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SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE REGULAR MEETING
AGENDA
WEDNESDAY, May 27, 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, 4.22.15	*Hirsch*	Action
4. THE PATIENT EXPERIENCE	*Kobe*	Inform/Action
5. INFECTION PREVENTION AND HAI REPORTS	*Mathews*	Inform/Action
6. POLICY AND PROCEDURE • Code Blue #PC8610-115 • Standardization Med Screen Exam OB #PC8610-209 • Rehab Dept. #7770-100 to 139 • Dispensing of Meds #MM8390-148	*Kobe/Kutza/ Lovejoy*	Inform/Action
7. QUALITY REPORT MAY 2015	*Lovejoy*	Inform/Action
8. CLOSING COMMENTS/ANNOUNCEMENTS	*Hirsch*	
9. ADJOURN	*Hirsch*	
10. UPON ADJOURNMENT OF THE REGULAR OPEN SESSION	*Hirsch*	
11. CLOSED SESSION: Calif. Health & Safety Code § 32155 Medical Staff Credentialing & Peer Review Report-Board Quality Dashboard Q1	*Amara*	Action
12. REPORT OF CLOSED SESSION	*Hirsch*	Inform/Action
13. ADJOURN	*Hirsch*	

3.

CONSENT CALENDAR

SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
REGULAR MEETING MINUTES
Wednesday, April 22, 2015
Schantz Conference Room

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

AGENDA ITEM	DISCUSSION	ACTION	FOLLOW-UP
1. CALL TO ORDER/ANNOUNCEMENTS	*Hirsch*		
	Meeting called to order at 5:05pm Ms. Hirsch shared that the Advanced Directives seminars given at Vintage House last week were very successful. They were well attending and the feedback was positive. Due to popular demand, more seminars are planned in future.		
2. PUBLIC COMMENT	*Hirsch*		
	None		
3. CONSENT CALENDAR	*Hirsch*	Action	
• QC Minutes, 3.25.15 • Annual Review QA/PI Program		**MOTION** by Rymer to approve Consent and 2nd by Idell. All in favor.	
4. ANNUAL HOME CARE REPORT	*Lee*	Inform/Action	
	Ms. Lee presented *Healing at Home Annual Evaluation 2014.* Topics included management, staff and performance improvement assessments, department visit activity, patient satisfaction surveys, primary patient diagnoses and goals. Ms. Lee distributed the *Quality Assurance & Performance Improvement Plan 2015-16.*		

AGENDA ITEM	DISCUSSION	ACTION	FOLLOW-UP
5. PATIENT CARE SERVICES REPORT	*Kobe/Lovejoy*	Inform/Action	
	Mr. Kobe and Ms. Lovejoy share their report on *Nursing Services at Sonoma Valley Hospital*. Most significantly, the improvements implemented after the 2012 Strategic Planning Session were presented in detail. They also shared their plans for future improvements and developments 2015-16. Mr. Kobe will present on HCAHPS next month and will incorporate the Committees' areas of interest.		Board Clerk to email QC asking for feedback on HCAHPS survey.
6. QUALITY REPORT FOR APRIL 2015	*Lovejoy*	Inform/Action	.
	Ms. Lovejoy presented the Quality Report for April covering priorities for the month, risk management, budget development and departmental functions.		
7. CLOSINGCOMMENTS	*Hirsch*		
			.
8. ADJOURN	*Hirsch*		
	Regular Session adjourned at 6:09 pm.		
9. UPON ADJOURNMENTOF REGULAR OPEN SESSION	*Hirsch*		
10. CLOSED SESSION	*Amara*	Action	
Calif. Health & Safety Code § 32155 • Medical Staff Credentialing/Peer Review Rpt.			
11. REPORT OF CLOSED SESSION	*Hirsch*	Inform/Action	
12. ADJOURN	*Hirsch* Closed Session adjourned at 6:12 pm.		

4.

THE PATIENT EXPERIENCE

SERVICE EXCELLENCE

NRC PICKER

NATIONAL RESEARCH CORPORATION;
Harvard Picker Institute

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NRC

•Founded in 1981dedicated to improving healthcare quality

•2001 acquired the Harvard Picker Institute, dedicated to research on patient/family experience

•Surveys designed to have patients and families OBJECTIVELY report on their experience; they measure BEHAVIORS to improve outcomes

•Press Ganey is a SUBJECTIVE rating of experience

•Partnered with CMS in 2002 to develop HCAHPS survey. Their research resulted in development of the 8 Dimensions of Care

•2012 recognized as largest patient satisfaction network in U.S

•Contract saved SVH $30K

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Performance Linked

- Leaders have defined goals for achieving HCAHPS results
- Leaders are held to maintaining 5 of the 8 domains at or > 50th %tile

- Medicare reimbursement is pro-rated based on HCAHPS results

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QUESTION FORMAT

Press Ganey	**HCAHPS**
•Friendliness/courtesy of the nurses	•During this hospital stay, how often did nurses treat you with courtesy and respect?
•Physician's concern for your questions and worries	•During this hospital stay, how often did Doctors listen carefully to you?
•Room cleanliness	•During this hospital stay, how often were your room and bathroom kept clean?
•Extend to which you felt ready to be discharged	•During this hospital stay, did doctors, nurses or other hospital staff talk with you about whether you would have the help you needed when you left the hospital?

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Answer Format

Press Ganey	**HCAHPS**
Very poor	Never
Poor	Sometimes
Fair	Usually
Good	Always
Very Good	

HCAHPS DOMAINS

Inpatient (9)

1-Overall hospital rating (1-10)
2-Nurses communicated well
3-MDs communicated well
4-Pain was controlled well
5-Always received help needed when requested
6-Staff explained medications
7-Environment clean and quiet
8-Patients given information what to do in their recovery
9-Care Transitions

Emergency (7)

1-Overall facility rating (1-10)
2-Communication with Nurses
3-Communication with Providers
4-Pain Management
5-Cleanliness/quietness
6-Discharge Information
7-Would recommend facility

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HCAHPS Domains

1. Clean and Quiet The actual survey questions that comprise your composite are:
- During this hospital stay, how often were your room and bathroom kept clean?
- During this hospital stay, how often was the area around your room quiet at night?

2. Doctors always communicated well The actual survey questions are:
- During this hospital stay, how often did doctors treat you with courtesy and respect?
- During this hospital stay, how often did doctors listen carefully to you?
- During this hospital stay, how often did doctors explain things in a way you understood?

3. Nurses always communicated The actual survey questions are:
- During this hospital stay, how often did nurses treat you with courtesy and respect?
- During this hospital stay, how often did nurses listen carefully to you?
- During this hospital stay, how often did nurses explain things in a way you understood?

4. Patients always received help as soon as they wanted The actual questions are:
- During this hospital stay, after you pressed the call button, how often did you get help as soon as you wanted it?
- How often did you get help in getting to the bathroom or in using a bedpan as soon as you wanted?

5. Pain was always controlled The actual survey questions are:
- During this hospital stay, how often was your pain well controlled?
- During this hospital stay, how often did the hospital staff do everything they could to help you with your pain?

6. Staff always explained about medicines before giving them to you The actual questions are:
- Before giving you any new medicine, how often did hospital staff tell you what the medicine was for?
- Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand?

7. Yes, patients were given information about what to do during their recovery
- During this hospital stay, did doctors, nurses or other hospital staff talk with you about whether you would have the help you needed when you left the hospital?
- During this hospital stay, did you get information in writing about what symptoms or health problems to look out for after you left the hospital?

8. Patients who gave a rating of 9 or 10 /overall rating of care Actual questions are:
- Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay?
- Would you recommend this hospital to your friends and family?

9. Care transitions Actual questions are:
- During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left.
- When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.
- When I left the hospital, I clearly understood the purpose for taking each of my medications.

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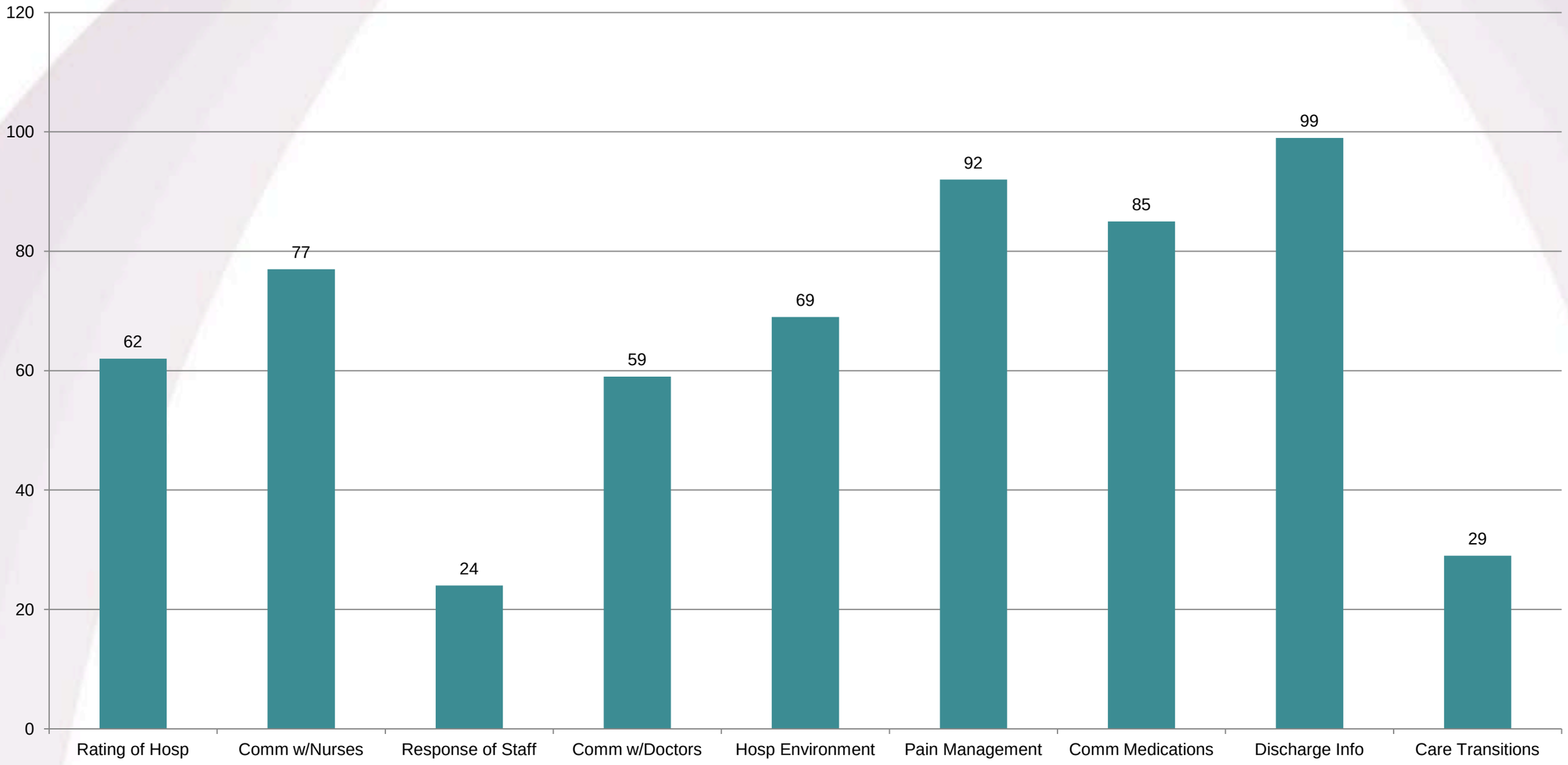
MARCH 2014 HCAHPS



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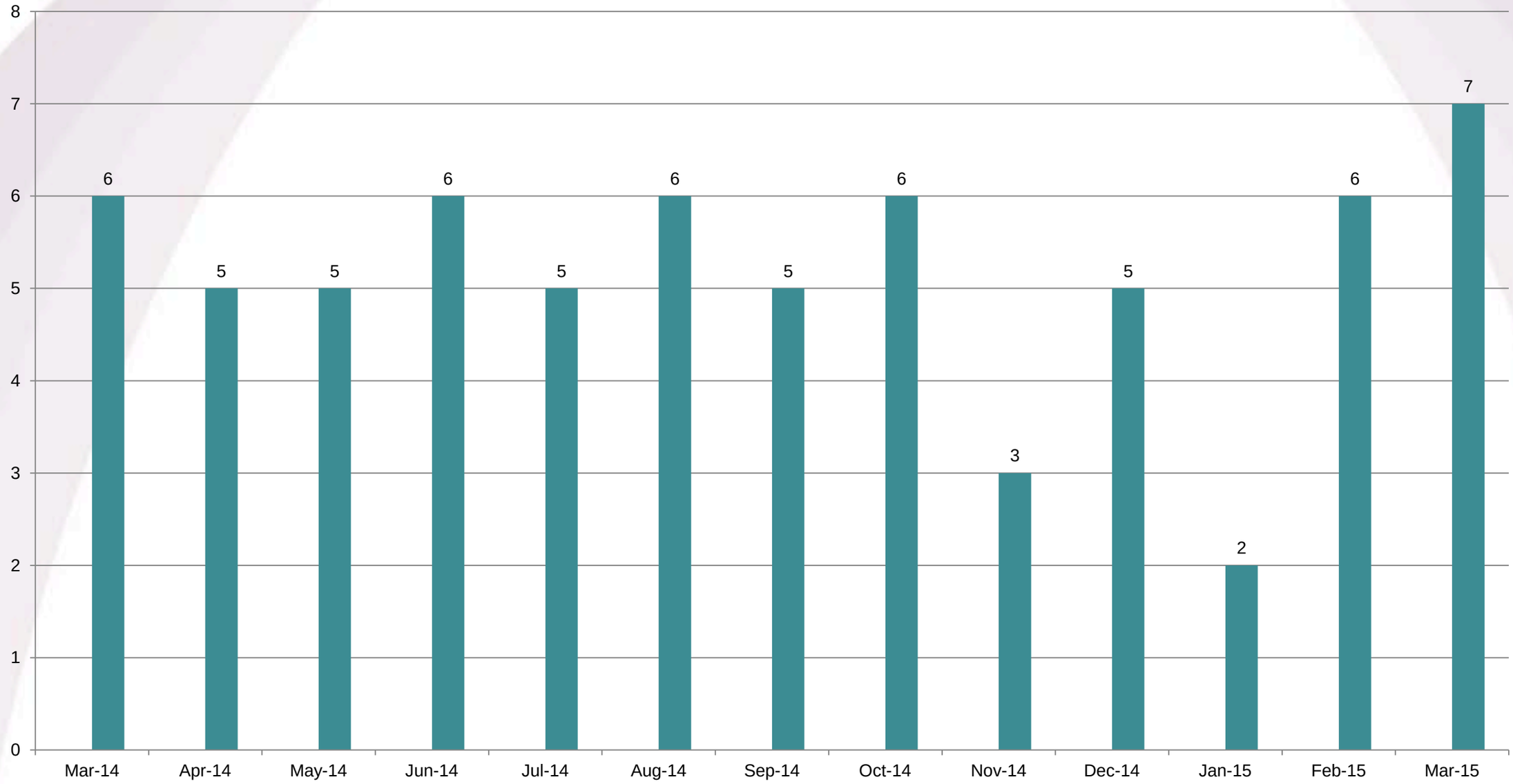
HCAHPS DOMAINS ≥ 50TH %TILE
ROLLING 12 MONTHS 2014-2015



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Sampling and Scoring

- Sampling parameters set for patient stay ≥ one day
- Recently discovered sampling parameter error for the Emergency Department
- NRC uses the National Education Association (NEA) model for sampling size at 95% confidence level
- At 900 patients/month, sample size for survey sendouts is 269 (30%)
- We experience a 32% response rate since contract inception, July 2014
- “Always” is the only answer that counts
- Answers left blank or n/a are not counted
- OBS patients are not surveyed
- Monthly survey data is terminated at 42 days for inpatient and 84 days for ED

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Staff Education

- Service Excellence annual performance expectation
- Daily Huddles and Manager rounding
- AIDET, white boards, hourly rounding, call backs
- ‘Scripting’ or key words for key phrases while rounding….”May I pull the curtain to protect your privacy?”…….”Do you feel that you’re being treated respectfully by everyone?”……Do you feel your pain is managed appropriately?”….Do you know the adverse reactions of the medications that have been prescribed to you?

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Physician Collaboration

- Lead Hospitalist/ED medical director focused on results
- Sitting at the bedside, introductions, managing up the healthcare team.
- Current practice is to ‘pre-round’ to establish physician presence with patient
- Each month they select a new monthly initiative; currently Announcing (AIDET) before entering room

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5.

INFECTION PREVENTION AND HAI REPORTS

Infection Prevention

Annual Board Quality Committee Report
May 27, 2015

Kathy Mathews RN, CIC
Clinical Quality Coordinator for Infection Prevention
and Risk Management

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Introduction

- Acknowledgement
- Evaluation of the 2014 Infection Prevention Program
- Goals for 2015
- Risk Management Highlights

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Evaluation of 2014 Program

Achieve a successful CIHQ survey

- Addressed CIHQ findings in Medical Imaging disinfection practices
- Surgery immediate use sterilization rates decreased

Limit unprotected exposure to pathogens throughout the hospital

- 4 influenza exposures in the Emergency Dept. early in season
- Inservice education, no further influenza exposures
- No healthcare associated influenza cases in patients

Enhance hand hygiene

- Training in orientation and annually
- Monitoring program remains a goal in 2015

Maintain a sanitary environment

- Introduced Xenon UV light disinfection robot to enhance environmental disinfection

Ensure that the hospital-wide Quality and Performance Improvement programs address problems identified by IP, and that subsequent corrective action plans are successfully implemented

- C. difficile multidisciplinary performance improvement project (poster session winner)
- Overall C. difficile rate decreased <50%. SNF rate remained above benchmark.

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Comply with all State mandated reporting requirements and HAI prevention measures.

- discontinue use of Contact Isolation for MRSA nasal carriage only. No subsequent outbreaks.

Comply with Cal/OSHA regulations including Bloodborne Pathogen and Aerosol Transmissible Disease Standards.

Maintain a system for identifying, reporting, investigating, and controlling infections and communicable diseases including

- Central Line Associated Bloodstream Infections (CLABSI): none since 2011
- Ventilator Associated Events (VAE): below NHSN (CDC) benchmark
- Catheter Associated Urinary Tract Infections (CAUTI): Acute below benchmark. SNF slightly above benchmark. SNF education in 2015
- Surgical Site Infections (SSI): slight increase 2nd quarter, resolved. Post discharge surveillance reporting by surgeons 57%
- Reduce the incidence of Multi-drug Resistant Organism (MDRO): Active antimicrobial stewardship program. Low incidence of MDRO (ESBL 5%, no CRE, MRSA incidence 20%) 1 HAI MRSA i.e., SSI.

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Improvement

- Influenza Immunization Program 2014 vs. 2015
  - Vaccination rate MDs: 28% (2014)
    76% (2015)
  - Vaccination rate staff (excluding contractors): 86% (2014), 87% (2015)

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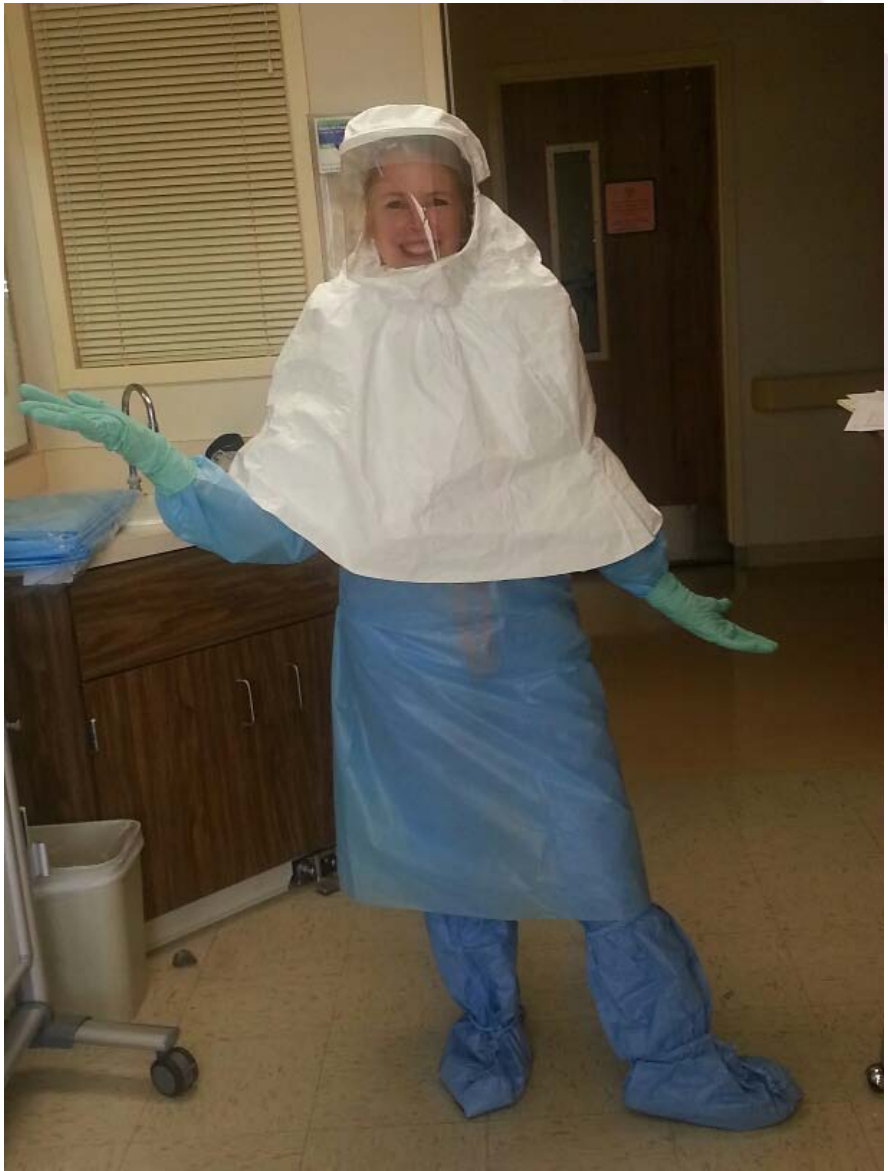
2014 Most Memorable Pathogen: Ebola

- Oct. 8: 1st US Ebola Death in Texas with Secondary spread to HCW
- 10/ 27-31/15 74 staff trained to safely care for Ebola patients.
- Ebola team identified
- Isolation rooms in ED and 2 So. prepared



2015 IP Goals

- Implement the 2015 IP Plan to include:
- Hand hygiene monitoring program
- Reach 90% influenza immunization compliance
- Consider Tdap requirement for staff
- Infection Prevention dept. rounds
- Extend MDRO isolation discontinuation policy and monitor
- Continued improvement in CDI rate

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2015 IP Goals

- Review and revise IP P&P by 2016
- SNF CAUTI rate at benchmark
- Improved post discharge SSI reporting
- Improve the balance of IP with Risk Management

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Questions?

For more information or comments contact Kathy at 935-5180

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Infection Prevention HAI Report

Indicator	Comparison 2013 /2014 rates	Q1 2015	Q2 2015	Q3 2015	Q4 2015	Benchmarks/Actions/Comments
National Healthcare Safety Network (NHSN) indicator data are a requirement of California Department of Public Health (CDPH) and Senate Bill 1058 mandated reporting Data is entered into the National Healthcare Safety Network (NHSN) system for public reporting by CDPH. Overall SSI rate includes all SSIs identified regardless of wound class. There is no NHSN benchmark. NHSN risk stratefies SSI rates by procedure therefore a range is provided. Green indicates no action, yellow indicates above benchmark, red indicates greater than the NHSN 90th percentile. Action is recommended when rates exceed the 90th percentile. New Requirements in 2015: All MRSA and VRE bacteremia identified in Emergency Department, all SSIs acquired from Outpatient surgeries.						
CLABSI (NHSN) (CMS Never Event) *# Central Line Associated Bloodstream Infections (CLABSI)/1000 central line days*	0 0	0 0/162	]			NHSN Benchmark: 0.9 (ICU) and 0.8 (med surg) per 1,000 central line days ICU. SVH (acute) has not had a CLABSI since 2011! Practitioner CLIP practices reported to CDPH. No action required.
CDI (NHSN) *#Inpatient Hospital Acquired infections due to C. difficile per 10,000 patient days*	2.1 7.2	9.3 1/1072				NHSN median rate 7.4/10,000 patient days . Pt. #1 had diarrhea on admission but CDI testing not done until day 3 therefore met NHSN CDI criteria. Pt. #2 NPO to CL diet, delay in ordering probiotics/yogurt 3 days after dietician recommended it. Dietician follows up with all pts on abx to recommend L. C. yogurt or probiotics.
MRSA Bloodstream Infections (NHSN) *#bloodstream infections due to MRSA per 1000 pt. days*	1.3 0	0 0/1072				SVH Benchmark: 1 per 1,000 patient days. 2015 New requirement: Report ED and acute care unit infections. 1 community acqured MRSA bacteremia in ED. No action required.
VRE Bloodstream Infections (NHSN) *#Hospital Acquired bloodstream infections due to VRE per 1000 pt. days*	0 0	0 0/1072				SVH Benchmark: 1 per 1,000 patient days. 2015 New Requirement report ED and acute care unit infections. No action required
Hip: Deep or Organ/Space Surgical Site Infections (NHSN) *# infections/ # Total Hip Cases x 100*	0 0	0 0/12				NHSN Benchmark: Risk stratified. Rate range 0.67% (0 risk index) to 2.40% (higher risk index).
Knee: Deep or Organ/Space Surgical Site Infections (NHSN) *# infections/ # Total Knee Cases x 100*	0 1.7%	0 0/17				NHSN Benchmark: Risk stratefied. Rate range 0.58% (0 risk index) to 1.60 (higher risk index).
Overall Surgical Site Infections (SSI) *Total # SSI/Total # surgeries x 100*	0.2% (3 SSIs) 0.7%(12 SSIs)	0.2% 1/402				<1% (SVH trended data). No NHSN benchmark for all surgeries. 1 SSI s/p perforated appi (dirty case)
Class I SSI rate	0.2 % 0.8%	0/332				Benchmark 1.2-2.9 2nd Qtr: 2 ORIF R ankle, L hip cemented bipolar prosthesis . Exostosis with degenenerative joint disease. Action: Referred to Surgery Committee for review. Rate increasing
Class II SSI rate	0 0	0/55				Benchmark 2.4-7.7 No action required.
Total Joint SSI rate	0	0 /33				No NHSN benchmark for combined total joint cases.
Post discharge surveillance surgeon compliance	57% July-Dec	41% Jan-Feb				Surgery Committee approved post discharge surveillance plan with reporting by surgeons monthly in 2014 to promote accurate SSI

Infection Prevention HAI Report

Indicator	Comparison 2013 /2014 rates	Q1 2015	Q2 2015	Q3 2015	Q4 2015	Benchmarks/Actions/Comments
National Healthcare Safety Network (NHSN) indicator data are a requirement of California Department of Public Health (CDPH) and Senate Bill 1058 mandated reporting Data is entered into the National Healthcare Safety Network (NHSN) system for public reporting by CDPH. Overall SSI rate includes all SSIs identified regardless of wound class. There is no NHSN benchmark. NHSN risk stratefies SSI rates by procedure therefore a range is provided. Green indicates no action, yellow indicates above benchmark, red indicates greater than the NHSN 90th percentile. Action is recommended when rates exceed the 90th percentile. New Requirements in 2015: All MRSA and VRE bacteremia identified in Emergency Department, all SSIs acquired from Outpatient surgeries.						
Flash Sterilization *# of flashed loads due to case turnover/total number of procedures (excludes eve cases)*	12% 9.3%	5.2%				Internal Benchmark 12%. Minimize the use of immediate use sterilization when performing routine sterilization for opth surgical cases.
Ventilator Associated Event (VAE): Pneumonia *# Ventilator Associated Pneumonia/ # vent days x 1000*	0 0	0 0/46				NHSN Benchmark: 1.1 per 1,000 ventilator days
Hospital Acquired Pneumonia (HAP) *# hospital acquired pneumonia/# patient days*	0.2 0.47	2.7 1/365				SVH Benchmark: 1 per 1,000 patient days
Inpatient Hospital Acquired Catheter Associated Urinary Tract Infections (CA-UTI) (CMS Never Event) *# inpatient CAUTI/# catheter days x 1000*	0.7 0	0 0/112				NHSN Benchmark: 1.4 per 1,000 catheter days. NHSN 90th percentile is 3.2. Action: Monitor July and provide CAUTI prevention education for staff if rate remains elevated.
SNF Hospital Acquired Catheter Associated Urinary Tract Infections (CA-UTI) *# SNF CAUTI/# catheter days x 1000*	2.6 3.3	13.8 4/288				NHSN Benchmark: 2 per 1,000 catheter days. 1 patient had two UTIs. Action Plan: CAUTI prevention inservice for staff in May. Revise EMR for daily assessment of foley need.
SNF Hospital Acquired *C. Difficile* Infections (CDI) *# SNF CDI/# patient days x 10,000*	20.4 11.7	0 0/1930				NHSN Benchmark: 7.4 per 10,000 patient days. Significant overall decrease in CDI rate in 2014. No cases in 1st qtr! SNF + Acute rate: 6.7 Lab tested 53 specimens, 8 positive (2 inpt and 6 outpt)
SNF Central line associated bloodstream infections (CLABSI) *# Central Line Associated Bloodstream Infections (CLABSI)/central line days x 1000*	1 0	0 0/184				NHSN Benchmark: 1 per 1,000 central line days (SNF). 3rd Qtr CLABSI vs fistula as source. Organism Citrobacter amaionaticus.
Home Care Associated Infections *# of infections/Total visits x 1000*	0.3 0.6	0 0/3438				SVH Benchmark: 1.5 per 1,000 home care visits (SVH Trended Data). Twenty-three home health care records were randomly selected for review.
MRSA Active Surveillance Cultures (nares cultures only) *# positives/total screened x 100*	14% 20%	6% 5/82				Required patients have a nasal screen in accordance with California law, notified and provided with patient education. MRSA rate for all cultures is 38.2^
% ESBL(E. coli;K. pneumoniae, K. oxytoca, P. mirabilis)	2%	5%				Antimicrobial Stewardship Program monitors antibiogram, reviews and updates annually.
# CRE	0	0	]	]		No action required.

References: 1.) MA Dudeck et al., National Healthcare Safety Network (NHSN) Report, Data Summary for 2012, Device-associated Module, AJIC, 4 (2013), 1148-66 2.) MMWR, Vital Signs: Preventing Clostridium difficile Infections, March 9, 2012/61 (09); 157-162 3.) J R Edwards et al., National Healthcare Safety Network (NHSN) report: Data summary for 2006 through 2008, issued December 2009, AJIC, 2009; 37:783-805 HOMECARE * Twenty-three home health care records were randomly selected for review. This is greater than 10% of the average daily census. Start of care, recertification, discharge and multidisciplinary cases were included.

6.

POLICY AND PROCEDURE

Policy Submission Summary Sheet

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Title of Document: **Organizational Policies**
Revision written by: **Mark Kobe/Bonnie Bernhardy**
Date of Document: **5-1-2015**

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

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

PC8610-115 <u>Code Blue and Broselow Emergency Resuscitation Cart Maintenance</u>:

1. Policy revised to identify locations and standardized contents of Pediatric Emergency Resuscitation Carts and supplies.
2. Pediatric Drug tray revised to delete Digoxin and Dopamine.
3. Drawer 3 of Adult Crash Cart formerly assigned to contain NG supplies, now contains Pediatric Medication Resuscitation Tray. NG supplies eliminated from crash carts.

Reviewed by:	Date	Approved (Y/N)	Comment
Policy & Procedure Team	3/24/2015	Yes	
Surgery Committee	5/06/2015		
Medicine Committee	5/14/2015		
Medical Exec Committee	5/21/2015		
Board of Directors	6/04/2015		

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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.

Departmental: Rehabilitation Therapy Department Policies	
APPROVED BY:	DATE: **4/09/2015**
Director's/Manager's Signature	Printed Name **Dawn Kuwahara RN**

Michael Brown, MD Chair Surgery Committee	Date
Douglas S Campbell, MD Chair Medicine Committee	Date
D. Paul Amara, MD President of Medical Staff	Date
Kelly Mather Chief Executive Officer	Date
Sharon Nevins Chair, Board of Directors	Date

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Policy Submission Summary Sheet

Title of Document: **Rehabilitation Department**

New document or revision written by: **Dawn Kuwahara RN**

Type **X Revision ❑ New Policy**	**Regulatory** **❑ CMS** **❑ CDPH** (formerly DHS) **X CIHQ** **❑ Other:**
❑ Organizational: Clinical/Non-clinical *(circle which type)*	**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)

All of the policies below have been reviewed and to current standard.

7770-100	Cancellation Policy
7770-101	Clinical Competency
7770-103	Cold Pack Usage
7770-105	Contested Decision to Discontinue Skilled Rehab Services
7770-107	Collection of Co-Payment
7770-109	Department Staffing Plan
7770-111	Discharge Criteria
7770-112	Downtime Scheduling Procedures
7770-113	Fluidotherapy Usage
7770-115	Frequently Used Terminology and Abbreviations
7770-117	Gaits Belts, Use and Cleaning of
7770-119	Hot Pack/Heating Pad Usage
7770-121	Hoyer Lift
7770-123	Ice Massage
7770-125	Initial Evaluation
7770-127	Iontophoresis
7770-129	MD Notification
7770-131	Paraffin Use
7770-133	Patient Education
7770-135	Phonophoresis
7770-137	Transcutaneous Electrical Nerve Stimulation
7770-139	Ultrasound

Reviewed By	Date	Approved (Y/N)	Comment
Surgery Committee	**5/06/2015**		
Medicine Committee	**5/14/2015**		
Medical Executive Committee	**5/21/2015**		
Board of Directors	**6/04/2015**		

POLICY AND PROCEDURE
Approvals Signature Page

Review and Approval Requirements

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- 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/Organizational: PC8610-209 Standardized Procedure for Medical Screening Examination for the Obstetrical Patient Performed by RN-New Policy	
APPROVED BY: **Mark Kobe RN**	DATE: **5/05/2015**
Director's/Manager's Signature	Printed Name **Cynthia McAleer, RN Manager**

Leslie Lovejoy, RN, PH.D.
Chief Nursing Officer — Date

Douglas S Campbell, MD
Chair Medicine Committee — Date

Michael Brown, MD
Chair Surgery Committee — Date

D. Paul Amara, MD
President of Medical Staff — Date

Sharon Nevins
Chair, Board of Directors — Date

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

Policy Submission Summary Sheet

Title of Document: **Organizational Policy New**

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

Date of Document: **5/04/2015**

Type:	**Regulatory:**
❑ **Revision** **X New Policy**	**X CIHQ** **X CDPH** **X CMS** ❑ **Other:**
Organizational:	❑ **Departmental** **X Interdepartmental** –All 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)

PC8610-209 Standardized Procedure for Medical Screening Examination for the Obstetrical Patient Performed by RN- new policy

- Emtala requires all persons presenting to the hospital to have a MSE performed by a doctor or a qualified medical person (QMP).
- This standardized procedure is created in order to meet the legal requirements for the provision of MSEs for the obstetric patient,
- Details the process for perinatal nursing staff to become QMPs and
- Provides a standardized process for OB RNs for performing a MSE of the pregnant patient.

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Reviewed by:	Date	Approved (Y/N)	Comment
Surgery Committee	**05/06/2015**		
Medicine Committee	**5/14/2015**		
Medical Executive Committee	**5/21/2015**		
Board of Directors	**6/04/2015**		

Policy Submission Summary Sheet

Title of Document: **Pharmacy Department**

New document or revision written by: **Chris Kutza, Director**

Type **X Revision**	**Regulatory** ❑ **CMS** **X CDPH** (formerly DHS) ❑ **TJC** (formerly JCHAO) ❑ **Other:**
X Organizational	**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)

MM8390-148 Dispensing of Medication—Reviewed & Updated

Reviewed By	Date	Approved (Y/N)	Comment
Performance Improvement Committee	**2/26/2015**	**yes**	
Medical Executive Committee	**5/21/2015**		
Board of Directors	**6/04/2015**		

SUBJECT: Dispensing of Medication	POLICY #MM8610-148
	PAGE 1 OF 3
DEPARTMENT: Organizational	EFFECTIVE: 08/2014
APPROVED BY: Director of Pharmacy	REVISED: 02/2015

Purpose:
To ensure that compounding, packaging, distributing, and dispensing of medications, including record keeping, is in compliance with applicable laws and regulations, licensure and professional standards of pharmacy practice.

Policy:
The Director of Pharmacy Services is responsible for ensuring that compounding, packaging, distributing, and dispensing of medications, including record keeping, is consistent with federal and state laws, rules, and regulations as well as all applicable law or regulation governing professional licensure and operation of pharmacies and professional standards of pharmacy practice.

Procedure:

Individuals Authorized to Prepare, Dispense, Transfer Medications, and Make Labeling Changes

- Medication preparation and dispensing is restricted to a licensed pharmacist or to a designee under the supervision of a pharmacist.
- Medication preparation and dispensing by non-pharmacists is authorized in the following circumstances:
    - A licensed independent practitioner (LIP) (or authorized prescriber in accordance with state regulatory requirements) controls the ordering, dispensing, and administration of the medication, such as in the operating room, endoscopy suite, emergency room, and labor and delivery.
    - Emergent situations when time does not permit a pharmacist's prospective review of medication orders, urgent situations when patient harm could result from delay in administration of a medication, or when a patient experiences a sudden change in clinical status (such as new onset nausea).
- A licensed pharmacist must supervise and monitor all medication preparation by non-pharmacist personnel.
- Only a pharmacist, or authorized pharmacy personnel under the supervision of a pharmacist, may fill and label containers from which medications are to be distributed or dispensed, make labeling changes, or transfer medications to different containers.
- Licensed pharmacy technicians may restock and seal emergency medication supplies used throughout the facility.

Amounts to Dispense

- The amount dispensed is sufficient to meet patient needs and to minimize the potential for diversion.

Dispensing in Ready-To-Administer Forms
Medications are dispensed in the most ready-to-administer forms available to the extent that it is both practical and safe.

Labeling
Medication labeling meets the specifications of the hospital's labeling policy.

Verifying Order Filling Accuracy
A pharmacist performs a final check after the order has been filled or refilled. This check verifies that the order was prepared, filled and labeled accurately. The pharmacist verifies the following:

- Patient's name
- Medication name
- Medication dosage form
- Medication dose
- Medication route
- Medication is in date
- Preparation and compounding procedure is correct

Time Frames for Medication Dispensing
Medications are dispensed within the time frames defined to meet patient needs whenever possible:

- Stat medications are dispensed within 15 minutes of receiving the order.
- Now medications are dispensed within 30 minutes of receiving the order.
- Routine medications are dispensed as soon as possible after receiving the order, but no longer than 2 hours.

Delivery of Medications to Patient Care Areas

- The pharmacy ensures that medications are delivered to patient care areas and are available for administration at the scheduled times.
- Whenever feasible, medications will be dispensed via an Automated Dispensing Cabinet (i.e. Pyxis Medstation)

- If the pharmacy is unable to provide a medication prior to the scheduled administration time, the pharmacy will inform the nurse responsible for the area and/or the nurse responsible for the patient.
- Pharmacy personnel verify that the medications are delivered to the appropriate unit and that the medications are stored in the appropriate secure area.
- When delivering medications to a patient specific cassette/drawer, pharmacy personnel reconcile the patient's name or other identifier information on the medication bag with information on the patient cassette/drawer.

Reference:

- Centers for Medicare and Medicaid Services (CMS) CoP §482.25(b)(1)
- CA B&PC Section 4115(i)(1)&(2)
- CCR, Title 22 Section 70263(f)(2)
- Policy MM8610-132 Labeling of Medications
- Policy MM8610-117 Sterile Compounding
- Policy MM8610-137 Compounding Drug Products
- Policy MM8610-147 Pyxis Medstation, Management and Use of

7.

QUALITY REPORT
MAY 2015

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

To: Sonoma Valley Healthcare District Board Quality Committee
From: Leslie Lovejoy
Date: 05/27/15
Subject: Quality and Resource Management Report

May Priorities:

1. Palliative Care Program
2. Quality Infrastructure Checking
3. HACP Certification
4. Project Management Team

1. Palliative Care Program:

The initial program was developed by Drs Cohen, Sebastian, Pauline Headley, Melissa Evans and Hospice by the Bay to address palliative care issues within the acute setting a few years ago. Hospice by the Bay also has a contract in the Skilled Nursing Unit for the "End of Life Room" that they use exclusively. A Palliative Care Nurse Practitioner was provided by Hospice by the Bay to facilitate both programs. Last year, Hospice was told that they could not provide the role and that they would need to amend their contract for the Palliative Care Program into a staffing contract. The scope of work included physician referrals for POLST/Advance Directive consults; building a nursing palliative care program; identifying non-invasive strategies for symptom management and healing under the hospital's Healing Hospital model; and developing metrics to measure the effectiveness of the program. In addition the NP could identify and bill for her services and Hospice would pass through a percentage of the fees generated to keep program costs down. As the contract neared the end (June 30th), I sought our physicians, staff, our social worker and nurse leaders to identify potential barriers and overall effectiveness of the program. It was found that the program was not effective as previously developed and little progress was being made in the current scope of work. I discussed this with Drs Sebastian and Cohen and it was agreed that we would terminate the current staffing contract and seek another direction. I have noticed all stakeholders and have a meeting with Hospice in June to do a final analysis. I will work with the Nurse Leaders to identify a new direction and include the Hospitalists in the discussion.

2. Quality Infrastructure Checking:

Quality Monitoring reports were due to our department by April 15th and revisions of department specific PI plans are due by the end of this month. Quality Monitoring compliance is 13/17 completed; and 6/17 have updated their PI plan. Will send data out and set meetings with leaders needing assistance. Review of the CIHQ deficiencies from our accreditation survey indicate we are now in 100% compliance and have documentation to support performance improvement. I will be asking leaders to provide me with their PI fair topic by July.

3. HACP Certification:

I completed the certification examination that is sponsored by CIHQ and am now a Healthcare Accreditation Certified Professional. It has been awhile since I went for any certification and with the move to a CMS focused accreditation process, I decided to do this. I will be attending the CIHQ quality conference the second week in June.

Topics for discussion: Infection Control Annual Report; Patient Experience Report