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

SVHCD QUALITY COMMITTEE
AGENDA
WEDNESDAY, AUGUST 24, 2016
5:00 p.m. Regular Session
(Closed Session will be held upon adjournment of the Regular Session)

Location: Schantz Conference Room
Sonoma Valley Hospital – 347 Andrieux Street, Sonoma CA 95476

AGENDA ITEM	RECOMMENDATION	
In compliance with the Americans with Disabilities Act, if you require special accommodations to attend a District meeting, please contact the District Clerk, Gigi Betta at ebetta@svh.com or 707.935.5004 at least 48 hours prior to the meeting.		
MISSION STATEMENT The mission of the SVHCD is to maintain, improve, and restore the health of everyone in our community.		
1. CALL TO ORDER/ANNOUNCEMENTS	*Hirsch*	
2. PUBLIC COMMENT SECTION At this time, members of the public may comment on any item not appearing on the agenda. It is recommended that you keep your comments to three minutes or less, Under State Law, matters presented under this item cannot be discussed or acted upon by the Committee at this time For items appearing on the agenda, the public will be invited to make comments at the time the item comes up for Committee consideration.	*Hirsch*	
3. CONSENT CALENDAR • QC Minutes, 7.27.16 • Annual Risk Management Report from 7.27.16	*Hirsch*	Action
4. MEDICATION SAFETY	*Kutza*	Inform
5. CYBER SECURITY & RISK MANAGEMENT	*Sendaydiego*	Inform
6. POLICY & PROCEDURES • Policy IC7471-114 & PC7420-107 Surgical Services • Multiple Policies June 2016 • Policy IM8480-07 Cyber Attack (presented for revision)	*Lovejoy*	Action
7. QUALITY REPORT AUGUST 2016	*Lovejoy*	Inform/Action
8. CLOSING COMMENTS/ANNOUNCEMENTS	*Hirsch*	
9. ADJOURN	*Hirsch*	
10. UPON ADJOURNMENT OF REGULAR OPEN SESSION	*Hirsch*	
11. CLOSED SESSION: • Calif. Health & Safety Code § 32155 Medical Staff Credentialing & Peer Review Report • Board Quality Dashboard	*Sebastian/Lovejoy*	Action
12. REPORT OF CLOSED SESSION	*Hirsch*	Inform/Action
13. ADJOURN	*Hirsch*	

3.

CONSENT

+

SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
MINUTES
Wednesday, July 27, 2016
Schantz Conference Room

Members Present	Members Present cont.	Excused	Public/Staff
Jane Hirsch	Brian Sebastian, MD		Leslie Lovejoy
Michael Mainardi, MD	Howard Eisenstark, MD		Gigi Betta
Kelsey Woodward	Ingrid Sheets		Robbie Cohen, MD
Susan Idell	Joshua Rymer		
Carol Snyder	Cathy Webber		

AGENDA ITEM	DISCUSSION	ACTION
1. CALL TO ORDER/ANNOUNCEMENTS	*Hirsch*	
	The meeting was called to order at 5:00pm	
2. PUBLIC COMMENT	*Hirsch*	
	No public comment.	
3. CONSENT CALENDAR	*Hirsch*	Action
QC Minutes, 6.22.16		**MOTION** by Eisenstark and 2nd by Idell. All in favor.
4. ANNUAL RISK MANAGEMENT REPORT	*Lovejoy*	Inform
	Ms. Lovejoy shared the Risk Management report which focuses on strategies to minimize adverse effects and potential losses to the Hospital. FY16 was mixed year in terms of mediating risk and meeting risk reduction. Detailed in the report were FY16 goals and risk reduction strategies as well as the goals and strategies for next fiscal year. Ms Lovejoy also reviewed the claims history from 2010-15, analysis of adverse events, patients relations summary and Good Catch summary,	This report was noticed as an *Inform* item therefore no action could be taken. The report will be brought forward to the August 24, 2016 meeting for approval under the Consent Calendar.
5. POLICY & PROCEDURES	*Lovejoy*	Action

AGENDA ITEM	DISCUSSION	ACTION
• IS Department #IM8480-07 • HR Department #HR8610-143 • Multiple Organizational #CE8610-147	Dr. Eisenstark's requested that IS Department policy #IM8480-07 be returned to the IS Department manager for revision and additional details.	**MOTION** by Rymer to approve all but #IM8480-07 and 2nd by Eisenstark. All in favor.
6. QUALITY REPORT JULY 2016	*Lovejoy*	Inform/Action
	Ms. Lovejoy clarified the PRIME grant structure and action plan. The grant does not have to be *matched* but the Hospital does need to establish an IGT and *fund it* up front. It's a non restrictive grant provided metrics are met. Other July 2016 priorities included CLIA Licensing Survey, COV selection and personnel changes in the Quality Department. The Prime Grant will be presented to the Board as information only on 9.1.16.	**MOTION** by to approve Idell and 2nd by Eisenstark. All in favor.
7. CLOSING COMMENTS/ANNOUNCEMENTS	*Hirsch*	
8. ADJOURN	*Hirsch*	
9. UPON ADJOURNMENT OF REGULAR SESSION	*Hirsch*	
10. CLOSED SESSION: Calif. Health & Safety Code § 32155 Medical Staff Credentialing & Peer Review Report	*Sebastian*	Action
11. REPORT OF CLOSED SESSION	*Hirsch*	Inform/Action
12. ADJOURNMENT AND ANNOUNCEMENTS	*Hirsch*	
	Meeting adjourned at 6:010pm. In lieu of the Regular Quality Committee meeting on October 26, 2016, there will be a presentation by Dr. Rory Jaffe, Medical Director at the California	

AGENDA ITEM	DISCUSSION	ACTION
	Hospital Patient Safety Organization. His presentation will be preceded by a short reception in the SVH Basement Conference Room beginning at 5:00pm.	

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

Periodic Risk Management & Patient Safety Report (FY16)

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.

II. Year in Review:

Sonoma Valley Hospital had a mixed year in terms of mediating risk and meeting risk reduction strategies. The Risk Management function underwent some changes and then resulted in a decision to change the role responsibility. We uncovered areas for improvement in the medical staff peer review process, physician orientation and on-boarding, and in surgical services. The hospital settled one claim and closed other pending claims without incurring costs. Litigation activity resulted in an increase in insurance premiums for fiscal year 2017.

We joined the California Hospital Patient Safety Organization which allows for greater protection of protected risk information in order to benchmark and take advantage of national best practice strategies.

Four of our team members completed an intensive in Adverse Outcome Disclosure sponsored by Program Beta to improve our Sorry Works Program and now have an opportunity to put into practice what was learned to improve our program. In addition, five of our leaders attended the Annual Risk Management Conference in San Diego and our Risk Manager attended the annual California Association for Risk Management Conference in Napa.

We brought our policy and procedure process up to date and it was hardwired. We maintained a fully functioning grievance process and committee structure as well.

The Table below addresses the goals set for fiscal year 2016 and our progress towards meeting them.

FISCAL YEAR 2016 GOALS AND RISK REDUCTION STRATEGIES
• Bring the organization into alignment with the NQF Patient Safety Goals by completing a risk assessment and mitigation plan that adds to the current "Culture of Safety" program and strengthens our patient safety culture. **A Leapfrog measure that has been met through the Quest for Zero programs in the ED and in OB. Both departments met their goals this year.**
• Contact Program Beta and complete a perioperative risk assessment. Develop an improvement plan and identify needed education for the perioperative team. Consider Quest for Zero in 2016. **This was completed and actions were taken by Surgical Services to reduce the risk of retained sponges. Beta also provided mandatory education for the Surgical Services team and a general documentation in-service for nursing staff. Program Beta has not launched the Quest for Zero program as expected.**
• Develop a feedback loop for e-notification results and teach leaders how to discuss when an adverse event occurs. **This was completed and risk data is updated by the second week of the month. We still have an opportunity to improve the leaders use of the tool and documentation of feedback to frontline staff during staff meetings.**
• Complete the recommended risk assessment for the Life Safety requirements regarding infant and child abduction. **Not completed, will make a priority in fall 2016.**
• Develop education modules regarding risk, human factors and documentation to improve their knowledge and understanding of patient safety. **Introduction to Human Factors Design was provided to leaders in June. Fall 2016 Health Stream module will address for frontline staff.**
• Work with the medical staff to align By-laws and Rule and Regulations with current CMS standards. **Medical Staff decided to ask Dr. Smith to revise both documents and this is expected to be complete by the end of 2016.**
• Bring Medical Screening Exam into regulatory compliance for OB patients presenting to the ED. **This was completed.**
• Complete a Leapfrog Action Plan and resubmit in June 2016. **Done**

III. 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 in fiscal year 2015, SVH has received renewal and special dividend checks. In addition, each year Beta sets aside $2,500 for risk related education and $2,500 for outside peer review activities. Program Beta also provides

free registration for numerous educational seminars and annual conferences and offers free on-site consultations and educational programs.

Sonoma Valley Hospital has a very low claims history. The table below outlines our claims from calendar years 2010 through December 2015. Like the rest of the nation, the Emergency Department is at the most risk for having a claim reported.

Calendar Year	***Origin of claim***	***Total Claims***	***Beta Paid***	***SVH Paid***
2010	Emergency Dept (8) Medical Imaging (1) Lab (1) Surgery (1)	11 Closed	$129,680	$2,000
2011	Emergency Dept (2)	2 Closed	$25,000	$10,000
2012	Emergency Dept (5)* Medical Imaging (1) Birth Center (1)	ED Closed 1 Closed (NP) 1 Closed (NP)	$1,070,245 (MD)	$5,000
2013	Emergency Dept (2) Grounds (1)	3 Closed	0	0
2014	Emergency Dept (2) Medical Imaging/SNF (1)	ED cases Closed MI case Dismissed	$350,000 (District) $59,998 (MDs)	11,000
2015	Emergency Dept (1)	Closed	0	0
Total	23 cases		$1,609,948	$28,000

* One case

B. **Business Claims**: No new claims. The web HIPAA breach has been completed and closed. The hospital completed its mandatory risk assessment and the Compliance Committee has developed and is on track in the implementation of its action plan. We paid out a negotiated penalty of $37,500 for a 2012 retained foreign object, that happened during a total knee replacement, in April 2016.

C. **Regulatory Claims**: In 2014, the hospital was cited for an EMTALA violation which was corrected and we are in compliance with our ongoing action plan. The OIG notified the hospital that the violation was going to invoke a penalty. To date we have not completed this process as the Counsel for the OIG has not sent the paperwork despite repeated attempts by the hospital to get this settled. The fine could be as high as $25,000 and the hospital will share the exposure with Valley Emergency Medical Group.

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

The hospital did not have any serious or unusual events that resulted in the death or serious disability of a patient, personnel or visitor during this fiscal year. There were some events that we decided to conduct an intense analysis review as they warranted systemic improvement.

ANALYSIS OF ADVERSE EVENTS OR NEAR MISSES IN July 2015-June 2016: System or Process Failure

	Date	Nature of Failure	Patient/Family Informed	Improvements Implemented
1.	11/23/15	Hoyer lift handling and skills were suboptimal during a patient transfer which resulted a patient fall.	Yes	Hoyer lift competency based on manufacturer's recommendations was revised. Staff trained. Annual lift training was added to annual skills fair to reinforce compliance.
2.	2/1/2016	Verification process for confirming correct lens for insertion during cataract surgery resulted in the wrong lens used during a cataract surgery	Yes	Surgeons will have the patient and their lens information in their visual line of sight to confirm during time out process. Change the OR schedule font size and place it at eye level of the person reading it.
3.	6/10/2016	Failure of the e-notification system and QAPI program to detect change in patient condition for patient experiencing temporary reduced function post shoulder surgery.	Patient complaint through CIHQ	Updated our policies and procedures; mandatory re-training of PT, surgery and med/surg nursing staff.

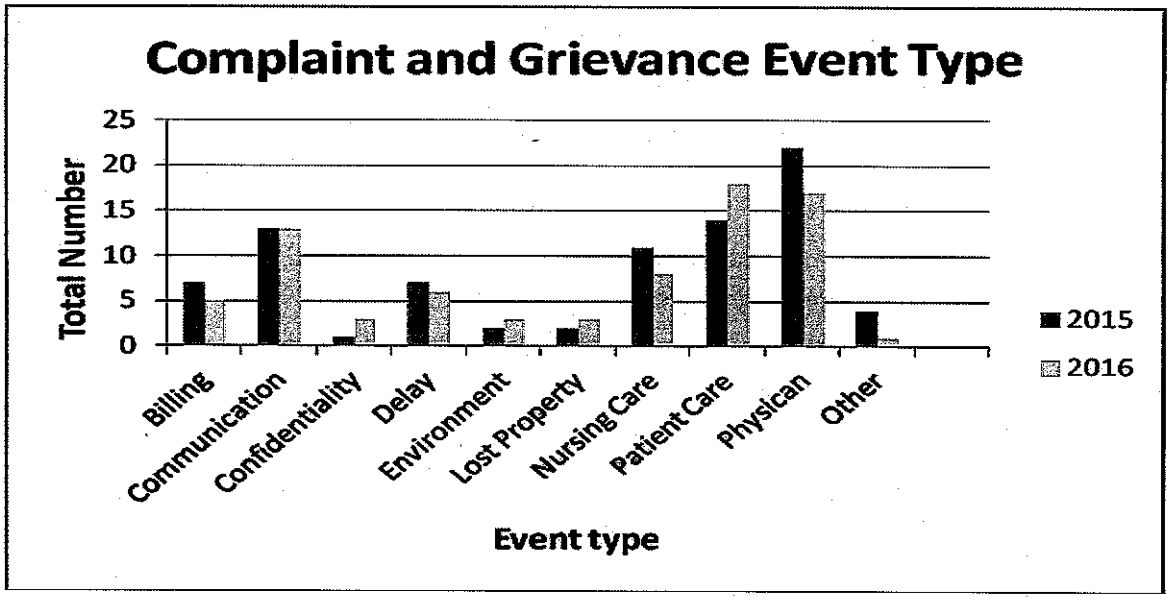
IV. Patient Relations Summary Data

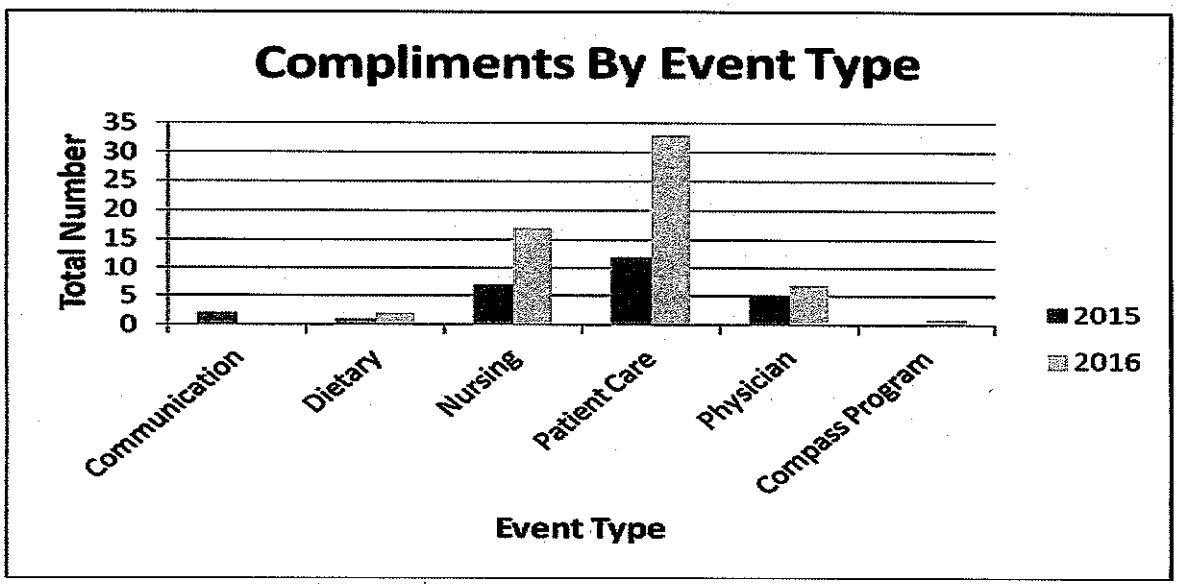
Patients are encouraged to provide feedback about their care experience through the complaint/grievance process and we respond to those concerns in accordance to CMS guidelines that require an acknowledgement of the concern within 7 days if it can't be remedied while in the hospital and a final resolution letter within 30 days of the concern. We have an opportunity to improve as we are not consistently meeting those targets

We have seen a decrease in complaints while in the hospital and an increase in grievance and compliment reporting after discharge. This does not mean that our patients perceive our care as declining. It is more likely to indicate a willingness of our patients to engage with us to improve care as our culture has demonstrated an openness to receiving and responding to patient concerns. In addition, our culture was vague on how we define the terms complaint and grievance in FY 2015. The following graphs provide information about totals and event types. As we have two years of data, it is difficult to determine trends. Leaders are expected monitor issues and make process improvements as identified.

Event Type	Fiscal Year 2015	Fiscal Year 2016	Activity
Complaints*	24	7	Decline
Grievances**	59	70	Increase
Compliments	27	60	Increase
Total	110	137	

*Complaints = Concerns resolved while still in the hospital or upon discharge
**Grievances = Concerns formally addressed through a phone call or letter by the patient





V. Good Catch and E- Notification Summary Data:

One indicator of the effectiveness of any risk management program is the willingness of frontline staff to report unusual occurrences and concerns through the notification system. We moved to electronic reporting in 2013 and saw a slow rise in reporting. In 2015 we added medication error reporting to the system. In response to our AHRQ Culture of Safety Survey data, Leadership has been tasked with identifying and reducing the perception of the potential for punitive action for reporting and for providing feedback to staff about what happens when they do report. The Table below demonstrates a continued improvement in the staff's willingness to report.

Notification Type	2015	2016	Activity
Good Catch • Medication related • Systems/Process related	 5 7	 10 15	 100% increase
Risk Notification	781	1132	45% increase

Themes identified by both types of reporting are addressed by Leadership, Medical Staff and the Safety Committee to reduce the potential for harm for patients, employees and visitors. The ideal level of reporting proposed by national patient safety and quality forums is 2 notification forms per employee per year. We are not there yet but have made an excellent start.

VI. Goals and Risk Reduction Strategies for fiscal year 2017

Proposed Goals for the next fiscal year include:

- Continue to build the infrastructure of the program through database development and reporting.
- Monitor compliance with the use of risk reports to ensure frontline staff feedback.
- Continue Human Factors design education to leadership and staff in collaboration with Program Beta.
- Continue to work with the Medical Staff to hardwire an effective case review and reporting process.
- Focused work on meeting compliance standards for grievance resolution.
- Complete any incomplete strategies from last year.

4.

MEDICATION SAFETY

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

MEDICATION SAFETY

Chris Kutza, PharmD
Director of Pharmacy
Sonoma Valley Hospital

WHY MEDICATION SAFETY?

- 2001: 18 month old Josie King died of a third world disease – dehydration--- in the best hospital in the world. Peter J. Pronomost, MD
- 1994: Betsy Lehman, "Boston Globe Reporter Dies After Receiving An Accidental Four-Fold Overdose of Chemotherapy"
- "ADEs account for nearly 700,000 emergency department visits & 100,000 hospitalizations each year. ADEs affect nearly 5% of hospitalized patients, making them one of the most common types of inpatient errors"*

*https://psnet.ahrq.gov/primers/primer/23/medication-errors (Accessed 8/2016)

OBJECTIVES

- Show how SVH identifies unsafe practices
- Summarize how the hospital addresses unsafe practices
- Report the SVH rate of “Good Catches”
- Report the SVH rate of high risk errors
- Provide overview of home medication reconciliation process improvement initiative

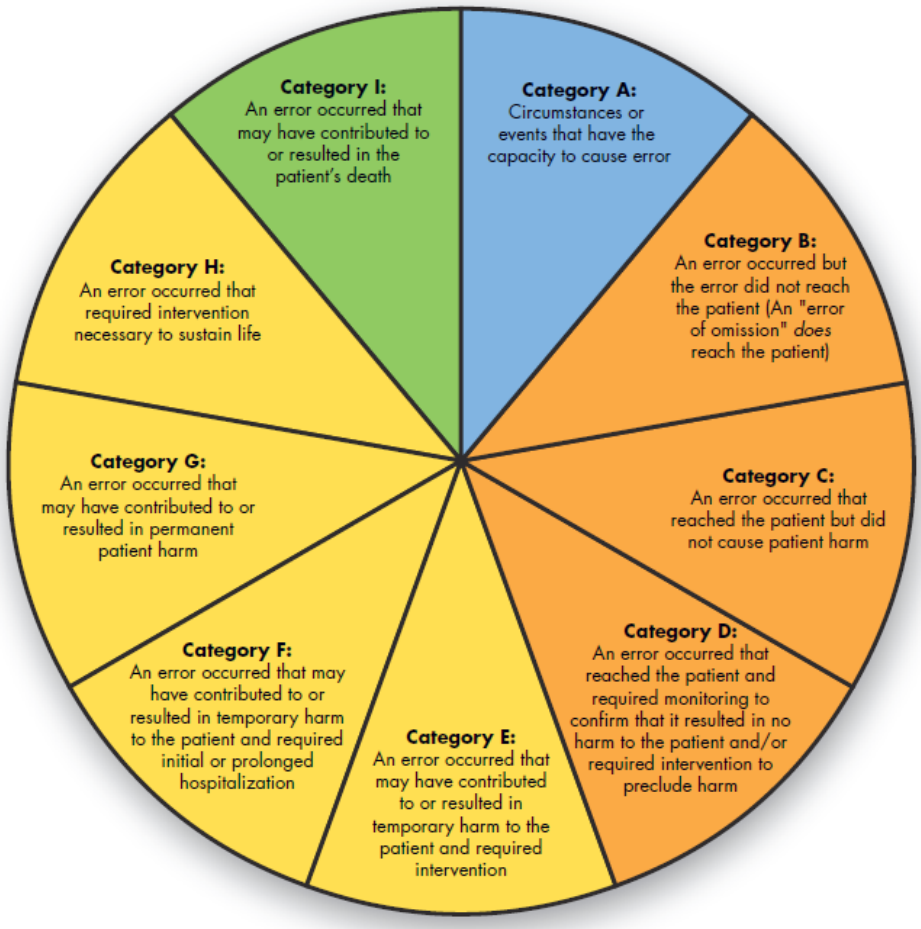
HOW DO WE IDENTIFY UNSAFE PRACTICES?

Midas eNotification System

eNotification Reporting System

(Unexpected Event, Good Catch, Grievance, Compliments)

MEDICATION ERROR CLASSIFICATION-SEVERITY



- No Error
- Error, No Harm
- Error, Harm
- Error, Death

Definitions

Harm
Impairment of the physical, emotional, or psychological function or structure of the body and/or pain resulting therefrom.

Monitoring
To observe or record relevant physiological or psychological signs.

Intervention
May include change in therapy or active medical/surgical treatment.

Intervention Necessary to Sustain Life
Includes cardiovascular and respiratory support (e.g., CPR, defibrillation, intubation, etc.)

MEDICATION ERROR CLASSIFICATION-11 CATEGORIES

- Administration
- Compounding
- Dispensing
- Education
- Monitoring
- Packaging and nomenclature
- Prescribing
- Prescription order communication
- Product Labeling
- Use

HOW DO WE ADDRESS IDENTIFIED ISSUES?

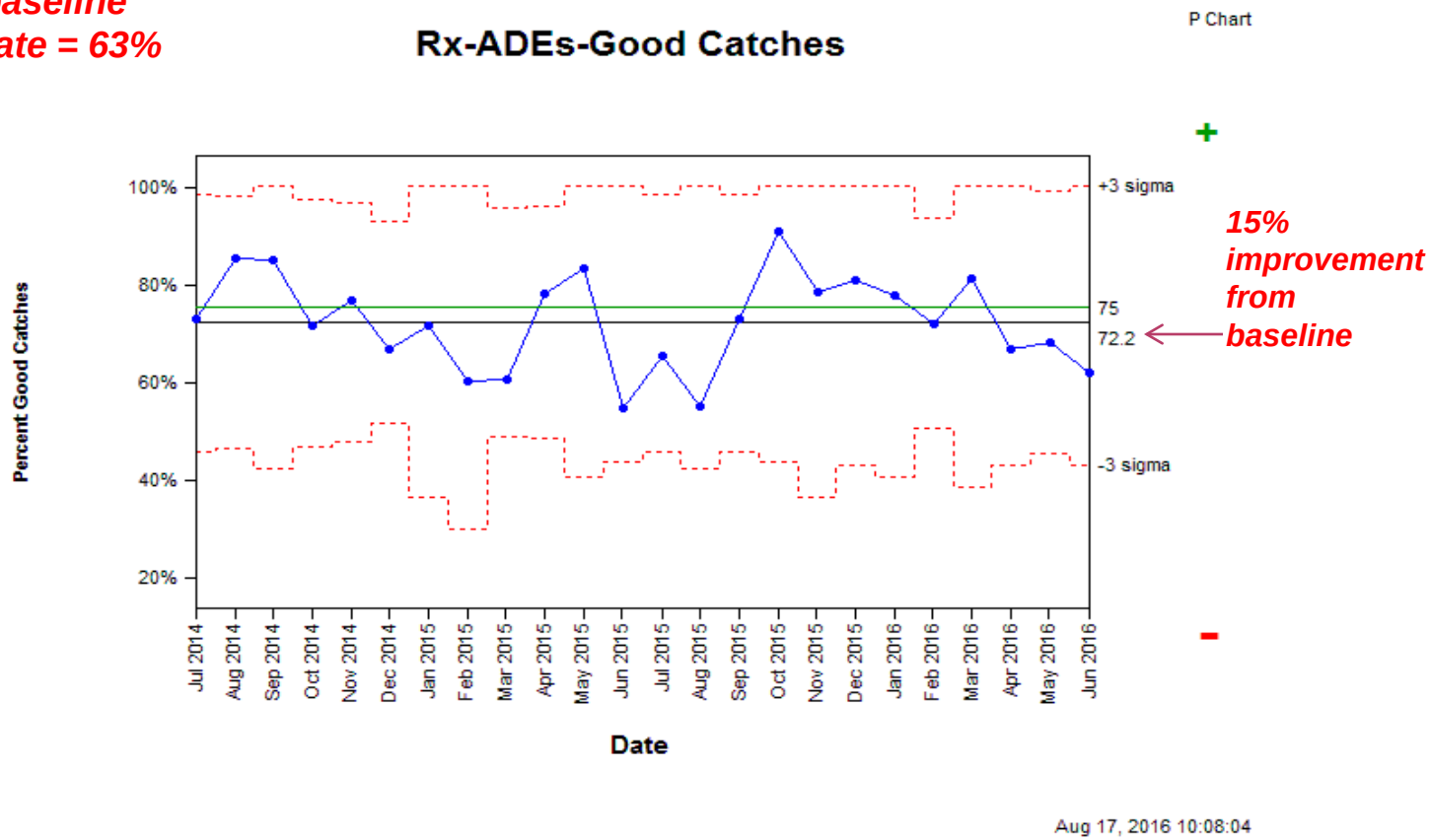
- Good Catch program to recognize those who report safety issues
- Summarize actions taken in annual MERP update
  - Vancomycin level timing issue-multidisciplinary team created and process adjusted to address weak points
  - Look alike vials reported-barcode scanning implemented for pharmacy delivery and changed method of storage
  - Computer system did not cap dose for a pediatric medication-informatics team created CPOE order set to correct this issue and reviewed other orders for same issue
- Root cause analyses
  - Determine the root cause or causes and correct those system steps to prevent future problems

MONITORING PROGRESS

- QAPI includes two metrics
  - Percent of notifications that are good catches (i.e. near misses)
    - The higher the better
  - Errors involving high risk medications that reach the patient per 10,000 doses dispensed
    - Insulin
    - Opiates
    - Anticoagulants
    - Paralytics
    - Parenteral nutrition

MONITORING PROGRESS

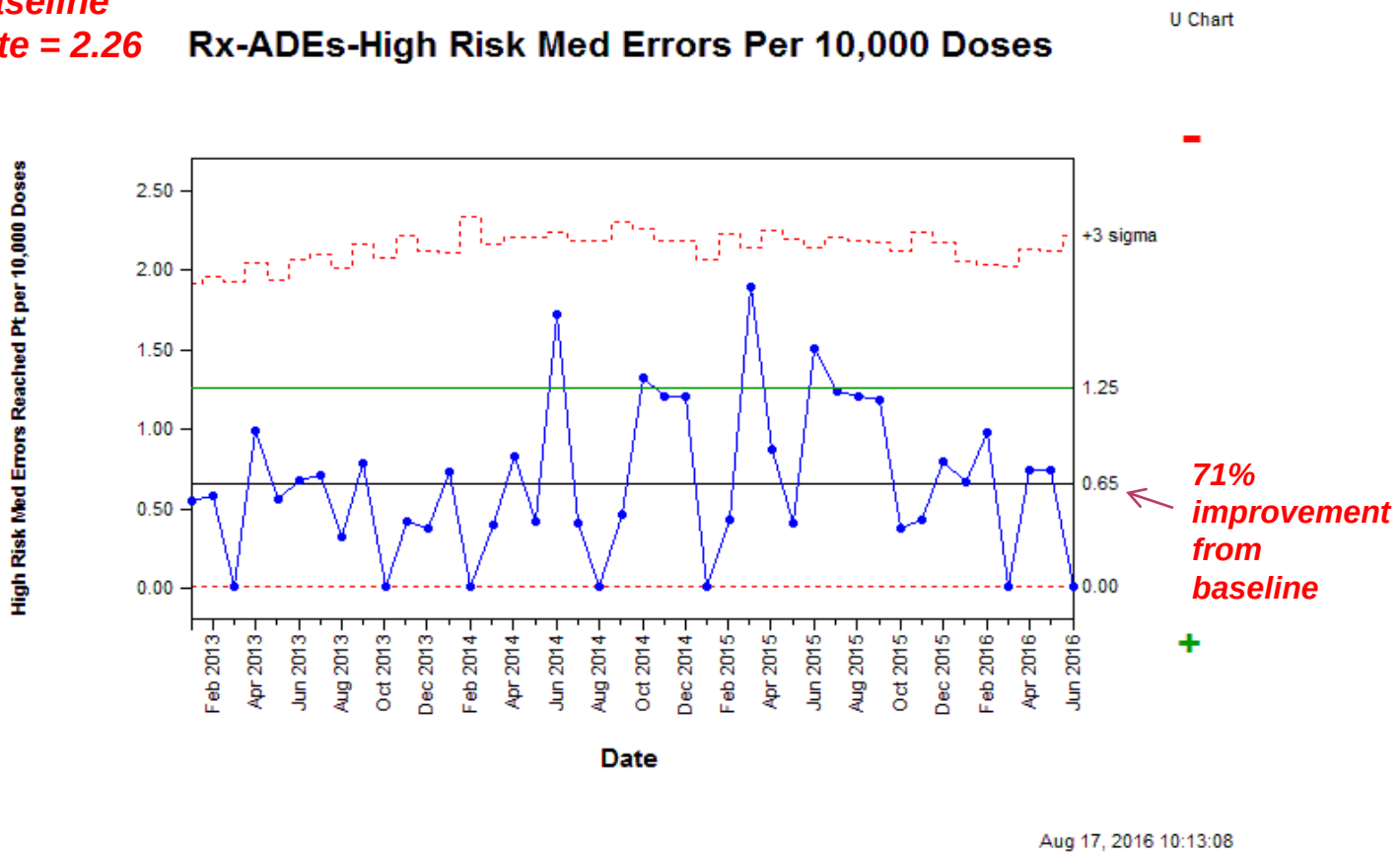
Original baseline rate = 63%



15% improvement from baseline

MONITORING PROGRESS

Original baseline rate = 2.26



71% improvement from baseline

SUMMARY OF REPORTS AT SVH

- In 2016 YTD top categories are
  - Prescription order communication
  - Prescribing
  - Use
- Administration errors decreased by approximately 70% after implementation of bedside barcoding
  - 51 in 2012
  - Averaging 14 per year for 2013-2016

ERRORS WITH HARM

- One error report that involved harm in past 24 months
  - Patient received Lorazepam instead of Glucagon
  - Developed nausea and was given ondansetron to treat adverse effect
  - Patient given correct medication and informed of error
  - Apparent cause of error was bypassing of key medication administration steps and not labeling syringes

MEDICATION RECONCILIATION

- Definition: Medication reconciliation is the process of creating the most accurate list possible of all medications a patient is taking — including drug name, dosage, frequency, and route — and comparing that list against the physician's admission, transfer, and/or discharge orders, with the goal of providing correct medications to the patient at all transition points within the hospital.
- Past studies of the accuracy of home medication histories showed 70%-80% rate of inaccuracy per patient and 30%-40% rate of inaccuracy per drug
- At SVH process changed to have pharmacist or pharmacy intern perform medication histories on inpatients
  - Prior study showed pharmacist performed medication histories resulted in 70% improvement in completeness
- Challenges include long turn-around time, ready access to accurate information, time spent on process can be extensive

MEDICATION RECONCILIATION

- *Upcoming actions being taken:*
  - *Use of remote pharmacy services to update home medication histories in real time*
    - *Will improve turn around time*
    - *Allows on site pharmacist to focus attention on patient interview process*
  - *Purchase of workflow software (MedMined) with Prime grant funds for transitions of care*
    - *Allows 30 day post discharge prescription monitoring*
    - *Provides pharmacy fill data in an easy to interpret format*
  - *Upgrade of McKesson Paragon to include Rx Writer and Electronic Prescribing of Controlled Substances*
    - *Allows prescribers to transmit prescriptions electronically while capturing the data in the patient's chart and medication list*

THANK YOU!

6.

POLICY & PROCEDURE

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

Policy and Procedure - Approvals Signature Page

Review and Approval Requirements

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

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

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

Departmental: Surgical Services IC7471-114 Flexible Endoscopes Reprocessing of, PC7420-107 Attire and Traffic in the Operating Room	
APPROVED BY: **Director of Surgical Services**	DATE: **5-22-16**
Director's/Manager's Signature	Printed Name **Allan Sendaydiego, RN BSN**

Michael Brown, MD
Chair Surgery Committee

7/26/16
Date

Douglas S Campbell, MD
Chair Medicine Committee

6/9/16
Date

Keith J. Chamberlin, MD MBA
President of Medical Staff

7/21/16
Date

Kelly Mather
Chief Executive Officer

7/21/16
Date

Jane Hirsch
Chair, Board of Directors

7/27/16
Date

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

Policy Submission Summary Sheet

Title of Document: **Organizational Policies**

New Document or Revision written by: **Multiple – May List**

Date of Document: **5-18-16**

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

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

IC7471-114 Flexible Endoscopes, Reprocessing of – Revised; added instructions that Scope Buddy to be left full of decontamination fluid or clean rise water - never to left air-purged and stored empty between use.

PC7420-107 Attire and Traffic in the Operating Room – Revised; added surgical masks should be replaced for each procedure; masks to be removed and discarded when leaving Surgery Department and Surgery Care Unit areas.

Reviewed by:	Date	Approved (Y/N)	Comment
Policy & Procedure Team	5/17/2016	Yes	
Surgery Committee	6/01/2016	Yes	Allan to present
Medicine Committee	6/09/2016	Yes	Allan to present
P.I. or P. T. Committee	n/a		
Medical Executive Committee	6/16/2016	Yes	
Board Quality	6/22/16	No	Not *agendized*
Board of Directors	7/7/16	No	Not *agendized*
Board Quality	**8/24/2016**		
Board of Directors	**9/01/2016**		

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

SUBJECT: Flexible Endoscopes, Reprocessing of	POLICY # IC7471-114
	PAGE 1 of 3
DEPARTMENT: Central Sterile	EFFECTIVE: 2/96
APPROVED BY: Director of Surgical Services	REVISED: 8/01, 9/06, 8/13, 5/16

Purpose:
To prevent disease transmission through use of flexible endoscopy equipment

Policy:
Flexible endoscopes will be manually cleaned in the reprocessing room and placed in the Medivator DSD-201 endoscope reprocessor for decontamination and high level disinfection following each use.

Procedure:

1. Immediately after procedure is complete, wipe down insertion tube and distal tip with disinfectant. With tip in enzyme solution, suction appropriate amount of fluid through scope until suction tubing is clear. Turn off light source/processor, air/water bottle, and suction tubing from light guide.
2. Disconnect scope from processor and then cap EVE (camera) connector, and place in transport container and carry to reprocessing room in a covered container or bag.
3. Materials/equipment needed in the reprocessing room:
    - Personal protective equipment (gloves, gown, facemask, eyewear).
    - Sink of enzymatic solution prepared according to manufacturer's directions
    - Channel cleaning brushes
    - Lint free wash cloth
4. In reprocessing room, scope is removed from transport container and bag to do macro leak test. Look for major leaks, (rapid drop in pressure). If this occurs, **discontinue reprocessing and call for technical assistance.**
5. Place scope in enzymatic cleaning solution and check for micro leaks while leaving leak tester attached to scope. Do not submerge leak tester. If no leaks are found, disconnect leak tester after lifting connector out of the solution and continue reprocessing.
6. Air/water suction and channel suction valves (if applicable) are removed and cleaned.
7. Brush suction valve housing and biopsy port housing, then pass channel brush from control section to suction barb inlet, to* biopsy port inlet, and then to distal tip (1, 2, 3 method). NOTE: use triple pulsating technique as you work brush through scope. *To be brushed with a 1 ½" cleaning brush.
8. Scopes are then flushed with a power flush (Scope Buddy®). Scopes are placed into the Medivator CER-2 reprocessor so that they will be completely submerged and cleaning lines are attached at the proximal suction and air/water connectors, and the water jet channel.

~~8.~~ If the "Scope Buddy" was unused for an extended period of time such as overnight or over the weekend, it should be left full of decontamination fluid or clean rinse water. This

maintains the pump head decontamination, lubrication, and facilitated priming. The "Scope Buddy" should never be left air-purged and stored empty between use.

9. Test the disinfectant concentration, determine if disinfectant meets minimum effective concentration (MEC) and log results. Replace disinfectant if beyond reuse life date or below MEC.
10. Load endoscope and attach appropriate endoscope hook-up to endoscope. For DSD-201 machines, attach all channel hook-ups before loading the second endoscope. Verify tubing is not kinked or pinched.

Run the Reprocessing Cycle

1. Place floating lid on the basin. Verify endoscope or hookup does not contact floating lid and close reprocessor lid.
2. Test HLD with test strips to confirm potency.
3. Press Station Select and choose Station A or B
4. Press ID DATA button and enter ID data (if applicable): serial number, operator ID, patient ID, physician ID
5. Select disinfection program and press START
6. DSD Prompts: LCG Test Pass? "PRESS ENTER," if test strip passed. Press "CANCEL" if failed; dump and replace HLD.
7. Verify fluid flows through hookups, endoscope channels and from distal end and that there are no leaks.
8. Complete the Reprocessing Cycle
9. Open reprocessor lid when LCD Screen displays "Completed". Confirm endoscope ID number on print out is correct, and "Completed" is documented.
10. Remove floating lid, disconnect hookup and remove endoscope. If any hookup component connection is loose or disconnected during the cycle, endoscope must be reprocessed.
11. Store hookup and reprocessed endoscope with all removable parts detached.

End of Day Shutdown
Close incoming water line
Sanitize upper basins and basin lids with an EPA-registered sanitizer

To empty and Refill High-Level Disinfectant (HLD), Detergent and Alcohol

1. Amount of HLD required: 4 gallons
2. Load disinfectant from basin or internal transfer pump
3. Disinfection cycle count (set-up 16) cycle warning/override (Set-up 7)
4. Draining HLD (dump) automatically or with internal transfer pump
5. Cleaning of disinfectant reservoir tank with lint-free cloth and water
6. Replacing disinfectant filters - at every disinfectant dump/load procedure

7. Perform a Set-up 16 to verify cycle count has reset to zero. Clearing cycle count (Set-up 11)
8. Load detergent and alcohol (if applicable)

Daily Maintenance

1. Check and refill detergent reservoir if used
2. Clean detergent reservoir if using diluted solution
3. Refill alcohol reservoir if necessary
4. Wipe basins with lint-free cloth
5. Drain condensation from air tank (pull ring on tank)

Weekly Maintenance

Lubricate the connector O-ring in the leak test hookup with silicone oil

References:

Medivator Reprocessing Systems DSD-201 Endoscope Reprocessor User/Service Manual

Standards of Infection Control in Reprocessing of Flexible Endoscopes. Society of Gastroenterology Nurses and Associates. (2009)

Recommended Practices for Cleaning and Processing Endoscopes and Endoscope Accessories. AORN Standards, Recommended Practices, and Guidelines, 261-267 (2012).

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

SUBJECT: Attire and Traffic in the Operating Room	POLICY # PC7420-107
	PAGE 1 of 2
DEPARTMENT: Surgery	EFFECTIVE: 1997
APPROVED BY: Director of Surgical Services	REVIEW/REVISED: 12/07 8/13, 5/16

Purpose:
To decrease the risk of hospital and medical staff members and visitors serving as potential sources of infection, surgical attire, which includes scrub clothes, hair coverings, masks, protective eyewear, and other protective barriers, is worn to provide a barrier to contamination that may pass from personnel to patient as well from patient to personnel

Policy:
All persons entering the semi-restricted and restricted areas of the surgical suite shall wear attire intended for use only within the surgical suite.

Procedure:

A. All persons must be attired in a scrub suit provided by the hospital when entering the semi-restricted or restricted areas of the surgical suite. Appropriate attire is laundered by the hospital and made of fabric that meets or exceeds the "standards for the Use of Inhalation Anesthetics" of the National Fire Protection Association.

B. All head and facial hair shall be covered with a disposable surgical cap or hood provided by the hospital.

C. Scrub tops should be tucked into pants.

D. Non-scrubbed personnel should wear long-sleeved jackets that are buttoned or snapped closed during use. This prevents shedding from bare arms.

E. Clean, single-use, disposable masks should be worn in surgical environments where open sterile supplies or scrubbed persons may be located. Masks should cover both mouth and nose and secured to prevent venting. The string of the tie mask is tightly secured at the top of the head. The bottom string is tightly secured at the nape of the neck. Surgical masks should be replaced for each procedure. Masks should be removed and discarded when leaving the Surgery Department and Surgery Care Unit (SCU).

F. Shoes that provide protection are worn. Cloth shoes are not recommended since they do not offer protection against spilled liquids or sharp items that may be dropped or kicked. Shoes have enclosed toes and heels to minimize injury. When outside shoes are worn, shoe covers should be worn for sanitation purposes. Shoe covers should be removed when leaving surgery department. They should be changed whenever visibly soiled.

G. Nails are short, clean, and free of infection and the cuticles manicured. Artificial nails may not be worn.

H. Jewelry worn in the OR must be confined within the scrub attire. Rings should be removed from hands. If a wedding band is worn, it must be removed when washing hands. A watch may be worn except by those who scrub. Facial jewelry (i.e. eyebrow piercing, nose piercing) is contained with a Band-aid.

I. Sterile gloves must be worn when performing sterile procedures.

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

SUBJECT: Attire and Traffic in the Operating Room	POLICY # PC7420-107 PAGE 2 of 2
DEPARTMENT: Surgery	EFFECTIVE: 1997
APPROVED BY: Director of Surgical Services	REVIEW/REVISED: 12/07 8/13, 5/16

J. Unsterile gloves may be worn for other tasks, changed between patients and hands should be washed after removing gloves.
K. Protective eyewear, masks or face shields are worn to reduce incidence of contamination of mucous membranes.
L. "Bunny Suits" are acceptable for covering street clothes to enter a restricted area for a short amount of time.
M. Persons arriving in scrub attire to the department must change into clean SVH scrub attire before entering restricted areas. Under no circumstance will a person wear scrubs from outside SVH into the operating rooms.
N. After daily use, reusable surgical attire should be laundered in a facility approved and monitored laundry.
O. Clean personal hygiene is expected. Fragrances are not allowed due to staff and patient sensitivities and allergies.
P. Cover apparel is not required when individuals leave the operating room area. Scrub apparel that becomes soiled or contaminated is changed before re-entry to the operating room area.
Q. Hospital Infection Control Policy and OSHA regulations prohibit food and liquid consumption by personnel in areas used for patient care and patient care equipment. Liquids are consumed in designated, non-patient care area only.
R. Newspapers, cloth backpacks, cloth tote bags, or other non-work related items are prohibited in the operating rooms.

References:
2012 AORN Standards, Recommended Practices, and Guidelines, Denver
OSHA
CDC Guidelines
NIAHO IC.1, SS.1

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

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 Policies June List 2016	
APPROVED BY:	DATE: **5-22-16**
Director's/Manager's Signature	Printed Name **Mark Kobe, RN MPA**

Michael Brown, MD
Chair Surgery Committee — Date: 6/9/16

Douglas S Campbell, MD
Chair Medicine Committee — Date: 6/9/16

Keith J. Chamberlin, MD MBA
President of Medical Staff — Date: 6/21/16

Kelly Mather
Chief Executive Officer — Date: 7/21/16

Jane Hirsch
Chair, Board of Directors — Date

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

Policy Submission Summary Sheet

Title of Document: **Organizational Policies**

New Document or Revision written by: **Multiple June List**

Date of Document: **5-18-16**

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

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

PR8610-103 Aid in Dying - New Policy addressing the hospital's response to California End of Life Option Act.

PC8610-109 Autotranfusion Protocol – New Policy

QS860-106 Code Management for Patient Emergency - Code Blue - Revised; Code Blue to be announced in the all areas including ED; updated ED response protocol The operator will announce Code Blue and location on the overhead paging system three (3) times in succession, ten (10) seconds apart; Code Blues will not be announced overhead for codes occurring in the Emergency Department.

GL8610-126 Code of Conduct - Revised; changed reporting format to E-Notification on policy and form.
Code of Conduct Form – Reviewed, no changes

GL8610-136 Conflict Management - Revised; added to align with District Board policy; In the event of a conflict between the Medical Staff and the District Board and or Administration that cannot be resolved informally, the conflict resolution process described in section 14.6 of the Medical Staff By-Laws shall be followed. Outlines the process according to Section 14.6 of the By-Laws.

MM8610-105 Malignant Hyperthermia, Management of the Patient with - Revised; Deleted Sterile Water 1L bags, tubing, and stockcock from Contents list; Added Sterile Water 100ml vials x12, added locations for insulin vials, increased number of alcohol pads and mini-spikes to 30 each

Reviewed by:	Date	Approved (Y/N)	Comment
Policy & Procedure Team	**5/17/2016**	**Yes**	
Surgery Committee	**6/01/2016**	**Yes**	Mark Kobe to present
Medicine Committee	**6/09/2016**	**Yes**	Chris/Mark to present
P.I. or P. T. Committee	n/a		
Medical Executive Committee	**6/16/2016**	**Yes**	
Board Quality	**8/24/2016**		
Board of Directors	**9/01/2016**		

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

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.

Department: Information Systems Department IM8480-07 Information Systems Cyber Attack Response – New Policy	
APPROVED BY: **Director of Information Systems**	DATE: **4-19-16**
Director's/Manager's Signature	Printed Name **Beverly Seyfert**

Brian Sebastian, MD
Chair, P.I. & P.T. Committees

6/23/16
Date

Leslie Lovejoy, RN
Chief Quality & Nursing Officer

6/23/16
Date

Keith J. Chamberlin, MD MBA
President of Medical Staff

7/21/16
Date

Kelly Mather
Chief Executive Officer

7/21/16
Date

Jane Hirsch
Chair, Board of Directors

Date

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

Policy Submission Summary Sheet

Title of Document: **Information System Department Policy**

New Document or Revision written by: **Beverly Seyfert**

Date of Document: **4-19-16**

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

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

IM8480-07 Information Systems Cyber Attack Response– New Policy to ensure a swift and effective response to an actual or perceived cyber attack. To safeguard the hospital's key clinical and business systems and data.

Reviewed by:	Date	Approved (Y/N)	Comment
Policy & Procedure Team	**4/19/2016**	Yes	
Surgery Committee	n/a		
Medicine Committee	n/a		
P.I. Committee	4/28/2016	No	No quorum
P.I. Committee	**6/23/2016**	Yes	Beverly to present
Medical Executive Committee	**7/21/2016**	**Yes**	
Board Quality	**8/24/2016**		Fe to present
Board of Directors	**9/01/2016**		

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

SUBJECT: Information Systems CyberAttack Response	POLICY # IM8480-07
	PAGE: 1 OF 2
DEPARTMENT: Information Systems	EFFECTIVE: 04/16
APPROVED BY: CIO	REVIEW/REVISED:

Purpose:
To ensure a swift and effective response to an actual or perceived cyber attack. To safeguard the hospital's key clinical and business systems and data.

Policy:
This policy describes the steps to be taken if a cyber attack appears to be taking place. This may occur at any time in or outside of business hours. If the attack begins outside of business hours, the IS On-call tech will probably be the first to be notified. If the attack begins during business hours, the Help Desk will probably receive the call. Regardless, a rapid response will be critical to managing and mitigating the attack.

Key thoughts:

Since time will be critical, the IS tech notified (either at the Help Desk or on-call after hours) will need to move quickly to determine the threat and respond. There may not be time to involve senior IS management in decision-making. The IS tech will have **full authority** to have the Nursing Supervisor call a Code Triage, move the clinical departments to downtime, and deal with the threat.

Procedure:

1. IS is notified (though a call to the Help Desk or a page to the IS On-call tech.

During Business Hours:

1. The tech receiving the report notifies everyone currently in the IS department
2. The tech receiving the call may turn over primary response to another tech who is more qualified, if applicable.
3. The people in the department will divide up and perform the following tasks **in sync**:

Investigation / Remediation team

1. Confirm (through remote access / other methods) that an attack appears to be occurring.
2. Remove the affected workstation from the network (have it shut off, remotely shut it off, etc)
3. Disconnect the following devices in order from the network:
    a. SVH-FP01

b. SVH-FP02
c. Unitrends backup system
d. SVH-HISDB-LIVE
e. Others?

Communication Team:

1. Notify the Nursing Supervisor to call a Code Triage and move all clinical departments to downtime.
2. Notify the CIO and Director of Information Services.
   a. CIO will alert Senior Administrative Leadership. If she/he isn't available, the Director of Information Services will notify Senior Administrative Leadership.
3. Notify the Help Desk (internal – may need to brief afternoon support staff)
4. Install a laptop in the Schantz conference room for use by Incident Command staff.

After Business Hours:

1. The tech receiving the call confirms (through remote access / other methods) that an attack appears to be occurring.
2. Remove the affected workstation from the network (have it shut off, remotely shut it off, etc)
3. Notify the Nursing Supervisor to call a Code Triage and move all clinical departments to downtime.
4. Disconnect the following devices in order from the network:
   a. SVH-FP01
   b. SVH-FP02
   c. Unitrends backup system
   d. SVH-HISDB-LIVE
   e. Others?
5. Notify the CIO and Director of Information Services.

7.

QUALITY REPORT
AUGUST 2016

To: Sonoma Valley Healthcare District Board Quality Committee
From: Leslie Lovejoy
Date: 08/24/16
Subject: Quality and Resource Management Report

August Priorities:

1. PRIME Grant Activities
2. CMS published metrics for quality outcomes
3. Credentialing Verification Organization Selection
4. Annual PI Fair (handout attached; need two judges)

1. *Prime Grant Activities*

I provided education on the Prime Grant to Leadership, Home Care, the Emergency Department and provided an overview of the grant metrics and budget to the Finance Committee. Enthusiasm is high. I have attached the proposed budget and the table below outlines the activities needed to meet metrics as well as the timeline. Our Community Case Manager is in orientation for both SNF and Acute Case Management so she can understand out process and then I will start her learning curve for the Emergency Department and Home Care. We sent a case management team to the SVCHC Open House and Tour on the 12th and they began to identify key contacts. We will have a follow-up visit in the next two weeks.

Metric Activities	***% Complete***	***Final Completion Date per DCHS***	***Reporting Dates***
Infrastructure #1: • Hire a Community/ED Case Manager • Establish a high risk tool for the ED & Acute • Develop a standardized workflow for case management • Build the Midas Community Case management module for tracking activities & train case managers.	25%	January 30, 2017	Progress Reports: September 2016, March 2017, final June 2017
Infrastructure #2: • Install Care Transitions Module of the MedMind software and test linkages to area outpatient pharmacies. • Train physicians and case managers on the use of the	25%	March 30, 2017	Progress Reports: September 2016, March 2017, final June 2017

module for tracking home med and completing medication reconciliation • Identify medication reconciliation process in the PCP's office and how to capture data.			
<u>Infrastructure#3</u>: • Develop a role description, workflow process, educational standards for the community health coach role. • Recruit and train voluntary health coaches. • Pilot project to identify any gaps in process. • Full implementation for health coach caseloads.	25%	June 30, 2017	Progress Reports: September 2016, March 2017, final June 2017
<u>Pay for Performance</u> • Medi-Cal ED utilization rates reduction	Ability to report is in place (100%)	Still under some construction for baseline and expected improvement targets by DCHS	Baseline June 2017, then every 6 months until end of grant
• Medi-Cal all Cause Readmission rate	Ability to report is in place (100%)	Still under some construction for baseline and expected improvement targets by DCHS	Baseline June 2017, then every 6 months until end of grant
• HCAHPS Care Transitions questions: need to identify the process for telephonic surveys; have the script from CMS. Will bring a team together to work on.	0% will want to have the process in place by January 30, 2017	Still under some construction for baseline and expected improvement targets by DCHS	Baseline June 2017, then every 6 months until end of grant
• Discharge Medication Reconciliation includes in hospital ADE/Allergies information. Team working on and will have a solution by the end of this month.	75% Will start manually abstracting and build electronic version this fall	Still under some construction for baseline and expected improvement targets by DCHS	Baseline June 2017, then every 6 months until end of grant
• Medication reconciliation in the outpatient PCP office within 30 days of discharge. This is challenging but I think I have a plan.	0%	There is some push back from hospitals that down own their own clinics. This may disappear but will go forward anyway.	Baseline June 2017, then every 6 months until end of grant
• Transition Record: there are 6 elements to this report which needs to be created from items in the electronic record. Team set for the next few weeks to begin this build.	0%	Still under some construction for baseline and expected improvement targets by DCHS	Baseline June 2017, then every 6 months until end of grant

2. *Quality Outcome Metrics*

CMS has published the following Data regarding our performance in Quality Metrics.

- Our annual values Based Purchasing Metric based on calendar year 2015 performance has resulted in earning back the 2% Medicare withholding and an additional 1.0435695254% incentive payment for fiscal year 2017 reimbursement.
- Our performance on 30-day all cause unplanned readmissions resulted in our meeting national benchmarks and therefore not incurring a readmission penalty of 2%. This is base on July 2012 through June 2015 data.
- CMS awarded the hospital 4 stars out of 5 putting us in the top 25% of hospitals included in their database.

3. *Credentialing Verification Organization(CVO)*

We have selected a CVO (Verge Credentialing Solutions)and had our first implementation webinar on the 19th. It is a web based product and will in the near future eliminate the need for paper processing. I expect to have the whole process up and running by the end of October.

4. Annual PI Fair: September 29, 2016. See flyer attached.

Topics for discussion this meeting:

- Medication Safety and Adverse Medication Events: Chris Kutza, PharmD, Director
- Cyber Security and Risk Management: Fe Sendaydiego, CIO

Annual Performance Improvement Fair

***WHEN**:* Wednesday, September 29, 2016 from 0800-1430

WHERE: Administrative Conference Room

WHAT: Come view the innovative performance improvement projects the organization has focused on in an effort to improve the quality, safety and affordability of patient care. Each Department/Leader will have a story to tell!!

PARTICIPATE: Come and vote for your favorite in the annual People's Choice Award. Judges from the Board Quality Committee, Senior Leadership and Medical Staff will award First Prizes to Clinical and Support Services entries.