SVHCD QUALITY COMMITTEE
AGENDA
WEDNESDAY, August 23, 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
Call In Phone 866-228-9900 guest code 294221

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	*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 • Minutes 07.26.17	*Hirsch*	Action
4. POLICY & PROCEDURES	*Lovejoy*	Action
5. PHARMACY DEPARTMENT REVIEW & ADE REPORT	*Kutza*	Inform
6. PATIENT CARE SERVICES DASHBOARD	*Kobe*	Inform
7. QUALITY REPORT 2017	*Lovejoy*	Inform/Action
8. UPON ADJOURNMENT OF REGULAR OPEN SESSION	*Hirsch*	
9. CLOSED SESSION: Calif. Health & Safety Code § 32155 Medical Staff Credentialing & Peer Review Report	*Lovejoy*	Action
10. REPORT OF CLOSED SESSION	*Hirsch*	Inform/Action
11. ADJOURN	*Hirsch*	

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SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
July 26, 2017, 5:00 PM
MINUTES
Schantz Conference Room

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

AGENDA ITEM	DISCUSSION	ACTION
1. CALL TO ORDER/ANNOUNCEMENTS	*Rymer*	
	Meeting called to order at 4:59p.m.	
2. PUBLIC COMMENT	*Rymer*	
	None	
3. CONSENT CALENDAR	*Rymer*	Action
• QC Minutes, 05.24.17		**MOTION:** by Minardi to approve, 2nd by Sheets All in favor
4. POLICY & PROCEDURES	*Lovejoy*	Action
		MOTION: by Minardi to approve, 2nd by Snyder. All in favor.
5. ANCILLARY SERVICES ANNUAL REPORT	*Kuwahara*	Inform
	Ms. Kuwahara presented the Ancillary Services Annual Report. She presented an overview of who and what the ancillary services are. Staff satisfaction scores – roll up report is 4.28 out of 5. 86% with 93% participation. Direct reports 4.5 out of 5. 90% engagement with 100% participation. Ms. Kuwahara gave an overview on the community benefit that ancillary services participates in. Things such as: back to school fair, balance classes, binational health fair, gentle yoga class, heart health, ostomy education, Parkinson's support	Have Lynn report entire engagement survey next year.

AGENDA ITEM	DISCUSSION	ACTION
	group, Remind program. She also presented a rollup for fiscal year 2016. Gross revenue was up due to annual pricing increase, total expenses were up due to annual salary increases, agency costs, professional fees, pharmacy costs and purchased services, OP UOS down due to possible leakage. The committee suggests the net revenue be presented. Quality indicators, goals, results and analysis plan was reviewed and discussed for the last year. Ms. Kuwahara spoke on the great improvements in Medication Bar Code compliance and RUG levels in the last year. Performance Improvement projects in 2016- In patient PT did early mobilization in the ICU will be continued in 2017. Outpatient PT and Hand Therapy Treatment worked on strategies to maximize outcomes and reimbursement, will be continued in 2017. New projects in 2017– Cardiopulmonary – efficient scheduling of outpatient testing. Medical Imaging – Head CT/MRI results within 30 minutes of arrival for strokes. Future plans- Electronic Health Record for wound care, occupation health and outpatient rehab implemented this year. 3D Mammo project to bring the technology back into the hospital will begin next week. We serve as a clinical rotation site for multiple colleges.	
6. QUALITY REPORT JUNE 017	*Lovejoy*	Inform/Action
	Ms. Lovejoy reported that the Prime grant data abstraction and gathering will be complete by the September meeting. Ms. Lovejoy reviewed the action planning for CIHQ survey She will bring back the report in September. Ms. Lovejoy reviewed the medical staff projects that are ongoing, which include moving closer to having an all-electronic credentialing and privileging process. She also announced a cocktail reception for Dr. Veluz and Dr. Mariano on August	**MOTION:** by Webber to approve, 2nd by Rymer. All in favor.

AGENDA ITEM	DISCUSSION	ACTION
	10th. She also reviewed the current medical staff election results for the various departments.	
7. BOARD QUALITY DASHBOARD	*Lovejoy*	Inform
	Ms. Lovejoy presented the Quality dashboard. A lengthy review and discussion ensued regarding the findings. The committee found opportunities for clarification on some of the presented data, Ms. Lovejoy agreed to follow up this. In reference to the clinical process of care core measures the committee expressed concerns regarding the some of the Emergency Department metrics, particularly the long average length of time between arrival and discharge. These metrics have not been close to meeting the benchmarks for at least the last year. They discussed the options of how to address these issues and follow up with them.	**MOTION**: Rymer recommends that a performance improvement project be under taken to understand what is causing the longer than benchmarked time from door to discharge in the ED. With a follow up back to the committee on whether and how to get them to the benchmark. 2nd by Minardi. **MOTION:** by Minardi to approve Ms. Lovejoy taking the committee recommendation to the Board of Directors, 2nd by Woodward. All in favor
8. PATIENT CARE SERVICES DASHBOARD	*Kobe*	Inform
	Deferred to next month	
9. UPON ADJOURNMENT OF REGULAR SESSION	*Rymer*	
	Regular session adjourned at 6:36 p.m.	
10. CLOSED SESSION • Calif. Health & Safety Code § 32155 Medical Staff Credentialing & Peer Review Report	*Rymer/Lovejoy*	Action
11. REPORT OF CLOSED SESSION	*Rymer*	Inform/Action
		MOTION: by Minardi to approve 2nd by Rymer. All in favor
12. ADJOURN	*Rymer*	
	Meeting adjourned at 6:39 p.m.	

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Policy and Procedure - Approvals Signature Page
GL8610-142, QS8610-126, GL8610-160, PR8610-110, QS8610-114, QS8610-104, PC8610-360, PC8610-104,LB7500-64

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.

June 20th, 2017—Policy & Procedure Team

Leslie Lovejoy — 5/16/17
Leslie Lovejoy — Date
Chief Quality Officer

July 13th, 2017—Medicine Committee

8/21/17
Douglas S. Campbell, MD — Date
Chair Medicine Committee

July 20th, 2017—Med Exec Committee

8 July
~~Keith J. Chamberlin, MD MBA~~ Brian Sebastian MD — Date
President of Medical Staff

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

Mark Kobe, Chief Nursing Officer	
Signature:	DATE: 7-0-7

ORGANIZATIONAL

REVIEWED/NO CHANGES

QS8610-126 Patient Resuscitation Code Status
GL8610-160 Plan for Patient Family Education

REVISIONS

GL8610-142 Customer Relations
Customer Relations: deleted verbiage re; paper documentation and departmental distribution. Added CIHQ reference

RETIRE

PR8610-110 Do Not Resuscitate
Substance included in QS8610-126 Patient Resuscitation Code Status
QS8610-114 Education Patient and Family
Substance included in GL8610-160 Plan for Patient Family Education

Mark Kobe, Chief Nursing Officer		Bonnie Bernhardy, Education Coordinator	
Signature:	DATE: 7-6-7	Signature: Bonnie Bernhardy	DATE: 7/6/17

ORGANIZATIONAL

REVISED

QS8610-104 Code Blue-Broselow Carts and Emergency Medications

1. Benzacaine ointment has been removed from the inventory of the Intubation tray, Drawer 4. Clinicians no longer use the product to assist endotracheal intubation and the product frequently expires, necessitating restocking of the tray.
2. Language added to monthly checks of cart clarifying Broselow Bag examination for expired product.
3. P&T committee has approved the elimination of Verapamil from the crash cart medication tray contents list since it is no longer an ACLS drug for cardiac arrest

1. Addition of suction equipment to Drawer # 6 in the Adult Crash Carts as listed below (pg. 7)
2. Removal of O2 cannulas from Drawer # 6 in the Adult Crash Carts (pg. 7)

Drawer 6 Ambu Bag/Suction Supplies/Arm Boards (added to title of drawer)

1 Adult Ambu bag	1-Yankauer Suction Tube
1 Pediatric Ambu bag	2-14 Fr. Suction Catheters
1 Large Adult Arm Board	1-Suction Canister (1500 ml)
1 Small Adult Arm board	1-Suction Canister Tubing (6 Ft.)
1 Oxygen tubing Ext Set/connector	1-Suction Canister Liner (1500 ml)

3. Corrected spelling of intraosseous (pg. 8, 9, 10 & 11)

4. Corrected spelling of cricothyrotomy (pg. 10)
5. Removed the word "unit" and replaced it with "tray" to describe Crash Cart replacement trays (pg. 3)
6. Imaging and Cardio have a Crash Cart and Broselow Bag
   - Added "clinical personnel" for Crash Carts and Broselow Bag monthly checks (pg. 1)
   - Added "clinical personnel" to notify nursing supervisors or pharmacy to replace used Crash Cart trays or Broselow Bag supplies (pg. 3)
7. Removed the word "discharge" and replaced it with "SHOCK" to describe the shock button (pg. 2)
8. Added "except in the ED and SCU" to list which Crash Cart have a Broselow Bag instead of a Broselow Cart (pg. 2)
9. Changed "Birth Center" to "Birthplace" (pg. 3)

PC8610-360 Care of Patients Under Legal Restriction

Appendix B is used to educate new hire clinical staff. Additional safety practices for staff caring for a patient under legal restriction are listed below:

- Remove items brought into a patient's room that are no longer needed
- Be aware of surrounds and escape route
- Don't turn back to the patient
- Don't discuss patient info within earshot of patient to avoid anticipating routines
- Bring extra staff into room to assist if uncomfortable
- When ordering food, Order "Safety Tray". When patient finished eating, remove all tray items from room
- If patient expires, treat as coroner's case
- If conflict arises between staff and peace officer, notify nsg. supervisor or manager
- Orient peace officer with forensic staff information sheet
- Peace officer stays with patient during transfers, procedures and in the OR
- Peace officer can deny/limit visitors and phone calls. If visitors present, peace officer will inspect purses, bags, etc. For drugs, weapons
- Forensic restraints are the responsibility of the peace officer and exempt from our restraint policy

Competency revised with these additions

Melissa Evans, SNF Director of Nursing	
Signature: MEvans	DATE: 7/6/17

ORGANIZATIONAL

REVISIONS

PC8610-104 Admission Guidelines for Transfers to SVH SNF from Outside Facilities

Amended to reflect hiring an Intake Coordinator to assist with referrals.

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Lois Valenzuela, Laboratory Manager		Dawn Kuwahara, Chief Ancillary Services Officer	
Signature: Lois Valenzuela	DATE: 7/6/2017	Signature: D Kuwahara	DATE: 7.6.17
Frederick Kretzschmar, M.D., Medical Director, Surgical Pathology Services Department			
Signature: F. Kretzschmar MD	DATE: 7-6-17		

DEPARTMENTAL

REVISIONS

LB7500-64 Results Reporting
Revised Hematocrit and Hemoglobin
Critical Laboratory Values
Changes Approved P&P Team 5/16/17
Updated policy to reflect what we do now:
PRIMARY CARE PHYSICIAN NOT AVAILABLE:
REMOVED—Call Hospitalist and Call the Chief Medical Officer

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Policy and Procedure - Approvals Signature Page
NS7010-07

Review and Approval Requirements

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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.

Administrative Approvals

Cynthia Lawder, M.D. | Medical Director, Emergency Department — Date

Kelly Mather | Chief Executive Officer — Date

Committee Approvals

Policy & Procedure Team—February 21st, 2017

Leslie Lovejoy | Chief Quality Officer — 2/21/17 — Date

Medicine Committee—July 13th, 2017

Douglas S. Campbell, MD | Chair, Medicine Committee — 8/13/17 — Date

Medical Executive Committee—July 20th, 2017

Keith J. Chamberlin, MD MBA | President of Medical Staff — 8/1/17 — Date

Brian Sebastian MD

Board Quality Committee —July 26th, 2017

Jane Hirsch | Chair, Board Quality Committee — Date

Board of Directors—August 3rd, 2017

Jane Hirsch | Chair, Board of Directors — Date

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Policy Submission Summary Sheet

Deborah Bishop, ED & ICU Clinical Director		Mark Kobe, Chief Nursing Officer	
Signature: D Bishop	DATE: 6/9/17	Signature: M Kobe	DATE: 6/9/17

DEPARTMENTAL

NEW
NS7010-20 Emergency Department Nursing Protocols

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Policy and Procedure - Approvals Signature Page
LB7500-06, LB7500-26, LB7500-64

Review and Approval Requirements

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Administrative Approvals

Frederick Kretzschmar, M.D. | Medical Director, Surgical Pathology Services Department — Date

Kelly Mather | Chief Executive Officer — Date

Committee Approvals

Policy & Procedure Team—May 16th, 2017

Leslie Lovejoy | Chief Quality Officer — 5/16/17 Date

Medicine Committee—July 13th, 2017

Douglas S. Campbell, MD | Chair, Medicine Committee — 7/13/17 Date

Medical Executive Committee—July 20th, 2017

~~Keith J. Chamberlin, MD MBA~~ Brian Sebastian, MD | President of Medical Staff — 8/1/17 Date

Board Quality Committee —July 26th, 2017

Jane Hirsch | Chair, Board Quality Committee — Date

Board of Directors—August 3rd, 2017

Jane Hirsch | Chair, Board of Directors — Date

SONOMA VALLEY HOSPITAL
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Policy Submission Summary Sheet

Lois Valenzuela, Laboratory Manager		Dawn Kuwahara, Chief Ancillary Services Officer	
Signature: Lois Valenzuela	DATE: 5/15/2017	Signature: D Kuwahara	DATE: 5.15.2017

DEPARTMENTAL

REVISIONS
LB7500-06 Approved Reference Labs
Deleted Muir Lab
Added Queen of the Valley

LB7500-26 Laboratory Fax Policy
Removed VERIFICATION__YEARLY AUDIT
Added a purpose

LB7500-64 Results Reporting
Updated policy to reflect what we do now:
PRIMARY CARE PHYSICIAN NOT AVAILABLE:

REMOVED—Call Hospitalist and Call the Chief Medical Officer

This is the last—total of 3

- Reference lab
- Lab Fax
- Results Reporting

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Policy and Procedure - Approvals Signature Page
IC8610-110, IC8610-114, IC8610-116, IC8610-128, IC8750-125

Review and Approval Requirements

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- 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.

August 23rd, 2017—Board Quality Committee

_____ _____
Jane Hirsch Date
Chair, Board of Directors

Hospital CEO

_____ _____
Kelly Mather Date
Chief Executive Officer

September 7th, 2017—Board of Directors

_____ _____
Jane Hirsch Date
Chair, Board of Directors

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Policy Submission Summary Sheet

MANAGER		SENIOR LEVEL MANAGER	
Name: Kathy Mathews		Name: Leslie Lovejoy	
Title: Infection Control Coordinator		Title: Chief Quality Officer	
Signature: Kathy Mathews	DATE: 8/16/17	Signature: Leslie Lovejoy	DATE: 8/17/17

ORGANIZATIONAL

IC8610-110 Blood and Body Fluid Spill Policy and Procedure
Reviewed; minor changes

IC8610-114 Contact Isolation Precautions
Revised; Multi-drug resistant gram negative organisms that are resistant to three or more categories of antibiotics including 3rd generation cephlasporins, the quinolones Ciprofloxacin, moxifloxacin, levofloxacin, and the aminoglycosides gentamicin or tobramycin. Contact the Infection Preventionist for assistance; the lab informs the nursing unit when MDRO organisms are identified and flags the EMR to indicate that Contact Isolation is required.

IC8610-116 Contact Plus Enteric Precautions
Revised; change in that 3 loose stools within a 24 hour period with unknown etiology will now trigger testing and isolation to reduce the risk of transmission of C. difficile in patient care areas.

- Patients with 3 loose bowel movements within a 24 hour period shall have a stool sample tested for C. difficile toxin.
- The nurse will inform the physician of the patient's condition and request C. difficile toxin test and Contact Plus Enteric isolation orders.
- The patient will be placed in Contact Plus Enteric isolation in a private room.
- A positive C. difficile laboratory finding is a critical lab value. The laboratory will contact the ordering unit with the lab result as soon as it is final.
- The nurse caring for the patient will inform the physician of the positive result. In the event the patient has been discharged, e.g, Emergency Department, designated Emergency Department personnel will contact the patient's primary care physician. If no primary care physician is listed in the electronic medical record, the patient will be contacted, informed of the laboratory results and instructed to seek follow up medical care.
- Isolation may be discontinued following Clostridium difficile or viral gastroenteritis when the patient's diarrhea is resolved plus 48 hours
- Patient's room needs to be terminally cleaned before isolation precautions can be discontinued even if patient is not being discharged.
- The isolation sign remains affixed to the patient's door until Environmental Services completes the terminal clean with bleach solution, changes the curtains and performs Xenex UV disinfection with the robot.
- EVS will hand off the isolation sign to the nurse once the terminal clean has been completed.

IC8610-128 Equipment Cleaning Policy; Revised; added Alternate Schedules cleaning equipment and room areas in Patient areas

DEPARTMENTAL

IC8750-125 Post-Discharge Surgical Site Infection Surveillance
Reviewed; minor changes

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.

PHARMACY DEPARTMENT ANNUAL REVIEW

Introduction and Overview: The pharmacy is a core required service for acute care hospitals, and oversees all matters relating to inpatient and outpatient procurement and use of medications. Components of this oversight include the Pharmacy & Therapeutics Committee, medication error report management, 340B purchasing program management, and the annual update of the state required MERP (Medication Error Reduction Plan). In addition, pharmacist informaticists oversee the maintenance of McKesson Paragon Pharmacy and CPOE medication related order sets.

Department Mission: To positively impact patient care by collaborating with the interdisciplinary care team to promote safe and effective pharmaceutical care.

Leadership Team: Director of Pharmacy

Statistical Overview:

Staff Category	Function	Total FTE's
Director of Pharmacy	The pharmacist in charge on the state pharmacy license, daily oversight and management of all pharmacy functions and personnel	1FTE 1 full time Director of Pharmacy
Pharmacist Informaticist	Supports the oversight and maintenance of the pharmacy computer system (Paragon Pharmacy) as well as medication components of any CPOE order sets. Ensures that medication billing codes are functional and maintained in partnership with patient accounting.	0.5FTE 1 Full-time pharmacist splitting status with staff pharmacist duties 50-50 1 Per Diem pharmacist
Staff Pharmacist	Provides day to day direct patient care including but not limited to medication histories, med order processing, antimicrobial stewardship, patient care rounds, collaboration with other hospital clinical staff, supervision of pharmacy technicians	4.2FTE 2 Full time pharmacists (1 of which is also pharmacist informaticist) 1 part time pharmacist 6 per diem pharmacists
Pharmacy Buyer	Responsible for the management of pharmacy inventory, ordering, and management of 340B purchasing processes. Troubleshoots and coordinates management of shortages and recalls.	1FTE 1 full time pharmacy buyer
Pharmacy technicians	Manage the technical aspects of the pharmacy including refilling and restocking of medications within the pharmacy and patient care areas; billing; expiration date tracking; invoice management; preparation/packaging of medications and IV's	3.4FTE 1 Full time technician 2 Part time technicians 2 Per diem technicians

Staffing decisions are made based legal minimum requirements, patient care workload, and ongoing Electronic Medical Record projects and maintenance. The pharmacy currently averages over 26,000 doses dispensed per month and performs medication histories on most of the more than 1,400 patients admitted per year. The current total budget for the pharmacy is $3,087,205 of which $1,300,000 is medication purchases. Hospital pharmacies are typically not revenue generating departments since most of the patient care expenses relating to pharmacy are not individually reimbursed by payors. The budgeted hospital pharmacy revenue across both inpatients and outpatients is $11,855,437. The pharmacy does impact the bottom line of the hospital by ensuring that patients have the safest and most effective medication related care as possible, including antimicrobial optimization, anticoagulant management, parenteral nutrition management, thorough medication histories, and other patient care related clinical duties. This translates to lower lengths of stay, efficient medication spending, and avoidance of readmissions.

Quality Metrics

The pharmacy department measures indicators relating to pharmacy operations, patient safety, and IV compounding to ensure we meet regulatory, reporting, and internal quality control standards. Quality metrics are used to determine that a process is within statistical control, identify processes that are trending in a negative or positive direction, and if interventions or process changes are having an effect on the quality of our departments output. Via the use of Statit Statistical Software, we can track this closely and in a meaningful way.

For 2017:

Indicator Name	***Type of Indicator: Process/Outcome***	***Goal/Threshold***	***Frequency of Monitoring***	***# of Observations***
High risk medication errors that reach the patient per 10,000 doses dispensed	*Outcome*	*≤1.25 errors reach the patient per 10,000 doses dispensed*	*Monthly*	*100% of error reports*
Administration errors per 10,000 doses dispensed	*Outcome*	*≤1.00 errors per 10,000 doses dispensed*	*Monthly*	*100% of error reports*
Near miss error reports	*Process*	*>75% of error reports are near misses*	*Monthly*	*100% of error reports*
Pyxis Overrides	*Process*	*<1% of transactions involve an override*	*Monthly*	*100% of Pyxis transactions*
Pyxis Stockouts	*Outcome*	*<6.2% of transactions result in a stockout*	*Monthly*	*100% of Pyxis transactions*
Pharmacy Interventions	*Process*	*Investigate outliers or trends for causality*	*Quarterly*	*100% of reported pharmacy interventions*
Adverse Drug Reactions (ADRs)	*Outcome*	*Investigate outliers or trends for causality*	*Quarterly*	*100% of reported ADRs*
Antimicrobial stewardship: Length of Stay (LOS) by DRG	*Outcome*	*Maintain at minimum a flat trend line for average LOS by DRG*	*Monthly*	*100% of reported LOS for DRGs related to simple pneumonia & pleurisy, septicemia, respiratory infections & inflammations,*

				and cellulitis
Antimicrobial stewardship: Antibiotic spend per pharmacy adjusted patient day (PAPD)	*Outcome*	*Maintain at minimum a flat trend line for antibiotic spend PAPD*	*Monthly*	*100% of antibiotic spend per PAPD*
Inpatient controlled substance charting audit	*Process*	*>95% of controlled substances audited are charted properly in the eMAR*	*Monthly*	*100% of controlled substance Pyxis withdrawals in a 24 hour period once per month*
Anesthesia controlled substance waste reconciliation audit	*Process*	*<4% of anesthesia controlled substance removals result in a discrepancy in the reconciliation of use, waste, and returns.*	*Monthly*	*>90% of anesthesia controlled substance transactions*
Personnel glovetip testing	*Process*	*100% pass rate per USP797 standards*	*Annually*	*100% of compounding personnel*
Aseptic technique testing	*Process*	*100% pass rate per USP797 standards*	*Annually*	*100% of compounding personnel*
End product testing of compounded sterile solutions	*Outcome*	*100% sterile*	*Quarterly* *Annually*	*3 individual samples* *1 sampling from a non patient-specific sterile compounding batch*
Quantitative testing of compounded IV solutions	*Outcome*	*No more than ±10% variance in intended concentration of the compounded product*	*Quarterly*	*1 IV sample*
Surface testing of hoods and IV room	*Process*	*100% pass rate per USP797 standards*	*Quarterly*	*1 sample from each IV hood; 3 samples total from IV room and anteroom*
Room and hood certification	*Process*	*100% rate of room and hoods meeting USP797 standards for ISO status and airborne particulates*	*Semi-annually*	*100%*
Personnel written competencies	*Process*	*100% pass rate for any personnel compounding or checking sterile IVs*	*Annually*	*100%*

Below (Attachment A) please find the Year to Date 2017 results.

For 2017: will add the following:

- Antimicrobial Stewardship-Days of Therapy Cefepime, Ertapenem, and Pipercillin-Tazobactam

PHARMACY DEPARTMENT ANNUAL REVIEW

Past and Future plans for Performance Improvement:

The pharmacy department is/has been working on the following projects:

* *Use of Statit:* As mentioned above, the use of Statit allows for assessment of statistically relevant trends in all of the pharmacy quality measures, and identification of process change impacts.

* *CPOE order set optimization:* In order to make our CPOE system safer and more user friendly, pharmacy informatics is tasked with the ongoing project of addressing "pain points" for end users and addressing safety issues as they relate to prescribing.

* *Antimicrobial stewardship:* With our new software, MedMined, we can now assess our use of antimicrobials in an in depth and comprehensive way. Both long term and current trends can be assessed in real time and discussed at the hospital Antimicrobial Stewardship Program Committee to determine actions to take.

* *340B Management:* SVH's recent eligibility for participation in HRSA's 340B Drug Purchasing Discount program comes with significant compliance monitoring. We will be forming a committee that looks at all the required aspects of this program to ensure efficient use and compliance with the rules of this federal program.

* *Medication Safety:* This is a core quality measure of the pharmacy department. Evaluation of medication error reports, annual updating of the state mandated MERP plan, and review of actions taken is an ongoing effort. Much of this is managed via the Pharmacy & Therapeutics Committee.

* *Medication Reconciliation:* In 2017 we have begun a multi-year PI project to improve the global medication reconciliation process. This is a multidisciplinary effort that involves multiple processes.

Conclusion:

The Pharmacy Department is an efficient, high functioning team with very dedicated staff. Employee engagement is among the highest in the hospital and staff work together to ensure safe and effective patient care provided as cost effectively as possible.

Attachment A: All Pharmacy Indicators

Status	Indicator	Current Value	Target	SPC Alert	Updated
Quality > Pharmacy > Adverse Drug Events					
▽ ▲	**Rx-ADEs-Administration Errors Per 10,000 Doses**	2.86	1.00		Jul 2017
▽ ▲	**Rx-ADEs-Good Catches**	61%	75%		Jul 2017
★ ▼	**Rx-ADEs-High Risk Med Errors Per 10,000 Doses**	0.00	1.25		Jul 2017
▲	**Rx-Adverse Drug Reactions**	4	n/a		Q2 2017
▼	**Rx-Adverse Drug Reactions-Antibiotics**	0%	n/a		Q2 2017
▲	**Rx-Adverse Drug Reactions-Anticoagulants**	25%	n/a		Q2 2017
▲	**Rx-Adverse Drug Reactions-Cardiovascular**	25%	n/a		Apr 2017
★ ▼	**Rx-Warfarin-Inpatient**	0.0%	5.0%		Dec 2016
Quality > Pharmacy > Antimicrobial Stewardship					
▽ ▼	**Rx-Antimicrobial Stewardship Cefepime DOT**	56.72	50.00		Jun 2017
▽ ▼	**Rx-Antimicrobial Stewardship Ertapenem DOT**	23.11	20.00		Jun 2017
★ ▲	**Rx-Antimicrobial Stewardship LOS-Cellulitis (Days)**	3.7	4.0		May 2017
★ ▲	**Rx-Antimicrobial Stewardship LOS-Pneumonia (Days)**	4.0	4.0		Jun 2017
✕ ▲	**Rx-Antimicrobial Stewardship LOS-Resp. Infections-Inflammations (Days)**	8.0	4.0		Jun 2017
▽ ▲	**Rx-Antimicrobial Stewardship LOS-Septicemia (Days)**	5.7	4.5		Jun 2017
✕ ▲	**Rx-Antimicrobial Stewardship Pip-Tazo DOT**	31.51	20.00		Jun 2017
★ ▲	**Rx-Antimicrobial Stewardship-Antimicrobial Spend PAPD ($)**	5.96	8.00		Jun 2017

PHARMACY DEPARTMENT ANNUAL REVIEW

Quality > Pharmacy > Controlled Substances					
	Rx-Controlled Substance Audit-Anesthesia	0.0%	2.0%		Jun 2017
	Rx-Controlled Substance Audit-Inpatient	100.0%	95.0%		Jun 2017
Quality > Pharmacy > IV Room					
	Rx-Cleanroom Aseptic Technique	100%	100%		2016
	Rx-Cleanroom Certification	100%	100%		Jan-Jun 17
	Rx-Cleanroom Contact Plates	100%	100%		Q1 2017
	Rx-Cleanroom End Product Testing	n/a	100%		Q2 2017
	Rx-Cleanroom Glovetip Testing	100%	100%		Q1 2016
	Rx-Cleanroom Hood Cleaning	95%	100%		May 2017
	Rx-Cleanroom Quantitative Analysis	n/a	100%		Q2 2017
	Rx-Cleanroom Room Cleaning-Daily	100%	100%		May 2017
	Rx-Cleanroom Room Cleaning-Weekly	100%	100%		May 2017
	Rx-Cleanroom Written Competencies	100%	100%		2016
Quality > Pharmacy > Pharmacy Services					
	Rx-After Hours Interventions	0.8%	3.0%		Jun 2017
	Rx-After Hours Pharmacy Errors	0.00%	0.00%		Jun 2017
	Rx-Clinical Interventions-Dollars Saved	$100,491	$125,000		Q2 2017

	Rx-Clinical Interventions-Time Spent	208	n/a		Q2 2017
Quality > Pharmacy > Pyxis					
	Rx-ER Pyxis Overrides	0.88%	1.00%		Jul 2017
	Rx-Pyxis Overrides	1.29%	1.52%		Jul 2017
	Rx-Pyxis Stockouts	6.2%	6.0%		Jul 2017
Service > Inpatient > HCAHPS					
	HCAHPS Inpatient (M) (Communication About Meds)	55.0	70.0		May 2017
	HCAHPS Inpatient (M) (Pain Management)	1.0	70.0		May 2017

Status Legend

- The most recent period meets or exceeds the Target
- The most recent period is between the Target and Alarm
- The most recent period violates the Target (and Alarm if applicable)
- The current value increased signifying improvement from the previous period
- The current value increased signifying deterioration from the previous period
- The current value decreased signifying deterioration from the previous period
- The current value decreased signifying improvement from the previous period
- The current value did not change from the previous period
- The indicator has not been validated
- The indicator has been validated

SPC Alert Legend

- Most recent period is below Lower Control Limit
- Most recent period is above Upper Control Limit
- Process shift: Most recent 8 periods are all above the Center Line
- Process shift: Most recent 8 periods are all below the Center Line
- Most recent 6 periods are all increasing
- Most recent 6 periods are all decreasing

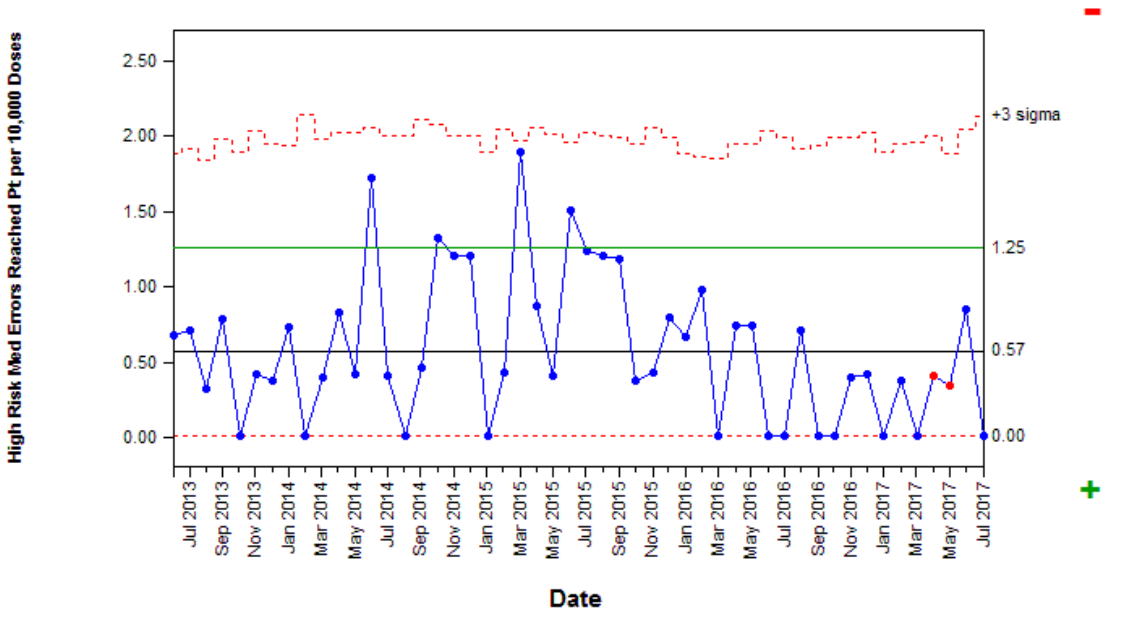
Green border: The alert is in a positive direction

Red border: The alert is in a negative direction

No border: There is no target direction for the indicator

U Chart

Rx-ADEs-High Risk Med Errors Per 10,000 Doses



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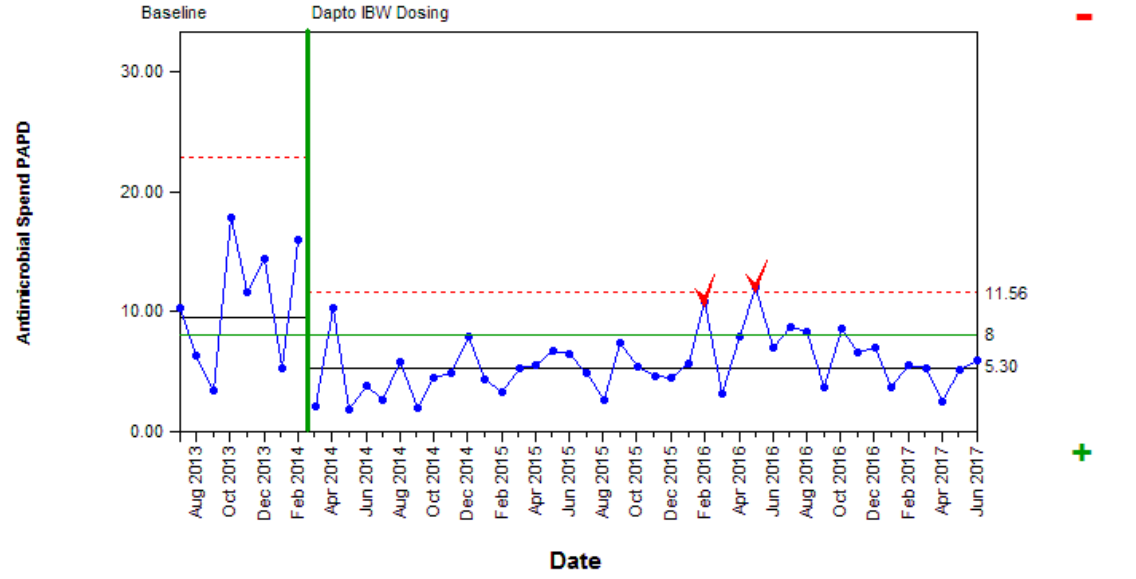
I Chart

Rx-Antimicrobial Stewardship-Antimicrobial Spend PAPD ($)



√ - Assignable Cause

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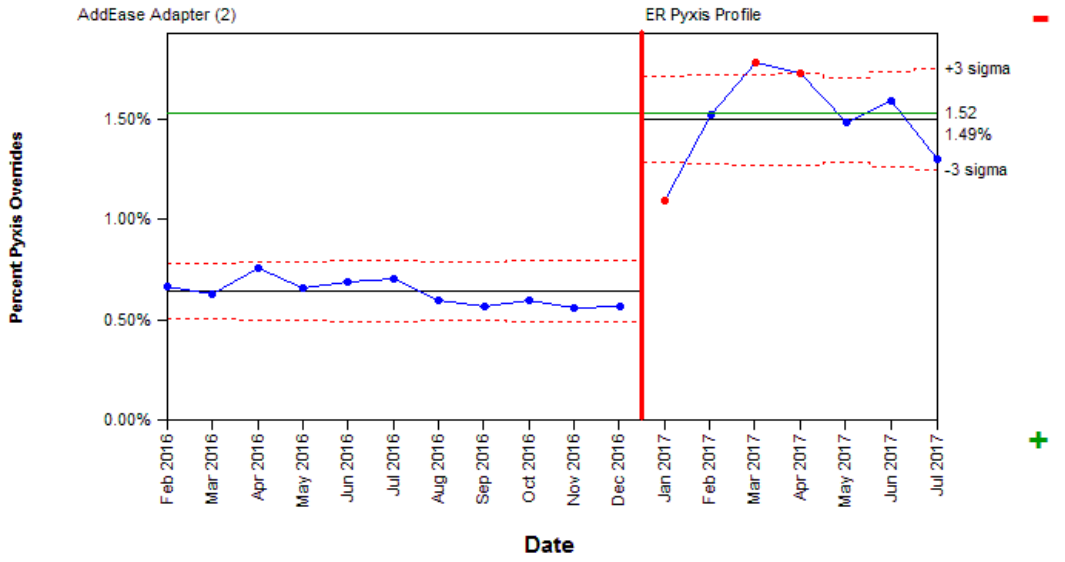
P Chart

Rx-Pyxis Overrides



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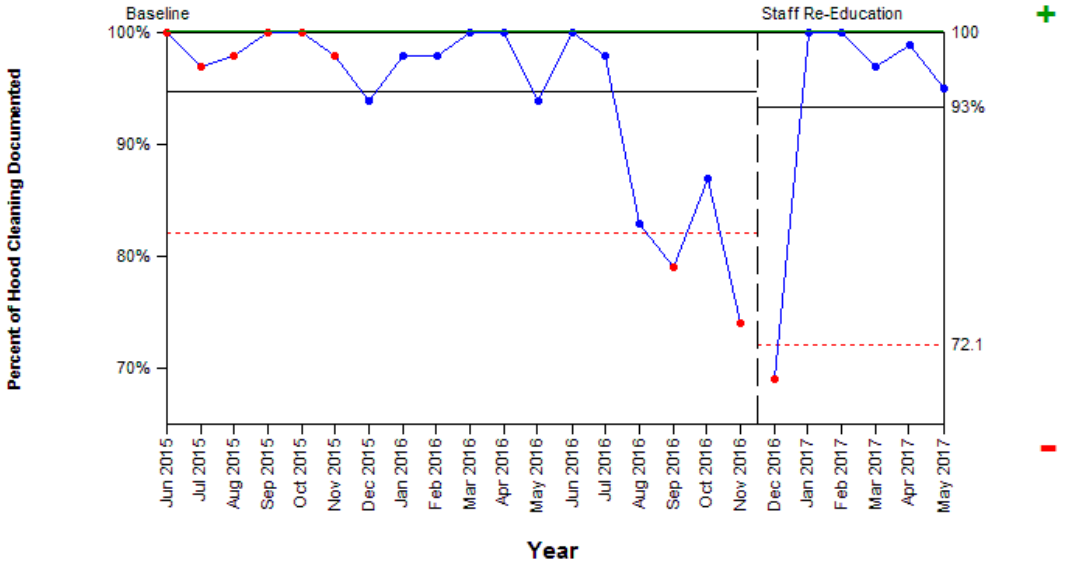
I Chart 3-Sigma

Rx-Cleanroom Hood Cleaning



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Patient Care Services Dashboard 2016

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

Medication Scanning Rate	2016-17				
	Q4	Q1	Q2		Goal
SNF	85.7%	88.0%	89.3%		≥80%
Acute	89.7%	90.0%	89.0%		≥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

Green = Goal Met Yellow = Below goal Red = Continues below goal or significantly below goal

To: Sonoma Valley Healthcare District Board Quality Committee
From: Leslie Lovejoy
Date: 08/23/2017
Subject: Quality and Resource Management Report

July Priorities:

1. PRIME Grant Activities
2. Performance Improvement
3. Medical Staff Office Update

1. *Prime Grant Activities*

Have created an MOU with the Community Health Center to allow for data sharing for the post discharge medication reconciliation data required as part of the grant's metrics. Have completed the annual data abstraction for our baseline data and will be sharing it with committees in September. If done, I will bring the baseline data to this meeting. Our three new community health coach volunteers have begun to come in and complete post discharge phone calls and are doing very well.

In the Case Manager's staff meeting this month, we decided to expand our Transition Record project to the Skilled Nursing Unit and include these patients in our population going forward. In addition we decided to initiate the My Plan at the time of the pre-op visit for all inpatient surgery cases. The Nurse Navigators will initiate the form and forward the form to the Case Managers for the day of admission. We are seeing an opportunity to identify the primary care provider for these patients and so have asked the Nurse Navigators to document this information prior to the date of surgery. I am expecting to see an improvement in the flow of information with these additions.

2. Performance Improvement:

The following Performance Improvement projects have been approved for implementation.

- ED throughput: Door to Decision for outpatient ED visits. Formed per BQC request.
- Home Care Financial Improvement Project. To re-look at the efficiency and profitability of Home Care as they move into the hospital.
- Women's Center Development Project. To build a comprehensive women's department consisting of OB, Breast Surgery and Gyn.
- Patient Satisfaction Survey Project. To move towards using Health Stream as the total vendor for HCAHPS.

Leaders have been meeting with Danielle and myself to review their PI projects for the fair. This is going well and Danielle is providing a fresh perspective and additional tools to increase their knowledge and ability to tell their story.

Partnership's Quality Improvement Project (QIP) sponsored their first mandatory Performance Improvement conference on August 8th. Danielle and I attended. There are two more in 2018 and involve hospital sharing their projects and ideas along with some speakers.

The annual PI fair will be held on October 17th from 0800-1530 and October 18th from 0800 – 1330. We will need judges.

3. Medical Staff Office Update:

The Surgery Chair is Dr. Sawyer and Vice-Chair is Dr. Kidd. The reception for Drs. Veluz and Mariano went well with 25 physicians attending. I am working with the Facilities Director to identify a physician lounge for meals. Currently the physicians eat in the Café and there have been some instances of potential PHI sharing. They have requested a separate space to mitigate the issue.

Topic: Pharmacy Annual Report & ADE Report by Chris Kutza