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

SVHCD QUALITY COMMITTEE
AGENDA
WEDNESDAY, MAY 23, 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 Interim District Clerk, Vivian Woodall, at vwoodall@svh.com or 707.935.5005 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 04.25.18	*Hirsch*	Action
4. EMERGENCY DEPARTMENT TRIAGE	*Bishop*	Inform
5. A WOMAN'S PLACE ANNUAL REPORT	*Staples*	Inform
6. QUALITY ASSURANCE/PERFORMANCE IMPROVE-MENT PROGRAM REVIEW 2017	*Jones*	Inform
7. PATIENT CARE SERVICES DASHBOARD	*Kobe*	Inform
8. POLICIES & PROCEDURES	*Jones*	Action
9. UPON ADJOURNMENT OF REGULAR OPEN SESSION	*Hirsch*	
10. CLOSED SESSION: a. Calif. Health & Safety Code § 32155 Medical Staff Credentialing & Peer Review Report	*Jones*	Action
11. REPORT OF CLOSED SESSION	*Hirsch*	Inform/Action
12. ADJOURN	*Hirsch*	

3.

CONSENT

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SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
APRIL 25, 2018, 5:00 PM
MINUTES
Schantz Conference Room

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

AGENDA ITEM	DISCUSSION	ACTION
1. CALL TO ORDER/ANNOUNCEMENTS	*Hirsch*	
	Meeting called to order at 5:02 pm	
2. PUBLIC COMMENT	*Hirsch*	
	None	
3. CONSENT CALENDAR	*Hirsch*	Action
• QC Minutes, 03.28.18	The spelling of Remicade would be corrected in the March minutes.	**MOTION:** by Idell to approve pending correction, 2nd by Mainardi. All in favor.
4. SVH FOUNDATION PRESENTATION	*Pier*	Inform
	Mr. Pier gave an overview of the Foundation with its primary role to raise money for the hospital. It is a separate 501c3 organization which reports to the Foundation Board Chair with a dotted line to the SVH CEO. He also reviewed the largest capital campaign in the Valley for the new ER/Surgery wing. Mr. Pier works with the hospital on funding priorities. Recent accomplishments have included quite a few capital equipment needs. The current focus is on the next capital campaign for the Outpatient Diagnostic Center and upgrading imaging equipment.	
5. POLICIES & PROCEDURES	*Jones*	Action
	Ms. Jones reviewed each of the policies. Mr. Kobe reviewed the Hospital Evacuation During Disaster general policy. Revisions were discussed.	**MOTION:** by Eisenstark to approve, 2nd by Mainardi. All in favor.

AGENDA ITEM	DISCUSSION	ACTION
6. QUALITY REPORT	*Jones*	Inform
	Ms. Jones has been reviewing department quality improvement plans during the past month, especially for processes that are high risk, new, high volume, or low volume. Also, a medication reconciliation team is reviewing procedures and plans to pilot a new program.	
7. UPON ADJOURNMENT OF REGULAR SESSION	*Hirsch*	
	Regular session adjourned at 6:17 p.m.	
8. CLOSED SESSION a. Calif. Health & Safety Code § 32155 Medical Staff Credentialing & Peer Review Report b. Calif. Health & Safety Code § 32155 Root Cause Analysis c. Calif. Health & Safety Code § 32155 California Dept. of Public Health Deficiencies	*Jones*	Action
9. REPORT OF CLOSED SESSION	*Hirsch*	Inform/Action
		MOTION: by Eisenstark to approve credentialing, 2nd by Idell. All in favor.
10. ADJOURN	*Hirsch*	
	Meeting adjourned at 6:18 p.m.	

5.

A WOMAN'S PLACE ANNUAL REPORT

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
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A WOMAN'S PLACE ANNUAL REVIEW

Introduction and Overview

The main scope of service is to provide care to women in our community and the surrounding areas with their health needs at every stage of their life. We offer a variety of health services, including Gynecology Procedures, Breast Health Counseling, Procedures and Surgery, 3D Mammography, Pelvic Health Physical Therapy, Incontinence Procedures and Therapy, Menopause, Perimenopause Management, as well as Personalized Obstetrical Care including Contraception Management, Birth Control and Fertility Management. A Woman's Place also has a dedicated Breast Patient Navigator to assist women having procedures or surgeries. We strive to be the indispensable link for a woman in Sonoma Valley to all their healthcare needs. This is completed by working closely with our dynamic interdisciplinary team that is dedicated to serving the needs of our inpatient and outpatient population.

The organization made the decision to expand and transition from solely a birthing center to include the above mentioned services for a couple of reasons. First, we wanted to be that special place where women could come for their healthcare and feel special or pampered. Second, with our declining number of deliveries, we felt like combining and expanding the service line to accommodate women of all ages for healthcare needs would make a successful and hopefully sound financial combination.

A Woman's Place (AWP) consists of 10 inpatient/outpatient beds. We have a small triage room for OB outpatient procedures. We have three family-friendly LDRP (Labor, Deliver, Recover, and Postpartum) rooms where women are admitted for labor. They labor, deliver and recover in these rooms with their newborn baby. This is nice for the patients as they can stay in the same room their entire stay at AWP. They are attended by two highly trained OB nurses offering personalized care, newborn teaching and breast feeding support. Sofa beds are in these rooms for dad or the significant other to spend the night. We also have an operating room for moms who need to deliver by C-Section. There are six smaller rooms decorated in a calming spa like atmosphere for those patients coming in for gynecological procedures or surgeries. We currently have had a few breast cancer patients that have had 3-D mammography, medical imaging and outpatient surgery. We expect to have patients that are desiring breast augmentation as well.

Overview

Staff Category	Function	Total FTE's
A Woman's Place Nurse Manager	Oversees all day-to-day activities of the unit. Provides in-services, rounding, break relief, quality control monitoring. Also is Breast Patient Navigator, helping the breast patients navigate their way	Part time 0.9 FTE 1 Nurse Manager/ Breast Navigator

	through their procedures and/or surgeries with follow-up afterwards.	
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 7 Registered Nurses 0.6 FTE 2 Registered Nurses Per Diem 3 Registered Nurses

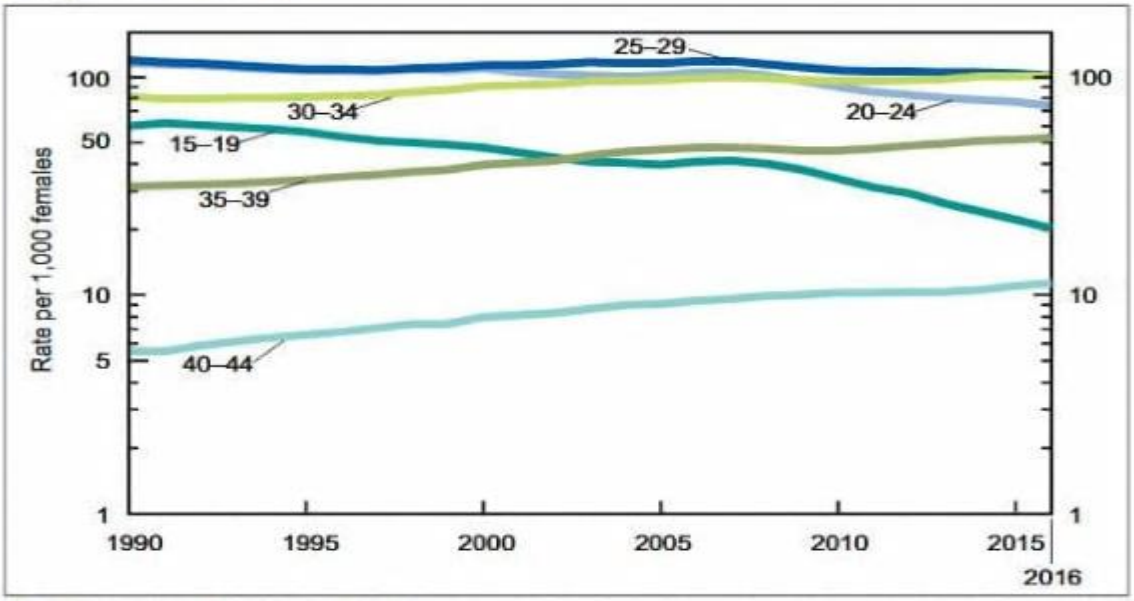
Staffing decisions are made based on California mandated nursing ratios and patient acuity. The Nurse-to-Patient Ratio for Laboring Patients is 1:1 with two Labor nurses in attendance for delivery. Title 22 requires we always have one Labor nurse on the unit and one Labor nurse on call at all times. The ratio for mom-baby couplets is 1:4. The same ratio for staffing GYN patients would be 1:4 as well.

A barrier the unit faces is the cost to maintain one RN on the unit and one RN on call, even when there are no patients admitted and the unit is closed. AWP hires only experienced Labor nurses with a minimum of two years Labor and Delivery experience. It is very much identical to an ED department and is considered an extension of the ED under EMTALA law. Not knowing what may present at any time and with our small volumes and minimal staffing is why experienced Labor and Delivery nurses are required. The positive for cost containment is we do not have much orientation costs for the nurses. We can quickly assess their L&D competency and focus orientation on hospital routines, policies and procedures.

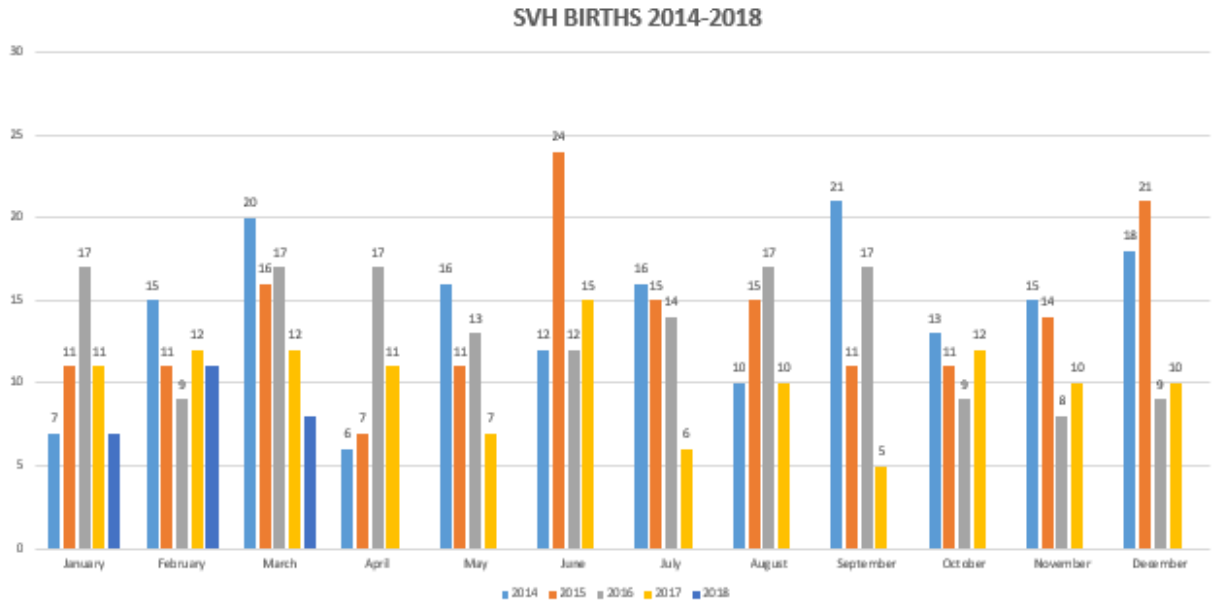
Our deliveries have declined over the past four years, we believe mostly due to an increase with Kaiser patients. Also, the cost of living in the in the Valley makes it difficult for young couples to reside here, and the national birth rate is declining. According to provisional 2016 population data released by the Centers for Disease Control and Prevention, the number of births fell 1 percent from a year earlier, bringing the general fertility rate to 62.0 births per 1,000 women ages 15 to 44. The trend is being driven by a decline in birthrates for teens and 20-somethings. The birthrate for women in their 30s and 40s increased — but not enough to make up for the lower numbers in their younger peers. Therefore we have to be competitive in what we offer. We do however have

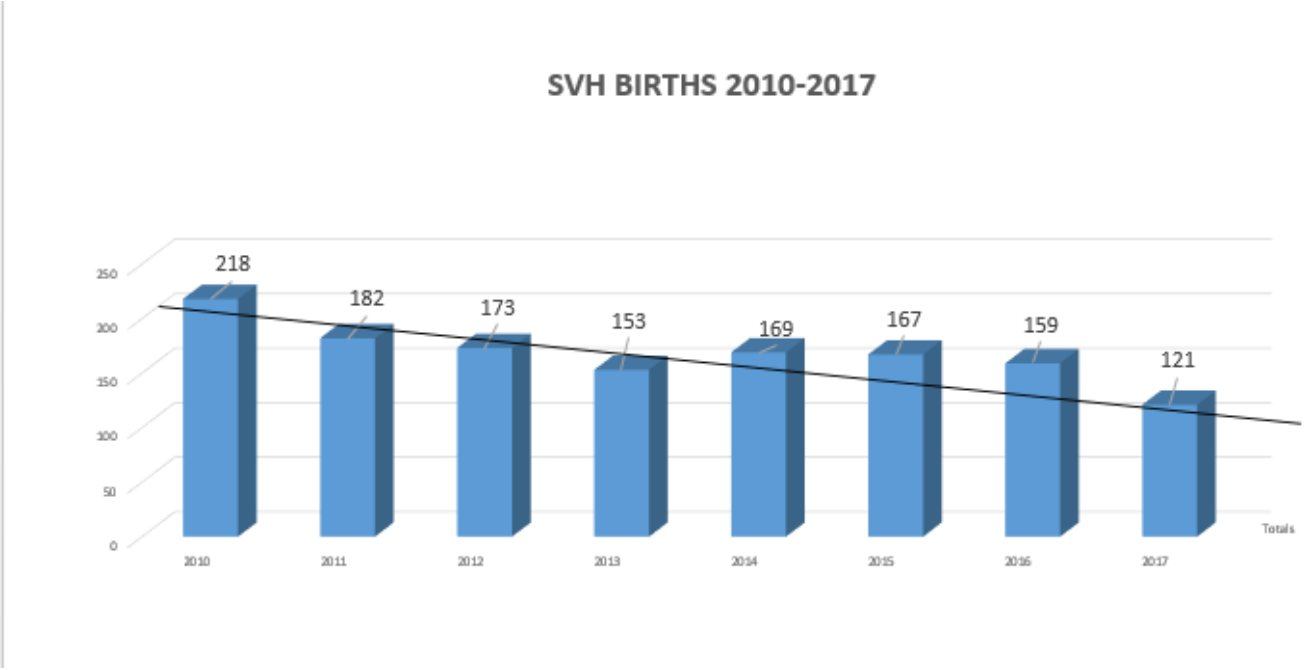
two new OB/GYN physicians with privileges here at SVH planning to deliver here. That will hopefully boost our delivery rate.

Figure 2. Birth rates, by selected age of mother: United States, final 1990–2015 and provisional 2016



NOTE: Rates are plotted on a logarithmic scale.
SOURCE: NCHS, National Vital Statistics System.





Perinatal Core Measures

AWP 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. This is directly related to the teaching and auditing process we have implemented on the unit. Chart and fetal monitoring strip audits are done annually by the Manager of Risk Management and Patient Safety for Beta Healthcare Group, as well as the Manager of AWP auditing random charts monthly.

Indicator	Data Outcome	Percentage	Frequency of Monitoring	Plan/Analysis
Narcotic inventory weekly check	12/12	100%	Weekly (1)	Fully compliant
Barcode scanning compliance		81%	Quarterly	Goal to be greater than 90%
Medication administration	100%	100%	Monthly	Fully compliant
Baby warmer checklists for neonatal resuscitation	100%	100%	Daily	Fully compliant

Quality Care Measures

STABLE- S*-sugar and safe care****, T****-temperature****, A****-airway****, B****-blood pressure****, L****-lab work* ***E****-emotional support*

This is an excellent program for Labor nurses to become familiar with unexpected sick or premature newborns who deliver at our facility and need to be transferred to a higher acuity hospital with a NICU. It teaches stabilization of these neonates. UCSF provided this 8 hour program for the nurses through our affiliation. The nurses earned 8 CEU's for attending. This certification is renewed every 2 years.

USCF Case Review - We have a contract with UCSF and twice a year physicians from UCSF, usually a Neonatologist and a Perinatologist, review unusual cases we have had delivered here at SVH. They offer expert opinions, advice and evidence based practices for physicians and AWP nursing staff. Our plan is to offer CEUs and an open invitation to house-wide RN's and Medical staff.

California Maternal Quality Care Collaborative- This is a Regional Perinatal Program of California. Annually the Regional Perinatal Director meets with the AWP Manager to review the statistics for our hospital. SVH came in at 24.2% for our C-Section rate, compared to 32.2% for the State in 2015. Our exclusive breastfeeding success rate was 87.8% compared to 68.8% for the State. Many of the hospitals state-wide are designated "Baby Friendly" hospitals in California. We are not one of the designated "Baby Friendly" hospitals, so that makes our high percentages more impressive.

Past and Future Plans for Performance Improvement

AWP 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.
- Education: Nursing staff are getting more involved in education on courses being offered through our UCSF affiliation.

Patient Experience Team/ HCAHPS

- HCAHPS Goal: Maintain HCAHPS scores greater than 70th percentile in 6/10 dimensions.
- Nursing staff complete daily: AIDET, hourly rounding, update white boards, education about medications, discharge medication teaching, and prompt follow up to patient concerns.
- Celia and the team have completed a hospital wide sign translation to Spanish.
- Unit manager rounds daily on all new patients to the unit and those who have any concerns or need follow up.
- Nurses and Manager/Breast Navigator complete follow-up calls in 48 hours after discharge. Breast Navigator follows up with breast patients on an as-needed basis.

Staff Satisfaction

Staff Satisfaction top three concerns were:

- My pay is fair compared to other healthcare employers in this area.
- I get the training I need to do a good job.
- I am satisfied with my job security.

The top three strengths were:

- This organization contributes to the community.
- Employees in my work unit help others to accomplish their work.
- I have sufficient time to provide the best care/service for our clients/patients.

Our plan is to target the training needs of the nurses. The STABLE class mentioned earlier in the report, was introduced for the first time last year. I am working with Bonnie, our nurse educator, on certain competencies for the nurses as we start caring for new types of patients.

Conclusion:

AWP team is an exceptional team with their caring, compassion and understanding of women of any age. They truly embrace our values at Sonoma Valley Hospital and have teamwork as a basis for all unit activities.

6.

QAPI PROGRAM REVIEW 2017

Quality Assurance/Performance Improvement
Program Review 2017

Purpose

The Quality Department, in cooperation with the Medical Staff Performance Improvement Committee and Administrative Leadership, has completed an appraisal of the Performance Improvement Program.

The purpose of this appraisal is to:

- Evaluate the comprehensiveness and scope of the program.
- Assess the effectiveness of the FOCUS / PDSA model.
- Measure the extent of interdisciplinary collaboration.
- Assure that all key functions and dimensions of performance have been addressed.
- Provide the Governance, Administration and Medical Staff leaders with the results of prior year activities to assist in development of priorities for improvement.
- Determine the extent to which the Performance Improvement Program supported the mission and vision.

Scope and Applicability

This is an organization-wide program. It applies to all settings of care and services provided by Sonoma Valley Hospital.

Findings

Over the past year there was a great deal of improvement in the development of a performance improvement infrastructure and department specific performance improvement such that each department identified the complexity of work flow processes and opportunities to improve based on some form of prioritization process, including considerations of risk, volume and problem proneness. Leaders have improved in their ability to write plans of corrections for deficiencies including the integration of monitoring activities as part of their departmental plans. It was also identified that we have an opportunity to improve these plans as many lack depth and quality monitoring varies from department to department. The Board Quality Committee identified a structure for annual department reports that will strengthen and deepen the thought processes involved in developing a QAPI plans and the reporting of data.

The senior team performed a formal organization-wide Performance Improvement Project prioritization process that identified three projects: Catheter Associated Urinary Tract Infection (CAUTI) Reduction, Care Transition Record, and Medication Reconciliation.

The CAUTI Reduction Project was a multidisciplinary effort to implement evidence-based best practices to reduce the risk of catheter associated urinary tract infections (CAUTI). The Infection Preventionist and Nurse

Educator revised the existing Foley catheter policy to provide evidence-based guidelines. The procedure provides the criteria for urinary catheter use i.e., placing catheters only when medically necessary and removing them promptly when the medical necessity no longer exists. The procedure also provides guidance on insertion, maintenance and removal. Documentation within the electronic medical record was revised to reflect the criteria for placement and removal of a Foley catheter, prompt nursing assessment and documentation every shift validating continuing need for catheterization. The revised policy and procedure was reviewed by all Nursing staff and highlighted in the annual Skills Fair. The outcome revealed CAUTI rates in Acute Care Units have remained relatively stable and near NHSN benchmark while SNF experienced a significant decrease from 7.6 to 2.6 cases per 1000 patient days.

The Care Transitions Record Project was implemented in response to the increasing pressure to reduce readmissions and to take more accountability in maintaining and improving the health of our community, this project, funded by a grant from the Centers for Medicare and Medicaid and administered by the California State Department of Health Services, challenges the hospital to improve the transition of care for both patients and providers. This project will continue to be an organizational focus for 2018.

The objective of the Medication Reconciliation project is to develop a process that will ensure that an accurate list of all patients' medications are collected and then compared to the physicians' admission, transfer and/or discharge orders. This process will also create an improved and safer system by increasing communication between settings of care through a common medication history process and therefore reducing the potential for medication errors at these patient transition points. In 2017 the team collected baseline data. This project will continue to be an organizational focus for 2018.

Additional projects are monitored by the Project Review Team to ensure that they are on-track, completed and retired.

The organization held its fourth Annual Performance Improvement Fair to continue to improve the organization's use of performance improvement tools and to move towards data driven decision making. There was great improvement in the quality of the projects and in the presentations. There were 12 Clinical Projects and 7 Ancillary projects submitted for the fair. 75 guests visited the PI fair in 2017. Community members, hospital staff, physicians, administration and board members voted on 19 projects. Surgery, Home Health and Medical Records were recognized for their impact on improving the quality of patient care and resource stewardship.

The Quality Department provided monthly education to leadership on the topics of CIHQ standards interpretation and compliance, and Program Beta provided an educational session on Human Factors Design. The department held drop-in Quality/ Risk Management Clinics every two weeks to provide coaching and provided weekly drop in sessions for leaders to become proficient in e-notification reporting and management. The Patient Relations committee reviewed grievances and complaints on a bi-monthly basis. The Director of Quality and Risk attended the Northern California Hospital Quality Symposium and brought back best practices that are in the process of being adopted. The Quality Data Analyst attended the annual Midas conference bringing back refinements to our use of this database that have improved data gathering and reporting. An annual review of the budget for Quality, Risk Management and Patient Safety indicates adequate staffing and resources have been allocated to these functions.

Completed triennial Center for Improvement in Healthcare Quality survey for re-accreditation. Achieved deemed status approval of Sonoma Valley Hospital with CMS. The Skilled Nursing Facility also successfully completed California Department of Public Health, Life Safety and CMS validation surveys to achieve deemed status of approval.

The transfer to Verge was completed. The new credentialing verification organization allowed us to maintain electronic physician files. This move also allows us to put paper files in storage. By February 2019 all physician records will be electronic.

In in support of the Care Transitions Program, the department has refined the Midas Community Case Management module. The first PRIME reporting for baseline data was submitted in 2017. At this point we are working on standardizing the processes that have been implemented. The transient record exists and we are now on to continuous performance improvement.

The Quality Department provided Anthem Blue Cross with hospital data this year for their Q-HIP program. We also provided healthcare associated infection data to the National Healthcare Safety Network and the Centers for Disease Control for surveillance and benchmarking purposes. We successfully reported quarterly data to our Patient Safety Organization. Lastly, in a combined effort, Information systems and Quality were able to successfully send Electronic Quality Measures to CMS. This data had to be mapped to portions of the electronic record so that the data could be pulled right from the record rather than manually abstracted. There is an incentive for this coming in 2019.

Interdisciplinary collaboration was demonstrated through the following:

Sorry Works	Culture of Safety Program	Good Catch Program
Safety Committee	Project Review Team	Clinical Informatics Team
Pharmacy and Therapeutics Committee	Departmental and cross departmental performance improvement projects and organization wide performance improvement	Medical Staff Performance Improvement Committee
Grievance Committee	Safety Rounds	Policy & Procedure Committee
Antimicrobial Stewardship	Compliance Committee	Med Staff Committees
IT Steering Committee	Daily Huddle	Utilization Review Program

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Assessment of Performance

The Performance Improvement Program supports the hospital's mission and is well on the way to supporting an organizational Culture of Quality and Safety. The effectiveness of the PI program is measured by its accomplishments. Data was collected and aggregated on performance measures and thoroughly analyzed. Intensive assessments were completed when SVH detected or suspected a significant undesirable performance or variation. Progress was made on the following program goals:

I. ***Performance Improvement Infrastructure Goals***

Performance Goal	Outcome
Assist the CEO in creating an organization-wide scorecard for monthly reporting to Medical Staff Committees and the Board.	Organization score card was created and is used in monthly reporting to Medical Staff Committees and the Board.
Work with department leaders and their staff to revise, refine and improve their department specific QAPI plans including development and reporting of meaningful quality and patient safety indicators	One on one meetings with department leaders to provide guidance and support of QAPI. Continued focus in 2018 with increase in new leadership over the last year.
Integrate the statistical process control software (STATIT) into data mining and display for at least three Performance Improvement Projects this year.	We did not meet this goal for 2017. Continued focus in 2018 with increase in new leadership over the last year.
Define and develop the tools to build a "High Reliability" Organization through expanded use of both Lean principles and further exploration of Human Factors Design.	Introduced No Harm Concept and development of a Zero Harm Score card to encourage understanding of "High Reliability". Leaders attended Human Factors Design presented by Beta. Behavior Based Expectations and Human Error Prevention Tools provided to each new employee in orientation.
Provide education to frontline staff and leaders on continuous quality improvement methods.	Continuous improvement theory and methodology explored during quarterly Leadership Development Institute.

II. ***Performance Improvement, Reportable Outcome Measures***
See Attached Dashboards

Assessment of Effectiveness

The Performance Improvement Program, in 2017, met the needs of the Performance Improvement Committee, Medical Executive Committee and Sonoma Valley Hospital.

Objectives for Next Evaluation Period

With input from the medical staff and leadership, the Administrative Team performed an assessment of potential organizational performance improvement activities for 2018 that align with the strategic plan and core strategic initiatives and reflects the scope and complexity of patient care services. In addition to departmental and

interdepartmental continuous performance improvement activities, the organization will focus on the following priorities.

A. Prioritized Organizational Performance Improvement Projects for 2018 include the following:

- Medication Reconciliation PI Project: this will be a 2-3 year project to improve medication histories and medication reconciliation through the continuum and then through the Care Transition process. Steering Committee: Dr. Streeter, Chris Kutza (Pharmacy), Mark Kobe, Danielle Jones & Deborah Bishop (ED). Oversight will be in the Medicine Committee.

- Transition Record PI Project: this began in 2016 and will carry through 2018 until hardwired. Physician Champions: Drs Verducci/Streeter. Team: Quality, Case Management, Nurse Leaders. Oversight will be Medicine & Surgery Committees.

- Healthcare Associated Pneumonia Prevention: Kathy Mathews (Infection Prevention), Mark Kobe, Respiratory Therapy, Nurse Leaders. Oversight will be in the Medicine Committee.

- Stroke Ready Hospital Certification: Establish stroke certification through CIHQ. Team: Deborah Bishop (ED), Mark Kobe, Danielle Jones, ED Nursing, Education. Oversight will be in the Medicine Committee.

B. Performance Improvement Infrastructure Goals 2018:
A change in leadership with an increase in new leaders over the past 12 months has prompted us to reinforce the 2017 goals.

- Work with department leaders and their staff to revise, refine and improve their department specific QAPI plans including development and reporting of meaningful quality and patient safety indicators.

- Integrate the statistical process control software (STATIT) into data mining and display for at least three Performance Improvement Projects this year.

- Define and develop the tools to build a “High Reliability” Organization through expanded use of both Lean principles and further exploration of Human Factors Design.

- Provide education to frontline staff and leaders on continuous quality improvement methods.

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Medical Staff QAPI Program 2017

Measures	Q1.2017	Q2.2017	Q3.2017	Q4.2017	Comments/Actions
1. Adverse Outcomes of Care					No trends
Outcomes related to procedural sedation	0	0	0	0	
Sentinel/Adverse Events	0	0	0	0	
Near Miss/Good Catch	3	11	9	2	
Never Events	0	0	0	0	
2. Autopsies & Mortality					No trends
Total Deaths reviewed by MS	7	8			
Total Autopsies Indicated	0	0			
Total Autopsy reports received & reviewed	1	NA			Death related to methamphetamine use. Reviewed by Dr. Campbell. No issues.
3. Blood & Blood Utilization (Hospital-wide)					
Appropriateness (Hemoglobin>7 or 8)	40%	80%	0%	40%	Uptick in utilization for Hemoglobin>7;focus study in 2018
Consent	100%	100%	100%		
C:T Ratio Medicine	1.0	1.4	1.4		
C:T Surgery	1.3	1.8	1.5		
Reactions	0	0	1.0		
Service Delays	0	0	0.0		
Wasted Units	3FFP,	1FFP 2PLT	1FFP2RBC		
Units transfused	114	76	89		
See Tab 3 for Hospital Out Patient (HOP) and other Core Measures					
5. Patient Safety					
Falls					No trends
ICU falls/1000 patient days	3.3445	3.7453	3.7453	4.4240	
Med/Surg falls/1000 patient days	1.0941	2.6667	3.3613	1.3927	
OP falls (whole number)	1	0	0	0	
ED falls (whole number)	0	2	2	0	
Total SNU falls/1000 patient days	0.56465	1.30804	1.32710	8.21680	
Total Home Care Falls	26	34	29	30	
HC Falls Witnessed by Staff	0	1	0	0	
HC Falls Reported by Patients	26	34	29	30	All analyzed, no trends were identified.

Medical Staff QAPI Program			2017		
Measures	Q1.2017	Q2.2017	Q3.2017	Q4.2017	**Comments/Actions**
Restraint					
Med Surg restraint days rate per 1000 patient days	51.4223	1.3333	0.0000	22.2841	
ICU restraint days rate per 1000 patient days	107.0230	86.1423	50.3876	44.2477	
ED restraint days rate per 1000 patient days	2.5072	1.0155	1.4919	0.3903	
SNF restraint days rate per 1000 patient days	0.0000	0.0000	0.0000	0.0000	
6. Surgery and Anesthesia					
Surgical Complication Rate					Surgical Complications are discussed in Surgery Committee Peer review
Pre-Post-op diagnosis discrepancies	0.00%	0.00%	0.00%	0.00%	
7. Results of Resuscitation	Q1.2017	Q2.2017	Q3.2017	Q4.2017	No trends; code Blue team minutes for review quarterly.
Code Blue ED Rate (per 1000 Visits)	0.716332	0.677048	1.118985	0.0000	Q1=2/2792, Q2=2/2954 Q3=3/2681
% Survival Rate ED	0.00%	50.00%	33.33%	NA	
Code Blue /1,000patient days(ICU)	0.0000	0.0000	0.0000	8.8496	2/226
% Survival Rate ICU	NA	NA	NA	50.00%	
Code Blue /1,000patient days(MS)	0.0000	0.0000	0.0000	1.3928	1/718
% Survival Rate MS	NA	NA	NA	100%	
Code Blue /1,000patient days(OB/**NB**)	0.0000	0.0000	0.0000	0.0000	
% Survival Rate IP	NA	NA	NA	NA	
Total **Acute** (non LAB, Non SNF)Rapid Response Event	3 Events	3 Events	1 Events	2 Events	All Med Surg
%Survival Rate	100.00%	100.00%	100.00%	100.00%	
8. Patient Experience of Care	✓	✓	✓	✓	see attached report (Tab 2)

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Experience of Care

(Goal: >70% rank) ***Finalized*** *Data is one quarter behind real-time*

Inpatient NRC Measures	(NRC PercentileRanking)							
Measures	***Q1.2017***		***Q2.2017***		***Q3.2017***		***Q4.2017***	
	mean	% rank	mean	%rank	mean	*%rank*	***mean***	***% rank***
Dr Discussed worries & concerns	60.5	21	56.8	12	72.2	72	71.4	69
Doctors: Trust/Confidence in	77.4	38	83.0	65	79.2	49	81.6	62
HCAHPS	(NRC PercentileRanking)							
Measures	***Q1.2017***		***Q2.2017***		***Q3.2017***		***Q4.2017***	
	always	% rank	always	%rank	*always*	*%rank*	always	% rank
Rate hospital 9-10	70.6	36	75.5	57	72.0	43	75.5	58
Recommend the hospital	71.2	37	83.7	83	82.6	81	71.4	37
Comm w/ Nurses	70.4	3	84.0	77	84.0	76	87.8	92
Response of Hosp Staff	62.7	24	65.2	36	72.9	72	77.5	83
Comm w/ Doctors	77.8	22	85.0	74	76.0	12	90.1	93
Hospital Environment	65.7	38	64.3	29	64.0	29	68.4	52
Pain Management	60.5	3	64.9	10	81.3	92	78.1	85
Comm About Medicines	51.4	2	66.1	51	75.0	91	59.7	15
Discharge Information	90.2	68	87.5	41	97.7	99	88.3	45
Care Transitions	46.0	14	60.8	87	58.7	81	52.1	47
Emergency Department CAHPS	(NRC PercentileRanking)							
Quarter	**Q1.2017**		***Q2.2017***		***Q3.2017***		***Q4.2017***	
	mean	% rank	mean	%rank	*mean*	*%rank*	mean	% rank
MD Communication Overall	74.5	24	82.2	71	84.0	80	81.1	62
MD Courtesy	85.7	63	89.7	85	89.6	84	94.5	96
MD Took time to listen	65.7	4	81.2	73	81.3	71	72.6	23
MD explained things	75.0	47	75.3	47	80.5	77	78.1	62

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

Medical Staff QAPI Program-Core Measures 2017

Core Measures

Finalized Core Measure data is one quarter behind real-time.

Indicator	Q1.2017	N/D	Q2.2017	N/D	Q3.2017	N/D	Q4.2017	N/D	Target Direction	CMS Nat'l
Emergency Department :HOP AMI/CP Hospital Outpatient Acute Miocardial Infarction/Chest Pain										
OP 3b Mean Time to Transfer to Another Facility for Acute Coronary Intervention	61.33 mins	184/3	161 mins	483/3	200.5	802/4	124.4	622/5	↓	58 Mins
OP-4a Aspirin at Arrival	92.86%	13/14	100.00%	08-Aug	60.00%	6/10	100.00%	17/17	↑	96.00%
OP 5 Mean Time to ECG	8.07 mins	113/14	85.091 mins	936/11	13.667 mins	164/12	21.85 mins	437/20	↓	8 mins
Emergency Department: HOP ED Throughput										
OP-18: Mean Time from ED Arrival to ED Departure for Discharged ED Patients	197.297 mins	21249/100	216.6 mins	22571/101	214.43 mins	21443/100	206.196 mins	21032/102	↓	132
OP-20: Door to Diagnostic Evaluation by a Qualified Medical Professional	24.232 mins	2399/99	50.416 mins	5092/101	30.42 mins	3042/100	21.485 mins	2170/101	↓	21
Emergency Department: HOP Pain Management										
OP-21: ED-Median Time to Pain Management for Long Bone Fracture	77.412 mins	1316/17	75.545 mins	1662/22	111.667 mins	2345/21	64.955 mins	1429/22	↓	49 mins
Emergency Department: HOP Stroke										
Core OP-23 - Head CT/MRI Results for STK Pts w/in 45 Min of Arrival	40.00%	2/5	0.00%	0/3	66.67%	2/3	33.33%	1/3	↑	71.60%
HOP Colon Cancer Screening										
Core OP29/ASC9 - Colonoscopy:F/U for Avg Risk Pts	75.00%	9/12	88.00%	22/25	73.08%	19/26	84.62%	11/13	↑	90.00%
Core OP30/ASC10 - Colonoscopy:Interval for Pts w/Hx of Adenomatous Polyps	84.62%	11/13	55.56%	5/9	80.95%	17/21	83.33%	10/12	↑	90.00%
Acute and Emergency Patients Admitted to Acute Care:										
IMM-2 Influenza Immunization (rate)	98.41%	124/126	Data not collected during this period				88.43%	107/121	↑	94.00%
ED 01b- Time from ED Arrival to ED Departure (median time in minutes)	379.538 mins	34538/91	352.576 mins	20802/59	338.636 mins	26705/77	346.205 mins	27004/78	↓	258 mins
ED-02b Admit Decision Time to ED Departure Time (median time in minutes)	165.798 mins	14756/89	166.649 mins	9499/57	131.07 mins	9306/71	121.767 mins	8889/73	↓	86 mins
SEP1 - Early Management Bundle, Severe Sepsis/Septic Shock	75.00%	21/28	80.00%	16/20	66.67%	6/16	66.67%	7/17	↑	85%
SEPa - Severe Sepsis 3 Hour Bundle	75.00%	21/28	85.00%	17/20	72.73%	16/22	71.83%	17/24	↑	85%
SEPb - Severe Sepsis 6 Hour Bundle	100%	21/21	100%	17/17	100%	16/16	100%	17/17	↑	85%
SEPc - Septic Shock 3 Hour Bundle	100%	21/21	100%	17/17	93%	14/15	100%	17/17	↑	85%
SEPd - Septic Shock 6 Hour Bundle	100%	3/3	50%	1/2	100%	2/2	50%	1/2	↑	85%

Emergency Department :HOP AMI/CP Hospital Outpatient Acute Miocardial Infarction/Chest Pain										
OP 3b Mean Time to Transfer to Another Facility for Acute Coronary Intervention	61.33 mins	184/3	161 mins	483/3	200.5	802/4	124.4	622/5	↓	58 Mins
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7.

PATIENT CARE SERVICES DASHBOARD

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

Patient Care Services Dashboard 2018

Medication Scanning Rate	2017-18				
	Q2	Q3	Q4	Q1	Goal
SNF	89.3%	88.4%	89.0%	89.0%	≥80%
Acute	89.0%	91.3%	87.0%	87.0%	≥90%
ED	92.7%	86.0%	82.0%	87.0%	≥90%

Falls (Per 1000 days)	2018 Rolling Quarterly Average				
	Q3-Q2	Q4-Q3	Q1-Q4	Q2-Q1	50th %tile
SNF	1.1	0.9	1.0	1.40	6.22
Acute	2.5	1.7	2.1	2.30	3.75

Hospital Acquired Pressure Ulcer Incidents (Per 1000 admissions)	2017-18				
	Q2	Q3	Q4	Q1	National
SNF	0.0	0.0	0.0	0.0	3.17
Acute	0.0	0.0	0.0	0.0	3.68

Nursing Turnover	2017-18 RNs/Quarter				
	Q2	Q3	Q4	Q1	Goal
SNF (n=18)	1	0	1	1	≤1
Acute (n=65)	1	5	6	3	≤6
Healing at Home (n=11)	0	0	2	2	≤1
Total Nursing Turnover	2	5	9	6	≤8

Patient Experience (CAHPS)	2017-18				
	Q2	Q3	Q4	Q1	Goal
HCAHPS					
RN Communication	84.0	84.0	87.5	N/A	80.0
Pain Management	64.9	81.3	80.6	N/R	71.0
OASCAHPS					
Care of Patients (MD/RN respect)	New Survey tool			N/A	97.1
Would Recommend				N/A	88.6
RATE MY HOSPITAL - ED					
Overall score	N/A	N/A	4.5	4.6	≥4.5

Nurse Staffing Effectiveness: Transfers r/t staffing/beds	2017-18				
	Q2	Q3	Q4	Q1	Goal
	4	1	0	0	≤0

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

2013 Hospital falls std from J Amer Med, AHRQ & PubMed

8.

POLICIES & PROCEDURES

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

Policy and Procedures – Summary of Changes
Board Quality Committee, May 23rd, 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 Stroke Practice Guidelines NS8610-122
This policy was created to outline the process for when patients present with a signs and symptoms consistent of acute stroke. Sonoma Valley Hospital has adopted these practice guidelines in order to delineate a consistent, evidence-based approach to treating the patient who presents with signs and symptoms consistent with acute stroke.

Code Stroke Paging NS8610-124
This policy was created to outline the process of paging overhead when patients present with a signs and symptoms consistent of acute stroke. Sonoma Valley Hospital has adopted these practice guidelines in order to delineate a consistent, evidence-based approach to treating the patient who presents with signs and symptoms consistent with acute stroke in accordance with CIHQ requirement for Stroke Ready Certification.

Wound Care Protocol NS8610-120
This policy was created to enable the wound care technician to perform wound care without delay in compliance with state and federal regulations.

SUBJECT: Code Stroke Practice Guidelines	POLICY: NS8610-122
	PAGE 1 OF 5
DEPARTMENT: Organizational	EFFECTIVE:
REVISED:	

PURPOSE:

To outline the process for when patients present with a signs and symptoms consistent of acute stroke.

Goals:

- Rapid identification of vascular events.
- Manage appropriately and efficiently according to the 2018 AHA Guidelines for Management of Acute Ischemic Stroke.
- Evaluate in a cost-effective manner.

POLICY:

Sonoma Valley Hospital has adopted these practice guidelines in order to delineate a consistent, evidence-based approach to treating the patient who presents with or develops signs and symptoms consistent with acute stroke.

Definitions:

Stroke Team: ED Attending MD, Primary ED RN, House Supervisor, Telemedicine MD (if indicated).
EVT: Endovascular Treatment

Compliance-Key Elements:

EMS**:**

1. When EMS calls into Emergency Department with an early Stroke notification, call PBX operator to page “Code Stroke ED eta ____minutes”.

2. EMS will stop at the Nursing Station, give MD and RN quick report of events, to include last known well. MD and Primary RN will do a rapid Neuro assessment together. EMS will then take patient directly to CT, accompanied by Primary RN with SVH portable monitor.

3. EMS will assist staff with moving patient over to CT table. Primary RN will attach patient on portable cardiac monitor and remain with patient in designated radiologically safe area of CT.

4. EMS will return to service.

5. ED Technician will bring weighted gurney to CT. Patient will be transferred from CT table to weighted gurney upon completion of CT/CTA. RN will accompany patient back to ED and continue with policy guidelines.

PBX**:**

1. Page Code Stroke overhead according to Code Stroke Policy.

Registration**:**

1. If patient presents stating they feel as if they are having a stroke, notify RN immediately.

2. Prioritize for bedside registration.

Triage**:**

1. Screen all patients for suspected stroke.

2. If a suspected stroke; document chief complaint, to include but not limited to sudden onset of numbness, weakness, difficulty speaking, vision changes, changes in coordination.

3. Document last known well, onset of symptoms, and whether improving or resolved.

4. If signs and symptoms have not fully resolved, notify PBX operator to page “Code Stroke Now ED”.

5. Move patient immediately to a room with weighted gurney, weigh patient and document in EHR.

6. Call in house Pharmacy with weight, during pharmacy in house hours.

7. Enter EDNUR CODE STROKE PROTOCOL for persistent symptoms with onset <3 hrs.

SUBJECT: Code Stroke Practice Guidelines	POLICY: NS8610-122
	PAGE 3 OF 5
DEPARTMENT: Organizational	EFFECTIVE:
REVISED:	

Stroke Team**:**

1. MD and Primary RN complete a rapid assessment prior to CT. If available, second RN to attempt IV access and draw labs while MD/RN completing initial assessment.
2. RN to place patient on portable monitor and accompany patient to CT
3. MD to consider consulting Telemedicine Neurologist and/or Neurologist via phone.
4. RN to attempt IV access and draw labs in CT (do not delay CT for IV access).
5. If unable to draw labs within 5mins, notify ED MD. *Per new guidelines, for patients who otherwise meet criteria for EVT, it is reasonable to proceed with a CTA if indicated in patients with suspected intracranial LVO before obtaining a serum creatinine concentration in patients without a history of renal impairment. 2.2.9
6. Return patient to ED upon completion of CT and CTA.
7. RN and MD to complete full NIH Stroke Scale together upon patients return from CT.
8. RN to confirm O2 Saturation greater than 94%. * Supplemental oxygen is not recommended in nonhypoxic patients with AIS. 3.1.3
9. RN to establish 2nd IV access (do not delay alteplase for access).
10. ECG, 12 lead (do not delay alteplase for ECG).
11. CXR (do not delay alteplase for CXR).
12. MD to assure CT scan resulted and note time of read in patient's medical record.
13. Only the assessment of blood glucose must precede the initiation of IV alteplase in all patients. *Given the extremely low risk of unsuspected abnormal platelet counts or coagulation studies in a population, IV alteplase treatment should not be delayed while waiting for hematologic or coagulation testing if there is no reason to suspect an abnormal test. 2.3.1
14. MD to finalize decision on alteplase administration after reviewing the CT results, timeline of events, and contraindications. MD to also consider alteplase for patients with onset of <4.5 hours of last known well per AHA recommended criteria.

15. MD to enter order for alteplase and communicate with primary RN that alteplase has been ordered.

16. Confirm verbal informed consent for alteplase is obtained, complete consent.

17. Patients who have elevated BP and are otherwise eligible for treatment with IV alteplase should have their BP carefully lowered so that systolic BP is <185 mm Hg and their diastolic BP is <than 110 mm Hg before IV fibrinolytic therapy initiated.

18. RN to administer alteplase per dosing guidelines.

19. RN to waste any unneeded alteplase, if necessary, per pharmacy policy.

20. RN to complete and document Neuro assessments and vital signs every 15mins during and after IV alteplase infusion for 2hrs, then every 30 min for 6 hrs, then hourly until 24hr after IV alteplase.

21. If the patient develops severe headache, acute hypertension, nausea, or vomiting or has a worsening neurological examination, discontinue the infusion, alert the MD, and obtain an emergency head CT scan.

22. If MD has decided that patient does not meet administration criteria, MD and RN to document time decision made that no alteplase will be given.

23. Sources of hyperthermia (temperature >38*C) should be identified and treated, and antipyretic medications should be administered to lower temperature in hyperthermic patients with stroke.

24. Hypotension and hypovolemia should be corrected to maintain systemic perfusion levels necessary to support organ function.

25. MD to consider transport to higher level of care if additional intervention may be indicated.

REFERENCES:
2018 Guidelines for Management of Acute Ischemic Stroke
CIHQ Disease Specific Guidelines Policies, Standards, and Survey Process

OWNER:
Mark Kobe, Chief Nursing Officer

SUBJECT: Code Stroke Practice Guidelines	POLICY: NS8610-122
	PAGE 5 OF 5
DEPARTMENT: Organizational	EFFECTIVE:
REVISED:	

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Lois Valenzuela, Laboratory Manager
Lisa Duarte, Admitting Manager
Chris Kutza, Director of Pharmacy

APPROVALS:
Policy & Procedure Team: 4/17/18
Medicine Committee: 5/10/18
Medical Executive Committee: 5/17/18
Board Quality Committee:
The Board of Directors:

SUBJECT: Code Stroke Paging	POLICY : NS8610-124
	PAGE 1
DEPARTMENT: Organizational	EFFECTIVE:
REVISED:	

PURPOSE:

To provide a mechanism to assure that trained staff respond efficiently to a Code Stroke in a timely fashion. To assure that other departments are alerted that a patient has arrived or will be arriving soon with time sensitive procedures needed. To promote the health and safety of patients under our care.

POLICY:

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

PROCEDURE:

PBX**:**

1. When alerted by 5-5-5-5 call, the operator will page "Code Stroke".
2. The operator will announce Code Stroke and location on the overhead paging system three times in succession, pause 30 seconds and repeat announcement x 1.

When notified by ED staff that Code Stroke can be cancelled, PBX operator will do a one-time overhead announcement "Code Stroke, All Clear".

Emergency Department:
MD and RN will respond to any area of the hospital for a rapid assessment of the patient. Code Stroke Practice Guideline Policy will be initiated, if indicated.

Radiology:
Will emergently ready the CT table in anticipation of the patient's arrival. Facilitate rapid CT completion, allow nursing to establish an IV between CT and CTA when necessary. CT Technician to phone Radiologist to confirm CT has been received.

Laboratory:
Phlebotomist will respond to location to rapidly draw patient's blood, return to lab, and assure blood is immediately processed.

Pharmacy:
During in house hours, Pharmacist will facilitate the mixing of alteplase and assure proper dosing guidelines are followed.

OWNER:
Mark Kobe, Chief Nursing

AUTHOR/REVIEWERS:
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Sonja Todorova, Diagnostic Imaging Manager
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Chris Kutza, Director of Pharmacy

APPROVALS:
Policy & Procedure Team: 4/17/18
Medicine Committee: 5/10/18
Medical Executive Committee: 5/17/18
Board Quality Committee:
The Board of Directors:

SUBJECT: Wound Care Protocol	POLICY #
	PAGE 1 OF 6
DEPARTMENT: Organizational	EFFECTIVE:
REVIEW/REVISED:	

PURPOSE:

To define the scope of practice and process for wound care referrals made by in-patient departments. All in-patients are to receive prompt, effective care of wounds.

POLICY:

This policy addresses the scope of practice for wound care in the acute care hospital and skilled nursing facility. It is applicable to:

- All locations within the hospital including the Medical/Surgical Unit, Intensive Care Unit, Emergency Department, Skilled Nursing Facility, and the Surgical Care Unit.
- All hospital patients, except hospice patients which are taken care of by an outside service for their wound care.
- The wound and ostomy nurse and any assigned designee such as a physical therapist whom is trained in wound care.

Definitions

Wound Care: Any activities dealing with the repair of a patients skin such as wound healing, interventions to prevent skin breakdown, training the patient to care for wound(s), or repairing compromised skin. Referred to in the following policy as the "Wound Care Clinician".

Ostomy Care: Any activities dealing with pouching system maintenance, problems with stoma periarea, and training the patient to perform self-care of their ostomy.

ABI: Ankle Brachial Index

NPWT: Negative Pressure Wound Therapy

SNAP: NPWT device

PROCEDURE:

Clinicians are to adhere to the following protocol:

SUBJECT: Wound Care Protocol	POLICY #
	PAGE 2 OF 6
DEPARTMENT: Organizational	EFFECTIVE:
REVIEW/REVISED:	

- The wound care clinician receives a request for wound evaluation and treatment from the MD via verbal or electronic notification through Paragon.

- This order entitles the Wound Care Clinician to perform the following:
    - Assess the wound.
    - Evaluate the type of wound.
    - Determine the appropriate treatment following the moist warm healing environment, the TIME wound assessment tool, as well as other various wound care objectives.
    - Perform treatment as determined by the wound conditions .outlined in this policy
    - Inform the provider of findings and treatments preformed and additional recommendation.
        - TIME stands for:
            - T= Tissue management- The wound bed and wound periarea.
                - Elimination (debridement) of Non-viable tissue from the wound bed is critical to wound healing. Examples of non-viable tissue are: Eschar, Slough, and hypergranulated tissue.
                - Techniques use to remove eschar and slough from the wound bed are:
                    - Biological- Using medical grade maggots.
                    - Enzymatic- Santyl is the only FDA approved enzymatic.
                    - Autolytic- Controlling the discharge in the wound bed by holding it in the wound bed without causing damage to the wound periarea. This allows the various enzymes in the discharge to break down the slough and eschar.
                        - Products that work to achieve autolytic debridement are:
                            - Iodosorb, hydrocoloid dressings, clear film dressings.
                    - Mechanical Debridement- By using cotton swabs, 4x4 gauze and other materials, the slough and eschar are removed by wiping and/or scrubbing the wound bed.
                    - Sharp conservative debridement- With MD order, perform conservative sharp debridement following organization policy Conservative Sharp Debridement Policy # PC7740-103.

- I= Infection/inflammation management- Of the wound environment. By controlling the bioburden (microbial activity) in the bed and wound periarea, the wound can progress from the inflammatory stage of wound healing to the proliferative stage.
    - Examples of products that work toward reducing bioburden in the wound bed are:
        - Iodosorb, Restore Ag Contact layer, Acticoat flex, Xeroform, Silvasorb, Iodoform,
- M= Moisture management- The discharge from the wound needs to be controlled to enable a moist healing environment and to prevent any complications from excessive moisture in the wound.
    - The discharge from the wound can cause several complications with wound healing such as:
        - Increase the pH of the wound bed and wound periarea making the area susceptible to fungal and bacterial infections.
        - Enzymes in the discharge can break down collagen in viable tissue cause the wound to get bigger.
    - The type of moisture in the wound bed is important to achieve wound healing:
        - Examples of products that encourage the right amount and type of moisture are:
            - Adaptic, Iodosorb, Iodoform, Restore Ag Contact layer, Xeroform, Santyl, and Silvasorb.
    - For moderate to copious discharge, choose a dressing that control the discharge.
        - Examples of adsorbent dressings are:
            - Foam dressings, Ca Alginate, Ag Alginate, and Xtrasorb dressings.
- E= Edge management- The quality and character of the wound edge needs to be controlled for epithelialization to occur.
    - If wound edge has epibole, consider AgNO3 or mechanical debridement.
    - If wound edges are dry, consider adding more moisture to the wound by choosing Adaptic, Iodosorb, Iodoform, Restore Ag Contact layer, Xeroform, Santyl, Silvasorb.
    - If wound edges are macerated, consider adding one of the following products: Ca Alginate, Ag Alginate, and Xtrasorb dressings.

- If wound edge has callus, consider conservative sharp debridement of the callus.

- Other Wound Care objectives:
  - Keep the wound bed warm (at body temperature) - this warmth is for optimal cellular activity.
    - The warmest dressing is a foam dressing, consider this dressing for most wounds.
  - Off-load the wound (reduce trauma)- Reducing the trauma to the wound bed by, but not limited to the following:
    - A foam dressing has attenuation which cushions the wound bed, consider this bandage for most wounds.
    - Off-loading shoes.
    - Mattress type
    - Floating heals
    - Pillows and/or foam cushions
    - Wheel chair cushions
    - Bandaging technique
    - Limit activities
    - Turning patient in bed every 2 hours
    - Reposition patient in wheel chair every 15 minutes.
  - Protect wound from contamination:
    - Choose a dressing that protects the wound from contamination from outside sources and bodily fluids.
      - Most foam dressings have an adhesive boarder and achieve a seal that can withstand showering and contamination from bodily fluids.
  - Improve quality and quantity of blood to the wound.
    - If the wound is on a Lower extremity and there is edema present consider on of the following compression options:
      - Coban2 compression system for ABI >0.9
      - Coban2 Lite compression system for ABI 0.5-0.9.
      - Compression stockings 20-30mmHg
      - Elevate legs
      - Ambulation/exercises, as tolerated by the patient that does not cause trauma to wound bed.
    - If the patient is nutritionally compromised consult with Doctor and Registered Dietitian.
    - If patient is a diabetic, review blood glucose levels for the recent past and patient A1C for compliance with tight blood glucose levels.

- Frequency of dressing change should be as infrequent as possible:
    - This reduces the trauma and cooling of the wound bed.
    - It can take up to 4 hours for a wound bed to return to body temperature after a dressing change and start growing granular tissue.
    - The biggest factor that will determine frequency of dressing change is the level of discharge and the bandage one is able to use on the wound.
- Fill the wound bed:
    - General guide line is that if the wound bed is deeper than 0.5cm some sort of product should be used to fill the wound bed and prevent formation of abscess, consider:
        - Iodoform, Ca Alginate, Ag Alginate, foam or Gauze.
- Cleaning the wound bed:
    - Should be performed every dressing change.
    - Wound cleanser should be used primarily unless patient has a reaction to the product.
    - Normal saline is acceptable except when a silver product is used in wound bed or Santyl is used due to the neutralizing effect saline has on those products.

- The wound care clinician then enters the order determined by the wound care clinician and the provider into the Paragon EMR system.

- The wound care clinician then documents finding with the wound into the Paragon EMR system.

REFERENCES:
Wound, Ostomy, and Continence Society Core Curriculum: Wound Management 1st edition, Authors: Dorothy B. Doughty MN RN CWOCN FAAN ,and Laurie L. McNichol MSN RN GNP CWOCN CWON, **Publisher:** LWW; 1 edition (September 17, 2015)

OWNER:
Chief Nursing Officer

AUTHORS/REVIEWERS:
Joe Cornett, Wound and Ostomy Nurse
Alexis Alexandridis, MD, Wound Care Medical Director

SUBJECT: Wound Care Protocol	POLICY #
	PAGE 6 OF 6
DEPARTMENT: Organizational	EFFECTIVE:
REVIEW/REVISED:	

APPROVALS:
Policy & Procedure Team: 4/17/18
Medicine Committee: 5/10/18
Medical Executive Committee: 5/17/18
Board Quality Committee:
The Board of Directors: