LA General Medical Center
Annual Performance Improvement, Patient Safety, & Risk Assessment Evaluation
July 2022- June 2023

A. Annual Summary

LA GENERAL Medical Center conducts a comprehensive performance improvement and patient safety program. Through its balanced score card, each department and service line establishes goals for each of the five pillars of the LA GENERAL 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 LA GENERAL 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. LA GENERAL 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 line 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.

LA GENERAL 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. LA GENERAL'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 • 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

LA GENERAL Medical Center continued the Healthcare Scholars Program and the Quality Academy during this evaluation year to continue to build improvement capacity within its' workforce. The Quality Academy set a goal to provide education on QI principles to 250 participants by 2021. As of May, 2023 (Wave 12) the Academy enrolled over 450 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. During this evaluation year, we also moved to team-based training in our Quality Academy, so that we train teams of people, rather than individuals.

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 (LA GENERAL second victim support) Continues to support wellness for employees
- HAPI reduction

E. Patient Family Advisor Committee (PFAC) Integration

The LA GENERAL 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 LA GENERAL projects. Since December 2019 the PFAC collaborated on over 30 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 LA GENERAL 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.

F. Risk Assessment & Evaluation of Patient Safety Culture

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

G. Goals for 2023-2024

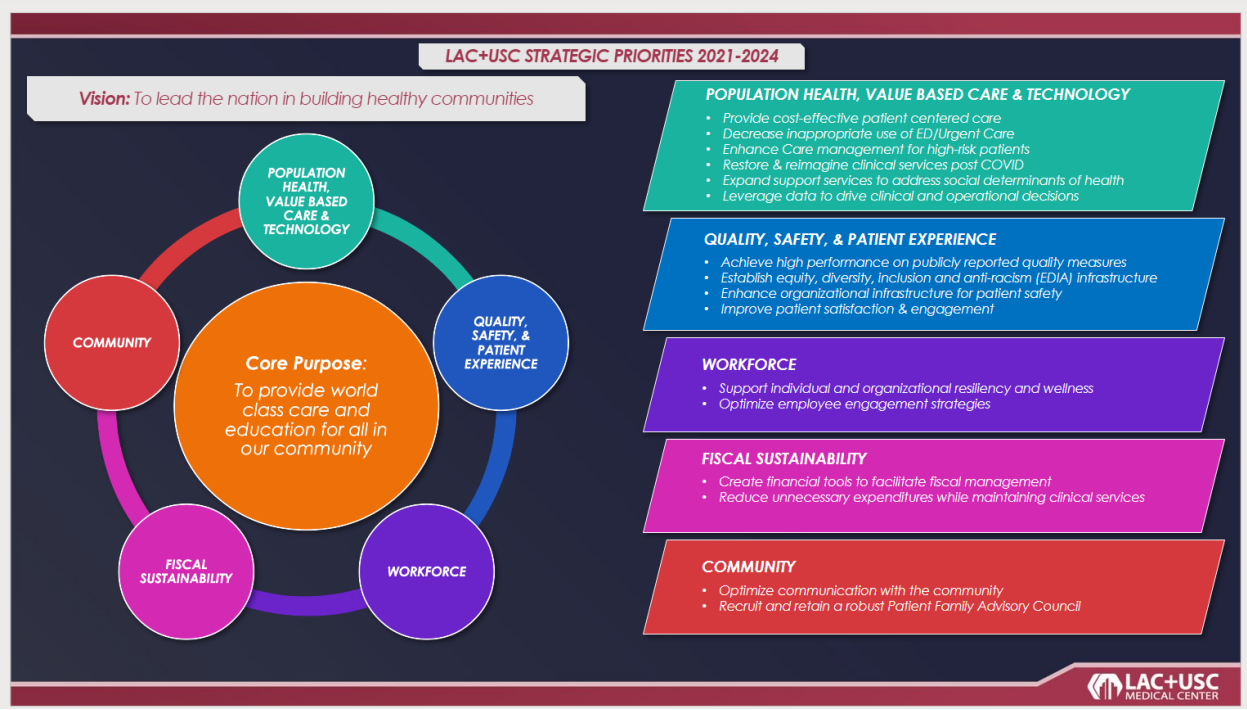
Reflecting on a critical analysis of the current program and the risk assessment goals for 2022-2023 include the following:

- 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.
    - Continue to strengthen a wellness infrastructure
    - Conduct 2-4 organization-wide performance improvement projects consistent with organizational goals.
    - Apply the lenses of equity, diversity and inclusion in all our work

Appendix A

LA GENERAL Strategic Priorities

2021-2024



LA GENERAL Quality/Patient Safety Risk Assessment for FY 2022-2023

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

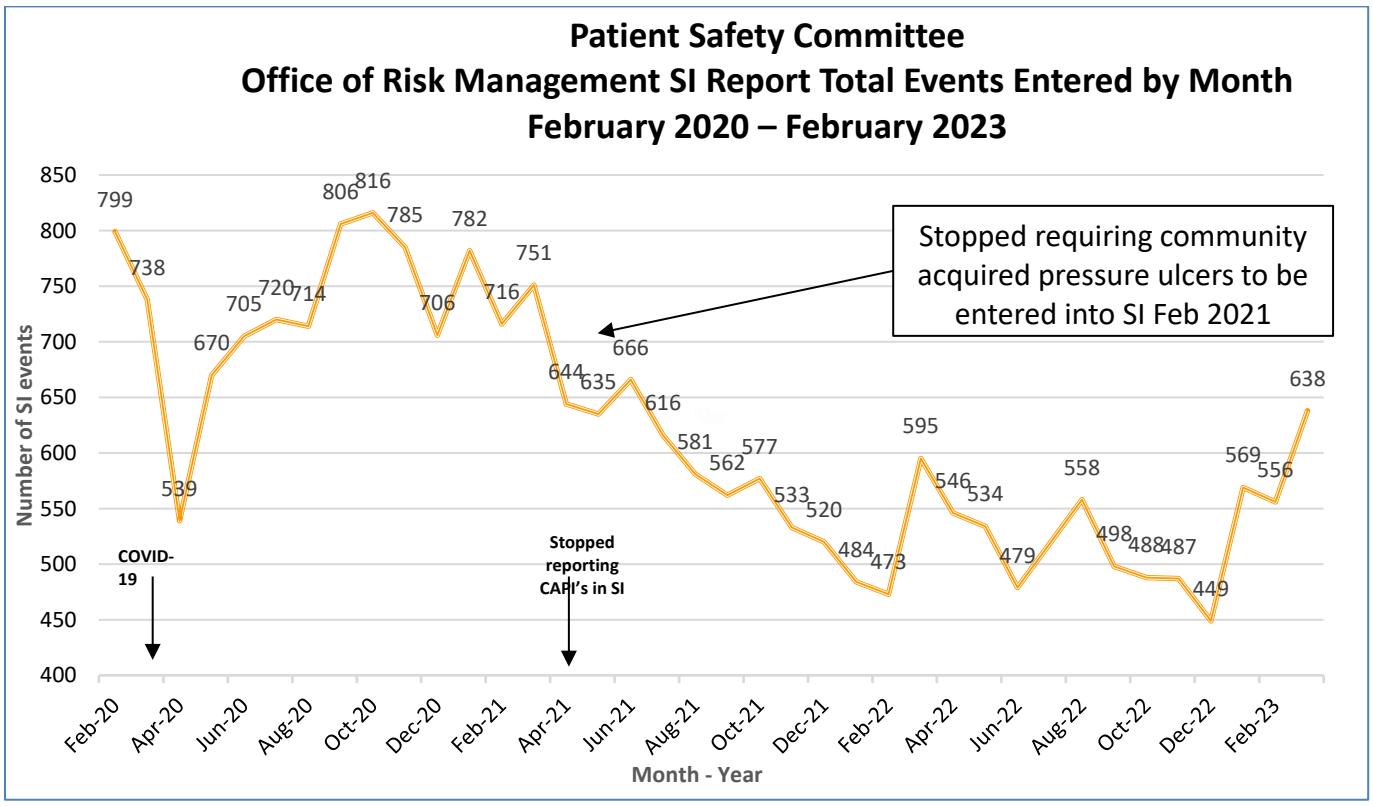
During this evaluation period, we began to recover from a world-wide pandemic (COVID-19); as we moved from pandemic operations to normal operations with an ongoing endemic, we observed ongoing impact on normal hospital operations and procedures from the pandemic. We experienced a surge in COVID -19 cases 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.

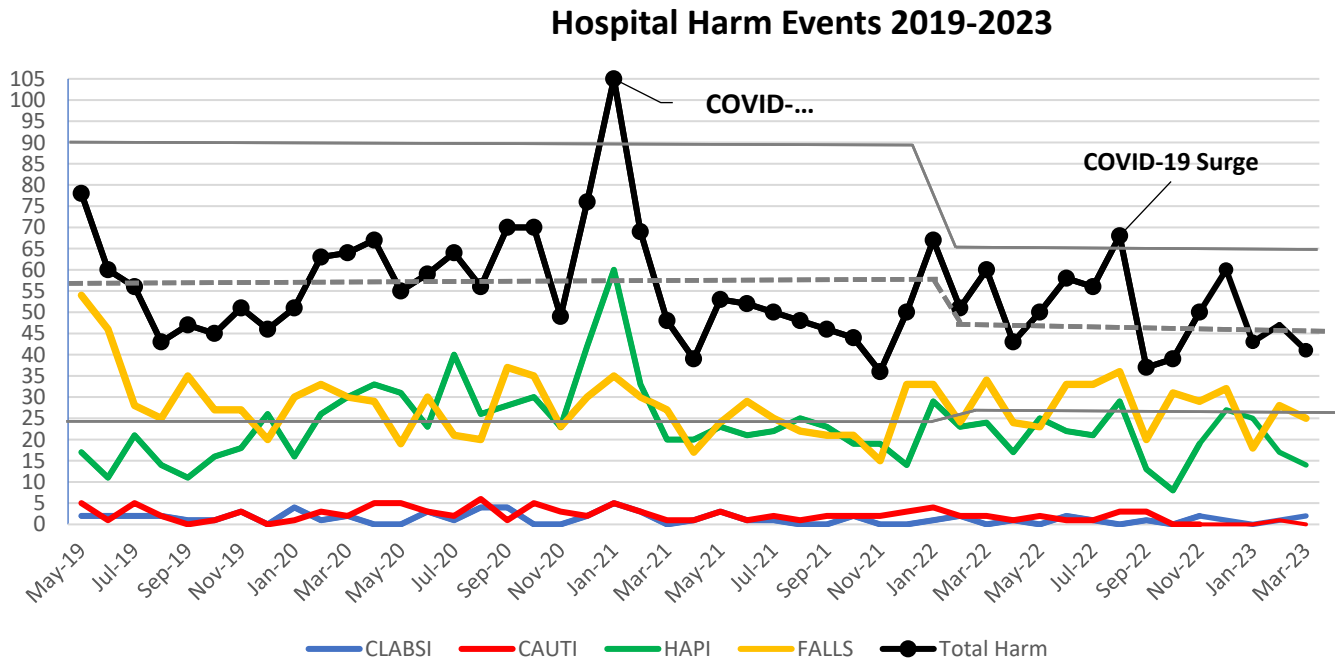
1. Total Events Reported

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



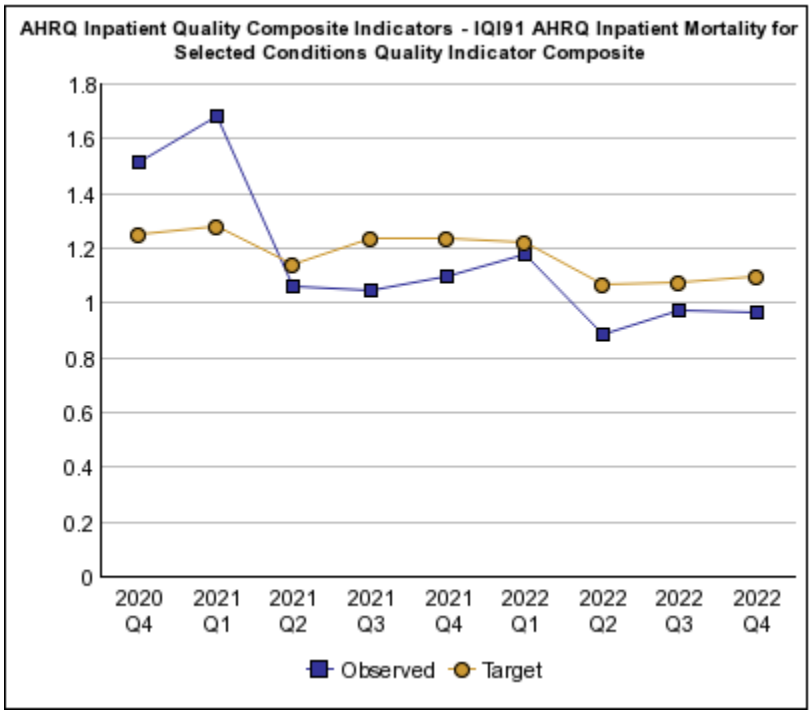
average of 1800 events are reported each quarter.

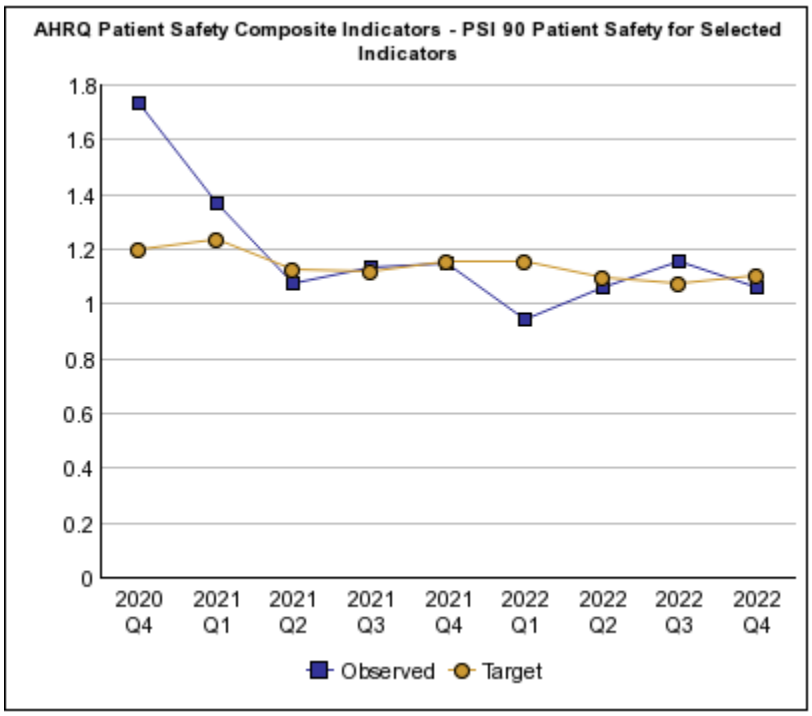
A.



B. AHRQ Safety Indicators

LA GENERAL 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 mortality (Mortality index <1 for last 7 quarters) and PSI 90 composite (we are below target for the last 4 of the last 5 quarters). Efforts are ongoing to improve our PSI composite scores. LA GENERAL continues with measure surveillance to sustain ongoing measure improvement projects (Core Measures/eCQMs). LA GENERAL 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 >6, 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 2022 to June 2023 the QRS committee reviewed 277 events. We did RCAs on 17 of these events, Intensive Reviews on 16 of these events, and reached out to departments for a more robust local response in >100 of these events.

D. Deficiencies Identified by California Department of Public Health

From July 2022 to June 2023, LA GENERAL reported the following "Never Events" to the California Department of Public Health:

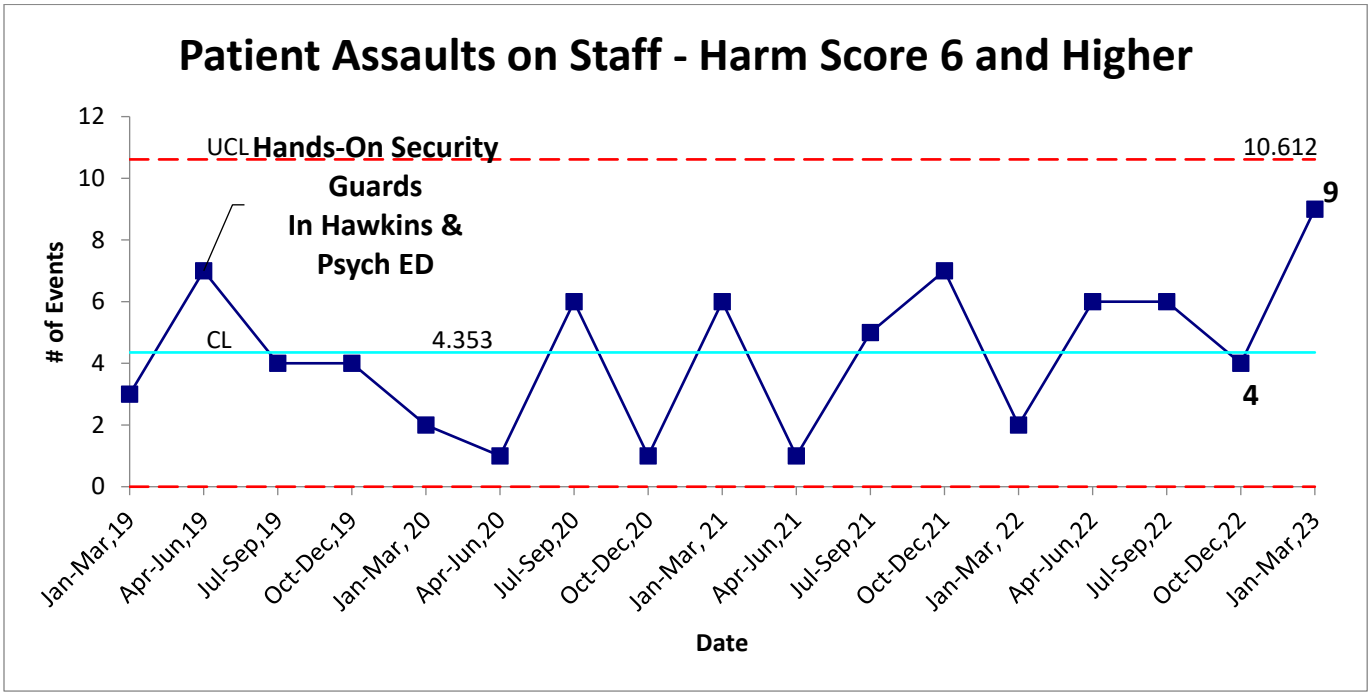
Pressure Injuries	34
Retained foreign body	1
Alleged physical/sexual assault (staff to patient)	20

Patient complication during surgery	1

55%of reported pressure injury cases resulted in findings of "deficiency". Majority of deficiencies were related to lack of documentation and failure to follow established policies. All reported alleged assault/abuse cases were unsubstantiated with 66% of cases found with deficiencies related to failure to follow policy. The increase of reported alleged physical/sexual assault (staff to patient) cases are believed to be due to staff's increased awareness of reporting requirements.

E. Workers' Compensation Workplace Violence 2022

			1st Quarter			2nd Quarter			3rd Quarter			4th Quarter		
PI MEASURE	FREQUENCY	GOAL	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
SECURITY MANAGEMENT														
# Grand Theft Autos	Monthly	<5	0	0	3	2	2	1	2	1	1	1	1	4
# Vehcle Burglary	Monthly	<5	0	0	0	0	0	0	0	0	0	1	0	1
# Co. Property stolen	Monthly	<5	0	0	0	1	0	0	0	0	0	0	1	0
# Crimes/Persons	Monthly	<5	1	3	3	4	3	0	3	1	2	2	4	1
# Crimes/Property	Monthly	<5	3	2	6	3	4	5	3	9	2	3	2	6
HAZMAT & WASTE MANAGEMENT														
Number (#) of actual hazardous spill incidents per month.	Monthly	<2	0	2	0	0	0	2	0	0	0	0	1	1
Discrepancies found during the monitoring of the hazardous waste yards and satelite accumilation areas.	Monthly	<2	0	1	0	0	0	0	0	0	0	1	0	0
All (Red) Sharps and Biohazardous Waste Containers are Properly Labeled and contain no Pharmaceutical Waste.	Monthly	<3	0	0	1	0	0	0	0	0	0	0	0	0
Employees are familiar with the location of the Safety Data Sheets (SDS) in their work location	Monthly	8	8	8	8	8	8	8	8	8	8	8	8	8



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.

Dashboard Strategy / National Patient Safety Goals

			Freq	CY19 Q4	CY20 Q1	CY20 Q2	CY20 Q3	CY20 Q4	CY21 Q1	CY21 Q2	CY21 Q3	CY21 Q4	CY22 Q1	CY22 Q2	CY22 Q3	CY22 Q4	CY23 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 (Updated Jan 2023 to include EP covering misidentification in re: to blood tranfusions)	Y	98%	100%	*	99%	*	*	*	96%	*	-	-	96%	*	93%	90%	
NPSG 2	Improve the effectiveness of communication among caregivers		Freq	CY19 Q4	CY20 Q1	CY20 Q2	CY20 Q3	CY20 Q4	CY21 Q1	CY21 Q2	CY21 Q3	CY21 Q4	CY22 Q1	CY22 Q2	CY22 Q3	CY22 Q4	CY23 Q1	Target/ Comparative	Status
	Update 2023* 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	97%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	*	98%	90%	
NPSG 3	Improve the safety of using medications.		Freq	CY19 Q4	CY20 Q1	CY20 Q2	CY20 Q3	CY20 Q4	CY21 Q1	CY21 Q2	CY21 Q3	CY21 Q4	CY22 Q1	CY22 Q2	CY22 Q3	CY22 Q4	CY23 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	**	*	**	*	**	*	*	**	**	96%%	90%	98%	*	100%	90%%	
		BCMA Bar Code Medication Administration (Added 2019)	Q	97.7%	97.3%	96.3%	96.9%	97%	95%	97%	97%	97%	96%	97%	96%	96%	P	90%	
		Maintain and communicate accurate patient medication information																	
	03.06.01	Inpatient Medication History	Y	*	99%	99%	99%	100%	99%	99%	100%	*	-	-	99%	*	P	90%	
		Inpatient Admit Medication Reconciliation	Q	**	76%	73.3%	77.2%	73.2%	73.5%	68.3%	66.7%	53.9%	62.0%	64.0%	62.0%	67.0%	P	90%	
		Inpatient Discharge Medication Reconciliation	Y	*	97.3	97.3%	98.5%	98.3%	97.8%	98.5%	98.7%	*	-	-	98%	*	P	90%	
		Outpatient Medication History	Q	**	**	**	**	**	**	**	**	**	77.8%	**	**	**	N/A	90%	
		Outpatient Medication Reconciliation	Q	**	**	**	**	**	**	**	**	**	53.9%	**	**	**	N/A	90%	

Dashboard Strategy / National Patient Safety Goals

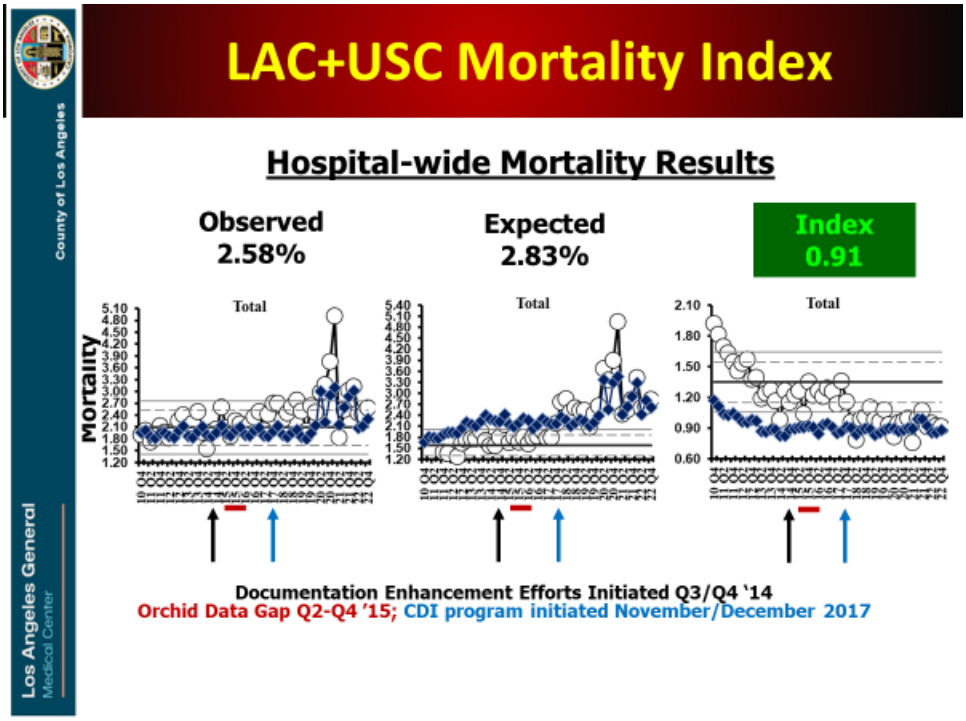
			Freq	CY19 Q4	CY20 Q1	CY20 Q2	CY20 Q3	CY20 Q4	CY21 Q1	CY21 Q2	CY21 Q3	CY21 Q4	CY22 Q1	CY22 Q2	CY22 Q3	CY22 Q4	CY23 Q1	Target/ Comparative	Status
NPSG 1		Improve the accuracy of patient identification																	
	01.01.01	Use at least two patient identifiers when providing care, treatment, and services (Updated Jan 2023 to include EP covering misidentification in re: to blood tranfusions)	Y	98%	100%	*	99%	*	*	*	96%	*	-	-	96%	*	93%	90%	
NPSG 2		Improve the effectiveness of communication among caregivers	Freq	CY19 Q4	CY20 Q1	CY20 Q2	CY20 Q3	CY20 Q4	CY21 Q1	CY21 Q2	CY21 Q3	CY21 Q4	CY22 Q1	CY22 Q2	CY22 Q3	CY22 Q4	CY23 Q1	Target/ Comparative	Status
	Update 2023* 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	97%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	*	98%	90%	
NPSG 3		Improve the safety of using medications.	Freq	CY19 Q4	CY20 Q1	CY20 Q2	CY20 Q3	CY20 Q4	CY21 Q1	CY21 Q2	CY21 Q3	CY21 Q4	CY22 Q1	CY22 Q2	CY22 Q3	CY22 Q4	CY23 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	**	*	**	*	**	*	*	**	**	96%%	90%	98%	*	100%	90%%	
		BCMA Bar Code Medication Administration (Added 2019)	Q	97.7%	97.3%	96.3%	96.9%	97%	95%	97%	97%	97%	96%	97%	96%	96%	P	90%	
		Maintain and communicate accurate patient medication information																	
	03.06.01	Inpatient Medication History	Y	*	99%	99%	99%	100%	99%	99%	100%	*	-	-	99%	*	P	90%	
		Inpatient Admit Medication Reconciliation	Q	**	76%	73.3%	77.2%	73.2%	73.5%	68.3%	66.7%	53.9%	62.0%	64.0%	62.0%	67.0%	P	90%	
		Inpatient Discharge Medication Reconciliation	Y	*	97.3	97.3%	98.5%	98.3%	97.8%	98.5%	98.7%	*	-	-	98%	*	P	90%	
		Outpatient Medication History	Q	**	**	**	**	**	**	**	**	**	77.8%	**	**	**	N/A	90%	
		Outpatient Medication Reconciliation	Q	**	**	**	**	**	**	**	**	**	53.9%	**	**	**	N/A	90%	

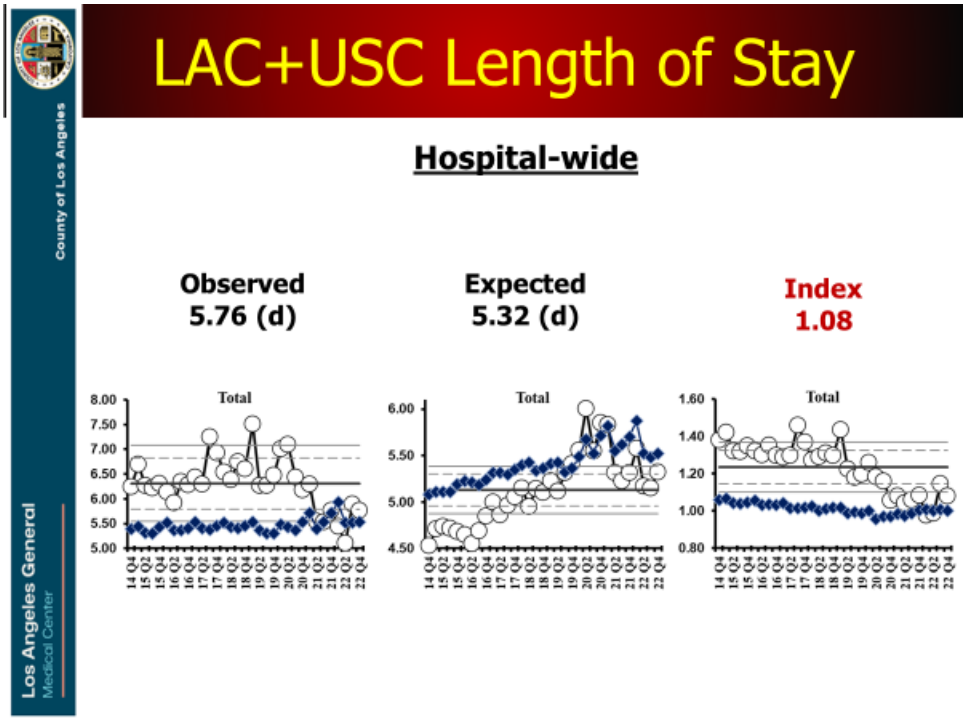
			Freq	CY19 Q4	CY20 Q1	CY20 Q2	CY20 Q3	CY20 Q4	CY21 Q1	CY21 Q2	CY21 Q3	CY21 Q4	CY22 Q1	CY22 Q2	CY22 Q3	CY22 Q4	CY23 Q1	Target/ Comparative	Status
NPSG 6	Reduce patient harm associated with clinical alarm systems																			
	06.01.01	Improve the safety of clinical alarm systems. * *(Effective Jan. 2023 EP 3 is deleted)*	Y	100%	100%	*	*	*	100%%	*	*	*	100%%	*	*	*	N/A	100%	
NPSG 7	Reduce the risk of health care–associated infections		Freq	CY19 Q4	CY20 Q1	CY20 Q2	CY20 Q3	CY20 Q4	CY21 Q1	CY21 Q2	CY21 Q3	CY21 Q4	CY22 Q1	CY22 Q2	CY22 Q3	CY22 Q4	CY23 Q1	Target/	Status
	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	87%	83%	83%	80%	84%	86%	81%	85%	84%	85%	87%	90%	89%	89%	90%	
NPSG 15	The hospital identifies safety risks inherent in its patient population		Freq	CY19 Q4	CY20 Q1	CY20 Q2	CY20 Q3	CY20 Q4	CY21 Q1	CY21 Q2	CY21 Q3	CY21 Q4	CY22 Q1	CY22 Q2	CY22 Q3	CY22 Q4	CY23 Q1	Target/ Comparative	Status
		Identify patients at risk for suicide.																	
	15.01.01	Nursing suicide risk assessment upon admission	T	100%	100%	*	100%	*	100%	*	100%	*	73%	*	100%		100%	90%	
		Nursing suicide risk assessment upon discharge	T	100%	100%	*	100%	*	100%	*	100%	*	99%	*	100%		100%	90%	
Universal Protocol	Universal Protocol: Preventing Wrong Site, Wrong Procedure		Freq	CY19 Q4	CY20 Q1	CY20 Q2	CY20 Q3	CY20 Q4	CY21 Q1	CY21 Q2	CY21 Q3	CY21 Q4	CY22 Q1	CY22 Q2	CY22 Q3	CY22 Q4	CY23 Q1	Target/ Comparative	Status
	01.01.01	Conduct a preprocedure verification process.* *(Effective Jan. 2023 EP 3 is deleted)*	Y	*	**	*	**	**	**	**	**	*	100%	*	100%	*	100%	90%	
	01.01.02	Mark the procedure site	Y	*	**	*	**	**	**	**	**	*	100%	*	100%	*	100%	90%	
	01.01.03	A time-out is performed before the procedure.	Y	*	**	*	**	**	**	**	**	*	95.00%	*	93%	*	63%	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

LAC+USC MEDICAL CENTER Patient Safety

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

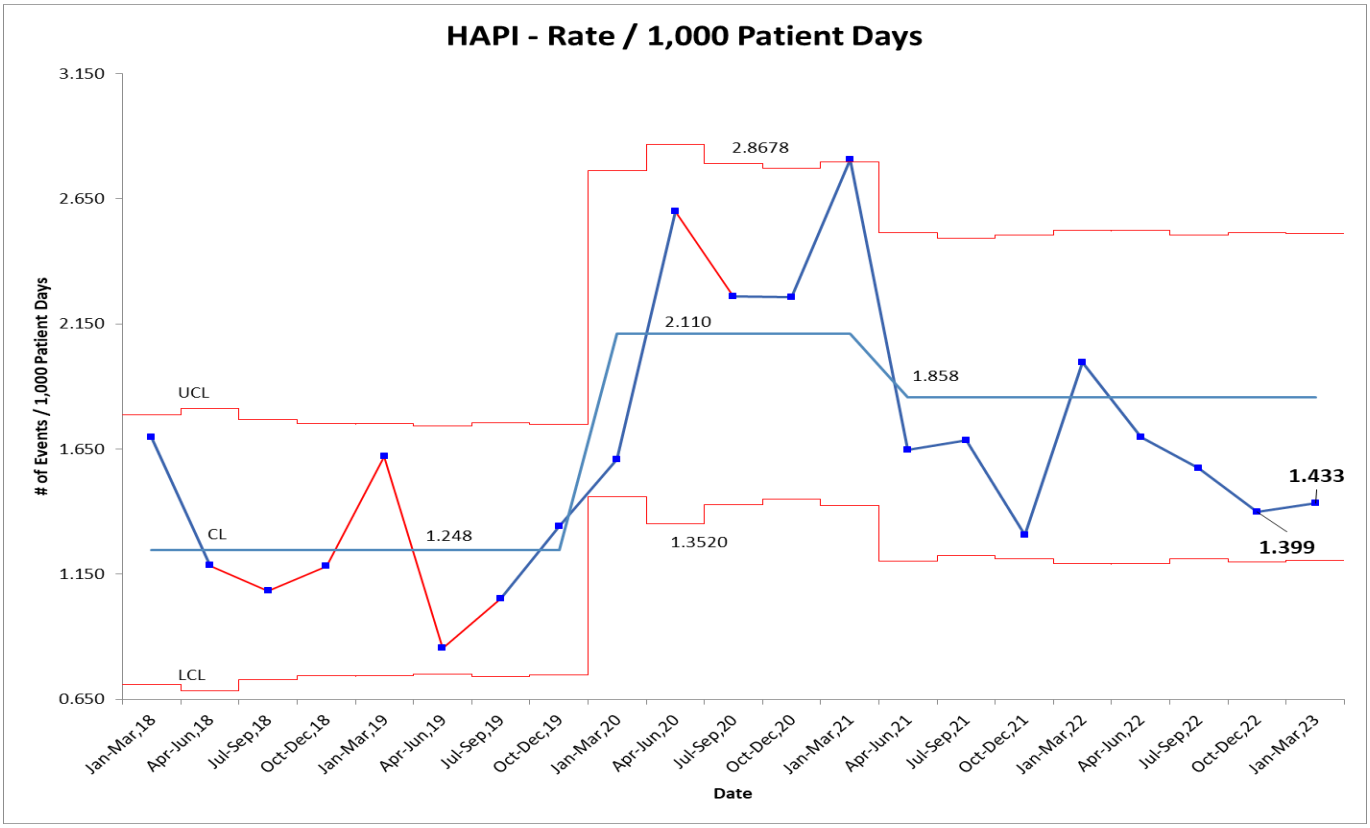
Chairs and Service Chiefs to improve both the clinical documentation and the quality of care delivered. The Mortality Index is Below 1.0, indicating a high level of quality care being delivered. Our length of stay index is currently >1.0 due to several patients awaiting placement in community facilities.

H. Quality/Patient Safety Risk Mitigation Plan

LA GENERAL has identified the following risk mitigation strategies to address areas of opportunity.

1) Pressure Ulcers

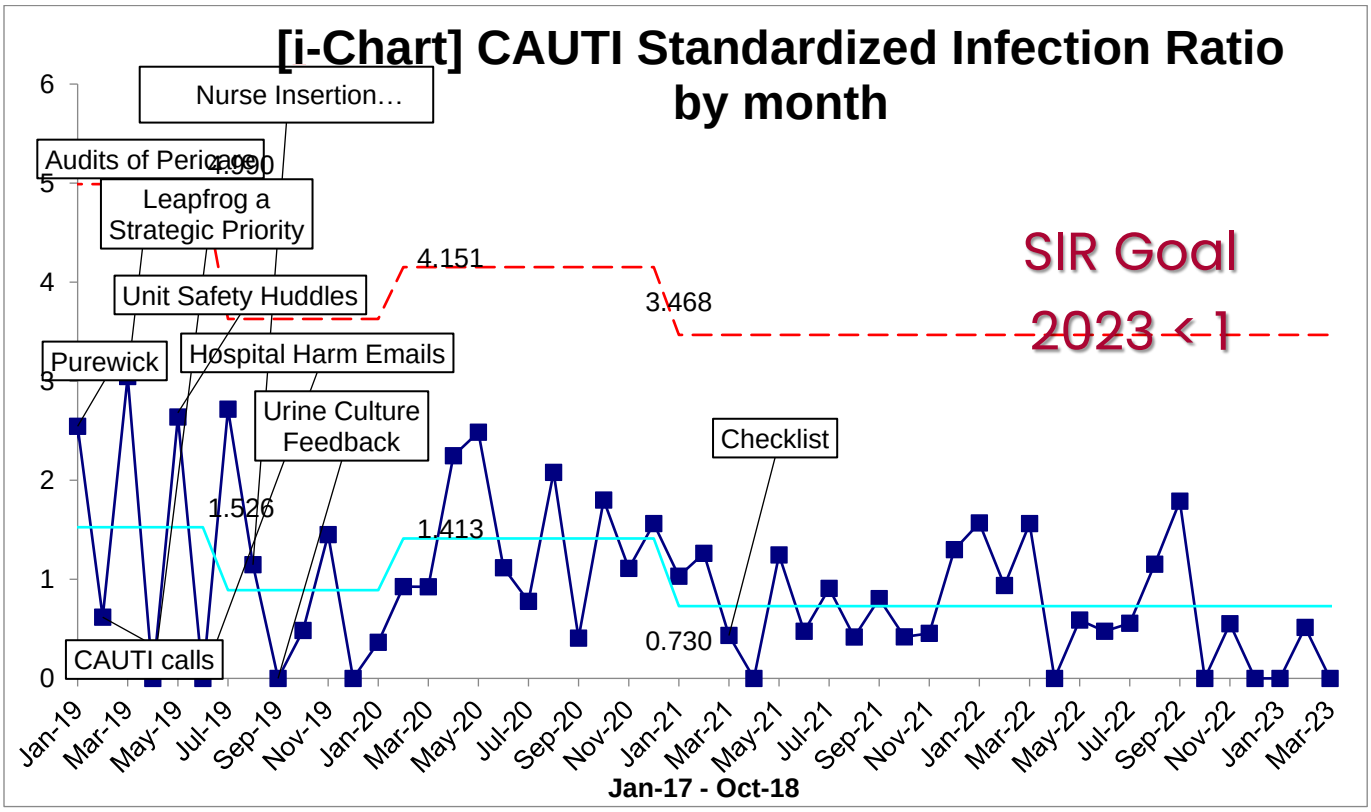
- Pressure ulcers continue to be a challenging patient safety problem. Numbers increased throughout COVID due to proning and use of oxygenation devices. Staff continue to review each event and identify opportunities to improve.



2) CAUTI/CLABSI

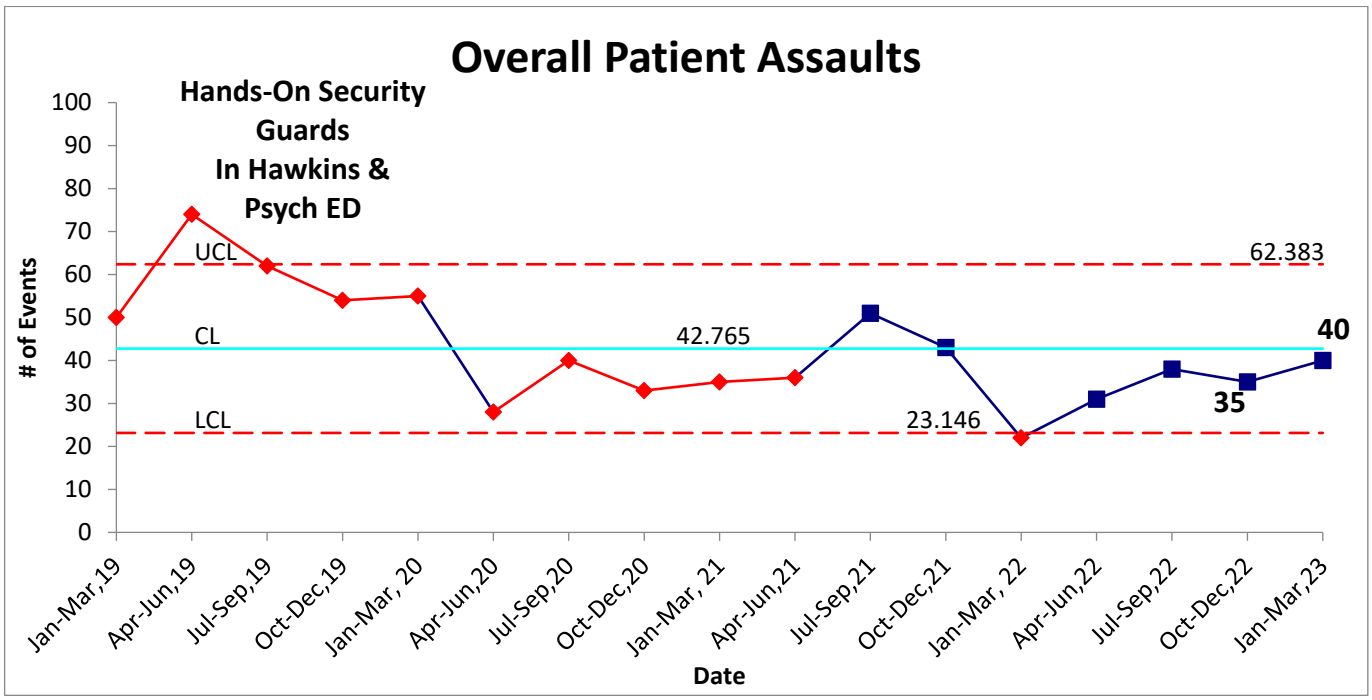
CLABSI and CAUTI rates have improved but remain higher than our goal SIR <0.4. We have implemented a checklist for patients with foley catheters and central lines where staff are to assess the daily need for these invasive devices and to ensure the cleanliness of them and keep up with the current CDC guidelines and LA GENERAL policies. Many units have discussed these patients in their

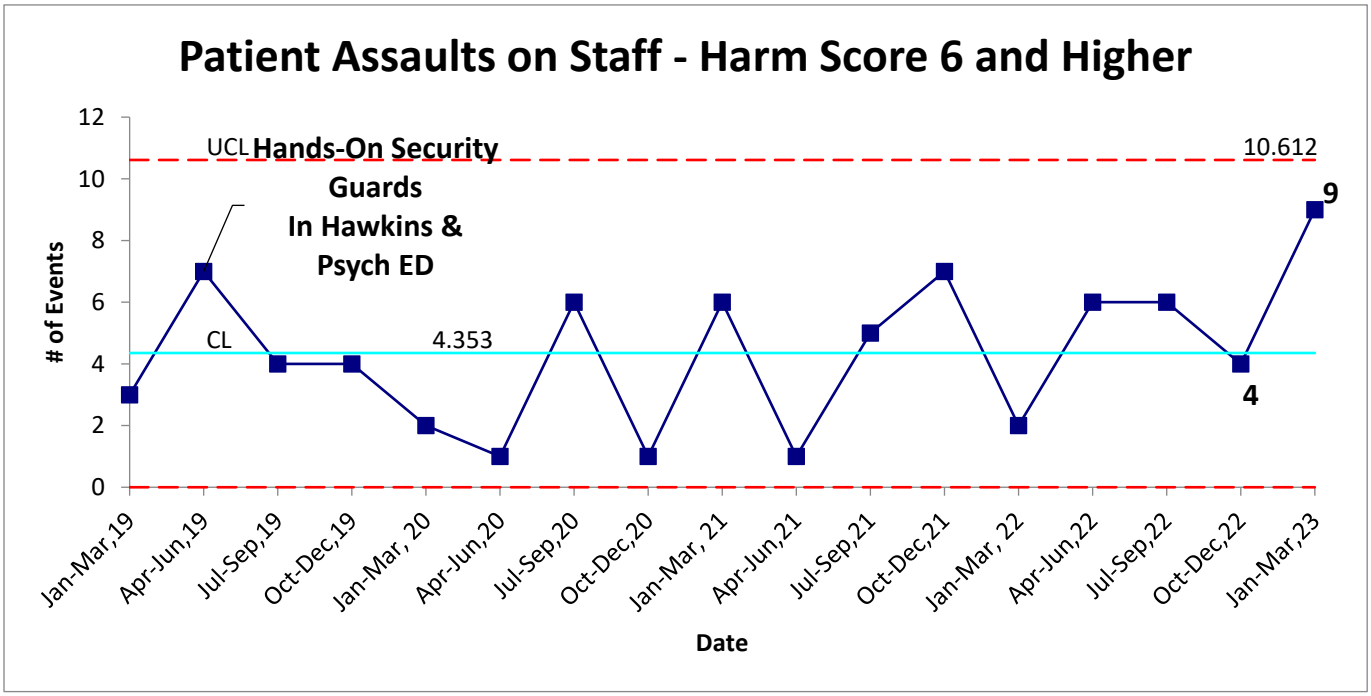
unit safety huddles or rounds, and work to decrease the overall number of foley catheters and central lines in our patients. We continue to review each event at our CLABSI and CAUTI committees respectively to search for ways to improve.



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".

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 >150 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 (October 2022) demonstrate improvements and opportunities. Our plans to improve these scores are underway, and is led by our new Chief Diversity and Community Engagement Officer. Our next survey is scheduled for October 2024 and will be reported in the next evaluation period.

ENGAGEMENT

Benchmark	2022	2020
Safety Net	23rd	39th

KEY DRIVERS

1. High-quality care & service
2. Actively improving patient safety
3. Emp/mgr work toward safe workplace

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Results Overview

Survey Admin: October - November 2022
n=3,660, 56% Response Rate (2020: 38%)

STRENGTHS

- **Management** and **Nursing-Other** roles provided **Engagement** ratings significantly higher than the organizational average of 3.83.
- Overall **Leader Index** score remained steady (80) since 2020

OPPORTUNITIES

- Perceptions of **high-quality care** & **safe, error-free care** are critical to engagement, sig. underperforming the benchmark and sig. declining since 2020
- Feelings of **organizational respect** is a key driver of engagement, scoring sig. below the benchmark (-.24) and decreasing sig. since 2020 (-.08)
- Perceptions of **safe working conditions** are critical to engagement, scoring sig. below the benchmark (-.25)

Note – In this presentation BLUE/RED notes a statistically significant difference.
Natl Safety Net Avg +/- .04 2022 Overall +/- .04 History +/- .06

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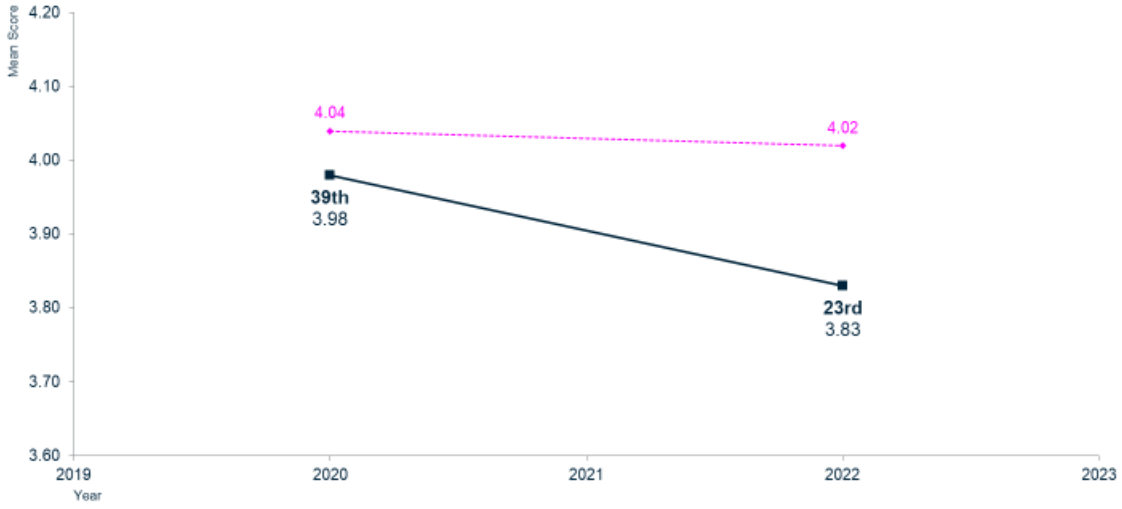
Engagement Trending

2022 Natl Safety Net Avg
Facilities: 120
Respondents:103,937



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Safety Culture & Resilience Results Overview

Safety Culture

Evaluation of attitudes and behaviors impacting patient and workplace safety

	2022	vs. Safety Net	vs. Overall	vs. 2020
Prevention & Reporting	3.83	-.22	-.05	-.03
Resources & Teamwork	3.44	-.21	-.05	-.12
Pride & Reputation	3.86	-.23	-.02	-.08

Resilience

Ability to recover and bounce back from adversity—early warning system for burnout

	2022	vs. Safety Net	vs. Overall	vs. 2020
Decompression	3.63	-.08	-.01	-.04
Activation	4.34	-.16	-.01	-.03

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