SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
REGULAR MEETING AGENDA
Wednesday, July 23, 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, 06.25.14 B. Policy & Procedures Approval	*Hirsch*	Action
4. REVISED QUALITY COMMITTEE CHARTER	*Hirsch*	Action
5. HIGH-RISK OB MANAGEMENT	*Amara*	Inform
6. QUALITY REPORT JUNE 2014	*Lovejoy*	Inform/Action
7. 2013 ANNUAL RISK MANAGEMENT REPORT	*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	*Amara*	Action
12. REPORT OF CLOSED SESSION	*Hirsch*	Inform
13. ADJOURN		

3.

CONSENT CALENDAR

SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
REGULAR MEETING MINUTES
Wednesday, June 25, 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 Ingrid Sheets	Michael Mainardi MD Kelsey Woodward Carol Snyder Howard Eisenstark MD	Cathy Webber	Robert Cohen M.D. Gigi Betta Mark Kobe Kathy Mathews Paula Davis Lois Valenzuela Barbara Lee

AGENDA ITEM	DISCUSSION	ACTION	FOLLOW-UP
1. CALL TO ORDER	*Hirsch*		
	Meeting called to order at 5:05PM		
2. PUBLIC COMMENT	*Hirsch*		
	None		
3. CONSENT CALENDAR	*Hirsch*	Action	
A. QC Meeting Minutes, 5.28.14		**MOTION:** by Eisenstark to approve Minutes and 2nd by Mainardi. All in favor.	
4. ANNUAL EMPLOYEE SATISFACTION SURVEY REPORT	*Davis*	Inform	
	Ms. Davis reviewed the highlights from the *Press Ganey* SVH Employee Partnership Survey for 2014.		
5. ANNUAL HEALING AT HOME PERFORMANCE IMPROVEMENT REPORT	*Lee*	Inform	
	Ms. Lee presented the Annual Healing At Home Performance Improvement Report including process design, data collection, current performance analysis and sustained performance improvement.		
6. ANNUAL LABORATORY PERFORMANCE IMPROVEMENT REPORT	*Valenzuela*	Inform	

AGENDA ITEM	DISCUSSION	ACTION	FOLLOW-UP
	Ms. Valenzuela presented the SVH Annual Clinical Laboratory Effectiveness Summary Report for 2013.		
7. QUALITY REPORT MAY 2014	*Lovejoy*	Inform/Action	
	Ms. Lovejoy gave her Quality and Management Report for May 2014 which included performance improvement, quality monitoring, and updates on both the Clinical Nurse Informaticist position and the Medical Staff credentialing process.	**MOTION:** by Eisenstark to approve QC Report and 2nd by Mainardi. All in favor.	
8. CLOSING COMMENTS/ANNOUNCEMNTS	*Hirsch*		
9. ADJOURN	*Hirsch*		
	Regular Session adjourned at 6:20PM		
10. UPON ADJOURNMENTOF REGULAR OPEN SESSION	*Hirsch*	Inform	
11. CLOSED SESSION	*Iredale*	Action	
12. REPORT OF CLOSED SESSION	*Hirsch*	Inform	
13. ADJOURN	Closed Session adjourned at 6:35PM		

POLICY AND PROCEDURE
Approvals Signature Page

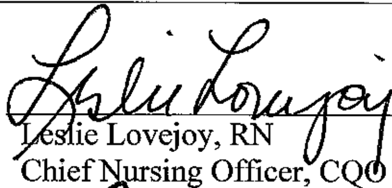
Review and Approval Requirements

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 Summary Sheet) June List	
APPROVED BY **Leslie Lovejoy, RN**	DATE: **7/02/2014**
Director's/Manager's Signature	Printed Name



Leslie Lovejoy, RN
Chief Nursing Officer, CQO

7-8-14
Date

Robert Cohen, MD
Chief Medical Officer

7/14/14
Date

D. Paul Amara, MD
President of Medical Staff

Date

Kelly Mather
Chief Executive Officer

Date

Sharon Nevins
Chair, Board of Directors

Date

	Policy Submission Summary Sheet	
	Title of Document: Organizational-Multiple Departments	
	Type: **Revision**	
June Policies		
Policy	**Notes**	
EC-UT8610-115 Boiler Failure/High Pressure	retire; not needed, new system	
EC-UT8610-115 Boiler Failure/Low Pressure	retire; not needed, new system	
EC-UT8610-124 Bulk Liquid Oxygen	retire; department policy #77	
EC-UT8610-118 Communications	retire; not needed, an IS policy	
EC-UT8610-107 Commuications Phones List	retire; not needed, an IS policy	
EC-UT8610-119 Emergency Delivery/Diesel Fuel	retire; department policy #59	
EC-UT8610-121 Emergency Generator Testing	retire; department policy #65	
EC-UT8610-109 Engineering/Earthquake Procedures	retire; department policy #42	
EC-UT8610-113 Equipment Failure/Offsite	retire; not needed, included in ECUT8610-112	
EC-UT8610-112 Equipment/Utility Failure	retire; department policy #51	
EC-UT8610-106 Equipment Phone List	retire; department policy #31	
EC-UT8610-122 Fire Alarm Testing Procedures	retire; not needed in Life Safety Plan	
EC-UT8610-104 Interim Life Safety	retire; refer ECLS8610-101 Interim Life Safety Measures	
EC-UT8610-101 On-Call Engineer	retire; department policy #4	
EC-UT8610-102 Preventative Maintenance	retire; department policy #7	
EC-UT8610-108 Utilities Failure Phone List	retire; department policy #38	
HR8610-164.8 Asbestos Medical Surveillance	reviewed; addition of Physician Assistant to care for patients	
IM8610-119 HIPPA Committee Reporting, Monitoring and	reviewed; no changes	
IM8610-110 Medical Record Review-closed	retire; not needed department policy, TJC standard	
IM8610-101 Noting and Transcribing Orders	retire; included in PC8610-160 Documentation	
LD8610-152 Administrative Call	revised; updated to current protocol	
LD8610-143 Advance Approval for Hospital Inspection by	retire; not needed	
LD8610-157 Alcoholic Beverages	reviewed; no changes	
LD8610-200 Treat and Transfer of Patients (aka: Diversion of	revised; name change, updated Admin Nursing Supervisor as responsible	
MS8610-125 Specialty Physician Emergency Care	revised; update to current standard re medical care & orthopedists on call	
PC8610-142 Telemetry Monitoring	retire; use PC8610-210 Cardiac Rhythm Monitoring	
PC8610-146 Transporting of Monitored Patients	revised; added E.H.R. documenting, reference	
RC 8610-101 Medical Record Documentation Practices	retire; refer to PC8610-160 Documentation	
RC8610-125 Clinical Documentation in the Patient Medical	retire; now PC8610-160	
RC8610-111 Medical Record Review for Timely completion	revised; changed number from IM8610-111; updated to current standards	
RC8610-325 Medical Record Content	reviewed; updated to current standards	
Reviewed By:	**Date**	**Approved (Y N)**
Policy & Procedure Team	**6/26/14**	Yes
Surgery Committee	**7/2/14**	Yes
Medicine Committee	**7/10/14**	Yes
Medical Executive Committee	**7/17/14**	
Board Quality Committee	**7/23/14**	

4.

REVISED QC CHARTER

SUBJECT: Quality Committee Charter	
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 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 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.

- Up to four ~~Three~~ members of the public. In addition, substitutions may be made at all QC meetings from three 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.
- Members of the public must be stakeholders of the District. Stakeholders have been defined by the District Board for the purposes of committee membership as:
  - Living some or all of the time in the District
  - Maintaining a place of Business in the District
  - Being an accredited member of the Hospital's staff

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.

6.

QUALITY AND RESOURCE MANAGEMENT REPORT JUNE 2014

To: Sonoma Valley Healthcare District Board Quality Committee
From: Leslie Lovejoy
Date: 07/23/2014
Subject: Quality and Resource Management Report

July Priorities:

1. Onboarding Nurse Informatics Analyst
2. Pre-admission pre-operative flow process performance improvement project
3. CDPH activity
4. Plans for regulatory changes

1. Onboarding the Nurse Informatics Analyst

Albert Espinas RN joined our team on the 16th and is beginning his orientation to our workflow processes and the Paragon/McKesson system. He has experience with three other electronic health records and we anticipate that the orientation process will be easier due to that experience.

2. Pre-admission pre-operative flow process performance improvement project

This workflow was identified as an opportunity for improvement by our Surgery Consultant Team last year. The Surgical Services Director and members of the Pre-Admit team have been looking for best practices and we are ready to kick-off the project on the 16th. We will focus on Outpatient Surgical cases first as that is the bulk of our surgeries. The documentation process in the electronic record is especially problematic and needs a deep analysis and re-working in order to make it more efficient. I will use budgeted dollars to contract with our current per diem Nurse Informatics Analyst to take on this task exclusively over the next three months.

3. CDPH activity

CDPH came out twice this month to inspect the new Nurse Call system and then the new Isolation room, showers, and Nutrition Room. All areas have been approved for use and occupancy. We had a physician reviewer come in to look at a patient complaint and are awaiting his follow-up. In addition, CDPH has informed us that we may not use the old emergency department for Dr. Brown to see Napa State patients. Finally, we will be starting the licensing application process for the satellite PT department located at Palm Drive.

4. Plans for regulatory changes

CMS has published it latest update on the Conditions of Participation. While we are compliant with most of the changes there are two areas that we will need updating. There is a new requirement that the medical staff needs to determine if non-medical staff members may order

tests and treatments for outpatient and if the answer is yes, then the medical staff must implement a process of primary source verification before the physician can order these tests. This will be challenging and CIHQ has already given me some guidance. In addition, CMS has dropped the requirement that a physician be a board member but expects that the President of the Medical Staff participate in Board Meetings. The CMO is explicitly excluded from this role. CIHQ has provided some suggestions and I will have discussed this with MEC prior to our meeting.

CALOSHA has just published it requirements for compliance with the “Safe Patient Handling” legislation. A formal plan will need to be developed in the next few months as the requirement goes into effect October 1.

Topics for discussion: 2013 Annual Risk Management Program Review

7.

ANNUAL RISK MANAGEMENT REPORT

2013 Annual Risk Management Report

I. ***Introduction***

The purpose of the Risk Management Program is to develop, implement, continuously improve, and maintain processes for making and carrying out decisions that will minimize the adverse effects of potential losses to the organization in three areas of risk: business, regulatory and clinical. The governing body delegates responsibility to the CEO and the Senior Leadership and to the Medical Executive Committee.

Areas of Potential Risk:

1. **Clinical Risk** addresses all issues regarding the provision of patient care including competency of personnel, credentialing and privileging of medical staff members, information technology and medical equipment used in providing care and documentation in the medical record. This is typically delegated to the Risk Manager, Chief Medical Officer and the President of the Medical Staff.

2. **Regulatory Risk** addresses issues of compliance with regulations, standards that cover not only the provision of care but how we conduct the organization's business and the state of the facilities. This is delegated to the Senior Leadership Team.

3. **Business Risk** addresses issues surrounding contractual, insurance, billing, compliance and business ethics. This is typically delegated to the CFO.

While there is an overlap with Performance Improvement, there are some differences as the following Table points out.

Risk Only	***Overlap***	***Performance Improvement Only***
Workers Compensation/ Insurance/Contracts	Commits to the dimensions of healthcare quality by "doing goodness" in: • Patient safety (do no harm) • Effectiveness (use best practice)	Dept and Med Staff ongoing *measurement* and assessment activities

	• Patient centered (patient/family participate) • Timeliness (avoid delays) • Efficiency (avoid waste) • Equity (provide equal access, same standard of care	
Corporate Compliance	Maintains processes to identify and communicate unsafe conditions	Competency and Performance review
Participates in pre, concurrent, and post litigation activities	Applies principles of human factors engineering to care processes	Med Staff credentialing, reappointment
Conducts Adverse Event RCA process	Analyzes multiple data sources (internal communication, Core Measures, PI Indicators, QA checks, Med Staff Screens, Third Party communication, etc.	Practice/utilization patterns
Grievance Resolution	Clinical performance measures for contracted services	Care of the environment
Billing practices	Regulatory Compliance	

II. Claims Reports

A. ***Clinical Claims***:

SVH has had an association with BETA Healthcare Group since 1997. BETA HCG Risk Management Authority administers risk-sharing pools under a joint powers agreement pursuant to California Government Code Claim Section 6500, et seq. and Section 990, et seq. Coverage limits for Hospital Professional and General liability is $15 million with a $5,000 deductible. Emergency Department Professional coverage limits are $1 million/$3 million with a $5,000 deductible. As a member in good standing, SVH has received renewal and special dividend checks.

Sonoma Valley Hospital has a very low claims history. From 2007 through 2013, there was a yearly average of 1.3 claims for a total of 9 claims. Currently, there are 2 claims that have not been closed; one involving the Emergency Department and the other involving Medical Imaging. Over this time span, Program Beta has paid out a total of $341K in expenses related to the nine claims and the hospital has paid out $10K in deductable expenses. Most claims

originate from the Emergency Department in any hospital and this is true for Sonoma Valley Hospital.

Year	***Origin of claim***	***Total Claims***	***Beta Paid***	***SVH Paid***
2007	Surgery Emergency Dept	2	$23,343	0
2008	None	None	None	None
2009	Emergency Dept (2) Surgery	3	$96,370	$5,000
2010	Emergency Dept Medical Imaging	2	$129,680	$2,000
2011	Emergency Dept	2	$25,000	$10,000
2012	Emergency Dept Medical Imaging	2	$66,985	0
2013	None	None	None	None

B. ***Business Claims***: There is currently one claim against the hospital from DeRosa construction regarding the termination of their contract. This also involves a Sodexho contracted employee who entered into contracts without proper authority. DeRosa is claiming damages and while the hospital will settle, the cost will be passed through to Sodexho.

C. ***Regulatory Claims***: The website HIPPAA Breach claim is currently under consideration with the Office of Civil Rights and the civil suit is still pending a court date.

III. "Never Events/Hospital Acquired Conditions(HACS)/Adverse Events

The National Quality Forum (NQF), a voluntary organization that set consensus standards for care, created a list of 27 "never events" (see Page 6, Table 1). Ca Senate Bill 1301 added language to Ca Health & Safety code §1279.1 that mandated hospitals (effective July 7, 2007) to report any adverse event within 5 days (or within 24 hours if the event is an ongoing threat to the safety, health, and welfare of patients, personnel and visitors) to the California Department of Public Health (CDPH). Beginning October 1, 2008, the Centers for Medicare and Medi-Cal (CMS) no longer provide hospital payment for these hospital conditions.

ANALYSIS OF ADVERSE EVENTS OR NEAR MISSES IN 2013: System or Process Failure

	Date	Nature of Failure	Patient/Family Informed	Improvements Implemented
1.	05/23/13	Medication Administration Pump Failure related to lack of consistent cleaning protocol in ICU. Patient received a bolus of	Yes	Developed and implemented process for pump exchange and cleaning so that central sterile is responsible for cleaning. Educated EVS to process and provided training if emergency arises and they need to clean a pump, they know how to do it correctly.
2.	08/25/2013	Patient death during move into surgery and start of anesthesia. Reported to CDPH as an adverse event.	Yes	Clarified SNF-Acute process; educated surgery and surgeons to need for H&P prior to surgery.

IV. Goals and Risk Reduction Strategies

2013 GOAL ACCOMPLISHMENTS & RISK REDUCTION STRATEGIES
• Implemented e-Notification trained clinical leaders in electronic follow-up process. 50% of leaders now on Midas.
• Implemented Culture of Safety initiative, including Good Catch
• Maintained established safety processes so there were no adverse/sentinel events related to abduction, abuse, falls, pressure ulcers, procedural outcomes, surgical site infections, restraints use, and treatment.
• Educated key team members in Sorry Works process and Implemented. Had program Beta do an education session for Board Quality Committee?
• Implemented Quest for Zero: Excellence in OB program and continued Quest for Zero for the Emergency Department
• Completed process for quarterly monitoring of clinical contracts by Leaders.
• Launched contractual agreement with Executive Health Resources for denial and appeals management, concurrent physician advising for medical necessity, and to reduce loss related to utilization.

2014 GOALS AND RISK REDUCTION STRATEGIES
• Increase the number of leaders trained to use the Midas system for E-Notification responses. Build a feedback process to frontline staff.
• Completion of OB Quest for Zero training in the OB Department.
• Improve the Complaint Management system including adding additional training for the “Sorry Works” Team. Ensure full disclosure of adverse events to patient and their families.
Improve medical staff credentialing process including case review, policies and procedures and work with the medical staff to align By-laws and Rule and Regulations with current CMS standards.
• Patients Rights and Risk Management Organizational policies are complete, up to date and the staff has been educated to any changes.

Appendix 1

TABLE 1 REPORTABLE ADVERSE EVENTS THAT SHOULD NEVER HAPPEN	
1.	Surgery wrong body part
2.	Surgery on wrong patient
3.	Wrong surgical procedure performed on a patient
4.	Object left in a patient after surgery
5.	Death of a patient (who had been has been generally healthy) during or immediately after surgery for a localized problem
6.	Patient death or a serious disability associated with the use of contaminated drugs, devices, or biologics
7.	Patient death of serious disability associated with the misuse or malfunction of a device
8.	Patient death or serious disability associated with intravascular air embolism
9.	Infant discharged to the wrong person
10.	Patient death or serious disability associated with patient disappearing for more than 4 hours
11.	Patient suicide or attempted suicide resulting in serious disability
12.	Patient death or serious disability associated with medication error
13.	Patient death or serious disability associated with transfusion of blood or blood products of the wrong type
14.	Maternal death or serious disability associated with labor or delivery in low-risk pregnancy
15.	Patient death or serious disability associated with onset hypoglycemia, drop in blood sugar
16.	Death or serious disability associated with failure to identify and treat hyperbilirubinemia, a blood abnormality in newborns
17.	Severe pressure ulcers acquired in hospitals
18.	Patient death or serious disability due to spinal manipulative therapy
19.	Patient death or serious disability associated with electric shock
20.	Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances
21.	Patient death or serious disability associated with a burn incurred in the hospital
22.	Patient death associated with a fall suffered in the hospital
23.	Patient death or serious disability associated with restraints or bedrails
24.	Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist or other licensed healthcare provider
25.	Abduction of a patient
26.	Sexual assault on a patient
27.	Death or significant injury of a patient or staff member resulting from a physical assault in the hospital
28.	A CATCH-ALL: Any adverse event or series of adverse events that causes the death or serious disability, personnel or visitor.