SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
REGULAR MEETING AGENDA
Thursday, December 19, 2013
5:00 p.m. Regular Session
(Closed Session will be held upon adjournment of the Open 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	*Nevins*	
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.*	*Nevins*	
3. CONSENT CALENDAR: A. Quality Committee Minutes, 11.21.13	*Nevins*	Action
4. POLICIES AND PROCEDURES 1. Environment of Care 2. Emergency Department Manual	*Lovejoy*	Action
5. RESULTS OF ROOT CAUSE ANALYSIS FOR REPORTED SENTINEL EVENT	*Lovejoy*	Inform/Action
6. QUALITY REPORT DECEMBER 2013	*Lovejoy*	Inform
7. 2013 WORK PLAN	*Lovejoy*	Inform/Action
8. CLOSING COMMENTS/ANNOUNCEMENTS	*Nevins*	
9. ADJOURN	*Nevins*	
10. UPON ADJOURNMENT OF THE REGULAR OPEN SESSION	*Nevins*	
11. CLOSED SESSION: Calif. Health & Safety Code § 32155 – Medical Staff Credentialing & Peer Review Report	*Amara*	Action
12. REPORT OF CLOSED SESSION	*Nevins*	Inform

3.

CONSENT CALENDAR

SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
REGULAR MEETING MINUTES
Thursday, November 21, 2013
Schantz Conference Room

Committee Members Present	Committee Members Present	Committee Members Absent/Excused	Administrative Staff /Other
Sharon Nevins Leslie Lovejoy Susan Idell Jane Hirsch Paul Amara Joel Hoffman		John Perez Howard Eisenstark Robert Cohen	Gigi Betta Mark Kobe

AGENDA ITEM	DISCUSSION	CONCLUSIONS/ ACTION	FOLLOW-UP/ RESPONSIBLE PARTY
1. CALL TO ORDER	*Nevins*		
	5:04 PM		
2. PUBLIC COMMENT	*Nevins*		
	No public comment.		
3. CONSENT CALENDAR	*Nevins*	Action	
A. QC Meeting Minutes, 10.23.13		**MOTION:** by Hirsch to approve and 2nd by Idell. All in favor.	
4. QUALITY DASHBOARD 3rd QUARTER REPORT	*Lovejoy*	Inform	
	Ms. Lovejoy presented the following: 1. Quality Dashboard 3rd Quarter Report 2. Quality and Resource Management Report a. Good Catch Awards b. Percent Near Miss Error Report		1. 3rd Quarter Dashboard Report goes to 12/5 Board Meting. 2.Quality Mgmt Report* goes to 12/5 Board Meeting.
5. POLICIES AND PROCEDURES	*Lovejoy*	Action	
1. Infection Control Manual 2. Materials Management Manual 3. Patient's Rights and Ethics P/P 4. Human Resources Manual		**MOTION:** by Hirsch to approve P&Ps 1-5 and 2nd by Hoffman. All in	5 P&Ps go to 12/5 Board for approval under Consent Calendar.

AGENDA ITEM	DISCUSSION	CONCLUSIONS/ ACTION	FOLLOW-UP/ RESPONSIBLE PARTY
5. Leadership Finance P/P		favor.	
6. SENTINEL AND ADVERSE EVENT REPORTING	*Nevins*	Inform	
	Ms. Lovejoy will revise and clarify this policy in early 2014 and then it will be a two step process to obtain Board approval: the first Board meeting will be to inform and the second Board meeting will be to approve.		
7. EDUCATIONAL SESSIONS	Lovejoy/Kobe	Inform	
1. Annual Contracts Review Report 2. The Patient Experience	Ms. Lovejoy and Mr. Kobe presented on Annual Contracts Review and Patient Experience.		The Patient Experience presentation goes to 12/5/13 Board Meeting.
7. CLOSING COMMENTS	*Nevins*		
8. ADJOURN	*Nevins*		
		.	
9. UPON ADJOURNMENTOF REGULAR OPEN SESSION	*Nevins*		
10. CLOSED SESSION	*Amara*		
11. REPORT OF CLOSED SESSION/ADJOURN	*Nevins*		
	Adjourn 6:20 pm The next QC meeting is on December 19, 2013 at 5:00pm		Medical Staff Assistant to revise the credentialing report for Board's approval by removing "paid dues" section.

4.

POLICIES & PROCEDURES

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.

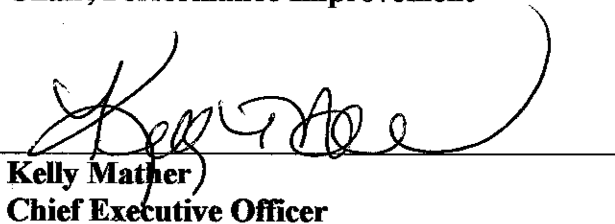
Organizational Environment of Care	
APPROVED BY: **Director of Facility**	DATE:
Director's/Manager's Signature	Printed Name **Kevin Coss**

Leslie Lovejoy, CNO
Chair, Safety Committee

12-12-13
Date

D. Paul Amara, MD
Chair, Performance Improvement

Date



Kelly Mather
Chief Executive Officer

12/13/13
Date

Sharon Nevins
Chair, Board of Directors

Date

Sonoma Valley Hospital
Sonoma Valley Healthcare District
Document Submission
Summary Sheet

Title of Document: **Environment Of Care**	**Reviewed By Safety Committee**
Type ✓ **Review: Policy**	**Regulatory** ✓ **CMS** ✓**CDPH** (formerly DHS) ✓**TJC** (formerly JCHAO) ✓ **Other:**
✓ **Organizational**	✓ **Interdepartmental** *(All Departments)*

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

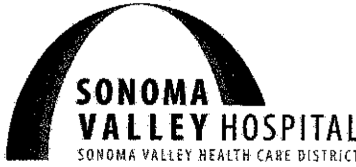
Following organizational plans and policies have been updated:

Fire Safety Management Plan – EC-LS8610-100
Security Management Plan – EC-SAF8610-100
Infant Security and Code Pink - #4
Utility Management Plan – EC-UT8610-100
Hazardous Materials and Waste Management Plan – EC-HAZ8610-101
Medical Equipment Management Plan – EC-EQP8610-100
Building Maintenance Plan – EC-SAF8610-101
Interim Life Safety Measures – EC-LS8610-101
Key Return Process – EC- SEC8610- 100
Equipment Disposition Form Process – EC- EQ8610- 101
Emergency Operations Plan 2013 – EM8610-100

Reviewed By	Date	Approved (Y/N)	Comment
Fire Safety Management Plan, Safety Committee	February 2013	Y	
Security Management Plan, Safety Committee	February 2013	Y	
Infant Security and Code Pink, Safety Committee	September 2012	Y	
Utility Management Plan, Safety Committee	February 2013	Y	
Hazardous Materials and Waste Management Plan, Safety Committee	June 2013	Y	
Medical Equipment Management Plan, Safety Committee	March 2013	Y	
Building Maintenance Plan, Safety Committee	July 2013	Y	

Sonoma Valley Hospital Sonoma Valley Healthcare District **Document Submission** **Summary Sheet**	
Title of Document: **Environment Of Care**	**Reviewed By Safety Committee**

Interim Life Safety Measures, Safety Committee	July 2013	y	
Key Return Process, Safety Committee	July 2013	Y	
Equipment Disposition Process, Safety Committee	August 2013	Y	
Emergency Operations Plan, Safety Committee	August 2013	Y	



Healing Here at Home

POLICY AND PROCEDURE
Approvals Signature Page

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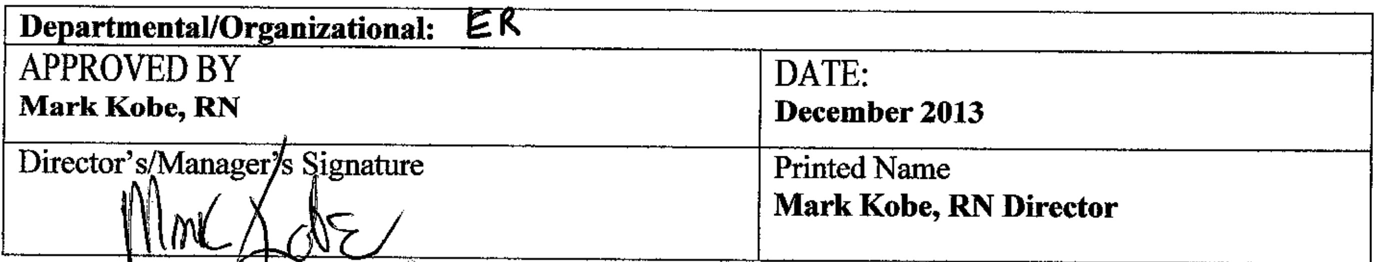
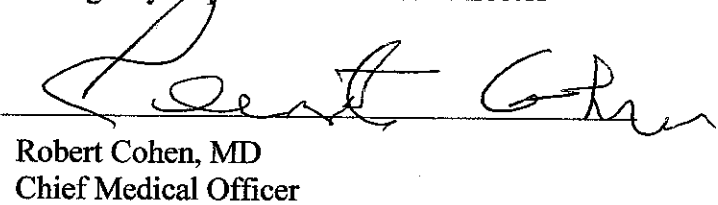


Departmental/Organizational: ER	
APPROVED BY **Mark Kobe, RN**	DATE: **December 2013**
Director's/Manager's Signature	Printed Name **Mark Kobe, RN Director**

Jared Hubbell, MD
Emergency Department Medical Director

12/12/13
Date



Robert Cohen, MD
Chief Medical Officer

12/6/13
Date

Leslie Lovejoy, RN
Chief Nursing Officer, CQO

12-12-13
Date

Sharon Nevins
Chair, Board of Directors

Date

Policy Submission Summary Sheet

Emergency Department Policy and Procedures

New document or revision written by: Mark Kobe, DON

Type **X Revision ❑ New Policy**	**Regulatory** **X CMS** **X CDPH** (formerly DHS) **D TJC** (formerly JCHAO) **❑ Other:**
Departmental: Clinical/Non-clinical *(circle which type)*	**XXXDepartmental** *(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)

The following ED Department policies have been revised:

7010-8 Legal Blood Draws: reviewed, no changes
7010-9 E-notification Screening in the ED: reviewed, updated to incorporate E-notification process
7010-10 ED log: reviewed, no changes
7010-11 Laboratory Studies followup: reviewed, no changes
7010-12 Capnography in the ED: reviewed, no changes
7010-13 Psychiatric Emergency Services: reviewed, no changes
7010-14 Guidelines for Chest Pain: reviewed, updated to reflect changes in Oxygen usage and bilateral blood pressure measurements as standard protocol

POLICIES/PROCEDURES MANUAL
Emergency Services Department
TABLE OF CONTENTS

A.	
7010-3	Admission to the Hospital from the ED
B.	
C.	
7010-12	Capnography in the ED
7010-14	Chest Pain, Non-traumatic
7010-7	Cobra transfers
7010-13	Criteria for PES
D.	
7010-4	Discharge from the ED
E.	
7010-10	ED log
7010-9	E-notification in the ED
F.	
G.	
H.	
I.	
7010-6	Intraosseous infusion
J.	
K.	
L.	
7010-11	Laboratory Studies Followup in the ED
7010-8	Legal Blood Draws
M.	
N.	
O.	
P.	
7010-2	Patient Valuables in the ED
Q.	
R.	
S.	
T.	
7010-5	Telephone Advice
7010-1	Triage
U.	
V.	
W.	
X.	
Y.	
Z.	

5.

RESULTS OF ROOT CAUSE ANALYSIS

Sonoma Valley Hospital

ROOT CAUSE ANALYSIS DOCUMENTATION FORM

SECTION ONE: DESCRIPTION OF EVENT / SERVICE AREA(S) IMPACTED

93y/o female seen in the ED on 7/22 and admitted to the hospital in extremis with a non-ST AMI. Dementia, CHF and ARF. Was transferred to the skilled nursing facility on 7/25 for rehabilitation . On 8/23 fell while in the skilled nursing facility and sustained a L Femur Fracture. On assessment the patient was found to have an elevated creatinine and INR and needed medical clearance for surgery. The patient and the DPOA agent requested surgery and knew the potential risks involved. The surgeon scheduled the surgery for 8/23 but it was delayed until 8/25 to obtain medical clearance by the skilled nursing facility hospitalist. On Sunday, 8/25 the surgery was scheduled for the afternoon. The patient was discharged from the Skilled Nursing Unit at 1300 and brought to OR#1 in her hospital bed. She was pleasantly confused but alert and answering questions. Anesthesia assessed the patient as being an ASA4, noted thread y radial pulses and administered a spinal, (without incident), Ketamine, and Propofol. She was positioned on the fracture table by the surgeon and staff and the staff began to prep the left hip. In the 3-5 minute move from the bed to the table and the monitor reconnection, the patient was found to not have a heart rate and an increased CO2. The patient received 2 doses of epinephrine and three shocks and then was declared deceased by the anesthesiologist and surgeon at 1423. The patient was a DNR. Surgeon notified family, Nursing contacted the Coroner who indicated that it was not a coroner's case and the Anesthesiologist agreed to sign the death certificate.

Service Areas Impacted: ***Skilled Nursing; Surgical Services, Anesthesia Services, Hospital, Medical Staff*** Date RCA Initiated: 09/18/2013 Date RCA Completed: 09/18/2013

Team Members: Robert Cohen, MD CMO; Andrew Solomon, MD, Chief Anesthesia Services; Scott Robinson, MD Anesthesiologist; Michael Brown, MD, Chief Surgery Department, Leslie Lovejoy, RN, Chief Quality & Nursing Officer; Pam Reed, RN, Director Surgical Services; Lynne Teixeira, RN, Nursing Supervisor; Melissa Evans, RN, Director of Nursing Skilled Nursing; Heather Plomteaux, RN Surgical Services; and Nathan Stone, Admitting.

SECTION TWO: FIRST LEVEL INVESTIGATION AND ANALYSIS – Determination of Proximal Cause(s)
(Under the appropriate column, identify factors that led directly to the event.)

Human Factor Issues	Process Breakdown Issues	Equipment Malfunction / Failure Issues	Controllable Environmental Factors	Uncontrollable Environmental Factors	Other Reasons
Date and time of surgery limited resources Decision to not admit for medical work up and do in SNF Use of Code Blue in surgery; having access to ED MD	Discharge from the Skilled Nursing Unit to the Hospital for an acute admission resulted in: 1. No Acute record 2. No H&P by surgeon & no Summation note from SNF Hospitalist.	NONE	Assessment/Reassessment Informed Consent	NONE	Patient's underlying condition resulted in high probability of outcome.

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SECTION THREE: SECOND LEVEL INVESTIGATION AND ANALYSIS - Determination of Special Cause(s) Variation *(For each factor identified, determine the underlying process involved. Include in this section the minimum scope of root cause analysis for the specific type of sentinel event identified – per Attachment A of the "CHW System Guidelines for Managing Sentinel Events." Analyze each process to determine what (if any) special cause variation existed that contributed to the event). Include findings of any literature search conducted.*			
Factor	**Underlying Process Involved**	**Special Cause Variation of the Process**	**Results of Literature Review**
Scheduling of Surgery	Medical clearance of patient for surgery	No special cause variation	
Code Blue in surgery	It is the policy of the surgery department to not call a code blue when resuscitation is required. Contacting the EDMD as a resource when this occurs in the future needs to be explored. Review of the case by RCA team and peer review did not deem this as critical in this case.	No special cause variation	
Lack of an Acute Care record	Lack of communication between medical staff and surgery staff and admitting during the week before the surgery resulted in the patient being discharged from the Skilled Nursing Facility prior to surgery and no acute admission orders, H&P, and elements of an acute care record. Communication breakdown between business office and admitting compounded confusion.	Lack of clarity on plan of care.	
Patient's underlying condition	Medical staff, nursing and social worker clearly documented patient and DPOE decision maker request for the surgery and their acknowledgement of the high probability of not surviving. Medical staff clearly documented the patient's underlying co-morbidities and her ASA status.	Root cause of event is located here.	

SECTION FOUR: THIRD LEVEL INVESTIGATION AND ANALYSIS – Determination of Common Cause Variation *(This section is used to identify common cause variation in systems that underlie the processes previously identified. A rationale / justification must be provided for any question with a "yes" answer)*					
Human Resource Issues	**Information Management Issues**	**Environmental & Equipment Management Issues**	**Leadership Issues**	**Communication Issues**	**Other Issues**
Are staff properly qualified and currently competent in their responsibilities? The surgical team has demonstrated competencies and the surgeon and anesthesiologist is currently credentialed and in good standing on the medical staff. There appears to be a gap in understanding the process of admitting from our SNF for an	*Is all necessary information available when needed? Accurate? Complete? Unambiguous?* No, there was a breakdown in available information as it relates to a complete acute care record. It was very clear from the Skilled Nursing documentation that the patient and decision maker understood that she may not make	*Was the physical environment appropriate for the processes being done?* Yes, all equipment was fully functional and the environment of the OR was appropriate for the procedure.	*Is the culture conducive to risk identification and reduction?* Yes. The hospital has a very aggressive and proactive culture of safety program including risk identification and reduction through our Good Catch program.	*Is there a lack of barriers to the communication of potential risk factors?* Yes. Leadership and Medical Staff leaders actively seek to reduce any perceived barriers; using an SBAR hand off process.	

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inpatient surgery.	it through the surgery.				
Is staffing adequate? Yes, the staffing for surgical services was appropriate to a Sunday as was the hospital staffing.	*Is communication among participants adequate?* No, communication between the skilled nursing, surgery and admissions was not clear regarding acute care status.	*Are systems in place to identify environmental and equipment risks?* Yes, the hospital has a robust risk reporting process. We encourage the use of the chain of command. There is a process for biomedical equipment and safety inspections. Staff have been trained on what to look for and how to identify faulty equipment.		*Is the prevention of adverse outcomes adequately communicated as a high priority?* Yes, Patient Safety is a core value at SVH as part of the hospital's culture of safety. Staff are annually trained and safety based behavioral expectations. Our Good Catch program encourages safety risk identification proactively.	
Does planning account for contingencies that would tend to reduce effective staffing levels? Yes, staffing is looked at by need, acuity and takes into account staff wellness and work-life balance.		*Are emergency and failure-mode responses adequately planned and tested?* . Yes, the hospital drills to test emergency and failure mode responses through disaster and all hospital code drills.			
Is staff performance in the operant processes addressed? Yes, through annual competencies and/or performance evaluations.					
Can orientation and inservice training be improved? Yes, both inpatient and skilled nursing staff, and admitting staff will be educated regarding this process.					

SECTION FIVE: CORRECTIVE ACTION PLAN
(Use this section to describe the corrective actions taken on issues (both proximal and root) identified through the root cause analysis)

Findings / Issues Identified	**Corrective Actions / Risk Reduction Strategies (identify party(s) responsible and date action implemented)**	**Measurement Strategies Developed to Assure Corrective Actions Will be Effective**
1. Use of Code Blue in the OR	1. CMO to discuss with Medical Staff Department leaders how this process might work. This was discussed in the executive medical leadership meeting on 9/19/13. The ED Medical Director will work with Medical Directors of Surgery and Anesthesia to develop a call process. 2. Add, call to the EDMD when code occurs in OR for back up assistance.	1. Medical Staff committee meeting minutes. 2.Code Blue Records

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2. Medical Clearance process for Skilled Nursing patients going for inpatient surgery	1. CMO to bring to medical staff committees for discussion and resolution and report back to Leaders. 2. Peer review process in Anesthesia and Surgery Departments.	1. Medical staff committee meeting minutes 2. Actions taken as part of this Root Cause Analysis
3. Lack of education regarding patient status between Skilled Nursing and Acute Hospital	1. Chief Quality Officer to identify where decision broke down and ensure education is provided to staff, medical staff , and leaders.	1. Staff attestation to receiving education and medical staff minutes.

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6.

QUALITY REPORT
DECEMBER 2013

To: Sonoma Valley Healthcare District Board Quality Committee
From: Leslie Lovejoy
Date: 12/12/13
Subject: Quality and Resource Management Report

December Priorities:

1. Skilled Nursing Facility Annual Survey
2. Staff and Stock status in the new wing
3. Policy and Procedure Infrastructure
4.

1. The Skilled Nursing Facility had their annual licensing and CMS survey on November 15th. It went very well. There were two main areas in need of improvement: when medications are prescribed on admission or during the stay, the physician must state and indication for the medication; and there was a push for a SNF specific Food and Fluids disaster plan. Currently, the SNF has been folded into the hospital disaster plan but it was clear that the expectation is that it now be separate. The Directors of Nutritional Service, Skilled Nursing and Pharmacy have worked on an action plan and monitoring for these issues. It was followed by an Interim Life Safety Survey that focuses on the facility. Shelves near the heat table were discolored and a copper pipe was found to be oxidized and finally a drain pipe was not permanently centered in a drain. The Facilities Director removed and replaced the shelves, cleaned the pipe and centered the drain pipe.
For the most part this was a very good survey. What was different was that the surveyor requested proof, down to an itemized list of tools used, that our actions were implemented. This is a first but according to the surveyor, this will be the trend from now on.

2. We have permission to enter the building and begin the process of stocking the areas and doing the in-service education for new equipment. Mark Kobe is working with his team in the new Emergency Department and I am handling the Surgery Department. We are bringing in the nursing team to look at throughput and assessing staffing needs. I have invited the Anesthesiologists and Surgeons to come to the new department and work on the same issues over the next few weeks. Dr. Hubbell and Mark are doing the same with the Emergency Physicians. I have put in a request for licensing to come on January 9 & 10 but have not heard back.

3. Policy and Procedure Infrastructure

We have made the decision to let the Web based policy and procedure program expire. The process is too big and cumbersome for a small organization. I have tasked a Quality team member with creating a excel spreadsheet process for tracking both organizational and departmental policies and procedures. This will be rolled out to the Leadership in January. I will bring the revised policy and procedure on policies and procedures to this group in January.

Topic for discussion: 2013 Work Plan discussion and evaluation

7.

QUALITY COMMITTEE WORK PLAN 2013

2013 Quality Committee Work Plan

January	February	March	April
▪ Review of Quality Performance Indicators ▪ Quarterly Dashboard	▪ Quality Education Seminar	▪ Annual Environment of Care Report*	▪ Annual Performance Improvement Evaluation and Goals Report ▪ Quarterly Dashboard
May	**June**	**July**	**August**
▪ Annual Infection Control Report*	▪ Annual Risk Management Report* ▪ Performance Improvement Team Presentations	▪ Annual Human Resources Report* ▪ Quarterly Dashboard	▪ Meaningful Use Stage 2 ▪ Utilization Management Efforts and Outcomes
September	**October**	**November**	**December**
▪ Performance Improvement Reports – Outpatient ▪ AHRQ Culture of Safety Initiative and Survey	▪ Service Line Patient Care Outcomes ▪ Quarterly Dashboard	▪ Annual Contract Evaluation Report* ▪ Trends and Best Practices in Quality and Safety	▪ Evaluation of the Quality Committee Work Plan

*Required