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SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
REGULAR MEETING AGENDA
Wednesday, May 28, 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, 04.23.14 B. Revised QC Charter C. Policy & Procedure Approval	*Hirsch*	Action
4. INFECTION CONTROL REPORT	*Matthews*	Inform
5. HCAHPS: HOSPITAL CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS REPORT	*Kobe*	Inform
6. QUALITY REPORT MAY 2014	*Lovejoy*	Action/Inform
7. BOARD QUALITY COMMITTEE DASHBOARD 2014	*Hirsch*	Action/Inform
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	*Amara*	Action
12. MEDICAL STAFF BYLAWS AMENDMENT	*Lovejoy*	Action
13. REPORT OF CLOSED SESSION	*Hirsch*	Inform

3.

CONSENT CALENDAR

SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
REGULAR MEETING MINUTES
Wednesday, April 23, 2014
Schantz Conference Room

Committee Members Present	Committee Members Present	Committee Members Absent/Excused	Admin Staff /Other
Jane Hirsch Kevin Carruth Susan Idell Leslie Lovejoy Paul Amara M.D. S. Douglas Campbell M.D	Michael Mainardi MD Kelsey Woodward Ingrid Sheets Carol Snyder Cathy Webber	Robert Cohen M.D. (E) Howard Eisenstark (A)	Gigi Betta Mark Kobe

AGENDA ITEM	DISCUSSION	ACTION	FOLLOW-UP
1. CALL TO ORDER	*Hirsch*		
	5:06PM Five new community members were welcomed to the Committee and introductions were made. Mr. Eisenstark was absent from the meeting and Ms. Woodward sat-in for him as a voting member of the Committee.		
2. PUBLIC COMMENT	*Hirsch*		
	None		
3. CONSENT CALENDAR	*Hirsch*	Action	
A. QC Meeting Minutes, 3.26.14	Ms. Betta made two corrections to the Minutes from 3.26.14 and they were approved as amended.	**MOTION:** by IDELL to approve 3.26.14 Minutes *as amended* and 2nd by MAINARDI. All in favor.	
4. POLICIES & PROCEDURES	*Lovejoy*	Action	
		MOTION: by IDELL to approve Policy and 2nd by MAINARDI. All in favor.	

AGENDA ITEM	DISCUSSION	ACTION	FOLLOW-UP
5. QUALITY REPORT FOR APRIL 2014	*Lovejoy*	Inform	
	Ms. Lovejoy presented the Quality Reports for March 2014 covering the HIPAA breach response, credentialing process issues, budget priorities for 2015 and announced the Annual Performance Improvement Fair (first annual on September 18, 2014).		
6. ANNUAL PERFORMANCE IMPROVEMENT EVALUATION	*Lovejoy*	Inform	
	Ms. Lovejoy presented highlights of the **Annual Performance Improvement Evaluation** focusing on an extensive and impressive list of awards and accomplishments as well as project ***PDSA--Reducing Readmissions***. A timeline on the latter was distributed at the meeting. She also touched on opportunities for improvement in the future and program goals for 2014-2015.		
7. CLOSING COMMENTS/ANNOUNCEMNTS	*Hirsch*		
	Next month there will be two presentations: **Infection Control** by Kathy Mathews; and **HCAHPS *(Hospital Consumer Assessment of Healthcare Providers and Systems*)** by Mr. Kobe. Ms. Woodward requested the results of the **SVH Employee Satisfaction Survey**. Ms. Lovejoy will ask Paula Davis, HR Director, to present on this topic next month as well. Ms. Betta sent Ms. Hirsch the **Approved Quality Committee Charter** to be updated to reflect four non-voting members on the Committee (increase of one position).		Ms. Lovejoy to ask Ms. Davis to present on the Employee Satisfaction Survey results at next meeting on 5.28.14 Bring Charter back to the next meeting for approval on 5.28.14.
8. ADJOURN	*Hirsch*		
	6:05PM		
9. UPON ADJOURNMENTOF REGULAR OPEN SESSION	*Hirsch*	Inform	
10. CLOSED SESSION	*Amara*	Action	

AGENDA ITEM	DISCUSSION	ACTION	FOLLOW-UP
11. REPORT OF CLOSED SESSION/ADJOURN	*Hirsch*	Inform	
	6:14PM		

SUBJECT: Quality Committee Charter	
	PAGE 1 OF 6
DEPARTMENT: Board of Directors	EFFECTIVE: 12/1/11
APPROVED BY: Board of Directors (12/1/11)	REVISED: 3/27/13

Purpose:
Consistent with the Mission of the District the Board, with the assistance of its Quality Committee (QC), serves as the steward for overall quality improvement for the District. The QC shall constitute a committee of the District Board of Directors. The Board shall refer all matters brought to it by any party regarding the quality of patient care, patient safety, and patient satisfaction to the QC for review, assessment, and recommended Board action. The QC makes recommendations and reports to the Board. It has no authority to make decisions or take actions on behalf of the District unless the Board specifically delegates such authority.
The QC shall assist the Board in its responsibility to ensure that the Hospital provides high-quality patient care, patient safety, and patient satisfaction. To this end the QC shall:

1. Formulate policy to convey Board expectations and directives for Board action;
2. Make recommendations to the Board among alternative courses of action, including but not limited to physician credentialing, and oversight activities;
3. Provide oversight, monitoring and assessment of key organizational processes, outcomes, and external reports.

Policy:

SCOPE AND APPLICABILITY
This is a SVHCD Board Policy and it specifically applies to the Board, the Quality Committee, the Audit Committee, the Medical Staff, and the CEO of SVH.

RESPONSIBILITY

Physician Credentialing

1. The QC shall ensure that recommendations from the Medical Executive Committee and Medical Staff are in accordance with the standards and requirements of the Medical Staff Bylaws, Rules, and Regulations with regard to: completed applications for initial medical staff and allied health staff appointment; initial staff category assignment, initial department/divisional affiliation; membership prerogatives and initial clinical privileges; completed applications for reappointment of medical staff, staff category; clinical privileges; establishment of categories of allied health professionals permitted to practice at the hospital; the appointment and reappointment of allied health professionals; and privileges granted to allied health professionals.

2. The QC shall, in closed session, on a case by case basis, fully, rigorously, and carefully review the recommendations of the Medical Staff regarding the appointment, reappointment, and privilege delineation of physicians and submit recommendations to the Board for review and action.

Develop Policies

1. The QC shall submit recommendations for action to the Board on draft policies developed by the QC and those developed by the Hospital regarding quality patient care, patient safety, and patient satisfaction.

Oversight

Annual Quality Improvement Plan

1. The QC shall review and analyze findings and recommendations from the CEO resulting from the Hospital's prior year Annual Quality Improvement Plan, including but not limited to a comparison of the plan to actual accomplishments, administrative review, and evaluation activities conducted, findings and actions taken, system or process failures and actions taken to improve safety, both proactively and in response to actual occurrences.

2. The QC shall review the Hospital's Annual Quality Improvement Plan for continuously improving quality, patient safety, and patient satisfaction and submit the analysis with recommendations establishing priorities to the Board for discussion and action. The Hospital's plans should include, but not be limited to, assessing the effectiveness and results of the quality review using metrics and benchmarks, utilization review, performance improvement, implementing and improving electronic medical/health records, professional education, risk management programs, and patient care related activities and policies of the Hospital and/or Medical Staff, as applicable.

Medical Staff Bylaws

1. The QC shall assure that the Medical Staff's Bylaws are reviewed and approved by the Board and are consistent with the District and Hospital Mission, Vision and Values, Board policy, and accreditation standard, prevailing standards of care, and evidence-based practices.

2. The QC shall review the Medical Staff's fulfillment of its responsibilities in accordance with the Medical Staff Bylaws, applicable law and regulation, and accreditation standards and make recommendations to the Board.

Quantitative Quality Measures

1. The QC shall assess and recommend quantitative measures to be used by our Board in assessing the quality of the Medical Staff's and Hospital's services and submit them to the Board for deliberation and action. The recommendations shall include descriptions that show how the organization measures and reports the improvement of patient care, as well as management accountability.

2. The QC shall review all reports by and Hospital responses to accreditation organizations, e.g., Fire Marshals, Environmental Health, State Department of Health Services (DHS), and other external organizations conducting management, programmatic, physical plant audits/assessments/reviews that are directly or indirectly related to the quality of health care delivery in the Hospital (quality patient care, patient safety, and patient satisfaction). Track all uncompleted/open items until remedied/closed by the Hospital, and make recommendations and report to the Board for its action as appropriate. This includes the final OSHPD report on a construction project prior to licensing by DHS, but it does not include on-going OSHPD reviews/inspections/reports while a project is in design or construction. This does not include routine financial audits, unless the audit identifies quality patient care, patient safety, and/or patient satisfaction issues, in which case the Audit Committee shall refer the audit to the QC for its review and recommendations to the Board.

3. The QC shall ensure there is an effective, supportive, and confidential process for anyone (the Medical Staff, other health care professionals; Hospital administration; leaders and staff; patients, and their families and friends; and the public) to bring issues to the QC directly or via the Hospital—as a group, personally or anonymously--in order to promote the reporting of quality and patient safety problems and medical errors, and to protect those who ask questions and report problems.

4. The QC shall review and assess the process for identifying, reporting, and analyzing "adverse patient events" and medical errors. The QC shall develop a process for the QC

to address these quality deficiencies, in the most transparent manner possible, without unnecessarily increasing the District's liability exposure.

5. The QC shall review the assessment of patient needs/satisfaction, and submit this assessment with recommendations to the Board for review and possible action. This may include, but is not limited to CMS Value Based Purchasing information; ~~Press Ganey~~ patient satisfaction surveys; reports and comparisons to other hospitals, state and national standards; and patient and/or family compliments and complaints.

6. The QC shall review and assess the system for resolving interpersonal conflicts among individuals working within the Hospital environment that could adversely affect quality of care, patient safety or patient satisfaction, and make recommendations to the Board.

Hospital Policies

1. The QC shall assure that the Hospital's administrative policies and procedures, including the policies and procedures relative to quality, patient safety and patient satisfaction, are reviewed and approved by the appropriate Hospital leaders, submitted to the Board for action, and are consistent with the District and Hospital Mission, Vision and Values, Board policy, accreditation standards, and prevailing standards of care and evidence-based practices.

Other

1. Perform other duties related to high-quality patient care, patient safety, and patient satisfaction as assigned by the Board.

Annual QC Work Plan

The QC shall develop an Annual QC Work Plan comprised of the required annual activities and additional activities selected by the QC. The Annual QC Work Plan shall be reviewed and acted on by the Board after considering the CEO's work plan to support the QC.

Required Annual Calendar Activities:

1. The QC shall review the adequacy of financial and human resources currently allocated for maintaining high-quality care, patient safety, and patient satisfaction in April, in advance of the annual budget process and provide an assessment to the Board and CEO with recommendations for action.

2. The QC Work Plan shall be submitted to the Board for its review and action no later than December.

3. The QC shall report on the status of its prior year's work plan accomplishments by December.

4. The QC reviews and assesses all Board policies regarding quality specifically including the QC Charter, and makes recommendations to the Board for action in December.

QC Membership and Staff

The QC shall have seven voting members and ~~three~~ four non-voting public member alternates appointed pursuant to Board policy. Pursuant to Health and Safety Code Section 32155, based on the need for Medical Staff quality assessments. Hospital employees who staff the QC are not voting members of the QC. QC membership is:

- Two Board members one of whom shall be the QC chair, the other the vice-chair. Substitutions may be made by the Board chair for Board QC members at any QC meeting--for one or both Board members.

- Two designated positions from the Medical Staff leadership, i.e., the President and the President-Elect. Substitutions may be made by the President for one Medical Staff member at any QC meeting.

- Three members of the public. In addition, substitutions may be made at all QC meetings from ~~three~~ four prioritized non-voting members of the public as alternate public members. Alternates shall attend closed session QC meetings and vote as QC members when substituting for a voting public member. Alternates may attend QC meetings as non- voting alternates and fully participate in the open meeting discussions.

Staff to the QC include the Hospital's Chief Medical Officer (CMO), Chief Nursing Officer (CNO), and the Director of Quality and Resource Management who shall be the lead staff in support of the QC Chair for meetings, documents, and activities. Staff is expected to attend the QC meetings. The CEO may attend all QC and subcommittee meetings and shall be a resource at the QC meetings upon request of the QC Chair.

Frequency of QC Meetings
The QC shall meet monthly, unless there is a need for additional meetings.

Public Participation
All QC meetings shall be announced and conducted pursuant to the Brown Act. Physician Credentialing and Privileges are discussed and action is taken in QC Closed Session without the general public.

The general public, patients and their families and friends, Medical Staff, and Hospital staff are always welcome to attend and provide input. Other Board members may attend but may not comment as it may be a Brown Act violation.

Narrowly focused and short term ad hoc subcommittees may meet to address specific issues that will be brought to the QC for review and referral to the Board for its deliberation and action. Subcommittee meetings are not subject to the Brown Act.

Reference:

POLICY HISTORY
December 1, 2011--Board Policy regarding the QC was first adopted.

FREQUENCY OF REVIEW/REVISION
This shall occur annually or more often if required. If revisions are needed they will be taken to the Board for action.

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POLICY AND PROCEDURE
Approvals Signature Page

Review and Approval Requirements

The SVH departmental/organizational policies and/or procedures on the attached list have been reviewed and approved by the following organizational leaders for meeting all of the following criteria. All of these policies and procedures are:

- Consistent with the Mission, Vision and Values of the Sonoma Valley Health Care District
- Consistent with all Board Policy, Hospital Policy and Hospital Procedures
- Meet all applicable law, regulation, and related accreditation standards
- Consistent with prevailing standards of care
- Consistent with evidence-based practice

We recommend their acceptance by the Quality Committee and that the Quality Committee forward them to the Sonoma Valley Health Care District Board with a recommendation to approve.

Organizational: Multiple (refer to attached Summary Sheet) March List	
APPROVED BY	DATE: **3/31/2014**
Director's/Manager's Signature	Printed Name

Leslie Lovejoy — 5-20-14

Leslie Lovejoy, RN
Chief Nursing Officer, CQO — Date

5/22/14

Robert Cohen, MD
Chief Medical Officer — Date

P Amara, MD — 5/22/14

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: Organizational-**Multiple Departments**
Type: **Revision**

March policies	
Policy	**Notes**
EC-EQP8610-107 Preventive Maintenance	reviewed; additions to reflect the new building and equipment
EC-EQP8610-108 Bio-Medical Safety PM system	Reviewed; changed storage of the documentation and generating reports
EC-EQP8610-109 Expired Testing	reviewed; minor changes in wording
EC-EQP8610-133 Bio-Medical Equipment Phone directory	reviewed; updated to current
EC-EQP8610-146 Patient Owned Electrical Equipment	reviewed; only minor change to the text
EC-EQP8610-147 Extension cords and Adapters	reviewed; minor corrections to text,changed the purpose of policy
EC-SAF8610-128 Construction Contract Stipulation	reviewed; added minor changes
EC-SAF8610-127 Infection control for Construction and Re	delete; now IC8610-142 to current standard
IM8610-100 Notice of Health Information Privacy Practice	reviewed; no changes
IM8610-120 Workforce HIPPA regulations	revised; updated protecting data on personal devices
LD 8610-317 Organ donation After Cardiac Death	reviewed; no changes
LD8610-318 Organ Donation after Brain Death	reviewed; no changes
LD8610-167 Unusual Occurrence report to governmental	reviewed; minor changes re e-notifications
LD8610-179 Sentinel and Adverse Event Reporting	reviewed; minor changes in wording
LD8610-185 Risk Management Policy	reviewed;
LD8612-180 E-Notification System Policy	reviewed; changed from Notification Form Policy
LD8610- Plan for the Provision of patient Care	retire
PC 8610-206 Adult Hypoglycemia	reviewed; no changes
PC8610-107 Use of Restraint Policy	revised; updated to current standards
PC8610-122 Pressure Ulcer & Wound Care Assessment &	reviewed; minor changes
PC8610-200 Patient Elopement	new policy
PCLB 8610-207 Pathology Specimen Handling	reviewed; minor changes
PCLB 8610-209 Chromosome Studies	reviewed; updated to current
PCLB8610-Formalin spill cleanup	reviewed; no changes
PCLB8610-208 Placenta Disposition	reviewed; updated to current standard
RI8610-115 Patient Personal Belongings/Valuables	reviewed; minor changes in wording

Reviewed By:	Date	Approved
Policy & Procedure Team	03/22/2014	Yes
Surgery Committee	4/2/14	yes
Medicine Committee	4/10/14	yes

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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.

Departmental: Intensive Care Unit (ICU)	
APPROVED BY **Mark Kobe, RN**	DATE: **April 2014**
Director's/Manager's Signature Mark Kobe	Printed Name **Mark Kobe, RN Director**

Dennis Verducci, MD
Medical Director of Intensive Care Unit — Date

Robert Cohen, MD
Chief Medical Officer — 5/22/14 Date

Leslie Lovejoy, RN
Chief Nursing Officer, CQO — 5-20-14 Date

Sharon Nevins
Chair, Board of Directors — Date

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Policy Submission Summary Sheet

Intensive Care Department Policy and Procedures

New document or revision written by: Mark Kobe, DON

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

6010-1 Admission Criteria to the ICU: reviewed with minor changes replacing 'paperwork' with EHR
6010-2 Arterial Line Setup: reviewed, minor change of addition of Biopatch to dressing protocol
6010-3 Cardioversion: reviewed no changes
6010-4 Central Venous Pressure Monitoring: reviewed no changes
6010-5 Discharge from the ICU: reviewed no changes
6010-6 Documentation in the ICU; reviewed and revised to include documentation process for EHR
6010-7 Implanted Subcutaneous Ports Access and Management: reviewed no changes
6010-8 Intravenous Management: reviewed no changes
6010-9 Mechanical Ventilation Management: reviewed no changes
6010-10 Oral Care for Mechanically Ventilated Patient: reviewed no changes
6010-11 Percutaneous Central Vascular Access Device: reviewed no changes
6010-12 Physical Assessment of Adult and Pediatric Patients: reviewed no changes
6010-13 Staffing Criteria for 1:1 staffing in the ICU: reviewed, revised to include titration parameters
6010-14 Suctioning Patients in the ICU: reviewed no changes
6010-15 Tracheostomy Care: reviewed no changes
6010-16 Transvenous Pacing: reviewed no changes
6010-17 Ventilator Associated Pneumonia Prevention: reviewed no changes
6010-18 Visitor Policy in the ICU: reviewed, no changes

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POLICIES/PROCEDURES MANUAL
Intensive Care Unit
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4.

INFECTION PREVENTION REPORT

Infection Prevention and Risk Management

Quality Committee Report

May 28, 2014

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

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Introduction

- Where's Courtney and who is the new IP?
- Acknowledgements
- Evaluation of 2013 Infection Control Program
- Infection Prevention and Risk Management- A New Vision of Patient Safety

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2014 Goals

Limit unprotected exposure to pathogens throughout the hospital

- Standard and Transmission based precautions, respiratory hygiene stations in waiting areas, safety and construction rounds

Enhance hand hygiene

- Audit practice to assess current state

Minimize the risk of transmitting infections with the use of IP procedures for medical equipment and medical devices

- Maintain a sanitary environment to avoid sources and transmission of infections and communicable diseases. Address CIHQ findings in Medical Imaging disinfection practices and Surgery (flash sterilization rates).

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

- Performance Improvement Committee

Implement Hospital Acquired Infection (HAI) prevention measures in accordance with SB 739, and SB 1058.

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Comply with the MRSA active surveillance culturing requirements of SB 158 and discontinue use of Contact Isolation for nasal carriage only.

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

Implement a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel including Central Line Associated Bloodstream Infection (CLABSI), Ventilator Associated Events(VAE), Catheter Associated Urinary Tract Infection (CAUTI), Surgical Site Infections (SSI) and reduce the incidence of Multi-drug Resistant Organism (MDRO) in accordance with California Department of Public Health (CDPH), National Health and Safety Network (NHSN), and The Joint Commission (TJC) requirements.

Assess and maintain low rates of device associated infections and C. difficile gastroenteritis in Home Care patients. Optimize hand hygiene and standard precautions in the home setting.

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Central Line-Associated Bloodstream Infection Prevention 'Bundle' Training

1. Hand Hygiene
2. Maximal Barrier Precautions
3. Chlorhexidine skin antisepsis
4. Optimal catheter site selection
5. Daily review of line necessity with prompt removal of unnecessary lines
6. Biopatch (Chlorhexidine disk)
7. Document on CLIP form

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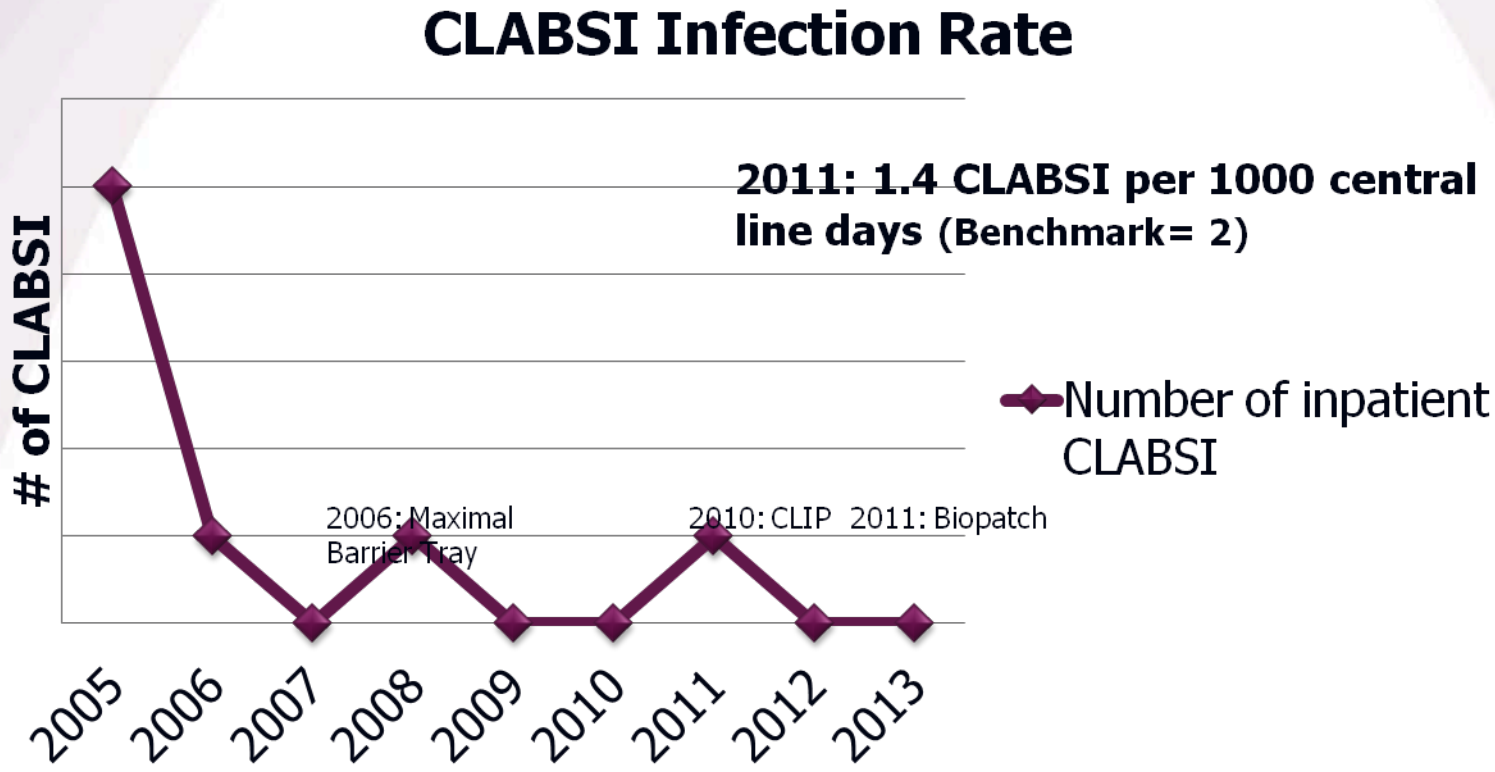
Central Line-Associated Bloodstream Infection Rate



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Training for the Prevention of Catheter-Associated UTIs

Increase in CAUTIs noted in 2013. Education performed in acute and SNF. Back to baseline rate 1st quarter 2014.

1. Use only when medically necessary...NOT for nursing convenience.
2. Remove promptly when no longer necessary
3. Insert with strict aseptic technique
4. Secure catheter to minimize movement of catheter
5. Keep bag below level of bladder at all times but not on floor
6. Maintain good hygiene
6. Disinfect healthcare worker hands before touching the catheter
7. Maintain closed drainage system (minimize irrigations)
8. Remove catheters on Day 2 post op.

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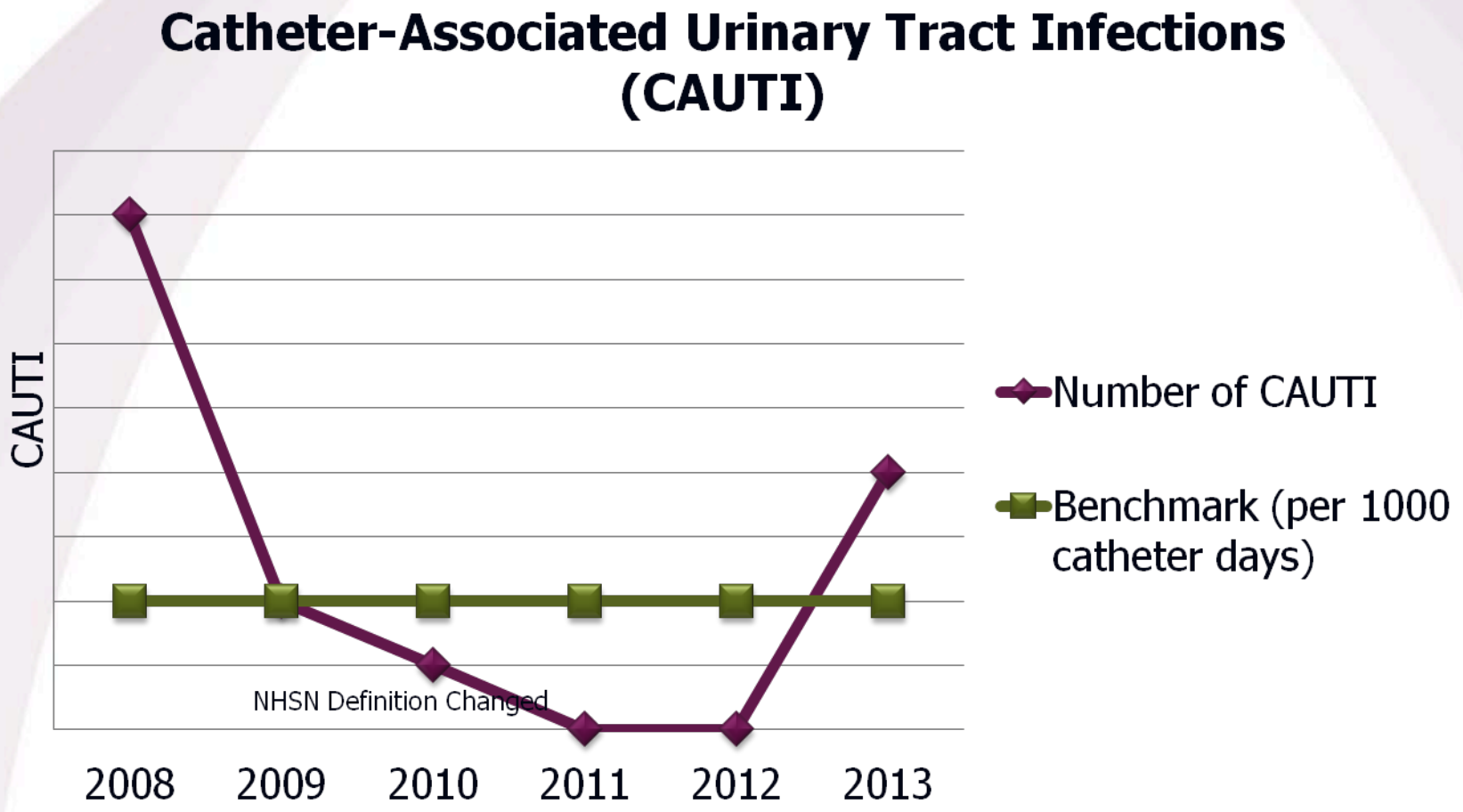
Catheter-Associated Urinary Tract Infections (Acute/SNF)



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Prevention of Surgical Site Infections

1. Appropriate use of pre op antibiotics and timing
2. Appropriate hair removal (clippers not razors)
3. Postoperative normothermia
4. Postoperative glucose control
5. Continue the 2011Total Joint Protocol (CHG wipes/showers and mupirocin in nose)

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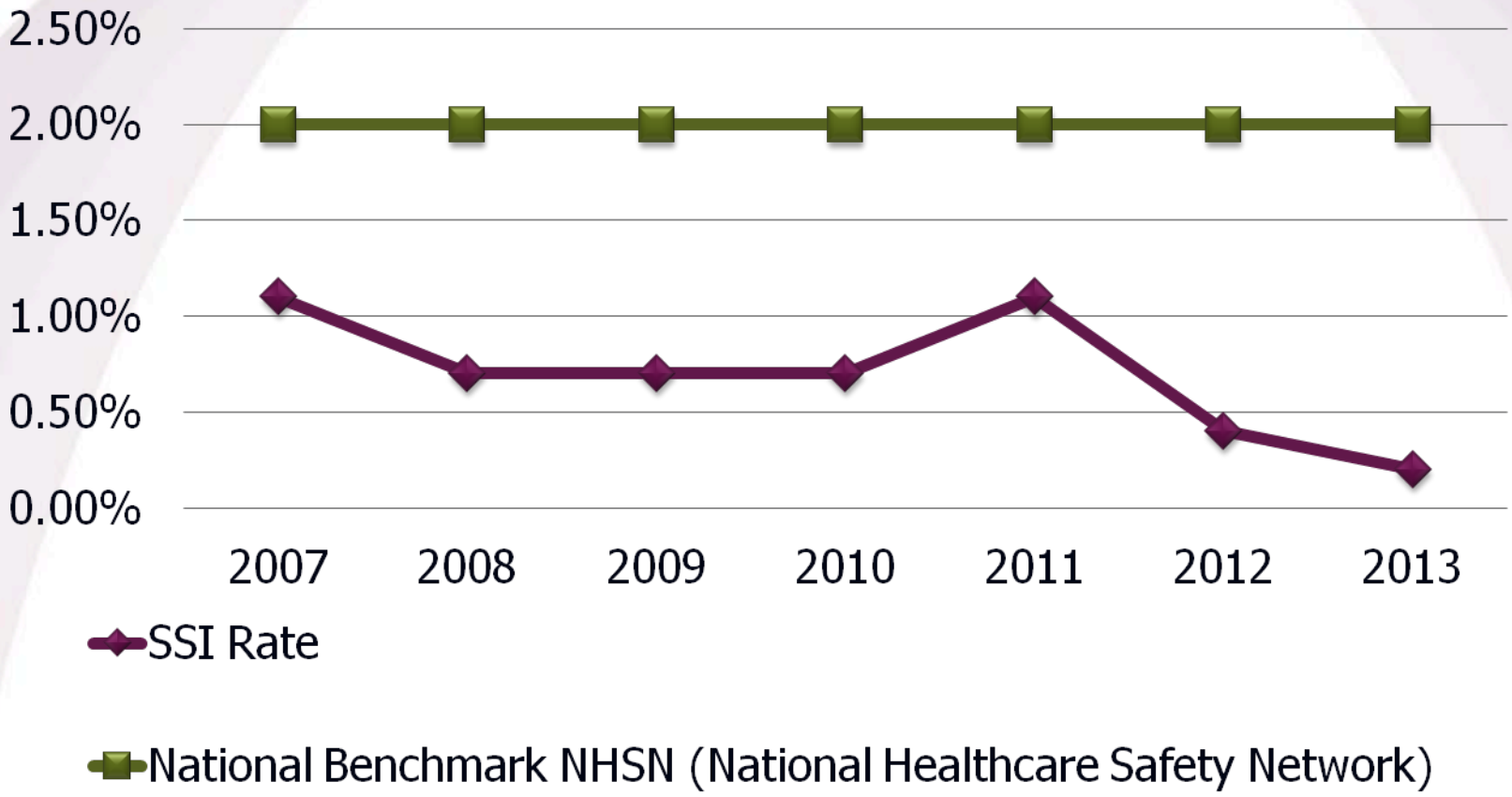
Sonoma Valley Hospital
Surgical Site Infection Rate
(voluntary reporting, coding review, culture review, rounds)



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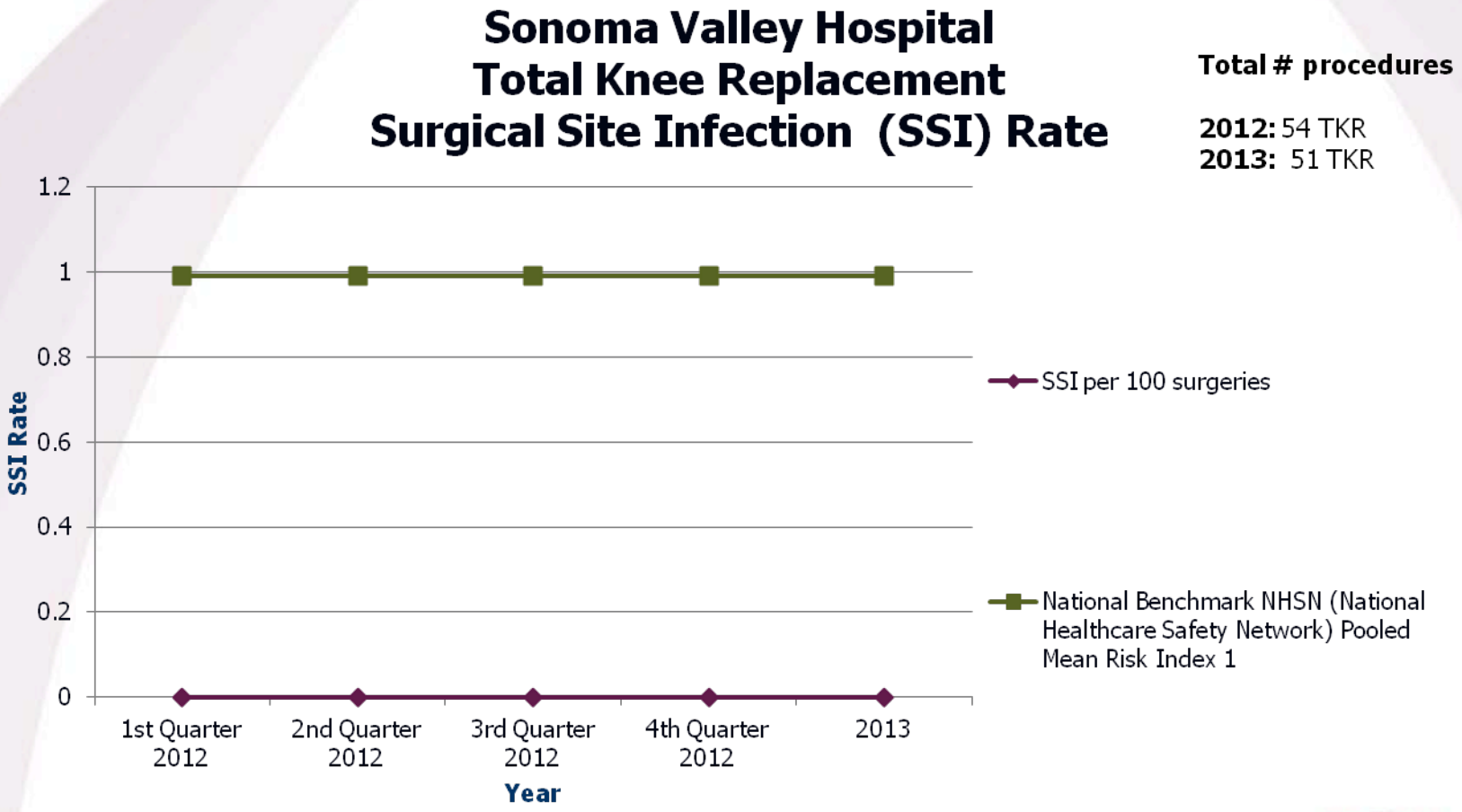
Total Joint Program: Knee



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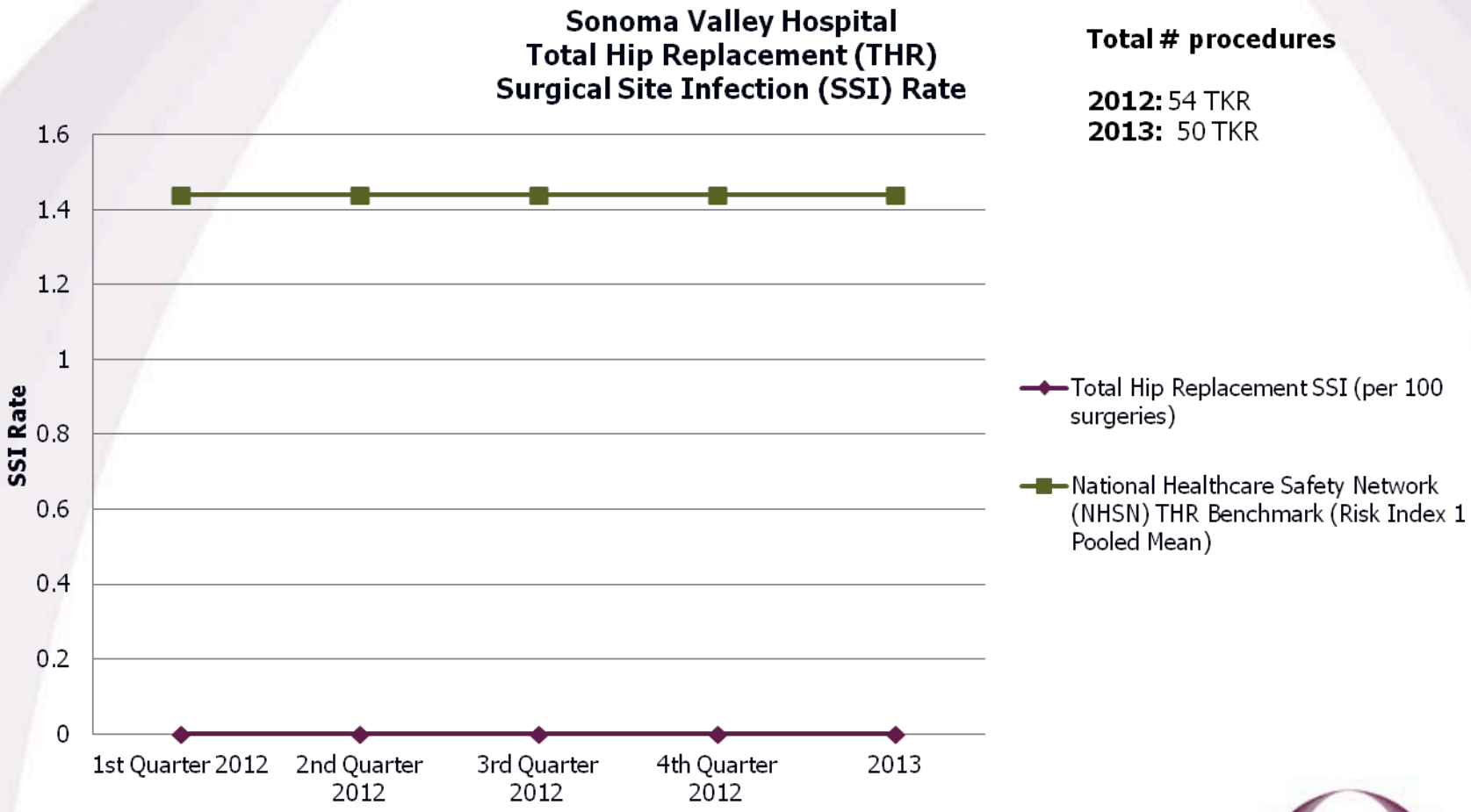
Total Joint Program: Hips



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Multi-Drug Resistant Organisms (MDRO)

- MRSA, VRE, ESBL, **CRE** - spread by contact/touch
- Isolation for MRSA infection but NOT colonization of nasal passages. Reduces cost without compromising safety
- Patient and family education per law
- Antimicrobial Stewardship (increased sensitivities of some microorganisms!)

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Healthcare- Associated (HA) MRSA Infections

Year	MRSA HAI	Source
2013	0	NA
2012	1	SSI (post discharge)
2011	3	SSI (post discharge)
2010	1 1 1 1	SSI (post discharge) Pneumonia (acute) Skin UTI (SNF)
2009	1	UTI (SNF)
2008	2	UTI (SNF)

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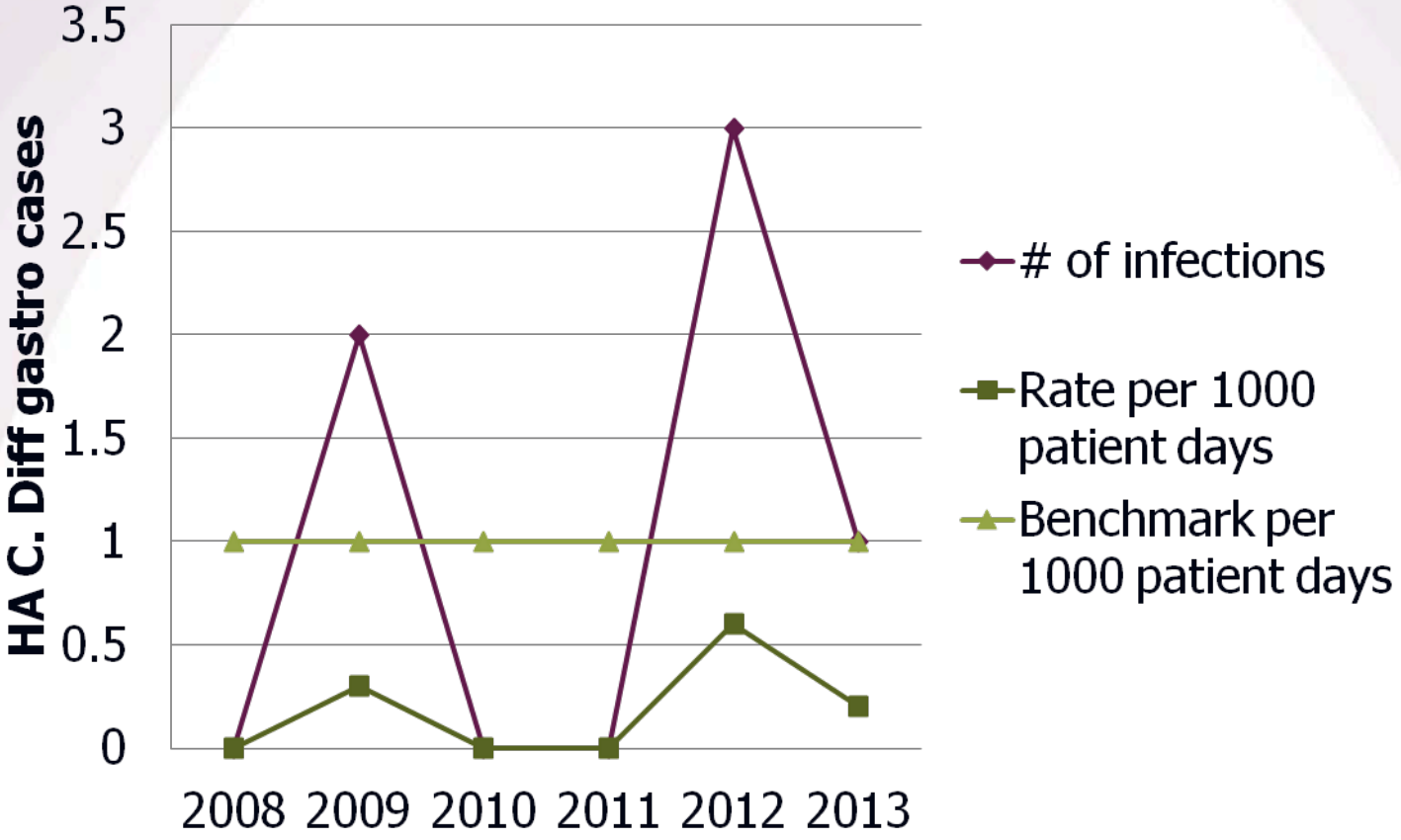
HA: Clostridium difficile
Gastroenteritis: Inpatient



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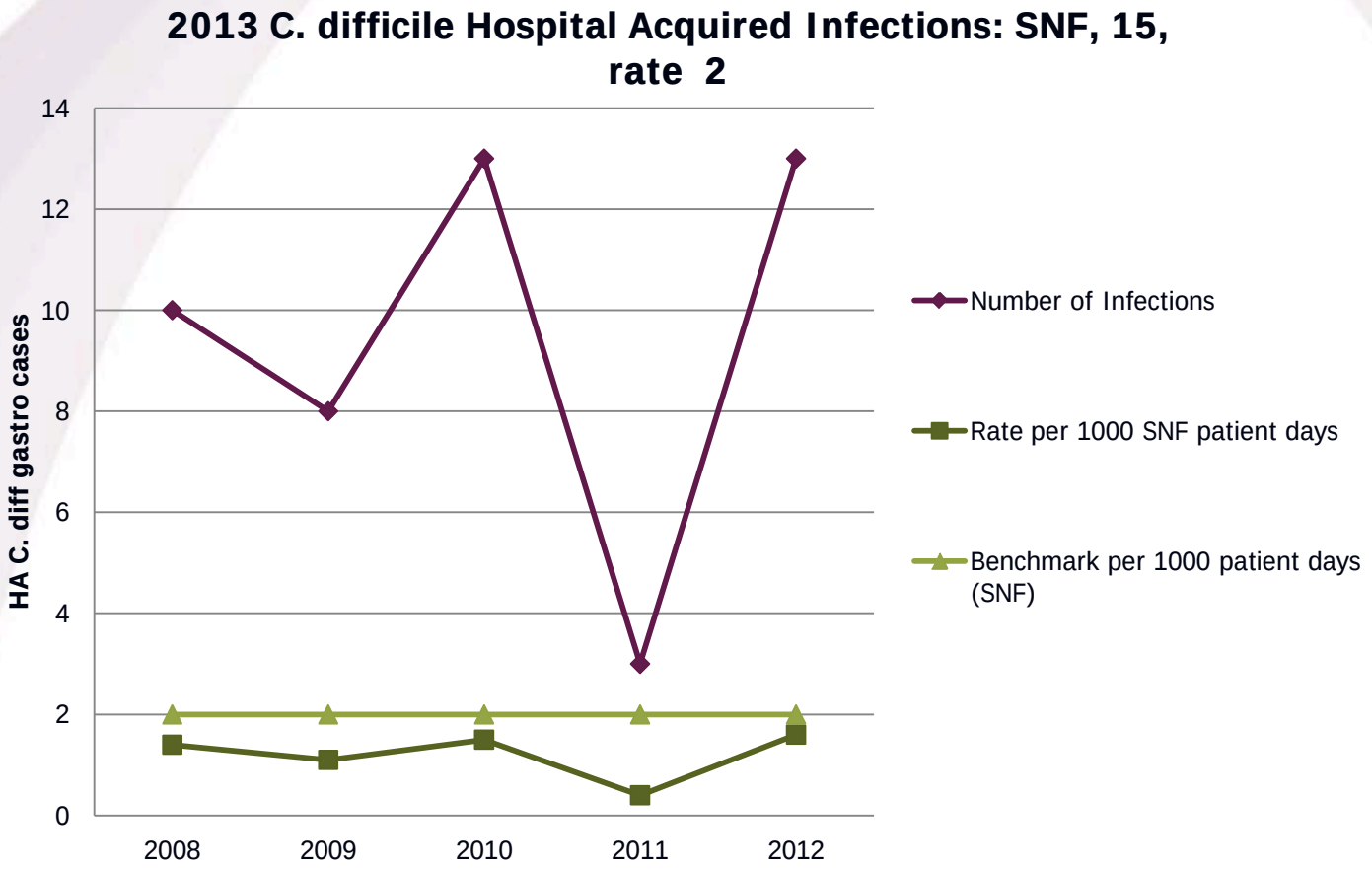
HA: Clostridium difficile
Gastroenteritis: SNF



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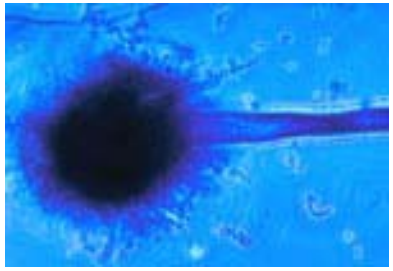
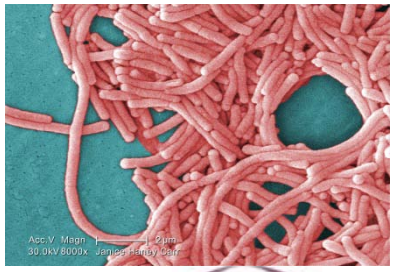
New Wing Construction and Renovations

- Risk assessment and consultation on infection mitigation measures performed on all construction projects to keep patients, staff, and visitors safe



- Fungi: zero Aspergillus cases



- Bacteria: zero Legionella cases

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Antimicrobial Stewardship Program (ASP)

- Weekly ID and antimicrobial review with MDs, IP, Pharmacy, Micro, students.
- Recognition for best practice: AHRQ Innovations Exchange website profile
- 2014 “Spotlight on Antimicrobial Stewardship” CDPH website

- Presented at ID Week October 2012

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Opportunities for Improvement

- Mandatory Influenza Immunization Program
  - Vaccination rate MDs: 28%
  - Vaccination rate clinical staff: 76%
  - Vaccination rate non-clinical staff: 87%
  - Overall rate: 73%
  - Quality GOAL: 90%
  - Reportable to CDPH and Sonoma DPH
  - Action Plan

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Risk Management

- SNF Handoff Process Improvement
- Use of Rapid Response in SNF
- CPOE in SNF to reduce risk of medication errors
- Improve Influenza Vaccination of Healthcare workers with focus on physicians
- Root cause analysis for all incidents of significant risk
- Improved response time for grievances and complaints

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Questions?

For more information or comments contact Kathy at 935-5180

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5.

HCAHPS: Hospital Consumer Assessment of Healthcare Providers and Systems

Patient Experience

HCAHPS: Hospital Consumer Assessment of Healthcare Providers and Systems

Press Ganey

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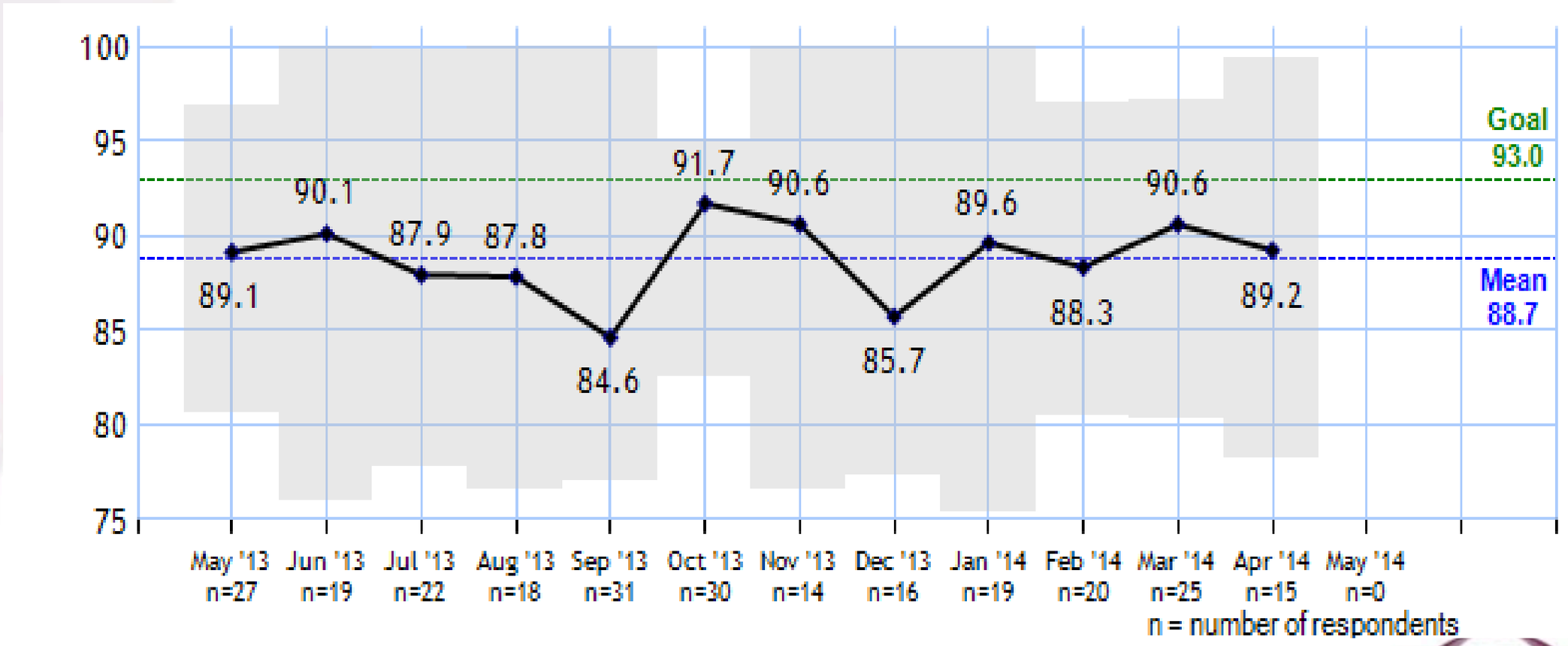
Press Ganey Data

Emergency Department (April 2014 80%tile)



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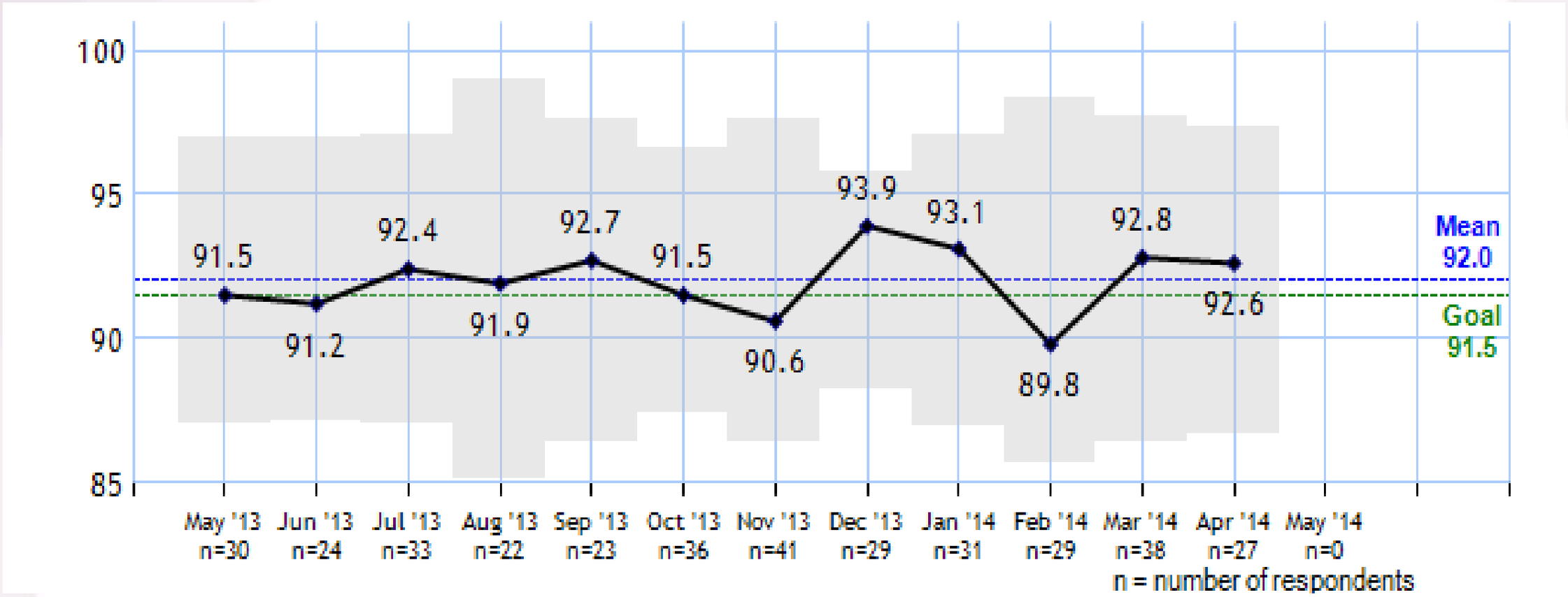
Press Ganey Data

AMBULATORY SURGERY

April: 38th %tile



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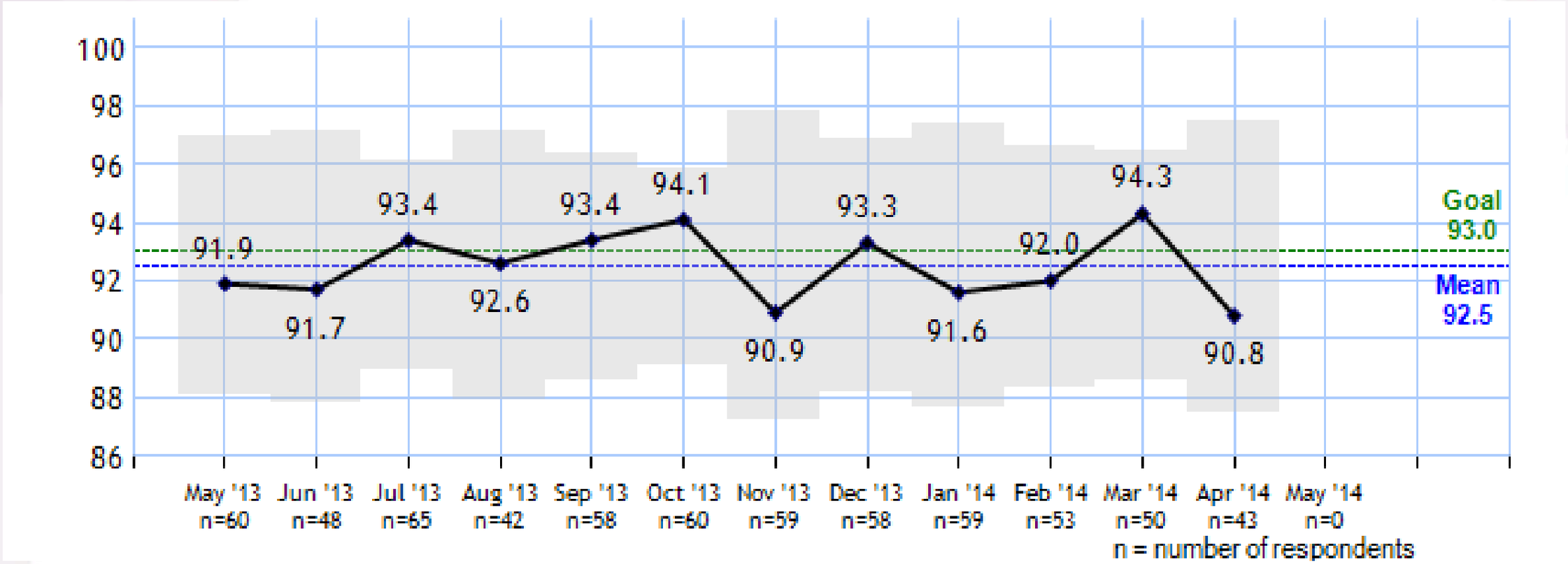
Press Ganey Data

OUTPATIENT SERVICES

April: 10th%tile



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HCAHPS

•2002 CMS partners with AHRQ (Agency for Healthcare Research and Quality) to standardize survey protocol for inpatient services

•2006 HCAHPS survey implemented; to receive full reimbursement, hospitals must collect and submit HCAHPS data

•2010 Patient Protection and Affordable Care Act includes HCAHPS performance in calculation of value-based incentive payments

•Results are posted on *Hospital Compare Web site (*www.hospitalcompare.hhs.gov*)*

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Different Questions

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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Different Answers

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

SAMPLE

VISITORS AND FAMILY	very poor 1	poor 2	fair 3	good 4	very good 5
1. Accommodations and comfort for visitors	O	O	O	O	O
2. Staff attitude toward your visitors	O	O	O	O	O

Comments (describe good or bad experience): _____

PHYSICIAN	very poor	poor	fair	good	very good
1. Time physician spent with you	O	O	O	O	O
2. Physician's concern for your questions and worries	O	O	O	O	O
3. How well physician kept you informed	O	O	O	O	O
4. Friendliness/courtesy of physician	O	O	O	O	O
5. Skill of physician	O	O	O	O	O

Comments (describe good or bad experience): _____

DISCHARGE	very poor	poor	fair	good	very good
1. Extent to which you felt ready to be discharged	O	O	O	O	O
2. Speed of discharge process after you were told you could go home	O	O	O	O	O
3. Instructions given about how to care for yourself at home	O	O	O	O	O

Comments (describe good or bad experience): _____

PERSONAL ISSUES	very poor	poor	fair	good	very good
1. Staff concern for your privacy	O	O	O	O	O
2. How well your pain was controlled	O	O	O	O	O
3. Degree to which hospital staff addressed your emotional needs	O	O	O	O	O
4. Response to concerns/complaints made during your stay	O	O	O	O	O
5. Staff effort to include you in decisions about your treatment	O	O	O	O	O

Comments (describe good or bad experience): _____

OVERALL ASSESSMENT	very poor	poor	fair	good	very good
1. How well staff worked together to care for you	O	O	O	O	O
2. Likelihood of your recommending this hospital to others	O	O	O	O	O
3. Overall rating of care given at hospital	O	O	O	O	O

Comments (describe good or bad experience): _____

Patient's Name: _____ *(optional)* Telephone Number: _____ *(optional)*

THANK YOU. Please return the completed survey in the postage-paid envelope.

123456789-1
Precode 1
Precode 2
Precode 3

PRESS GANEY®

123456789

SAMPLE

Sonoma Valley Hospital
SONOMA VALLEY HEALTH CARE DISTRICT

OMB Control Number: 0938-0981

SURVEY INSTRUCTIONS: You should only fill out this survey if you were the patient during the hospital stay named in the cover letter. Do not fill out this survey if you were not the patient. Answer all the questions by completely filling in the circle to the left of your answer. You are sometimes told to skip over some questions in this survey. When this happens you will see an arrow with a note that tells you what question to answer next, like this: O Yes
● No → **If No, Go to Question 1**

Please answer the questions in this survey about your stay at Sonoma Valley Hospital. Do not include any other hospital stays in your answers.

Please use black or blue ink to fill in the circle completely.
Example: ●

YOUR CARE FROM NURSES

1. During this hospital stay, how often did nurses treat you with courtesy and respect?
   O Never
   O Sometimes
   O Usually
   O Always
2. During this hospital stay, how often did nurses listen carefully to you?
   O Never
   O Sometimes
   O Usually
   O Always
3. During this hospital stay, how often did nurses explain things in a way you could understand?
   O Never
   O Sometimes
   O Usually
   O Always
4. During this hospital stay, after you pressed the call button, how often did you get help as soon as you wanted it?
   O Never
   O Sometimes
   O Usually
   O Always
   O I never pressed the call button

YOUR CARE FROM DOCTORS

5. During this hospital stay, how often did doctors treat you with courtesy and respect?
   O Never
   O Sometimes
   O Usually
   O Always
6. During this hospital stay, how often did doctors listen carefully to you?
   O Never
   O Sometimes
   O Usually
   O Always
7. During this hospital stay, how often did doctors explain things in a way you could understand?
   O Never
   O Sometimes
   O Usually
   O Always

THE HOSPITAL ENVIRONMENT

8. During this hospital stay, how often were your room and bathroom kept clean?
   O Never
   O Sometimes
   O Usually
   O Always
9. During this hospital stay, how often was the area around your room quiet at night?
   O Never
   O Sometimes
   O Usually
   O Always

YOUR EXPERIENCES IN THIS HOSPITAL

10. During this hospital stay, did you need help from nurses or other hospital staff in getting to the bathroom or in using a bedpan?
    O Yes
    O No → **If No, Go to Question 12**
11. How often did you get help in getting to the bathroom or in using a bedpan as soon as you wanted?
    O Never
    O Sometimes
    O Usually
    O Always
12. During this hospital stay, did you need medicine for pain?
    O Yes
    O No → **If No, Go to Question 15**
13. During this hospital stay, how often was your pain well controlled?
    O Never
    O Sometimes
    O Usually
    O Always
14. During this hospital stay, how often did the hospital staff do everything they could to help you with your pain?
    O Never
    O Sometimes
    O Usually
    O Always

(continued...)

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HCAHPS Domains

- Hospital Environment: Clean and Quiet

- MD communication: Doctors always communicated well
- RN communication: Nurses always communicated well

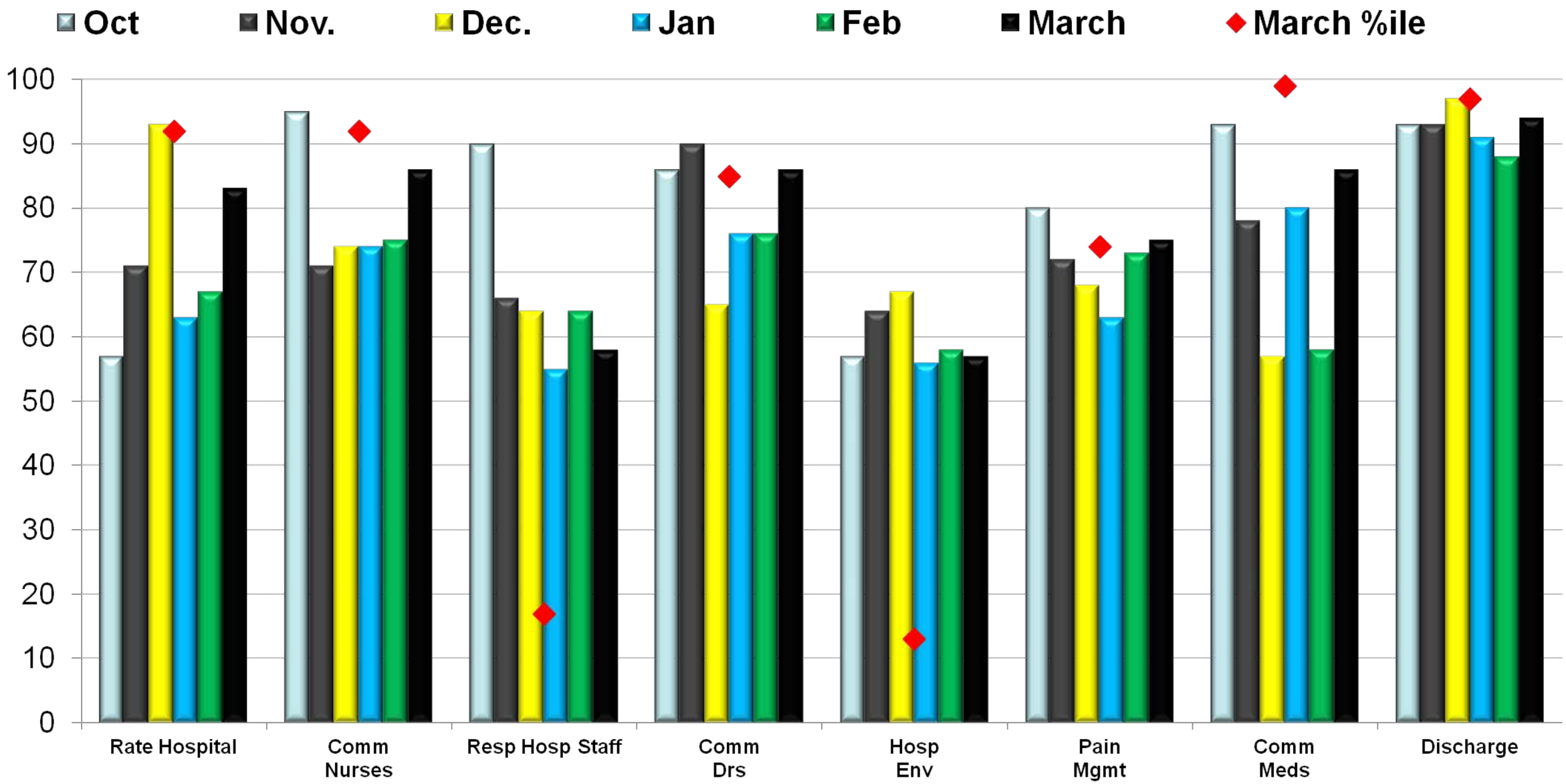
- Responsive Staff: Patients always received help as soon as they wanted
- Pain Management : Pain was always controlled

- Communication about medicines: Staff always explained about medicines before giving
- Prepared for Discharge: Patients were given information about what to do in recovery

- Hospital Rating: Patients who gave a rating of 9 or 10/overall rating of care

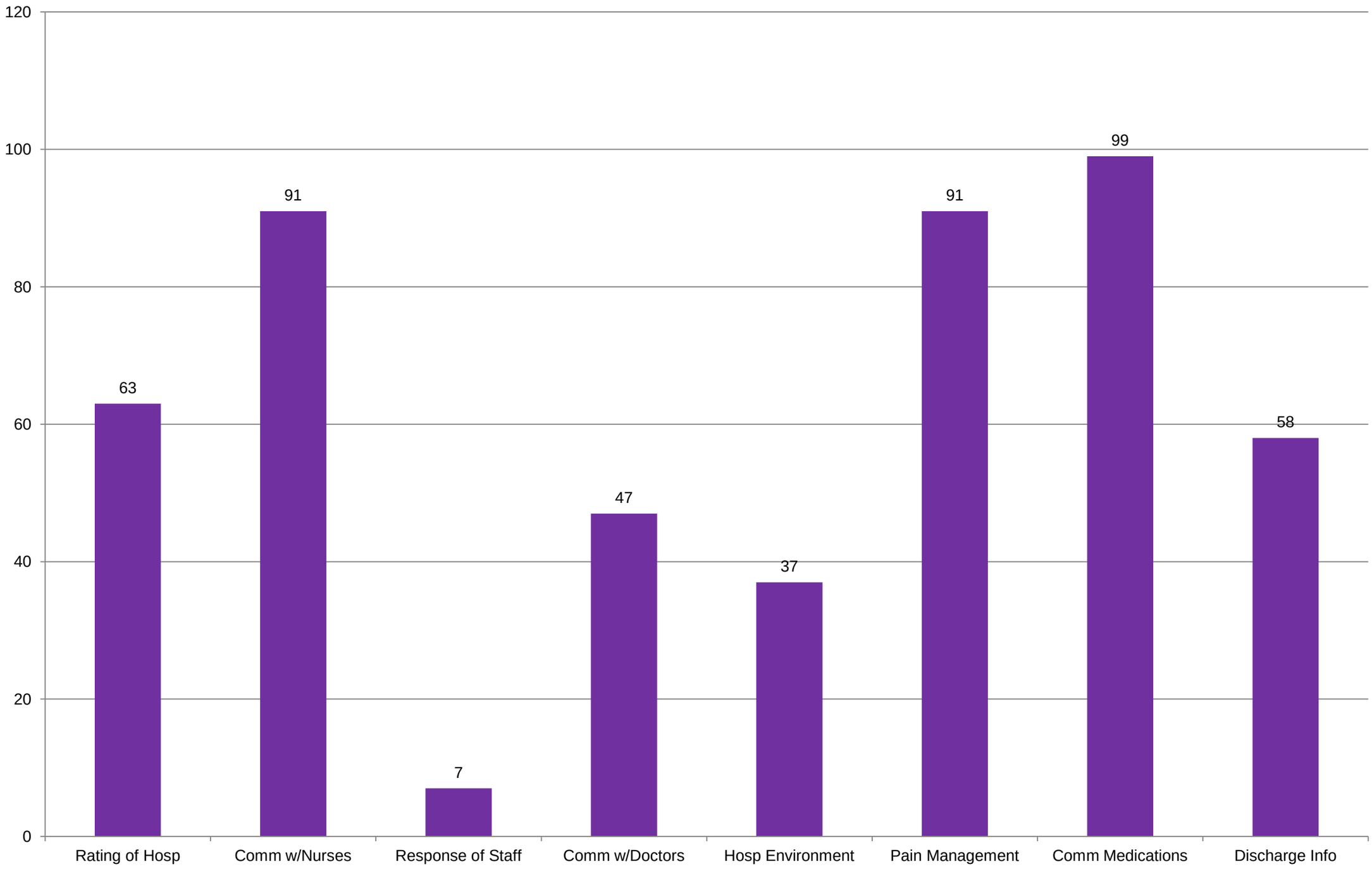
Sonoma HCAHPS

Data extracted 4/11/14



SONOMA HCAHPS

April 2014 (percentile ranking)



National Research Corporation (NRC); Leaving Press Ganey Behind

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Questions?

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6.

QUALITY AND RESOURCE MANAGEMENT REPORT

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
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To: Sonoma Valley Healthcare District Board Quality Committee
From: Leslie Lovejoy
Date: 05/28/2014
Subject: Quality and Resource Management Report

April Priorities:

1. Office of Civil Rights Response Follow-up
2. CIHQ Survey Action Plans
3. Review of Budget For Quality and Resource Management FY 2015
4. Adverse Event Policy and Procedure

1. Office of Civil Rights Response Follow-up (at request of Kevin Carruth)

Background: On April 17, 2013, SVH learned that an employee had inadvertently uploaded the personal information of surgery patients to the hospital website (www.svh.com) on February 14, 2013. This occurred when the employee inadvertently uploaded an excel spreadsheet containing this information as part of a routine website update using software called WordPress. The inadvertent upload was not discovered until April 17, 2013 because the information was placed in a section of the website that was not directly accessible through the website, but only accessible through an Internet search using a search engine. Upon discovery, the file was immediately removed and SVH began an investigation of the cause. The employee involved with the incident also had job duties related to creating Operation Room reports. SVH's investigation found that the electronic folder the employee used to store photos, meeting/agenda/minutes and brochure content for website updates was closely located to another electronic folder containing reports including patient information. SVH's investigation confirmed that the incident affected patients admitted to the hospital for surgery during the period July 1, 2011 to June 30, 2012. The patient information was accessible on the hospital website only if an applicable search was undertaken with a search engine from February 14, 2013 to April 17, 2013. Patient information inadvertently posted was limited to patient name, date of service, procedure, surgeon, hospital charges and name of insurance company. No other information such as Social Security number, date of birth, driver's license or address was affected.

On April 30, 2013, SVH began notifying patients whose information had been inadvertently uploaded and accessible on its website if an applicable search was undertaken using a search engine via United States Postal Service Certified Mail with Return Receipt. SVH consulted with a California Department of Health Licensing and Certification reviewer regarding the notification letter sent to affected patients. A total of 1,386 individuals were notified regarding the incident. SVH also provided a dedicated telephone number and e-mail address for affected individuals to ask any questions.

A class action lawsuit was filed first against the Hospital Foundation, dismissed and then finally filed against the hospital. This case will be heard in court in June and we believe that it will be dismissed as there is precedence in another case just recently closed in favor of the hospital involved. The second effort involves a detailed response to the Federal Office of Civil Rights which was filed on April 28th.

Potential Exposure: Maximum penalties from both the OCR and Civil Suit could be as high as $1K per violation for a total of 1.4 million dollars. ($1K per individual). The hospital has insurance that distinctly covers "cyber privacy breaches". After a $50K deductable paid out by the hospital, the insurance covers up to $2.2 million in penalties and civil litigation. The insurance company is currently working with two teams of attorneys: one for the civil case and the other to present the OCR response.

Precautions Implemented: In order to prevent a similar event, the following actions have been taken.

1. SVH has implemented a new policy and procedure for use of WordPress designed to prevent a similar incident from happening again.

2. Immediately following the incident, SVH management reformatted the single PC on which WordPress is operated to mitigate the risk that any patient information may be inadvertently uploaded to WordPress again.

3. The employee associated with the incident, SVH has sanctioned the employee per SVH policy.

4. The employee has also been re-educated regarding policies and procedures for safeguarding of patient information, including education on accessing patient data and report generation, and the secure use of WordPress.

5. Policies and procedures re: Administrative/physical/technical safeguards policies and procedures to protect PHI from impermissible use/disclosure were reviewed, revised and changes were communicated to employees.

6. The hospital completes an Annual Risk Analysis to identify potential compliance issues and develops plans for mitigation of any risks identified. CIHQ provided the hospital with a more rigorous template which has been adopted in 2014.

2. CIHQ Survey Action Plans: We were successfully accredited by this organization in April and the final action plans were accepted on May 9, 2015. We received our accreditation letter this week and I have sent on to California Department of Health Services for review. The following is a synopsis of the cited deficiencies.

Citation	***Action Plan***	***Monitoring***	***Responsible Person(s)***
Medical Staff Bylaws: wording (from "of" to "after") change for H&Ps	Change by-laws to update language for H&P requirements	MEC approval 5/15 Board acceptance 6/5	CMO/President Medical Staff
Appointment or Reappointment to the Medical Staff: lack of primary source verification and out of expired information	Moving CVO function in-house and building an infrastructure to ensure compliance at all times	Monthly monitoring of all reappointments and initial appointments. Monthly pending expirations reports and tracking	CQO/ MS Coordinator
Granting of Clinical Privileges: oversight of the	Chief of anesthesia will review all ED physicians at initial and	Review of all EDMD initial and	MS Coordinator

provision of "deep sedation" in the ED	reappointment for evidence of competency for providing deep sedation	reappointments for proof of competency	
Provision of a Safe Environment: adequate functioning of a med/surg eyewash station; too much lint in dryer outlet and contradictory labeling on a medical gas shut off valve	Monthly cleaning and verification of functioning of all eyewash stations; weekly lint trap cleaning; and updated signage for medical gas shut off valve.	Weekly rounds and monthly quality monitoring	Facilities Director/ EVS Manager
Providing a Secure Environment: not all OB staff have documented competency in their role in a Code Pink.	Training provided to new OB staff and documented in the HR files.	Competency added to unit orientation checklist. 100% compliance monitoring.	Director, OB
Compliance to the NFPA Life Safety Code: blockage of electrical panels, gift shop propping fire door, oxygen cylinder storage	Training provided to departments. Cardiopulmonary develop plan for storage and checking for compliance.	Weekly Engineering and RT rounds.	Facilities Director, Cardiopulmonary Manager
Inspection & Testing of Life Safety Systems: smoke detector shutdown valves in air handlers failed	Vendor report was inaccurate. New vendor contracted. Replacement of faulty valves.	Completion of replacement. New Contract in place. Compliant bi annual inspection	Facilities Director
Disinfection & Sterilization Practices: disinfection of transvaginal probes in Medical imaging and the use of flash sterilization for surgical instruments	Medical Imaging revamped their process to bring it into compliance. Surgical Services identified a list of the most often "flashed" instruments and have ordered additional sets.	Monthly monitoring Reduction of flash sterilization	Ancillary Services Director, Director Perioperative Services
Informing Patients of Their Rights: provision of the Important Message from Medicare within 2 days of discharge	Admissions developed process to capture information regarding potential discharge in order to meet the 2 day deadline. The registration clerk will present to the patient the "Patient Information Guide" and advise the patient that contained in this guide is important information regarding the patient's rights and responsibilities. Registration clerks were educated individually and for staff not present at the time of their next shift Our Conditions of Admissions is in the process of being updated with a place to note that we have given the patient their rights and responsibilities.	Weekly quality monitoring for compliance	Admission Manager
Notification of Hospitalization: no documentation the we met patient's wish for the hospital to notify their primary physician	Admission Manager has instituted the CIHQ template form; staff have been educated. In addition, hospitalist are expected to cc the primary care physician when they dictate the H & P.	Monthly quality monitoring	Admission Manager/CMO

Participation in Care Planning: documentation of a patient/family discussion of DNR status	SVH deployed phys doc 4/11/14 review of IP eH&P template found that it did not include required field for pt discussion of code status. By 05/02/14 the eH&P template will be modified to include mandatory element for pt discussion of code status.	Monthly quality monitoring	CMO
Storage of Medications: normal saline bags found in contrast warmer in Radiology unlabeled	Bags removed; staff educated regarding the storage of IV fluid and labeling	Monthly quality monitoring	Ancillary Services Director
Use of Unsafe Abbreviations: trailing zeros on Vancomycin orders	A software issue as part of the electronic medical record was fixed to delete this issue.	Pharmacy to review order sets to ensure compliance.	CIO/Director, Pharmacy
Medication Orders: multiple PRN orders for pain medication without direction to nurse	Review all order sets that include pain medication to ensure the nurse does not need to choose which to give for PRNs	Pharmacy to review all medication order sets to ensure compliance	CMIO/Director, Pharmacy
Minimum Content of the Medical Record: update to H7P prior to surgery did not include that the patient was examined	OB and Surgical Services updated their date stamp to include this statement.	Monthly record review to ensure compliance	Directors, OB and Surgical Services
Initial Order for Restraint / Seclusion: MD order not implemented within an hour of applying soft wrist restraints	Policy & procedure reviewed; staff educated and competencies completed in skills Fair.	100% monitoring of all restraint documentation for compliance	Nurse Leaders
Renewal of Orders for Restraint / Seclusion: failure to review and obtain a continuation order within 24 hours	Policy & procedure reviewed; staff educated and competencies completed in skills Fair.	100% monitoring of all restraint documentation for compliance	Nurse Leaders
Tissue Management: failure to provide updated FDA licenses and state certificates	We had them but were not able to locate them. Process put into place to ensure that certificates and licenses are kept with tissue log. Assigned responsibility to coordinator to ensure compliance	Monthly quality monitoring	Director, Perioperative Services
Provision of Anesthesia: pre-anesthesia and post anesthesia evaluation documentation did not meet all required elements	Developed up dated anesthesia documentation forms that meet all required elements.	Monthly quality monitoring	Anesthesia Chief and Director, Perioperative Service
Delivery of Nursing Care; care plans did not address patient care needs in Med/Surg and OB even though the nursing documentation showed that care needs were met.	Reviewed findings with nursing staff and provided education in care planning	Monthly quality monitoring	Director, Med/Surg and OB
Preventing Wrong Patient / Wrong Site Procedures:	A software issue as part of the electronic medical record was fixed	Monthly quality monitoring	CIO/Director. Perioperative

pre-population of data elements not applicable to the patient being cared for	to delete this issue.		Services
Policies Governing the Performance of Operative and Invasive Procedures: software for documenting fire precautions taken does not allow all options for nurse to document.	A software issue as part of the electronic medical record was fixed to delete this issue. Vendor will conduct in-service by June 30, 2014 for surgical services team to address fire prevention with use of chloroprep.	Monthly quality monitoring	CIO/Director. Perioperative Services

3. Quality Department Budget Analysis: The Chief Quality Officer, along with the Senior Team, identified the Performance Improvement Activities for the 2015-2014 year, using accepted criteria, and determined that the organization has the resources and financial ability to sponsor four organization-wide PI projects. In addition, an analysis of the Quality and Resource Management Department functions identified additional functions as well as a number of efficiencies. The department is organized along four functional roles: (a)data abstraction, reporting and analysis for quality, infection control, risk management, utilization review, case management, clinical informatics and medical staff; (b) care coordination across the continuum and the building of strong community agency relationships to promote community health and reduce readmissions; (c) support, consultation, and education to hospital leadership in the area of continuous performance improvement and survey readiness; and (d) the development of data interfaces that assist the organization in using meaningful data to support decision making. In 2015 we will see the expansion of the department's role in credentialing and the use of physician specific data for reappointment. In addition, we will also be rolling out a Statistical Process Control software that will provide leaders with the tool to make decisions regarding data that is generated. In collaboration with the Cost Accounting System, this will provide more confidence as we move through the next few years of healthcare reform.
That being said, the budget set for FY 2015 will meet the needs of the department to fulfill its goals and maintain the high level of customer service that the department is known for. I have made some adjustments in staffing to reflect the decreased inpatient census; made a good decision to change patient satisfaction vendors; reduced the hours of the Behavioral Health Consultant; brought the credentialing process in-house; and changed our accreditation vendor. The department team was consulted and agrees to the plan for the coming fiscal year.

4. Adverse Event Policy and Procedure: This policy comes back to the Quality Committee for review of the role of the Board in this process. Attached please find the policy for your review.

Topics for discussion: 2013 Annual Infection Control Program Review and The Experience of Care Presentation

SUBJECT: Adverse Event Reporting	POLICY # LD8610-179 PAGE 1 OF 6
DEPARTMENT: Organizational	EFFECTIVE: 11/97
APPROVED BY: CQO	REVIEW/REVISED: 3/04 6/06,3/07,9/07,4/08, 2/10,3/11, 3/14

Purpose:
The purpose of the Adverse Event Reporting policy and procedure is to describe Sonoma Valley Hospital's mechanism to identify, respond to, and report adverse events that occur in the organization. This is an organization-wide policy and applies to all care settings.

The President and CEO, Senior Management and Leadership are accountable to plan, design, implement, and evaluate the process for adverse event reporting. Responsibility is delegated to all physicians, hospital staff and the Risk Manager to participate in identification, reporting and correcting problems specific to potential or identified adverse events.

DEFINITIONS

1. Adverse Event
An adverse event is defined as an unexpected occurrence involving death or serious physical injury, or has risk thereof to patients, personnel, or visitors. Sonoma Valley Hospital's Sentinel and Adverse Event Reporting Policy and Procedure is consistent with the California Health Services Department's Adverse Event Reporting Requirement (appropriate to the care and services provided by Sonoma Valley Hospital).

Serious Injury/Disability
"Serious injury/disability" is described as a physical or mental impairment that limits one or more of the major life activities of an individual, or the loss of bodily function (if the impairment or loss lasts more than 7 days or is still present at the time of discharge from an inpatient health care facility) or the loss of a body part. It usually results in a transfer to a higher level of care, extends hospital stay and/or requires additional medical treatment.

Risk Thereof
For purposes of this policy, the "risk thereof" is defined as an event that did not result in death or serious disability/injury, but carries a significant chance of recurring—the recurrence of which may have a more untoward outcome—often referred to as a "near miss". To determine the risk of event recurrence, the following guidelines should be used:

- Processes involved in the event that are not well defined or standardized across the organization are more likely to result in recurrence.
- Processes that cross multiple disciplines and department lines and involve multiple steps in the process are more likely to result in recurrence of the event.

- Processes that demonstrate significant variation (ie, lack of stability) are more likely to result in the recurrence of the event.

Examples of occurrences that would meet the definition of an adverse event include the following:

A. Surgical Events:
   1. Procedures on the wrong patient, wrong side of the body, wrong organ or body part.
   2. Unintended retention of a foreign object after surgery or other procedure.
   3. Unexpected death during surgery or within 24 hours of anesthesia begins.

B. Product/Device Events:
   1. Death/serious disability associated with use of contaminated drug device/biologic
   2. Death/serious disability associated with use/function in ways other than intended.
   3. Death/serious disability associated with intravascular air embolism

C. Patient Protection Events:
   1. Infant discharged to wrong person/family
   2. Death/serious disability associated with patient disappearance/elopement for more than 4 hours (excluding adults with capacity)
   3. Death/serious disability due to patient suicide or attempted suicide up to 72 hours from discharge

D. Care Management Events:
   1. Unanticipated death or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition.
   2. Death/serious disability associated with a health care associated infection
   3. Death/serious disability associated with a medication error
   4. Hemolytic transfusion reaction involving administration of blood products having major blood group incompatibilities.
   5. Death/serious disability related to hypoglycemia, onset in hospital
   6. Maternal death/serious disability associated with labor or delivery in low-risk pregnancy
   7. Perinatal death unrelated to congenital condition in infant with birth weight greater than 2,500 grams.
   8. Death/serious disability associated with failure to identify and treat neonatal hyperbilirubinemia(bilirubin >30 milligrams/deciliter) during first 28 days of life
   9. Stage 3 or 4 ulcer acquired after admission (unless progression to Stage 3 was from a Stage 2 identified at admission)
   10. Death/serious disability from spinal manipulation at hospital

11. Prolonged fluoroscopy with cumulative dose >1500 rads to a single field, or any delivery of radiotherapy to the wrong body region or >25% above the planned radiotherapy.
12. Patient death or major permanent loss of function associated with a delay in treatment.

E. Environmental Events:
1. Death/serious disability associated with electric shock (excluding planned treatments)
2. Any incident where line designated for oxygen or other gas contains wrong gas or is contaminated by toxic substance
3. Death/serious disability associated with burn in facility
4. Death associated with fall in facility
5. Death/serious disability associated with restraints/bedrails

F. Criminal Events:
1. Care ordered or provided by someone impersonating a licensed health care provider
2. Abduction of patient, any age
3. Sexual assault of patient
4. Death or significant injury of patient or staff resulting from physical assault

2. Major Permanent Loss of Function

This condition represents a sensory, motor, physiological, or intellectual impairment, not present upon entry into the care setting, which requires continued and ongoing treatment or life-style change.

3. Root Cause Analysis

A root cause analysis is defined as a documented process that seeks to identify the basic and causal factor(s) that underlie variation in performance, including the occurrence or possible occurrence of an adverse event. A root cause is that most fundamental reason a problem—a situation that does not meet expectation—has occurred.

A root cause analysis is considered thorough if it includes the following:

- Determines human and other factors most directly associated with the sentinel/adverse event, and the process(es) and systems related to its occurrence;
- Analyzes underlying systems and processes through a series of “Why?” questions to determine where redesign might reduce risk;
- Identifies risk points and their potential contributions to this type of event;
- Determines potential improvement in processes or systems that would likely decrease such events in the future, or determine, after analysis, that there were no opportunities for improvement; and

- Addresses the minimum scope of analysis required for specific types of adverse events as outlined in the Root Cause Analysis Matrix. (See Appendix.)

A root cause analysis is considered credible if the following can be demonstrated:
- Leadership and individuals (most closely involved in the processes and systems under review) participates.
- Is congruent—it does not contradict itself or leave obvious questions unanswered.
- Explains reason for a finding in which "no problem" was identified, or investigates process or system that was determined to be "non-applicable" to the analysis.
- Considers relevant literature.

4. Action Plan

The action plan is a product of the root cause analysis that defines the strategies that an organization intends to implement to reduce the risk of similar events occurring in the future. An appropriate action plan should demonstrate the following:
- Identifies changes that can be implemented to reduce risk, or states reason for no change.
- Addresses responsibility for implementation, oversight, pilot testing as appropriate, timelines, and strategies for measuring the effectiveness of the actions.

Procedure:

1. First Response to Known or Potential Adverse Event

Chief Nursing Officer, Director of Nursing/Manager or Designee on duty will
a) Assure that immediate needs related to the potential or known Sentinel/Adverse Event are appropriately addressed (ie, render treatment, notify and discuss event with physician, other health team members, sequester medications, equipment, accessories, and supplies, provide family/significant other support, direct and support staff, etc.).
b) Report event to senior management representative.
c) Direct staff to complete and submit E-Notification Report

2. Identify Adverse Event

Once notified, the senior management representative or designee on duty will perform or direct an initial investigation to determine if the occurrence is indeed a sentinel/adverse event as defined by this policy. *The Adverse Event Investigation and Determination Tool* may be used in this decision. (See Appendix.) If the event is determined not to be sentinel in nature, then the organization shall respond as noted in this policy.

3. Communicate Sentinel/Adverse Event

Once a sentinel/adverse event has been determined, the senior management representative or designee on duty will:

- Notify Chief Nursing Executive, Safety Officer, Chief Medical Executive, and President of the Medical Staff who will authorize and appoint medical staff to participate in the performance improvement activity/analysis.
- Instruct the Chief Quality Officer or Risk Manager to arrange meeting of the RCA Team.

4. Support Employees

Leadership will ensure that caregivers receive timely attention that is just, respectful, and compassionate. Resource options from the Human Resource Director, Behavioral Consultant and Medical Social Workers should be considered.

5. Activate RCA Team

The team is responsible for responding to a adverse event. Team membership includes, but is not necessarily limited to, the following:

- Chief Nursing Officer, Chief Quality Officer, Chief Medical Officer, and Risk Manager.
- Individuals directly involved in the event.

The purpose of the team will be to coordinate an investigation into the incident, conduct a root cause analysis and determine corrective actions in response to findings and/or opportunities for improvement.

6. Protect from Discovery

All activities of the response team should be done under the auspices of the Medical Staff Performance Improvement Committee/peer review process. Other legal protections are to be implemented as determined by legal counsel.

7. Remediate

The team will take necessary actions to remedy any immediate threat or likelihood of adverse event recurrence.

8. Investigate Event/Analyze Root Cause(s)

The team will conduct a thorough and credible root cause analysis (RCA) of the adverse event. The RCA should be completed within 45 days of the event, unless a longer period of time is necessary for the RCA to be truly thorough and credible. The *Root Cause Analysis Documentation Form* will be used as a guideline for the investigative process and its documentation. (See Appendix.)

9. Create and Implement Action Plan
Once the RCA has been completed, the team is to develop and implement an action plan that will address both direct and root causes as well as—when appropriate—special and common cause variation.

10. Report internally
A summary (blinded) of the adverse event, the root cause(s) identified, and the corrective actions taken will be reported to the appropriate medical staff committee in executive session, the Medical Executive Committee, Performance Improvement Committee and the Quality Committee of the Board. The corrective action plan will also be communicated to appropriate personnel in the organization with need to know.

11. Report to the Licensing Agency
An adverse event that resulted in death or serious physical injury, or carried a risk of such to a significant percentage of the population would be considered an unusual occurrence and will be reported by the Chief Nursing Officer, or designee, to the California Department of Health within five (5) days after detection, **or** if an ongoing urgent or emergent threat, not later than twenty-four (24) hours.

12. Record Keeping
Record of the investigation into the adverse event, the subsequent RCA, and any quality improvement activities is to be maintained by the Medical Staff Office and should be constructed in such a way as to be afforded statutory protection from discovery.

Reference:
CMS §482.2 (a)(2)

7.

BOARD QUALITY COMMITTEE DASHBOARD 2014

BOARD QUALITY COMMITTEE DASHBOARD 2014

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 2014/2015

	Jul-Sept2013 Q1.FY14		Oct-Dec2013 Q2.FY14		Jan-Mar2014 Q3.FY14		Apr-Jun2013 Q4.FY13		Totals
SERVICE	**IP**	**OP**	**IP**	**OP**	**IP**	**OP**	**IP**	**OP**	
General	44	44	29	55	27	44	30	48	311
OBGYN	6	16	13	19	14	26	11	22	120
Ophthalmology	0	48	0	63	0	59	0	48	204
Orthopedic	55	111	40	106	70	98	57	101	631
Pain Management	0	49	0	45	0	35	0	39	170
Podiatry	1	8	1	7	0	11	3	4	39
Urology	0	5	2	17	3	10	1	5	36
Vascular Surgery	0	3	0	3	0	3	0	7	18
Endoscopy	9	76	21	79	18	89	14	82	371
Totals	**115**	**360**	**106**	**394**	**132**	**375**	**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 2013	2014 Q1	2014 Q2	2014 Q3	2014 Q4	Q Change	YTY (2012/13) Trend	Benchmark Goal	Benchmark Perform
27.72	20.69						30	

Note: Reliable data collection in EMR is in development >>>GO LIVE with PhysDoc 05/2014<<<<

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 2013	2014 Q1	2014 Q2	2014 Q3	2014 Q4	Q Change	YTY (2012/13) Trend	Benchmark Goal	Benchmark Perform
60.69	47						96	

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 2013	2014 Q1	2014 Q2	2014 Q3	2014 Q4	Q Change	YTY (2012/13) Trend	Benchmark Goal	Benchmark Perform
73%	69.4%						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 2013	2014 Q1	2014 Q2	2014 Q3	2014 Q4	Q Change	YTY (2012/13) Trend	Benchmark Goal	Benchmark Perform
86.93	86.3%						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 2013	2014 Q1	2014 Q2	2014 Q3	2014 Q4	Q Change	YTY (2012/13) Trend	Benchmark Goal	Benchmark Perform
88.95	90.6%						90.00%	

3. 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.

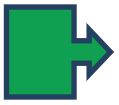
Measurement:	Readmission Rates for Medicare Patients (Lower # is better)
Category:	Quality Patient Outcomes
Definition:	Readmitted to SVH within 30 days - All Diagnosis

CALENDAR YEAR 2013	2014 Q1	2014 Q2	2014 Q3	2014 Q4	Q Change	YTY (2012/13) Trend	Benchmark Goal	Benchmark Perform
5.80%	3.101%						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 2013	2014 Q1	2014 Q2	2014 Q3	2014 Q4	Q Change	YTY (2012/13) Trend	Benchmark Goal	Benchmark Perform
2.24%	**2.0**						**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 2013	2014 Q1	2014 Q2	2014 Q3	2014 Q4	Q Change	YTY (2012/13) Trend	Benchmark Goal	Benchmark Perform
0.00%	**0.00%**						**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 2013	2014 Q1	2014 Q2	2014 Q3	2014 Q4	Q Change	YTY (2012/13) Trend	Benchmark Goal	Benchmark Perform
9.17%	0.00%						23.0%	

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 2013	2014 Q1	2014 Q2	2014 Q3	2014 Q4	Q Change	YTY (2012/13) Trend	Benchmark Goal	Benchmark Perform
2.78%	0.00%						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 2013	2014 Q1	2014 Q2	2014 Q3	2014 Q4	Q Change	YTY (2012/13) Trend	Benchmark Goal	Benchmark Perform
4.13%	**0.00%**					**N/A**	**TBD**	**TBD**

Measurement:	Readmission Rates for Medicare Patients (Lower # is better)
Category:	Quality Patient Outcomes
Definition:	Readmitted to SVH within 30 days Hip/Knee Arthroplasty

CALENDAR YEAR 2013	2014 Q1	2014 Q2	2014 Q3	2014 Q4	Q Change	YTY (2012/13) Trend	Benchmark Goal	Benchmark Perform
2.70%	**0.00%**						**5.4%**	

Chart Definitions:	Calendar Year	Average of all quarters previous year
	Q Change	Change from previous quarter/calendar year
	YTY Trend	Change from previous calendar year s based on an average of the annual values.
	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

4. 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	