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

SVHCD QUALITY COMMITTEE
AGENDA
WEDNESDAY, MARCH 28, 2018
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**	*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 02.28.18	*Hirsch*	Action
4. 340B DRUG DISCOUNT PURCHASING PROGRAM	*Kutza*	Inform
5. MED/SURG PATIENT CARE SERVICES REPORT	*Kobe*	Inform
6. POLICIES & PROCEDURES	*Jones*	Action
7. QUALITY REPORT	*Jones*	Inform/Action
8. UPON ADJOURNMENT OF REGULAR OPEN SESSION	*Hirsch*	
9. CLOSED SESSION: Calif. Health & Safety Code § 32155 Medical Staff Credentialing & Peer Review Report	*Jones*	Action
10. REPORT OF CLOSED SESSION	*Hirsch*	Inform/Action
11. ADJOURN	*Hirsch*	

3.

CONSENT

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SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
February 28, 2018, 5:00 PM
MINUTES
Schantz Conference Room

Members Present	Members Present cont.	Excused	Public/Staff
Jane Hirsch Peter Hohorst Carol Snyder Susan Idell Kelsey Woodward	Michael Mainardi, MD Howard Eisenstark, MD Carol Snyder Cathy Webber	Ingrid Sheets Michael Brown, MD	Danielle Jones Kathy Mathews

AGENDA ITEM	DISCUSSION	ACTION
1. CALL TO ORDER/ANNOUNCEMENTS	*Hirsch*	
	Meeting called to order at 4:59 pm	
2. PUBLIC COMMENT	*Hirsch*	
	None	
3. CONSENT CALENDAR	*Hirsch*	Action
• QC Minutes, 01.24.18		**MOTION:** by Dr. Mainardi to approve, 2nd by Idell. All in favor.
4. POLICIES & PROCEDURES	*Jones*	Action
	Ms. Jones briefly reviewed each policy. Ms. Hirsch clarified the procedure for reviewing policies. The Diet Manual and Approval was removed. Changes or clarification were requested for many of the policies. Chris Kutza was asked to come next month to answer questions.	**MOTION:** by Dr. Eisenstark to approve those policies without changes to be made, 2nd by Dr. Mainardi. All in favor.
5. ANNUAL INFECTION CONTROL REPORT	*Mathews*	Inform
	Ms. Mathews reviewed 2017 infection prevention goals and results. It was interesting to note that the only uptick in infections occurred during the third quarter 2017. The Skilled Nursing C. difficile rate has been below benchmark for three years. The Skilled Nursing C. difficile rate has steadily gone down the last five years while the acute rate has	

AGENDA ITEM	DISCUSSION	ACTION
	steadily gone up. Ms. Mathews reviewed the interventions implemented. Some intervention will focus on earlier detection. 2018 goals include a hospital acquired pneumonia prevention initiative. Over 50% of patients with pneumonia develop sepsis. She reviewed flu stats for the season. No patients developed health care associated flu. A new goal for 2018 is a water management program in connection with the legionella organism; this is a CMS mandate.	
6. DISCUSSION REGARDING HQI QUALITY TRANSPARENCY DASHBOARD	*Hirsch*	Inform/Action
	Ms. Hirsch said California hospitals have been asked to share a quality transparency dashboard on their websites before the end of the year. This effort is being made by the Hospital Quality Institute (HQI) in conjunction with CHA. HQI is a California organization but does follow national guidelines.	No action requested.
7. QUALITY REPORT	*Jones*	Inform
	Ms. Jones reviewed performance improvement initiatives for 2018.	
8. UPON ADJOURNMENT OF REGULAR SESSION	*Hirsch*	
	Regular session adjourned at 6:44 p.m.	
9. CLOSED SESSION • Calif. Health & Safety Code § 32155 Medical Staff Credentialing & Peer Review Report	*Jones*	Action
10. REPORT OF CLOSED SESSION	*Hirsch*	Inform/Action
		MOTION: by Dr. Mainardi to approve credentialing, 2nd by Dr. Eisenstark. All in favor.
11. ADJOURN	*Hirsch*	
	Meeting adjourned at 6:49 p.m.	

5.

MED/SURG PATIENT CARE SERVICES REPORT

MEDICAL SURGICAL DEPARTMENT ANNUAL REVIEW

Introduction and Overview:

The Medical/Surgical Unit consists of 20 Inpatient beds. The main scope of service is to provide care to Medical and Surgical patients in our community. This is completed by working closely with our dynamic interdisciplinary team that is dedicated to serving the needs of our inpatient and outpatient population. We serve a variety of acute Medical/Surgical patients who are experiencing Respiratory, Cardiac, Gastrointestinal, and Neurological conditions as well as a variety of surgical procedures. The surgical procedures range from gynecological, orthopedic and bariatric to general. In addition we also complete on average three Outpatient infusions on the unit per day. This patient population includes infusions or injections that a patient is unable to complete at home and/or requires close monitoring or administration by a Registered Nurse.

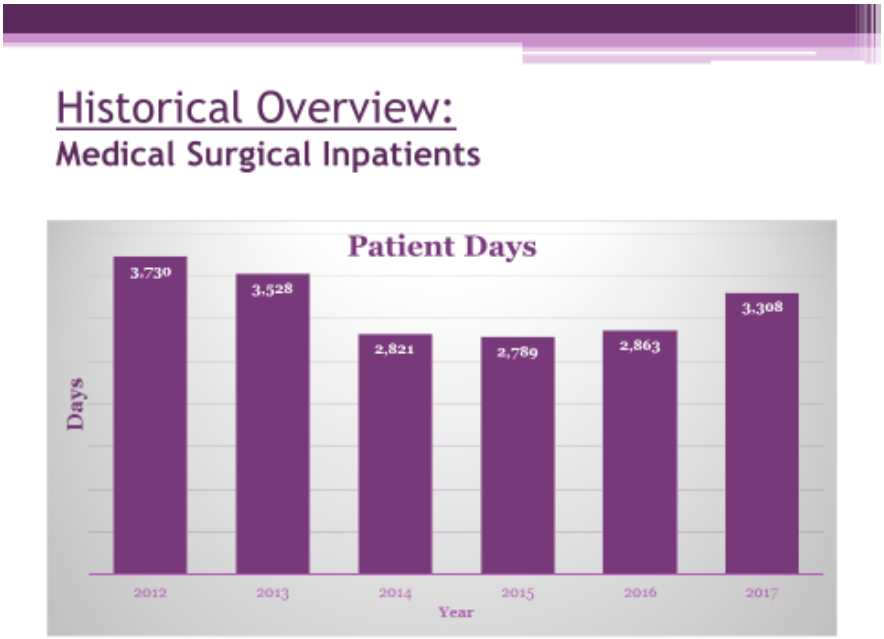
Statistical Overview:

Staff Category	**Function**	**Total FTE's**
Medical/Surgical Nurse Manager	Oversees all day-to-day activities of the unit. Provides in-services, huddles, rounding, break relief, quality control monitoring. Works as house supervisor weekly to assist in cost savings.	1FTE 1 full time Nurse Manager
Registered Nurse	The Registered Nurse is responsible for the delivery of high quality individualized patient care through the nursing process of assessment, diagnosing, planning, implementation, and evaluation; is responsible for directing and coordinating all nursing care for patients based on established clinical nursing practice standards; and functions as a member of the health care team through independent, interdependent, and dependent roles within the health care system. The Registered Nurse utilizes interpersonal skills to maximize customer service in a manner that supports excellence in customer service, safe patient care, and professionalism; contributes to a work environment of caring and cooperation among a culturally diverse workforce and patient population; serves as a patient advocate and assumes the responsibility and accountability for patients.	0.9 FTE 15 Registered Nurses 0.6-0.7 FTE 3 Registered Nurses Per Diem 2 Registered Nurses
Unit Assistants	The Unit Assistant/Telemetry Technician is a partner in the care team fostering a harmonious work environment in which high customer service is consistently provided. This position is a frontline member of the nursing team and serves as coordinator of all clerical aspects of processing the patient medical record; collaborates with manager to ensure safe bed assignment for each patient on the unit. The Unit Assistant/Telemetry Technician utilizes interpersonal skills to maximize customer service in a manner that supports excellence, safe patient care, and professionalism; promotes a cooperative working relationship by communication, displaying honesty and respect.	0.9 FTE 3 Full-time Unit Assistants 0.7 FTE 1 part-time Unit Assistants Per diem 3 Per Diem Unit Assistants

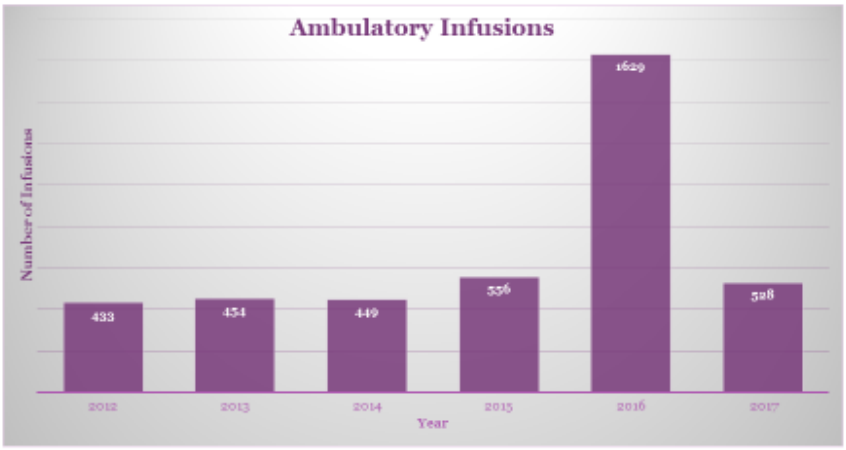
Staff Category	Function	Total FTE's
Certified Nursing Assistants	The CNA promotes a cooperative working relationship by communication, displaying honesty and respect, displaying sensitivity to cultural differences and accepting feedback in a positive manner. Key role responsibilities include: performing direct patient care consistent with scope of practice, assisting patients with activities of daily living including basic health and hygiene tasks.	0.9 FTE 4 full-time Certified Nursing Assistants 0.5 FTE 1 Certified Nursing Assistant Per Diem 3 Certified Nursing Assistants

Staffing decisions are made based on California mandated nursing ratios and patient acuity. The Nurse to Patient Ratio for Medical/Surgical and Outpatient Infusion Patients is 1:5. Patients requiring Cardiac Monitoring and Pediatric patients are 1:4. The Medical/Surgical Unit is a unique place due to the required California ratios for our telemetry patients. Even though we may have 10 patients, if 1 of those patients is on telemetry a third Registered Nurse would be required. This creates a challenge in budgeting for the staffing of the unit. There is never a consistent number of patients being monitored for a cardiac dysrhythmia, so it is difficult to estimate and differentiate this in the budget analysis. We also care for Outpatient Infusions on 2 South, which also affects the total staffing of the unit. The current inpatient direct margin is 4,577,678. To manage our expenses and remain profitable, the Medical/Surgical team is flexed off and cancelled in low census times to maintain financial viability.

Another barrier the unit faces is the cost of training new team members. On average to orient a new nurse it costs between $40,000 and $50,000. It is difficult to hire experienced nurses because we compete with some of the highest paying hospitals in the Bay Area. Therefore, we take on new graduate nurses who require extra training to be proficient in their skills. Their orientation hours are then combined with the overall staffing hours, thus skewing the staffing expenses.



Historical Overview :Ambulatory Infusions



Quality Metrics

The Medical/Surgical department measures indicators relating to core measures, patient safety, and nursing documentation compliance to ensure we meet regulatory reporting and quality control standards. We have consistently maintained high quality and documentation standards on 2 South. This is directly related to the teaching and auditing process we have implemented on the unit. We continue to successfully maintain our care planning goal of greater then 95th %ile in each of the five domains: Falls, Restraints, Diabetic, Discharge, and individualizing. This is completed by random auditing of nursing charts monthly. We also strive to administer influenza vaccines to ALL patients discharging from the Medical/Surgical Unit. The Medical/Surgical RNs have continued to maintain a 90% or greater overall barcode scanning average.

Indicator	Data Outcome	Percentage	Frequency of Monitoring	Plan/Analysis
Narcotic inventory weekly check	12/12	100%	Weekly (1)	Fully compliant
Barcode scanning compliance	91%	91%	Quarterly	Fully compliant. Goal to be greater than 90%.
Chart Audits Compliance: 1. Skin 2. Restraints 3. Diabetics 4. Individualized 5. Discharge 6. Fall Risk	1. 44/45 2. 45/45 3. 45/45 4. 44/45 5. 45/45 6. 45/45	1. 95% 2. 100% 3. 100% 4. 95% 5. 100% 6. 100%	Monthly	Continue to monitor monthly.
Crash Cart Defibrillator Check	1. 92/92	1. 100%	Daily	Fully compliant

Indicator	Data Outcome	Percentage	Frequency of Monitoring	Plan/Analysis
Influenza Vaccines Fallout	2 fallouts		Random Audit: Quality	Followed up with RN who had the fallout and ensured that the unit assistants were reminding the traveling nursing staff. Continue to monitor during influenza season

Past and Future plans for Performance Improvement:

The Medical/Surgical department has been working on the following projects:

- Cross training: Nursing staff to become more proficient in other units to decrease the amount of cancellations.
- Staff Satisfaction: Maintain response rate greater than 80% and formulate yearly goals to improve and promote unit cohesiveness and job satisfaction.
- Promote Nursing Excellence: Four of our team members have been awarded the DAISY award for extraordinary nurses.
- Influenza Vaccination: Continue to strive to attain 100% compliance.

Patient Experience Team/ HCAHPS:

- HCAHPS Goal: Maintain HCAHPS scores greater than 70th %ile in 7/10 domains.
- Nursing staff complete daily: AIDET, Hourly Rounding, update white boards, education about medications, discharge medication teaching, and prompt follow up to patient concerns.
- Patient Experience team members all have chosen a month to do targeted rounding on 10 inpatients.
- Celia and the team have completed a hospital wide sign translation to Spanish.
- The pharmacy team has implemented specialized discharge teaching to patients going home from the Medical Surgical unit.
- Unit managers round daily on all new patients to the unit and those who have any concerns or need follow up.
- Case managers complete follow-up calls in accordance with the Care Transitions grant 48 hours after discharge and weekly for six weeks.
- The Patient Experience Team has onboarded a patient family advisor over the past year to be a voice of the community and provide feedback on new processes we are implementing.

Conclusion:

The Medical/Surgical team is an exceptional team. They truly embrace the values of Sonoma Valley Hospital and have teamwork as a basis for all unit activities.

6.

POLICIES & PROCEDURES

Policy and Procedures – Summary of Changes
Board Quality Committee, March 28th, 2018

Review and Approval Requirements

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

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

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

ORGANIZATIONAL

NEW (Full Policies are attached)**:**

Code Neonate PC8610-174

We have recognized that there is an area of opportunity related to neonatal codes within our organization. This policy has outlined how to initiate a code neonate, who is to respond, what equipment to respond with, and what to do upon arrival.

Precipitous Birth in the ED PC8610-176

We have identified an opportunity for improvement within our organization with precipitous deliveries and neonatal resuscitations. This policy outlines that if delivery is imminent, the delivery and care will be provided in the Emergency Department until the Mother and Baby are deemed stable by a qualified physician for transfer. The policy also serves as a guideline for the delivery, resuscitation, and needed documentation, following NRP standards.

Water Management IC8610-178

The Centers for Medicare & Medicaid Services (CMS) posted a Survey and Certification letter (S&C 17-30 memo) on June 6, 2017, indicating that Medicare-certified healthcare facilities are expected to have water management policies and procedures to reduce the growth and spread of Legionella. Between 2000 and 2014, there was a fourfold increase in the number of cases of Legionnaires' disease according to the Center for Disease Control. 85% of all Legionnaires' disease outbreaks were attributed to water system exposures that could have been prevented by effective water management programs.

REVISIONS:

Authority Statement IC8610-102

Added "including microbial cultures of involved/effected staff, patients or the environment"-expecting to see this in a water management program

Color Coded Wristbands and Door Placards PC8610-126

A gray strip placed into the patient's door placard will be used to communicate to healthcare providers when a patient or visitor is at risk for violence. Use of the gray strip will be used to notify staff of this risk prior to entering a patient's room.

Contact Plus Enteric Isolation Precautions IC8610-128
Added: When a patient is receiving antibiotics and he/she has a liquid stool, the RN is authorized to immediately obtain a stool specimen and order C. difficile testing via protocol order. Patients who are taking antibiotics at the time of admission and have loose stool shall also be tested.

Rehabilitation Services with Patients in Contact Isolation Management of IC8610-136
"Patients with active diarrhea e.g., C. difficile, should not leave the isolation room" was added to the policy

DEPARTMENTAL

Skilled Nursing

Weighing and Measuring the Resident 6580-150
Policy amended to notify the Dietician of significant weight loss and document refusal of weight in EMR.

Surgical Services Departmental Manual

Table of Contents listing changes is attached

REVISED ACCORDING TO BOARD QUALITY RECOMMENDATIONS MADE ON 2/28/18

340B Drug Discount Purchasing Program
Access to Medication When the Pharmacy is closed
Handling of Medical Gas Cylinders in Patient Care
Non-Obstetric Elective Surgery during Pregnancy
Medical Imaging Operational Hours and support services
MRI, Patient Preparation
Workplace Violence Prevention Program

SUBJECT: Code Neonate	POLICY PC8610-174
	PAGE 1 OF 2
DEPARTMENT: Organizational	EFFECTIVE:
REVISED:	

PURPOSE:

To provide a mechanism to assure that trained staff and equipment respond efficiently to a Code Neonate situation in a timely fashion to the proper department. To provide organized, standardized, and effective management of resuscitation emergencies. To promote the health and safety of patients under our care.

POLICY:

Code Neonate is activated by dialing 5-5-5-5, stating Code Neonate and providing location. Code Neonate is announced in all areas of the hospital, including the Emergency Department.

PROCEDURE:

A. Responsibilities of PBX:
   1. When alerted by 5-5-5-5 call, or by any other means, the operator will page the appropriate pagers/cellphones of the Code Response Team.
   2. The operator will announce Code Neonate and location on the overhead paging system three times in succession, pause 30 seconds and repeat announcement x 1

B. Neonatal Code paged in the Emergency Department:
   1. Deliver the Infant Warmer, and Broselow cart to the patient's room.
   2. OB RN will respond to ED.

C. Neonatal Code paged to A Women's Place:
   1. ED MD and one ED RN will respond to A Women's Place to assist if Code Neonate is paged to the A Women's Place and remain until cleared by OB personnel.

D. Neonatal Code paged to any other area of the Hospital, including the parking lot:
   1. ED RN responds to area with precipitous bassinet.
   2. The responding Neonatal Code Response Team will initiate the Precipitous Birth Protocol and immediately move the neonate to the Emergency Department to continue the resuscitation.

E. Neonatal Code Response Team:
-ED physician
-OB RN
-ED RN
-Respiratory Therapist
-Lab-Phlebotomist
-Nursing Supervisor
-XRAY Technician (respond to OB or ED, dependent on location of call)
-OB MD to be called immediately (By the ED Tech on duty)
-Pediatrician to be called immediately (By the ED Tech on duty)

REFERENCES:
CIHQ Nursing Services, 42 CFR; 482.23 except as permitted by law, the organization must provide 24-hour inpatient nursing services that are furnished or supervised by a registered nurse (RN).
ECC Guidelines, American Heart Association, 2011

OWNER:
Chief Nursing Officer

AUTHORS/REVIEWERS:
Deborah Bishop, ED & ICU Clinical Director
Sally Staples, A Woman's Place Manager
Mark Kobe, Chief Nursing Officer
Cynthia Lawder, M.D., Medical Director, Emergency Department

APPROVALS:
Policy & Procedure Team: 10/17/17
OB Task Force: 12/5/17
Safety Committee: 2/28/18
Code-Blue Committee: 2/28/18
Medicine Committee: 3/8/18
Medical Executive Committee: 3/15/18
Board Quality Committee:
The Board of Directors:

SUBJECT: Precipitous Birth in the Emergency Department	POLICY #PC8610-176
	PAGE 1 OF 5
DEPARTMENT: ORGANIZATIONAL	EFFECTIVE:
REVISED:	

PURPOSE:

To provide guidelines to the Emergency Department staff and A Women's Place on the care and management of obstetrical patients in whom delivery is imminent, while in the Emergency Department.

POLICY:

Patients presenting to the Emergency Department at Sonoma Valley Hospital who are pregnant where delivery is imminent will be cared for by qualified staff. After delivery in the Emergency Department and stabilization of mother and infant(s), mother and infant(s) will be transported by qualified staff to A Women's Place or another institution for admission and continuing care, whichever is deemed most appropriate by the attending physician on duty.

PROCUDURE:

(1) If delivery is imminent, delivery will occur in the Emergency Department, unless a cesarean section is known to be necessary, in which case the surgery team will be contacted immediately and the patient will be taken to surgery upon the team's arrival.

(a) **Code Neonate ED** will be paged overhead. RT, x-ray, House Supervisor, OB RN will respond immediately to the Emergency Department. If the OB MD and/or Pediatrician are already in house, they will also respond immediately to the Emergency Department.
(b) Initial examination will be conducted immediately by the ED attending Physician.
(c) The OB MD on-call at Sonoma Valley Hospital will be notified immediately of the patient and the delivery status. (If not in house).
(d) If the patient has an established OB physician, that physician will also be notified.
(e) The Pediatrician on-call at Sonoma Valley Hospital will be notified immediately of the patient and the delivery status. (If not in house).
(f) If the second OB RN is not in house, the Nursing Supervisor will call them in.

(2) Establish a Team Leader-Team Leader to have this protocol and NRP Protocol in hand (both located on bassinet).

(3) Delivery
- (a) Bring Infant Warmer to bedside.
- (b) Open precipitous delivery pack.
- (c) Have Broselow cart brought to outside of room.
- (d) Explain all that will be taking place to the patient, prior to treatments, procedures, etc.
- (e) Mother will be placed on the cardiac monitor and vital signs obtained and documented, if time allows.
- (f) Assess and document fetal heart tones.
- (g) Start IV (preferably 18 gauge) of LR, obtain labs (CBC, Hold clot, PNC panel-rainbow).
- (h) Administer 10L/min O2 via face mask, as needed.
- (i) Prep as directed by the physician, as time permits.
- (j) Assure newborn warmer has been delivered by OB RN and plugged in.
- (k) Note time of delivery.
- (l) Document time of placenta delivery and hold placenta for evaluation by OB MD.
- (m) Clamp the umbilical cord at least 2 to 4 inches from umbilicus of baby and 2-4 inches from the placenta. Cut the cord between the clamps.
- (n) If infant is moving/crying and well in appearance, dry and stimulate, if infant is full-term. If infant is premature, use extreme caution while drying and assessing. Stimulate by gently rubbing extremities only. Place infant skin to skin on mom's bare chest. *If you need to clear the airway, suction mouth w/bulb syringe.
- (o) If infant is blue, not moving, appears to have no respiratory effort, initiate Neonatal Resuscitation. (Proceed to number 3).
- (p) Perform and document APGAR score at 1 minute and 5 minutes. Continue to assess and document every 5 minutes until greater than 7.
- (q) If possible and needed for medication administration, obtain and record the newborn weight.
- (r) Perform ongoing assessment of maternal status including vital signs, bleeding and fundal checks.
- (s) Administer medications, per MD order

(4) Neonatal Resuscitation-
- (a) Neonate gasping or apneic, HR below 100? Immediately initiate NRP protocol, located on Infant Warmer.
- (b) If placenta still attached to Mother, Clamp cord 2-4 inches from umbilicus of baby, and 2-4 inches above that clamp, leaving clamps in place. Cut the cord between the clamps.
- (c) Immediately take infant to another room within the ED for the resuscitation.

(d) Obtain and record the newborn weight. *Scale in triage room. Weigh in kg, remove the point (.) to have grams i.e. .323kg = 323gms
(e) Ensure infant is kept warm during resuscitation with warming bed or infant warmer.
*Current NRP Guidelines no initiation of resuscitation may be deemed ethical when the birth occurs prior to 22 weeks gestation.

(5) Disposition of Mother and/or Infant(s)
(a) If mother and/or infant(s) are to be transferred to another institution which provides obstetrical/neonatal services, they will be transported (ground or air) from the ED at the discretion of the responding OB MD and/or Pediatrician.
(b) All records, laboratory reports, initial radiological interpretations, and any other information obtained in the ED will be sent with the patient when transferred.
(c) If mother and/or infant(s) are to be kept at Sonoma Valley Hospital, they will be transferred to A Women's Place once they have been deemed **stable for safe transfer** between floors by both the ED MD and the OB MD and/or Pediatrician. Patients will be accompanied by appropriate staff members to maintain a safe transition to the floor.

(6) Birth Certificate
(a) Obtain the correct forms from A Women's Place.
(b) These papers must be completed prior to transfer to another institution.
(c) Birth certificate will be completed and signed by the Emergency Department attending or the physician/RN who actually delivered the infant(s)

(7) Emergency Department Medical Record – Mother and Infant(s)
(d) An Emergency Department medical record will be generated for the mother upon her arrival to the Emergency Department.
(e) The infant(s) will be registered using the time of delivery as the time admitted to the Emergency Department.
(f) An Emergency Department medical record will then be completed on each infant(s)

(8) Identification
(a) Mother and infant(s) identification bands will be made using the arm bands currently used in the Emergency Department
(b) Matching Mother Baby identification bands will be placed on mother and infant.

SUBJECT: Precipitous Birth in the Emergency Department	POLICY #PC8610-176
	PAGE 4 OF 5
DEPARTMENT: ORGANIZATIONAL	EFFECTIVE:
REVISED:	

Supplies to be stocked in the Infant Warmer:

UVC Insertion Tray: expiration mo/yr
Precipt Tray
Sterile Gown
Sterile Towels x8
Straight Mayo Scissors
Mayo Clamps x2
Cord Clamps x2
Ring Forceps
Baby Blankets x2
Pkg 4x4 Bandage
Gel Warming Mattress exp:
Heel Warmers
Baby Blankets x2- extra
Baby Hat
IV packet: Earliest exp date on outside of pkt
Heplock
Saline Flush
3cc syringe x2
Pink lab tube x2
Green lab tube x2
23g Vacutainer
Blood transfer device
24g IV Catheter x2
IV Start Kit
Primary IV Tubing
Cord Blood Collection kit-purple top
Airway Drawer: Earliest exp date on outside
Bulb Syringe
Neonate OPA
Neonate BVM mask size 1
Infant BVM mask size 2

Hyperinflation System
Neo-Tee (Preferred for Ventilation)
Mini End Tidal CO2 Detector
Neonate ET Tubes 2.5, 3.0, 3.5
5Fr Stylet
Meconium Suction Device
Infant Pulse Oximeter

*Size 1 Miller Blade in Broselow cart Pink/Red Drawer, as well as, all full term supplies.

REFERENCES:
Besuner, P. (2007). AWHONN Templates for Protocols and Procedure for Maternity Services. 2nd edition.
The American College of Obstetrics and Gynecology; The American Academy of Pediatrics (2012). Guidelines for Perinatal care 7th edition.
Simpson, K. R. & Creehan, P. A. (2014). Perinatal Nursing 4th edition (AWHONN)

OWNER:
Chief Nursing Officer

AUTHORS/REVIEWERS:
Deborah Bishop, ED & ICU Clinical Director
Sally Staples, A Women's Place Manager
Cynthia Lawder, M.D., Medical Director, Emergency Department:
Mark Kobe, Chief Nursing Officer
PBX Staff

APPROVALS:
Policy & Procedure Team: 2/28/18
Surgery Committee: 3/8/18
Medicine Committee: 3/8/18
Medical Executive Committee: 3/15/18
Board Quality Committee:
The Board of Directors:

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

POLICIES/PROCEDURES MANUAL
Surgical Services Department
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TS7420-112	Cartilage Biopsy and Transplant **What: references**	8/13
PC7420-113	Cesarean Section Birth Roles and Responsibilities **What: references**	8/13
LD7420-114	Charging for Surgical Services **What: Reviewed, no changes**	8/13
IC7471-103	Chemical Disinfection, High Level **What: no longer use this in our department** **Why: not our practice**	9/13
EC7420-115	Code Red in the Operating Room **What: references**	8/13
MM8610-108	Controlled Substance Distribution for Anesthesia **What: delete** **Why: duplicate policy, see MM7450-113**	8/13
PC7420-117	Cord Blood Gas Collection **What: Reviewed, no changes**	8/13
PC7420-119	Counts, Sponges, Sharps and Instruments **What: references, completed sentence on sponges, added verbiage regarding RFU sponge counts** **Why: Surgery acquired a radio-frequency unit and purchases sponges with radiopaque indicators for improved accuracy in assuring that no surgical sponges are left in body cavities from surgical procedures.**	8/13
D.		
LD7471-109	Daily Routine , Central Sterile **What: Reviewed, no changes**	9/13
EC7471-106	Damaged Equipment, Management of **What: deleted regarding cleaning of dirty equipment (IV pumps, etc.); added OB department; changed cleaning of laryngoscope blades according to manufacturer's guidelines.** **Why: Central Sterile no longer in charge of hospital equipment outside surgery. Laryngoscope blades used to be cleaned with Cidex, changed our practice.**	9/13
PC7420-120	Direct Admissions to ICU from Surgery **What: references**	8/13
PC7430-104	Discharge of Patients Criteria from Surgical Care Unit (SCU) **What: references**	10/13
PC7430-105	Documentation in Surgical Care Unit (SCU) **What: Reviewed, no changes**	10/13
PC7420-146	Documentation in Surgery Briefly state changes and include reasons for making change(s). **What: references; deleted "The manual entry will be labeled as: LATE ENTRY. 2.1. If an employee on a previous shift failed to document, do not leave blank lines. They will be required to make a late entry as described as above."** **Why: delete obsolete content related to paper charting**	8/13
PC7420-147	Draping of the Patient in Surgery **What: Reviewed, no changes**	8/13
HR7471-108	Dress Code, Central Sterile **What: Reviewed, no changes**	9/13

MS7450-104	Duties and Responsibilities of the Chief of Anesthesia **What: references**	8/13
E.		
EC7420-164	Electric Equipment Safety **What: references**	8/13
EC7420-124	Electrosurgical Units Safe Use of **What: DELETED ACCORDING TO OUR PRACTICE, REFERENCES** **Why: Cautery units live on rolling free standing carts so that they can be interchanged between the OR's**	8/13
IC7471-110	Equipment Cleaning **What: obsolete, no longer our process** **Why: Central Sterile no longer in charge of outside surgery department equipment**	9/13
EC7420-122	Event Related Shelf Life Policy, Surgery **What: REFERENCES**	8/13
EC7471-113	Event Related Shelf Life, Central Sterile **What: duplicated policy, please see EC7420-122 Event Related Shelf Life, Surgery**	9/13
F.		
PC7420-165	Fasting Guidelines **What: Reviewed, no changes**	8/13
IC7471-114	Flexible Endoscopes, Reprocessing of **What: update to current practice, location of devices, procedure changes per manufacturer's recommendations** **Why: changed to location of areas of cleaning for best practice**	9/13
EC7420-148	Fluid Warmer Use **What: UPDATE TO CURRENT WARMER AND USE** **Why: changed brand and type of fluid warmer, updated for the device differences**	8/13
EC7420-125	Fluoroscan Use **What: changed to reflect newer model fluoroscan, added the record keeping of minutes of fluoro time, references** **Why: purchased newer model fluoroscan within past year; radiology recommends tracking minutes for patient exposure**	8/13
IC7471-115	Glidescope, Cleaning and Processing of **What: change way of processing, deleted all references to Cidex (no longer used)** **Why: no longer have Cidex**	8/13
G.		
IC7420-126	Gowning and Gloving **What: references**	8/13
H.		
MM7450-113	Handling of Anesthetic Drugs in Secure Anesthetizing Locations **What: references**	8/13
PC7420-128	Hand-off Protocol **What: references**	8/13
I.		
IC7471-138	Immediate Use Steam Sterilization **What: remove all references to 'flash' sterilization; update to current system in place "One Tray", with definitions of such. Added biologicals to criteria that much be monitored. Eliminated line regarding "insufficient surgical inventory"** **Why: current standard is for changing nomenclature from flash sterilization to immediate use steam sterilized (IUSS); Our IUSS system is called One Tray. Standard is to add biologicals to all loads along with the monitoring of such**	9/13

LD7420-149	Implant Reimbursement, Protocol for Surgical **What: references; updated sterilization technique to use current approved terminology, deleted "flash"; deleted unnecessary incomplete list of "possible" implantable items**	8/13
PC7420-129	Implantation of Medical Device **What: references; updated sterilization technique to use current approved terminology, deleted "flash"; deleted unnecessary incomplete list of "possible" implantable items**	8/13
IC7471-116	Infection Control for Sterilization **What: Reviewed, no changes**	9/13
IC7420-166	Infection Control in Surgical Services **What: references**	8/13
IC7471-118	Instruments, Cleaning and Processing of **What: Reviewed, no changes**	9/13
L.		
MM8610-113	Labeling Medications On and Off a Sterile Field **(Organizational Policy)** **What: Reviewed, no changes**	8/13
PC7420-131	Latex Allergy Precautions **What: references**	8/13
PC8610-202	Lidocaine Injection Prior to Insertion of an IV Cath, Use of **(Organizational Policy)** **What: Reviewed, no changes**	8/13
EC7420-132	Loaner Instrument Trays from Outside the Facility **What: Reviewed, no changes**	8/13
M.		
MM8610-105	Malignant Hyperthermia , Management of Patient with **What: Reviewed, no changes**	8/13
IC7471-125	Monitoring of Sterilization Practices **What: Reviewed, no changes**	9/13
N.		
EC7471-122	Neutralization for Disposal of Cidex OPA **What: We no longer have Cidex in our department**	9/13
PC7430-106	Nurse to Patient Ratios (in Phase I Recovery)in Surgical Care Unit (SCU) **What: REFERENCES**	10/13
O.		
RI7420-134	Observers and Visitors in the Operating Room **What: references**	8/13
P.		
PC7420-123	Pacemaker/ICD, Care of Patients Undergoing Surgery **What: references**	8/13
IC7471-123	Packaging Guidelines **What: Reviewed, no changes**	9/13
PC7420-136	Pathology Specimens: Handling Cultures and Specimens **What: references**	8/13
PC7420-138	Patient Positioning **What: references, updated to current equipment** **Why: no longer own an OEC fracture table; we own an OSI Hana fracture table**	8/13
RI7420-158	Patient Privacy **What: Reviewed, no changes**	
PC7420-147	Patient Safety in Surgery **What: references**	8/13

PC7420-111	Pediatric Patient in Surgery, Care of **What: references, updated for our unit name and practice** **Why: changed "will" to "may" regarding patients in room during induction; deleted "outpatient or pediatric unit" to SCU; deleted "encouraged' under comfort measures**	8/13
PC7430-103	Pediatric Patient in Surgical Care Unit (SCU), Care of **What: additional s/s respiratory distress**	10/13
PI7450-108	Performance improvement, Department of Anesthesia **What: Reviewed, no changes**	8/13
PC8610-201	PICC Line Insertion Peripherally Inserted Central Catheter **(Organizational Policy)** **What: Reviewed, no changes**	8/13
PC7430-107	Pre-Admission Evaluation, Surgical Care Unit (SCU) **What: additions to preop teaching re:medicationinstx for blood thinners, insulin and metformin**	10/13
	Pre-Op Testing Protocols Chart	10/13
PC7420-142	Pre-Operative Skin Preparation of Patients **What: references, clipping of hair outside the OR** **Why: reflects current recommended practice per AORN standards**	8/13
PC8610-108	Procedural Sedation **(Organizational Policy)** **What: Reviewed, no changes**	8/13
R.		
EC7420-144	Radiological Safety **What: references**	8/13
PC7420-145	Rho-Gam Administration **What: references; to be done before discharge** **Why: to give time frame for patient receiving evidence of injection**	8/13
S.		
RI7420-151	Sales Representative in the Operating Room **What: current practice for check in using automated system** **Why: check in for vendors was done manually; now SVH has automated system**	8/13
EC7420-152	Sanitation in the Operating Room **What: deleted all references to glutaraldehyde (no longer use this method); added current mopping method for OR's;**	8/13
LD7420-157	Scheduling Surgical Procedures **What: changed charge nurse to clinical coordinator**	8/13
PC7420-153	Scope of Practice, Surgery **What: added licensure/required certifications of PACU RN, difference in shift PACU RN for on call**	8/13
PC7430-101	Scope of Service, Surgical Care Unit (SCU) **What: REFERENCES; REFERENCE STAFFING POLICY FOR AFTER HOURS PATIENTS**	10/13
HR7420-154	Staff Scheduling Practices **What: update to current staffing practices** **Why: establish guidelines and minimal requirements for taking call; d/t changing traffic patterns, allow additional time to arrive for after-hours case; circulator now required to stay as 2nd nurse for shorter recovery time; rotation of flexing off**	8/13
PC7430-108	Standardized Procedure for Patient Discharge from Surgical Care Unit (SCU) **What: Reviewed, no changes**	10/13
EC7471-127	Sterile Supplies, Storage of **What: Reviewed, no changes**	9/13
IC7471-128	Sterilization **What: eliminate ETO-not in use here; eliminate "Flash" and changed to IUSS**	9/13

	Why: ETO no longer commonly used in hospitals; current standard is change flash sterilization to Immediate Use Steam sterilization	
IC7471-136	Sterrad NX Sterilizer Usage **What: Reviewed, no changes**	9/13
IC7420-156	Surgical Hand Scrub/Antisepsis **What: references**	8/13
PC7420-155	Surgical/Invasive Procedure Site Confirmation/Verification **(Organizational Policy)** **What: update to current OR layout (Delete ACU and preop holding area) SCU unit, references**	8/13
T.		
PC7420-158	Tourniquet: Use of the Pneumatic Tourniquet in the Operating Room **What: references**	8/13
EC7420-159	Traffic Control in the Operating Room **What: references**	8/13
IC7471-134	Traffic Patterns, Central Sterile **What: Reviewed, no changes**	9/13
U.		
IC7471-135	Ultrasonic Cleaner **What: Reviewed, no changes**	9/13
PC7450-112	Unintended Intra-Operative Awareness During General Anesthesia **What: delete** **Why: was a JCAHO driven policy, no need for a scenario to be a policy**	8/13
PC8610-125	Universal Protocol **(Organizational Policy)** **What: Reviewed, no changes**	8/13
V.		
PC7420-160	Vacuum Assisted Wound Closure **What: Reviewed, no changes**	8/13
	VAC Wound Closure Guide	
W.		
MM8610-112	Warming Fluids for IV and Irrigation Purposes, Storage and Handling of	8/13
PC7420-161	Wound Classification **What: references**	8/13
X.		
Y.		
Z.		

Policy & Procedures Committee: 1/16/18
Surgery Committee: 2/8/18
Medical Executive Committee: 2/15/18
Board Quality Committee:
The Board of Directors:

SUBJECT: Water Management	POLICY: IC8610-178
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PURPOSE:

To reduce the risk of healthcare associated Legionella and other pathogens associated with contaminated water.

POLICY:

SVH utilizes a water management program to reduce the risk of growth and spread of Legionella and other opportunistic pathogens associated with building water systems.

Conduct a facility risk assessment to identify where Legionella and other opportunistic waterborne pathogens could grow and spread in the facility water system.

Implement a water management program consistent with ASHRAE industry standards and the CDC Guidelines for the Prevention of Nosocomial Pneumonia.

Include physical controls, temperature management, disinfectant level control, visual inspection and environmental testing for pathogens when indicated. Note: In the absence of cases, the relationship between the results of water cultures and the risk for legionellosis remains undefined by the Centers for Disease Control. The CDC reports that the bacterium has been frequently present in water systems of buildings, often without being associated with known cases of disease. (1)

Background: Legionnaires Disease

Sonoma Valley Hospital has not identified any cases of hospital acquired Legionella. However, Legionella sp. are commonly found in various natural and man-made aquatic environments and may enter hospital water systems in low or undetectable numbers. Cooling towers, evaporative condensers, heated potable-water-distribution systems within hospitals, and locally produced distilled water can provide a suitable environment for legionellae to multiply. Factors known to enhance colonization and amplification of legionellae in man-made water environments include temperatures of 25-42 C, stagnation, scale and sediment, and the presence of certain free-living aquatic amoebae that are capable of supporting intracellular growth of legionellae.

A person's risk for acquiring legionellosis after exposure to contaminated water depends on a number of factors, including the type and intensity of exposure and the person's health status. Persons who are severely immunosuppressed or who have chronic underlying illnesses, such as hematologic malignancy or end-stage renal disease, are at a markedly increased risk for

legionellosis. Persons in the later stages of acquired immunodeficiency syndrome (AIDS) also are probably at increased risk for legionellosis, but data are limited because of infrequent testing of patients. Persons who have diabetes mellitus, chronic lung disease, or nonhematologic malignancy; those who smoke cigarettes; and the elderly are at moderately increased risk.

Definition of Nosocomial Legionnaires Disease:

The incubation period for Legionnaires disease is usually 2-10 days; thus, laboratory-confirmed legionellosis that occurs in a patient who has been hospitalized continuously for greater than or equal to 10 days before the onset of illness is considered a definite case of nosocomial Legionnaires disease, and laboratory-confirmed infection that occurs 2-9 days after hospital admission is a possible case of the disease.

Prevention Practices
The Centers for Disease Control recommends the following for hospitals without identified cases of Legionnaires Disease:

A. maintaining a high index of suspicion for legionellosis and appropriately using diagnostic tests for legionellosis in patients who have nosocomial pneumonia and who are at high risk for developing the disease and dying from the infection (385,445),
B. initiate an investigation for a hospital source of Legionella sp. upon identification of one case of definite or two cases of possible nosocomial Legionnaires disease, and
C. routinely maintain cooling towers and
D. using only sterile water for the filling and terminal rinsing of nebulization devices

General Infection-Control Strategies for Preventing Legionnaires Disease

A. Conduct an infection-control risk assessment of the facility to determine if patients at risk or severely immunocompromised patients are present.
B. Implement general strategies for detecting and preventing Legionnaires disease in facilities that do not provide care for severely immunocompromised patients (i.e., facilities that do not have HSCT or solid-organ transplant programs)
    1. Establish a surveillance process to detect health-care--associated Legionnaires disease
    2. Inform health-care personnel (e.g., infection control, physicians, patient-care staff, engineering) regarding the potential for Legionnaires disease to occur and measures to prevent and control health-care--associated legionellosis.
    3. Establish mechanisms to provide clinicians with laboratory tests (e.g., culture, urine antigen, direct fluorescence assay [DFA], and serology) for the diagnosis of Legionnaires disease.
C. Maintain a high index of suspicion for health-care--associated Legionnaires disease, and perform laboratory diagnostic tests for legionellosis on suspected cases, especially in

patients at risk who do not require a PE for care (e.g., patients receiving systemic steroids; patients aged ≥65 years; or patients with chronic underlying disease (e.g., diabetes mellitus, congestive heart failure, or chronic obstructive lung disease)

D. Periodically review the availability and clinicians' use of laboratory diagnostic tests for Legionnaires disease in the facility; if clinicians' use of the tests on patients with diagnosed or suspected pneumonia is limited, implement measures (e.g., an educational campaign) to enhance clinicians' use of the test(s)
E. If one case of laboratory-confirmed, health-care--associated Legionnaires disease is identified, or if two or more cases of laboratory-suspected, health-care-associated Legionnaires disease occur during a 6-month period, certain activities should be initiated.
    1. Report the cases to state and local health departments.
    2. If the facility does not treat severely immunocompromised patients, conduct an epidemiologic investigation, including retrospective review of microbiologic, serologic, and postmortem data to look for previously unidentified cases of health-care--associated Legionnaires disease, and begin intensive prospective surveillance for additional cases.
    3. If no evidence of continued health-care--associated transmission exists, continue intensive prospective surveillance for ≥2 months after the initiation of surveillance.
F. If there is evidence of continued health-care--associated transmission (i.e., an outbreak), conduct an environmental assessment to determine the source of *Legionella* spp.
    1. Collect water samples from potential aerosolized water sources.
    2. Save and subtype isolates of *Legionella* spp. obtained from patients and the environment.
    3. If a source is identified, promptly institute water system decontamination measures per recommendations in accordance with the CDC recommendations.
    4. If *Legionella* spp. are detected in ≥1 culture (e.g., conducted at 2-week intervals during 3 months), reassess the control measures, modify them accordingly, and repeat the decontamination procedures; consider intensive use of techniques used in the initial decontamination, or a combination of superheating and hyperchlorination.
G. If an environmental source is not identified during a Legionnaires disease outbreak, continue surveillance for new cases for ≥2 months. Either defer decontamination pending identification of the source of *Legionella* spp. or proceed with decontamination of the hospital's water distribution system, with special attention to areas involved in the outbreak.
H. No recommendation is offered by the CDC regarding routine culturing of water systems in health-care facilities that do not have patient-care areas (i.e., PE or transplant units) for persons at high risk for *Legionella* spp. Infection.

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VII. Cooling Towers and Evaporative Condensers

A. When planning construction of new health-care facilities, locate cooling towers so that the drift is directed away from the air-intake system, and design the towers to minimize the volume of aerosol drift (*153,203,221*). Category IC (ASH
B. Implement infection-control procedures for operational cooling towers)
    1. Install drift eliminators (*153,203,222*). Category IC (ASHRAE 12-2000)
    2. Use an effective EPA-registered biocide on a regular basis. (ASHRAE 12-2000)
    3. Maintain towers according to manufacturers' recommendations, and keep detailed maintenance and infection-control records, including environmental test results from legionellosis outbreak investigations. (ASHRAE 12-2000)
    If cooling towers or evaporative condensers are implicated in health-care--associated legionellosis, decontaminate the cooling-tower system.

Water Sampling

A. When conducting any form of environmental sampling, identify existing comparative standards and fully document departures from standard methods
B. When sampling water, choose growth media and incubation conditions that will facilitate recovery of waterborne organisms

When environmental samples and patient specimens are available for comparison, perform the laboratory analysis on the recovered microorganisms down to the species level at a minimum, and beyond the species level if possible (*343*).

REFERENCES:
Guidelines for Environmental Infection Control in Health-Care Facilities, Lynne Sehulster, Ph.D.,
Raymond Y.W. Chinn, M.D, MMWR, June 6, 2003/52(RR10);1-42

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Policy & Procedure Team: 2/20/18
Performance Improvement Committee: 2/22/18
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The Board of Directors:

7.

QUALITY REPORT

To: Sonoma Valley Healthcare District Board Quality Committee
From: Danielle Jones
Date: 3/28/2018
Subject: Quality and Resource Management Report

March Priorities:

1. Quality Dashboards
2. CIHQ Mid Cycle Survey preparation
3. Water Management program

Quality Dashboards

In March we have been working on migrating our internal quality dashboards from a manual process to an electronic platform by using Statit. Statit provides SVH with a means to access, track, analyze, compare and contrast data and is integrated with Midas data analytics. One of the benefits is the ability to use control charts for ongoing monitoring of processes. We will review the both dashboards during committee.

CIHQ Mid Cycle Survey preparation

We expect our CIHQ mid cycle survey anytime in Q4 2018. The focus on this survey is the Water management program and Emergency Preparedness. I am working with the directors to ensure that targeted policies, data and management plans are in place.

Water Management Plan

Kathy Mathews and I have reviewed the CMS Legionella prevention control and compliance requirements for CMS surveyors. Development of Water Management Program policy, which we will review during committee. Working with vendor to schedule samples for Chlorine levels, temperature and legionella by mid-April. Next steps are to conduct a risk and environmental assessment for potential areas of growth.