SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
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SVHCD QUALITY COMMITTEE MEETING
AGENDA
WEDNESDAY, November 18, 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, 10.28.15 •	*Hirsch*	Action
4. BARIATRIC SERVICE LINE PRESENTATION	*Dr. Perryman/ Donaldson*	
5. POLICY & PROCEDURE There are no Policies or Procedures for this meeting.	*Lovejoy*	Action
6. QUALITY REPORT NOVEMBER 2015	*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 •	*Dr. Sebastian*	Action
11. REPORT OF CLOSED SESSION	*Hirsch*	Inform/ Action
12. ADJOURN	*Hirsch*	

3.

CONSENT

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SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
REGULAR MEETING MINUTES
Wednesday, October 28, 2015
Schantz Conference Room

Committee Members Present	Committee Members Present cont.	Members Not Present	Admin Staff /Other
Jane Hirsch Joshua Rymer Carol Snyder Michael Mainardi Cathy Webber Ingrid Sheets Susan Idell Brian Sebastian, M.D.		H. Eisenstark Kelsey Woodward Keith Chamberlin, MD, MBA	Leslie Lovejoy Mark Kobe Dr. D. P. Amara Cynthia McAleer Michelle Donaldson Gigi Betta

AGENDA ITEM	DISCUSSION	ACTION
1. CALL TO ORDER/ANNOUNCEMENTS	*Hirsch*	
The meeting was called to order at 5:00pm.		At the next meeting on November 18, 2015 Dr. Perryman and Michele Donaldson will present on Bariatrics.
2. PUBLIC COMMENT	*Hirsch*	
No public comment.	None	
3. CONSENT CALENDAR	*Hirsch*	Action
QC Minutes, 9.23.15		**MOTION** to approve Consent by Rymer and 2nd by Mainardi. All in favor.
4. QUARTERLY PATIENT CARE SERVICES DASHBOARD	*Kobe*	Inform
Mr. Kobe shared scores on medication scanning rate, nursing turnover, falls, RN certification and pressure ulcer incidents.		
5. THE BIRTHPLACE PRESENTATION	*Amara/Smith/McAleer*	Inform
Ms. McAleer gave a presentation on The Birthplace including accomplishments over the past 12 months, services provided, works in progress and future goals.		
6. POLICY & PROCEDURE	*Lovejoy/Kobe*	Action
• Emergency Department Staff (revised) • Multiple Policies September 2015		**MOTION** by Rymer to approve and 2nd by Hirsch. All in favor.

AGENDA ITEM	DISCUSSION	ACTION
• Newborn Screening		
7. QUALITY REPORT OCTOBER 2015	*Lovejoy*	Inform/Action
Quality and Resource Management Report Ms. Lovejoy shared October priorities including STATIT Training, CMS Complaint Validation Survey Plan of Correction and Board Quality Update on Incentives and Penalties. Quality Performance Metrics This report provides an update on CMS incentives and 2016 penalties and informed the Committee on additional performance measures that have recently been publicly reported. Over CMS reporting years 2013-14, SVH was placed in the top quartile nationally on most quality measures		**MOTION** by Rymer to approve and 2nd by Mainardi. All in favor.
***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		**MOTION** by Rymer to approve and 2nd by Mainardi. All in favor.
12. REPORT OF CLOSED SESSION	*Hirsch*	Inform/Action
13. ADJOURN Meeting adjourned at 6:20pm	*Hirsch*	

6.

QUALITY REPORT NOVEMBER 2015

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To: Sonoma Valley Healthcare District Board Quality Committee
From: Leslie Lovejoy
Date: 11/18/15
Subject: Quality and Resource Management Report

November Priorities:
1. AHRQ Culture of Safety Survey
2. Leapfrog Hospital Survey Results
3. Pharmacy Survey Results
4. Quality Monitoring of Quality Monitoring

1. AHRQ Culture of Safety Survey

We have sent out a sample of surveys to all departments. A random sample of employees have until November 20th to send them back. Once the data has been entered, aggregated and analyzed, I will bring the results to the January or, at the latest, February meeting.

2. Leapfrog Hospital Survey Results:

We received our hospital's letter score last week. See attached report and plan for improvement.

3. Pharmacy Quality:

The pharmacy was visited by the California Board of Pharmacy for a surprise inspection and what will probably be more intensive surveillance of compounding processes within the pharmacy. There has been an increase in legislation and regulations around drug compounding processes and engineering controls. I have attached the two findings and the Director of Pharmacy's action plan to remediate the deficiencies.

In addition, Chris has been asked to present the hospital's Antibiotic Stewardship Program at the American Health Systems Pharmacists annual conference. Chris is being sponsored by CPS (Comprehensive Pharmacy Services) to give this best practice presentation at the conference.

4. Quality Monitoring of Quality Monitoring:

The purpose of this section is to ensure this committee that action plans are being completed and that department leaders are current in there department specific PI projects and quarterly quality monitoring. See the following attachments:

- CIHQ Accreditation Survey Action Plan reporting grid
- CIHQ Mid-Cycle Survey Action Plan reporting grid

I will bring an update on the monitoring for the CMS complaint survey next session.

Topics for discussion: Dr. Perryman's presentation on the Bariatric Service Line

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SONOMA VALLEY HEALTH CARE DISTRICT
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November 3, 2015
To: Admin Team, Leadership Team, Medical Executive Committee & Board Quality Committee
From: Leslie Lovejoy, Chief Quality Officer
Re: Leapfrog Hospital Survey Results

In the past, Sonoma Valley Hospital has not participated in the annual Leapfrog Hospital Survey administered by the Leapfrog Group. Each year the group publishes a letter score based on what data they have for each hospital. Our past letter scores have been based on publicly reported data that the Leapfrog Group has accessed from the Medicare website, Hospital Compare. This resulted in letter scores of A for the past few times the letter scores have been posted accompanied by a comment that we did not report the survey data.

This year we made the decision to delve deeper into national best practices in order to improve and support the efforts we have been making to build a just and safe culture for our patients, physicians and staff. The National Quality Forum Patient Safety Standards are a major portion of the Leapfrog Hospital Survey and go beyond quality outcomes to guide hospitals to make systematic changes in the way they do the work of providing healthcare. While we have implemented some, we still have work to do, hence the letter score of C. We are committed to building on what we have achieved in the past so that we can say we are one of the safest hospitals in the nation.

The hospital survey includes the following dimensions and all or none standards for achieving full compliance.

CPOE Attestation	Physician Staffing in the ICU	Maternal Care
Safe Practices	Managing Serious Error	
Bar Code Scanning	Resource Use for Common Acute Conditions	

The following represent areas of opportunity to further grow and refine our Culture of Safety.

Areas of Opportunity for Improvement 2015-2016

National Quality Forum Standard	Opportunity	Suggested Strategy	Responsible Person(s)
Culture of Safety/Leadership/Systems	Patient and family members are formally part of safety and quality committees	Patient Experience team to do focus sessions with patients regarding safety and quality of care. Invite patients or family members to attend Board Quality committee as community member	Mark/Leslie
	Senior leaders perform "walk arounds"; lead safety meetings	Mark attends Safety Committee with Patient Safety Officer, Dawn and Paula are ad hoc. Add rotation for all of us on Safety Rounds?	C-Suite
	CEO and the Board approve patient safety strategies as outlined in RM/PS annual plan and the annual PI plan	Board already approves; add approval line for CEO at end of reports	Leslie/Kelly
	No accountability or mention of a culture of safety in performance evaluations or in core values	Add under accountability section on patient safety, place patient safety in values statements	Paula/Leslie
Governance	Annual documentation that the board has confirmed that the behaviors of the organization related to quality and safety mirror its values with respect to patient safety.	Do at the end of each fiscal year	Jane/Leslie/Kelly
	Dedicated period of basic training in teamwork, communication, patient safety per board member per year as determined by the Board and as documented by agendas and attendance records	Jane to set the agenda for training with Leslie & Kelly's assistance	Jane/Leslie/Kelly

	At least annually the board needs to discuss its own competency and document its strategy for ensuring that all existing and new board members are well versed in patient safety.	Jane to facilitate	Jane/Leslie/Kelly
Teamwork and Training	Develop ongoing skill building through didactic and interactive methods for risk identification and mitigation.	Find training programs in: principles of human factors design, interpersonal team dynamics, hand offs, stop the line methods, using effective assertion skills.	Leslie/Mark
	Ventilator complication prevention	ICU: plan formal training on ventilator complication prevention Develop patient/family education tool regarding ventilators, risk strategies to prevent complications	Mark/David
	Medication Reconciliation	Nursing staff: plan formal training on medication reconciliation	Mark/Nurse Leaders
Identification and Mitigation of Risk	Medication error reporting is reported to the board at least annually	Add Chris to agenda for Board Quality Committee	Leslie/Chris
	Lack of frontline education regarding risk events and actions taken	Leaders to print department specific reports and discuss with staff as documented by agendas and attendance sheets.	C-Suite
	At least on Prospective Risk Assessment is completed yearly with action taken and communicated through organization and board.	Leslie to find tool and work with Nurse Leaders	Leslie/Mark
	Specific risk assessments and	Develop annual effectiveness	Mark/Nurse Leaders/Bob

	mitigation activities are completed and communicated through organization and board.	reviews and continuous quality improvement activities: Fall Prevention Program Malnutrition Pneumatic Tournequit (If use) Aspiration Precautions Workforce Fatique Pressure Ulcers	
Misc	Lack of reporting up through organization of efforts to reduce risk related to Rapid Response, Code Blues, AED training and Malignant Hypothermia.	Suggest Bonnie and Mark complete a PDSA and report to leadership, frontline and then Mark can take it to Board Quality	Paula/Mark
	Lack of skill mix as a patient safety indicator in either risk plan or nursing dashboard	Mark and Leslie to discuss and determine home.	Leslie/Mark
	Bar code scanning documentation of three data elements. We already do the % of bar code scanning.	Add second element: % of meds administered prior to bar code scanning. Add third element: real time observation of bar code scanning to departmental quality monitoring quarterly report.	Mark/Fe/Nurse Leaders
	Nursing Standards	Leslie to review with Mark	Leslie/Mark

We are in the process of completing our annual AHRQ Culture of Safety Survey and will have the report to you in January or at the latest February depending on the data aggregation and interpretation process. We will add these results and any actions that result to our Organizational Performance Improvement and Risk Management Plans for 2016.

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October 16, 2015

Inspector Lin Hokana, RPh, California Board of Pharmacy:

In response to the Board of Pharmacy inspection of Sonoma Valley Hospital Pharmacy on 10/8/2015, I would like to submit the required plans of correction as follows:

1. CCR 1751(b)(2): Walls were not painted with a non-porous paint. Plan: The hospital's engineering department was contacted on 10/8/2015 regarding the need to repair and repaint the pharmacy cleanroom walls with a non-porous paint. The paint department at Sonoma Valley Hospital will investigate appropriate paints with which to repaint the cleanroom walls and accomplish the repair by 12/15/2015. This will include coordination with personnel who can temporarily move equipment away from the walls so that the walls can be completely repainted. Micro Technology Inc. (MTI) has been contacted to inform them of the need to recertify the room after the repairs and painting have been completed.

2. CCR 1714(c): No hot water flowed at the sink used to cleanse hands in the ante area. Plan: The hospital's engineering department was contacted on 10/8/2015 to arrange for the repair of the sink's hot water supply. Engineering personnel completed the repair of the hot water supply on 10/12/2015, resulting in hot water being reliably supplied to the sink in the cleanroom ante area.

Please inform me if any further information or documentation will be required.

Thank you,

Christopher M. Kutza, PharmD
Director of Pharmacy and PIC, Sonoma Valley Hospital

SONOMA VALLEY HOSPITAL

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Accreditation Survey Final Report

Dates of Survey: **April 15 – 17, 2014**

Type of Accreditation: **ACUTE CARE HOSPITAL**

Chapter	Standard Level	Respons Person	Monitoring Description	Term	Duration	Goal	Compliance 2014								Compliance 2015											
							May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
Governance & Leadership	GL-3	Nancy	Governing body to approve credentialing	quarterly	ongoing	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%			
Medical Staff	MS-3	Nancy	By-law changes to include 'after' rather than 'or'	final doc	completed	100%	N/A																			
	MS-3	Nancy	Include date bylaw change will be approved by governing body	final doc	completed	100%	N/A																			
	MS-4	Nancy	Primary source verification clearly documented	quarterly	ongoing	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%			
	MS-5	Nancy	Med Staff meet established privileging criteria at reapp	quarterly	ongoing	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%			
Managing the Care Environme	CE-3	Kimberly	PMs for eyewash and Lint trap check	monthly	ongoing	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	*to QAPI reporting*		
	CE-4	Cynthia	OB staff attest to Infant Security Policy-policy signed-filed in HI	annually	ongoing	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	*to QAPI reporting*		
	CE-15	Kimberly	Appealed-Compliance to the NFPA Life Safety Code																							
	CE-19	Kimberly	Fire Device PMs (only annuatly per Grigory)	quarterly	ongoing	100%	100%	n/a	100%	n/a	n/a	100%	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	100%	n/a	n/a	n/a		
Infection Prevention & Control	IC-7	Jessica	Temperature of Cidex and QC of Test strips	weekly	ongoing	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	*no longer in use*									
	IC-7	Allan	IUSS report-% of instruments not flashed tor case turnover	monthly	ongoing	95%	67%	67%	71%	69%	79%	74%	79%	88%	81%	83%	79%	82%	86%	83%	76%	83%	83%	90%		
	IC-7	Allan	Sterilize instruments in open position (3 mos-then random qua	quarterly	3 mos	95%	n/a	100%	100%	100%	100%	100%	n/a	100%	100%	100%	100%	100%	100%	n/a	100%	100%	100%	100%		
Patient Rights	PR-2	Lisa	Presence of IMM	monthly	3 mos	90%	n/a	62%	46%	79%	65%	88%	83%	88%	81%	*92%*	*86%*	*84%*	*86%*	*84%*	*73%*	*98%*	*90%*	94%	**complete**	
	PR-3	Lisa	Notification of Representative and/or MD documented	monthly	3 mos	90%	n/a	83%	66%	84%	65%	93%	63%	65%	81%	87%	85%	82%	93%	70%	73%	92%	90%	99%	**complete**	
	PR-13	Pauline	Patient's Plan of Care	monthly	3 mos	90%	100%	100%	100%								**monitoring complete**									
Medication Management	MM-5	Jessica	Expiration date for saline bags in warmer	daily	ongoing	100%	100%	100%	100%	97%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	97%	100%	*to QAPI reporting*		
	MM-20	Chris	Appropriate Abbreviations for Vanco & Coloscopy patients	monthly	3 mos	100%	100%	100%	100%								**monitoring complete**									
	MM-22	Chris	Medication orders	monthly	3 mos	90%	n/a	n/a	100%	100%	100%						**monitoring complete**									
Management of Medical Reco	MR-5	Allan	Presence of accurate and timely H & P and complete update	monthly	3 mos	90%	97%	97%	93%								**monitoring complete**									
Use of Restraint & Seclusion	RS-7	Mark	Restraint documentation	monthly	3 mos	100%	100%	100%	100%								**monitoring complete**									
	RS-9	Mark	Restraint Order documentation-complete																							
Anesthesia Services	AN-2	Mark	All procedural sedation documentation in the ED	monthly	3 mos	90%	100%	100%	0%	100%	*n/a*	40%	0%	14%	50%	100%	60%	100%	92%	67%	67%	71%	89%	77%		
	AN-2	Allan	Anesthesia accurately document pre-anesthesia airway	monthly	6 mos	90%	100%	97%	97%	97%	100%	100%						**monitoring complete**								
	AN-2	Allan	Anesthesia accurately document hydration & nausea/vomit sta	monthly	6 mos	90%	97%	100%	97%	97%	100%	100%						**monitoring complete**								
Discharge Planning Services	DC-2	Pauline	Appealed																							
Laboratory Services	LB-6	Allan	Tissue and license expiration dates	monthly	ongoing	100%	n/a	n/a	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
Nursing Services	NS-3	Pauline	Plan of care being updated every shift	monthly	3 mos	90%	100%	100%	100%								**monitoring complete**									
Operative & Invasive Procedu	OI-3	Allan	Plan of care for fire safety in the OR	monthly	3 mos	90%	n/a	n/a	100%	97%	100%						**monitoring complete**									
	OI-4	Allan	Presence of the accurate Plan of Care; Wrong patient/site	monthly	3 mos	90%	n/a	n/a	100%	100%	100%						**monitoring complete**									
	OI-7	Mark	Appealed																							

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SONOMA VALLEY HOSPITAL HEALTHCARE DISTRICT
Mid-Cycle Survey Final Action Plan 2015

Dates of Survey: **July 6, 2015**

Type of Accreditation: **ACUTE CARE HOSPITAL**

Chapter	Standard Level	Respons Person	Monitoring Description	Term	Duration	Compliance 2015 Aug	Sept	Oct	Nov	Dec	Compliance 2016 Jan	Feb	Mar	Apr	May	June	July	Aug
Medical Staff	MS-3	Nancy	Medical Staff By-laws revised and posted	final doc	Completed													
Managing the Care Environment	CE-3	Kimberly	Compliance of 3 feet clearance around electrical panel-Surgery Depart	final	Work order completed													
	CE-3	Kimberly	Compliance of 3 feet clearance around electrical panel-audit	monthly	12 mos	100%	100%											
	CE-8	Kimberly	Record medical equipment service providers & dates accepted into servi	monthly	6 mos	100%	100%											
	CE-10	Kimberly	Record utility equipment service provider & dates accepted into service	monthly	6 mos	100%	100%											
	CE-11	Kimberly	Surgical and OB humidity logs and work order actions	monthly	6 mos	100%	100%											
Infection Prevention & Control	IC-7 #1	Allan	Rapicide Solution, test strip bottle label, pass/fail	monthly	12 mos	100%	100%											
	IC-7 #2	Allan	Compliance with 14 day and tagging workflow scopes	monthly	12 mos	100%	100%											
	IC-7 #3	Allan	Relocation of gross decontamination to Decontamination Room	final doc	Completed 8/1415													
	IC-7 #4	Allan	Instrument tips are separated during sterilization	monthly	12 mos	100%	100%											
Patient Rights	PR-10	Allan	Patient information is secure at all times	monthly	6 mos	100%	100%											
	PR-10	Allan	Staff education/attestation regarding Workforce HIPAA Regulations polic	final doc	Complete to date													
Medication Management	MM-8	Allan	Fluids in warmer not to exceed 14 days-audit	monthly	6 mos	100%	100%											
	MM-8	Allan	Staff education regarding "Storage of Medications" policy/Meds secure	final doc	Complete to date													