SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE REGULAR MEETING
AGENDA
WEDNESDAY, July 22, 2015
5:00 p.m. Regular Session
(Closed Session will be held upon adjournment of the Regular Session)

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

AGENDA ITEM	RECOMMENDATION	
MISSION STATEMENT The mission of the SVHCD is to maintain, improve, and restore the health of everyone in our community.		
1. CALL TO ORDER/ANNOUNCEMENTS	*Hirsch*	
2. PUBLIC COMMENT SECTION At this time, members of the public may comment on any item not appearing on the agenda. It is recommended that you keep your comments to three minutes or less, Under State Law, matters presented under this item cannot be discussed or acted upon by the Committee at this time For items appearing on the agenda, the public will be invited to make comments at the time the item comes up for Committee consideration.	*Hirsch*	
3. CONSENT CALENDAR • QC Minutes, 6.24.15	*Hirsch*	Action
4. POPULATION HEALTH STRATEGY PRESENTATION	*Mather*	Inform
5. QUARTERLY PATIENT CARE SERVICES DASHBOARD	*Kobe*	Inform/Action
6. POLICY AND PROCEDURE ▪ Ebola Viral Disease Policy and Procedure_IC8610-145 ▪ NEW Dietician Nourishments Modification_8340-173 ▪ Universal Protocol_PC8610-125 • Counts, Sponges, Sharps and Instruments_PC7420-119	*Lovejoy*	Action
7. QUALITY REPORT JULY 2015	*Lovejoy*	Inform/Action
8. CLOSING COMMENTS/ANNOUNCEMENTS	*Hirsch*	
9. ADJOURN	*Hirsch*	
10. UPON ADJOURNMENT OF THE REGULAR OPEN SESSION	*Hirsch*	
11. CLOSED SESSION: Calif. Health & Safety Code § 32155 • Medical Staff Credentialing & Peer Review Report • Revised Medical Staff Bylaws Rules & Regulations	*Chamberlin*	Action
12. REPORT OF CLOSED SESSION	*Hirsch*	Inform/Action
13. ADJOURN	*Hirsch*	

3.

CONSENT CALENDAR

+

SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
REGULAR MEETING MINUTES
Wednesday, June 24, 2015
Schantz Conference Room

Committee Members Present	Committee Members Present cont.	Committee Members Excused	Admin Staff /Other
Jane Hirsch Carol Snyder Cathy Webber H. Eisenstark Susan Idell Joshua Rymer M. Mainardi Paul Amara MD Kelsey Woodward		Ingrid Sheets	Robert Cohen MD Leslie Lovejoy Mark Kobe Joe Cornett Dawn Kuwahara Vivian Woodall

AGENDA ITEM	DISCUSSION	ACTION	FOLLOW-UP
1. CALL TO ORDER/ANNOUNCEMENTS	*Hirsch*		
	The meeting was called to order at 5:00 pm.		
2. PUBLIC COMMENT	*Hirsch*		
	None		
3. CONSENT CALENDAR	*Hirsch*	Action	
• QC Minutes, 5.27.15		**MOTION** by Rymer to approve and 2nd by Mainardi. All in favor.	
4. WOUND CARE	*Cornett*	Inform	
	Mr. Cornett gave a report on outpatient wound care services including changes in ER practices. An additional nurse will be added in July 2015 to accommodate departmental growth. Mr. Cornett has received national certification and will be receiving diabetic wound certification this summer.		
5. POLICY AND PROCEDURE	*Lovejoy*	Action	.

AGENDA ITEM	DISCUSSION	ACTION	FOLLOW-UP
• Emergency Ops Plan 2015 and HVA 2014-15 • Organizational Multiple, June 2015 • Nutrition Services Multiple #150-172 • Wound Care Multiple PC7740, PC7420, PC 8610… • Organizational Multiple, May 2015-GL8610, PI8610, PR8610 • Pharmacy Policies-MM8610 124, 141, 147 • Discharge Planning-DC8610 265 • Infection Prevention Program-IC8610-113	All policies have been moved to a three-year review cycle. Ms. Hirsch asked to see completed signature pages on all policies. The Board Clerk will make this change going forward. Mr. Rymer asked whether it would be helpful to have a sentence about what each policy does. Ms. Lovejoy said it is not necessary to understand existing policies in any greater detail, that Quality and Board approval are part of a compliance process. In most instances these policies have already been through several Medical Staff Committees.	**MOTION** by Rymer to approve and 2nd by Idell. All in favor.	
6. QUALITY REPORT JUNE 2015	*Lovejoy*	Inform/Action	
	Ms. Lovejoy attended the CIHQ conference in June and gave a short report of the conference to the Committee.	**MOTION** by Rymer to approve and 2nd by Eisenberg. All in favor.	
7. CLOSING COMMENTS	*Hirsch*		
	None		.
8. ADJOURN	*Hirsch*		
	Regular Session adjourned at 5:49 pm.		
9. UPON ADJOURNMENT OF REGULAR OPEN SESSION	*Hirsch*		
	Dr. Amara announced he is stepping down as President of the Medical Staff. Dr. Chamberlin is the newly appointed President will attend his first QC meeting in July. On behalf of the entire Committee, Ms. Hirsch thanked Dr. Amara for his service.		
10. CLOSED SESSION	*Amara*	Action	
Calif. Health & Safety Code § 32155 • Medical Staff Credentialing & Peer Review Report • Dashboard • Reportable Quality Issue • Changes to Med Staff Bylaws Rules & Regulations		**MOTION** by Idell to approve credentialing and 2nd by Eisenberg. All in favor.	
11. REPORT OF CLOSED SESSION	*Hirsch*	Inform/Action	

AGENDA ITEM	DISCUSSION	ACTION	FOLLOW-UP
12. ADJOURN	*Hirsch* Closed Session adjourned at 6:25 pm.		

4.

POPULATION HEALTH STRATEGY PRESENTATION

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Population Health Strategy 2015 - 2016

- What should SVH do for population health? Screenings, Education, Counseling, Targeted Wellness Coaching
- How should SVH segment community health? Kids, Healthy (Asymptomatic) People, and Symptomatic People
- How do we define or measure success? Number of screenings; Pre/Post test of knowledge and/or Return Demonstration for Education; Counseling & Coaching patient goals met which will soon be reflected in community health dashboard

Healthy Kids are Contagious!	Plan	Goal	Person(s)	Update
Teachers & Parent Wellness Models	Offer Wellness U	10 teachers	Steven	Goal partially met
Health Fairs (School, Health Center, La Luz)	School/Binational/ At Hospital	1000 people	Community Trust Team	School and Binational Health Fair are scheduled. Considering Hospital Fair.
School Wellness Education	6th & 9th grade education	500 kids	Steven/Kelly	Complete, goals met
Health Round Table (Hanna Boys)	ACE Education	All schools	Kelly	Underway with presentations this summer
Parent Health Education through OB	Distribute to new parents	150 parents	Kelly	Complete, goals met
Health Education Books in Emergency	Books in children's area	300 kids	Kelly	Complete will need more books
Health Education Rack Cards	PCP, Health Center, Fairs	1000 people	Suzannah/Celia	Complete (now doing Spanish version)
Pediatric Obesity Program	Consider for FY 2016	n/a	Michelle	Researching options

Keeping Healthy People Healthy	Plan	Goal	Person(s)	Update
Active Aging (Vintage House)	Senior Education & Yoga	500 people	Dawn/Celia	Continue, goals being met
Girl Talk	Quarterly Education	400 people	Celia	Continue with each sold out, expand
Health Moments Education	Radio sponsorship	Weekly	Bob/Celia	Continue using 5 keys for base messages
Outpatient Nutrition Counseling	Counsel at hospital	75 patients	Michelle	Continue to expand, goals met
Aches & Pains Education	Quarterly Education	50 people	Dawn	Continue, goals being met
Balance Screening & Classes	Offer through Rehab	50 patients	Dawn	Continue, goals being met
SVH Staff Wellness Program	Healthy Staff	200 people	Steven	Continue, goals being met
Compass Health Assessment Center (Park Point)	Exercise is medicine	100 people	Steven/Suzannah	Improving system, goal not yet met
Employer Wellness	Market to Occ health	10 orgs	Bob/Steven	Pilot underway, marketing to be done
Integrative Health Network	Team approach to Healing	50 members	Steven/Celia	Succeeding with Case Studies, Next level
Wellness University	Offer 3 times per year	75 Grads	Leslie/Steven	Continue, goals being met

Leading Healing for Life (symptomatic)	Plan	Goal	Person(s)	Update
Community Care Network (Touro & Sonoma State University)	Medi-Cal pilot	8 patients in pilot	Leslie/Robbie	Infrastructure underway, doing grant, will work with PCPs
Advance Directive Education (County)	Community education	# people with AD	Bob/Robbie	Three sessions held so far
Cancer Support Program (NBCA)	Community & Research	100 clients	Kelly	Just beginning
Disease Reversal Program	12 month program	8 clients with CCN	Steven	Begin pilot in 2016
Palliative Care	Education/Focus on ICU	50 Consults/yr	Leslie	Goals not met, Re-doing service
Meritage ACO Coordination	Septicemia Readmission	Reduce	Leslie	Begin in Fall
Buck Institute Lifestyle Medicine	Pilot in August	18 participants	Kelly	Underway
Men's Health Awareness	Consider offering	TBD	Celia/Bob	Researching best practices
Healing Hospital	Model for hospitals	Implement modules	Kelly	Implemented most modules
Mental Health Services	Consider services	TBD	Leslie	Research options in 2016
Ceres & Green light menus	Nutrient rich foods	All patients & staff	Steven	Just beginning
Ceres Project Partnership	Good food to more	Plan	Michelle	Planning grant given by Impact

SUMMARY:

Sonoma Valley Hospital serves the healthcare district which has approximately 40,000 lives which are considered "our population." This overview of our population health services demonstrates this is a major strategy for SVH for the next few years. We are a major leader in health and wellness for Sonoma Valley and are working with our physicians and health care practitioners to create a healthier community. The definition of a "healthy community" and how it is measured is still not clear. However, we aim to create a health dashboard that captures the current state of health and measures the impact these initiatives have on the health of our community in 2016.

The committee is led by the CEO, Kelly Mather and members include Dr. Suzanna Bozzone – Medical Director of Wellness; Dr. Robert Cohen – Chief Medical Officer; Leslie Lovejoy, R.N., PhD – Chief Quality Officer; Steven Lewis – Wellness Coordinator; Dawn Kuwahara, R.N. – Chief Ancillary Officer; Bob Kenney – Chief Marketing Officer; Celia Kruse de la Rosa – Marketing & Community Relations Manager and Michelle Donaldson – Chief Revenue Officer. The hospital offers screenings, health education, counseling and targeted coaching. We segment the population into three major groups: Kids under 18, Asymptomatic Adults and Symptomatic Adults and then offer services that will impact the health of these groups. There is a common message using the "5 Keys to Wellness" health improvement system. We also use agreed upon health education reviewed by physicians and subject matter experts. The population health services listed under each segment have measurable goals. Many of these initiatives are also partnerships with other community organizations. We define our success by the number of screenings, the pre and post knowledge and/or return demonstration after education, and by whether or not coaching or counseling patients meet or make improvement toward their health goals.

5.

QUARTERLY PATIENT CARE SERVICES DASHBOARD

Patient Care Services Dashboard 2015

Patient Care Services Dashboard,
Quarter ending

Medication Scanning Rate	2015				
	Q1	Q2	Q3	Q4	Goal
SNF	N/A				90%
Acute	82.80%				90%

Nursing Turnover	2015			
	Q1	Q2	Q3	Q4
SNF	0	8.40%		
Acute	1.5	8.40%		

Falls (Per 1000 acute care days)	2015				
	Q1	Q2	Q3	Q4	50th %tile
SNF	0.52%				
Acute	1.88%				2.32%

Professional RN Certification	2015			
			Higher Education	
	SVH	Goal	BS	MS
Emergency (CEN)	0	1		
ICU (CCRN)	2	3		
The Birthplace (Inpatient Obstetrics)	1	2		
Med Surg (MSRN)	0	1		
Surgery (AORN, ASPAN)	3	4		
SNF (Gerontology, Palliative care, Long-term care, Resident Assessment Coordinator)	9	10		

Hospital Acquired Pressure Ulcer Incidents (Per 1000 patients)	2015				
	Q1	Q2	Q3	Q4	National
SNF	0%				3.17
Acute	0%				3.68

6.

POLICY AND PROCEDURE

Signed copies of the attached Policies will be emailed separately to Committee members prior to meeting. Signed policies are also available in hardcopy by request.

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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: Ebola Virus Disease Policy and Procedure	
APPROVED BY	DATE: **6-17-15**
Director's/Manager's Signature	Printed Name **Kathy Mathews, RN CIC**

Leslie Lovejoy, RN
Chief Nursing Officer, CQO

Date

D. Paul Amara, MD
President of Medical Staff

Date

Kelly Mather
Chief Executive Officer

Date

Sharon Nevins
Chair, Board of Directors

Date

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Policy Submission Summary Sheet

Title of Document: **Ebola Viral Disease Policy and Procedure**

New Document or Revision written by: **Kathy Mathews RN CIC**

Date of Document: **6-02-15**

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

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

IC8610-145 Ebola Viral Disease Policy and Procedure - NEW policy

The Centers for Disease Control, local and state Departments of Health have recommended that all U.S. hospitals be prepared to care for patients with suspected or confirmed Ebola Virus Disease (EVD). The policy and procedure ensures that the facility is prepared to receive and isolate persons under investigation for EVD and care for the patient until discharge or transfer to a designated EVD treatment hospital is completed. Care will be coordinated under the guidance of the Sonoma County Public Health Department. The purpose of the procedure is to standardize the assessment, triage, management and transport of patients with suspected or confirmed EVD in accordance with CDC recommendations. SVH is committed to providing a safe environment for our patients, staff and visitors. Infection Prevention measures are consistent with the recommendations of the Centers for Disease Control, local and State Departments of Public Health.

Policy

1. The Hospital has staff that is appropriately trained and have documented competency in safe practices to care for EVD patients.
2. The staff follows procedures to identify, isolate and inform appropriate hospital and Department of Health officials when EVD is suspected.
3. The Hospital has systems in place to safely manage waste disposal, cleaning and disinfection.
4. Infection Prevention measures shall be adhered to by all staff involved in the care of EVD patients.

Reviewed by:	Date	Approved (Y/N)	Comment
Policy & Procedure Team	**6/16/2015**	✓	
Surgery Committee	n/a	✓	
Medicine Committee	n/a	✓	
P.I. or P. T. Committee	**6/25/2015**	✓	
Medical Executive Committee	**7/16/2015**		
Board Quality	**7/22/2015**		
Board of Directors	**8/06/2015**		

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POLICY AND PROCEDURE
Approvals Signature Page

Review and Approval Requirements

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- Consistent with prevailing standards of care
- Consistent with evidence-based practice

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

Organizational: 8340-173 Registered Dietitian Nourishment Modifications-new policy	
APPROVED BY:	DATE: **6/17/15**
Director's/Manager's Signature	Printed Name **Paula Davis**

Douglas S Campbell, MD
Chair Medicine Committee

Date

Michael Brown, MD
Chair Surgery Committee

Date

Keith J. Chamberlin, 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: **Nutritional Department-New Policy**

New Document or Revision written by: **Allison Evanson, MS RD**

Date of Document: **6-17-15**

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)

8340-173 Registered Dietitian Nourishment Modifications- NEW policy
When "Nourishment per RD" activated as part of the patient diet order, the Registered Dietitian is allowed to arrange for snacks and/or oral supplements (example: Ensure, Glucerna, Nepro, Magic Cup, protein powder) when appropriate to maximize patient nutrition stats.

Reviewed by:	Date	Approved (Y/N)	Comment
Policy & Procedure Team	6/16/2015	yes	
Surgery Committee	7/01/2015	YES	
Medicine Committee	7/09/2015	YES	
P.I. or P.T. Committee	n/a	NA	
Medical Executive Committee	7/16/2015		
Quality Board	7/22/2015		
Board of Directors	8/06/2015		

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SUBJECT: Registered Dietitian Nourishment Modifications	POLICY # 8340-173
	PAGE 1 OF 2
DEPARTMENT: Nutritional Services	EFFECTIVE: 5/15
APPROVED BY: Food & Nutritional Services Manager	REVIEW/REVISED:

Policy:
To provide protocol for which a Registered Dietitian (RD) may place or modify patient nourishments to facilitate timely intervention for optimizing patients' nutrition intake in promoting nutrition related health outcomes.

Procedure:
1. Physician is responsible for initiating diet order.
2. If physician orders "nourishment policy per RD" as part of the diet order, the RD nourishment protocol will be active.
3. A "nourishment" is defined as any food, snack, or oral nutrition supplement provided with or between patient meals.
4. Nourishments will be provided per physician order or RD request unless contraindicated by the diet order, as outlined in policy 8340-153.
5. If a patient is NPO the RD cannot initiate the nourishment protocol.
6. An active nourishment protocol indicates:
    a. Foods/Snacks
        i. RD can enter meal preferences into the "likes/dislikes" patient meal preferences tab, which becomes a part of the patient tray card. Non-menu meal items can be provided per patient preference unless contraindicated by the diet order.
        ii. Snacks may be provided at 10am, 2pm, and 8pm daily.
    b. Oral Nutrition Supplements
        i. Oral nutrition supplements include: Ensure Plus, Ensure Clear, Glucerna Shake, Nepro, Magic Cup, and Beneprotein Protein Powder. Refer to policy 8340-167 for information on nutrition supplement and formulary.
        ii. Only oral nutrition supplements approved for ordered therapeutic diets may be requested by RD – refer to Attachment 1.
        iii. RD may enter oral nutrition supplements under the "order management" tab of the electronic health record. Amount and frequency of supplement to be provided will be defined.
        iv. RD may modify the frequency, delivery time, and flavor of existing oral nutrition supplements already ordered by the physician.
        v. Oral nutrition supplements ordered by the physician may only be discontinued by the physician.
        vi. Oral nutrition supplements ordered by the RD can be discontinued by the physician or the RD.

Reference:
CIHQ Standard of Care NU-04

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SUBJECT: Registered Dietitian Nourishment Modifications	POLICY # 8340-173
	PAGE 2 OF 2
DEPARTMENT: Nutritional Services	EFFECTIVE: 5/15
APPROVED BY: Food & Nutritional Services Manager	REVIEW/REVISED:

Attachment 1- Approved Oral Nutrition Supplements for Therapeutic Diets

	Ensure Clear	Ensure Plus	Glucerna	Nepro	Magic Cup	Beneprotein
Regular	Y	Y	Y	Y	Y	Y
Cardiac	Y	Y	Y		Y	Y
CCD (Consistent Carbohydrate Diet)			Y	Y		Y
2 Gram Sodium	Y	Y	Y	Y	Y	Y
Renal				Y		
Soft	Y	Y	Y	Y	Y	Y
Mechanical Soft	Y	Y	Y	Y	Y	Y
Puree	Y	Y	Y	Y	Y	Y
Full Liquid	Y	Y	Y	Y	Y	Y
Clear Liquid	Y					
Bariatric Clear Liquid						
NPO						

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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
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- Consistent with prevailing standards of care
- Consistent with evidence-based practice

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

Organizational: PC8610-125 Universal Protocol	
APPROVED BY:	DATE: **6-29-15**
Director's/Manager's Signature	Printed Name **Leslie Lovejoy, RN PhD**

Douglas S Campbell, MD
Chair Medicine Committee

Date

Michael Brown, MD
Chair Surgery Committee

Date

D. Paul Amara, MD
President of Medical Staff

Date

Kelly Mather
Chief Executive Officer

Date

Sharon Nevins
Chair, Board of Directors

Date

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Policy Submission Summary Sheet

Title of Document: **Organizational Policy**

New Document or Revision written by: **Allan Sendaydiego, RN BSN**

Date of Document: **6-29-15**

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

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

POLICY # PC8610-125 Universal Protocol - revised;

1. Changed revised date to 06/15.
2. Under Purpose:
   - Changed "surgical/procedural safety checklist" to "Surgical Safety Checklist".
   - Changed "*pre=procedure verification and procedural site marking*" to "Sign-in section checklist".
   - Changed "*procedural time-out" to "Time-out checklist is…"*
3. Under Procedure:
   - "Pre-Procedure Checklist Verification (TJC – UP.01.01.01)" changed to "Operative Preparation – Sign In".
   - Procedural Site Marking: Omitted "(TJC – UP.01.01.01)."
   - Added, "Procedural Briefing – Time Out". Omitted "(TJC – UP.01.03.01)".
   - Added, ". **It is the responsibility of the entire team to participate in this process and any team member may "STOP THE LINE" until full participation is obtained. All team members are accountable to this process and failure to participate will be documented and reported to the Department Director or Medical Director for follow-up".**
   - Added, "Procedural Debriefing – Sign Out".
4. Under Reference:
   - Removed, "The Joint Commission (TJC) 1/2009 FAQ for the Revised Universal Protocol: UP.01.01.01; UP.01.02.01; UP.01.03.01; TJC SpeakUp Universal Protocol Reference Guide 1/2009."
   - Added World Health Organization websites: www.who.int/patientsafety/en/ and www.who.int/patientsafety/challenge/safe.surgery/en/.
   - Removed "numerous American Medical…".
   -

	Date	Approved (Y/N)	Comment
Policy & Procedure Team	n/a		
Surgery Committee	**07/01/2015**	YES	
Medicine Committee	**7/09/2015**	YES	
P.I. or P. T. Committee	n/a	NA	
Medical Executive Committee	**7/16/2015**		
Board Quality	**7/28/2015**		
Board of Directors	**8/06/2015**		

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SONOMA VALLEY HEALTH CARE DISTRICT
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SUBJECT: Universal Protocol	POLICY # PC8610-125 PAGE 1 OF 5
DEPARTMENT: Organizational	EFFECTIVE: 3/03
APPROVED BY: CNO	REVIEW/REVISED: 1/04 2/08, 4/09, 8/13, 6/15

Purpose:
The overall purpose of this evidence-based Universal Protocol is to improve patient safety and to prevent procedural errors through standardized processes, teamwork and clear communication.

The intent is to ensure that the Surgical Safety Checklist is being completed throughout the process:

1. Sign-in checklist and site marking are completed before induction/administration of anesthesia/sedation.
2. Time-out checklist is completed before skin incision.
3. Sign-out checklist is completed to confirm that specimens are secured and accurately labeled and when applicable, instrument, sponge and needle counts are correct, and identifying any equipment issues before the patient leaves the room.

Policy:
The protocol is not limited to operating rooms; it is relevant to all settings where invasive procedures are performed. The protocol and its implementation guidelines apply to all operative and other invasive procedures. Exemptions are noted in their respective sections.

Procedure:
<u>Operative Preparation – Sign-in</u>
Verification of the correct person, correct site, and correct procedure occurs at the following times:

1. At the time the procedure is scheduled
2. At the time of preadmission testing and assessment
3. At the time of admission or entry into the facility for a procedure, whether elective or emergent.
4. Anytime the responsibility for the care of the patient is transferred to another member of the procedural care team (including the anesthesia providers) at the time of, and during the procedure.
5. With the patient involved, awake, and aware, if possible.
6. When the patient is in the pre-procedure area, immediately prior to moving the patient into the procedure/surgical room, a surgical/procedural safety checklist is to be used to review and document the following items:
   a) Required and all relevant documentation (for example, a valid History and Physical of thirty (30) days old or less with a 24 hour update; nursing assessments, consultations, pre-anesthesia assessment, and physician informed consent.)
   b) Accurately completed and signed procedure/surgical consent form and validated against the physicians order for procedure/surgery ensuring language is spelled out clearly and without abbreviations.

c) Correct diagnostic and radiology test results (for example radiology images and scans, and/or pathology and biopsy reports that are properly labeled with the patient's identification sticker.)
d) Any required blood products, implants, devices and/or special equipment, or assistive personnel (for example vendor representatives or assistants) for the procedure/surgery.

Procedural Site Marking
The objective is to identify without ambiguity, and standardized throughout the facility, for marking the intended site for surgery/ procedure.

A licensed independent practitioner (or other provider who is privileged or permitted by the hospital to perform the intended procedure/surgery) marks the procedure/surgical site **with their initials**. This individual will also be involved directly in the procedure and will be present at the time the procedure is performed.

1. Using a marker that is sufficiently permanent to remain visible after skin preparation and draping. Adhesive site markers are not to be used as the sole means of marking the site.
2. For patients with dark skin pigmentation, the site still should be marked with indelible ink, in addition to using an adhesive sticker with the surgeons/ proceduralists initials, placed next to the site.
3. Mark all procedures that involve incisions, percutaneous punctures (see areas to be excluded - item number 7), or insertion of instruments; taking into consideration: Surface (e.g. flexor, extensor)
   - Spine level
   - Specific digit or lesion to be treated
   - Laterality: for procedures involving laterality of organs, but where the incision (s) or approaches may be from the mid-line or from a natural orifice, mark the site and make a note of the laterality.

The mark is made before the patient is moved to the location where the procedure/ surgery will be performed and with the patient, (or the patient's designated representative,) involved, and is awake and aware, if possible.

If a procedural/ surgical site requiring site marking has not been marked, or if a discrepancy exists regarding verifying the site with the patient, the patient's designated representative, or with the surgeon's/ proceduralist's orders, the patient flow preparation process is to **STOP** until the site can be verified and marked.

Patients who refuse site marking will be required to sign a release form indicating that they have been informed of the risks associated with not marking procedural/surgical sites by the surgeon/ proceduralist.

In the event of a life or limb threatening emergency, under the discretion of the surgeon/ proceduralist, not all these steps may be followed and will be documented by the surgeon/ proceduralist in the medical record.

Excluded procedures **not requiring** site marking are as follows:

a. Areas in which no laterality exists
b. Venipuncture
c. Peripheral intravenous line placement
d. Insertion of a naso-gastric tube
e. Insertion of a bladder catheter
f. Lithotripsy
g. Performance of dialysis
h. Mucosal surfaces
i. Perineum
j. Premature infants
k. Interventional procedure cases for which the catheter/ instrument insertion site is not predetermined such as:
    i. Cardiac catherization
    ii. Pacemaker insertion
    iii. Procedures in which real-time CT Guidance or Ultrasound are utilized.
l. Teeth-The operative tooth name(s) and number are indicated on the documentation or the operative tooth (teeth) is marked on the dental radiographs or dental diagram.

Included procedures **requiring** site marking are as follows:

1. Sites involving laterality: Internal organs involving laterality, but where the incisions(s) or approaches may be from the mid-line or from a natural orifice, the surgeon/ proceduralist marks the site externally.
2. For spinal procedures, the mark is made in the general spinal region and the mark is made in addition to special intra-operative radiograph techniques used for marking the exact vertebral level.
3. Insertion of PICC lines
4. Insertion of Central lines
5. Insertion of Chest tubes
6. Insertion of dialysis catheters

Procedural Briefing - Time-Out

The objective is to conduct a final assessment of the following components:

1. Correct patient identified
2. Accurate procedure consent form
3. Agreement on correct procedure
4. Site/side, correct patient position
5. Safety precautions implemented based upon patient history or medication use
6. Any special equipment or implants are available and in the room
7. Relevant images and/or results are properly labeled and appropriately displayed
8. Any preoperative medications administered (for example, antibiotics or beta blockers) are confirmed and documented.

The time-out involves the surgical/ procedural team members who will be participating in the room when the case begins. **It is the responsibility of the entire team to participate in this process and any team member may "STOP THE LINE" until full participation is obtained. All team members are accountable to this process and failure to participate will be documented and reported to the Department Director or Medical Director for follow-up.**

The time-out is initiated by the Circulating RN or surgeon/ proceduralist.

Ideally the time-out is done before the patient receives anesthesia/ sedation unless contraindicated. If not done prior to anesthesia/ sedation, the time-out is done **before** starting the procedure.

- A second time-out is needed to be performed to confirm each subsequent procedure **before** it is started (when two or more procedures are being done on the same patient.

During the time-out, other activities are suspended to the extent possible without compromising patient safety, so that all relevant team members are focused on the active confirmation of the correct patient, procedure, site and other critical elements of the procedure.

- All team members are expected to use interactive verbal communication. Any team member is able to express concerns about the procedure verification. If responses very, the time-out process is to **STOP** until the differences have been reconciled.

The completed components of the Universal Protocol and time out are clearly documented and timed in the patient's medical record by the Circulating RN or surgeon/ proceduralist.

Procedural Debriefing - Sign-Out

Before the patient leaves the room, the following needs to be validated:

1. Circulating RN/ procedure assistant documents the name of the final procedure performed in the nursing/ patient record.

2. Circulating RN confirms with the scrub technician if applicable, that the instrument, sponge, and/or needle count is correct.
3. If applicable, the Circulating RN confirms all specimens removed during the case with the surgeon/ proceduralist and ensures they are all secured and labeled correctly. The specimen information is to be recorded in the nursing documentation.
4. Circulating RN/ procedure assistant, inquires if there were any equipment problems or other issues requiring attention/ follow-up.

Reference:

The World Health Organization (WHO) Surgical Safety Checklist 4/2009; Endorsed by Institute for Healthcare Improvement (IHI). World Health Organization (WHO) website: www.who.int/patientsafety/en/; www.who.int/patientsafety/challenge/safe.surgery/en/.

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POLICY AND PROCEDURE
Approvals Signature Page

Review and Approval Requirements

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

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

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

Departmental: PC7420-119 Counts, Sponges, Sharps and Instruments	
APPROVED BY **Surgical Services Department Director**	DATE: **6-29-15**
Director's/Manager's Signature	Printed Name **Allan Sendaydiego, RN BSN**

Leslie Lovejoy, RN Chief Nursing Officer	Date
Michael Brown MD Chair Surgery Committee	Date
D. Paul Amara, MD President of Medical Staff	Date
Kelly Mather Chief Executive Officer	Date
Sharon Nevins Chair, Board of Directors	Date

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Policy Submission Summary Sheet

Title of Document: **Surgical Services Department Policy**

New Document or Revision written by: **Allan Sendaydiego, RN BSN**

Date of Document: **6-29-15**

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

PC7420-119 Counts, Sponges, Sharps and Instruments- revised;

- Under Section D (Instruments):
  2. Added, "For example, in Total Knee Replacement procedures, patella protectors, patella sizers, and fixation pins will included in the count."
  3. Added, "Inspect sharps, instruments, or other items returned from the operative site for signs of breakage to prevent the retention of device fragments. The process may include a physical inspection of the wound and sterile field, and an x-ray film image of the surgical wound.
  4. Removal of hardware – an operative x-ray will be performed after removal of orthopedic hardware such as intra-medullary nails, plates, and screws. This is to ensure all hardware components have been explanted and to prevent the retention of device fragments.

- Under PROCEDURE, added:
  B. Sponges will be counted **and documented in the electronic intra-operative record. Documentation of surgical counts should be entered concurrently or after the count has actually been performed.**
  C. Sharps will be counted **and documented in the electronic intra-operative record. Pre-charting is prohibited. Documentation of surgical counts should be entered concurrently or after the count has actually been performed.**
- Under GENERAL CONSIDERATION:
  4. Added, " **All discarded sponges will be stored in pocketed transparent counting bags on all procedures. Sponges will be placed one sponge per pocket."**

Reviewed by:	Date	Approved (Y/N)	Comment
Policy & Procedure Team	n/a		
Surgery Committee	**07/01/2015**	Yes	
Medicine Committee	**7/09/2015**	Yes	
P.I. or P. T. Committee	n/a	na	
Medical Executive Committee	**7/16/2015**		
Board Quality	**7/28/2015**		
Board of Directors	**8/06/2015**		

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SUBJECT: Counts, Sponges, Sharps and Instruments	POLICY # PC7420-119
	PAGE 1 of 3
DEPARTMENT: Surgery	EFFECTIVE: 11/96
APPROVED BY: Director of Surgical Services	REVIEWED/REVISED: 12/07, 8/13, 6/15

Purpose:
To define responsibility and protocol for counting sponges, sharps and instruments used during surgical procedures to prevent the retention of foreign objects.

Policy:
A. Sponges
   1. Will be counted on all procedures in which the possibility exists that a sponge could
   2. Sponges used in surgical procedures will be x-ray detectable
B. Counted sponges will not be used for dressings.
C. Sharps
   1. Will be counted on all procedures by two individuals, one of whom is the RN circulator.
   2. Sharps consist of knife blades, hypodermic needles, ESU (bovie) tips or any other device designed to cut or puncture skin or tissue.
D. Instruments
   1. Will be counted on all procedures where a body cavity is entered.
   2. Will be counted on all procedures where there is a reasonable danger that an instrument could be accidentally retained by the patient. Including identifying in the preliminary, first and final counts any and all high risk instruments included in consignment/vendor trays by any vendor. For example, in total Knee Replacement procedures, patella protectors, patella sizers,and fixation pins will be included in the count.
   3. Inspect sharps, instruments, or other items returned from the operative site for signs of breakage to prevent the retention of device fragments. The process may include a physical inspection of the wound and sterile field, and an x-ray film image of the surgical wound.
   4. Removal of hardware – an operative x-ray will be performed after removal of orthopedic hardware such as intra-medullary nails, plates, and screws. This is to ensure all hardware components have been explanted and to prevent the retention of device fragments.

Procedure:
A. Sponges care counted audibly and viewed concurrently by the scrub and registered nurse. Additional sharps added to the sterile filed should be counted when added.
B. Sponges will be counted and documented in the electronic intra-operative record. Documentation of surgical counts should be entered concurrently or after the count has actually been performed.
   1. Before the case starts
   2. Prior to closure of a cavity within a cavity
   3. Before the wound closure begins
   4. At skin closure or end of procedure

5. At the time of permanent relief of the scrub or circulating nurse
6. When sponges are added during the procedure
7. Sponge counts will be recorded on the intra-operative nurses notes

C. Sharps will be counted and documented in the electronic intra-operative record. Pre-charting is prohibited. Documentation of surgical counts should be entered concurrently or after the count has actually been performed.
   1. Before the case starts
   2. Prior to closure of a cavity within a cavity
   3. Before the wound closure begins
   4. At skin closure or end of case
   5. At the time of permanent relief of the scrub nurse or circulating nurse
   6. When sharps are added during the case
   7. Sharp counts will be recorded on the Intra-operative nurses notes

D. General Consideration
   1. Counted sponges and sharps must remain on the operative field or in the Operating Room until the procedure has finished
   2. Contaminated sponges or sharps are handled using appropriate protective techniques and disposed of according to the hospital policy and procedure.
   3. Counts should begin at the operative site and immediate surrounding area and proceed to the mayo stand, back table and to sponges that have been discarded from the field.
   4. All discarded sponges will be stored in pocketed transparent counting bags on all procedures. Sponges will be placed one sponge per pocket.

Incorrect counts - Procedure:

1. When a count is incorrect both the scrub and circulating nurses recount a second time.
2. Care is taken to be sure sponges are well separated and are not under any feet, the table or kick bucket and not in the room with a specimen and are not in the saline basin.
3. The surgeon is notified of the missing item. The circulating nurse and scrub person should ask the surgeon to conduct a manual search of the wound. They should also conduct a thorough manual and visual search of the sterile area around the wound and the rest of the sterile area.
4. If the item is not recovered, an intra-operative x-ray should be taken before final closure of the wound.
5. The x-ray should be read by the radiologist for greater accuracy.
6. If the x-ray is negative, the closure will be completed.
7. If the x-ray is positive, the wound is opened and the missing item retrieved.
8. The count is recorded in the EMR documentation by the circulator assigned to the room.

9. If the inventory of the consignment/vendor tray is missing an item the vendor is notified as well as the Surgeon and manager or designee.
10. Documentation of the count discrepancy should include all measures taken to recover the missing item. The event shall be investigated to address any error that occurred.

Reference:

Recommended Practices for Sponge, Sharp, and Instrument Counts, AORN Guidelines 2012.
CIHQ Standards & Requirements (42 CFR – 482.51)

7.

QUALITY REPORT
JULY 2015

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
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To: Sonoma Valley Healthcare District Board Quality Committee
From: Leslie Lovejoy
Date: 07/22/2015
Subject: Quality and Resource Management Report

July Priorities:

1. CIHQ Mid Cycle Survey
2. Quality E Measure reporting
3. Leapfrog Hospital Survey
4. Surgical Services Action Plan
5. Reminder: Annual PI Fair

1. CIHQ Mid Cycle Survey

We had our mid cycle survey on July 6th and received our statement of deficiencies last Wednesday. There were some environment of care issues, a focus on surgery processes, and a medical staff by-law issue. The team is working on action plans that are due for submission by the 18th. Once accepted we will make sure the corrective actions plans are accomplished. I will provide you with a report of deficiencies and actions next month.

2. Quality E Measure reporting:

Information Systems and Quality have been working to map our electronic documentation so that we can begin to send our quality measures electronically by November 1st. We have participated in a pilot work group with CMS to see if that can happen and we will be complete with the mapping codes to allow for data transfer by the 20th of this month.

3. Leapfrog Hospital Survey:

We submitted hospital information covering an array of National Quality Forum patient safety goals and practices to the Leapfrog Group on June 30, 3015. The survey included an electronic test of CPOE (Computerized Physician Order Entry). Leapfrog Group is a national organization of insurance companies focused on helping employers have more informed choices about purchasing healthcare for their employees. Their mission is" to trigger giant leaps forward in safety, quality and affordability in healthcare". Western Health Advantage, our employee insurance has asked that we participate as part of their contract with the hospital. In the past, Leapfrog has used our CHospital Compare data to provide us with a score on an annual basis. We should see a score by, hopefully, the end of this month.

4. Surgical Services Action Plan

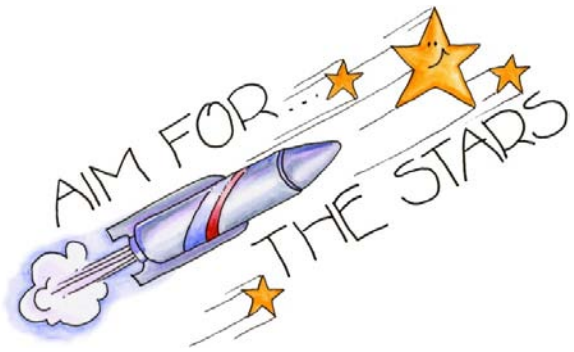
See attached Action Plan.

5. Annual Performance Improvement Fair:

Attached please find the flyer for the annual performance improvement fair. Ingrid and Jane served as judges last year. I will need 2 judges this year. It takes about 1.5-2 hours to read and do the judging. Criteria and judging form will be provided.

The Surgical Services Team has been working on implementing their action plan to address the retained foreign body incident. The Action Plan below, once completed will become part of the Surgery Director's quality monitoring and be reported up to the Surgery Committee monthly.

Topics for discussion: Risk Management Report (Lovejoy) & Population Health& Health Leadership Roundtable Discussion (Mather)



Annual Performance Improvement Fair

***WHEN**:* Wednesday, September 30, 2015 from 0730-1530

WHERE: Basement Conference Room

WHAT: Come view what each department has worked 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.