SVHCD QUALITY COMMITTEE
AGENDA
WEDNESDAY, July 26, 2017
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 Quality Committee meeting, please contact the District Clerk, Stacey Finn, at sfinn@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	*Rymer*	
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.	*Rymer*	
3. CONSENT CALENDAR • Minutes 6.28.17	*Rymer*	Action
4. POLICY & PROCEDURES	*Lovejoy*	Action
5. ANCILLARY SERVICES ANNUAL REPORT	*Kuwahara*	Inform
6. QUALITY REPORT 2017	*Lovejoy*	Inform
7. BOARD QUALITY DASHBOARD	*Lovejoy*	Inform
8. PATIENT CARE SERVICES DASHBOARD	*Kobe*	Inform
9. UPON ADJOURNMENT OF REGULAR OPEN SESSION	*Rymer*	
10. CLOSED SESSION: Calif. Health & Safety Code § 32155 Medical Staff Credentialing & Peer Review Report	*Lovejoy*	Action
11. REPORT OF CLOSED SESSION	*Rymer*	Inform/Action
12. ADJOURN	*Rymer*	

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SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
June 28, 2017, 5:00 PM
MINUTES
Schantz Conference Room

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

AGENDA ITEM	DISCUSSION	ACTION
1. CALL TO ORDER/ANNOUNCEMENTS	*Hirsch*	
	Meeting called to order at 5:00 p.m.	
2. PUBLIC COMMENT	*Hirsch*	
	No public comment.	
3. CONSENT CALENDAR	*Hirsch*	Action
• QC Minutes, 05.24.17		**MOTION:** by Eisenstark to approve, 2nd by Rymer. All in favor
4. POLICY & PROCEDURES	*Lovejoy*	Action
	Committee approved old policies with the request that the new policies come back in their entirety next meeting.	**MOTION:** by Woodward to approve old policies, 2nd by Minardi. All in favor.
5. HOSPITALISTS SERVICES REPORT	*Streeter*	Inform
	Dr. Streeter, Chief Hospitalist, gave an overview of the Hospitalist program at SVH. He said that the Hospitalists have various duties including, but are not limited to: admissions, rounding, transfers, consultations and discharges, and that they are unique in the fact that they provide critical care. He said that one of the biggest issues that they face is that there is only one Hospitalist on at a time. He reported that they round on approximately 80% of the patients in the hospital. He then reviewed case mix, length of stay, productivity, and encounter	

AGENDA ITEM	DISCUSSION	ACTION
	data, all with positive showings. The Hospitalist group has shown good improvements in core measures and low readmission rates. They have an opportunity for improvement with the doctor communication domain.	
6. QUALITY REPORT JUNE 017	*Lovejoy*	Inform
	Ms. Lovejoy presented the Prime grant activities. She reported that we began our training sessions for the Community Health Coach role this month, and that we have four solid coaches. She said that one issue that she is currently working on is how to obtain the data for the medication reconciliation within 30 days of discharge. The focused study database to capture metric data has been completed. The hope is that the raw data reports will produce something by next month. Ms. Lovejoy reported that the FY2018 final Quality budget has been completed. It clearly supports the organization's ongoing performance improvement program and will provide for all the needed resources to maintain and support safe, high quality, patient centered care. Ms. Lovejoy then gave an overview and explanation of the Quality monitoring report that is a result of an audit of each department's performance. Ms. Lovejoy introduced Danielle Jones, who recently joined SVH as the new Director of Quality.	
7. ANNUAL RISK MANANGMENT REPORT	*Lovejoy*	Inform
	Ms. Lovejoy presented the annual report of the effectiveness of the Risk management program. She gave an overview of the last year which included: claim activity, CLIA survey in Laboratory, a state survey on skilled nursing, as well as improved processes for the med staff peer review process. She said reporting to California Hospital Patient Safety Organization has begun and we are awaiting our first benchmarking. Ms. Lovejoy reviewed the goals for the upcoming fiscal year 2018. They include: Training new	

AGENDA ITEM	DISCUSSION	ACTION
	leaders in responding to e-notifications and complaint/grievance process. Provide at least one training in risk mitigation for leaders. Attend departmental staff meetings and go over department specific data and get feedback on the system from frontline staff. And to determine feasibility in the ability to track leadership follow-through with departmental specific data.	
9. UPON ADJOURNMENT OF REGULAR SESSION	*Hirsch*	
	Regular session adjourned at 618 p.m.	
10. CLOSED SESSION • Calif. Health & Safety Code § 32155 Medical Staff Credentialing & Peer Review Report	*Hirsch/Lovejoy*	Action
11. REPORT OF CLOSED SESSION	*Hirsch*	Inform/Action
	The Medical Staff Credentialing was unanimously approved. Ballot nominees – Sebastian, Chief of Staff. Brown, Vice- Chief of Staff. Committee had no issues with nominations	**MOTION**: by Rymer to approve 2nd by Eisenstark. All in favor
12. ADJOURN	*Hirsch*	
	Meeting adjourned at 6:22p.m.	

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Policy and Procedure - Approvals Signature Page
CE8610-114, CE8610-124, CE8610-126, CE8610-128, CE8610-164, CE8610-176, CE8610-198

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.

July 18th, 2017—Policy & Procedure Team

Leslie Lovejoy — 7/20/17
Leslie Lovejoy — Date
Chief Quality Officer

July 26th, 2017—Board Quality Committee

Jane Hirsch — Date
Chair, Board of Directors

Hospital CEO

Kelly Mather — Date
Chief Executive Officer

August 3rd, 2017—Board of Directors

Jane Hirsch — Date
Chair, Board of Directors

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Policy Submission Summary Sheet

MANAGER		SENIOR LEVEL MANAGER	
Name: Kimberly Drummond		Name:	
Title: Director of Facilities		Title:	
Signature:	DATE: 7/18/17	Signature:	DATE:

ORGANIZATIONAL

REVIEWED/NO CHANGES

CE8610-124 Equipment Inventory

REVISIONS

CE8610-128 Equipment Utility Failure

minor revision to change reporting to Safety Committee to Quarterly from Monthly

CE8610-164 On-Call Engineer

Minor revision includes: language added that states the on-call Engineer is expected to report to the Hospital in response to trouble outlined in the policy and for conditions as requested by Nursing Supervisor, Administration, Engineering Supervisor or alarm activations reported by PBX Operator. Updated Engineer cell phone numbers

CE8610-114 Closed Circuit TV, Security Management

Minor revision to include language about timely reporting via e-notification or to Engineering about any incident so that footage can be reviewed within the 2 week recorded life span.

CE8610-176 Traffic Control and Vehicle Access, Security Management

Minor revisions reflect the new location of the Emergency Department parking lot, new patient loading/unloading zone and ambulance entrance.

RETIRED

CE8610-126 Equipment Repair/Loaner Request

Departments no longer manage the repair coordination of their equipment. This process is managed through the Clinical Engineering Program outlined in Policy CE8610-108 Clinical Engineering Equipment Safety/PM. In the event that a loaner is needed for specific equipment it will be coordinated by the Renovo Asset Management Tech.

GL8610-198 Vendor Purchase Order

Departments no longer manage the repair coordination of their equipment. This process is managed through the Clinical Engineering Program outlined in Policy CE8610-108 Clinical Engineering Equipment Safety/PM. The repairs & PM's on all clinical equipment is coordinated through Renovo who will also work with Engineering if an SVH P.O. is required.

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Policy and Procedure - Approvals Signature Page
HR8610-112, HR8610-123

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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.

June 20th, 2017—Policy & Procedure Team

Leslie Lovejoy — 7-20-17

Leslie Lovejoy
Chief Quality Officer — Date

July 26th, 2017—Board Quality Committee

Jane Hirsch
Chair, Board of Directors — Date

Hospital CEO

Kelly Mather
Chief Executive Officer — Date

August 3rd, 2017—Board of Directors

Jane Hirsch
Chair, Board of Directors — Date

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Policy Submission Summary Sheet

Lynn McKissock, Director of Human Resources	
Signature: Lynn McKissock	DATE: 7/18/17

ORGANIZATIONAL

REVISIONS

HR8610-112 Orientation Period

Renamed Probation Period to Orientation Period and revised to combine three separate policies into one. The three policies that have been combined include Probationary Period (discussing the requirements and process for completing a competency assessment & probationary evaluation form); Minimum Orientation Requirements Prior to Providing Care, Treatment, or Service (discussing the requirements and process for completing a first day orientation checklist); and Hospital Orientation (discussing the requirement for attending the hospital orientation program within a specified timeframe from date of hire). Additionally, adding a section to address these same requirements for contract and/or volunteer staff as well as the requirement to complete assigned training courses through HealthStream within 30 days of hire.

HR8610-123 Disability Hours

Renamed Disability Hours and removed the word "sick" throughout the policy to eliminate the inference that this is a sick leave benefit. Clarified that employees must qualify for FMLA or Worker's Compensation before any disability hours are accessed. Removed the requirement that employees provide documentation showing they are receiving State Disability Insurance (SDI) income to qualify for use of Disability Hours, but also clarified that disability hours are paid at the coordinated rate – coordinated with SDI or Worker's Compensation. Removed reference to coordination with Paid Family Leave as a leave of absence to care for an ill family member is not eligible for use of Disability Hours, only PTO. Finally, removed language regarding the process of taking FMLA leave and inserted reference to the appropriate policy.

RETIRED

HR8610-113 – Minimum Requirements Prior to Providing Care, Treatment or Service

HR8610-106 – Hospital Orientation

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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.

Douglas S. Campbell, MD Chair Medicine Committee	5/11/17 Date
Cynthia Lawder, MD Medical Director, Emergency Department	5/18/17 Date
Keith J. Chamberlin, MD MBA President of Medical Staff	5/18/17 Date
Kelly Mather Chief Executive Officer	5/18/17 Date
Jane Hirsch Chair, Board of Directors	Date

Reviewed by:	Date	Approved (Y/N)	Comment
Medicine Committee	5/11/2017		
Medical Exec. Committee	5/18/2017		
Quality Committee	~~5/24/2017~~ ~~6/28/17~~ 7/26/17		
Board of Directors	~~6/01/2017~~ ~~7/06/17~~ 8/02/17		

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Policy Submission Summary Sheet

Mark Kobe, Chief Nursing Officer		Deborah Bishop, Director of ED and ICU	
Signature:	DATE: 5.9.17	Signature: D Bishop	DATE: 5/11/17

DEPARTMENTAL

NEW
PC7010-20 Nursing Orders
refers to new EDNUR Protocols by Dr. Lawder

REVIEWED/NO CHANGES
PC7010-06 Intraosseous Infusion
PC7010-10 ED Log
PC7010-13 Criteria for PES Admission
PC7010-18 Critical Care Transport
QA7010-09 E-notification in the ED

REVISED
PC7010-01 Emergency Initial Assessment Triage
Added statement that EMTALA, COBRA, and HIPAA laws will be followed

PC7010-02 Patient Valuables in ED
Added verbiage regarding proper documentation

PC7010-03 Admission to the Hospital from the ED
Separated the admission of telemetry and ICU patients, adding that telemetry patients can be transported to floor without monitor if an MD order states that this can be safely accomplished

DC7010-04 Discharge from ED
Included ESI 4 or 5 with length of stay less than an hour

PC7010-05 Telephone Advice
Added verbiage to signs/symptoms, when to call 911, when in doubt, come to ED

PC7010-07 COBRA Transfers
Added verbiage in regards to belongings

PC7010-08 Legal Blood Draws
Added urine

PC7010-11 Laboratory Studies Follow-up
Changed to ED Tech or RN. RN to Check EHR.

PC7010-12 Capnography – EtCO2 Monitoring

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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.

Brian Sebastian, MD
Chair, P.I./P.T. Committee

4/27/17
Date

Kelly Mather
Chief Executive Officer

5/18/17
Date

Jane Hirsch
Chair, Board of Directors

Date

Reviewed by:	Date	Approved (Y/N)	Comment
Policy & Procedure Team	1/17/2017	Y	
P.I. Committee	2/23/2017	Y	
Quality Committee	~~3/22/2017~~ ~~6/28/17~~	7/26/17	
Board of Directors	4/06/2017 ~~7/6/17~~	8/02/17	

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Policy Submission Summary Sheet

Robert Harrison, Manager of Nutritional Services		Mark Kobe, Chief Nursing Officer	
Signature: Robert Harrison	DATE: 2/22/17	Signature: Mark Kobe	DATE: 2/22/17

ORGANIZATIONAL

NEW
PC8610-101 Alcoholic Beverages

DEPARTMENTAL – FOOD AND NUTRITION SERVICES

NEW
8340-176 Carbohydrate Consistent Diet

Kimberly Drummond, Facilities Director		Mark Kobe, Chief Nursing Officer	
Signature:	DATE: 2/22/17	Signature: Mark Kobe	DATE: 2/22/17

ORGANIZATIONAL

NEW
CE8610-139 Fire Watch Policy

SUBJECT: Fire Watch Policy	POLICY # CE8610-139
	PAGE 1 of 2
DEPARTMENT: Organizational	EFFECTIVE:
APPROVED BY: Director Of Facilities	REVIEW/REVISED: 10/16

Purpose:
Sonoma Valley Hospital has a responsibility to its employees, patients, physicians and visitors to provide a safe and healthful environment.

Definition:
Fire Watch is the assignment of a person or persons to an area for the express purpose of notifying the fire department, the building occupants, or both of an emergency; preventing a fire from occurring; extinguishing small fires; or protecting the public from fire or life safety danger.

Fire watch is required:

1. When, in the opinion of the Safety Officer or PLOP Manager, it is essential for public safety in any place where people congregate, due to the number of persons, or the nature of the performance, exhibition, display, contest or activity. One or more qualified persons are to be employed to be on fire watch duty at such place
2. A fire watch is required when Hot Work is being performed and continues for 30 minutes after the conclusion of the work.
3. A fire watch may be required in the event of temporary failure of the alarm system or where activities require the interruption of any fire detection, suppression or alarm system components

Policy:
It is the policy of Sonoma Valley Hospital to establish an active Fire Watch anytime a sprinkler system, fire alarm or other fire suppression or detection system is hindered or out of service for more than 10 hours in a 24-hour period. Additionally, the following agencies must be contacted to advise that a system is out of service and a fire watch has been posted.
See list of current contacts at the end of the document.

- Sonoma Fire Department;
- CDPH Life Safety supervisor;
- CDPH Health Facilities Evaluator Supervisor;
- OSHPD Fire Life Safety Officer

Procedure:
Assigned fire watch personnel shall:
1. Not be performing any other duties.
2. Be thoroughly familiar with the area they are patrolling.
3. Perform patrol operations according to instructions from PLOP Manager.
4. Patrol their designated area at least once every hour.
5. Make reports as instructed. A written record of patrol rounds and any significant information shall be recorded in the fire watch log (logs will be provided by Engineering)

SUBJECT: Fire Watch Policy	POLICY # CE8610-139
	PAGE 1 of 2
DEPARTMENT: Organizational	EFFECTIVE:
APPROVED BY: Director Of Facilities	REVIEW/REVISED: 10/16

6. Remain on duty until properly relieved by next scheduled fire watch personnel.

In case of a danger to the occupants:

1. Notify occupants to evacuate when there is a fire in the building.
2. Notify Sonoma Fire Department to initiate emergency personnel response.
3. Activate fire protection systems, e.g., in order to release door holders, close smoke dampers, and shut down fans.

Sonoma Fire Department (707) 996-2102

CDPH Life Safety supervisor:
Robert Compton w (530)-895-4435, Cell 661 978-7361, robert.compton@cdph.ca.gov

CDPH Health Facilities Evaluator Supervisor:
Barbara Ebert w (707) 576-2741 barbara.ebert@cdph.ca.gov

OSHPD Fire Life Safety Officer:
Kimberly Korff - (916) 995-7404 Kimberly.Korff@oshpd.ca.gov

References:
NFPA 101, 2012 edition, OSHPD PIN 14

PIN 14 Fire Watch.pdf

SUBJECT: Carbohydrate Consistent Diet	POLICY # NU8340-176
	PAGE 1 OF 2
DEPARTMENT: Food and Nutrition Services	EFFECTIVE: 10/1/2016
APPROVED BY: Food and Nutrition Services Manager	REVIEW/REVISED:

Purpose:
To provide guidelines for meal and snack preparation for patients with a "Carbohydrate Consistent Diet" (CCD) diet order.

Policy:
The CCD is designed to provide approximately 50% of calories from carbohydrates, 20% of calories from protein, and 30% of calories from fat divided among three daily meals and an HS snack.

Procedure:
1. Patients will be provided with 4-5 carbohydrate servings (60-75 grams carbohydrates) for each of three daily meals and 1-2 carbohydrate servings (15-30 grams carbohydrates) for HS snack, unless otherwise ordered by the physician.
2. Patients on modified consistency diets (ie soft, mechanical soft, puree) will receive comparable carbohydrate servings, as appropriate with modified consistency diet order.
3. Patients on clear liquid and full liquid diet orders will receive 3-4 carbohydrate servings (45-60 grams) for each of three daily meals and 1-2 carbohydrate servings (15-30 grams carbohydrates) for HS snack. Please see Attachment 1 for example of CCD Clear Liquid and CCD Full Liquid Diet examples.
4. If additional meal items are requested, protein-rich foods (ie animal proteins, eggs, cottage cheese, nuts) and/or sugar-free options (ie sugar-free gelatin) consistent with diet order may be offered.
5. The Registered Dietitian will be contacted by diet office staff for approval prior to sending additional carbohydrate servings.
6. The Registered Dietitian will continue to complete nutrition assessments per policy and communicate with the diet office if different carbohydrate servings are indicated for specific patients.

Reference:
CIHQ Standards & Requirements. www.cihq.org/hospital.accreditation.asp, 482.28, NU-4.

SUBJECT: Carbohydrate Consistent Diet	POLICY # NU8340-176
	PAGE 2 OF 2
DEPARTMENT: Food and Nutrition Services	EFFECTIVE: 10/1/2016
APPROVED BY: Food and Nutrition Services Manager	REVIEW/REVISED:

Attachment 1

CCD Clear liquid Diet

Breakfast	Lunch	Dinner	HS snack
4oz juice Lemon Ice ½ cup Regular Jello Broth Coffee/tea Sugar Substitute	4oz juice Lemon Ice ½ cup Regular Jello Broth Coffee/tea Iced tea Sugar substitute	4oz juice Lemon Ice ½ cup Regular Jello Broth Coffee/tea Iced tea Sugar substitute	Lemon Ice

*Please send Sugar-free jello if patient requests additional jello on meal trays or between meals

CCD Full liquid Diet

Breakfast	Lunch	Dinner	HS snack
4oz juice Oatmeal or Cream of Wheat ½ cup Regular Jello Coffee/tea 2% milk* Sugar Substitute	4oz juice Puree Soup Sugar-Free Pudding** Coffee/tea Iced tea 2% milk* Sugar substitute	4oz juice Puree Soup Sugar-Free Pudding** Coffee/tea 2% milk* Sugar substitute	No sugar added ice cream

* Soymilk can be substituted for 2% milk patients that request it

**It is allowable to provide Regular Jello instead of Sugar-free Pudding at lunch or dinner

SUBJECT: Emergency Department Nursing Protocols	POLICY #PC7010-20
	PAGE 1 OF 2
DEPARTMENT: Emergency Department	EFFECTIVE: 1/17
APPROVED BY:	REVISED:

PURPOSE:

1. To provide a pathway of timely, coordinated care for patients with specific symptoms, determined through assessment by an RN that correspond to a specific Nursing Protocol delegated by a medical provider to reduce delays in medical treatment and care.

2. To provide a set of Nursing Protocols that the Hospital Emergency Department Registered Nurse (RN) can initiate to address urgent/emergent medical condition(s) of patients presenting to the Emergency Department.

3. To provide direction to the Hospital Emergency Department RN to address injuries and/or medical problems ranging from critical and life threatening to minor and self limiting and establishing a layer of safety for patients presenting to the Emergency Department while determining appropriate treatment in a timely manner.

Definitions:

Standing Order: Nursing Protocol

Nursing Protocol: An order approved by the applicable Medical Executive Committee that may be executed prior to an individual provider order. Nursing Protocols are limited to a subset of orders in regards to a patient condition or circumstances that are necessary for timely and efficient care.

POLICY:

1. These Emergency Department Nursing Protocols have been approved by the Medical Executive Committee whom has chosen to utilize any or all of these Nursing Protocols. These Nursing Protocols are not intended to replace more detailed department specific, clinically based emergency response order sets such as Code Blue protocols.

2. The Nursing Protocol sets are complaint specific and were developed to be within the critical thinking skill set of a bedside Emergency Department RN.

3. A Nursing Protocol set does not need to be implemented in its entirety. The RN should implement applicable section(s) of the Nursing Protocol set based on patient assessment and established criteria.

4. More than one Nursing Protocol set may be used for a patient as appropriate per patient need and RN assessment.

5. The RN is accountable and responsible for the delegation of any intervention in the Nursing Protocol set.

6. The Nursing Protocol sets may be added to, changed, or deleted as the Medical Executive Committee deems necessary.

PROCEDURE:

1. The Registered Nurse (RN) will initiate orders off the Emergency Nursing Protocol set if the patient assessment findings warrant the Nursing Protocol intervention within their scope of competency and within the resources of the applicable Emergency Department.

2. The RN will consult with an on-duty ED physician/provider if clarification is needed in initiating a Nursing Protocol.

3. The RN may only alter the Nursing Protocol after a patient and complaint specific discussion with the Physician on duty. The alterations and discussion must be documented in the patient's medical record.

4. The RN will document assessment findings, interventions, and outcomes per this policy.

5. Emergency Department Nursing Protocols must be entered into the patient's medical record and authenticated by the responsible provider for the patient according to the facility/department specific order authentication process.

REFERENCE:

Centers for Medicare & Medicaid Services, Conditions of Participation Section 482.23© (2)
Banner Health Policy Title: Emergency Department Standing Orders Version 11914.6
May 23, 2013.

SUBJECT: Alcoholic Beverages-New Policy	POLICY # PC8610-101
	PAGE 1 OF 1
DEPARTMENT: Organizational	EFFECTIVE: 10/16
APPROVED BY: CNO	REVIEW/REVISED:

Purpose:
To provide guidelines for serving alcoholic beverages for patients with a "Wine or Beer with Lunch & Dinner" diet order.

Policy:
Alcoholic beverages will be provided to patients only with a specific written order from the patient's physician.

Procedure:
1. When a diet order reading "Wine (4oz) or Beer (12oz), with Lunch & Dinner" is entered by a physician, the updated order will be electronically sent to the Diet Office.
2. The Diet Clerk will attempt to speak with the patient either in person or by phone to obtain alcoholic beverage preference, which will be entered into the patient preference section of on the tray card.
3. If the patient is unavailable or does not provide a preference, 4oz white wine at lunch and dinner will be provided as default.
4. During tray line, the specified quantity of wine or beer will be labeled and placed on the patient tray.
    a. No more than 4oz wine or 12oz beer will be provided per patient,per meal.
5. Once the alcoholic beverage portion leaves the kitchen, additional portions or different alcoholic options will not be sent to patient.
6. Any alcoholic beverage portion that is not consumed and returns to the kitchen on the dirty tray will be disposed of.

Reference:
http://www.nutrition411.com/content/alcoholic-beverages

ANCILLARY SERVICES ANNUAL REVIEW- 2016

Introduction and Overview:

Ancillary Services includes the following clinical departments: Cardiopulmonary, Inpatient Rehab Services, Laboratory Services, Medical Imaging, Occupational Health, Outpatient Rehab Services, and Wound Care.

Ancillary Services Mission: To support the mission and vision of the hospital with a focus on customer service, collaboration, and quality of care.

Department Tag Line: Clear Path to Excellence

Leadership Team: Chief Ancillary Officer, Cardiopulmonary Manager, Inpatient Rehab and Occupational Health Manager, Lab Manager, Medical Imaging Manager, Outpatient Rehab Manager, Speech Therapy Coordinator, Wound Care RN Clinical Coordinator.

Cardiopulmonary

Department Mission Statement: To positively impact patient care by keeping you breathing to the best of your ability so that we don't have to treat you in the hospital; but if we do, we are equipped with all of the necessary tools to get you back on the right track.

Scope of Services: The department offers Respiratory Therapy, Echocardiography, Pulmonary Function Testing, Stress Testing, EKG's, and Holter Monitoring. Respiratory Therapy is staffed 24 hours a day, 7 days a week. Echocardiography, Stress Testing and Pulmonary Function testing is available Monday through Friday by appointment.

Staffing: The department is staffed with a combination of Respiratory Therapists, an Echocardiograph Sonographer, a full time manager and a .5 Secretary. **Total FTEs: 7.75**

Certifications/Licenses: All clinical staff is licensed by their governing board in the State of California. Respiratory Therapists are required to have the following certifications: Basic Life Support, and Neonatal Resuscitation. The Echocardiograph Sonographer is required to have Basic Life Support and is certified in Diagnostic Cardiac Sonography.

Financial Data:

Fiscal Year	Gross Revenue	Total Expenses	Total UOS	IP UOS	OP/ER UOS
FY2016	$11,136,057	$758,347	18,618	13,718	4,830
FY2015	$10,609,734	$731,856	18,552	14,430	4,122

- Units of Service- Respiratory- one unit for every 15 minutes. All other modalities- one unit per test.

- Gross Revenue has increased due to an increase in pricing and a volume increase in Outpatient and Emergency Room Services
- Total Expenses have increased due to salary and supply and supply cost increases.
- Inpatient Units of Service have decreased due to efforts to decrease testing that can be performed by nursing.

***Quality Metrics*:**
The department measures the following indicators to ensure that we meet regulatory and patient safety standards.
In 2016:

Medication Bar Code Compliance
ED Chest Pain Follow Up

4th Quarter 2016 results:

Indicator	Goal	Result	Analysis	Plan
Medication Bar code compliance	95%	95%	Goal Met	Continue to Monitor
ED Chest Pain Follow Up	EKG within 10 minutes	Avg. 7 minutes	Goal Met	Continue to Monitor

Note: Significant improvement in Medication Bar Code Compliance over 2015. (72%).

Past and future plans for Performance Improvement:
Due to administrative medical leave, the department did not submit a Performance Improvement Project in 2016.

In 2017, this department will work on the following project: Process for more efficient scheduling of Outpatient testing which impacts physician and patient satisfaction and department revenue.

Community Benefit
The Cardiopulmonary Department hosted Heart Health Month in February. They offered blood pressure checks in the department for the public. The Medical Director and Cardiopulmonary Manager held an education event focusing on commonsense health tips and how to recognize the signs of a cardiac event.

Other
Respiratory Therapy serves as a clinical rotation site for Rancho Cordova Junior College and Napa Valley Junior College Respiratory Therapy Programs.

SONOMA VALLEY HOSPITAL
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Inpatient Rehab Services

Department Mission Statement: To positively impact patient care using a comprehensive approach focusing on the whole patient while providing safe, quality, patient centric care**.**

Scope of Services: Inpatient Physical Therapy, Occupational Therapy and Speech Therapy. Physical Therapy is offered 7 days a week; Occupational and Speech Therapies are offered Monday through Friday.

Staffing: The departments are staffed with a combination of Physical Therapists, Physical Therapy Assistants, Occupational Therapists and 2 Speech Language Pathologists. We have a full time Manager and a fulltime Scheduling Coordinator. Note: The SLP's provides service to Outpatient (including Pediatrics), and Home Care. **Total FTE: 8.9.** Staffing needs is determined by the patient census and number of minutes required for treatment to meet RUG (Resource Utilization Group) in the Skilled Nursing Unit. These numbers are calculated on a daily basis.

Certifications/Licenses: All clinical staff is licensed by their governing board in the State of California. All staff is certified in Basic Life Support.

Specialty Certifications: Two of our physical Therapists are APTA Clinical Instructors. One Occupational Therapist has specialty training in Ergonomics and provides Ergonomic Assessments and Recommendations to SVH employees and Occupational Health Clients. Our Speech Language Pathologists are certified in Big and Loud, a method of treating Parkinson's Patients.

Advanced Education: Two of our Physical Therapists have doctorates in Physical Therapy. One Physical Therapist has an MBA, one Occupational Therapist is Masters Prepared in her field. Both of our Speech Language Pathologists have Masters Degrees in their field.

Financial Data

Fiscal Year	Gross Revenue	Total Expenses	Total UOS	IP UOS	OP/ER UOS
FY2016	11,408,651	1,076,321	43,486	42,608	878
FY2015	10,165,057	1,119,189	39,987	39,320	667

- Units of Service- for PT and OT this number is based on number of treatments provided. For Speech, it is based on number of patient encounters.
- FY2016 Gross Revenue has increased due to increase in UOS.
- FY2016 Total Expenses have decreased due to a significant reduction in the use of agency staff. The departments are now fully staffed.

Quality Metrics

The department monitors the following indicators to ensure that we meet CMS and safety standards for our Skilled Nursing Patients.
In 2016:

RUG Levels
Reduction in Patient Falls

4th Quarter 2016 results:

Indicator	Goal	Result	Analysis	Plan
RUG Levels are maintained within 10% of assigned minutes	90%	96%	Goal Met	Continue to monitor
*Reduction in patient falls by 50% over previous year	50% reduction in falls over previous year.	1/3 months in 4th qtr. Met goal	Not Met	See Note

Note: Falls are designated assisted meaning that they have occurred while therapists are working with patients on gait training. Patients are assisted to the floor, no injuries reported.

Past and future plans for Performance Improvement:
In 2016, Inpatient Physical Therapy submitted a project on early mobilization in the ICU. This will be continued in 2017.

Community Benefit
Physical Therapy offers two Gentle Yoga classes weekly at no cost to the public. There are 29 participants in the program.
Physical Therapy hosted the REMIND program: Offered twice in 2016, this program helps the older adult acquire knowledge and skills to achieve optimal lifestyle results. (Buck Institute on Aging).
The Speech Language Pathologists participate in a Community Parkinson's Support Group.

Other
Inpatient Rehab Services serves as a clinical rotation site for the following colleges:
Physical Therapy- Samuel Merritt, UCSF, University of Pacific, Sacramento State, and Arizona State
Occupational Therapy- Dominican College
Speech Therapy- Idaho State University and the University of Oregon
Physical Therapy Assistant- Sacramento City College

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Laboratory Services

Department Mission Statement: To provide laboratory test results in a timely & accurate manner & deliver those results to the physicians promptly.

Scope of Services: Testing in the areas of Hematology, Coagulation, Chemistry, Microbiology, Urinalysis, Serology and Blood Bank is provided. STAT testing is available within 1 hour; most routine testing is available the same day. Additional services include the following: Home draws for bed bound patients, Physician Office specimen collection, Transfusion, Anatomic and Clinical Pathology services and consults, collection service for Quest Partnership patients, weekend holiday and night testing for Sonoma Developmental Center, and Microbiology and Coagulation testing for Sonoma Development Center. Services are provided 24 hours a day, 7 days a week.

Staffing: The lab is staffed with a combination of Clinical Lab Scientists, a Microbiologist, Phlebotomists, a Pathology Coordinator and a full time Manager. **Total FTE: 16.30**

Certifications and Licenses: All clinical staff is licensed by their governing board in the State of California. All staff is certified in Basic Life Support.

Financial Data

Fiscal Year	Gross Revenue	Total Expenses	Total UOS	ER UOS	Outpatient, Drop offs, House Call
FY 2016	$27,321,573	$2,348,147	143,402	25,415	17,844
FY 2015	$24,573,796	$2,559,417	147,065	22,467	19,209

- UOS are Units of Service which are billable tests or groups of tests reported together. The decrease in Units of Service is reflective of lower inpatient, SNF and outpatient volumes.
- Gross revenue is up due to price increases.
- Expenses are down due to economies made within the lab. The laboratory makes an on-going effort to investigate and implement expense efficiencies. The laboratory works closely with our vendors and Materials Management to assure the best pricing for reagents and supplies.
- ER volume is up significantly due to the community use of the new facility. ER
- Outpatients are patients who came to the lab to have services, Drop offs are specimens collected in a physician office or other facility and brought to the lab. House Calls are visits to a patient's home to collect a specimen. In April, 2015 SVCHC opened a draw station on their premises and started drawing their patients. MediCal converted many patients to Partnership insurance which is contracted with Quest for lab testing. These events resulted in a decrease in our outpatient volume.

Quality Metrics/Past and Future Plans for Performance Improvement
In September, Lab Manager reports to Quality Committee.

Community Benefit
Department staff participated in the 4th of July Parade, Back to School Health Fair, and the Binational Health Fair.

Medical Imaging

Department Mission Statement: To achieve optimal quality diagnostic studies for our patients while keeping radiation dose As Low As Reasonably Achievable (ALARA).

Scope of Services: Medical Imaging offers the following modalities: X-Ray, Fluoroscopy, CT Scan, MRI, Ultrasound, Nuclear Medicine and Interventional Radiology. Mammography and Bone Dexa Scanning is offered at the Women's Health Center on Perkins Street Monday through Friday by appointment. X-Ray and CT are offered 24 hours a day, 7 days per week. MRI, Ultrasound, Nuclear Medicine, Fluoroscopy and Interventional Radiology are offered Monday through Friday by appointment. Ultrasound techs are on call after hours and weekends for emergent exams.

Staffing: The department is staffed with a combination of technologists, sonographers, a full time manager, 2 secretaries and a transporter. **Total FTE 17.6**

Certifications and Licenses: All clinical staff is licensed by their governing boards in the State of California. All staff is certified in Basic Life Support. At this time staff is not required to have a separate license to perform CT exams. This is likely to change in the near future. Three Radiology techs are multi licensed in more than one modality. All Radiology techs are trained to perform a head CT. (stroke protocol). All Radiology Techs have a Fluoroscopy License.

Financial Data

Fiscal Year	Gross Revenue	Total Expenses	Total UOS	IP UOS	OP/ER UOS
FY2016	55,644,705	2,673,661	26,681	3,435	23,246
FY2015	52,534,621	2,423,723	27,538	3,805	23,733

- UOS are based on the number of charges entered per exam
- Gross Revenue is up due to price increases
- Expenses are up due to staff salaries, new Radiology contract, increase in VRAD usage after hours and the use of agency for staffing needs.

Quality Metrics
The department measures the following indicators to ensure that we meet regulatory and patient safety standards.
For 2016:

Repeat Analysis
Pertinent Findings

4th Quarter 2016 Results:

Indicator	Goal	Result	Analysis	Plan
Repeat Analysis	<5%	2.67%	Goal Met	Continue to Monitor
Pertinent Findings	>90%	100%	Goal Met	Continue To Monitor

Past and Future Plans for Performance Improvement
The Department was excused from a PI Project in 2016.

In 2017, the department will work on the following project: Head CT/MRI Results for Stroke patients within 30 minutes of arrival.

Community Benefit
Mammography Staff have participated in the Binational Health Fair promoting education on Breast Self Exams.

Other
Radiology serves as a clinical rotation site for Santa Rose Junior College X-Ray Tech Program.

Outpatient Rehab Services

Department Mission Statement: To positively impact patient care using a comprehensive approach focusing on the whole patient while providing safe, quality, patient centric care**.**

Scope of Services: Services include manual (hands on) therapy, vestibular and falls prevention, postural corrections, pain management, therapeutic exercise, job site assessments and physical capability testing, ergonomic assessments, certified hand therapy, splinting and arthritic care, home management exercises. The department is open Monday through Friday by appointment.

Staffing: The department is staffed with a combination of Physical Therapists, Certified Hand Therapists, a full time Manager and 2 Secretaries. **Total FTE: 7.80**

Certifications and Licenses: All clinical staff is licensed by their governing boards in the State of California. Staff is certified in Basic Life Support**.**

Specialty Certifications: Our Therapists have a variety of specialized training and/or certifications including: Hand Certification, Visceral Manipulation, Selective Function Movement Assessment, Pelvic Health Specialist, Golf Performance Enhancement Specialist, and APTA Clinical Instructors.

Advanced Education: Two of our Physical Therapists have doctorates in Physical Therapy.

Financial Data

Fiscal Year	Gross Revenue	Total Expenses	Total UOS
FY2016	6,020,124	987,868	28,514
FY2015	6,239,876	847,601	29,099

- UOS are based on number of treatment provided
- Gross Revenue down from FY2015 attributed to loss of Workers Compensation contracts to 3rd party, change in payer mix.
- Expenses up in FY 2016 due to use of Staffing Agencies, Salary Increases

Quality Metrics

The department measures the following indicators to ensure that we meet patient safety standards. For 2016:

Fall Reduction

4th Quarter 2016 Results:

Indicator	Goal	Result	Analysis	Plan
Fall Reduction	Reduce by 50% over prior year	0	Goal Met	Continue to Monitor

Past and Future Plans for Performance Improvement

In 2016, the department implemented new treatment strategies to maximize patient outcomes and reimbursement. This project will be continued in 2017.

Community Benefit

Department staff participated in the Back to School and Binational Health Fairs (Scoliosis Screening), and community presentations on Balance and Fall Prevention to senior homes.
The department co-hosts the REMIND program with Inpatient Therapy.

Other

Outpatient Rehab Services serves as a clinical rotation site for the following colleges:
Physical Therapy - Samuel Merritt, UCSF, and University of Pacific.

Occupational Health

Department Mission Statement: To positively impact patient care using a comprehensive approach focusing on the whole patient while providing safe, quality, patient centric care.

Scope of Services: Treatment for work related injuries, Rehabilitation Services including Physical Therapy, Hand Therapy, and Ergonomic Assessments, Pre-Employment Physicals, Drug and Breath Alcohol testing, DMV physicals, Asbestos and hazardous material exposure and surveillance, hearing

conservation testing, and pulmonary function testing. We provide onsite flu vaccination clinics and education regarding workplace safety. In addition, we offer a Travel Medicine program for occupational travelers and the general public and adult vaccinations including Hepatitis B immunization for police, fire and medical personnel. The department is open Monday through Friday by appointment for most services. New Injuries do not require an appointment.

Staffing: Our providers include a Physician, one Physician Assistant, 3 Nurse Practitioners, 3 support staff and the manager who is also a Physical Therapist. **Total FTE: 4.15** (MD not included).

Certifications and Licenses: All clinical staff is licensed by their governing boards in the State of California. Staff is certified in Basic Life Support**.** The nurse practitioners have advanced practice nursing licenses.

Financial Data

Indicator	Gross Revenue	Total Expenses	Total UOS
FY2016	676,434	470,166	8,289
FY2015	645,632	341,967	7,921

- UOS are based on patient visits
- Expenses up related to salaries and the addition of nurse practitioners

Quality Metrics

The department measures the following indicators to ensure that we meet state regulation.
For 2016:

MD/PA Chart Review

4th Quarter 2016 Results:

Indicator	Goal	Result	Analysis	Plan
MD/PA Chart Review	MD to review 10 charts 10/12 mo.	100%	Goal Met	Continue to Monitor

Past and Future Plans for Performance Improvement

The department did not submit a performance improvement project in 2016.

In 2017, the department will implement an Electronic Health Record which will greatly improve documentation and workflow processes.

Community Benefit

Department staff participated in the following events: Back to School Health Fair, Back to School Immunization Clinics, and the Binational Health Fair.

Other

Occupational Health serves as a clinical rotation site for Dominican and Napa Valley College nursing students.

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Wound Care

Department Mission Statement: To provide comprehensive wound care services using a team approach while healing wounds in the shortest time with minimal pain, scarring, and discomfort.

Scope of Services: Outpatient Care includes negative pressure therapy, aqueous, conservative and sharp debridement, compression therapy, offloading shoes, Ostomy care and a comprehensive inventory of Wound Care supplies. In addition, our Wound Care nurse provides service and support to all nursing departments. The department offers comprehensive outpatient wound cares services Monday through Friday and weekends available by appointment.

Staffing: The department staffs one fulltime Wound Care Certified RN and one .6 Medical Assistant. New patients are evaluated by our Medical Director, Russell Sawyer MD. **Total FTE: 1.6**

Certifications/Licenses: All clinical staff is licensed by their governing board in the State of California. Clinical Staff are also required to have certifications in Basic Life Support.

Specialty Certifications: The Wound Care Nurse has a Wound Care Certification and a Diabetic Wound Care Certification.

Financial Data:

Indicator	Gross Revenue	Total Expenses	Total UOS	IP UOS	OP/ER UOS
FY2016	1,952,314	205,457	3,412	439	2,973
FY2015	1,694,433	167,627	3,632	276	3,356

- Units of Service- are based on number of patient treatment days; the department treats approximately 300 new patients each year.
- FY2016 Gross Revenue increased due to pricing increase
- FY2016 total expenses increased due to the purchase of an ABI machine, salaries (MA added in FY2016), and pharmacy supplies.
- Total UOS decreased due to loss of Napa State Wound Care contract.

Quality Metrics

The department measures the following indicators to ensure that we meet industry standards:
For 2016:

Mean Time to Heal
Per cent Outliers
Wounds Infected During Care

4th Quarter 2016 Results:

Indicator	Goal	Result	Analysis	Plan
Mean Time to Heal	<31 days	24	Goal Met	Continue to Monitor
Per cent Outliers	<22%	7	Goal Met	Continue To Monitor
Wounds Infected During Care	0	1	Co morbidities complicated wound healing	Continue to use products that address bioburden

Past and Future Plans for Performance Improvement

This department did not submit a Performance Improvement Project in 2016.

In 2017, the department will implement an Electronic Health Record which will greatly improve documentation and workflow processes.

Community Benefit

Two presentations were given to the Ostomy/Paraplegia Association on Ostomy Myths and Care.

Other

Wound Care serves as a clinical rotation site for Dominican and Napa Valley College.

Ancillary Services Staff Satisfaction

Who	Score	Engagement	Participation
All (Roll up)	4.28	86%	93%
Direct Reports	4.50	90%	100%

- Action Plan to focus on career development opportunities

Ancillary Services Plans to Further Improve Quality:

Implementation of an Electronic Health Record in Occupational Health, Wound Care, and Outpatient Rehab: This will allow us to transform our current system into a trusted resource that facilitates patient safety and quality improvement. These departments are currently paper based and inefficient and have multiple limitations including the inability to gather data for quality purposes.

Mammography Department Move to Hospital with Construction and Installation of 3D Mammography: 3 D Mammography is the latest technology for breast cancer screening. This revolutionary new tool is proven to produce higher detection rates and less false positives. It allows our radiologists to examine breast tissue layer by layer. Moving the department back to the hospital will allow for efficiencies in scheduling patients for additional procedures as well as ease of patients not having to travel between separate locations.

Ancillary Services Annual Review 2016

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TODAY'S TOPICS

- Who Are We
- Our Mission
- Leadership Team and Staffing
- Education and Certifications
- Staff Satisfaction
- Community Benefit

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TODAY'S TOPICS CONT'D

- Financial Data
- Quality
- Performance Improvement
- Future Plans
- Other

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Who Are We

- Cardiopulmonary
- Laboratory
- Medical Imaging
- Occupational Health
- Rehab Services
- Wound Care

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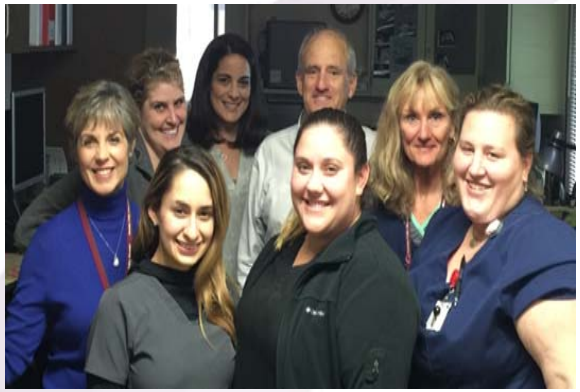
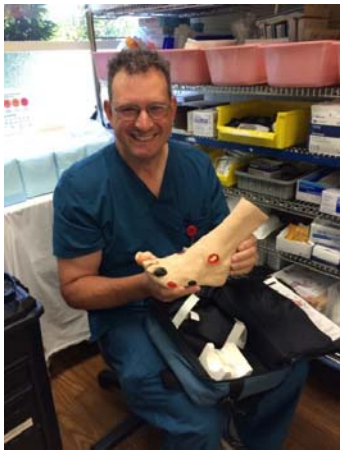
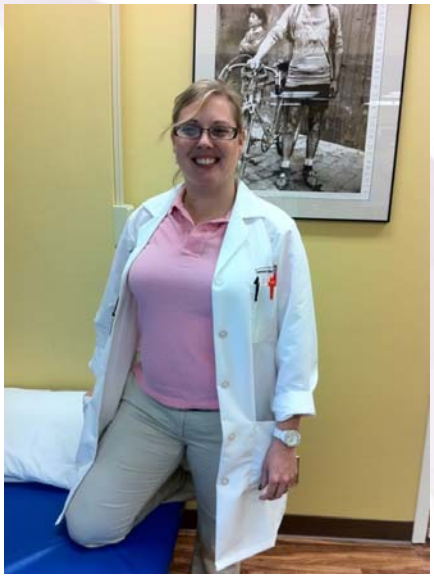
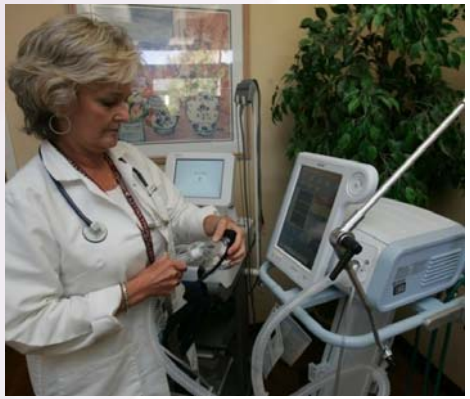
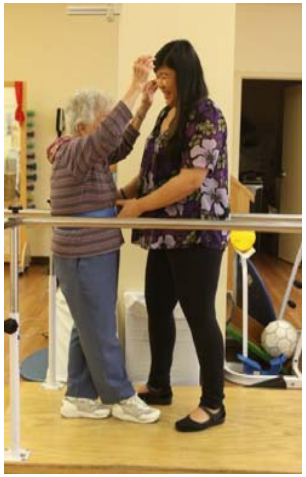
Our Staff

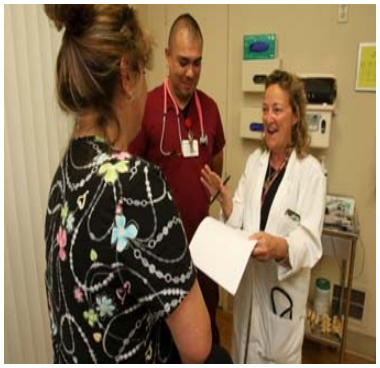


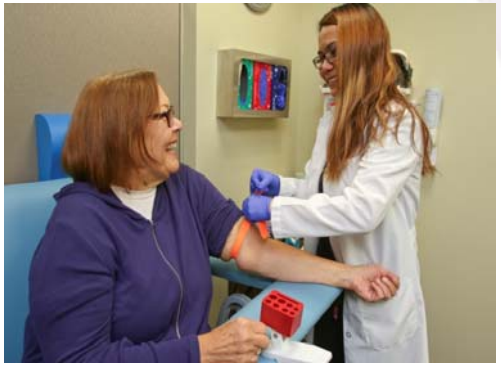












“Clear Path to Excellence”

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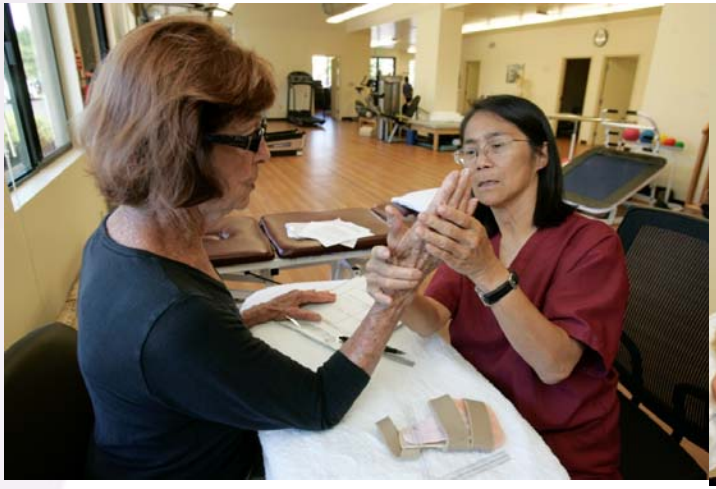
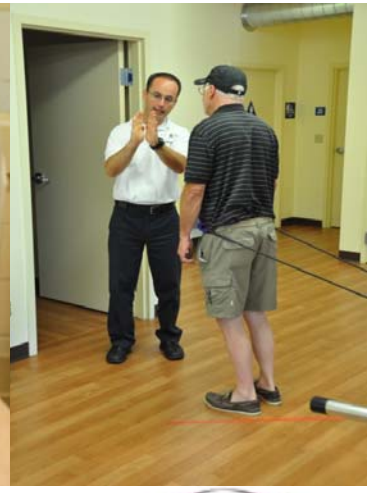
MISSION

“ To support the mission and vision of the hospital with a focus on customer service, collaboration and quality of care. “



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LEADERSHIP & STAFFING

- Leadership Team:
  - Chief Ancillary Officer, Cardiopulmonary Manager, Lab Manager, Inpatient Rehab and Occ Health Manager, Outpatient Rehab Manager, Speech Therapy Coordinator, and Wound Care RN Clinical Coordinator
  - 103 staff members

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EDUCATION & CERTIFICATIONS

Department	Education	Certifications
Cardiopulmonary	Graduates of Accredited Programs	ACLS, PALS, NRP, Cardiac Sonography
Medical Imaging	Graduates of Accredited Programs	4 Multi License Certifications
Inpatient Rehab	2 DPT's, 3 OT's, 2 SLPs	Ergonomics, APTA Clinical Instructors, Big and Loud
Occupational Health	3 FNP's, PA	Travel Medicine, MA cert.
Outpatient Rehab	2 DPT's, 4 MPT's, 2 OT's	Hand Therapy, APTA Clinical Instructors, Visceral Manipulation, Pelvic Health, FMA, and Golf Performance Specialist
Wound Care	ADN	WCC, DWC, MA cert.

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STAFF SATISFACTION

Type	Score	Engagement	Participation
Roll Up (All)	4.28	86%	93%
Direct Reports	4.50	90%	100%

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COMMUNITY BENEFIT

- Back to School Health Fair
- Balance Classes
- Binational Health Fair
- Gentle Yoga Class
- Heart Health
- Ostomy Education
- Parkinson's Support Group
- Remind Program

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FINANCIAL DATA

Fiscal Year	Gross Revenue	Total Expenses	TOTAL UOS	IP UOS	OP/ER UOS
FY2016	116,165,426	8,732,189	279,852	96,076	183,576
FY2015	107,527,495	8,199,436	281,557	95,509	186,048

- **Gross Revenue up due to annual pricing increase**
- **Total Expenses up due to annual salary increases, agency costs, professional fees, pharmacy costs and purchased services**
- **OP UOS down due to possible leakage**

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QUALITY

Dept.	Indicator	Goal	Result	Analysis	Plan
Cardiopulmonary	Medication Bar code compliance	95%	95%	Goal Met	Continue to Monitor
Cardiopulmonary	ED Chest Pain Follow Up	EKG within 10 minutes	Avg. 7 minutes	Goal Met	Continue to Monitor
Inpatient Rehab	Rug Levels	Within 10% of assigned minutes	90%	96%	Continue to Monitor
Inpatient Rehab	Fall Reduction	50% reduction in falls over previous year	1/3 months	Not Met	*See note
Medical Imaging	Repeat Analysis	<5%	2.67%	Goal Met	Continue to Monitor
Medical Imaging	Pertinent Findings	>90%	100%	Goal Met	Continue to Monitor
Outpatient Rehab	Fall Reduction	50% reduction in falls over previous year	O Falls	Goal Met	Continue to Monitor

*Falls are designated assisted meaning that they have occurred while therapists are working with patients on gait training. Patients are assisted to the floor, no injuries reported.

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QUALITY CONT'D

Depart.	Indicator	Goal	Result	Analysis	Plan
Occ Health	MD/PA Chart Review	10 charts 10/12 Months	100%	Goal Met	Continue to Monitor
Wound Care	Mean Time to Heal	<31 days	24	Goal Met	Continue to Monitor
Wound Care	Outliers	<22%	7%	Goal Met	Continue to Monitor
Wound Care	Wound Infections During Care	0	1	Co morbidities complicated healing	Continue to use products that address bioburden

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PERFORMANCE IMPROVEMENT 2016

- Inpatient PT- Early mobilization in the ICU, continued in 2017
- Outpatient PT and Hand Therapy- Treatment strategies to maximize outcomes and reimbursement, continued in 2017

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PERFORMANCE IMPROVEMENT 2017

- Cardiopulmonary
  - Efficient Scheduling of Outpatient Testing
- Medical Imaging
  - Head CT/MRI Results within 30 minutes of arrival

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FUTURE PLANS

- Electronic Health Record
- 3 D Mammo

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OTHER

- Clinical Rotation Sites
  - Cardiopulmonary
  - Medical Imaging
  - Occupational Health
  - Occupational Therapy
  - Physical Therapy
  - Speech Therapy
  - Wound Care

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Questions?

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To: Sonoma Valley Healthcare District Board Quality Committee
From: Leslie Lovejoy
Date: 07/26/17
Subject: Quality and Resource Management Report

July Priorities:

1. PRIME Grant Activities
2. CIHQ Action Plan Monitoring Report
3. Medical Staff Office projects

1. *Prime Grant Activities*

Based on our conversation regarding the curriculum, I have clarified the pre-requisites for both education and life experience in addition to the requirement to attend Wellness University. All our new coaches have received training by the Community case Manager and will be scheduled to start follow-up phone calls in August.

I am working on completing the data abstraction and gathering for the September year end reporting and will bring that data to this committee in September.

The state department of health services has scheduled a learning collaborative in November on the same day as the Board Quality Committee meeting on November 15th. I will have the Director of Quality and Risk Management take my place.

2. Action Plan Monitoring Status Post CIHQ Survey:

Please review the worksheet that accompanies this report for the status on our efforts to address the deficiencies cited by CIHQ during our March survey. We are working towards full compliance but have had some challenges with management turnover and vendor scheduling issues. I expect that all leaders will be able to report compliance next month. I will bring back the report in September.

3. Medical Staff Office Projects:

I have been working to streamline and improve the infrastructure of the office functions. We are moving closer to having an all electronic credentialing and privileging process such that 100% of physician files will be in the Verge database by the start of fiscal year 2019. In addition, a review of the by-laws and rules and regulations has identified some opportunities to improve the clerical support functions. We are orienting Stacey to take on more of the clerical pieces and that is working very well. We have scheduled a cocktail reception honoring Drs Veluz and Mariano for their 37 years of service to our community and hospital on August 10th in the Gilroy Garden. Both surgeons retired effective July 1, 2017 and are retiring. We are also in the midst of an election for Medical Staff Offices. Drs Sebastian and Brown will be serving as President and President Elect respectively

for the next two years. Drs Campbell and Verducci will serve as Medicine Chair and Vice-Chair respectively and there is currently a tie for Surgery Chair. This will require a run-off election as that will be finished prior to this meeting. Dr. Kidd will serve as Surgery Vice Chair.

Topic: Ancillary Service Annual Report by Dawn Kuwahara

SONOMA VALLEY HOSPITAL HEALTHCARE DISTRICT
Accreditation Survey Final Report

Dates of Survey: **March 21 – 23, 2017**

Type of Accreditation: **ACUTE CARE HOSPITAL**

Chapter	Standard Level	Respons Person	Monitoring Description	Term	Duration	Goal	Compliance 2017									Compliance 2018					
							April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
Governance & Leadership	GL-4	Pauline	Compliance with defibrillator testing	monthly	3 mos	100%	Delayed check test print out monitoring. staff training was instead monitored Apr-Jun														
QA/PI Program	QA-01	Lisa D	Admitting Quarterly Quality Monitoring Reports Submission	quarterly	1 yr	100%															
		Leslie	EVS Quarterly Quality Monitoring Reports Submission	quarterly	1 yr	100%															
Medical Staff	MS-6	Leslie	Audits are completed to ensure that temporary privileges do not exceed 120 days in a calendar year	monthly	6 mos	100%	100%	100%	100%												
Verification of Licensure & Certification	HR-01	Heidi	Primary source verification of credentials	monthly	3 mos	100%	100%	100%	100%												
Provision of Safe Environment	CE-03	Grigory	Generator Testing maintenance schedule is being completed	weekly	1 mos	100%	0%	75%	100%												
		Grigory	The annual fuel testing is completed during annual preventative maintenance on the generators	annually	1 yr	100%	100%														
		Grigory	3 ft clearance is being maintained in front of the electrical panel in the Cardio-storage closet	monthly	1 yr	100%	100%	100%	100%												
		Grigory	full and empty cylinders are not stored in the same rack	weekly	6 mos	100%	100%	100%	100%												
Ventilation, Lighting & Temp Control	CE-11	Grigory	Soiled Utility Rooms: Appropriate room air pressure is maintained according toASHRE 170-2013 standards	quarterly	1 yr	100%	n/a	25%	25%	Vendor solved exhaust issues in July. July 100%											
		Grigory	Surgery Department is recording temp/humidity in a daily log and reporting out of range conditions to Engineering	annually	1 yr	100%	100%	100%	100%												
		Grigory	Emergency Department is recording temp/humidity in a daily log and reporting out of range conditions to Engineering	annually	1 yr	100%	Validation data not available at time of report														
		Grigory	SPD Clean Room: Appropriate room air pressure is maintained according toASHRE 170-2013 standards	quarterly	1 yr	100%	100%	100%	100%												
Compliance to the NFPA Life Safety Code	CE-15	Grigory	All fire doors and other opening protectives will be inspected per the NFPA 80-2010 5.2.4.2 standard	annually	1 yr	100%	100%														
		Grigory	Any penetrations in fire rated corridors are firestopped	quarterly	1 yr	100%	100%														
		Grigory	Surgery Department Electrical Panel Clearance - to monitor electrical panel obstructions and 8 ft clearance in hallway	monthly	1 yr	100%	100%	50%	100%												
Inspection & Testing of Life Safety Systems	CE-19	Grigory	Fire Life Testing deficiencies have been corrected (4 smoke detectors not tested 2016)	annually	1 yr	100%	n/a	0%	0%	Vendor scheduling difficulty. Completed 7/10/17.											
		Grigory	Verify time for main drain residual pressure recovery has been documented	annually	1 yr	100%	n/a	0%	0%	Vendor scheduling difficulty. Completed 7/20/17.											
		Grigory	Fire Life Testing deficiencies have been corrected (document air handlers shutdown upon duct detection activation)	annually	1 yr	100%	n/a	0%	0%	Vendor scheduling difficulty. Completed 7/10/17.											
		Grigory	NFPA Standard has been referenced in Fire Life Safety report	annually	1 yr	100%	100%														
Infection Prevention & Control Policies	IC-03	Bob	Compliance with use of new sanitization log	monthly	1 yr	99%	99%	100%	100%												

Notification of Hospitalization	PR-03	Lisa D	Notification of Representative documentation compliance	weekly	2 mos	100%	Delayed due to Admitting prioritization																	
Use of Protocols and Standing Orders	MM-21	Dawn	Authentication of contrast administration by radiologist	monthly	1 yr	100%	Pending / Delayed due to Dept Manager on Leave																	
Medication Orders	MM-22	Sally	Clear instructions for use of naloxone and nalbuphine	weekly	1 mos	100%	Delayed due to transition in management																	
Preparation of Medications	MM-24	Bonnie	IV Admixture Compentency prior to Bedside Care	monthly	6 mos	90%	100%	100%	100%															
Minimum Content of the Medical Record	MR-05	Janine	All preoperative charts for H&P completion	weekly	3 mos	100%	100%	100%	100%															
		Rosemary	Discharge Summary Compliance	monthly	3 mos	100%	91%	96%	Rosemary is still compiling June data															
Renewal of Orders for Restraint / Seclusion	RS-09	Deborah	Ordering and re-ordering of restraint	weekly	6 mos	100%	100%	100%	100%															
Provision of Anesthesia	AN-02	Mark	Moderate Sedation Procedures Documentation - post-anesthesia evaluation documentation	monthly	6 mos	100%	100%	100%	71%															
Provision of Moderate Sedation / Analgesia	AN-03	Mark	Moderate Sedation Procedures Documentation - documentation of cardiopulmonary and airway assessment	monthly	6 mos	90%	100%	100%	86%															
Provision of Dietary Services	NU-01	Bob	Completeness of Sanitation Logs	weekly	1 yr	99%	99%	100%	100%															
		Bob	Dishwasher temperature and sanitation logs	weekly	1 yr	99%	99%	99%	99%															
Food Preparation & Storage	NU-03	Bob	Freezer Temperature Logs documentation	monthly	1 yr	99%	100%	100%	100%															
Tissue Management	LB-06	Janine	FDA & CA Tissues bank licenses are current	monthly	1 yr	100%		100%	100%	100%														
Organ, Tissue & Eye Procurement	OP-01	Bonnie	OPO annual Healthstream compliance	annually	1 yr	100%																		
Delivery of Nursing Care	NS-03	Pauline	Timely update of care plans for fall risk	monthly	6 mos	95%	100%	100%	100%															
Informed Consent	OI-05	Leslie	IC documentation in C/Section H&P	monthly	3 mos	100%	100%	100%	66%															

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

Patient Care Services Dashboard 2016

Medication Scanning Rate	2016-17				
	Q4	Q1	Q2		Goal
SNF	85.7%	88.0%	89.3%		80%
Acute	89.7%	90.0%			90%
ED	90.9%	91.0%	92.7%		90%

Falls (Per 1000 days)	2016-17				
	Q4	Q1	Q2		50th %tile
SNF	1.2	0.6	1.3		
Acute	3.6	1.5	1.2		
TOTAL	2.4	2.1	2.5		2.32%

Hospital Acquired Pressure Ulcer Incidents (Per 1000 admissions)	2016-17				
	Q4	Q1	Q2		National
SNF	0.0	2.2	0.0		3.17
Acute	1.0	3.3	0.0		3.68

Nursing Turnover	2016-17 RNs/Quarter				
	Q4	Q1	Q2		Goal
SNF (n=17)	0	1	1		≤1
Acute (n=65)	4	0	1		≤3
Healing at Home (n=11)	1	0	0		≤1
Total Nursing Turnover	5	1	2		≤5

Patient Experience (CAHPS)	2016-17				
	Q4	Q1	Q2		Goal
RN Communication					NRC Ave.
ED	82.9	80.2	N/A		76.5
Acute	78.3	70.4	N/A		76.5
Pain Management					NRC Ave.
ED	61.4	47.8	N/A		45.9
Acute	69.0	60.5	N/A		65.3
Communications re: Medications					NRC Ave.
Acute	70.0	51.4	N/A		62.7

Nurse Staffing Effectiveness: Transfers r/t staffing/beds	2016-17				
	Q4	Q1	Q2		Goal
	2	4	4		0