SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
REGULAR MEETING AGENDA
Wednesday, February 26, 2014
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	*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: A. Quality Committee Minutes, 01.29.14	*Hirsch*	Action
4. POLICY & PROCEDURE APPROVAL	*Lovejoy*	Action
5. QUALITY REPORTS FOR FEBRUARY 2014	*Lovejoy*	Inform/Action
6. EVALUATION OF 2013 WORK PLAN	*Hirsch*	Inform/Action
7. PROPOSED 2014 WORK PLAN	*Lovejoy*	Inform/Action
8. QC DASHBOARD 2013	*Lovejoy*	Inform/Action
9. CLOSING COMMENTS/ANNOUNCEMENTS	*Hirsch*	
10. ADJOURN	*Hirsch*	
11. UPON ADJOURNMENT OF THE REGULAR OPEN SESSION	*Hirsch*	
12. CLOSED SESSION: Calif. Health & Safety Code § 32155 – Medical Staff Credentialing & Peer Review Report	*Amara*	Action
13. REPORT OF CLOSED SESSION	*Hirsch*	Inform

3.

CONSENT CALENDAR

SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
REGULAR MEETING MINUTES
January 29, 2014
Schantz Conference Room

Committee Members Present	Committee Members Present	Committee Members Absent/Excused	Admin Staff /Other
Jane Hirsch John Perez Robert Cohen M.D. Susan Idell Paul Amara M.D.		Leslie Lovejoy Howard Eisenstark Joel Hoffman Kevin Carruth	Gigi Betta Mark Kobe

AGENDA ITEM	DISCUSSION	CONCLUSIONS/ ACTION	FOLLOW-UP/ RESPONSIBLE PARTY
1. CALL TO ORDER	*Hirsch*		
	5:00 p.m.		
2. PUBLIC COMMENT	*Hirsch*		
3. CONSENT CALENDAR	*Hirsch*	Action	
A. QC Meeting Minutes, 12.19.13		**MOTION:** by Idell to approve and 2nd by Perez All in favor.	
4. POLICIES & PROCEDURES	*Kobe*	Action	
a) Home Care Manual b) Emergency Department (ER) c) Compounding, Sterile (Rx) d) Compounding, Outside (Rx) e) Blood Administration (Lab)	Mr. Kobe explained that the Committee will be seeing more of these policies as SVH prepares for the upcoming CIHQ visit. The QC recommends approval of all policies (a-e) by the Board at the next regular Board meeting on February 6, 2014.	**MOTION:** by Idell to approve (a-e) and 2nd by Perez. All in favor.	
5. QUALITY REPORTS FOR DEC. 2013 AND JAN. 2014	*Kobe*	Inform	
	Mr. Kobe reviewed both December and January reports in Ms. Lovejoy's absence.		
6. ROOT CAUSE ANALYSIS	*Cohen*	Inform	
	Dr. Cohen detailed a recent incident that took place in the hospital and the analysis that followed.		

AGENDA ITEM	DISCUSSION	CONCLUSIONS/ ACTION	FOLLOW-UP/ RESPONSIBLE PARTY
7. CLOSING COMMENTS/ANNOUNCEMNTS	*Hirsch*		
	• For the remainder of 2014, all regular QC meetings will be held on the LAST Wednesday of the month EXCEPT when there is a conflict with a holiday (i.e. Thanksgiving and Christmas). In this case, the meeting will be moved up one week. • Ms. Hirsch asked QC Committee members to give feedback, express any concerns or bring up any opportunities concerning the hospital's environment.		
8. ADJOURN	*Hirsch*		
	5:30 pm		
9. UPON ADJOURNMENTOF REGULAR OPEN SESSION	*Hirsch*	Inform	
10. CLOSED SESSION	*Amara*	Action	
	By *Executive Action*, the Medical Staff Credentialing and Peer Review Report was approved by Mr. Carruth and Ms. Hirsch by telephone on 1.29.14 at 6:00 P.M.		
11. REPORT OF CLOSED SESSION/ADJOURN	*Hirsch*	Inform	
	Adjourn 5:36 pm Next QC meeting is on February 26, 2014.		

4.

POLICY AND PROCEDURE APPROVAL

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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: MM8390-110 Pipercillin-Tazobactam Extended Infusion Dosing	
APPROVED BY: **Chief Quality Officer**	DATE: 10/23/13
Director's/Manager's Signature	Printed Name Chris Kutza, Director of Pharmacy

Douglas S Campbell, MD — 10/23/13
Chair ~~Medicine Committee~~ — Date

Michael Brown, MD — Date
Chair ~~Surgery Committee~~

Robert Cohen, MD — 10/23/13
Chief Medical Informatics Officer — Date

Kelly Mather — Date
Chief Executive Officer

D. Paul Amara, MD — 11/11/13
President of Medical Staff — Date
Chair, Pharmacy and Therapeutics Committee

~~Bill Boerum~~ Sharon Nevins — Date
Chair, Board of Directors

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SUBJECT: Piperacillin-Tazobactam Extended Infusion Dosing	POLICY # MM8390-110
	PAGE 1 OF 2
DEPARTMENT: Pharmacy	EFFECTIVE: 5/2011
APPROVED BY: Chris Kutza, Director of Pharmacy	REVISED: 10/2013

Purpose:

Pipercillin-Tazobactam, as with other β-lactam antibiotics, exhibits **time-dependent** killing. Administering Pipercillin-Tazobactam as an extended infusion of 4 hours achieves longer duration of active antibiotic concentrations, reduces that patient's exposure to active drug, can decrease the risk of dose related side effects, and results in more cost-effective therapy.

Policy:

Orders for Pipercillin-Tazobactam are automatically converted to extended infusion administration (**4 hr infusion**) for all adult patients:

- Pipercillin-Tazobactam 3.375 gm IVPB administered as a 4 hour infusion every 8 hours will be administered to patients with a creatinine clearance greater than 20 ml/minute.
- Pipercillin-Tazobactam 3.375 gm IVPB administered as a 4 hour infusion every 12 hours will be administered to patients with a creatinine clearance less than or equal to 20 ml/minute.
- The **100ml** Pipercillin-Tazobactam **bag** is infused over 4 hours at **25 ml/hr** by Y-site into a line running with maintenance fluids.
- *This policy **DOES NOT INCLUDE** patients in the Emergency Department or patients with chemotherapy related neutropenic fever. These patients will receive Pipercillin-Tazobactam via standard infusion duration and dosing.*

Medication Ordered	Interchange With
Pip/Tazo 4.5gm IV q6hr	*Pip/Tazo* 3.375gm IV q8hr (4 hr infusion)
Pip/Tazo 3.375gm IV q6hr	*Pip/Tazo* 3.375gm IV q8hr (4 hr infusion)
Pip/Tazo 2.25gm IV q6hr	*Pip/Tazo* 3.375gm IV q12hr (4 hr infusion)
Pip/Tazo 2.25gm IV q8hr	*Pip/Tazo* 3.375gm IV q12hr (4 hr infusion)
Pip/Tazo 2.25gm IV q12hr	*Pip/Tazo* 3.375gm IV q12hr (4 hr infusion)

Procedure:

1. The pharmacist will review the patient's creatinine clearance, either as calculated by the computer OR using the Cockcroft-Gault equation (see below). Any patient over 75 years of age will have their creatinine clearance calculated using a minimum serum creatinine value of 1 for a more accurate estimation of renal function.

2. UNLESS the patient is being treated in the Emergency Department and/or has a diagnosis of neutropenic fever, the following automatic substitution for dosing regimens of Pipercillin-Tazobactam will occur:
    a. If it is determined that the patient's creatinine clearance is greater than 20 ml/min, the pharmacist will automatically change the dose of Pipercillin-Tazobactam to 3.375 grams over 4 hours IVPB q8hr and will enter that dose into the patient's profile.
    b. If the patient's creatinine clearance is less than or equal to 20 ml/min, the pharmacist will automatically change the dose of Pipercillin-Tazobactam to 3.375 grams over 4 hours IVPB q12h and will enter that dose into the patient's profile.

c. The pharmacist will discontinue the original order and communicate the fact the the original order was changed via an approved therapeutic interchange as per standard therapeutic interchange procedures.

COCKCROFT-GAULT EQUATION:

$$\frac{(140 - \text{AGE}) \times \text{IDEAL BODY WEIGHT}^*}{72 \times \text{SERUM CREATININE}} \quad \text{[MEN]}$$

$$\frac{(140 - \text{AGE}) \times \text{IDEAL BODY WEIGHT}^*}{72 \times \text{SERUM CREATININE}} \times 0.85 \quad \text{[WOMEN]}$$

IDEAL BODY WEIGHT FOR MEN = 50 + (2.3 X EVERY INCH OVER 5 FEET TALL)
IDEAL BODY WEIGHT FOR WOMEN 45.5 + (2.3 X EVERY INCH OVER 5 FEET TALL)

* *If the patient's ACTUAL body weight is LESS THAN the IDEAL body weight, use ACTUAL BODY WEIGHT in the equation.*

Reference:

1. Tam VH, Gamez EA, Weston JS, Gerard LN, et al. Outcomes of bacteremia due to *Pseudomonas aeruginosa* with reduced susceptibility to piperacillin-tazobactam: implications on the appropriateness of the resistance breakpoint. *Clin Infect Dis* 2008; 46: 862-867.
2. Eagye KJ, Sutherland CA, Christensen H, Kuti JL, Nicolau DP. Prevalence of *Pseudomonas aeruginosa* (PSA) with reduced susceptibility to piperacillin-tazobactam (TZP) at 40 hospitals. Poster# C2-201. Poster Presentation at the 48th Annual ICAAC/46th Annual IDSA Meeting, Washington D.C. 2008.
3. Lodise TP, Lomaestro BM, Drusano GL. Application of antimicrobial pharmacodynamic concepts into clinical practice: focus on β-lactam antibiotics: insights from the Society of Infectious Diseases Pharmacists. *Pharmacotherapy* 2006; 26: 1320-1332.
4. Kim A, Sutherland CA, Kuti JL, Nicolau DP. Optimal dosing of piperacillin-tazobactam for the treatment of Pseudomonas aeruginosa infections: prolonged or continuous infusion? *Pharmacotherapy* 2007; 27: 1490-1497.
5. Lodise TP, Lomaestro B, Drusano GL. Piperacillin-tazobactam for *Pseudomonas aeruginosa* infection: clinical implications of an extended-infusion dosing strategy. *Clin Infect Dis* 2007; 44: 357-363.
6. Patel N, Scheetz MH, Drusano GL, Lodise TP. Determination of antibiotic dosage adjustments in patients with renal impairment: description of a contemporary methodology. *Society of Infectious Diseases Pharmacists newsletter* 2008; 18:14-20.

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POLICY AND PROCEDURE
Approvals Signature Page

Review and Approval Requirements

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- 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: MM8390-109 Pharmaceutical Care Consulting for Skilled Nursing Facility	
APPROVED BY: **Chief Quality Officer**	DATE: 10/23/13
Director's/Manager's Signature	Printed Name Chris Kutza, Director of Pharmacy

Douglas S Campbell, MD
Chair Medicine Committee — 10/23/13 — Date

Michael Brown, MD
Chair Surgery Committee — Date

Robert Cohen, MD
Chief Medical Informatics Officer — 10/23/13 — Date

Kelly Mather
Chief Executive Officer — Date

D. Paul Amara, MD
President of Medical Staff
Chair, Pharmacy and Therapeutics Committee — 11/11/13 — Date

~~Bill Boerum~~ Sharon Nevins
Chair, Board of Directors — Date

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SUBJECT: Pharmaceutical Care Consulting for Skilled Nursing Facility	POLICY #MM8390-109
	PAGE 1 OF 2
DEPARTMENT: Pharmacy	EFFECTIVE: 10/2013
APPROVED BY: Director of Pharmacy	REVISED:

Purpose:
To define the consulting services provided by the Consultant Pharmacist for the Skilled Nursing Facility and its patients.

Policy:
The Consultant Pharmacist or a pharmacist designee retained by the Facilities shall:

1. Devote a sufficient number of hours during a regularly scheduled visit for the purpose of coordinating, supervising, directing, and reviewing the pharmaceutical services within the facilities at least quarterly.
2. Serve on the Pharmaceutical Service Committee (Pharmacy and Therapeutics Committee) and the Patient Care Policy Committee (Performance Improvement Committee).
3. Review the drug regimen of each patient at least monthly and prepare appropriate reports. The review of the drug regimen of each patient shall include all drugs currently ordered, information concerning the patient's condition relating to drug therapy, medication administration records, and where appropriate, physician's progress notes, nurse's notes and laboratory test results.
4. Be responsible for reporting, in writing, irregularities in the dispensing and administration of drugs and other matters relating to the review of the drug regimen to the Administrator and Director of Nursing Service.
5. Submit a monthly drug regimen review (DRR) report to the Director of Nursing Service and Administrator no later than the end of the month.
6. Submit a written report on the status of the pharmaceutical services to the Pharmacy and Therapeutics Committee at least quarterly.
7. Perform Skilled Nursing Unit Inspection monthly.

Procedure:

1. **The Consultant Pharmacist or a pharmacist designee will spend sufficient time to meet the needs of the residents per month on the following:**
    a. Reviewing selected resident's medication regimens
    b. Inspect medications in cassettes and automated dispensing cabinets.
    c. Review MAR's
    d. Inspect emergency trays
    e. Inspect pharmacy references
    f. Reconcile controlled substances count
    g. Inspect labeling and storage of medications
    h. Inspect all floor stock medications
    i. Attend interdisciplinary care plan meetings and record the services provided and hours spent in the unit.
2. **Pharmaceutical Service Committee (Pharmacy and Therapeutics Committee):**

a. Consists of the following members: Consultant Pharmacist or a pharmacist designee, Director of Nursing Service, Administrator and Medical Director.
b. Meets at least quarterly to address issues related to pharmacy services, revise pharmaceutical service policies and procedures, make recommendations for improvement, review the adequacy and appropriateness of the emergency drug content.
c. Develops a drug formulary to be used in the facility.
d. Receives input from the Consultant Pharmacist regarding the status of the pharmaceutical service in the facilities.

3. **Patient Care Policy Committee (Performance Improvement Committee)**
   a. Consists of Consultant Pharmacist or a pharmacist designee, Director of Nursing, Administrator and Medical Director.
   b. Meet every other month to discuss patient care plan policies.
4. **Interdisciplinary Team (IDT) Meeting Participation**
   a. Consultant Pharmacist or a pharmacist designee is a member of the IDT and shall provide input in pharmaceutical care plan as appropriate, based on resident needs and pharmacist availability.
   b. Pharmaceutical care plan may include but is not limited to evaluation of unnecessary drugs, psychotropic drug use, pain management, weight loss, and infectious control.
   c. If time and schedules permit, the Consultant Pharmacist or a pharmacist designee shall participate in IDT care plan meetings in addressing pharmaceutical needs for specific residents
   d. In the absence of a Consultant Pharmacist, other IDT members may submit a verbal or written request to the pharmacy requesting pharmacist involvement in pharmaceutical care plans.
   e. In response to the IDT requests, the Consultant Pharmacist shall provide input either verbally or in writing in a timely manner.
5. **Drug Regimen Review (DRR)**
   a. Refer to policy #MM8390-107 Drug Regimen Review for Skilled Nursing Facility

Reference:
Title 22:Sec 72375 , CFR Sec 483.60, Section 483.25

5.

QUALITY REPORTS FOR FEBRUARY 2014

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To: Sonoma Valley Healthcare District Board Quality Committee
From: Leslie Lovejoy
Date: 02/18/14
Subject: Quality and Resource Management Report

February Priorities:
1. Building Activation and Licensing
2 AHRQ Culture of Safety Results
3. Core Measure changes 2014 & VBP

1. Building Activation & Licensing

We were successfully licensed by the State of California on February 6th. We moved the Surgery Department on Friday, Saturday and Sunday and did our first case in the new OR on Monday February 10th. There we no incidents of patient safety concerns noted. We moved the old Emergency Department on Tuesday, February 11th over a two-hour period without incident and had our first patient in the new Emergency Department at 0730. It took about another two hours for everyone to settle in and organize the supplies. Staff are adapting to the new areas and learning how to navigate in a new space. The Building Activation Team included: Mark Kobe (ED), Beverly Seyfert (IT), Lisa Duarte (Admitting & PBX), Allan Sendaydiego(Surgery), Alley Brown (EVS), Chris Kutza(Pharmacy), Kevin Coss (Facilities) and Kimberly Drummond (Project Manager). They did a wonderful job.

2. AHRQ Culture of Safety Results

Attached you will find the results of the AHRQ Culture of Safety Survey. Sonoma Valley Hospital has used this survey since 2009 to assess how well we are doing. Last year, this committee requested benchmarking data from AHRQ to assess how we compare. The attached trending report provides 2009, 2011 and 2013 data as well as the national benchmark. We compare very favorably. In addition, this survey is important because it is the first one we have done while rolling out an organization wide Culture of Safety Program that includes the IHI Best Practice "Good Catch" program. We will discuss in Committee.

3. Core Measures changes and Value Based Performance

The Centers for Medicare Services have made some changes in what quality outcome measure are to be reported and added additional measures to what is already reported. The attached power point reflects the changes and identifies the latest model for values based performance. We will discuss in committee.

Topics for discussion: 2014 Work Plan

Core Measures 2014

What's New?

Core Measures 2014: IP & OP

- Inpatient Changes

  SCIP Inf 3: Added more reasons to extend antibiotic use past the 24 hour timeline.

  SCIP VTE 2: Allows for the use of Aspirin for VTE prophylaxis for Total Joints.

- CMS removed the following measures:

  Heart Failure Discharge Instructions
  BC performed in ED prior to 1st ABX
  Surgery Patients with Periop Temp Management
  Pneumococcal Immunization (suspended) will remain a voluntary measure

Core Measures: Outpatient

- New:

OP-29 Endoscopy/Polyp Surveillance: appropriate follow-up interval for normal colonoscopy in average risk patients;

OP-30 Endoscopy/Polyp Surveillance: colonoscopy for patients with a history of adenomatous polyps- avoidance of inappropriate use; and

OP -31 Cataracts: improvement in patient's visual function within 90 days following cataract surgery.

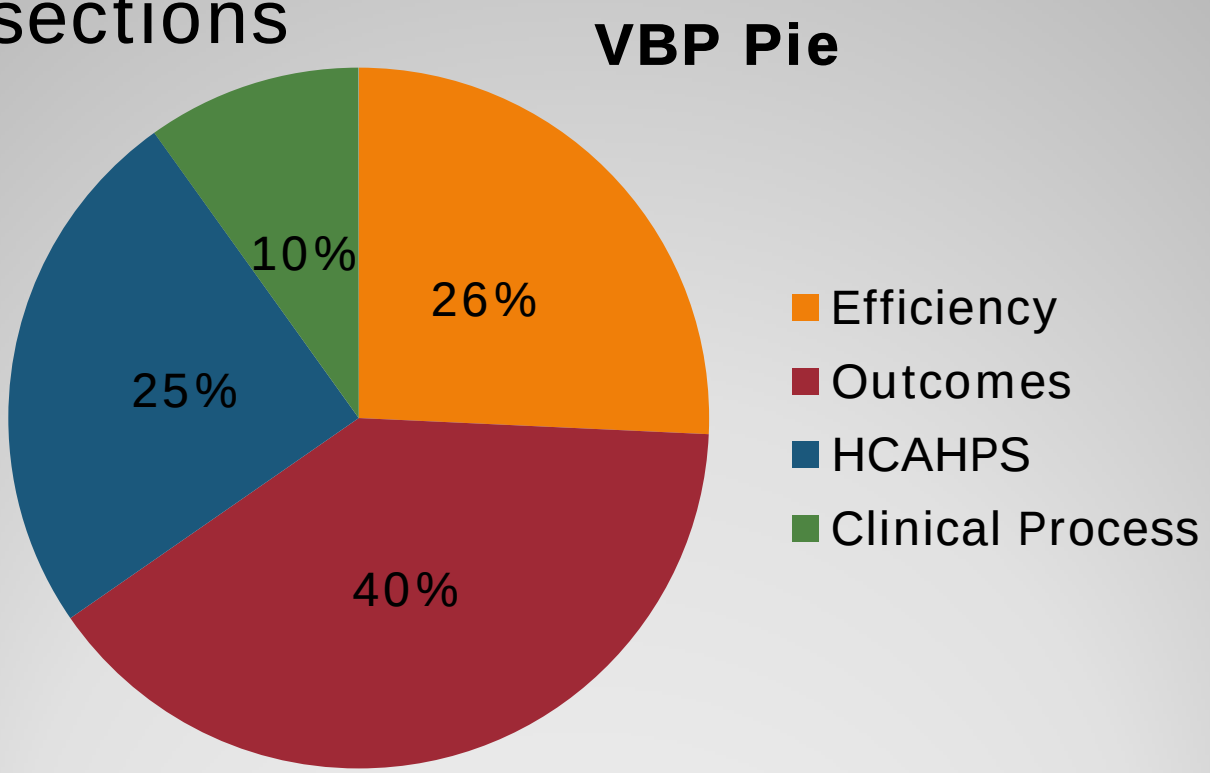
- Readmission within 30 days of total hip/knee arthroplasty (will add to the dashboard)
- Hip/Knee complication: hospital –level risk standardized complication rate following elective Primary Total Hip/Knee Arthroplasty

Core Measures: Misc

Value Based Performace Revisited

- January 2014 discharges impact 2016 FY VBP reimbursement @ 1.5%

Four sections



- Efficiency refers to Medicare spending per beneficiary (ratio across all hospitals during performance period, 1/14-12/14)

- Outcome refers to
  Mortality: AMI, HF, Pne (10/12-6/14)
  Complication/Patient Safety (AHRQ PSI composite) 10/12-6/14
  Three Hospital Acquired Infections: CLABSI, CAUTI, SSI(colon & ABD HYS) 2/14-12/14

VBP

- AHRQ/HAC Reduction Program: 6 measures which when compiled give a composite score

  Pressure Ulcer Rate
  Foreign Object left in body
  Iatrogenic pneumothorax
  Post op physiologic & metabolic derangement
  Post op PE or DVT
  Accidental puncture and laceration rate

VBP

VBP

- Clinical Processes of Care:

  Dropped: AMI PCI within 90 minutes of arrival; heart failure instructions; & blood cultures before 1st ABX dose

  Added: Influenza immunization

- Patient Experience of Care: HCAHPS

  Same questions, increased the floor for Communication with Physicians by 5.60 percentage points.

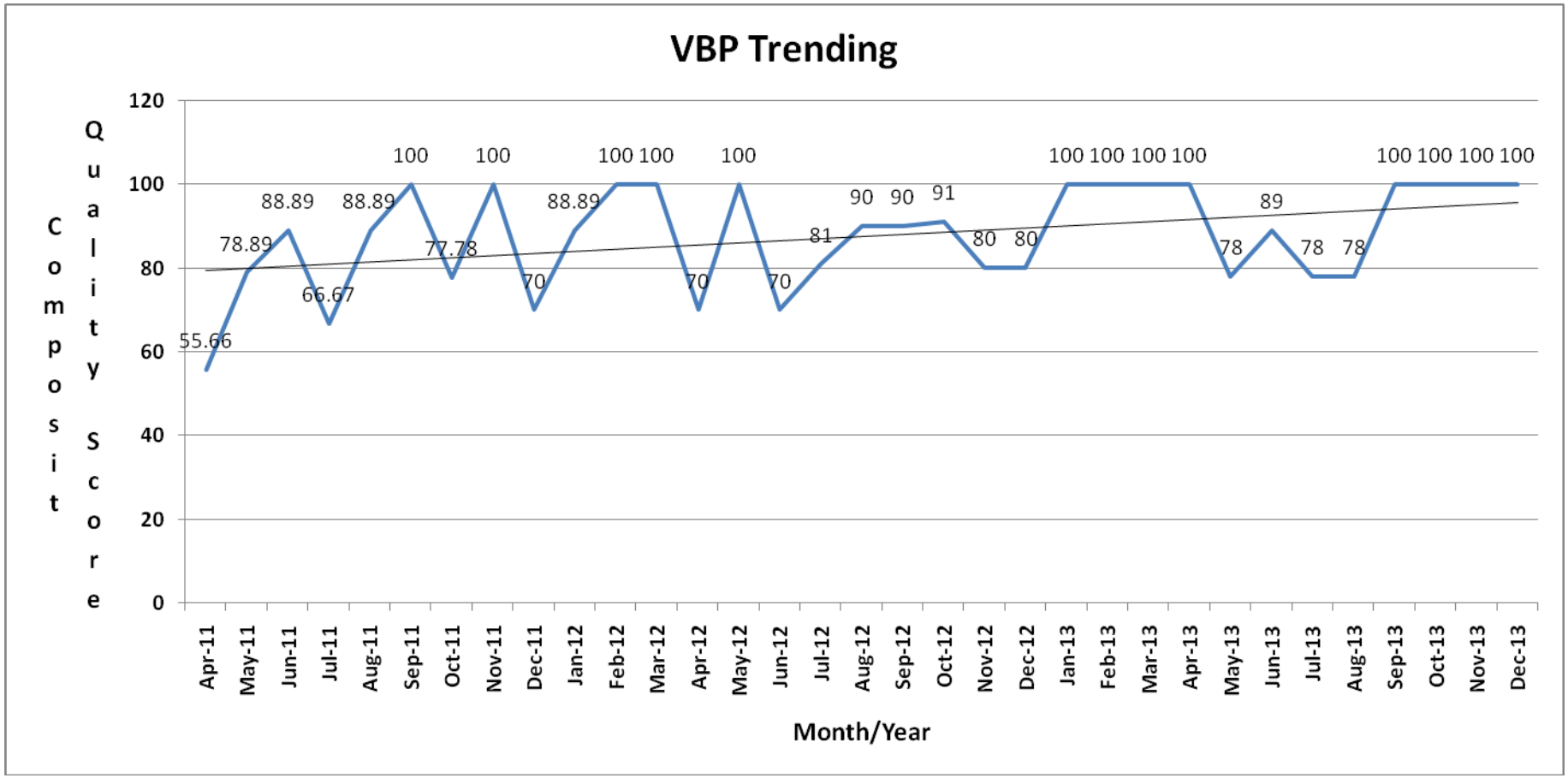
VBP: Our History

- January 2013 earn back was 1.025
- January 2014 earn back was .995
- January 2015 pending

- See graph attached

Trending Line

Attachment to Core Measures & VBP Power Point Presentation



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Culture of Safety: Organizational Performance Improvement Project

Project: Sonoma Valley Hospital lacks a systematic process for developing and maintaining a culture of safety for patients, staff and visitors.

Aim: To develop, implement, monitor, and continuously improve an organizational culture that ensures patient, employee, physician and visitor safety and to engage all providers so that safety is a core cultural value.

Team Leader: Leslie Lovejoy, CQO/CNO

Date Team Initiated: June 2012

Date Completed: December 2013

Team Members/Departments: Lorna Gantenbein, Risk Management; Courtney McMahon, Infection Control; Cindi Newman; Quality Data Analyst; & Chris Kutza, Director of Pharmacy.

Plan:

In alignment with Sonoma Valley Hospital's Strategic Mission and Vision to provide safe quality patient care,the team reviewed current literature, best practice strategies and identified opportunities to promote a broader patient safety program that proactively identifies safety risk and provides team members with tools to mitigate this risk. It was also determined that safety must become the central value out of which all other values and quality initiatives spring. The organization had results from two AHRQ Culture of Safety Surveys as a baseline as well as data regarding event reporting and a history of adverse event and root cause analyses. Opportunities were identified in the following areas:

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Culture of Safety: Organizational Performance Improvement Project

- Lack of a proactive reporting of unsafe events process
- Lack of a user friendly notification and reporting process
- Staff concerns regarding how event reporting is used
- Lack of clear behavioral based expectations
- Lack of education regarding what a culture of safety means
- Lack of leadership tools to educate and reinforce the program

After brainstorming potential solutions and reviewing the literature, it was decided that the following actions would be taken and implemented over a one year period and reinforced over an additional 2 year period..

Strategy	Actions Taken	Completion Date
1. Identify a program that reflects best practices.	1. Reviewed Literature and sought out programs. 2.Pharmacist provided a best practice program.	August 2012
2. Adapt program to organization and build infrastructure.	1. Develop materials, binder, handouts and evaluation method. Develop a leader rounding tool.	September 2012
3. Educate Leadership to program and supporting infrastructure.	1. Reserve time in October LDI. 2. Invite Program Beta participation in creating fun evaluation experience for leadership team. 3. Fund and purchase prizes.	October 25, 2012
4. Roll out remote electronic notification system “E-notification”	1. Place “E-notification” logo on Intranet. 2. Train Leadership on location and how to navigate.	November Leadership Meeting & on-going

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Culture of Safety: Organizational Performance Improvement Project

	3. Provide consultation and continued education as needed to leaders.	
5. Train employees to program, behavioral based expectations and new tools.	1. Scheduled Mandatory Forums. 2. Provided training to off-site departments at staff meetings. 3. Provided training tools to Leaders to provide training to staff who failed to attend.	January 2013 & ongoing
6. Roll out Good Catch section of the program.	1. Provide education to Leadership on how to teach staff to report. 2. Developed reporting process to the Safety Committee and on through committees and back to leadership. 3. Place Good Catch logo inside "E-notification" logo for easy identification and access. 4. Develop a recognition process.	January 2013
7. Add Culture of Safety Training to Orientation and annual competencies.	1. Adapt program for presentation at orientation. 2. Prepare program for loading onto Health Stream.	October 2013 December 2013

List of evidence based research references and resources:

IHI White Paper on Patient Safety Culture and Good Catch Programs
Why Hospitals Should Fly, J. Nance, JD
Sorry Works by D. Wojcieszak
Program Beta

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Culture of Safety: Organizational Performance Improvement Project

The Joint Commission, Title 22 and CMS CoParticipation
AHRQ Team STEPPS Program
To Err is Human: Building a Safer Health System published by the Institute of Medicine

Do:

The overarching measurement goal was to increase reporting by 10%(each year) over a two year period and to increase the proactive "good catch" reporting by 10% over current event reports each year to a total of 30% of all reporting. Additional measurement goals included: 90% of staff received initial training and improvement in AHRQ Culture of Safety Scores over past performance. All aspects of the action plan were implemented.

Measurement Results

Goal	Baseline	2013 Performance
Increase event reporting by 10%	508 reports	553 reports = 8%
10% of current reporting are Good Catch reports	No data	55/553 = 10%
Total staff receiving training	N/A	409/440 93% (90%)
Improvement in AHRQ survey scores	See Attached	See Attached

Study:

An indepth analysis of the survey questions and the four point scale used demonstrated more fence-sitters during this last survey e.g. neither agree or disagree than in previous years. It may be that our method of providing surveys increased reticence on the part of the staff. If that is true, we must ask ourselves why even now, there is hesitancy on the part of team members to share their thoughts. A win is demonstrated by the fact that we exceed the national performance benchmarks for all but two of the questions. Another win is that there was an increase in likelihood to report when an error reaches the patient over past years. There is a term in social psychology called "diffusion of responsibility" which refers to when an event happens that a number of people know about, each assumes the other reports it and it consequently does

not get reported. Based on conversations the team has had, this may be in operation here. We were effective in training most of the hospital team and met our goal of good catch reports. While we don't necessarily need a course correction, the recommended next steps would be:

- Have a discussion with leadership about how to make reporting non-threatening and how to fold events into staff meetings to discuss improvements;
- Move from Beta testing the Midas program to on-boarding all leaders so that each leader can see the results of a submitted report and provide feedback to their team;
- Coach leaders on how use the patient safety issues as one of their rounding questions and use morning huddles to ask about patient safety concerns.
- Re-do the survey at the Wellness Fair in October to increase participation.
- Determine a methodology to roll program out to physicians as appropriate.

Act:

Hardwiring a culture of safety and then moving it to a "Just Culture" will take time. We have made a great first step. We will formalize what we have done by using the Health Stream system to keep the program in mind. We have created policies and procedures for the program, e-notification and good catch. The team will attend staff meetings and report the results of this project and solicit feedback as well as implement next steps.

AHRQ Culture of Safety Trending Results

	N= 164	N= 115	N= 105		N=420,769	
1. Teamwork Within Units						
	2009	**2011**	**2013**		**NDB**	
a. People support one another in this unit.	92	97	95	↓	86	
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	↓	86	
c. In this unit, people treat each other with respect.	91	90	93	↑	79	
d. When one area in this unit gets really busy, others healp out.	79	85	81	↓	70	
2. Supervisor/Manager Expectations & Actions Promoting Patient Safety						
	2009	**2011**	**2013**		**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	↓	74	
b. My supervisor/manager seriously considers staff suggestions for improving patient safety.	87	92	83	↓	78	
c. Whenever pressure builds up, my supervisor/manager wants us to work faster, even if it means taking shortcuts.	85	82	76	↓	74	
d. My supervisor/manager overlooks patient safety problems that happen over and over.	78	83	76	↓	77	
3. OrganizationalLearning-Continuous Improvement						
	2009	**2011**	**2013**		**NDB**	
a. We are actively doing things to improve pateint safety.	88	97	91	↓	85	

b. Mistakes have led to positive changes here.	76	77	73		66	
c. After we make changes to improve patient safety, we evaluate their effectiveness.	72	86	66		69	
4. Management Support for Patient Safety						
	2009	**2011**	**2013**		**NDB**	
a. Hospital management provides a work climate that promotes patient safety.	91	87	80		82	
b. The actions of hospital management show that patient safety is a top priority.	80	90	80		76	
c. Hospital management seems interested in pateint safety only after an adverse event happens.	70	81	73		61	
5. Overall Perceptions of Patient Safety						
	2009	**2011**	**2013**		**NDB**	
a. It is just by chance that more serious mistakes don't happen around here.	64	70	74		63	
b. Pateint Safety is never sacrifieced to get more done.	73	70	68		65	
c. We have pateint safety problems on this unit.	73	85	74		65	
d. Our procedures and systems are good at preventing errors from happening.	78	78	76		73	
6. Feedback and Communication About Error						
	2009	**2011**	**2013**		**NDB**	
a. We are given feedback about changes put into place based on event reports.	45	68	63		58	
b. We are informed about errors that happen on this unit.	65	77	67		67	
c. In this unit, we discuss ways to prevent errors from happening again.	84	89	82		73	
7. Communication Openness						

	2009	2011	2013		NDB	
a. Staff will freely speak up if they see something that may negatively affect patient care.	83	83	87		76	
b. Staff feel free to question the decisions or actions of those with more authority.	56	54	55		50	
c. Staff are afraid to ask questions when something does not seem right.	70	87	70		65	
8. Frequency of Events Reported						
	2009	2011	2013		NDB	
a. When a mistake is made, but is caught and corrected befor affecting the pateint, how often is it reported?	57	44	59		55	
b. When a mistake is made, but has no potential to harm the patient, how often is this reported?	57	57	57		56	
c. When a mistake is made that could harm the patient, but does not, how often is this reported?	75	61	85		73	
9. Teamwork Across Units						
	2009	2011	2013		NDB	
a. Hospital units do not coordinate well with each other.	47	56	54		46	
b. There is good cooperation among hospital units that need to work together.	74	73	69		60	
c. It is often unpleasant to work with staff from other hospital units	66	54	86		60	
d. Hospital units work well together to provide the best care for patients.	85	88	83		68	
10. Staffing						
	2009	2011	2013		NDB	
a. We have enough staff to handle the workload.	74	66	67		55	

b. Staff in this unit work longer hours than is best for patient care.	23	45	43		53	
c. We use more agency/temporary staff than is best for patient care.	12	59	67		62	
d. We work in "crisis mode" trying to do too much, too quickley.	60	45	58		51	
11. Handoffs & Transitions						
	2009	**2011**	**2013**		**NDB**	
a. Things "fall between the cracks" when transferring pateints from one unit to another.	49	40	45		38	
b. Important patient care information is often lost during shift changes.	66	54	64		47	
c. Problems often occur in the exchange of information across hospital units.	53	54	54		41	
d. Shift changes are problematic for patients in this hospital.	72	45	59		42	
12. Nonpunitive Response to Error						
	2009	**2011**	**2013**		**NDB**	

a. Staff feel like their mistakes are held against them.	65	69	65		51	
b. When an event is reported, it feels like the person is being written up, not the problem.	56	56	48		48	
c. Staff worry that mistakes they make are kept in their personnel file.	46	41	49		37	

6.

EVALUATION OF 2013 WORK PLAN

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

7.

PROPOSED 2014 WORK PLAN

2014 Proposed Quality Committee Work Plan

January	February	March	April
▪ No Report	▪ Update on Core Measures and VBP ▪ Evaluation of 2013 Work Plan and Proposed 2014 Plan ▪ AHRQ Culture of Safety Survey Report ▪ Completed 2013 Quality Dashboard	▪ Annual Skilled Nursing Report (Melissa)	▪ Annual Performance Improvement Evaluation and Goals Report
May	**June**	**July**	**August**
▪ Annual Infection Control Report* (Kathy) ▪ Update on the Patient Experience (Mark)	▪ Annual Home Care Report (Barbara) ▪ Annual Laboratory Report (Lois)	▪ Annual Risk Management and Culture of Safety Report (Kathy) ▪ Safety Committee Annual Report (TBD)	▪ Utilization Management Efforts and Outcomes (Leslie) ▪ Perioperative Services Report (Allan)
September	**October**	**November**	**December**
▪ Performance Improvement Reports – PI Fair ▪ Update on Electronic Health Record and meaningful Use 2 (Dr. Cohen)	▪ Total Joint and Bariatric Service Lines (Drs Brown & Perryman?) ▪ Resource Management Report (Michelle)	▪ Annual Contract Evaluation Report* (Laura)	▪ Evaluation of the Quality Committee Work Plan

*Required

8.

QC DASHBOARD 2013

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

BOARD QUALITY COMMITTEE DASHBOARD 2013

The following are quality and patient safety indicators selected by the Board Quality Committee for quarterly reporting as part of the oversight mandate for ensuring the organization has an effective quality assurance and performance improvement program (QAPI).

1. Surgical Services Volumes by Service Fiscal Year 2013/2014

	Jul-Sept Q1.FY14		Oct-Dec Q2. FY14		Jan-Mar Q3.2013		Apr-Jun Q4.2013		Totals
SERVICE	**IP**	**OP**	**IP**	**OP**	**IP**	**OP**	**IP**	**OP**	
General	44	44	29	55	32	29	30	48	311
OBGYN	6	16	13	19	17	16	11	22	120
Ophthalmology	0	48	0	63	0	45	0	48	204
Orthopedic	55	111	40	106	55	106	57	101	631
Pain Management	0	49	0	45	0	37	0	39	170
Podiatry	1	8	1	7	0	15	3	4	39
Urology	0	5	2	17	3	3	1	5	36
Vascular Surgery	0	3	0	3	1	4	0	7	18
Endoscopy	9	76	21	79	24	66	14	82	371
Totals	**115**	**360**	**106**	**394**	**132**	**321**	**116**	**356**	**1900**

2. Emergency Department Patient Performance

a. **Time from presentation to the ED to time seen by MD based on a sampling of cases.**

Measurement:	Emergency Department Patient Throughput (Lower # is Better)
Category:	Patient Safety
Definition:	Time from arrival in ED to being seen by an MD in minutes (Average)

CALENDAR YEAR 2012	2013 Q1	2013 Q2	2013 Q3	2013 Q4	Q Change	YTD Trend	Benchmark Goal	Benchmark Perform
25.85	26.36	11.94	44.25	28.33		N/A	30	

Note: Reliable data collection in EMR is in development and will be ready for national reporting measures.

b. Time from decision to admit to bed on inpatient unit until patient departure from ED based on a sampling of cases.

Measurement:	Time from admit decision to depart to bed (Lower # is Better)
Category:	Patient Safety
Definition:	Time from decision to admit patient to departure to assigned bed in minutes (Average)

CALENDAR YEAR 2012	2013 Q1	2013 Q2	2013 Q3	2013 Q4	Q Change	YTD Trend	Benchmark Goal	Benchmark Perform
72.37	64.93	64.28	47.5	66.05		N/A	96	

3. Patient Satisfaction: Quality Patient Experience

Patient satisfaction is measured by the Press Ganey Patient Satisfaction Questionnaire that is mailed to the patient's home two weeks post discharge. There are many questions on the survey and the hospital has shown a significant improvement over the past two years. We chose 3 questions upon which to focus our attention.

Measurement:	Noise Level in and around rooms (Higher # is Better)
Category:	Patient Satisfaction
Definition:	% of Patients responding to Press Ganey Survey who gave a score of 5 (Very Good)

CALENDAR YEAR 2012	2013 Q1	2013 Q2	2013 Q3	2013 Q4	Q Change	YTD Trend	Benchmark Goal	Benchmark Perform
75.3%	70.7%	71.9%	72%	76%		N/A	90.00%	

Measurement:	Explanations re: tests and treatments (Higher # is Better)
Category:	Patient Satisfaction
Definition:	% of Patients responding to Press Ganey Survey who gave a score of 5 (Very Good)

CALENDAR YEAR 2012	2013 Q1	2013 Q2	2013 Q3	2013 Q4	Q Change	YTD Trend	Benchmark Goal	Benchmark Perform
87.1%	85.7%	86.1%	85.9%	90%		N/A	90.00%	

Measurement:	Likelihood to recommend SVH to others (Higher # is better)
Category:	Patient Satisfaction
Definition:	% of Patients responding to Press Ganey Survey who gave a score of 5 (Very Good)

CALENDAR YEAR 2012	2013 Q1	2013 Q2	2013 Q3	2013 Q4	Q Change	YTD Trend	Benchmark Goal	Benchmark Perform
89.6%	91.4%	88.7%	87.7%	88%		N/A	90.00%	

4. Readmissions Rates: Quality Patient Outcomes

Data is captured for patients who return to SVH within 30 days. The hospital focuses on four specific diagnostic groups as they are currently tied to Medicare pay-for-performance.

Measurement:	Readmission Rates for Medicare Patients (Lower # is better)
Category:	Quality Patient Outcomes
Definition:	Readmitted to SVH within 30 days - All Diagnosis

CALENDAR YEAR 2012	2013 Q1	2013 Q2	2013 Q3	2013 Q4	Q Change	YTD Trend	Benchmark Goal	Benchmark Perform
8.20%	8.40%	4.2%	5.7 %	4.9%		N/A	16.0%	

Measurement:	Readmission Rates for Medicare Patients (Lower # is better)
Category:	Quality Patient Outcomes
Definition:	Readmitted to SVH within 30 days with Same Diagnosis (DRG)

CALENDAR YEAR 2012	2013 Q1	2013 Q2	2013 Q3	2013 Q4	Q Change	YTD Trend	Benchmark Goal	Benchmark Perform
2.40%	**2.00%**	**4.2%**	**1.53%**	**1.23%**		N/A	**TBD**	**TBD**

Measurement:	Readmission Rates for Medicare Patients (Lower # is better)
Category:	Quality Patient Outcomes
Definition:	Readmitted to SVH within 30 days with AMI (Heart Attack)

CALENDAR YEAR 2012	2013 Q1	2013 Q2	2013 Q3	2013 Q4	Q Change	YTD Trend	Benchmark Goal	Benchmark Perform
6.00%	**0.00%**	**0.00%**	**0.00%**	**0.00%**		**N/A**	**18.0%**	

Measurement:	Readmission Rates for Medicare Patients (Lower # is better)
Category:	Quality Patient Outcomes
Definition:	Readmitted to SVH within 30 days with CHF (Congestive Heart Failure)

CALENDAR YEAR 2012	2013 Q1	2013 Q2	2013 Q3	2013 Q4	Q Change	YTD Trend	Benchmark Goal	Benchmark Perform
2.80%	**0.00%**	**0.00%**	**20.00%**	**16.67%**		N/A	**23.0%**	
			Small population **(1/ 5)**	*Small population* **(1/ 6)**				

Measurement:	Readmission Rates for Medicare Patients (Lower # is better)
Category:	Quality Patient Outcomes
Definition:	Readmitted to SVH within 30 days with PNE (Simple Pneumonia)

CALENDAR YEAR 2012	2013 Q1	2013 Q2	2013 Q3	2013 Q4	Q Change	YTD Trend	Benchmark Goal	Benchmark Perform
8.50%	**11.11%**	**0.00%**	**0.00%**	**0.00%**		N/A	**17.6%**	

Measurement:	Readmission Rates for Medicare Patients (Lower # is better)
Category:	Quality Patient Outcomes
Definition:	Readmitted to SVH within 30 days with COPD (Chronic Obstructive Pulmonary Disease)

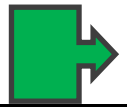
CALENDAR YEAR 2012	2013 Q1	2013 Q2	2013 Q3	2013 Q4	Q Change	YTD Trend	Benchmark Goal	Benchmark Perform
0.00%	**16.50%**	**0.00%**	**0.00%**	**0.00%**		**N/A**	**TBD**	**TBD**

Chart Definitions:	Calendar Year	Average of all quarters previous year
	Q Change	Change from previous quarter/calendar year
	YTD Trend	Change from previous calendar year based on an average of the quarterly values this year
	Benchmark goal	External standard or internally set benchmark for quality performance
	Benchmark Perform	Most recent quarter performance against the benchmark goal
		Red means performance declined or does not meet the benchmark goal
		Green means improved performance or meeting the benchmark goal

5. Hospital Acquired Infections: Quality Patient Outcomes and Safety

Infections are tracked for 16 different categories of infections are reported in detail only if quarterly or YTD performance does not meet the benchmark set and therefore potentially merits clinical and management remedial action. The following table summarizes those infection categories being tracked which are within benchmark.

Infection Category	Within Benchmark
Central line associated bloodstream infections	
Hospital acquired Cdiff infections	
Inpatient, MRSA infections	
VRE bloodstream infections	
Hip surgical site infections	
Knee surgical site infections	
Overall surgical site infections	
Class I SSI rate	
Class II SSI rate	
Total Joint SSI rate	
Ventilator Associated Events	
Hospital acquired Pneumonia	
Inpatient Hospital acquired Catheter associated urinary tract infections	
Home Care associated infections	
MRSA Active Surveillance cultures	
Flash sterilization measurements	