SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE REGULAR MEETING
AGENDA
WEDNESDAY, October 28, 2015
5:00 p.m. Regular Session
(Closed Session will be held upon adjournment of the Regular Session)

Location: Schantz Conference Room
Sonoma Valley Hospital – 347 Andrieux Street, Sonoma CA 95476

AGENDA ITEM	RECOMMENDATION	
MISSION STATEMENT The mission of the SVHCD is to maintain, improve, and restore the health of everyone in our community.		
1. CALL TO ORDER/ANNOUNCEMENTS	*Hirsch*	
2. PUBLIC COMMENT SECTION At this time, members of the public may comment on any item not appearing on the agenda. It is recommended that you keep your comments to three minutes or less, Under State Law, matters presented under this item cannot be discussed or acted upon by the Committee at this time For items appearing on the agenda, the public will be invited to make comments at the time the item comes up for Committee consideration.	*Hirsch*	
2. CONSENT CALENDAR • QC Minutes, 9.23.15	*Hirsch*	Action
3. QUARTERLY PATIENT CARE SERVICES DASHBOARD	*Kobe*	Inform
4. THE BIRTHPLACE PRESENTATION	*Amara/Smith/McAleer*	Inform
5. POLICY & PROCEDURE • Emergency Department Staff (revised and brought forward) • Multiple Policies September 2015 • Newborn Screening	*Lovejoy/Kobe*	Action
6. QUALITY REPORT OCTOBER 2015 • Quality and Resource Management Report • Update on Hospital Quality Performance Metrics	*Lovejoy*	Inform/ Action
7. CLOSING COMMENTS/ANNOUNCEMENTS	*Hirsch*	
8. ADJOURN	*Hirsch*	
9. UPON ADJOURNMENT OF REGULAR OPEN SESSION	*Hirsch*	
10. CLOSED SESSION: Calif. Health & Safety Code § 32155 • Medical Staff Credentialing & Peer Review Report 10.28.15	*Sebastian*	Action
11. REPORT OF CLOSED SESSION	*Hirsch*	Inform/ Action
12. ADJOURN	*Hirsch*	

2.

CONSENT

+

SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
REGULAR MEETING MINUTES
Wednesday, September 23, 2015
Schantz Conference Room

Committee Members Present	Committee Members Present cont.	Committee Members Excused	Admin Staff /Other
Jane Hirsch Carol Snyder Joshua Rymer M. Mainardi Kelsey Woodward Cathy Webber Ingrid Sheets Brian Sebastian, M.D.		Susan Idell H. Eisenstark Keith Chamberlin, MD, MBA	Robert Cohen MD Leslie Lovejoy Mark Kobe Gigi Betta

AGENDA ITEM	DISCUSSION	ACTION	FOLLOW-UP
1. CALL TO ORDER/ANNOUNCEMENTS	*Hirsch*		
	The meeting was called to order 5:00pm		
2. PUBLIC COMMENT	*Hirsch*		
	None		
3. CONSENT CALENDAR	*Hirsch*	Action	
• QC Minutes, 8.26.15		**MOTION** by Rymer to approve and 2nd by Mainardi. All in favor.	

4. POLICES, ORDER SET & REVISION	*Lovejoy/Kobe*	Action	
1) Access to Public Records Policy 2) Emergency Department Staffing Policy 3) Revised Alcohol Withdrawal Order Set 4) Revision to Medical Staff R&Rs	The Emergency Department Staffing Policy is to be revised and brought back to the next QC meeting for approval.	**MOTION** by Rymer to approve #1, 3, & 4 only and 2nd by Mainardi. All in favor.	

5. QUALITY REPORT SEPTEMBER 2015	*Lovejoy*	Inform/Action	
	The annual Performance Improvement Fair is 9.30.15 in the Basement Conference Room. Ms. Woodward and Ms. Sheets will be judging the 12 Clinical Projects and 10 Support Services projects. Attached to this report are the judging criteria and a list of topics to be presented. The Hospital had an unscheduled visit from the State for a federal complaint validation survey and all requirements to clear outstanding complaints may have been met. The Quality Department is working on a method to communicate Midas E-Notification data by department and event type to Leaders. The Quality Department has developed this process in response to AHRQ Culture of Safety results. Attached are the Good Catch Summary YTD and Policy & Procedure Feedback Template.	**MOTION** by Mainardi to approve and 2nd by Sheets. All in favor.	
6. CLOSING COMMENTS	*Hirsch*		
			.
7. ADJOURN	*Hirsch*		
	Meeting adjourned at 5:45pm		
8. UPON ADJOURNMENT OF REGULAR OPEN SESSION	*Hirsch*		
9. CLOSED SESSION	*Sebastian*	Action	
Calif. Health & Safety Code § 32155 Medical Staff Credentialing & Peer Review Report	No Credentialing & Peer Review Report submitted.		
10. REPORT OF CLOSED SESSION	*Hirsch*	Inform/Action	
11. ADJOURN	*Hirsch*		

3.

PATIENT CARE SERVICES

Patient Care Services Dashboard 2015

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
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Medication Scanning Rate	2015				
	Q1	Q2	Q3	Q4	Goal
SNF	N/A	80.0%	76.7%		90%
Acute	80.0%	81.0%	88.8%		90%
ED	80.0%	87.0%	85.4%		90%

Falls (Per 1000 days)	2015				
	Q1	Q2	Q3	Q4	50th %tile
SNF	0.0	1.1	2.2		N/A
Acute	0.0	1.0	0.0		2.32%

Hospital Acquired Pressure Ulcer Incidents (Per 1000 admissions)	2015				
	Q1	Q2	Q3	Q4	National
SNF	0.0	2.4	1.6		3.17
Acute	0.0	2.0	1.3		3.68

Nursing Turnover	2015				
	Q1	Q2	Q3	Q4	Goal
SNF	0%	1.50%	5.8% (1/17)		<3%
Acute	1.50%	1.40%	2.00%		<3%
Healing at Home	N/A	N/A	7.1% (1/14)		<3%
Total Nursing Turnover	N/A	N/A	3.80%		<3%

Professional RN Certification	2015			
			Higher Education	
	SVH	Goal	BS	MS
Emergency (CEN)	0	1	14% (3)	
ICU (CCRN)	2	3	29% (5)	5% (1)
The Birthplace (Inpatient Obstetrics)	1	2	50% (8)	19% (3)
Med Surg (MSRN)	0	1	42% (8)	5% (1 MSN)
Surgery (AORN, ASPAN)	3	4	60% (9)	
SNF (Gerontology, Palliative care, Long-term care, Resident Assessment Coordinator)	9	10	57% (8)	7% (1 MS) 7% (1 PhD)
Case Management	2	3	62.5% (5)	12% (1 PhD)
Healing at Home	2	3	50% (9)	2 MSN

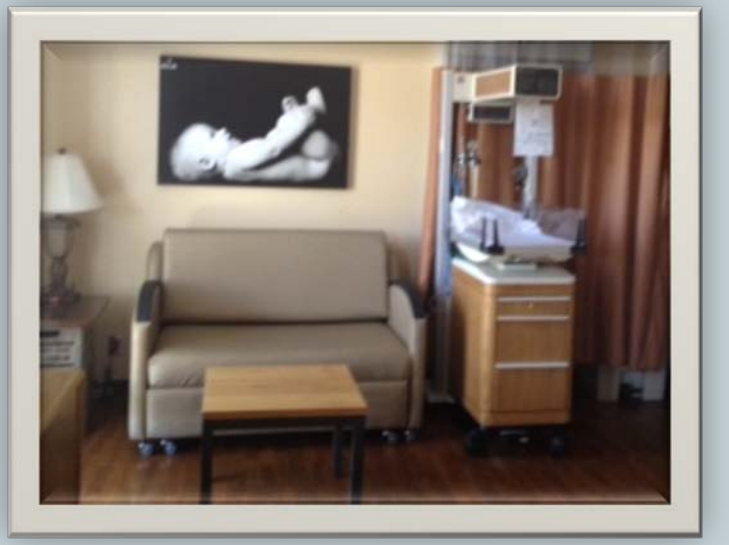
4.

BIRTHPLACE

The Birthplace

The Birthplace

- 3 LDRPs
- 6 Postpartum Rooms
- 1 Operating Room
- 1 Triage Room



- Hydrotherapy for laboring, tub or shower
- Birthing balls and birthing bar for labor beds
- Medication and epidurals available

STAFFING

Total : 14 Staff RNs, 1 Travel RN, & Nurse Manager

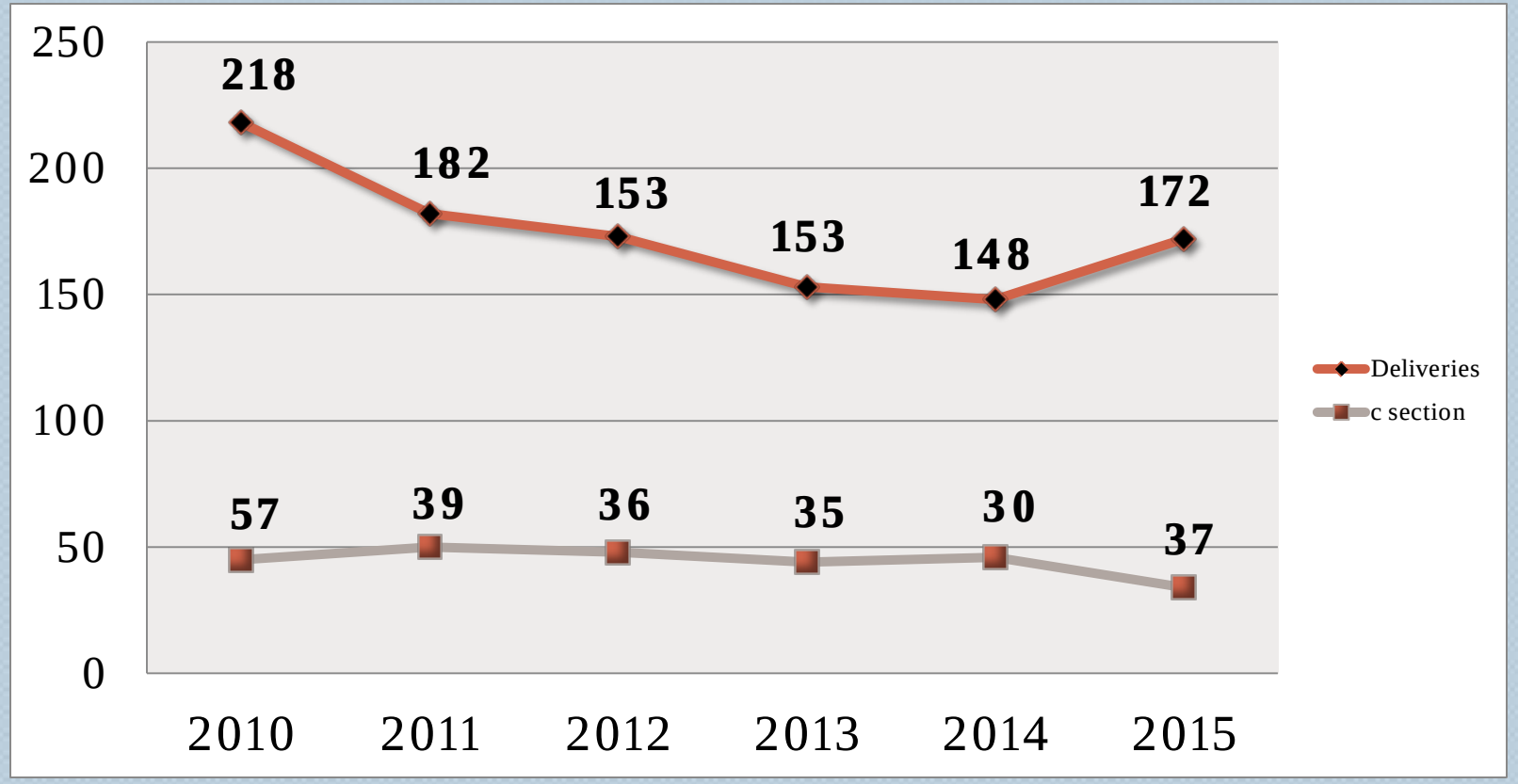
- Turnover rate of RNs has ***decreased:***
  - 2015 = 6%
  - 2014 = 5%
  - 2013 = 17%

- Use of travel RNs has ***decreased:***
  - 2015 = 2
  - 2014 = 6
  - 2013 = 6

Physicians:

- Obstetrician - Dr. Amara
- Family Practice – Dr. Ahern
- Pediatricians – Dr. Smith, Dr. DeTorres
- Anesthesiologists – Marin Anesthesia Group

Unit Statistics:
Deliveries per fiscal year:



Last 12 months…

Number of Births: 166

Cesarean Birth rate: 20%

- Primary 8%
- Repeat 12%

- No c-sections in January

Last 12 months

- Exclusive Breastfeeding Rate on Discharge: **81%**
- Outpatients Visits: **475**

❖ Several interesting patient conditions :

- Prolapsed cord event
- Delivery of **1** set of twins
- Transfer of **3** newborns to facilities for a higher level of care.
- Transfer of **5** mothers to facilities for a higher level of care.

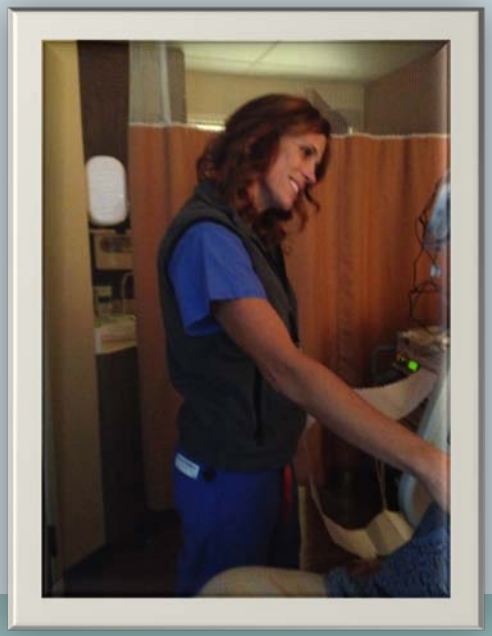
Service/People

Patient Satisfaction Scores

- For August 2014 – August 2015: 7 out of 9 of the dimensions surveys rated above the 70th percentile ranking

Employee Satisfaction score had *increased* to 74.6%

- With 70% participation of staff
- Up 13.6% from 2014 score



FINANCE

Cost Accounting System for OB started June 2015

Goal: 10%-15% margin

Project Outcome: To create a profitable OB unit before the inclusion of DSH funds built around high quality cost efficient care to our OB patients

FINANCE CONTINUED…

Before analysis and implementation of interventions the margin was 5% (Jan 15-March 15).

- Reduced supply costs
- Reduced medication costs
- Increased revenue charges

Trending June 2015-Aug 2015	
Total Charges	,000
Total net revenue	$683,244
Total direct costs	-$583
Direct Margin	15% or $100,000

Quality

Quest For Zero

- BETA Healthcare Group offers an OB Safety Program “designed to enhance the quality of care in this high-risk clinical area.”
- All OB nursing staff and obstetrician completed the Annual Electronic Fetal Monitoring Assessment, in 2015.
- SVH received the 5% premium renewal credit.

BETA HEALTHCARE GROUP

Quality

- Participating in the:

California Maternal Quality Care Collaborative (CMQCC) to optimize outcomes of perinatal hemorrhage

  - Toolkit to improve early detection and treatment implemented

- Implementing the:

Standardized Procedure for Medical Screening Examination for the Obstetrical Patient Performed by RN

  - Participate in monthly team meetings with other similar sized area hospitals
  - **OB Task Force**
    - Comprised of medical, nursing, and administrative personnel to make up a multi-disciplinary committee
    - Reviews and discusses relevant statistics, issues, and concerns
  - Implemented **Skin to Skin** in the OR for Cesarean Births

Quality

UCSF Benioff Children's Hospital San Francisco

Educational Opportunities:

UCSF Perinatal Outreach Program

- Provides 8 hours of perinatal education to The Birthplace staff per year
  - Participated in Obstetric and Neonatal Simulation Training in managing maternal and neonatal emergencies.

- Provides Perinatal Case Review conferences twice yearly for nursing and medical staff.

Community

- Offering Childbirth Preparation Classes quarterly
- Offering Mother and Infant Class and Support Group quarterly

Community

First 5 Kit for New Parents

Works in Progress

- Sweet Success program

NATIONAL
CHILD
PASSENGER
SAFETY
CERTIFICATION

A Program of
Safe Kids Worldwide

- Car Seat Technician Certification

Thank you for your continued support!

Any questions?

5.

POLICIES

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
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POLICY AND PROCEDURE
Approvals Signature Page

Review and Approval Requirements

The SVH departmental/organizational policies and/or procedures on the attached list have been reviewed and approved by the following organizational leaders for meeting all of the following criteria. All of these policies and procedures are:

- Consistent with the Mission, Vision and Values of the Sonoma Valley Health Care District
- Consistent with all Board Policy, Hospital Policy and Hospital Procedures
- Meet all applicable law, regulation, and related accreditation standards
- Consistent with prevailing standards of care
- Consistent with evidence-based practice

We recommend their acceptance by the Quality Committee and that the Quality Committee forward them to the Sonoma Valley Health Care District Board with a recommendation to approve.

Department: 7010-19 Emergency Department Staffing Plan-New Policy	
APPROVED BY:	DATE: **8-06-2015**
Director's/Manager's Signature	Printed Name **David Dunn, RN BSN**

Douglas S Campbell, MD
Chair Medicine Committee — 9/18/15 Date

Michael Brown, MD
Chair Surgery Committee — 9/21/15 Date

Keith J. Chamberlin, MD MBA
President of Medical Staff — 9/17/15 Date

Kelly Mather
Chief Executive Officer — 9/22/15 Date

Sharon Nevins
Chair, Board of Directors — Date

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Policy Submission Summary Sheet

Title of Document: **Emergency Department Policy**

New Document or Revision written by: **Mark Kobe, RN MPA**

Date of Document: **8-06-15**

Type:	**Regulatory:**
❑ **Revision** X **New Policy**	X **CIHQ** X **CDPH** X **CMS** ❑ **Other:**
Organizational:	X **Departmental**
X **Clinical** **Non-Clinical**	❑ **Interdepartmental** (list departments effected)

Please briefly state changes to existing document/form or overview of new document/form here:
(include reason for change(s) or new document/form)

7010-19 Emergency Department Staffing Plan- This policy defines the staffing patterns in the Emergency Department over a 24 hour, 7 days a week period. If further defines the expectations and role of the Relief/Triage nurse and their responsibilities for triaging, patient flow and oversight of the ED waiting room.

Reviewed by:	Date	Approved (Y/N)	Comment
Policy & Procedure Team	n/a		
Surgery Committee	**9/02/2015**	Yes	Mark Kobe-presenter
Medicine Committee	**9/10/2015**	Yes	
P.I. or P. T. Committee	n/a		
Medical Executive Committee	**9/17/2015**	Yes	Mark Kobe-presenter
Board Quality	**10/28/2015**		
Board of Directors	**11/05/2015**		

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SUBJECT: Emergency Department Staffing Plan	POLICY #7010-19
	PAGE 1 OF 2
DEPARTMENT: Emergency Department	EFFECTIVE: 10-2015
APPROVED BY: CNO	REVISED:

Purpose:

This policy will ensure adequate staffing for the Emergency Department to maximize patient safety and patient flow.

Policy:

The goal of the Emergency Department is to have staffing available to see presenting patients immediately or no later than 30 minutes throughout the day while maintaining California Department of Health Title 22 staffing ratios. Ratios are adjusted by patient acuity according to ED Policy 7010-1 Emergency Initial Assessment/Triage

Procedure:

Two qualified Emergency Department Registered Nurses (EDRN) will be present in the Department at all times when a patient is present in the department. See attached **STAFFING GUIDELINES FOR THE ED.**

References: CDPH Title 22

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SONOMA VALLEY HEALTH CARE DISTRICT
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SUBJECT: Emergency Department Staffing Plan	POLICY #7010-19
	PAGE 2 OF 2
DEPARTMENT: Emergency Department	EFFECTIVE: 10-2015
APPROVED BY: CNO	REVISED:

STAFFING GUIDELINES FOR ED

A. The staffing plan is as follows:

7am-7pm : Two Clinical EDRNs
11am-11pm: One Relief/Triage RN
12pm-8 pm: One additional Clinical EDRN
7pm-7am: Two Clinical EDRNs

B. At 11am, the Relief/Triage RN will be responsible for the following:

1. Break relief for the ICU RNs
2. Break relief for the ED RNs
3. Break relief will include documentation of care by Relief/Triage RN rendered during break.
4. Upon completion of the break coverage for ICU and ED, the Relief/Triage RN will then assume primary Triage duties in the ED
5. Primary Triage duties will consist of the following in no particular order, but based on department need/priorities and/or acuity:
   a. Triage of patients in waiting room to include electronic documentation in EDM of chief complaint, vital signs and patient profile as time and acuity permits, according to ED Policy and Procedure 7010-18
   b. Management of waiting room, collaborating with ED physician on flow of patients to accommodate high acuity patients in the waiting room.
   c. Repeating vital signs on patients in the waiting room at least every two hours.
   d. Updating patients in waiting room at least hourly on progress to be seen.
   e. Use of standardized protocol order sets to facilitate patient flow, pain management
   f. Full management of ESI level 4-5 patients as indicated and /or appropriate (includes full documentation and disposition) to facilitate patient flow
   g. Disposition/Discharge of patients within the department as appropriate
   h. Assisting EDRNs with IV starts, procedures as indicated.
   i. Other duties as assigned by the Administrative Nursing Supervisor based on housewide priority and/or need.

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POLICY AND PROCEDURE
Approvals Signature Page

Review and Approval Requirements

The SVH departmental/organizational policies and/or procedures on the attached list have been reviewed and approved by the following organizational leaders for meeting all of the following criteria. All of these policies and procedures are:

- Consistent with the Mission, Vision and Values of the Sonoma Valley Health Care District
- Consistent with all Board Policy, Hospital Policy and Hospital Procedures
- Meet all applicable law, regulation, and related accreditation standards
- Consistent with prevailing standards of care
- Consistent with evidence-based practice

We recommend their acceptance by the Quality Committee and that the Quality Committee forward them to the Sonoma Valley Health Care District Board with a recommendation to approve.

Organizational: Multiple Policies September 2015 List	
APPROVED BY:	DATE: **8-24-15**
Director's/Manager's Signature	Printed Name **Mark Kobe, RN MPA**

Douglas S Campbell, MD
Chair Medicine Committee

10/19/15
Date

Michael Brown, MD
Chair Surgery Committee

10-19-15
Date

out of town

Keith J. Chamberlin, MD MBA
President of Medical Staff

Date

Kelly Mather
Chief Executive Officer

Date

Sharon Nevins
Chair, Board of Directors

Date

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Policy Submission Summary Sheet

Title of Document: **Organizational Policies**

New Document or Revision written by: **Multiple Policies**

Date of Document: **8-24-15**

Type:	**Regulatory:**
X Revision **X New Policy**	**X CIHQ** **X CDPH** **X CMS** **❑ Other:**
Organizational:	❑ **Departmental** ❑ **Interdepartmental** (list departments effected)
X Clinical **X Non-Clinical**	

Please briefly state changes to existing document/form or overview of new document/form here:
(include reason for change(s) or new document/form)

PC8610-302 Implanted Port Access and Management-Revised; was ICU department policy, added Reference & link to Lippincott.

PCLB8610-202c Nurse Blood Administration-Picking Up Blood from Lab & Blood Product/Patient ID-Revised; ED patients do not need signed Transfusion/Gann consent form, patients admitted from ED must have the signed consent form before blood products are released.

PCLB8610-160 Release of Products to Nursing-Revised; ED patients do not sign a signed Transfusion/Gann consent form.

PCLB8610-301 Self Referral Testing- Revised; revised; lab to notify ED physician of critical values only if no primary care physician is given.

QS8610-110 Audibility of Clinical Monitoring & Intervention Alarm- New policy, to assure clinical monitoring and intervention systems are activated and sufficiently audible to health care workers.

LD8610-412 IV Pumps-Storage and Distribution-Revised; to establish and standardize the workflow process in terms of storage and cleaning

Reviewed by:	Date	Approved (Y/N)	Comment
Policy & Procedure Team	**8/19/2015**	**Yes**	
Surgery Committee	**9/02/2015**	Yes	Allan Sendaydiego; Mark Kobe
Medicine Committee	**9/10/2015**	No	No presenter, back in October
Medicine Committee	**10/08/2015**	[redacted] YES	Mark & Lois to present
PI or PT Committee	n/a		
Medical Executive Committee	**10/15/2015**	[redacted] YES	
Quality Board	**10/28/2015**		
Board of Directors	**11/05/2015**		

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
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SUBJECT: Implanted Port Access and Management	POLICY # PC8610-302
	PAGE 1 OF 1
DEPARTMENT: Organizational	EFFECTIVE: 12/07
APPROVED BY: Chief Nursing Officer	REVIEW/REVISED: 12/7 3/10, 3/14, 8/15

Purpose:
Provide guidelines for the RN to effectively access and manage a patient with an implanted port. It is the responsibility of the RN caring for the patient with an implanted port to maintain competency and skill level to provide safe care.

Only an RN or MD competent with the accessing of an implanted port may do so.

Procedure:
For accessing and general care of the patient with an implanted port, refer to:
Lippincott: http://procedures.lww.com/lnp/procedureselect.do

Flushing:

Using a 10 ml syringe, withdraw 5 ml from port and discard. Using a 10 ml syringe or larger, implanted ports will be flushed gently with 10 ml of preservative-free Normal Saline every 24 hours and PRN prior to and after medication administration or other intermittent IV therapy. Flush with 20ml Normal Saline after blood draw.

Follow Normal Saline flush with 5 ml of Heparin **10** units/ml after medication administration or other intermittent IV therapy, blood draw and every 24 hours while Huber needle is capped. The catheter will be clamped while maintaining pressure on the syringe plunger and then the syringe will be disconnected.

Instill 5ml of Heparin **100** units/ml prior to disconnecting Huber needle and once a month while implanted port is de-accessed.

For disinfection of catheter hubs/injection ports and dressing changes, refer to SVH Prevention of Central-line Associated Bloodstream Infections Policy # IC8620-131 (SVH Intranet, Organizational Policies, IC)

References:
1) Lippincott: http://procedures.lww.com/lnp/procedureselect.do
2) Maintenance of Patency of Intravenous Access Device

http://svhweb/Pharmacy/guidelines/Maintenance%20of%20Patency%20of%20Intravenous%20Catheters.doc

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SUBJECT: Nursing Blood Product Administration Part 3-Picking Up Blood from the Lab & Blood Product/Patient ID	POLICY # PCLB8610-202c PAGE 1 OF 3
DEPARTMENT: Organizational	EFFECTIVE: 5/12
APPROVED BY: Laboratory Medical Director	REVIEW/REVISED: 3/13 7/13

Purpose:
Patients coming to Sonoma Valley Hospital have the right to self-determination regarding blood transfusions. The purpose of this policy is to provide safe blood administration guidelines for nursing and licensed independent practitioner (LIP). This includes: utilizing devices and practices to reduce the risk of blood borne pathogens and to ensure complications are identified early & appropriate interventions are initiated

Policy:
A patient can expect to receive blood per hospital policy and under a physician's order. Sonoma Valley Hospital will follow policies of the American Association of Blood Banks (AABB) for blood storage and return.

Procedure:
PICKING UP BLOOD PRODUCTS FROM THE LAB:
Prior to picking up blood from Blood Bank, ensure MD's order is complete and all consents are signed. Verify that IV access is satisfactory and the transfusion can be started within 15 minutes after obtaining blood components from the blood bank. These procedures must be followed for all blood products.

1. Members of the hospital staff who have passed the Competency for Picking up Blood and have the appropriate sticker on their name badge (competent staff) may pick up blood from the lab.
2. A competent staff member will present themselves in the lab to request a blood product for a specific patient. They must bring a copy of the signed consent form (2900135 Transfusion/GANN signed by the patient, physician and an RN as a witness). A Blood Bank Armband label must be affixed to the signed GANN form. Under normal circumstances the lab staff will not release blood products without a completed consent form.
3. Patients being transfused in ER do not need to sign a consent form (2900135 Transfusion/GANN). Blood products can be released to a competent staff member without this document
4. ER patients who become inpatients must have a signed consent form (2900135 Transfusion/GANN) before blood products can be released
5. The CLS will retrieve the correct blood product for the patient
6. The CLS and the competent staff member will review the information on the CHART COPY of the Crossmatch & Blood Administration form (2900207), the DONOR UNIT COPY attached to the blood product, the labeling on the blood product and the Blood Bank Worksheet for completeness, correctness and agreement. The competent staff member will read the aforementioned information and the CLS will verify the information is correct.
7. The competent staff member will complete the sign out section (date, time and signature) on the Blood Bank Worksheet. The CLS will review those entries.

8. The CLS & competent staff member will check the product for appropriate appearance and the CLS will check the box indicating the blood product appeared acceptable. If any of the following are present the blood product should not be accepted for transfusion:

   Unacceptable appearance:
   - PRBC's—blackish, purple coloration, foaming, bubbles, abnormal cloudiness, clots, clumps or the integrity of the bag is compromised.
   - FFP—bright red color, foaming, bubbles, clots, clumps or the integrity of the bag is compromised. FFP which has a milky appearance is acceptable.

9. Check the consent column or write a "C" in the Comments column indicating the consent form was present and complete. The CLS will initial the Blood Bank Worksheet indicating all information was present & acceptable.
10. The CLS or competent staff member will stamp the Crossmatch & Blood Administration with the time out of lab.
11. One unit at a time may be removed from the lab unless there is a specific request from the physician for multiple units on the same patient.
12. Any discrepancy discovered in the above procedure must be resolved before a blood product can be released for transfusion.

RETURN OF BLOOD PRODUCTS TO THE LAB:
Blood transported short distances within the facility requires no special packaging. However, blood should not be allowed to reach temperatures outside the accepted range of 1° to 6° C. Units that have left the control of the Blood Bank and are returned will not be accepted for reissue unless the following conditions are met.

- Units must be returned to the Blood Bank refrigerator within 30 minutes of being checked out. Beyond that time the temperature of the unit may have risen above the allowable temperature.
- The container closure has not been penetrated, entered, or modified in any manner.
- All labels are present and intact.

Unit has not been stored in an unmonitored refrigerator.

BEDSIDE PATIENT & PRODUCT IDENTIFICATION PROCEDURE:
Two licensed nursing personnel, one of whom must be the qualified transfusionist who will administer the blood product, will check all identification information, and sign the chart copy of the Crossmatch & Blood Administration (#2900207) form. The following items must be checked on the Crossmatch & Blood Administration form (#2900207) the label on the blood product bag, verbally with the patient, the hospital ID band and the Blood Bank armband.

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SUBJECT: Nursing Blood Product Administration Part 3-Picking Up Blood from the Lab & Blood Product/Patient ID	POLICY # PCLB8610-202c
	PAGE 3 OF 3
DEPARTMENT: Organizational	EFFECTIVE: 5/12
APPROVED BY: Laboratory Medical Director	REVIEW/REVISED: 3/13 7/13

1. Blood Product and Blood Administration Form Check: compare for the following, everything must match.
    - The blood product to be administered is the same blood product requested.
    - Unit number
    - Blood type
    - Unit expiration date
    - Same blood bank armband number (BB#) on patient
    - Same patient name, date of birth (verbally if possible) and Medical Record #
2. Patient and Unit of Blood Check:
   The qualified licensed nursing personnel or LIP will pass the unit of blood to the second qualified licensed nursing personnel or LIP and compare the patient's ID band to the Crossmatch & Blood Administration form (#2900207).
    - Same patient name, date of birth (when appropriate ask the patient to state their name and date of birth.)
    - Same Medical Record # and Blood Bank Armband #.
    - If any of this information does not crosscheck, notify the Lab immediately. Do not begin the transfusion until the discrepancy is resolved.
    - If everything agrees co-sign the Blood Administration Form (#2900207) on the appropriate line at the time of the bedside check.

<u>UNUSUAL CIRCUMSTANCES OR EMERGENCY RELEASE:</u>

1. In the event an antibody screen is positive; the patient's blood will be sent to Blood Center of the Pacific for antibody ID and screening of units. A patient may be given blood that is compatible without an antibody ID if the physician is notified and approves.
2. In a situation where "Incompatibility cannot be Excluded" a transfusion will never be given without the physician's written approval in the patient's chart.
3. Uncrossmatched blood may only be given in extreme life threatening emergencies. The physician must sign, immediately after the crisis has passed, in the designated space on the Blood Administration form (grayed area). Every effort will be made to give type specific blood. If it is not possible to type the patient O Negative blood will be used.
4. A crossmatch will be initiated immediately. The results will be reported upon completion.
5. In trauma cases or other hemorrhagic emergencies, type specific blood units may be issued without completion of the crossmatch, if authorized by physician. The physician must sign the chart copy of the Blood Administration form in the highlighted box which states "IN EXTREME EMERGENCY BLOOD MAY BE GIVEN WITHOUT CROSSMATCH AT THE AUTHORIZATION OF ATTENDING PHYSICAN". This can happen after the crisis has passed.

Reference:

AABB Technical Manual, 17th edition, 2011.
Lippincott, Williams & Wilson, Blood & Blood Product Administration, revised July 9, 2011.

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SUBJECT: Release of Products to Nursing	POLICY # PCLB8610-160
	PAGE 1 OF 4
DEPARTMENT: Organizational	EFFECTIVE: 9/90
APPROVED BY: CNO	REVIEW/REVISED: 6/98 1/08,2/10,8/11,1/12,8/14 8/15

Purpose:
The purpose of this policy is to standardize the requirements for completing paperwork, documentation and releasing blood products by the lab to the nursing staff and define circumstances when those requirements can be suspended.

Policy:
It is the policy of Sonoma Valley Hospital that all blood products will be signed out by the nursing staff in a standard manner with all patient and donor information in agreement. In an emergency situation these requirements can be suspended at the request of the physician.

Procedure:

COMPLETION OF FORM:

A "Crossmatch" form (blue 8 ½ by 11, form #2900207) will be completed by the laboratory for each unit of blood product. This form must include the following:

- Patient name
- Date of birth
- Medical record number
- Blood Bank Armband number
- Patient ABO/Rh type
- Patient antibody screen result
- ABO/Rh confirmation
- Product (i.e. PRBC, FFP, etc.)
- Product Code
- Donor unit number
- Donor ABO/Rh type
- Compatibility result
- Date and time of crossmatch specimen
- Date and time crossmatch expires
- Initials of all CLS working on the crossmatch, (this includes type, antibody screen and crossmatch), must be documented on the Blood Bank worksheet & the crossmatch form.

The crossmatch form is a 4 part form. The above information must be consistent on all pages of the form. This can be accomplished by hand writing (hand writing is discouraged due to legibility) the information and/or reading each patient label as it is affixed to the crossmatch form. It is the responsibility of the CLS reporting the information to ensure all information is consistent and correct. The parts are distributed as follows:

- CHART COPY (8 ½ x 11, blue) is kept with the Blood Bank Worksheet and given to the nursing personnel who signs the blood product out.
- LAB AUDIT COPY (8 ½ x 11) is a duplicate of the CHART COPY, which is returned to the lab after completion of transfusion and documentation by the nursing staff.
- DONOR UNIT COPY is attached to the blood product using a "Swiftach" barb. Attach through a circular opening in the bag; do not puncture the bag.
- LAB BILLING COPY is kept in the lab and will be used for billing.

RELEASE OF BLOOD PRODUCT:

1. Members of the hospital staff who have passed the Competency for Picking up Blood and have the appropriate sticker on their name badge (competent staff) may pick up blood from the lab.
2. A competent staff member will present themselves in the lab to request a blood product for a specific patient. The competent staff member must bring a copy of the consent form 2900135 Transfusion/GANN signed by the patient, physician and an RN as a witness. A Blood Bank Armband label must be affixed to the signed GANN form. ER patients do not need a signed consent form (2900135 Transfusion/GANN). Under normal circumstances the lab staff will not release blood products without a completed consent form.
3. The CLS must verify that the person picking up the unit is a competent staff member who has a sticker on his or her badge, indicating completion of competency for picking up blood products.
4. The CLS will retrieve the correct blood product for the patient
5. The CLS and the competent staff member will review the information on the CHART COPY, the DONOR UNIT COPY attached to the blood product, the labeling on the blood product and the Blood Bank Worksheet for completeness, correctness and agreement. The competent staff member will read the aforementioned information and the CLS will verify the information is correct.
6. The competent staff member will complete the sign out section (date, time and signature) on the Blood Bank Worksheet. The CLS will review those entries.
7. The CLS will check the unit for appropriate appearance and then check the box indicating the blood product appeared acceptable, check the consent column or write a "C" in the Comments column indicating the consent form was present and complete. The CLS will initial the Blood Bank Worksheet indicating all information was present & acceptable.
8. The CLS or competent staff member will stamp the crossmatch chart copy with the time out of lab.
9. Only one unit at a time may be removed from the lab unless there is a specific request from the physician for multiple units on the same patient.

10. After the blood has been checked out, the unit must be logged out in the Blood Bank Log Book with the following information:
    - Recipient's name
    - Recipient's medical record number
    - Date
    - CLS initials

Any discrepancy discovered in the above procedure must be resolved before a blood product can be released to for transfusion.

ANTIBODY SCREEN POSITIVE EMERGENCY RELEASE

1. In the event an antibody screen is positive; the patient's blood will be sent to Blood Center of the Pacific for antibody ID and screening of units. A patient may be given blood that is compatible without an antibody ID only with the treating physician's approval.
2. In a situation where "Incompatibility cannot be Excluded" a transfusion will never be given without the physician's written approval in the patient's chart. The Laboratory Director will be notified. Notification must be documented as to date, time & CLS notifying.

UNCROSSMATCHED EMERGENCY RELEASE

1. Uncrossmatched blood may only be given in extreme life threatening emergencies. The physician must sign, immediately after the crisis has passed, in the designated space on the CHART COPY. Every effort should be made to give type specific blood. If it is not possible to type the patient O Negative blood should be used.
2. As soon as the request is made for O negative, uncrossmatched blood take the requested number of units from the refrigerator.
3. Take pigtails and unit number labels from each unit to be used for crossmatch.
4. On the Crossmatch & Blood Administration form (2900207) fill out as much information as is available.
    a. The donor unit information.
    b. As much patient information as is available. If the name is not known use the same patient designation as ER.
5. Attach the DONOR UNIT COPY to the blood product
6. Give the CHART COPY and LAB AUDIT COPY to the competent staff checking out the blood product.
7. Remind the person checking out the blood that the physician must sign in the designated area for uncrossmatched blood.
8. Follow the same procedure as the Release of Blood Product above for checking out the unit.

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SUBJECT: Release of Products to Nursing	POLICY # PCLB8610-160 PAGE 4 OF 4
DEPARTMENT: Organizational	EFFECTIVE: 9/90
APPROVED BY: CNO	REVIEW/REVISED: 6/98 1/08,2/10,8/11,1/12,8/14 8/15

9. In an emergency situation the CLS may use their professional judgment and release units of blood without a signed consent form. "No Consent" should be documented in the Comments column on the Blood Bank Worksheet with a brief explanation.
10. A signed consent form (2900135 Transfusion/GANN) is not needed for ER patients being transfused.
11. A crossmatch will be initiated immediately.
12. Crossmatch results will be recorded on the Blood Bank Worksheet.
13. Report the results to the physician if the units are incompatible.

Reference:

AABB Technical Manual, 17th edition, 2011.
CIHQ Standard of Care LB-7 Management of Blood & Blood Products

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SUBJECT: Self Referral Testing	POLICY # PC8610-301
	PAGE 1 OF 1
DEPARTMENT: Organizational	EFFECTIVE: 11/90
APPROVED BY: CNO	REVIEW/REVISED: 07/01 2/02, 04/03, 09/13, 8/15

Policy:
It is the policy of Sonoma Valley Hospital to offer laboratory testing on a patient self-referral basis pursuant to California Business and Professions Code section 1246.5:

"Section 1… "Notwithstanding any other provision of law, any person may request, and any licensed clinical laboratory or public health laboratory may perform, the laboratory tests specified in this section. A registered clinical laboratory may perform the laboratory tests specified in this section if the test is subject to a certificate of waiver under CLIA and the laboratory has registered with the department under paragraph (2) of subdivision (a) of Section 1265. The results from any test may be provided directly to the person requesting the test if the test is on or for his or her own body. These test results shall be provided in a manner that presents clear information and that identifies results indicating the need for referral to a physician and surgeon.

The tests that may be conducted pursuant to this section are: pregnancy, glucose level, cholesterol, occult blood, and any other test for which there is a test for a particular analyte approved by the federal Food and Drug Administration for sale to the public without a prescription in the form of an over-the-counter test kit."

As of January 2002 a patient may self-refer the following tests:

- Cholesterol
- HDL
- Glycohemoglobin
- Glucose
- Pregnancy (urine or serum)
- Fecal Occult Blood
- Triglycerides
- Urinalysis Screen (no micro)

Self-referral patients will register in admitting, be presented with our *Notice of Health Information Privacy Practices,* pay the appropriate fees, and present lab requisition at the laboratory window. Specimen collection and testing will be performed in compliance with all pertinent laboratory policies and procedures.

Admitting will request a primary care physician.

PHYSICIAN NOTIFICATION
The laboratory will notify CRITICAL VALUES ONLY:

- If a Primary Care Physician was given by the patient that physician will be notified.
- If no Primary Care Physician was given the Emergency Room physician will be notified.

Reference:
Senate Bill No. 1131, Chapter 80, Section 1. Section 1246.5 of the Business and Professions Code

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SUBJECT: Audibility of Clinical Monitoring & Intervention Alarm Systems	POLICY # QS8610-110
	PAGE 1 OF 1
DEPARTMENT: Organizational	EFFECTIVE: 1/1/15
APPROVED BY: CNO	REVIEW/REVISED:

Purpose:
To assure that alarms on designated clinical monitoring and intervention systems are activated and sufficiently audible to the health care worker so that timely intervention can occur. This is an organization-wide policy. As such it applies to all services and care settings in the organization.

The policy applies to clinical physiologic monitoring and diagnostic systems that contain alarms designed to alert staff to life-threatening or critical changes in a patient's condition. This policy also applies to clinical/diagnostic equipment that is attached to the patient.

Policy:
It is the policy of Sonoma Valley Hospital that critical, life-threatening alarms on clinical monitoring and intervention systems will be maintained in the "on" position and will be sufficiently audible to staff. The following is expected:

1. Alarm components will be checked as part of the equipment's routine preventive maintenance.

2. Alarms will be maintained in the "on" position as long as the equipment is being used on the patient. Alarms may be suspended while the patient is off the equipment, or staff is working directly with the patient, but must be returned to the "on" position when the equipment is placed back on the patient or when care is completed.

    a. Staff is expected to verify that critical (life threatening) alarms are in the "on" position.

    b. It is recognized that certain monitoring systems (i.e. ECG monitors) contain progressive levels of alarm designed to alert staff to a wide variety of clinical presentations. In some instance, these presentations are reflective of a patient's "normal and expected" condition. Under these circumstances, it is permissible to suspend the alarm component(s) or parameter(s) designed to alert staff of the clinical presentation. Alarms designed to alert staff of life threatening conditions are not to be suspended.

3. Alarm volumes will be set at a level so that staff can hear them. If there is competing noise in the area, or the patient is housed at some distance form staff, then the volume of alarms will be set high enough or augmented in a manner that allows staff to hear them above competing noise or from a distance.

4. Alarm parameters will be set in such a manner that they are consistent with the patient's clinical presentation and care needs.

Reference:
CIHQ Standard of Care QS-9

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SUBJECT: IV Pumps – Storage and Distribution	POLICY # LD 8610-412
	PAGE 1 OF 2
DEPARTMENT: Organizational	EFFECTIVE: 02//13
APPROVED BY: CEO	REVIEW/REVISED: 8/14 8/15

PURPOSE:

To outline a process that ensures a hospital wide supply of "clean" maintenance free IV pumps, their timely delivery to all units, and the implementation of consistent inspection, maintenance, and cleaning of "dirty" pumps on a daily basis.

POLICY:

It is the policy of Sonoma Valley Health Care District that Nursing Units, Environmental Services and Central Sterile will work together to ensure IV pumps are stored, distributed, and cleaned in a regulated and consistent manner.

PROCEDURE:

1. Clinical Administration to establish a par level of pumps for each floor. ED (9), MedSurg (12) SNF (4) ACU/PACU (2) ICU (8) OB (3).

2. Nursing will disconnect and appropriately dispose of all tubing and unused fluid bags from the dirty IV pumps before the room is called for a discharge. EVS will contact Nursing if IV pump has not been disposed of IV bags and tubing.

3. Environmental Services staff, trained in the proper cleaning techniques by Central Sterile Department staff, will clean the IV pumps and IV poles as part of the regular discharge cleaning. After cleaning, the pole and pump will be placed next to the patient bed in the room. Environmental Services staff will affix a green plastic tie to the pump's cord which indicates it has been cleaned. The tie will be affixed in such a way that it must be removed prior to use. NOTE: Only clean pumps will be tied with these tags.

4. Nursing Unit(s) will notify EVS of IV pumps in need of high level cleaning. Grossly soiled pumps will be taken off the IV pole and delivered to Central Sterile Department by EVS. After terminal cleaning, Central Sterile Technician will then deliver the clean pump to the Clean Equipment room (room #1221).

5. If the floors need an extra pump they will call the House Supervisor at 732-3729 and have an additional pump brought to the unit. The pump may come from another unit.

6. Should the need arise to rent additional pumps due to high census, the Unit Clerk will call Materials Management X5224 during working hours and request a rental. If it is after hours or on a weekend, the House Supervisor or Unit Clerk will call the rental company directly.

Instructions for Calling the Rental Company:

Call Universal Hospital Services (UHS) at 510-232-5335. This is the Richmond facility that all of our equipment is shipped from. You will need to give the UHS customer service person the following information:

a. Patient name
b. Patient's room number
c. Place in hospital that it should be delivered
d. Name of person placing the order

REFERENCE:
CIHQ Accreditation Standard IC-08
CMS Conditions of Participation for Acute Care Hospitals – §482.42(a)
SVH P&P IC8610-104 Equipment Cleaning Policy

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POLICY AND PROCEDURE
Approvals Signature Page

Review and Approval Requirements

The SVH departmental/organizational policies and/or procedures on the attached list have been reviewed and approved by the following organizational leaders for meeting all of the following criteria. All of these policies and procedures are:

- Consistent with the Mission, Vision and Values of the Sonoma Valley Health Care District
- Consistent with all Board Policy, Hospital Policy and Hospital Procedures
- Meet all applicable law, regulation, and related accreditation standards
- Consistent with prevailing standards of care
- Consistent with evidence-based practice

We recommend their acceptance by the Quality Committee and that the Quality Committee forward them to the Sonoma Valley Health Care District Board with a recommendation to approve.

Departmental: 6071-194 Newborn Screening	
APPROVED BY: **The Birthplace Manager**	DATE: **10-02-15**
Director's/Manager's Signature	Printed Name **Cynthia McAleer, RN**

Mark Kobe, RN MPA
Chief Nursing Officer — 10-6-15 Date

Douglas S Campbell, MD
Chair Medicine Committee — 10/19/15 Date

Out of town

Keith J. Chamberlin, MD MBA
President of Medical Staff — Date

Kelly Mather
Chief Executive Officer — Date

Sharon Nevins
Chair, Board of Directors — Date

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Policy Submission Summary Sheet

Title of Document: **Department Policy-The Birthplace**

New Document or Revision written by: **Cynthia McAleer, RN**

Date of Document: **10-02-2015**

Type:	**Regulatory:**
X Revision **❑ New Policy**	**X CIHQ** **X CDPH** **X CMS** **❑ Other:**
Organizational:	**X Departmental**
X Clinical **❑ Non-Clinical**	**❑ Interdepartmental** (list departments effected)

Please briefly state changes to existing document/form or overview of new document/form here:
(include reason for change(s) or new document/form)

6171-194- Newborn Screening-Revised; resubmission old policy with the following updates:

- State of California requires all newborns to have a Newborn Screening Test to detect inborn metabolic/genetic errors and/or disease.
- This revised policy addresses this requirement and,
- Describes the procedure to follow in meeting this requirement.

Reviewed by:	Date	Approved (Y/N)	Comment
Policy & Procedure Team	n/a		
Surgery Committee	n/a		
Medicine Committee	**10/08/2015**	YES	
P.I. or P. T. Committee	n/a		
Medical Executive Committee	**10/15/2015**	YES	
Board Quality	**10/28/2015**		
Board of Directors	**11/05/2015**		

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POLICY AND PROCEDURE
Approvals Signature Page

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Departmental: 6071-194 Newborn Screening	
APPROVED BY: **The Birthplace Manager**	DATE: **10-02-15**
Director's/Manager's Signature	Printed Name **Cynthia McAleer, RN**

Mark Kobe, RN MPA
Chief Nursing Officer — Date

Douglas S Campbell, MD
Chair Medicine Committee — Date

Keith J. Chamberlin, MD MBA
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Chair, Board of Directors — Date

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Policy Submission Summary Sheet

Title of Document: **Department Policy-The Birthplace**

New Document or Revision written by: **Cynthia McAleer, RN**

Date of Document: **10-02-2015**

Type:	**Regulatory:**
X Revision **❑ New Policy**	**X CIHQ** **X CDPH** **X CMS** **❑ Other:**
Organizational:	**X Departmental**
X Clinical **❑ Non-Clinical**	**❑ Interdepartmental** (list departments effected)

Please briefly state changes to existing document/form or overview of new document/form here:
(include reason for change(s) or new document/form)

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- State of California requires all newborns to have a Newborn Screening Test to detect inborn metabolic/genetic errors and/or disease.
- This revised policy addresses this requirement and,
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Reviewed by:	Date	Approved (Y/N)	Comment
Policy & Procedure Team	n/a		
Surgery Committee	n/a		
Medicine Committee	**10/08/2015**	YES	
P.I. or P. T. Committee	n/a		
Medical Executive Committee	**10/15/2015**	YES	
Board Quality	**10/28/2015**		
Board of Directors	**11/05/2015**		

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
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SUBJECT: Newborn Screening	POLICY # 6171-194
	PAGE 1 OF 3
DEPARTMENT: The Birthplace	EFFECTIVE: 11/02
APPROVED BY: Director of Maternity Services	REVIEW/REVISED: 6/10 2/05,10/15

Policy:
Collect blood specimens from all newborns to detect inborn errors of metabolism so treatment may be initiated as soon as possible, if there are abnormalities. An RN will collect a specimen from all newborns for screening for state-defined inborn errors of metabolism within the newborn period for early detection of biochemical disorders.

Procedure:

1. Patient education:
   a. Give the family the pamphlet "Important Information for Parents About the Newborn Screen Test" before the Newborn Screening Test (NBS) is collected.

2. Complete demographic information:
   a. Fill in the Test Request Form (**TRF**) according to the instruction on the back. Print legibly using **all capital letters with one character per box. All information must be completed**, i.e. newborn's name, birth date, time and weight, race, type of feeding; date, time and method of collection; maternal information; any prior transfusion information; follow-up pediatrician and hospital of birth information.
   b. If the mother's Social Security number is unknown or she does not have one, enter 9999. Do not leave blank or use zeros.
   c. If the mother's current last name is her maiden name, write her last name in the maiden name section. Do not leave blank.
   d. Surrogate or Adoptive/Foster cases: put the name of the person to be contacted if positive test results.

3. Collection:
   a. Specimen collection will be done using the approved California State form (California Newborn Screening Test Request Form, State of California – Health and Human Services Agency, California Department of Public Health). Check the expiration date.
   b. Collection should occur as soon as possible after 24 hours of age or at discharge for newborns <24 hours of age. Collection must not be drawn if less than 12 hours of age. Every effort should be made to collect between 24 hours of life to 5 days of age.
   c. Warm heel for at least 5 minutes before heel stick.
   d. Cleanse heel with alcohol.
   e. Puncture heel using a sterile disposable lancet.
   f. Use gauze pad to wipe away the first drop of blood.
   g. Allow a large drop of blood to form and drop off within the printed circles on the filter paper. Apply blood to ONLY ONE side of the filter paper. Fill one of the six circles completely (soaking through the paper so that opposite side of the circle is completely filled), before moving on to the next circle. The appearance of the blood spot should be

similar on both sides of the paper. Repeated dabbing of tiny drops will not give an adequately saturated specimen. Specimens not adequate for testing will be rejected by the State Department of Health Lab.

h. The filter paper specimens should be allowed to air dry for a minimum of 3-4 hours, away from sources of direct heat or light.
i. Complete the NBS Transport Log form and include the white copy with the NBS specimen form in the mailing envelope. The yellow copy of the NBS Transport Log is sent to the laboratory.
j. Specimens are to be mailed to the appropriate laboratory daily. Specimens should never be kept for more than two days. Early detection of the disorders tested on the NBS is important.

4. Exceptions:
   a. Parental Refusal: NBS is mandated by law, all newborns must be tested. A parent can only refuse collection of a NBS if the procedure conflicts with religious beliefs or practices. Complete the following documentation:
      1) The parent must sign the "Newborn Screening Test Refusal (NBS-TR)" form. File the appropriate copy in the newborn chart, give parents a copy, and send copy to CDHP, Newborn Screening Branch (see address on form).
      2) Complete the "Hospital Report of Newborn Screening Specimen Not Obtained (NBS-NO)" form. File the goldenrod copy in the newborn's chart. Follow instructions on form in sending a copy to the appropriate person/agency.

5. Transfers:
   a. If baby is transferred on or before the sixth day of life, it is the responsibilityof the receiving hospital to collect a Newborn Screening Specimen.
   b. The NBS-NO form must be completed with the goldenrod copy being filed in the newborn's chart, the pink copy going to the hospital of transfer and the original copy going to the State Newborn Screening Section.

6. Blood Transfusion
   a. When possible, a Newborn Screening Specimen should be collected prior to transfusion.

7. Missed Specimen:
   a. Complete a NBS-NO form and send copy to the Genetic Disease Branch, Newborn Screening Branch for any missed specimens.

8. Documentation:
   1. Document the date and time the specimen was obtained in the newborn chart.

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SUBJECT: Newborn Screening	POLICY # 6171-194
	PAGE 3 OF 3
DEPARTMENT: The Birthplace	EFFECTIVE: 11/02
APPROVED BY: Director of Maternity Services	REVIEW/REVISED: 6/10 2/05,10/15

2. Document newborn screening specimens obtained in all appropriate nursery documents.
3. Check that all information on the TRF is complete, correct, and matches the newborn's ID band. Verify the name of pediatric care provider with the parent.
4. After collecting the blood, tear out both the sender's copy and parents' copy which includes the privacy notification required by HIPPA. Give the pink and blue copy to the parent.
5. File the sender's copy, the yellow copy, in the newborn's chart.
6. Document in Newborn log book RN initials that drew the sample.

Reference:

California Code of Regulations (Title 17, Chapter 4, Subchapter 9, Sections 6500-6508)
Genetic Disease Screening Program, Newborn Screening Branch

6.

QUALITY REPORT

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
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To: Sonoma Valley Healthcare District Board Quality Committee
From: Leslie Lovejoy
Date: 10/28/15
Subject: Quality and Resource Management Report

October Priorities:

1. STATIT Training
2. CMS Complaint Validation Survey Plan of Correction
3. Board Quality Update on Incentives and Penalties

1. STATIT piMD

We are in the third year of process change in the area of quality and performance improvement. The overarching vision was to grow a continuous performance improvement culture through the promotion of a supportive learning environment and the development of a common set of tools and language. We began by bringing back the PDSA format and discussion about the what , why and how's of continuous quality monitoring and the origin and growth of performance improvement projects. Departments developed their own specific PI plans based on the unique aspects of their service. Last year we held our first PI Fair which began the dissemination of quality efforts throughout the organization and a change in perspective about our culture from the staff level up. We repeated the PI Fair this year and the projects showed great improvement. While new leaders will receive further education, quality concerns and discussions about quality are now more common. The final leg of this journey involves both the measurement of improvement efforts and the manner in which decisions are made based on the data. STATIT piMD (piMD= performance improvement manager dashboard) is a statistical process control software and program that allows data from sources throughout the organization as well as Excel spreadsheets to be linked with this program. This allows leaders to build scorecards and dashboard but also to report data through the use of control charts and begin to talk about processes in or out of control. A team of leaders agreed to be trained in this program and become the organization's super users. It will take about 3-4 months of building and becoming experts before the program is rolled out to the rest of leadership. I will arrange a demonstration of its usefulness at a committee meeting in early 2016.

2. CMS Complaint Validation Deficiencies and Plan of Correction:

The following is a table of the deficiencies identified during the survey and our actions to bring us into compliance. Since the focus was on Pressure Ulcers and the Retained Foreign body, you will see that the Actions for the Surgery deficiencies have already been addressed.

Deficient Practice	Actions Taken	Monitoring
Three patients lacked nursing care plans addressing: skin breakdown prevention, care in restraint, and diabetic nursing care.	100% of inpatient nursing staff will be provided a document titled "Care Plan Preparation" retrieved from Lippincott Nursing Procedures. This education will be provided to the Medical Surgical, Birthplace, and Intensive Care Units by each department's direct managers by October 17, 2015. Nursing staff that float to the inpatient units will also be expected to complete the education as well. In addition the nursing staff will be educated on the deficiencies through a document attached to the Lippincott education. 2. Inpatient nursing staff will complete an attestation following the Lippincott educational training to ensure staff education was comprehended.	The inpatient units will be responsible for completing a total of 30 chart audits a month beginning 10/07/15. The chart audits will include manual review of the care plan and document if skin breakdown, restraints, and diabetic needs were addressed in a timely manner. The goal is to have 95% compliance within 90 days. If 95% compliance is met the inpatient units will complete a total of 15 audits per month for 90 days. If compliance is maintained then random auditing will be performed as deemed necessary by unit manager. The Quarterly results will be reported to Quality via our QAPI plan and then reported quarterly to Medical Staff PI Committee and to the Quality Committee of the Board.
Surveyors noticed a number of instances where verbal and telephone orders were not cosigned according to policy. SVH has begun moving to a paperless, electronic verbal/telephone order process through our electronic health record (E H R). Policy #PC8610-160 was revised in July 2014 and states, "(handwritten) telephone orders must be signed by the MD within 48 hrs." Policy # MS8610-120, created February 2014 states, "all verbal and electronic orders issued and recorded on a paper record must be cosigned, dated and timed within 30 days." It was brought to light that we had two discrepant policies during the survey.	1. Policy #PC8610-160 has been revised to be consistent with cosigning of verbal/telephone orders whether paper or electronic, to be within 30 days. Nursing staff will be educated to this change in staff meetings and one on one. Documentation of attendance and education will be recorded through sign in sheets. 2. Effective 10/07/15, department managers will ensure, that paper verbal/telephone orders for physician cosigning are flagged indicating the need for the order to be cosigned and alert the MD to cosign. Department Managers will randomly audit charts for compliance. Should paper orders needing co signature be missed, they will be captured and flagged by the medical records department well within the 30 day time frame for physician signature.	Medical records beginning 10/15/15, will send a report weekly of number of paper verbal/telephone orders prior to 30 days in need of cosigning by physician to the Chief Nursing Officer. 100% compliance is expected within 30 day timeframe parameter. Chief Nursing Officer is responsible for data collection and reporting. Cosigning compliance will be added to the Medical Staff QAPI Dashboard and reported for fourth quarter data collection to the Medical Staff PI Committee.
Lack of compliance with policy on sponge counts.	1. Surgical Services OR team, surgeon, anesthesiologist, and senior leadership met to discuss the event involving the retained sponge and conducted an intense analysis on 6/16/15 of the event and identified	Auditing for compliance with action plan changes in practice began on 07/16/15 using a Surgery Safety Checklist. The Checklist was revised based on feedback during the survey. Using the revised Surgery Safety

	opportunities for improvement. The Action Plan was discussed in Surgery Committee on 7/1/15 and reported to the Quality Committee of the Board on 7/22/15. The Action Plan consisted of the following systematic changes. The deficiencies and action plans to correct those deficiencies identified in the CMS Validation Survey will be reported to the Surgery Committee on 11/4/15 and to the Quality Committee of the Board on October 28, 2015. a). A new Surgery Safety Checklist was created on 07/16/15 based on the international best practice World Health Organization (WHO) Checklist which requires verbal interchange and check-off for each step. b). Posters were created on 06/30/15 of new Surgery Safety checklist and installed in each OR suite and C-Section room. c). A Time-Out Check Sheet was created on 07/16/15 and implemented which the Circulating Nurse uses that includes time and line item signature. d). New surgical count boards were created and implemented to itemize sponges, instruments, and other sterile supplies on 07/22/15. e). A surgical sponge counter process was implemented on 09/14/15 to ensure accurate tracking of sponges in use at the time of each surgery. f). 100% of the Surgical Services Staff, Anesthesiologists and Surgeons were educated to the deficient practices and the new processes in staff meetings, Surgery Committee meetings and on a one on one basis by the Director of Perioperative Services. Attestations of understanding and compliance were obtained beginning on 07/27/15. g). The Surgery Safety Checklist Audit Tool was updated on 10/07/15 to include verification that counts are done at the appropriate times and to indicate what was done when counts were incorrect.	Checklist Audit Tool, the Director of Perioperative Services will continue to audit compliance with the above action plan. Audits will take the form of direct observation of all cases for the first week, random observation of 50% of cases the next two weeks and then random observations of 25% of cases for 30 days. A threshold of 100% has been set and once that has been achieved, direct observation of 10% of cases will be conducted on a quarterly basis to ensure that the new processes will remain in compliance. Documentation audits will be conducted until a compliance threshold of 100% is obtained. New employees and physicians will be educated to the new processes as part of their orientation to the department and documentation will be maintained to ensure compliance. Data collection and reporting will be performed by Surgical Director and will be incorporated into the department's QAPI plan. Results will be reported to the Surgery Committee monthly, the Medical Staff PI Committee quarterly and to the Quality Committee of the Board.
Use of Immediate Use Sterilization	a). The Director of Perioperative	The Director of Surgery will monitor the

	Services Identified instrument sets that frequently undergo IUSS. b). The hospital purchased additional instruments sets to minimize the occurrence of immediate use steam sterilization. c). Best practice guidelines were reviewed, by Perioperative Services in July 2015 and adjustments made to scheduling surgical procedures to separate same or similar procedures to allow sufficient standard instrument processing time. d).The Director of Perioperative Services identified and purchased (new technology) new Sterile/processing, on 08/15/15, trays from One Tray – a manufacturer who specializes in instrument processing using a special tray with better fluid dissipation capability. These products comply with CMS and AORN standards. e). Central Processing and OR staff were educated to this deficiency during staff meeting and educated regarding the purchase of new instruments trays, the use of the new technology "One Tray" and updates to the policy regarding Sterilization of Equipment. Education was provided and documented in the form of an attestation to compliance with new processes. f). The deficiencies and resultant action plan to correct those deficiencies identified in the CMS Validation Survey will be reported to the Surgery Committee on 11/4/15 and to the Quality Committee of the Board on October 28, 2015.	use of IUSS for all sterilized instruments/patients with particular attention to eye instruments, Bariatric instruments, and hip instruments. Threshold at or below 5% use of IUSS for these instruments. As part of the department's QAPI program, the data will be collected, aggregated, and analyzed by the Surgery Department with the Director of Surgical Services ultimately responsible for the ongoing monitoring. Results will be reported Quarterly to the Medical Staff Performance Improvement Committee, Monthly to the Medical Staff Surgery Department Committee, Quarterly to the Quality Committee of
Lack of a process to contain soiled instruments and solutions during transport to decontamination.	a).The Director of Perioperative Services identified and ordered a leak proof Back Table cover to minimize risk of spillage and exposing personnel to contaminates during transport. b). Educate staff on proper use of product by requesting an in-service from vendor. Documentation of education and compliance with new process will be in the form of a sign in sheet and attestation. c). The deficiencies and resultant	Director of Surgery will monitor, as part of the department's QAPI program, proper usage of product by utilizing audit tool. Audits will be performed until reaching 100% compliance threshold. Data collection will be reported to the Surgery Committee, Quality Committee of the Board and Medical Staff PI Committee.

	action plan to correct those deficiencies identified in the CMS Validation Survey will be reported to the Surgery Committee on 11/4/15 and to the Quality Committee of the Board on October 28, 2015.	
Organization changed the location of the red line in surgery between the surgery corridor and decontamination.	a). A work order was placed on 10/15/15 to Facilities to move the restricted red line back to its original position based on schematic design provided to the California Department of Public Health for licensing of the new operating rooms in 2013.	None

3. Board Quality update Regarding Incentives and Penalties

Attached you will find my report to the October meeting of the Board.

Topics for discussion: The Birthplace presentation. Next month will see Dr. Perryman and Michele Donaldson present on Bariatrics.

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
Healing Here at Home

To: Sonoma Valley Healthcare District Board
From: Leslie Lovejoy
Date: 10/07/2015
Subject: Update on Hospital Quality Performance Metrics

Quality Performance Metrics for CMS reporting years 2013 and 2014 place the organization in the top quartile nationally on most quality measures. The purpose of this report is to provide an update on CMS incentives and penalties for 2016 and to educate on additional performance measures that have recently been publicly reported.

1. Incentive Metrics Performance

Quality Incentive Program	***Goal***	***Implications for 2016 Reimbursement***
Value Based Purchasing(VBP): focuses on clinical quality measure performance, the patient experience survey scores (HCAHPS), selected mortality outcomes and patient safety measures including infection control.	Held back 1.75% of reimbursement; hospital earns this back through performance on quality metrics for 2014.	Sonoma Valley Hospital performance realized full earn back for fiscal year 2016 plus a 0.3905075186% incentive payment for performance.
Readmissions Reduction Program (RRP): probably the most significant incentive program that looks at hospital readmission rates for all unplanned readmissions within 30days of an acute stay.	Readmissions by DRG must be under 1.0 to avoid penalty.	Readmissions for CHF, Pneumonia and Acute Myocardial Infarction are all under .97. No penalties for FY 2015 and 2016
Hospital Acquired Conditions Reduction Program (HAC): included in the value based purchasing program but adds additional pressure to reduce certain complications from two domains: potentially preventative complications of care (Patient Safety Indicators) and hospital acquired infections (CDC Infection Prevention Indicators). 25%.	Based on 2013-2014 hospital data, the goal is to avoid penalties that are awarded to the bottom 25% of reporting hospitals. The bottom 25% scored at or below a threshold score of 6.75	Sonoma Valley Hospital's total HAC score is 2.75 and we do not incur any payment reduction penalties for Hospital Acquired Conditions. Note: during this period the hospital did not report any Central Line Infections, Catheter Associated Urinary Tract Infections or Surgical Site Infections thus exceeding national benchmarks.

2. CMS Hospital Compare Star Ratings

Star Ratings have been in place for both Home Care and the Skilled Nursing Facilities for quite awhile and we have maintained a 5 star rating for Home Care (top 25%) and a 4 Star rating for our Skilled Nursing Facility. CMS has been working on creating the same type of rating for hospitals. They are weighting all quality metrics and HCAHPS performance into a single star rating which is currently being published on the Hospital Compare website. Sonoma Valley Hospital received a 3 Star rating. Only 11% of hospitals nationally received a Star rating or 4 or 5. Data Range: 4thQ 2013 through 3rd Q 2014.

3. *Leapfrog Hospital Survey Results*

The hospital participated in the annual hospital survey this past June and the results are soon to be released. The Leapfrog Group is a voluntary program aimed at mobilizing employer purchasing power to alert America's health industry that big leaps in health care safety, quality and customer value will be recognized and rewarded. Among other initiatives, Leapfrog works with its employer members to encourage transparency and easy access to health care information as well as rewards for hospitals that have a proven record of high quality care.

Sonoma Valley Hospital's Summary Score		NATIONAL AVERAGES	
Quality	**62**	**Quality**	**61**
Resource Use	**68**	**Resource Use**	**62**
Value	**64**	**Value**	**62**

The Value score is a combination of Quality (65%) and Resource Use (35%). The updated Hospital Safety Score/Grade has not been released (A through D) at the time of this report.

4. *California Hospital Compare Performance Report*

A recent report published by Kaiser Permanente discussed the unveiling of the California Healthcare Compare Website. The site provides information on quality for five common conditions or procedures: childbirth, hip and knee replacement, colon cancer screening, diabetes, and back pain. And it gives cost information — by county for 100 procedures, ranging from treating a broken ankle to cancer chemotherapy. Sonoma Valley Hospital ranked fourth for hip and knee replacement in quality and first in the patient experience scores and 5th for childbirth in our region.

5. *Program Beta Incentive programs for Patient Safety*

Program Beta developed programs, Quest for Zero, to reduce the risk of harm for patient both in the Emergency Department and in OB. The programs include intensive clinical training for both the nursing staff and physicians and have a longstanding reputation for reducing risk and improving the quality of patient care. The Emergency Department successfully completed Tier 2 of the 3 tier program this year and the OB department completed Tier 1. This resulted in some premium credits as well as safe, quality patient care. Beta is piloting a Quest for Zero program for Surgical Services and we will be participating sometime in 2016.