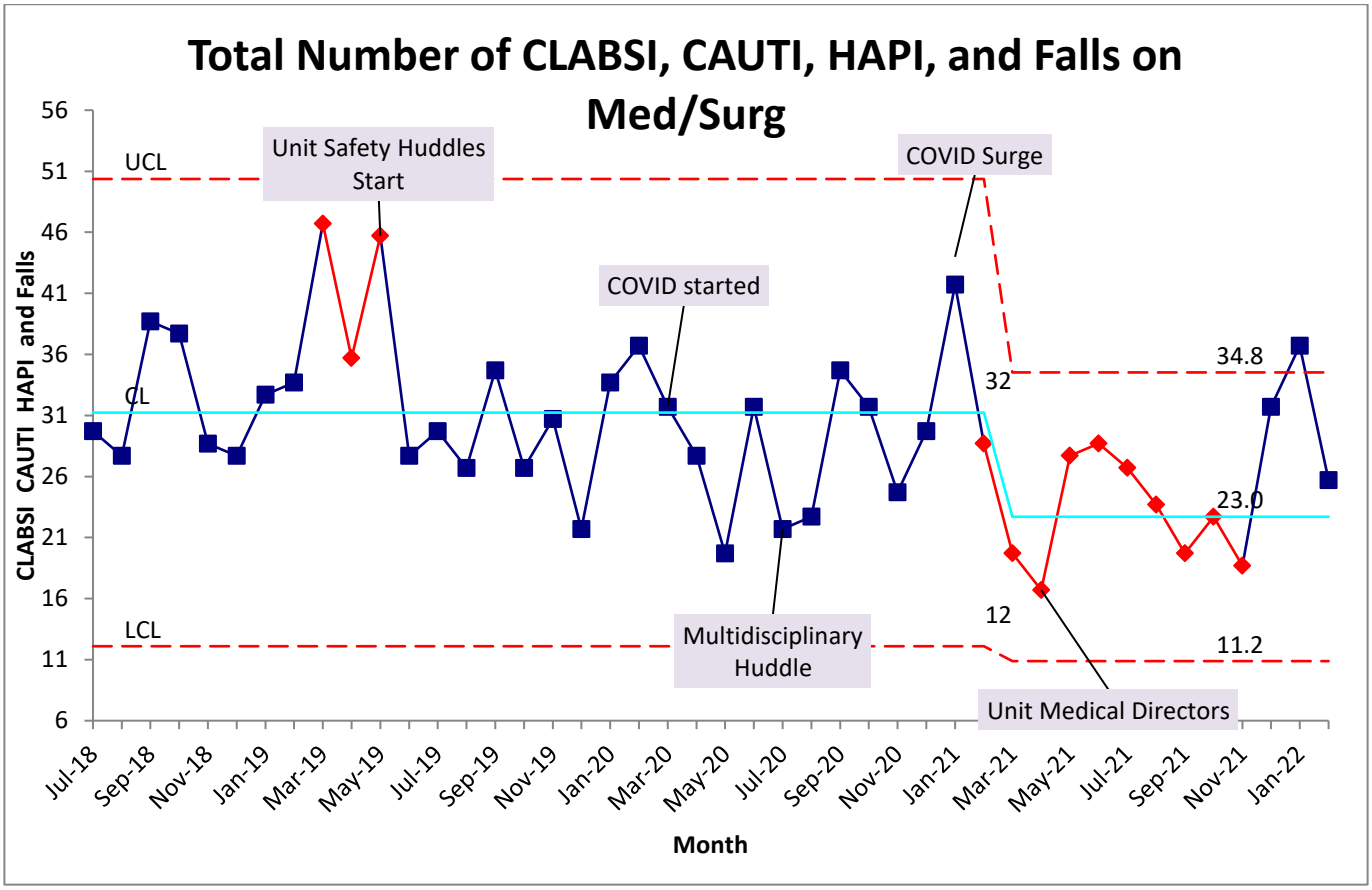




4) Staff Resilience & Safety

- Team training and skill building was previously identified as an important initiative to address both communication issues and teamwork in high-risk areas. Departments that have been trained and have implemented TeamSTEPPS include Labor and Delivery, OB/GYN, NICU, PICU, Pediatric and Adult ED, Primary Care, Specialty Care (Derm, Ortho, Ophtho, OB-GYN), CCU and Cardiac Cath, Neuro ICU, Burn ICU and Medical ICU, Operating room and medical/surgical units. Psychiatric areas will be the next area of focus for TeamSTEPPS training

- Unit Safety Huddles were developed to improve communication and reduce harm events via multidisciplinary huddles. They were developed in response to our safety culture survey results. The goals were to improve the safety of the unit by reducing CAUTI, CLABS, HAPI and Falls. Improve the safety culture and staff engagement by giving them a voice to discuss safety issues, and improve teamwork and communication across physicians, nurses and administration. Unit medical directors (safety champions) were assigned medical surgical units to "own". The results of the safety huddles on safety events is displayed below.

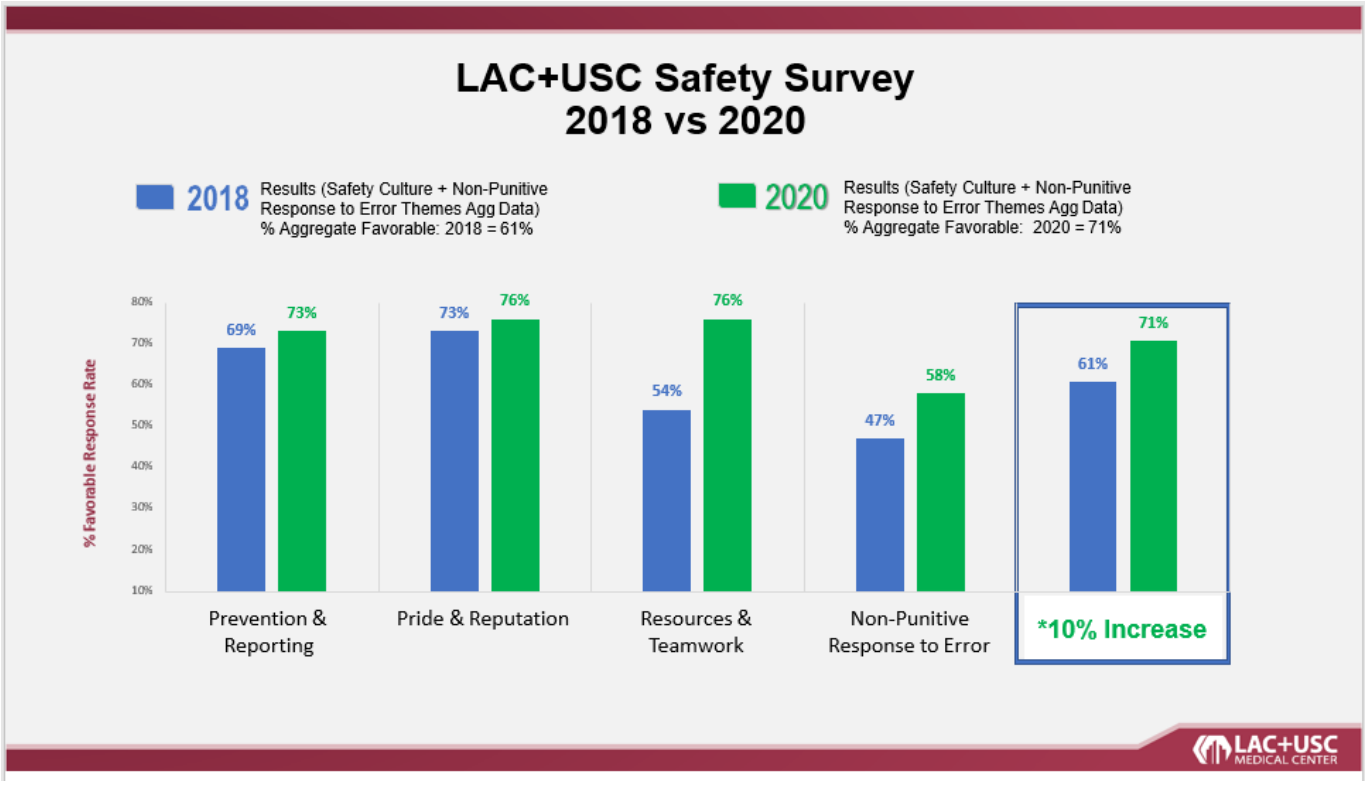


Staff wellness continues to be a priority. We have requested additional FTE's to support a Chief Wellness Officer. At the Enterprise level, a comprehensive evaluation of the current status of wellness is in progress with finalization expected this fall. Our local staff wellness committee

continues to support staff through voluntary peer support or H3 encounters, and through their wellbeing curriculum and exercise sessions. From July 2021 to April 2022 the committee has hosted 7 exercise classes, 3 meditation sessions, and 5 wellbeing education sessions servicing over 140 employees. We have also performed 92 H3 encounters. We put out a monthly newsletter on how to maintain wellness and continue to support Schwartz Rounds which remains virtual each month. The H3 wellness committee also partners with the nurse retention committee and PIO to put on wellness events across campus and host therapy dogs for staff.

5. Safety Culture

We conduct an organization-wide survey of our patient safety culture every 18-24 months. Results of our most recent survey (2020) demonstrate improvements and opportunities. Our next survey is scheduled for October 2022 and will be reported in the next evaluation period.



LAC+USC Results – Improved Favorable Responses

PS Theme/ *DHS Added category	Item Level Questions	2018	2020
Prevention & Reporting	In my work unit, we discuss ways to prevent errors from happening again.	72%	79%
	Employees will freely speak up if they see something that may negatively affect patient care.	70%	75%
	We are actively doing things to improve patient safety.	78%	80%
	When a mistake is reported, the focus is on solving the problem, not writing up the person.	58%	62%
	My work unit works well together.	65%	73%
*Non-Punitive Response to Error	Employees feel that mistakes they make are not held against them.	33%	54%
Resources & Teamwork	Different work units work well together in this organization.	57%	60%
Pride & Reputation	This organization makes every effort to deliver safe, error-free care to patients.	76%	79%
	Senior management provides a work climate that promotes patient safety.	66%	72%
Prevention & Reporting	Mistakes have led to positive changes here.	69%	71%

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LAC+USC Patient Safety Survey Results 2020

Highest Scores

- 4.04 • We are actively doing things to improve patient safety (Benchmark 4.19)
- 4.02 • This organization provides high quality care and service (Benchmark 4.15)
- 4.02 • This organization makes every effort to deliver safe, error-free care to patients (Benchmark 4.13)
- 3.99 • In my work unit, we discuss ways to prevent errors from happening again (Benchmark 4.17)
- 3.92 • I can report patient safety mistakes without fear of punishment (Benchmark 4.11)
- 3.91 • Employees will freely speak up if they see something that may negatively affect patient care (Benchmark 4.08)
- 3.87 • I feel free to raise workplace safety concerns (Benchmark 4.10)

Lowest Scores

- 3.66 •Communication between physicians, nurses, and other medical personnel is good in this organization (Benchmark 3.64)
- 3.64 • Different work units work well together in this organization (Benchmark 3.68)
- 3.60 • When a mistake is reported it feels like the focus is on solving the problem, not writing up the person (Benchmark 3.81)
- 3.52 • Communication between work units is effective in this organization (Benchmark 3.50)
- 3.34 • The amount of job stress I feel is reasonable (Benchmark 3.40)
- 3.13 • My work unit is adequately staffed (Benchmark 3.17)

What are we doing to address our low scores?

- H3 and Wellness Activities
- TeamSTEPPS
- Actively recruiting RNs through hiring fairs
- Just Culture

Benchmark = National Average for Safety Net Organizations

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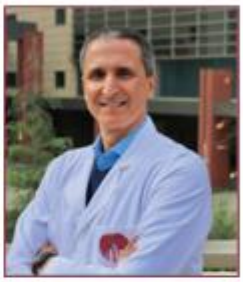
Back By Popular Demand

CHANGING CULTURE CASE BY CASE

Brought to you by
the Just Culture committee

2022
12:00PM
Conference Room IPT B

This month, Dr. Spellberg will discuss a mistake that he made during his career that he has never shared before, how he coped with the error, and how he wants to make sure it will never happen again to another patient.



Brad Spellberg,
Chief Medical Office

We are committed to improving the culture of safety at LAC+USC. This conference will present a monthly case that is focused on handling medical errors in a positive and fruitful way. The sessions will be centered around just culture, transparency, and psychological safety. We will begin by having key leaders in the organization share their difficult cases and then we will open it up to all staff to share cases going forward. We will walk through the just culture algorithm and decide what the best option is for each case as a group.

We are excited to start this journey toward a safe and just culture with all of you at LAC+USC. All staff, volunteers, and patients are welcome.

Conferences will be on the 3rd Thursday each month at noon.

Schedule

July 2022

Laura Sarff
CQO

August 2022

Jorge Orozco
CEO

September 2022

Chase Coffey
Assoc. CMO