Sonoma Valley Hospital
Sonoma Valley Health Care District
Healing Here at Home

SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE REGULAR MEETING
AGENDA
WEDNESDAY, April 22, 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*	
3. CONSENT CALENDAR • QC Minutes, 3.25.15 • Annual Review QA/PI Program	*Hirsch*	Action
4. ANNUAL HOME CARE REPORT	*Lee*	Inform/Action
5. PATIENT CARE SERVICES REPORT	*Kobe//Lovejoy*	Inform/Action
6. QUALITY REPORT FOR APRIL 2015	*Lovejoy*	Inform/Action
7. CLOSING COMMENTS/ANNOUNCEMENTS	*Hirsch*	
8. ADJOURN	*Hirsch*	
9. UPON ADJOURNMENT OF THE REGULAR OPEN SESSION	*Hirsch*	
10. CLOSED SESSION: <u>Calif. Health & Safety Code § 32155</u> Medical Staff Credentialing & Peer Review Report	*Amara*	Action
11. REPORT OF CLOSED SESSION	*Hirsch*	Inform/Action
12. ADJOURN	*Hirsch*	

3.

CONSENT CALENDAR

SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
REGULAR MEETING MINUTES
Wednesday, March 25, 2015
Schantz Conference Room

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

AGENDA ITEM	DISCUSSION	ACTION	FOLLOW-UP
1. CALL TO ORDER	*Hirsch*		
	Meeting called to order at 5:00 p.m.		
2. PUBLIC COMMENT	*Hirsch*		
	None		
3. CONSENT CALENDAR	*Hirsch*	Action	
• Quality Committee Minutes, 2.25.15		**MOTION** by Rymer to approve Consent and 2nd by Idell. All in favor.	
4. MEDICAL STAFF QA/PI PROCESS	*Lovejoy/Cohen*	Inform	
5. REVIEW OF REVISED DASHBOARD	*Lovejoy*	Inform	
	Ms. Lovejoy distributed and reviewed the revised QC Scorecard 2014. The Committee agreed that the scorecard was very well done and made suggestions for change to be included in the second revision. Ms. Lovejoy will incorporate the Committee comments, enter the 1st quarter data and bring it back in May.		

AGENDA ITEM	DISCUSSION	ACTION	FOLLOW-UP
6. QA/PI PROGRAM ANNUAL REVIEW	Ms. Lovejoy shared the appraisal of the Performance Improvement Program including its purpose, scope, findings, and assessment of performance/effectiveness and objectives for the next evaluation period. Although there was a Motion to approve, this is an Inform item on the Agenda and therefore, will be brought forward to April 2015 for approval.		Bring forward to April 22, 2015 meeting.
7. QUALITY REPORT FEBRUARY 2015	*Lovejoy*	Inform	
	Ms. Lovejoy's Quality Report for February/March 2015 focused on four priorities: (1) the Formation of Population Health/Community Care Network Team; (2) the Healing at Home PI Project; (3) the Surgeon Medical Office Staff Luncheon; and (4) the Integration of Preoperative Nurse Navigator role into Case Management.		
8. CLOSINGCOMMENTS	*Hirsch*		
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9. ADJOURN	*Hirsch*		
	Regular Session adjourned at 6:15 p.m.		
10. UPON ADJOURNMENTOF REGULAR OPEN SESSION	*Hirsch*		
11. CLOSED SESSION	*Amara*	Action	
Calif. Health & Safety Code § 32155 • Medical Staff Credentialing/Peer Review Rpt.			
12. REPORT OF CLOSED SESSION	*Hirsch*		
13. ADJOURN	*Hirsch* Closed Session adjourned at 6:25 p.m.		

Quality Assurance/Performance Improvement
Program Review 2014

Purpose

The Quality Department, in cooperation with the Medical Staff Performance Improvement Committee and Administrative Leadership, has completed an appraisal of the Performance Improvement Program.

The purpose of this appraisal is to:
- Evaluate the comprehensiveness and scope of the program.
- Assess the effectiveness of the FOCUS / PDSA model.
- Measure the extent of interdisciplinary collaboration.
- Assure that all key functions and dimensions of performance have been addressed.
- Provide the Governance, Administration and Medical Staff leaders with the results of prior year activities to assist in development of priorities for improvement.
- Determine the extent to which the Performance Improvement Program supported the mission and vision.

Scope and Applicability

This is an organization-wide program. It applies to all settings of care and services provided by Sonoma Valley Hospital.

Findings

In 2014, the hospital had its first accreditation survey by the Center for Improvement in Healthcare Quality (CIHQ) which it successfully completed. Home Care successfully completed their state survey as did the Skilled Nursing Facility. Any and all deficiencies identified through these surveys have been resolved and added to departmental quality control monitoring. Over the past year there was a great deal of improvement in the development of a performance improvement infrastructure and department specific performance improvement such that each department identified the complexity of work flow processes and opportunities to improve based on some form of prioritization process, including considerations of risk, volume and problem proneness. The senior team performed a formal organization-wide Performance Improvement Project prioritization process that identified four projects: completion of Meaningful Use Stage 2; Skilled Nursing Performance Improvement Project; Functional Units of Service Cost Accounting Project; initiation of the ICD-10 Implementation Project. Three of the four projects were successfully implemented and have moved to continuing performance monitoring and refinement. Each of the prioritized projects aligned with both our strategic plan and with the hospital's overarching mission, vision and values.

This year, there was an increased use of the PDSA as Leaders have become more confident in the process and the expectations have been set that all projects will be reported using this process. Departmental quality monitoring and reporting has become uniform with the exception of those departments seeing changes in leadership this year. There is now an on-boarding process to help new leaders get up to speed and the organization held its first annual Performance Improvement Fair to continue to improve the organization's use of performance improvement tools and to move towards data driven decision making. In addition, the implementation of a powerful and user friendly database tool that interfaces with Paragon and Midas Care Management and allows for sharing of data between departments such as finance and case management, has begun to break down silos and improve data sharing. We had thought to add a software tool that provides statistical process control analysis of data to enhance decision making around quality data. This was put on hold until this year.

There continue to be opportunities in the areas of: determining outcome measures continued monitoring once change has been implemented; leadership education regarding QAPI standards, and project development.

The organization clarified roles and responsibilities regarding project development and created a tracking process and a Project Review Team to coordinate projects of all scopes. The Project Review Team provides reports of new projects to the Administrative team where decisions are made regarding the availability of resources, including capital, and the project's alignment with the strategic initiatives and the hospital's mission. In an effort to more effectively manage all organizational projects, The Project Team and the IT Steering Committee aligned their projects into categories of: Quality Project only; IT Project only; and Combined Projects. As technology and the electronic health record have taken more of a center stage in continuous quality improvement, the IT Steering Committee has adjusted its focus and developed a subcommittee structure that includes non-clinical technology projects in one subcommittee and Clinical Informatics as the other. We are working on bring frontline staff into each of these committees and creating a charter for each. This will be more formalized in 2015.

Interdisciplinary collaboration was demonstrated through the Sorry Works process, Culture of Safety Program; Project Review Team, IT Steering Committee, Utilization Review Program; Pharmacy and Therapeutics Committee; Grievance Committee; departmental and cross departmental performance improvement projects and organization-wide performance improvement. Increasing the meetings of the Medical Staff Performance Improvement Committee and the further development of the Board Quality Committee allowed for more consistent and coordinated reporting of projects and mandated activities. The development and posting on the SVH website of the Board Quality Dashboard and Quality Scorecard by common medical conditions has increased public awareness of hospital performance.

The Performance Improvement Program does support the hospital's mission and is well on the way to supporting an organizational Culture of Quality and Safety.

Assessment of Performance

The effectiveness of the PI program is measured by its accomplishments. Data was collected and aggregated on performance measures and thoroughly analyzed. Intensive assessments were completed when SVH detected or suspected a significant undesirable performance or variation. Progress was made on the following program goals:

I. *Performance Improvement Infrastructure*

Performance Goal	Outcome
Annual Performance Improvement Fair: 95% of all leaders participate with effective PDSA Storyboard	95% of all leaders participated
Integration of survey deficiency citations into quality monitoring reports for 100% of citations by department	90%; still need some work here
Implement STATIT and train on statistical process control	On hold until January 2015
85% of all appropriate leaders now able to work on E-Notifications on Midas	71%; new leaders at end of year. Anticipate completion of training by end of 1st Q 2015
100% electronic submission of all QC reports to the shared drive; department files	75%; will monitor more closely in 2015
Implementation of Medical Staff QAPI and UR dashboards	Completed and full reporting in 2014
Re-establish Grievance Committee and reporting process	Completed; built reporting into Midas and reports are generated; committee meets regularly to review/discuss
.Project Management System Development	In process

II. *Performance Improvement, in addition to the prioritized organizational projects, efforts in 2014 focused on*:

Performance Initiative	Outcome
Improve Patient Satisfaction: move to 50th percentile rank for Inpatient HCAHPS for 5 of 8 domains	Changed vendors in September 2014; 4Q 2014: 5 of 8 at 50th percentile rank
Improve Patient Satisfaction: Emergency Department: 5 of 8 at 50th percentile rank	Changed Vendors in September 2014; 4Q 2014: 4 of 7 at 50th percentile rank
Employee Engagement Survey 2014 Goals: 80% Participation 75% Partnership Score	2014 Results: 76% Participation 76% Partnership Score 77th Percentile Rank
Organizational and Departmental policies & Procedures Updated and through committees 95% Organizational current 95% Departmental manuals current	• 97% of organizational P/Ps are current 393/406 • 23/28 departmental manuals are current 82%; currently working with department leaders
Surgical Services Transformation Project • Reduce Expenses by 10% • Increase fiscal year volume by 2% (total cases = 1619) • Reduce Supply Inventory by using PAR Levels • Move into New Wing: consolidate ACU & PACU	• Reduced by 6% YTD: expect to meet target by FY end • Fiscal year to date (2/15) Volume: 1317 • Par level established, supplies on budget • Completed; reduced FTE by 2 • Completed in March 2015

• Improve Scheduling & Preop process	
Culture of Safety Assessment • Improve by 5% over 2013 dimension scores • Meet or exceed AHRQ national benchmarks	• 6% improvement from 2013; opportunities to improve identified and education provided to leaders to coach staff. • 100% meet or exceed benchmark
Skilled Nursing PI Project • Reverse negative margin to positive contribution margin while maintaining high quality care • Reduce pharmacy costs • Decrease overutilization of lab, imaging and RT services • Improve financial counseling & billing	Decreased drug utilization by 23K; increased capture of RUG levels for therapy; timely and accurate billing; improved care coordination among physicians and decreased lab test over utilization by 60K; margin moved from -11% to a steady +2%-+8% depending on volume.
Outpatient Services: Primary Source Verification of non-medical Staff providers • Create workflow process & educate registration • Primary source verify licenses for current data base • Monthly review and updating of expireables	• Initial training page provided to registration clerks • 100% of 3,246 providers verification completed • 100%monthly review of current providers and updating of database through March 1 • Have identified some additional training needs and will work with team to refine process this year.
Development of an Emergency Department Transfer Record	Added EDIS program in the emergency department which allows for an ED transfer record to be generated. Completed.
Medical Staff Credentialing Process Project • Creation of workflow process • 100% primary sourced and fully complete credentialing and application documentation prior to privileging • Improve timeliness of credentialing/privileging as measured by # of expedited (Expedited = less than 5/yr)	• Completed • 100% • 3 expedited in CY 2014
Improved and standardized Brose low Pediatric Emergency Carts	100% of all crash carts are standardized
Improve Quality Outcomes, Utilization and Readmissions Prevention	Quality Core measures meet national benchmarks, with exception of flu vaccination documentation, there has been improved medical necessity documentation; and our readmission rate is below national and state benchmarks.

III. Accomplishments/Recognition

Skilled Nursing Facility	Silver Award for Quality
Healing at Home	Home Care Elite Award for quality outcomes

"A Grade"	Leapfrog Group
Listed the 11th Safest Hospital in US	Consumer Reports

Assessment of Effectiveness

The Performance Improvement Program is meeting the needs of the Performance Improvement Committee, Medical Executive Committee and Sonoma Valley Hospital.

Objectives for Next Evaluation Period

With input from the medical staff and leadership, the Administrative Team performed an assessment of potential organizational performance improvement activities for 2015 that align with the strategic plan and core strategic initiatives and reflects the scope and complexity of patient care services. In addition to departmental and interdepartmental continuous performance improvement activities, the organization will focus on the following priorities.

A. Prioritized Organizational Performance Improvement Projects for 2015 include the following:
   - Completion of the ICD-10 Project
   - Home Care Cost Accounting Project
   - Population Health/CCN/ Outpatient Services Project
   - Paragon 12.1 Update and preparation for Paragon 13

B. Performance Improvement Infrastructure Goals:
   - Provide an organized schedule of education for leaders to improve understanding and the quality of our program.
   - Implement STATIT.
   - Refine medical staff and board quality dashboards/scorecards to make them clinically relevant with meaningful data.
   - Refine Project Management process and infrastructure to better manage and communicate projects throughout the organization.

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4.

ANNUAL HOME CARE REPORT

HEALING AT HOME
SKILLED HOME HEALTH CARE
A Service of Sonoma Valley Hospital

ANNUAL EVALUATION OF DEPARTMENT
JANUARY 2014 – DECEMBER 2014

Healing At Home is a department of Sonoma Valley Hospital, which is a health care district hospital. The service area includes the hospital district and extends into the nearby communities of Santa Rosa, Petaluma, and metropolitan Marin County. As a department of the hospital, Healing At Home is governed by the Sonoma Valley Hospital District Board of Directors and is under the medical direction of the current designated Medical Director for Healing At Home. It adheres to all hospital wide policies and procedures, including personnel policies and procedures, which are reviewed and revised as necessary by the Human Resources Department. Healing At Home also has administrative and clinical policies, which are department specific. These policies are reviewed and revised as indicated by the Healing At Home Management Team. Policies governing the scope of services offered, admission and discharge, medical supervision and plans of care, emergency care, clinical records, personnel qualifications and performance, and program evaluation are annually reviewed by the Professional Advisory Group.

Aspects of Care and Major Clinical Functions

Healing At Home offers the following services:

- Skilled nursing
- Home health aide
- Physical, occupational and speech therapy
- Medical supplies
- Limited diagnostic or laboratory services
- Wound and enterostomal therapy
- Medical social work
- Nutritional assessment and education

Aspects of care include but are not limited to:

- Skilled observation and assessment
- Wound care
- Diabetic teaching
- IV therapy
- Enterostomal care and education
- Catheter care
- Home safety assessment
- Gait/transfer training
- Activities of daily living training
- Counseling for long-range planning and decision making
- Brief therapy to facilitate coping with and adjusting to diagnosis
- Treatment of language disorders and dysphagia
- Assistance with personal care
- Patient/family/caregiver education
- Nutritional assessment and education
- Pain assessment and management
- Palliative and end of life care

Management Assessment

Review of the scope, need, and adequacy of the provision of Healing At Home services, along with departmental functions and structure, is performed annually. This review of past performance facilitates more effective planning for the future. Input is received from Healing At Home staff on an ongoing basis through staff and team meetings. Other hospital departments, patients, and medical staff also provide input.

Issues identified in the past year include:

Finance and Productivity: The case management model provides a framework to deliver quality Healing At Home in a cost-effective manner. This year productivity standards were adjusted to reflect the impact of transitioning to point of care electronic documentation. Healing At Home management monitors productivity on an ongoing basis. Biweekly and monthly budget performance reports are evaluated in order to improve efficiency. All staff flex hours in relation to workflow fluctuations. Efforts to improve clinical productivity include close monitoring, centralized patient visit scheduling, and individual counseling. Beginning in July 2014, productivity results have increased to average 99% with the most recent report showing a 2 week productivity index of 106%. The EMR project enables planned geographic expansion. The Marin County expansion has been primarily with Kaiser and SCAN patients. Efforts to market to the Case Managers at Marin General have yet to yield a significant increase in referrals.

Policies and Procedures: All Healing At Home Policies and Procedures are undergoing review and updating in 2013 and 2014. Significant administrative policy changes have been approved by the Healing At Home Professional Advisory Group. Administrative policies and procedures were updated to remove references to The Joint Commission standards and cite all relevant Medicare Conditions of Participation (CoPs). Clinical Policies and Procedures are being updated to reference best practices and utilize the resource of the Lippincott manual.

Performance Improvement: In 2012-2014, Healing At Home utilized the rapid cycle improvement process (PDSA: Plan, Do, Study, Act) to select, train, and implement our new Electronic Medical Record (EMR). The process was lengthy and had a short term negative effect on finances and visit numbers. Achievements identified through this project include successful surveys at 4 months, 10 months, and 13 months post implementation. Real time point of care clinical documentation has enabled serving a larger geographic area with greater efficiency. Documentation of response to patient teaching improved from 50% on paper to 100% in the EMR. Opportunities include improving documentation of interdisciplinary communication and offering physician portal access to local MD offices.
We continue to track medication errors and patient fall data which are aggregated and trended quarterly. Infection Control Surveillance is analyzed and tracked by Healing At Home Quality Management and submitted to the hospital Infection Control Department. This has improved appropriate reporting of health care associated infections. Agency health care associated infections have been zero for 6 months. Both patient outcomes and process measures have been good; and in most cases we exceed the State and National Quality Initiative Measures.

Personnel Changes: In 2014 Healing At Home hired four RN Case Managers; two per diem Home Health Aides, and one full time PT. A Traveler PT was utilized for a 13 week assignment this fall as two PTs were on disability and one PT had a lengthy vacation. Two RN Case

Managers resigned, two per diem PTs resigned, one per diem ST resigned, and the receptionist was laid off. The agency is still in need of a full time PT to cover the Marin County area.

California Department of Public Health Surveys

Two CDPH surveys were held in 2014. This rigorous review of care is according to the Medicare CoPs and includes home visits to patients chosen by the surveyors, staff interviews, extensive medical record review and policy and procedure review. Findings from the first survey in June 2014 were:

- For two patients, random blood sugar checks were not done on every visit as ordered
- Home Health Aide supervision not documented every 14 days on two patients
- In one record, an antibiotic was not on the Plan of Care

A plan of correction was written, implemented, and accepted by the CDPH to correct the above findings.

The second CDPH survey in September 2014 resulted in two minor deficiencies which have been corrected:

- Medical records found outside of locked cabinets after hours in a locked, alarmed office
- One nurse did not disinfect her BP cuff after use per agency policy

The Plan of Correction for this survey has been verbally accepted by the CDPH but written confirmation has not yet been received.

Kaiser Re-credentialing survey:

The annual on-site survey was conducted by regional Kaiser Quality nurse in July 2014. No deficiencies were found and commendation was made for high quality care.

Staff Assessment:

Clinical staff completed training in the following subjects: Performance Improvement process, projects, and outcomes; Bag Technique and Infection Control; Protection of Medical Records; POLST; Insulin Flex Pen; Disaster Response; Meritage ACO; LVAD in the home setting; OASIS assessments; Depression Awareness APS Mandated Reporter Training; Dealing with the Difficult Patient; Hospice Care; Medication Reconciliation; Critical Lab Policy; Dietician/Nutritional Services; Interdisciplinary Referral Process; CHHA Supervision; Medication Management: Insulin; SBAR.

Healthstream**:** Healing At Home has completed 100% of the mandatory 2014 safety training in Healthstream. Courses included: infection control; corporate compliance; developmentally appropriate care of adult and pediatric patients; lifting and transferring patients, hazard communication; ethics; sexual harassment; patient rights; informed consent; advance directives; EMTALA; grievances; cultural competence; patient abuse/assault/neglect; safety (fire, electrical, back, MRI, ergonomics, workplace violence, emergency prep, HAI, hand hygiene, precautions)

Competencies: RNs completed waived testing (Accuchek, Coaguchek, and Occult Blood) and IV competencies. Rehab team completed Tinetti Assessment competency. MSWs completed Iatrogenic Addictions competency. All clinicians completed hand hygiene competency. CHHA completed required education hours.

Management/Administrative Staff Training: Patient Care Coordinator and Quality Management Coordinator attended survey preparation class. Quality Management Coordinator attended OASIS course and attained certification as an OASIS specialist. She also attended an ADR class.

Departmental Visit Activity

For fiscal year 2013-2014 annual budgeted visits were 12,575; actual visits were 11,410. This negative variance was due to the EMR training and implementation. For fiscal year 2014-2015, annual budgeted visits are 12,500. Patient visits to date from July 2014– November 2014 total 5787; the budgeted visits were 4716, a positive variance of 1071 thus far this fiscal year.

Home Health CAHPS:

SVH Healing At Home is participating in this standardized patient satisfaction survey process. Results are compared to state and national benchmarks in three realms: patient care; communication; and specific care issues. Most recent report attached.

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Primary Patient Diagnoses

1. Aftercare for specific procedures
2. Signs and symptoms and ill-defined conditions
3. Disease of skin and subcutaneous tissue

Performance Improvement Assessment:

The Healing At Home PI Program submits quarterly reports to the hospital PI Committee. This includes data collection via OASIS, review of potentially avoidable events, clinical record review, quality control and infection control data. PI indicators are updated as problems are identified and resolved. Pertinent results as well as OCS data is presented to all clinical staff at team meetings at least quarterly. In addition, the PI Report is presented to the Professional Advisory Committee. Healing At Home Management assesses and updates the PI Plan annually, analyzing internal and external customers, high risk, high volume, low volume and problem prone work processes.

Summary

Healing At Home is committed to providing quality service for our patients and meeting all regulatory requirements. Management and staff participate in ongoing assessments and performance improvement activities. Quarterly review of policies governing the scope of services is done. Staff productivity is monitored and addressed on an on-going basis. Variances from the standard are analyzed and addressed. OASIS data is monitored for accuracy and submitted in the allotted time frame.

Goals:

Goals for 2014 have been partially met. Productivity has improved but financial challenges continue as SVH implements cost accounting. Patient outcomes and satisfaction showed sustained improvement through the first 3 quarters of 2014 but have stalled in the final quarter.

Healing At Home goals for 2015 include:

1. Cost effectiveness in delivery of service with all staff responsible for meeting their productivity standards, adherence to PPS requirements, and utilization of cost accounting.
2. Improved patient outcomes will be achieved and sustained. Focus will be on improvement in dyspnea and continued improvement in oral medication management.
3. Continue increasing visits in expanded geographic areas to improve efficiency.
4. Collaborate with Marin General Hospital and Meritage ACO to increase referral sources.
5. Recruit rehab staff to cover expanding service areas.

5.

PATIENT CARE SERVICES REPORT

Nursing Services at Sonoma Valley Hospital: 2012-2014 and beyond….

Nurse leaders across the continuum attend retreats quarterly for the purposes of building a cohesive leadership team and developing a vision for the future of nursing at Sonoma Valley Hospital. The overarching goals of the nursing leadership group are:

- To strengthen the nurse leadership team;
- To increase the educational level and certification of nursing staff across the continuum.
- To implement a vision of what the department of nursing would look like over the next 3-5 years;
- To identify the way in which nursing aligns with the hospital's mission, vision and values, and strategic planning goals based on a changing healthcare environment; and
- To reduce silos within and between the nursing departments, as well as across the continuum with our ancillary partners.

Nurse Leaders develop and monitor progress toward a vision and strategic goals for Nursing across the care continuum.

Vision: Nursing Services is built on a foundation of highly professional, educated, competent and engaged nursing staff that are continually mentored and coached by innovative leaders driving success in an ever-changing healthcare environment.

1. Departments are staffed with the right people in the right job /function and in the right amount. Staff are aligned with and fully engaged with the mission, vision, values and strategic initiatives of the hospital. This is measured through the annual employee satisfaction survey, participation in the CEO Forums and staff meetings, an effective acuity and staffing system, and in participation in performance improvement activities within and across departments.

2. Workflow processes are efficient and care transitions are seamless across the continuum. This is measured by the annual AHRQ Culture of Safety Survey, performance improvement activities, fiscal operations, effectiveness of care coordination in reducing re-admissions, and quality outcome measures, such as: HAPU, CAUTI, VAP, Falls and Door to Admission times.

3. There are transition plans in place to ensure new nurses enter and are assimilated into the patient care environment and Nurse Leaders are committed to supporting and developing the new nurse. This is measured by nursing staff turnover, the hiring and mentoring of new grad and hybrid new grads, the development of a standardized orientation and mentoring process, and an annual assessment of areas of opportunity for further skill development. Senior nursing members are engaged to mentor the new nursing staff.

4. Nursing staff participate in the development of nursing practice excellence through professional organization certification and attending professional conferences. This is measured by the number of nurses certified in their areas of practice: Critical Care Registered Nurse (CCRN), Certified Emergency Nurse (CEN), Certified Nurse Operating Room (CNOR), American Society Perianesthesia Nurses (ASPAN), Certified Case Manager (CCM), Certified Medical-Surgical Nurse (CMSN), Palliative Care Certified Nurse (PCCN) and Certified Oasis Specialist (COS) for Home Care. We also set formal agreements in place with five on-line universities that provide BSN and MSN programs at a discounted rate for our nursing staff: Cal State, San Marcos; Arlington University, Texas; Grand Canyon University, Arizona; Chamberlain University and University of San Francisco.

5. As healers and teachers, nursing staff seek out best practices and continually seek to improve the provision of patient care. This is measured by patient experience surveys, use of the Studor Model, participation and advancing the healing hospital model through becoming a wellness ambassador, participation in employee wellness programs for self development, and leading performance improvement activities.

Since the original 2012 strategic planning session, Nurse Leaders have met at least three times a year in retreat to identify strategic goals that have moved nursing towards the vision. The following initiatives have been implemented and/or are on- going.

Initiative	Actions Taken	Outcomes
Electronic Health Record Implementation	Training of all nursing team on use of the electronic record/ Policy and Procedure development/ Training of Super Users	Successful launch of electronic record with continuous improvement each year. Measure of Success: Bar code scanning for medication administration compliance
Clinical Skills Development	Integration of skills fair with annual wellness fair/ identification of competency needed for 2015-16. Identification of low volume, high risk procedures/treatments	Implemented mock code blue drills; AED competencies; EBOLA training; Safe Patient Handling; Telemetry Training; PALS training on med surg; addition of age specific competencies; wound care, restraint, Malignant Hyperthermia, Crash C-section
Telemetry PI Project	24 hour telemetry techs implementation/ training to ensure rhythm identification	Measure of Success: improved rhythm recognition for RNs and successful completion of Telemetry

	competencies/ Reassessment of core competencies developed.	course and testing.
New wing transition	Policy and procedure changes/Orientation and training to new work environment/ Added Spacelab's patient monitors to the PACU, standardizing patient monitoring and transfer of vital data between nursing departments/ Upgraded ICU Spacelab central monitoring station to increase ability to monitor additional vital sign parameters	Successful move with successful CDPH approval to occupy. Improved patient satisfaction in the ED. Increase in OR caseload.
Nursing Forum to discuss healthcare changes.	Conduct a series of Nursing Forums to address healthcare reform and impact on nursing	5 Forums, 30 attendees.
Reconfigure and standardize code blue carts; adult and pediatric	Work with Pharmacy, Materials Management and RT to standardize carts/ Develop restocking process/Ensure compliance with daily checks	All adult and pediatric carts are now standardized. Measure of Success: quality monitoring for cart checks and re-stocking.
Quest for Zero in ED and OB	Nurses in both departments complete modules that identify patient care risks and demonstrate competency through testing.	Successful completion by all nurses on both units. SVH Beta carrier premium reduction.
Care transitions process	Train nursing supervisors on medical necessity to assist when case managers not available/Follow up phone calls upon discharge/Schedule post discharge appointment with PCP for inpatients/Train and enforce SBAR and handoffs/ Institute morning huddles to improve communication between shifts/ Hospitalist huddles for plan for the day and stay.	Measures of success: readmission rate 7.9%; patient compliance with going to see PCP as scheduled (75%)

Reduce silos between departments	Hospital Department Leaders to function as House Supervisors during the day/ Schedule Nurse Leader retreat at least three times per year	Partnered with Materials Management and Cardiopulmonary Departments to standardize re-stocking of Code Blue Crash Carts/ Hired a Nurse Informaticist to bridge gap between information systems and nursing/ Partnered with Ancillary (Lab, Case Managers, PT/OT and Pharmacy to reduce phone calls to ICU thereby reducing interruptions in patient care delivery
Maintain and improve service excellence	Multidisciplinary Patient Experience Team develops and implements strategies based on monthly result monitoring. Implements ancillary rounding, morning huddles, pharmacy consult for discharge medications, Rounding on waiting room, supervisors rounding	Measure of Success: HCAHPS, 5 of 8 Domains @ or > 50^{th} %tile for the inpatient side. 5 of 7 Domains @ or > 50^{th} %tile for the Emergency Department/ Studer model re-training for staff: AIDET, rounding techniques, Low-Medium-High performer evaluations/ Established Patient Care Experience Team

Goals for 2015 and into 2016:

1. Build and finalize a Nursing Services Scorecard.

2. Begin shared governance model by developing a Pharmacy/Nursing Council, then expand to House wide Governance Council.

3. Develop more opportunities for continuing education and certifications.

4. Transition CNO Leadership role.

5. Improve Performance Improvement and Quality Monitoring plans and identify opportunities for improvement across departments.

6. Further development of the Nurse Healer vision.

7. Address and implement strategies for transition planning for nursing line staff.

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

Nursing Leadership Dashboard 2015

Medication Scanning Rate	Quarterly		Trend
	SVH	National	
SNF			
Acute			

Hospital Acquired Pressure Ulcer Incidents	Quarterly		Trend
	SVH	National	
SNF			
Acute			

Falls	Quarterly		Trend
	SVH	National	
SNF			
Acute			

Nursing Turnover	Quarterly		Trend
	SVH	National	
SNF			
Acute			

Competency Certification	Quarterly		Trend
	SVH	National	
Emergency			
ICU			
The Birthplace			
Med Surg			
Surgery			
Home Care			
SNF			

6.

QC REPORT FOR APRIL 2015

To: Sonoma Valley Healthcare District Board Quality Committee
From: Leslie Lovejoy
Date: 04/22/15
Subject: Quality and Resource Management Report

April Priorities:

1. Risk Management and Infection Control coverage
2. Preliminary budget development
3. Departmental Functions

1. Risk Management and Infection Control coverage:

I was covering both functions this month as Kathy Mathews was on vacation. This took up quite a bit of time handling patient relations issues and e-notification monitoring. In conjunction with the Quality Data analyst, I worked with the leadership team weekly in the training room to maintain an up to date database.

2. Preliminary Budget development:

Assessed quality and other departmental needs for the next fiscal year and worked with the Finance Department to develop a preliminary budget for the cost centers for which I am responsible.

3. Departmental Functions:

This was one of those months where I needed to focus more locally on the functions of my departments. We took on quite a bit this fiscal year and the process changes needed some undivided attention: medical staff credentialing, outpatient MD credentialing for outpatient testing, implementation of some clinical informatics processes, pre-admission nurse integration into my team etc.

Topics for discussion: Nursing Services Report; Home Care annual report was supposed to happen this month however, Barbara was away for over a month and it will need to be deferred.