SVHCD QUALITY COMMITTEE MEETING
AGENDA
WEDNESDAY, February 24, 2016
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	
In compliance with the Americans with Disabilities Act, if you require special accommodations to attend a District meeting, please contact the District Clerk, Gigi Betta at ebetta@svh.com or 707.935.5004 at least 48 hours prior to the meeting.		
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, 01.27.16	*Hirsch*	Action
4. **POLICY & PROCEDURES** • Multiple-Feb. 2016: GL8610-190, PC8610-157, UR8610-100 • Multiple-Feb. 2016: IC8610-131, PC8610-120, PC8610136 • Sweet Success Program: PC6171-193	*Lovejoy*	Action
5. APPROVE 2016 WORK PLAN	*Hirsch/Lovejoy*	Action
6. QUALITY REPORT • Quality & Resource Management Report February 2016 • AHRQ Culture of Safety Survey Results • Good Catch Awards Summary	*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 • Board Quality Dashboard* * brought forward from 1.27.16	*Dr. Sebastian*	Action
11. REPORT OF CLOSED SESSION	*Hirsch*	Inform/Action
12. ADJOURN	*Hirsch*	

3.

CONSENT

+

SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
MINUTES
Wednesday, January 27, 2016
Schantz Conference Room

Committee Members Present	Committee Members Present cont.	Members Not Present	Admin Staff /Other
Jane Hirsch Carol Snyder Michael Mainardi Cathy Webber Ingrid Sheets Susan Idell Kelsey Woodward Brian Sebastian, M.D.		Joshua Rymer Howard Eisenstark	Leslie Lovejoy Robbie Cohen, M.D. Mark Kobe Gigi Betta

AGENDA ITEM	DISCUSSION	ACTION
1. CALL TO ORDER/ANNOUNCEMENTS	*Hirsch*	
	The meeting was called to order at 5:00pm	
2. PUBLIC COMMENT	*Hirsch*	
	No public comment.	
3. CONSENT CALENDAR	*Hirsch*	Action
• QC Minutes, 11.18.15 • No December 2015 Minutes		**MOTION** to approve Consent by Mainardi and 2nd by Idell. All in favor.
4. PATIENT CARE SERVICES DASHBOARD	*Kobe*	Inform
	Mr. Kobe presented the annual metrics for medication scanning rate, falls, pressure ulcer incidents, nursing turnover and RN certification.	
5. POLICY & PROCEDURES	*Lovejoy*	Action
• CNO Multiple October 2015 • HIM Multiple August 2015 • QS8610-106 Code Blue Management	Ms. Lovejoy and Mr. Kobe presented six policy revisions and one new policy. .	**MOTION** to approve P&Ps by Mainardi and 2nd by Idell. All in favor.

AGENDA ITEM	DISCUSSION	ACTION
• PC8610-306 De-clotting Central Venous Devices • LAB Multiple October 2015 • SNF Multiple December 2015 • PHARMACY ❖ MM8610-102 Controlled Substance ❖ MM8610-156 Electrolyte Replacement ❖ MM8610-157 Drug Supply Chain		Ms. Betta will change "due" to "do" on the summary sheet of the *De-clotting Central Venous Devices* policy.
6. QUALITY REPORT JANUARY 2016	*Lovejoy*	Inform/Action
	Ms. Lovejoy shared the priorities for December 2015/January 2016 including two new Quality & Risk initiatives (CHPSO and CALHEN 2.0) and the Leapfrog Action Plan implementation.	
7. REVIEW OF 2015 AND 2016 WORK PLANS		
	2015 Work Plan The Quality Committee met all goals on the 2015 Work Plan with the exception of the Palliative Care and Hospitalists educational presentations. The Annual Contract Evaluation Report was put on hold until the M.E.C. has approved it. 2016 Work Plan The following items will be added to the 2016 Work Plan: • IT Services Report in October • Hospitalists Presentation-June • Satellite Dialysis-September • Community Care Network (CCN)-TBD • Employer Direct Program-August	
8. CLOSING COMMENTS	*Hirsch*	
9. ADJOURN	*Hirsch*	
10. UPON ADJOURNMENT OF REGULAR OPEN SESSION	*Hirsch*	
11. CLOSED SESSION	*Sebastian*	Action
Calif. Health & Safety Code § 32155 • Medical Staff Credentialing & Peer Review Report	• Ms. Hirsch will approve the credentialing report via phone with Mr. Rymer.	

AGENDA ITEM	DISCUSSION	ACTION
• Board Quality Dashboard	• The Board Quality Dashboard will be brought forward to the next Quality Committee meeting on March 24, 2016.	
12. REPORT OF CLOSED SESSION	*Hirsch*	Inform/Action
13. ADJOURN	*Hirsch*	
	Meeting adjourned at 6:20pm	

4.

POLICY AND PROCEDURES

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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 February 2016**	
APPROVED BY:	DATE: **1-27-16**
Director's/Manager's Signature	Printed Name **Mark Kobe, RN MPA**

Michael Brown, MD
Chair Surgery Committee

Date

Douglas S Campbell, MD
Chair Medicine Committee

Date

Leslie Lovejoy, RN PhD
Chief Quality Officer

Date

Kelly Mather
Chief Executive Officer

Date

Jane Hirsch
Chair, Board of Directors

Date

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Policy Submission Summary Sheet

Title of Document: **Organizational Policies**

Revision written by: **Multiple Policies Feb 2016**

Date of Document: **1-27-16**

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

GL8610-190 Smoking Policy - ~~Revision~~ NEW; Change "LD" to GL for compliance with nomenclature; Changed Reference to correct California Health and Safety Code Regulation; policy to prohibit patients from smoking and to move to a "Smoke-Free" campus effective March 1, 2016.

PC8610-157 Post-Mortem Protocol - Revision; changed policy name from Death Procedures; restricts the staff who may pronounce death on a DNR patient to nursing supervisors vs any staff RN

UR8610-100 Patient Status Determinations - ~~Revised~~ NEW; Change from a Case Management Observation Status Policy to an organizational policy; Added Categories of patient status and the correct order format including observation; Added responsibilities for order input and changing status documentation for physicians and admitting personnel.

Reviewed by:	Date	Approved (Y/N)	Comment
Policy & Procedure Team	1/19/2016	Yes	
Surgery Committee	2/03/2016	YES	
Medicine Committee	2/11/2016	YES	
P.I. or P. T. Committee	n/a		
Medical Executive Committee	2/18/2016		
Board Quality	2/24/2016		
Board of Directors	3/03/2016		

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SUBJECT: Smoking Policy	POLICY # GL8610-190
	PAGE 1 OF 2
DEPARTMENT: Organizational	EFFECTIVE: 10/82
APPROVED BY: CEO	REVIEW/REVISED: 2/86, 6/89, 4/93, 3/99,12/01,11/07 3/11,2/14, 2/16

Purpose:
Sonoma Valley Hospital has a responsibility to its employees, patients, physicians and visitors to provide a safe and healthful environment. In addition, the mission of Sonoma Valley Hospital is to improve the health of the community and guide its healthcare team and community members towards optimal health and wellbeing. Research indicates that smoking and exposure to second hand smoke are significant health hazards for both smokers and non-smokers. Improperly discarded cigarette butts and other smoking and tobacco product residue are environmental pollutants that pose dangers to people and to wildlife. In addition to these hazards, smoking and discarded cigarettes may create fire hazards and increased cleaning, maintenance and repair costs; and exacerbate employee, patient and visitor illness. To address these interests and concerns, Sonoma Valley Hospital is issuing this Smoking Policy.

Definition:
For the purpose of this policy "smoking" means lighting, burning, carrying, inhaling, exhaling or holding a lit cigarette, cigar, bidi, pipe or other smoking or recreational vapor delivery apparatus containing tobacco or another substance. Substances and activities prohibited by this policy include use of other tobacco products such as smokeless tobacco, as well as the use of e-cigarettes and similar devices. Not prohibited by this policy are nicotine gum, patches, or other medically prescribed smoking cessation assistance devices.

Policy:
It is the policy of Sonoma Valley Hospital that smoking and other uses of tobacco products are prohibited on the hospital campus as well as at off-campus sites under hospital ownership or control, and in vehicles owned, leased or rented by Sonoma Valley Hospital.

Procedure:
A. Upon admission to the acute hospital, patients will be asked if they are currently smokers. If yes, the patient will be informed that this is a non-smoking campus and will be offered an alternative to cigarettes during their stay. Nursing staff will obtain the requisite order for a nicotine substitute unless contraindicated.

B. Residents in the Skilled Nursing Facility are exempted from this regulation and have the right to smoke in the area designated by signage or off-campus.

C. The transition from current hospital policy to a smoke free campus will become effective March 1, 2016.

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SUBJECT: Smoking Policy	POLICY # GL8610-190
	PAGE 2 OF 2
DEPARTMENT: Organizational	EFFECTIVE: 10/82
APPROVED BY: CEO	REVIEW/REVISED: 2/86, 6/89, 4/93, 3/99,12/01,11/07 3/11,2/14, 2/16

D. Signage, complying with regulatory language, will be posted at all campus locations and cigarette butt containers will be available.
E. This policy and the restrictions within will be widely publicized to employees, physicians, visitors, contractors, vendors and the community at large.

F. Employees needing assistance should they decide to quit smoking are encouraged to contact their primary care physician for assistance.

G. The success of this policy depends on the thoughtfulness, civility and cooperation of all members of the Sonoma Valley Hospital community including patients and visitors. Compliance is grounded in an informed and educated community. As with all hospital policies, it is a standard and reasonable duty of all employees, volunteers, physicians and students to fully comply with this policy. Incidents related to this policy will be addressed through applicable administrative processes. Violators of this policy should expect to be approached and reminded of their obligation to comply with this policy.

H. See "Frequently Asked Questions" fact sheet for more information.

References:
California Health and Safety Code Section 1286.

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SMOKE-FREE CAMPUS - FREQUENTLY ASKED QUESTIONS

Q: Why are we becoming totally smoke-free?

A: The goal in implementing this policy is to provide a healthy, comfortable and productive work environment for all patients, visitors and staff. It is stated in the California Health and Safety Code, Section 1286 "Smoking shall be prohibited in patient care areas, waiting rooms, and visiting rooms of a health facility .... " and it is a best practice that nearly all healthcare facilities have implemented. As a Healing Hospital, it is imperative that we adhere to our advised practices. It will provide a healthier environment for employees, visitors and patients, and will underscore our commitment to support the health of our employees, patients and community.

Q: Who made the decision to implement the policy?

A: At the request of the Medical Staff, the Leadership Team decided to make Sonoma Valley Hospital smoke-free based on best practice of our Healing Hospital philosophy and the well being of our employees, patients and visitors.

Q: What does the policy mean?

A: All smoking and other use of tobacco or tobacco-like products are strictly prohibited within owned and leased buildings and on our property, including during breaks and meal times. This policy applies to all SVH properties including, but not limited to all staff, patients (with the exception of SNF residents), contractors and visitors. (Note: California Health and Safety Section 1286 clearly states "This section shall not apply to skilled nursing facilities, intermediate care facilities, and intermediate care facilities for the developmentally disabled".)

Q: Who is responsible for implementing and enforcing the policy?

A: We are all responsible for implementing and enforcing this policy. It is important that we all work to promote good health and support an environment free of tobacco or vapor products.

Q: How will the new policy be enforced?

A: Initially employees will be reminded of the new policy. If an employee continues to violate the policy, he/she may be subject to formal corrective action.

Q: Where can I smoke?

A: The goal of this policy is to make our work environment and property completely smoke-free. This policy does not apply to public property. Please respect our neighbors and refrain from smoking or discarding cigarette butts on their property.

Q: May I smoke in my car?

A: If your car is on SVH property – No. Cigarette butts are the most common type of litter. Reducing cigarette butt litter will beautify our campus and lower clean-up costs. Discarded cigarette butts contain all the carcinogens and nicotine that make tobacco use the leading cause of preventable death. Cigarette butts are also dangerous when consumed by wildlife, pets, or young children.

Q: Won't this policy just send the smokers to restrooms, stairwells and their cars?

A: While that potential exists, the hope is that all will embrace the efforts to sustain a healthier environment for patients, families and employees. The presence of smoke is unhealthy for everyone and the smell of smoke is a trigger for those trying to quit or remain smoke-free while they are here. It is our responsibility to help each other, our patients and visitors in this process.

Q: Why can't we have smoking shelters?

A: Providing a place to smoke doesn't support our goal and mission to be an advocate for health and wellness by providing a totally smoke-free environment for our patients, families and employees. We need to effectively eliminate the triggers (like smoking shelters) that make smoking cessation difficult. To spend money to erect or maintain such structures would be giving inferred approval of smoking, not the message we want to give to our community. There are no designated smoking areas on campus other than for the residents of the Skilled Nursing Facility as required by and stated in the California Health and Safety Code, Section 1286.

Q: I work at a building off-campus that allows smoking. May I smoke there?

A: Sonoma Valley Hospital staff may not use smoking products in any building or on property that is owned or leased by SVH.

Q: Will patients be able to smoke?

A: The same policy applies to patients – they are not permitted to smoke on SVH property (unless residents of the Skilled Nursing Facility as permitted by California Health and Safety Code, Section 1286). Signage will communicate information about the Smoke-free policy to all patients, visitors and employees.

Q: **Won't this hurt patient volume?**

A: It's extremely unlikely. The overall conclusion is that smoke-free policies in healthcare facilities do not lead to a loss of revenue or jobs and may even improve business. Research shows there are no negative economic impact or loss of income resulting from taking protective measures against tobacco or like substances. California Health and Safety Code, Section 1286 prohibits smoking in patient care areas, waiting rooms and visiting rooms of a health facility.

Q: **How will we communicate to patients and visitors that we are smoke-free?**

A: New signage and announcements through the media will help inform patients and visitors. SVH employees will also help explain the new policy.

Q: **Are employees and managers expected to enforce this policy if they see someone smoking?**

A: Employees may approach an individual who is violating the policy and voice a short, simple, friendly reminder that "SVH is now a smoke-free facility". If the person is a visitor he/she may not be aware of the policy. If the person is a fellow employee you need only remind the employee that "SVH is a smoke-free facility now" and move on. No one should feel that he/she should have to "confront" another employee. If employees see someone who is repeatedly violating the policy, they are encouraged to contact Human Resources or that employee's Supervisor. The employee's manager who is apprised of his/her employees' infractions should address this appropriately through the Corrective Action Process.

Q: **What resources have been made available to employees who want to stop smoking?**

A: On-line smoking cessation information is available through our wellness partner Viverae. Alternatively, any individual may consult with their private primary care physician for local classes or prescription medication to assist with smoking cessation.

Q: **Will I be permitted to take longer for my smoke break, since I may have to go farther to take a smoke break?**

A: Breaks (other than the unpaid meal break) are paid at SVH. As employees are permitted to take paid breaks in the department, employees who smoke will be afforded the same amount of time as employees who do not smoke.

All employees are encouraged to be supportive and respectful to co-workers who smoke, as the transition is made to the new policy. Smoking is a powerful addiction and people who smoke will have an adjustment time as the new policy goes into effect.

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SUBJECT: Patient Status Determinations	POLICY # UR8610-100
	PAGE 1 OF 3
DEPARTMENT: Organizational	EFFECTIVE: 10/12
APPROVED BY: Chief Quality Officer	REVIEW/REVISED: 8/14 2/16

PURPOSE:
This policy is intended to clarify the categories for registration status and patient placement determinations to facilitate appropriate utilization and billing of both inpatient and outpatient observation services in compliance with Centers for Medicare Services (CMS) regulations and guidelines.

POLICY:
Sonoma Valley Hospital will use the designated patient status determinations outlined below in order provide effective and efficient care of patients who require either an inpatient stay or a brief stay in the hospital as an outpatient for diagnosis and treatment.

PATIENT STATUS CATEGORIES:

1. Inpatient Acute
The electronic health record order for this status includes the following:
A. If the patient is being admitted as an inpatient from the Emergency Department, the Order should be one of the following.
1. Admit from the ED to the ICU;
2. Admit from the ED to the Medical/Surgical Unit
3. Admit from the ED to Telemetry
4. Admit from ED to Skilled Nursing

B. Electively scheduled inpatient surgery cases or urgent/emergent will use the following electronic order format and the order must be completed prior to the patient going to surgery as the patient is considered an inpatient. The patient's registration status is confirmed by patient registration and nursing prior to the patient going to surgery during the admission or pre-op preparation process (if emergent) and re-confirmed in the Ambulatory Care Unit prior to taking the patient to the OR suite.
1. Admit to the ICU
2. Admit to the Medical/Surgical Unit

2. Inpatient from a Skilled Nursing Facility or other Agency
A.. If the patient is a direct admission from an outside agency to the Acute Inpatient area or to the Skilled Nursing Unit, the order should be written as follows.
1. Admit to the ICU
2. Admit to the Medical/Surgical Unit
3. Admit to Skilled Nursing
4. Admit to Telemetry

3. Inpatient Transfers Between Units

B. The electronic order to transfer patients between patient care units only applies to the movement of an admitted patient between the Intensive Care and the Medical Surgical Units and a recorded as follows. No other "Transfer To" is accepted.

1. Transfer from ICU to Medical Surgical Unit
2. Transfer from Medical Surgical Unit to ICU

4. Observation and Outpatient Status

There are four outpatient/observation status determinations that are accepted and documented in the electronic record.

A. "Place in Observation": this determination is used when a patient requires a brief stay (generally 24 hours or less) to determine if a hospital inpatient admission is warranted based on medical necessity.

B. "Place patient as Outpatient in a bed": refers to a patient that can't be safely discharged from the Emergency Department because of patient safety or social issues that need to be addressed prior to discharge. This designation is used if medical necessity can't be met.

C. "Place in SCU for Same Day Surgery(Type 4)": refers to patients who are scheduled as an outpatient surgery or emergent same day surgery patients.

D. "Place Patient in Extended Recovery" refers to patients who remain in the hospital overnight following surgery for pain control and/or protracted nausea and vomiting..

PROCEDURE:

I. Patient Status Orders:

1. Patient Status Orders shall be entered by the Emergency Department Physician, Hospitalist or Surgeon.
2. Patients may not leave the Emergency Department without a patient status order.
2. All physician orders must be signed, dated, timed in accordance with hospital policy.
3. Hospital staff may take telephone orders for observation services or inpatient admission in accordance with hospital policy.
4. Only PBX and Admitting staff may change a patient status in the electronic record once the order is written by the physician.
4. The time and date of an inpatient admission is the time and date of the physician's admission order.
5. A physician can order an outpatient receiving observation services to be admitted as an inpatient at any time during the hospital stay , but not retroactively.
6. Reversing an inpatient admission order requires the "Condition Code 44" process for Medicare patients only. See policy & procedure 8750-103.

7. Patient Status Orders, once written, will print out in PBX/Admitting for all new admissions and reports are forwarded to the Nursing Administration Office and Case Management for continual confirmation of the correct patient status order entry.

II. Patient Status Determination

1. The determination of inpatient or outpatient status for any given patient is reserved to the admitting physician. Case Managers and Physician Advisors may advise the admitting physician on InterQual criteria and/or medical necessity of inpatient or observation admission, but the decision must be based on the physician's expectation of care that the patient will require. In general, the physician should order an inpatient admission for patients who are expected to need hospital care for 24 hours (over two midnights) or longer.
2. Case Managers should refer patients who do not fit into one InterQual admission category to a UR physician advisor(current contract is with Executive Health Resources).
3. Case Managers should validate that the patient's status matches physician orders as documented in the electronic record.
4. A patient should be admitted for a procedure when either the morbidity associated with the procedure or the co-morbidity associated with a particular patient suggests that a 24 hour or longer stay will be required.

III. Documentation

1. Nursing documentation for the observation patient must reflect the assessment and reassessment of the patient's condition and the performance of services ordered by the physician. The patient must be in the care of a physician during the period of observation, as documented in the medical record by registration, discharge and other appropriate progress notes that are timed, dated and legibly signed by the physician.

IV. Patient Status Communication

1, The Case Manager or Admitting Representative will notify all outpatients in beds that they are outpatients and may be responsible for a coinsurance payment. Notification is done through a letter or brochure explaining observations services.
2. The Case Manager or Admitting Representative will notify patients in writing when "Condition Code 44" is used to change them from an inpatient to an outpatient status because they have a right to appeal their change in status.

REFERENCES:
CIHQ Utilization Review: UR-4

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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: **IC8610-131 Prevention Central-Line Assoc Infections, PC8610-120 Central Venous Access Catheter Management, PC8610-136 Implanted Port Access Management**	
APPROVED BY:	DATE: **1-27-16**
Director's/Manager's Signature	Printed Name **Mark Kobe, RN MPA**

Michael Brown, MD
Chair Surgery Committee

Date

Douglas S Campbell, MD
Chair Medicine Committee

Date

Leslie Lovejoy, RN PhD
Chief Quality Officer

Date

Kelly Mather
Chief Executive Officer

Date

Jane Hirsch
Chair, Board of Directors

Date

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Policy Submission Summary Sheet

Title of Document: **Organizational Policies**

Revision written by: **Bonnie Bernhardy**

Date of Document: **1-22-16**

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

IC8610-131 Prevention of Central-line Associated Bloodstream Infections Policy- Revision; added Appendix A Venous Access Device Adult Quick Reference Guidelines, added alcohol disinfecting port protectors; frequency of gauze dressing change from every 24 hours to every 48 hours; added "Full body sterile draping" for central venous catheter insertion; Central Venous catheters should be "evaluated daily for necessity". Removed: "evaluated routine; CLABSI rate data is reported to Quality "and the CDPH as required by law"

PC8610-120 Central Venous Access Catheter Management; Revision; flush central lines with 20ml NS instead of 10ml; Venous Access Device Adult Quick Reference Guidelines - Appendix A

PC8610-136 Implanted Port Access and Management; Revised; flush implanted ports with 20ml NS instead of 10ml; added Venous Access Device Adult Quick Reference Guidelines - Appendix A

Appendix A Venous Access Device Adult Quick Reference Guidelines-Revised outdated form to reflect current practice standards for venous access devices; added statement on Push-Pause flushing technique, Alcohol Cap change frequency and Stat Lock and change frequency

Reviewed by:	Date	Approved (Y/N)	Comment
Policy & Procedure Team	1/19/2016	Yes	
Surgery Committee	2/03/2016	YES	Bonnie Bernhardy to present
Medicine Committee	2/11/2016	YES	Bonnie Bernhardy to present
P.I. or P. T. Committee	n/a		
Medical Executive Committee	2/18/2016		
Board Quality	2/24/2016		
Board of Directors	3/03/2016		

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POLICY AND PROCEDURE
Approvals Signature Page

Review and Approval Requirements

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- 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: PC6171-193 Sweet Success Policy – New Policy	
APPROVED BY:	DATE: **1-19-16**
Director's/Manager's Signature Cynthia McAleer RN	Printed Name **Cynthia McAleer RN**

D. Paul Amara, MD
Birthplace Medical Director — Date

Michael Brown MD
Chair Surgery Committee — Date

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

Kelly Mather
Chief Executive Officer — Date

Jane Hirsch
Chair, Board of Directors — Date

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Policy Submission Summary Sheet

Title of Document: **Birthplace Department Policy**

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

Date of Document: **1-13-16**

Type:	**Regulatory:**
❑ **Revision** X **New Policy**	X **CIHQ** X **CDPH** X **CMS** ❑ **Other:**
Organizational:	
X **Clinical** X **Non-Clinical**	X **Departmental** ❑ **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)

PC6171-193 Sweet Success Program Policy- New Policy; Initiation of the Sweet Success program at SVH through The Birthplace requires a new policy outlining the program.

Reviewed by:	Date	Approved (Y/N)	Comment
Policy & Procedure Team	1/19/2016	Yes	
Surgery Committee	2/03/2016	YES	Cynthia to present
Medicine Committee	2/11/2016	YES	Cynthia to present
P.I. or P. T. Committee	n/a		
Medical Executive Committee	2/18/2016		
Board Quality	2/24/2016		
Board of Directors	3/03/2016		

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SUBJECT: Sweet Success Program	POLICY #PC6171-193
	PAGE 1 OF 3
DEPARTMENT: The Birthplace	EFFECTIVE: 01/16
APPROVED BY: Director of Maternity Services	REVIEW/REVISED:

Purpose:
The purpose of the Sweet Success Program is to promote best practices of care for pregnant women who have preexisting or gestational diabetes. Sweet Success strives to optimize maternal and fetal birth outcomes, slow, or prevent ongoing diabetes among women with gestational diabetes, and reduce complications of diabetes among women with preexisting diabetes. The purpose of offering the Sweet Success program at this facility is to improve access, convenience and compliance for women in this community.

The goal of the Sweet Success program is to promote quality medical management and nutrition interventions for women with diabetes, or for women who develop diabetes during pregnancy so their pregnancy outcomes match those of women in the general population.

The program provides outpatient-based comprehensive education, nutrition, and medical services to the pregnant woman with diabetes to accomplish this goal. The intent is to achieve active participation by the woman in managing the meal plan, medications, exercise and other strategies necessary for optimal glycemic control.

Policy:
Management and care of this target group will be based on the CDAPP (California Diabetes and Pregnancy Program) Sweet Success Guidelines for Care and utilize a multidisciplinary team composed of physicians, registered nurses, registered dietitians, and other health care professionals as needed to provide preventive and health promoting strategies that are culturally appropriate and research-based.

The Medical Director of the Sonoma Valley Hospital Sweet Success affiliate will be a practicing physician who sees pregnant diabetic patients. The team will include a Registered Nurse as the Nurse Educator, and a Registered Dietitian (RD).

Procedure:
1. Physician referral required
    a. When referral received appointment with the RN will be made as soon as possible.
2. Interventions:
    a. Medical Nutrition Therapy (MNT)
        i. Use of a patient nutrition assessment to determine treatment strategies by the RD
            1. Make recommendations on kilocalorie and macronutrient needs, distribution of carbohydrates, and meeting nutrient requirements during pregnancy
            2. The basic objectives of MNT:
                a. Set appropriate weight gain goals

b. Determine caloric needs
c. Develop and individualized, nutritionally balanced meal plan
d. Recommend vitamin/mineral supplements as needed
e. Provide education concerning nutrition related issues
f. Evaluate adherence to the meal plan
g. Provide evidence based recommendations
h. Promote patient empowerment

ii. Encourage breastfeeding and provide guidelines.

b. Exercise:
   i. Educate on benefits and risks
   ii. Individualized exercise program discussed after medical clearance.
   iii. Use Sweet Success guidelines when proposing an exercise program.
   iv. Educate patient on symptoms signaling when to stop a specific exercise session and contraindication to exercise
c. Education on blood glucose testing:
   i. Provide Sweet Success and other diabetes education handouts as needed.
   ii. Provide instruction on self blood glucose monitoring.
      1. Provide starter kit for glucose monitoring with glucometer, test strips, and lancets.
         a. Ordered per physician order.
      2. Use glucometer with memory.
      3. Instruct on when to test blood glucose and recording of results using the blood glucose log.
      4. Discuss target capillary glucose values.
         a. Fasting: 60-89mg/dl.
         b. Postprandial (one hour from first bite): 100-129mg/dl.
d. Management of medications: (see Management of Blood Glucose in GDM addendum)
   i. When medication is indicated (based on the CDPP Sweet Success guidelines) the physician will initiate order
      1. If >20% of fasting glucose values are >89 & <120 AND/OR
      2. >20% of postprandial glucose values are >129 & <180
   ii. Use Sweet Success protocols and in collaboration with physician for management of oral hypoglycemic agents
   iii. Use Sweet Success protocols and in collaboration with physician for management of insulin therapy
      1. Education provided to patient
         a. Insulin injection technique, carbohydrate counting to control postmeal peak glucose levels, and prevention and treatment of hypoglycemia.

e. Additional education provided:
    i. Symptoms and treatment of hypoglycemia
    ii. Sick day guidelines
    iii. Preterm labor guidelines
f. Antenatal Testing
    i. Instructions on fetal kick count beginning at 28 weeks
        1. Kick counts are the only antenatal testing recommended for diet controlled GDM
    ii. Twice weekly NST and weekly AFI
        1. Starting at 28 weeks gestation if vasculopathy, hypertension, or uncontrolled DM
        2. Starting at 32 weeks gestation if utilizing oral medication or insulin.
g. Documentation
    i. Initial Intake Form per RN
    ii. Initial Nutrition Assessment per RD
    iii. Care Plan per RN and RD
    iv. Telephone order from physician for medication if indicated
    v. Copy of each visit to Medical Records to be included in patient's medical record.
h. Communication with provider
    i. A record of all visits will be provided to the physician provider, include:
        1. Plan of care
        2. Progress notes
        3. Nutrition Assessment per the RD
    ii. Notification of glucose levels indicating need to start medication therapy
        1. Obtain verbal order
    iii. Immediate communication with provider if higher level of care indicated
        1. If unable to maintain normoglycemia during the pregnancy refer patients to a Sweet Success affiliate which provides the higher level of care needed.

Reference:

CDAPP Sweet Success, Guidelines for Care. State Program Guide. California Department of Public Health, Center for Family Health, Maternal, Child & Adolescent Health Division, 2012.

5.

2016 WORK PLAN

2016 Draft Quality Committee Work Plan

January	February	March	April
▪ 2015 Plan evaluation and development of 2016 Plan	▪ AHRQ Culture of Safety Results ▪ 3rd Quarter Quality Dashboard and Harm Score discussion	▪ Annual review of QA/PI Program ▪ 2015 Contract Evaluation Report*	▪ Annual Home Care Report *(Barbara) ▪ Skilled Nursing Report (Melissa)*
May	**June**	**July**	**August**
▪ Annual Infection Control Report* (Kathy)	▪ Patient Care Services Report (Mark) ▪ Hospitalist Services Report (Drs Cohen & Verducci)	▪ Annual Risk Management Report (Kathy)	• Medication Safety Report *(Chris)
September	**October**	**November**	**December**
▪ Performance Improvement Reports – PI Fair ▪ Community Care Network (Leslie & Dr. Cohen)	• Information Services Update	▪ Satellite Dialysis (Rep & Michelle) ▪ Employee Direct (Michelle)	▪ Evaluation of the Quality Committee Work Plan

*Required

6.

QUALITY REPORT

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

To: Sonoma Valley Healthcare District Board Quality Committee
From: Leslie Lovejoy
Date: 02/24/16
Subject: Quality and Resource Management Report

February Priorities:

1. AHRQ Culture of Safety Survey Report
2. Third Quarter 2015 Good Catch Awards
3. Completion of the work plan
4. Development of the Quality Management Database

1. ***AHRQ Culture of Safety Survey Report (see attached)***

Attached please find the excel spreadsheet trending results of this survey over time. We had 105 employees participate out of the 237 sampled. Our methodology changed to the required process set by AHRQ so it is difficult to know if that had an impact on the responses. Demographics include:

Survey Administration Statistics	
Number of completed surveys (response rate numerator)	106
Number of surveys administered (response rate denominator)	237
Response rate	45%

Work Area/Unit (Survey Item: Ai)	**N**	**%**
Many different units / No specific unit	11	10%
Medicine (non-surgical)	4	4%
Surgery	7	7%
Obstetrics	5	5%
Pediatrics	0	0%
Emergency department	4	4%
Intensive care unit (any type)	2	2%
Psychiatry / mental health	1	1%
Rehabilitation	10	9%
Pharmacy	6	6%
Laboratory	6	6%
Radiology	6	6%
Anesthesiology	0	0%
Other	44	42%
Total	106	100%

Staff Position (Survey Item: H4)	N	%
Registered nurse	24	23%
Physician assistant / Nurse practitioner	1	1%
LVN / LPN	1	1%
Patient care asst / Aide / Care partner	3	3%
Attending / Staff physician	0	0%
Resident physician / Physician in training	0	0%
Pharmacist	4	4%
Dietician	2	2%
Unit assistant / Clerk / Secretary	11	10%
Respiratory therapist	4	4%
Physical, occupational, or speech therapist	7	7%
Technician (e.g., EKG, Lab, Radiology)	17	16%
Administration / Management	12	11%
Other	20	19%
Total	106	100%

Interaction with Patients (Survey Item: H5)	N	%
YES, I typically have direct interaction or contact with patients	70	66%
NO, I typically do NOT have direct interaction or contact with patients	36	34%
Total	106	100%
Missing	0	

Talking Points:

1. ***Goal of the Culture of Safety Program***: continuous improvement efforts to create a safe culture for patients, staff and visitors.
2. At the end of October, we randomly selected 237 employees and asked for feedback using the AHRQ (Agency for Healthcare Research and Quality (CMS)) Culture of Safety Survey to measure our progress.

a. When you look at the current results, you will notice a column called NDB. This is the National database consisting of 397,291 hospital survey responses (N=680 hospitals). We will use this to determine how we are doing compared to national trends.

b. SVH has been participating in this survey since 2009 every 1-2 years. We will be measuring yearly from now on. The next measurement period will be during the fall.

c. How to read the responses. Most of the items are straight forward and scores are based on % Agreement with the statements. Occasionally there are questions that the scores may not make sense. For example, take the statements: *My supervisor/manager overlooks patient safety problems that happen over and over or It is often unpleasant to work with staff from other hospital units*. The score here is the % of respondents who Disagree with the statement. I have added the direction of a positive response in the last column to make this easier to read.

3. You will notice that our responses declined from previous year. It is not clear why, perhaps sampling, perhaps more trust to speak frankly, or just a change in the overall process. We will replicate the process next year and compare the results. I would like to open it up and sample physicians this year to establish a baseline for more engagement on their part.

2. ***Third Quarter Good Catch Awards Summary (see attached)***

A Good Catch is the recognition of an event that could have been harmful to a patient, employee or visitor but was prevented. Near misses occur at a much higher rate than actual errors in healthcare. Studies show that proactive reporting "near misses" can prevent more serious errors. At SVH, we do not want to "name and blame". We want to look for ways to identify and improve to create a Culture of Safety and Quality that we can be proud of. In 2013 we adopted the Good Catch Program which is a national best practice program endorsed by the Institute for Healthcare Improvement. Our Good Catch program is overseen by Kathy Mathews, Risk Manager and the Safety Committee of the hospital. Summaries are published quarterly and taken through leadership, committees and discussed at staff meetings so we can learn from events and celebrate catching them prior to harm.

3. ***Completion of the 2016 Work Plan***

The work plan draft has been included in your packet for approval. I will then send it out and work with the leaders on providing the presentations requested.

4. ***Development of the Quality Management Database***

The Quality Department has developed a Quality Management Database which will function as a repository for all medical staff case review, outcomes and follow-up documentation. Our process has been in need of improvement for awhile. Consequently, case review and how the medical staff achieves case review has been under redevelopment. It is my belief that the database will make it easier to track cases and improvement initiatives.

2015 Culture of Safety Assessment: Aggregate Data

AHRQ* Dimensions	2009	2011	2013	2014	2015	NDB
Teamwork In Units	88.5	92.5	91.5	92	88	81
Supervisor Expectations & Actions	83.25	87.5	78.25	88.5	83	76
OrganizationalLearning	78.66	86.66	76.66	84	78	73

	2009	2011	2013	2014	2015	NDB
Management Support for Patient Safety	80.33	86	77.66	85.6	84	72
Overall Perceptions of Patient Safety	72	75.77	73	80	76	66
Feedback and Communication About Error	64.66	78	70.66	74	74	67

	2009	2011	2013	2014	2015	NDB
Communication Openness	69.66	74.66	70.66	71	76	62
Frequency of Events Reported	63	54	67	72	61	66
Teamwork Across Units	68	67.75	73	80	72	61

	2009	2011	2013	2014	2015	NDB
Staffing	42.25	53.75	58.75	64	62	55
Handoffs & Transitions	60	48.25	55.5	56.5	52	47
Nonpunitive Response to Error	55.66	55.33	54	52.6	59	44

*AHRQ: Agency for Healthcare Research and Quality

AHRQ Culture of Safety Trending Results

NDB = National Database	N= 164	N= 115	N= 105	N=120	N= 106		N=397,291	680 hospitals	
1. Teamwork Within Units									Positive:
	2009	**2011**	**2013**	**2014**	**2015**		**NDB**		
a. People support one another in this unit.	92	97	95	98	96	↓	86	↑	Agree
b. When a lot of work needs to be done quickly, we work together as a team to get the work done	92	98	97	94	90	↓	86	↑	Agree
c. In this unit, people treat each other with respect.	91	90	93	94	92	↓	80	↑	Agree
d. When one area in this unit gets really busy, others help out.	79	85	81	81	74	↓	71	↑	Agree
2. Supervisor/Manager Expectations & Actions Promoting Patient Safety									
	2009	**2011**	**2013**	**2014**	**2015**		**NDB**		
a. My supervisor/manager says a good work when he/she sees a job done according to established patient safety procedures.	83	93	78	90	85	↓	75	↑	Agree
b. My supervisor/manager seriously considers staff suggestions for improving patient safety.	87	92	83	91	85	↓	77	↑	Agree
c. Whenever pressure builds up, my supervisor/manager wants us to work faster, even if it means taking shortcuts.	85	82	76	85	85	**NC**	75	↑	Disagree
d. My supervisor/manager overlooks patient safety problems that happen over and over.	78	83	76	88	79	↓	77	↑	Disagree
3. OrganizationalLearning-Continuous Improvement									
	2009	**2011**	**2013**	**2014**	**2015**		**NDB**		
a. We are actively doing things to improve patient safety.	88	97	91	92	89	↓	84	↑	Agree
b. Mistakes have led to positive changes here.	76	77	73	77	73	↑	64	↑	Agree
c. After we make changes to improve patient safety, we evaluate their effectiveness.	72	86	66	83	73	↓	71	↑	Agree

4. Management Support for Patient Safety

	2009	2011	2013	2014	2015		NDB		
a. Hospital management provides a work climate that promotes patient safety.	91	87	80	94	92	↓	81	↑	Agree
b. The actions of hospital management show that patient safety is a top priority.	80	90	80	86	82	↓	75	↑	Agree
c. Hospital management seems interested in patient safety only after an adverse event happens.	70	81	73	77	78	↑	61	↑	Disagree

5. Overall Perceptions of Patient Safety

	2009	2011	2013	2014	2015		NDB		
a. It is just by chance that more serious mistakes don't happen around here.	64	70	74	75	73	↓	62	↑	Disagree
b. Patient Safety is never sacrificed to get more done.	73	70	68	83	71	↓	64	↑	Agree
c. We have patient safety problems on this unit.	73	85	74	79	79	↑	65	↑	Disagree
d. Our procedures and systems are good at preventing errors from happening.	78	78	76	84	79	↓	73	↑	Agree

6. Feedback and Communication About Error

	2009	2011	2013	2014	2015		NDB		
a. We are given feedback about changes put into place based on event reports.	45	68	63	64	65	↑	59	↑	Agree
b. We are informed about errors that happen on this unit.	65	77	67	75	70	↓	67	↑	Agree
c. In this unit, we discuss ways to prevent errors from happening again.	84	89	82	83	87	↑	73	↑	Agree

7. Communication Openness

	2009	2011	2013	2014	2015		NDB		
a. Staff will freely speak up if they see something that may negatively affect patient care.	83	83	87	81	90	↑	76	↑	Agree
b. Staff feel free to question the decisions or actions of those with more authority.	56	54	55	64	69	↑	48	↑	Agree
c. Staff are afraid to ask questions when something does not seem right.	70	87	70	68	69	↑	63	↑	Disagree

8. Frequency of Events Reported

	2009	2011	2013	2014	2015		NDB		
a. When a mistake is made, but is caught and corrected before affecting the patient, how often is it reported?	57	44	59	71	52	↓	60	↓	Agree
b. When a mistake is made, but has no potential to harm the patient, how often is this reported?	57	57	57	67	60	↑	62	↓	Agree
c. When a mistake is made that could harm the patient, but does not, how often is this reported?	75	61	85	77	72	↓	75	↓	Agree

9. Teamwork Across Units

	2009	2011	2013	2014	2015		NDB		
a. Hospital units do not coordinate well with each other.	47	56	54	66	63	↓	48	↑	Disagree
b. There is good cooperation among hospital units that need to work together.	74	73	69	77	76	↓	62	↑	Agree
c. It is often unpleasant to work with staff from other hospital units	66	54	86	90	73	↓	62	↑	Disagree
d. Hospital units work well together to provide the best care for patients.	85	88	83	88	77	↓	71	↑	Agree

10. Staffing

	2009	2011	2013	2014	2015		NDB		
a. We have enough staff to handle the workload.	74	66	67	64	73	↑	54	↑	Agree
b. Staff in this unit work longer hours than is best for patient care.	23	45	43	63	50	↓	52	↓	Disagree
c. We use more agency/temporary staff than is best for patient care.	12	59	67	72	66	↓	66	ND	Disagree
d. We work in "crisis mode" trying to do too much, too quickly.	60	45	58	57	60	↓	50	↑	Disagree

11. Handoffs & Transitions

	2009	2011	2013	2014	2015		NDB		
a. Things "fall between the cracks" when transferring patients from one unit to another.	49	40	45	51	47	↓	43	↑	Disagree
b. Important patient care information is often lost during shift changes.	66	54	64	61	57	↓	53	↑	Disagree
c. Problems often occur in the exchange of information across hospital units.	53	54	54	58	56	↓	46	↑	Disagree
d. Shift changes are problematic for patients in this hospital.	72	45	59	56	49	↓	47	↑	Disagree

12. Nonpunitive Response to Error

	2009	2011	2013	2014	2015		NDB		
a. Staff feel like their mistakes are held against them.	65	69	65	62	71	↑	50	↑	Disagree
b. When an event is reported, it feels like the person is being written up, not the problem.	56	56	48	56	62	↑	48	↑	Disagree
c. Staff worry that mistakes they make are kept in their personnel file.	46	41	49	40	46	↑	35	↑	Disagree

GOOD CATCH AWARDS

The following employees were recognized for identifying and reporting potential safety issues affecting patient care or employee/visitor safety.

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

Employee	*Safety Issue Identified*	*Actions Taken to Prevent Harm*
David Efros (Speech) 15-869	Patient with partially correct wristband. Incorrect last name on wrist band. All other information on wrist band appeared correct. Good catch as patient was obtunded at the time, and therefore unable to speak and verify her identity to caregivers. Issue brought to attention of the nurses on the unit, who immediately removed incorrect wristband, and replaced it with correct wristband.	Pt ID wristband corrected
Dr Michael Mainardi (BOD Quality Committee) 15-804	Upon review of critical lab values, DR. Mainardi questioned the Troponin value and units. Upon talking with the lab Manager, it appears the form should have read 0.034 ng/mL instead of 0.035 ng/dL..	Lois has changed the form to the correct information and will educate physicians and nursing to the changes. A very good catch
Vily Pham (Pharmacy) 15-716	Pharmacy technician Vily Pham discovered a medication re-packaging label error. The wrong expiration date was typed on the label. Vily noticed the manufacturer package warning to discard 90 days after opening.	Vily corrected the expiration dates on all syringes in stock and added a warning on the packaging log sheet to adhere to the 90 days limit.
Lynne Teixeira (NR Admin) 15-850	This was a complex patient starting the first day of his infusion. Dr. Price was to follow patient and he was also being seen by the specialist at Marin General. The patient had multiple setbacks in his recovery from Marin General; none SVH related. I do think this was a good catch for Lynne to go back to the original source and prevent this patient from being at home and having an infection progress. Staff were very thankful for her support.	Pt returned to Marin General for further care.

GOOD CATCH AWARDS

The following employees were recognized for identifying and reporting potential safety issues affecting patient care or employee/visitor safety.

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

Employee	*Safety Issue Identified*	*Actions Taken to Prevent Harm*
Leslie Wren (Emergency) 15-643	Leslie discovered insulin vials in pyxis displayed dosing inappropriately that would have caused significant harm to patient. Pharmacy contacted	Pyxis server entry for item updated to be more clear.
Karen Rara (Med Surg) 15-662	It was noted that Humulin R and Humulin N insulin has a 31 day room temperature expiration, but the eMAR note stated it was 42 days.	Updated references & Paragon to reflect correct expiration, Good Catch!
Raymond Mercado (SNF) 15-846	Notified pharmacy that a "sample" medication brought in by a physician for patient use was outdated by several months.	Med was not given to patient and RN called MD.
Melanie McKenzie (Emergency) 15-847	Notified pharmacist of incorrect dose calculated. The order is for max of 10mg but the system does not have the capacity to stop at a pre-set maximum after calculating a mg/kg dose.	Pharmacist added note to the Standing Order used in the CPOE Oder Set to describe the need for the RN to correct the dose to 10mg for any automated calculation resulting above 10mg.
Melanie McKenzie (Emergency) 15-848	Notified the pharmacist of an incorrectly calculated dose for a 3 year old patient. It was discovered that the weight had been input as 79.3kg for a 15.1kg child. (height was incorrect at 65 inches also)	height and weight corrected, dose adjusted
Sue Rolling (ICU) 15-989	0900 medication metoprolol tartrate 25mg po removed from pyxis, but what was in the drawer & pulled out was metoprolol succinate 25mg po. Wrong drug in med drawer #4.2-B2. Double-checked in drawer & both medications in this drawer. Pharmacist notified.	To prevent this from occurring in the future, a different manufacturer of succinate will be used because of packaging look alike sound alike issue.

GOOD CATCH AWARDS

The following employees were recognized for identifying and reporting potential safety issues affecting patient care or employee/visitor safety.

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
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Employee	*Safety Issue Identified*	*Actions Taken to Prevent Harm*
Katherine Fegan (Resource Management) 15-992	Patient was being discharged to SVHSNF without prior auth. from the private insurance company. Monica notified the acute case managers & was able to hold the transfer until auth. was obtained.	Monica notified the acute case managers & was able to hold the transfer until auth. was obtained.
Pharmacy Staff 15-1026	Weight is entered incorrectly as kg instead of lb on the pre-op surgical order form. Mistake was discovered by pharmacist during drug order entry/ reconciliation.	Staff educated to importance of accurate Ht Wt on all clinical documentation