SVHCD QUALITY COMMITTEE
AGENDA
WEDNESDAY, August 22, 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 07.25.18	*Hirsch*	Action
4. PAIN MANAGEMENT PROGRAM	*Yang*	Inform
5. 2018 PHARMACY ANNUAL REPORT	*Kutza*	Inform
6. QUALITY COMMITTEE CHARTER	*Jones*	Inform
7. INFECTION PREVENTION Q2 DATA	*Mathews*	Inform
8. POLICIES & PROCEDURES	*Jones*	Action
9. CLOSED SESSION: a. Calif. Health & Safety Code § 32155 Medical Staff Credentialing & Peer Review Report	*Hirsch*	Inform
10. REPORT OF CLOSED SESSION	*Hirsch*	Inform/Action
11. ADJOURN	*Hirsch*	

+

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

Members Present	Members Present cont.	Excused	Public/Staff
Jane Hirsch Peter Hohorst Carol Snyder Howard Eisenstark, MD Michael Mainardi, MD	Cathy Webber Susan Idell Michael Brown, MD	Kelsey Woodward Ingrid Sheets	Danielle Jones Leslie Lovejoy Mark Kobe Sabrina Kidd, MD Brian Wolfe, Heartland Hospice

AGENDA ITEM	DISCUSSION	ACTION
1. CALL TO ORDER/ANNOUNCEMENTS	*Hirsch* *Ms. Hirsch introduced Dr. Kidd, SVH's new CMO.*	
	Meeting called to order at 5:00 pm	
2. PUBLIC COMMENT	*Hirsch*	
	Mr. Brian Wolfe from Heartland Hospice introduced himself.	
3. CONSENT CALENDAR	*Hirsch*	Action
• QC Minutes, 06.27.18		**MOTION:** by Mainardi to approve, 2nd by Hohorst. All in favor.
4. PATIENT CARE SERVICES DASHBOARD	*Kobe*	Inform
	Medication scanning rates are showing improvements, although Acute and ED are still below goal. A new upgrade on June 1st put into place an avoidance of the ability to scan a patient label rather than the patient's armband. The change in vendor for HCAHPs was reviewed. Press Ganey is again the vendor.	
5. HOME HEALTH HCAHPS UPDATE	*Jones*	Inform

AGENDA ITEM	DISCUSSION	ACTION
	Ms. Jones reviewed this follow up item from last meeting regarding the error in collecting data by Quality data.	
6. RISK MANAGEMENT& PATIENT SAFETY REPORT FY18	*Jones*	Inform/Action
	Ms. Jones reviewed the fiscal year 2018 report. This was the first time reporting to CHPSO which went well. The focus was feedback, loop closure and PI emphasis on good catches.	**MOTION**: by Eisenstark to approve, 2nd by Mainardi. All in favor.
7. POLICIES AND PROCEDURES	*Jones*	Inform/Action
	The following policies were reviewed: Standby Time HR8610-136 Call In Pay HR8610-138 Pediatric Patient in Surgery, Care of the PC7420-111	**MOTION:** by Idell to approve 2nd by Eisenstark. All in favor
8. REPORT OF CLOSED SESSION		Action
	Credentialing report was reviewed and approved.	**MOTION:** by Eisenstark to approve, 2nd by Idell. All in favor.
9. ADJOURN	*Hirsch*	
	Meeting adjourned at 5:40	

PHARMACY DEPARTMENT ANNUAL REVIEW

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

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

Leadership Team: Director of Pharmacy

Statistical Overview:

Staff Category	Function	Total FTE's
Director of Pharmacy	The pharmacist in charge on the state pharmacy license, daily oversight and management of all pharmacy functions and personnel	1FTE 1 full time Director of Pharmacy
Pharmacist Informaticist	Supports the oversight and maintenance of the pharmacy computer system (Paragon Pharmacy) as well as medication components of any CPOE order sets. Ensures that medication billing codes are functional and maintained in partnership with patient accounting.	0.5FTE 1 Full-time pharmacist splitting status with staff pharmacist duties 50-50
Staff Pharmacist	Provides day to day direct patient care including but not limited to medication histories, med order processing, antimicrobial stewardship, patient care rounds, collaboration with other hospital clinical staff, supervision of pharmacy technicians	4.2FTE 2 Full time pharmacists (1 of which is also pharmacist informaticist) 1 part time pharmacist 6 per diem pharmacists
Pharmacy Buyer	Responsible for the management of pharmacy inventory, ordering, and management of 340B purchasing processes. Troubleshoots and coordinates management of shortages and recalls.	1FTE 1 full time pharmacy buyer
Pharmacy technicians	Manage the technical aspects of the pharmacy including refilling and restocking of medications within the pharmacy and patient care areas; billing; expiration date tracking; invoice management;	3.4FTE 1 Full time technician 3 Part time technicians 1 Per diem technicians

	preparation/packaging of medications and IV's	

Staffing decisions are made based legal minimum requirements, patient care workload, and ongoing Electronic Medical Record projects and maintenance. The pharmacy currently averages over 36,000 doses dispensed per month and performs medication histories on most of the more than 1,500 patients admitted per year. The current total budget for the pharmacy is $3,212,525 of which $1,438,000 is medication purchases. Hospital pharmacies are typically not revenue generating departments since most of the patient care expenses relating to pharmacy are not individually reimbursed by payors. The budgeted hospital pharmacy revenue across both inpatients and outpatients is $12,019,000. The pharmacy does impact the bottom line of the hospital by ensuring that patients have the safest and most effective medication related care as possible, including antimicrobial optimization, anticoagulant management, parenteral nutrition management, thorough medication histories, and other patient care related clinical duties. This translates to lower lengths of stay, efficient medication spending, and avoidance of readmissions.

Quality Metrics

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

For 2018:

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

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

Below (Attachment A) please find the Year to Date 2018 results.

PHARMACY DEPARTMENT ANNUAL REVIEW

Past and Future plans for Performance Improvement:

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

* *Drug Utilization Optimization:* Using days of therapy (DOT) the department can track and trend utilization of targeted drugs and address changes in usage patterns in a proactive way.

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

* *CPOE order set optimization:* In order to make our CPOE system safer and more user friendly, pharmacy informatics is tasked with the ongoing project of addressing "pain points" for end users and addressing safety issues as they relate to prescribing. Most recently, changes in how ED medication orders are handled has helped to reduce the number of time nursing has to use override functionality to remove medications from Pyxis.

* *Pyxis stock optimization:* Periodically updating the par levels in the Pyxis automated dispensing cabinets helps to reduce the incidence of stockouts and excess inventory.

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

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

* *Medication Reconciliation:* In 2017 we began a multi-year PI project to improve the global medication reconciliation process. This is a multidisciplinary effort that involves multiple processes and will have its first implementation of significant changes to process later this year.

Conclusion:

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

Attachment A: All Pharmacy Indicators

Status	Indicator	Current Value	Target	SPC Alert	Updated
Quality > Pharmacy					
★ ▲	Rx-Ofirmev DOT	15.90	20.00		Jul 2018
Quality > Pharmacy > Adverse Drug Events					
▽ ▲	Rx-ADEs-Administration Errors Per 10,000 Doses	1.61	1.00		Jul 2018
✕ ▲	Rx-ADEs-Good Catches	46%	75%		Jul 2018
★ ▲	Rx-ADEs-High Risk Med Errors Per 10,000 Doses	0.32	1.13		Jul 2018
▼	Rx-Adverse Drug Reactions	4	n/a		Q2 2018
▲	Rx-Adverse Drug Reactions-Antibiotics	25%	n/a		Q2 2018
▼	Rx-Adverse Drug Reactions-Anticoagulants	25%	n/a		Q2 2018
▼	Rx-Adverse Drug Reactions-Cardiovascular	0%	n/a		Apr 2018
★ ▬	Rx-Warfarin-Inpatient	0.0%	5.0%		Nov 2017
Quality > Pharmacy > Antimicrobial Stewardship					
★ ▼	Rx-Antimicrobial Stewardship Cefepime DOT	46.77	50.00		Jul 2018
★ ▬	Rx-Antimicrobial Stewardship Ertapenem DOT	0.00	20.00		Jul 2018
★ ▼	Rx-Antimicrobial Stewardship Levofloxacin DOT	5.61	15.00		Jul 2018
✕ ▲	Rx-Antimicrobial Stewardship LOS-Cellulitis (Days)	6.5	4.0		Jul 2018
▽ ▼	Rx-Antimicrobial Stewardship LOS-Pneumonia (Days)	4.7	4.0		Jun 2018
✕ ▲	Rx-Antimicrobial Stewardship LOS-Resp. Infections-Inflammations (Days)	7.0	4.0		Jul 2018

PHARMACY DEPARTMENT ANNUAL REVIEW

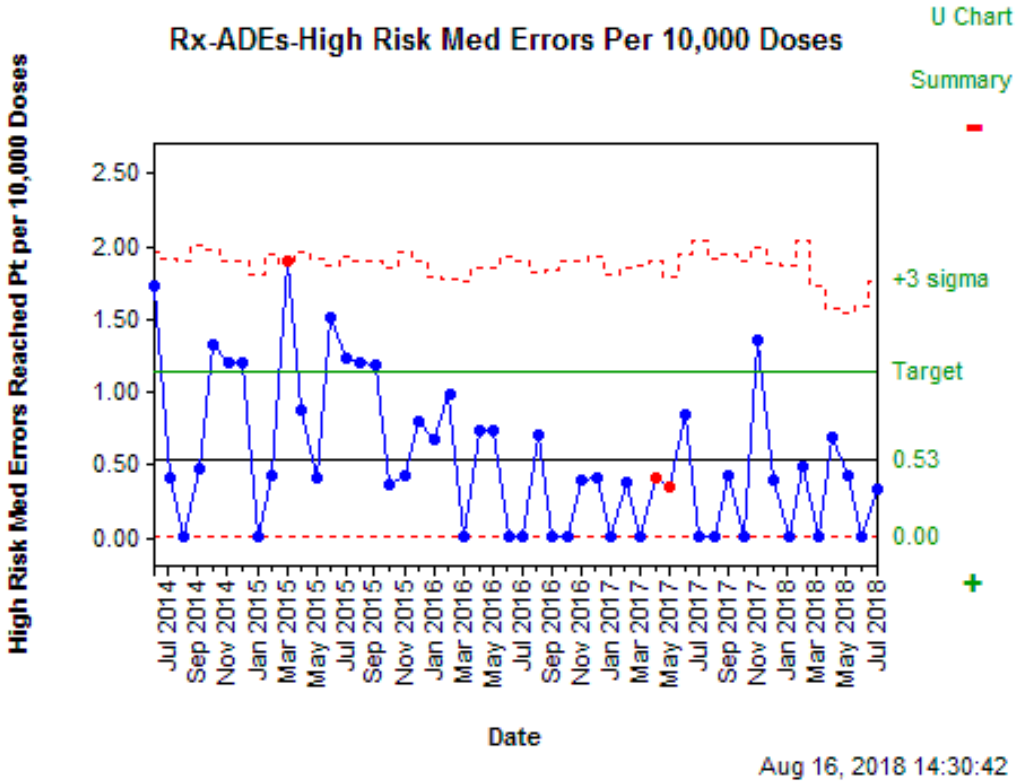
Status	Indicator	Current Value	Target	SPC Alert	Updated
	Rx-Antimicrobial Stewardship LOS-Septicemia (Days)	4.6	4.5		Jul 2018
	Rx-Antimicrobial Stewardship Pip-Tazo DOT	61.74	20.00		Jul 2018
	Rx-Antimicrobial Stewardship-Antimicrobial Spend PAPD ($)	3.79	8.00		May 2018
Quality > Pharmacy > Controlled Substances					
	Rx-Controlled Substance Audit-Anesthesia	n/a	2.0%		Jul 2018
	Rx-Controlled Substance Audit-Inpatient	n/a	95.0%		Jul 2018
Quality > Pharmacy > IV Room					
	Rx-Cleanroom Aseptic Technique	100%	100%		2017
	Rx-Cleanroom Certification	100%	100%		Jul-Dec 17
	Rx-Cleanroom Contact Plates	100%	100%		Q3 2017
	Rx-Cleanroom End Product Testing	100%	100%		Q3 2017
	Rx-Cleanroom Glovetip Testing	100%	100%		Q1 2017
	Rx-Cleanroom Hood Cleaning	100%	100%		Oct 2017
	Rx-Cleanroom Quantitative Analysis	100%	100%		Q3 2017
	Rx-Cleanroom Room Cleaning-Daily	100%	100%		Oct 2017
	Rx-Cleanroom Room Cleaning-Weekly	100%	100%		Oct 2017
	Rx-Cleanroom Written Competencies	100%	100%		2017
Quality > Pharmacy > Pharmacy Services					
	Rx-After Hours Interventions	4.1%	3.0%		Jul 2018

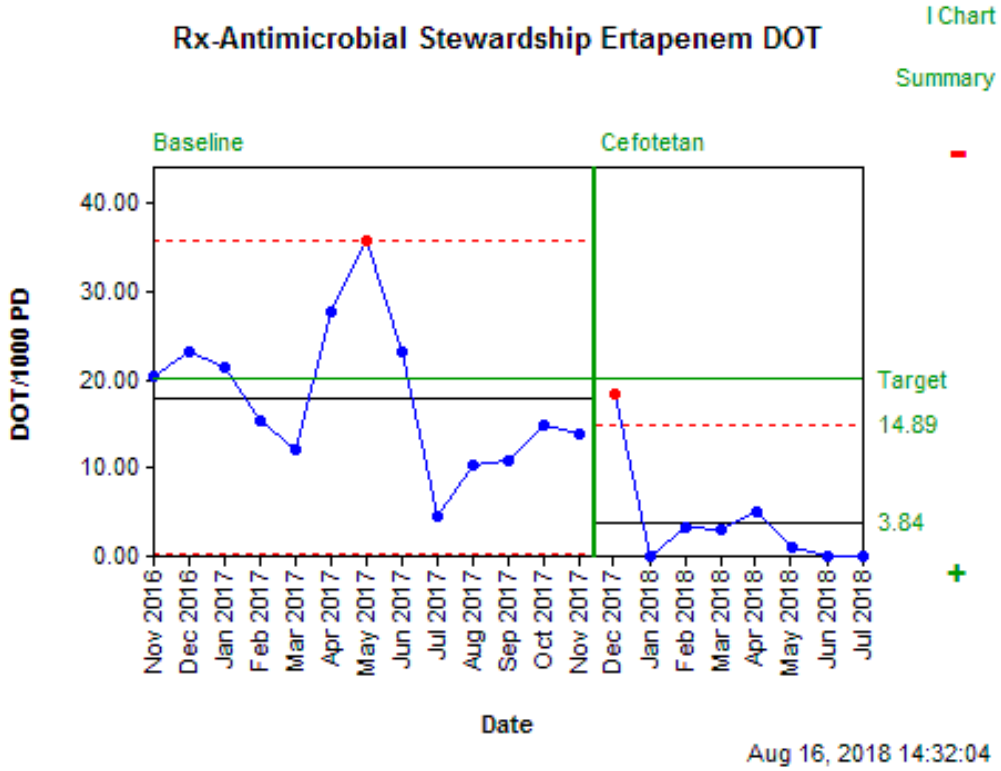
PHARMACY DEPARTMENT ANNUAL REVIEW

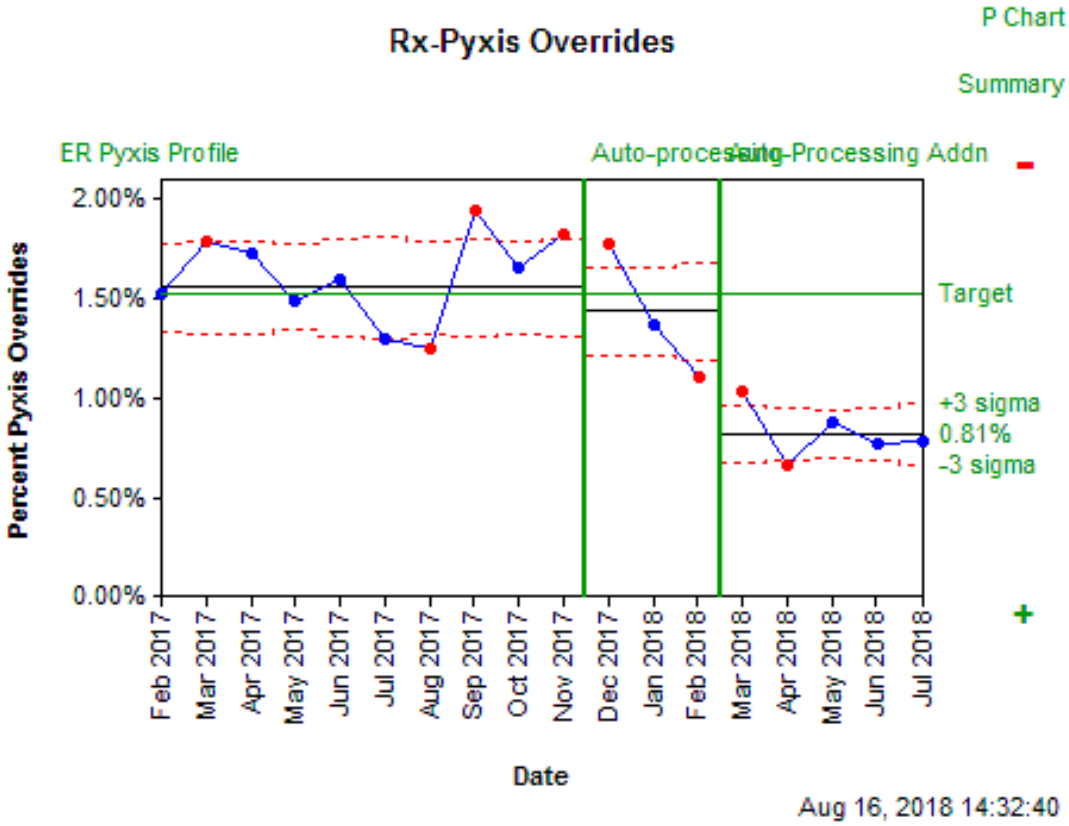
Status	Indicator	Current Value	Target	SPC Alert	Updated
★ ▼	Rx-After Hours Pharmacy Errors	0.00%	0.00%		Jul 2018
▽ ▲	Rx-Clinical Interventions-Dollars Saved	$99,475	$100,000		Q2 2018
▲	Rx-Clinical Interventions-Time Spent	271	n/a		Q2 2018
Quality > Pharmacy > Pyxis					
★ ▲	Rx-ER Pyxis Overrides	0.55%	1.00%		Jul 2018
★ ▲	Rx-Pyxis Overrides	0.77%	1.52%		Jul 2018
▽ ▲	Rx-Pyxis Stockouts	6.3%	6.0%		Jul 2018
Service > Inpatient > HCAHPS					
★ ▲✓	HCAHPS Inpatient (M) (Communication About Meds)	96.0	70.0		May 2018
✗ ▼✓	HCAHPS Inpatient (M) (Pain Management)	40.0	70.0		Jan 2018

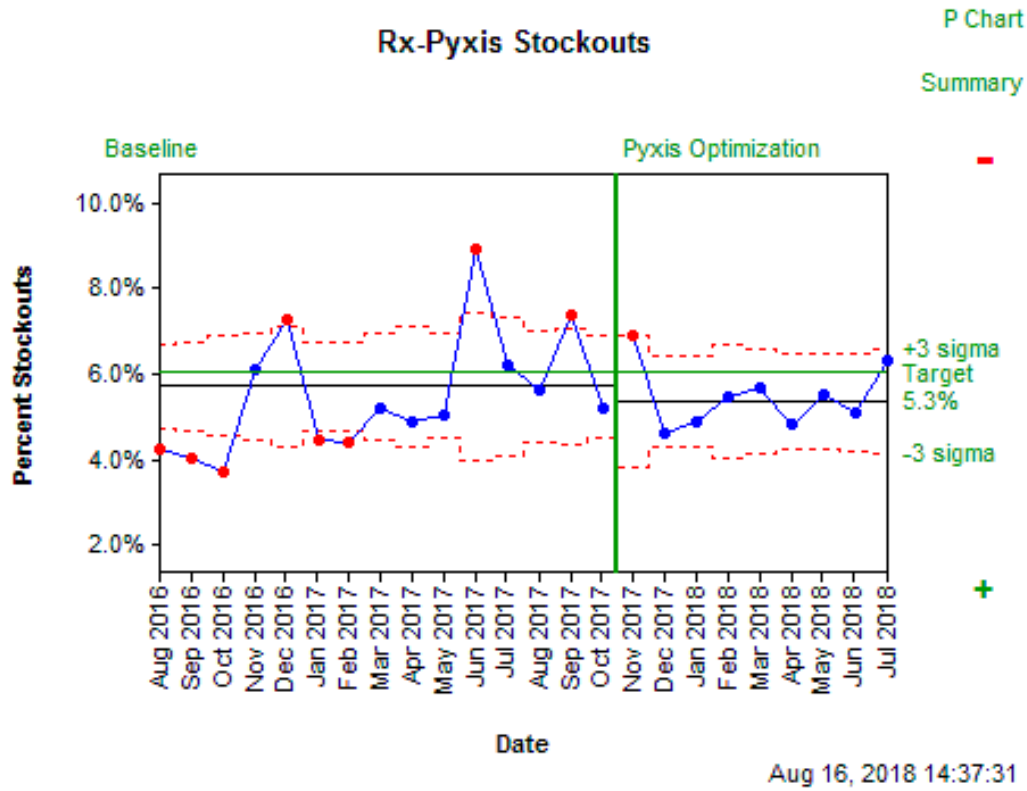
Status Legend

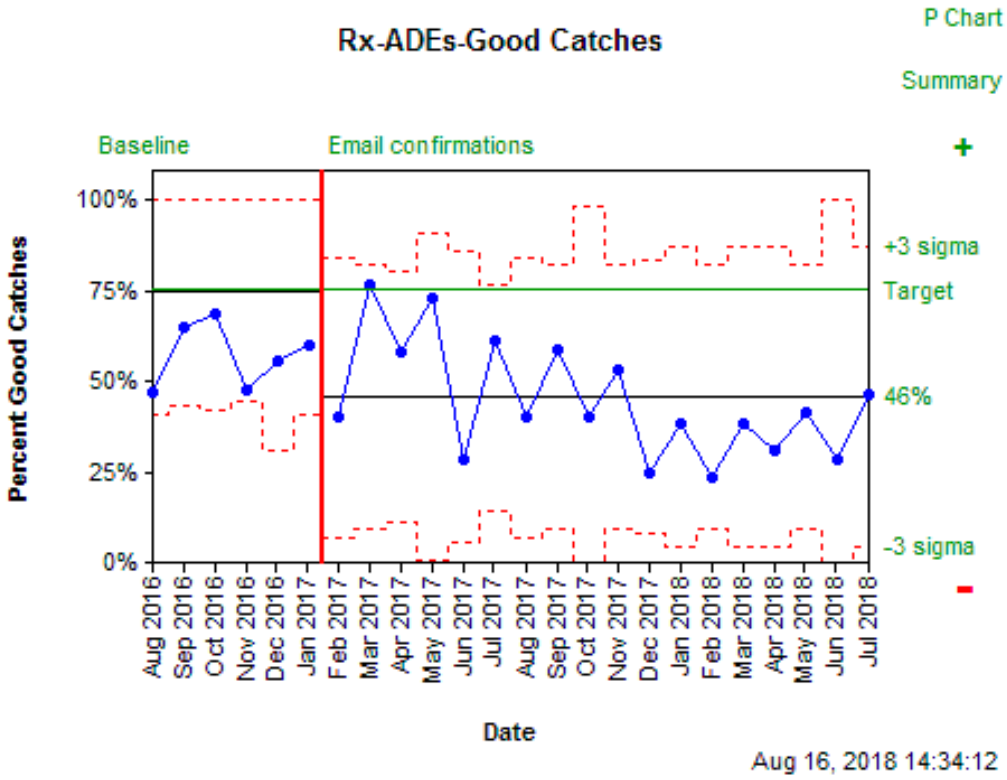
- ★ The most recent period meets or exceeds the Target
- ▽ The most recent period is between the Target and Alarm
- ✗ The most recent period violates the Target (and Alarm if applicable)
- ▲ The current value increased signifying improvement from the previous period
- ▲ The current value increased signifying deterioration from the previous period
- ▼ The current value decreased signifying deterioration from the previous period
- ▼ The current value decreased signifying improvement from the previous period
- ▬ The current value did not change from the previous period
- ☑ The indicator has not been validated
- ✓ The indicator has been validated
- The indicator is public
- The indicator is private


Rx-ADEs-High Risk Med Errors Per 10,000 Doses
U Chart
Summary
High Risk Med Errors Reached Pt per 10,000 Doses
2.50
2.00
1.50
1.00
0.50
0.00
+3 sigma
Target
0.53
0.00
Jul 2014
Sep 2014
Nov 2014
Jan 2015
Mar 2015
May 2015
Jul 2015
Sep 2015
Nov 2015
Jan 2016
Mar 2016
May 2016
Jul 2016
Sep 2016
Nov 2016
Jan 2017
Mar 2017
May 2017
Jul 2017
Sep 2017
Nov 2017
Jan 2018
Mar 2018
May 2018
Jul 2018
Date
Aug 16, 2018 14:30:42


Rx-Antimicrobial Stewardship Ertapenem DOT
I Chart
Summary
Baseline
Cefotetan
DOT/1000 PD
40.00
30.00
20.00
10.00
0.00
Target
14.89
3.84
Nov 2016
Dec 2016
Jan 2017
Feb 2017
Mar 2017
Apr 2017
May 2017
Jun 2017
Jul 2017
Aug 2017
Sep 2017
Oct 2017
Nov 2017
Dec 2017
Jan 2018
Feb 2018
Mar 2018
Apr 2018
May 2018
Jun 2018
Jul 2018
Date
Aug 16, 2018 14:32:04


Rx-Pyxis Overrides
P Chart
Summary
ER Pyxis Profile
Auto-processing
Auto-Processing Addn
Percent Pyxis Overrides
2.00%
1.50%
1.00%
0.50%
0.00%
Target
+3 sigma
0.81%
-3 sigma
Feb 2017
Mar 2017
Apr 2017
May 2017
Jun 2017
Jul 2017
Aug 2017
Sep 2017
Oct 2017
Nov 2017
Dec 2017
Jan 2018
Feb 2018
Mar 2018
Apr 2018
May 2018
Jun 2018
Jul 2018
Date
Aug 16, 2018 14:32:40


Rx-Pyxis Stockouts
P Chart
Summary
Baseline
Pyxis Optimization
Percent Stockouts
10.0%
8.0%
6.0%
4.0%
2.0%
+3 sigma
Target
5.3%
-3 sigma
Aug 2016
Sep 2016
Oct 2016
Nov 2016
Dec 2016
Jan 2017
Feb 2017
Mar 2017
Apr 2017
May 2017
Jun 2017
Jul 2017
Aug 2017
Sep 2017
Oct 2017
Nov 2017
Dec 2017
Jan 2018
Feb 2018
Mar 2018
Apr 2018
May 2018
Jun 2018
Jul 2018
Date
Aug 16, 2018 14:37:31


Rx-ADEs-Good Catches
P Chart
Summary
Baseline
Email confirmations
+
100%
75%
50%
25%
0%
+3 sigma
Target
46%
-3 sigma
-
Percent Good Catches
Aug 2016
Sep 2016
Oct 2016
Nov 2016
Dec 2016
Jan 2017
Feb 2017
Mar 2017
Apr 2017
May 2017
Jun 2017
Jul 2017
Aug 2017
Sep 2017
Oct 2017
Nov 2017
Dec 2017
Jan 2018
Feb 2018
Mar 2018
Apr 2018
May 2018
Jun 2018
Jul 2018
Date
Aug 16, 2018 14:34:12

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

SUBJECT: Quality Committee Charter	
	PAGE 1 OF 6
DEPARTMENT: Board of Directors	EFFECTIVE: 12/1/11
APPROVED BY: Board of Directors (12/1/11)	REVISED: 3/27/13

PURPOSE:

Consistent with the Mission of the District the Board, with the assistance of its Quality Committee (QC), serves as the steward for overall quality improvement for the District. The QC shall constitute a committee of the District Board of Directors. The Board shall refer all matters brought to it by any party regarding the quality of patient care, patient safety, and patient satisfaction to the QC for review, assessment, and recommended Board action. The QC makes recommendations and reports to the Board. It has no authority to make decisions or take actions on behalf of the District unless the Board specifically delegates such authority.

The QC shall assist the Board in its responsibility to ensure that the Hospital provides high-quality patient care, patient safety, and patient satisfaction. To this end the QC shall:

1. Formulate policy to convey Board expectations and directives for Board action;
2. Make recommendations to the Board among alternative courses of action, including but not limited to physician credentialing, and oversight activities;
3. Provide oversight, monitoring and assessment of key organizational processes, outcomes, and external reports.

POLICY:

Scope and Applicability
This is a SVHCD Board Policy and it specifically applies to the Board, the Quality Committee, the Medical Staff, and the CEO of SVH.

Physician Credentialing

1. The QC shall ensure that recommendations from the Medical Executive Committee and Medical Staff are in accordance with the standards and requirements of the Medical Staff Bylaws, Rules, and Regulations with regard to: completed applications for initial medical staff and allied health staff appointment; initial staff category assignment, initial department/divisional affiliation; membership prerogatives and initial clinical privileges; completed applications for reappointment of medical staff, staff category; clinical privileges; establishment of categories of allied health professionals permitted to practice at the hospital; the appointment and reappointment of allied health professionals; and privileges granted to allied health professionals.

2. The QC shall, in closed session, on a case by case basis, fully, rigorously, and carefully review the recommendations of the Medical Staff regarding the appointment, reappointment, and privilege delineation of physicians and submit recommendations to the Board for review and action.

Develop Policies

1. The QC shall submit recommendations for action to the Board on draft policies developed by the QC and those developed by the Hospital regarding quality patient care, patient safety, and patient satisfaction.

Oversight

Annual Quality Improvement Plan

1. The QC shall review and analyze findings and recommendations from the Hospital's prior year Annual Quality Improvement Plan, including but not limited to a comparison of the plan to actual accomplishments, administrative review, and evaluation activities conducted, findings and actions taken, system or process failures and actions taken to improve safety, both proactively and in response to actual occurrences.

2. The QC shall review the Hospital's Annual Quality Improvement Plan for continuously improving quality, patient safety, and patient satisfaction and submit the analysis with recommendations establishing priorities to the Board for discussion and action. The Hospital's plans should include, but not be limited to, assessing the effectiveness and results of the quality review using metrics and benchmarks, utilization review, performance improvement, implementing and improving electronic medical/health records, professional education, risk management programs, and patient care related activities and policies of the Hospital and/or Medical Staff, as applicable.

Medical Staff Bylaws

1. The QC shall review the Medical Staff's fulfillment of its responsibilities in accordance with the Medical Staff Bylaws, applicable law and regulation, and accreditation standards and make recommendations to the Board.

Quantitative Quality Measures

1. The QC shall assess and recommend quantitative measures to be used by our Board in assessing the quality of the Medical Staff's and Hospital's services and submit them to the Board for deliberation and action. The recommendations shall include descriptions that show how the organization measures and reports the improvement of patient care, as well as management accountability

2. The QC shall review all reports by and Hospital responses to accreditation organizations, e.g., Fire Marshals, Environmental Health, State Department of Health Services (DHS), and other external organizations conducting management, programmatic, physical plant audits/assessments/reviews that are directly or indirectly related to the quality of health care delivery in the Hospital (quality patient care, patient safety, and patient satisfaction). Track all uncompleted/open items until remedied/closed by the Hospital, and make recommendations and report to the Board for its action as appropriate. This includes the final OSHPD report on a construction project prior to licensing by DHS, but it does not include on-going OSHPD reviews/inspections/reports while a project is in design or construction. This does not include routine financial audits, unless the audit identifies quality patient care, patient safety, and/or patient satisfaction issues, in which case the Finance Committee shall refer the audit to the QC for its review and recommendations to the

Board.

3. The QC shall ensure there is an effective, supportive, and confidential process for anyone (the Medical Staff, other health care professionals; Hospital administration; leaders and staff; patients, and their families and friends; and the public) to bring issues to the QC directly or via the Hospital—as a group, personally or anonymously--in order to promote the reporting of quality and patient safety problems and medical errors, and to protect those who ask questions and report problems.

4. The QC shall review and assess the process for identifying, reporting, and analyzing "adverse patient events" and medical errors. The QC shall develop a process for the QC to address these quality deficiencies, in the most transparent manner possible, without unnecessarily increasing the District's liability exposure.

5. The QC shall review the assessment of patient needs/satisfaction, and submit this assessment with recommendations to the Board for review and possible action. This may include, but is not limited to CMS Value Based Purchasing information; Patient Satisfaction Survey Vendor; reports and comparisons to other hospitals, state and national standards; and patient and/or family compliments and complaints.

6. The QC shall in collaboration with and after consultation with the Director of Human Resources, review situations and systems that could adversely affect quality of care patient safety or patient satisfaction, and make recommendations to the Board.

Hospital Policies

1. The QC shall assure that the Hospital's administrative policies and procedures, including the policies and procedures relative to quality, patient safety and patient satisfaction, are reviewed and approved by the appropriate Hospital leaders, submitted to the Board for action, and are consistent with the District and Hospital Mission, Vision and Values, Board policy, accreditation standards, and prevailing standards of care and evidence-based practices.

Other

1. Perform other duties related to high-quality patient care, patient safety, and patient satisfaction as assigned by the Board.

Annual QC Work Plan

The QC shall develop an Annual QC Work Plan comprised of the required annual activities and additional activities selected by the QC. The Annual QC Work Plan shall be reviewed and acted on by the Board after considering the Hospital's work plan to support the QC.

Required Annual Calendar Activities:

1. The QC shall review the adequacy of financial and human resources currently allocated for maintaining high-quality care, patient safety, and patient satisfaction in advance of the annual budget process and provide an assessment to the Board and CEO with recommendations for action.

2. The QC Work Plan shall be submitted to the Board for its review and action no later than December.

3. The QC shall report on the status of its prior year's work plan accomplishments by December.

4. The QC reviews and assesses all Board policies regarding quality specifically including the QC Charter, and makes recommendations to the Board for action in December.

5. The QC reviews and assess the Annual Department Reports for: Infection Prevention, Contract Evaluation, Skilled Nursing, QAPI, Risk Management, Pharmacy, Laboratory, Perioperative Services, Emergency Department, ICU, Medical/Surgical Unit and Human Resources.

QC Membership and Staff

The QC shall have seven voting members and three non-voting public member alternates appointed pursuant to Board policy. Pursuant to Health and Safety Code Section 32155, based on the need for Medical Staff quality assessments. Hospital employees who staff the QC are not voting members of the QC. QC membership is:

- Two Board members one of whom shall be the QC chair, the other the vice-chair. Substitutions may be made by the Board chair for Board QC members at any QC meeting--for one or both Board members.

- One designated position from the Medical Staff leadership, i.e., the President or the President-Elect. Substitutions may be made by the President for one Medical Staff member at any QC meeting.

- Four members of the public. In addition, substitutions may be made at all QC meetings from three prioritized non-voting members of the public as alternate public members. Alternates shall attend closed session QC meetings and vote as QC members when substituting for a voting public member. Alternates may attend QC meetings as non-voting alternates and fully participate in the open meeting discussions.

Staff to the QC include the Hospital's Chief Medical Officer (CMO), Chief Nursing Officer (CNO), and the Director of Quality and Resource Management who shall be the lead staff in support of the QC Chair for meetings, documents, and activities. Staff is expected to attend the QC meetings. The CEO may attend all QC and subcommittee meetings and shall be a resource at the QC meetings upon request of the QC Chair.

Frequency of QC Meetings
The QC shall meet monthly, unless there is a need for additional meetings.

Public Participation
All QC meetings shall be announced and conducted pursuant to the Brown Act. Physician Credentialing and Privileges are discussed and action is taken in QC Closed Session without the general public.

The general public, patients and their families and friends, Medical Staff, and Hospital staff are always welcome to attend and provide input. Other Board members may attend but may not comment as it may be a Brown Act violation.

Narrowly focused and short term ad hoc subcommittees may meet to address specific issues that will be brought to the QC for review and referral to the Board for its deliberation and action. Subcommittee meetings are not subject to the Brown Act.

FREQUENCY OF REVIEW/REVISION
This shall occur annually or more often if required. If revisions are needed they will be taken to the Board for action.

Infection Prevention Report: 2nd Quarter 2018

Indicator	Comparison Rates: 2013-2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Benchmarks/Actions/Comments
Quarterly reporting of National Healthcare Safety Network (NHSN) indicator data is required by CDPH. NHSN provides the predicated number of HAIs based on standardized infection rations (SIRS). ** Indicates public reporting on CDPH website. Green indicates no action indicated, yellow indicates above the predicted number of infections, red indicates action is recommended to reduce infections.						
****CLABSI (NHSN) (CMS Never Event)** *# Central Line Associated Bloodstream Infections (CLABSI)/1000 central line days*	**0 since 2011**	**0** 0/106	**0** 0/131			**NHSN predicts 0.51 CLABSIs per year.**
****CDI (NHSN)** *#Inpatient Hospital Acquired infections due to C. difficile per 10,000 patient days*	**2.1 /7.2 /12 15/21.7**	**10** 1/978	**9.9** 1/1006			**NHSN predicts 3.51 cases per year (4). Benchmark (MMWR) is 7.4/10,000 patient days.**
****MRSA Bloodstream Infections (NHSN)** *#bloodstream infections due to MRSA per 1000 pt. days*	**1.3 /0 /0 0/ 0**	**0** 0/1018	**0** 0/1069			**NHSN predicts 0.13 infections per year.**
****VRE Bloodstream Infections (NHSN)** *#Hospital Acquired bloodstream infections due to VRE per 1000 pt. days*	**0 x 5 yrs**	**0** 0/1018	**0** 0/1069			**SVH Benchmark: 1 per 1,000 patient days.**
****Hip: Deep or Organ Space Surgical Site Infections (NHSN)** *# infections/ # Total Hip Cases x 100*	**0 / 1.8% / 0** **1.6% / 0**	**0** 0/12	**0** **0/7**			**NHSN predicts 0.26 SSIs per year.**
****Knee: Deep or Organ/Space Surgical Site Infections (NHSN)** *# infections/ # Total Knee Cases x 100*	**0 / 1.7% / 2** **1.4% / 1.3%**	**0** 0/20	**0** **0/13**			**NHSN predicts 0.28 SSIs per year.**
****Overall Surgical Site Infections (SSI)** *Total # SSI/Total # surgeries x 100*	**0.2%/0.7% (12)/** **0.4% (6)/ 0.5% (8)/ 0.4% (8)**	0 0/431	**0.2%** **1/470**			**NHSN predicts 1.6 SSIs per year for colon and hysterectomy surgery only, deep or organ space infections, within 30 days.**
Class I SSI rate	**<1% x 5 yrs**	0 0/341	**0.3%** **1/338**			**No NHSN Class I (Clean Wound) rate benchmark**
Class II SSI rate	**< 1.3% x 5 yrs**	0 0/69	**0 0/120**			**No NHSN Class II (Clean Contaminated) rate benchmark**
Total Joint SSI rate	**0 / 0.8%/1.9%/1.4%/1.4%**	**0 0/32**	**0 0/28**			**No NHSN Total Joint SSI rate Benchmark**
Post discharge surveillance surgeon compliance	**57% 2014/ 64% 2015/ 84% 2016/ 96.5% 2017**	99% Jan &Feb	**99%**			**2014 Surgery Committee approved SSI reporting by surgeons monthly, to promote accurate SSI rates.**

Infection Prevention Report: 2nd Quarter 2018

Indicator	Comparison Rates: 2013-2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Benchmarks/Actions/Comments
Quarterly reporting of National Healthcare Safety Network (NHSN) indicator data is required by CDPH. NHSN provides the predicated number of HAIs based on standardized infection rations (SIRS). ** Indicates public reporting on CDPH website. Green indicates no action indicated, yellow indicates above the predicted number of infections, red indicates action is recommended to reduce infections.						
Hand Hygiene Compliance *Stealth hand hygiene observations: # opportunities/# observed*	**2017 98.7%**	**100%** 6/6	**71%** **5/7**			**>90%**
****Ventilator Associated Event (VAE): Pneumonia** # *Ventilator Associated Pneumonias or events/ # vent days x 1000*	**0 x 4 yrs.**	**0** 0/20	**0** 0/41			**NHSN Benchmark: 1.1 per 1,000 ventilator days.**
****Hospital Acquired Pneumonia (HAP)** # *hospital acquired pneumonia/# pt days x 1000 pt days*		**acute 1/1018 .9** **SNF 1.2 2/1706**	**acute 0.9 1/1069** SNF 0 0/1493			**Benchmark 1.2 cases per 1,000 pt days. In 2018, rates calculated for acute and SNF separately.**
****Inpatient Hospital Acquired Catheter Associated Urinary Tract Infections (CA-UTI) (CMS Never Event)** # *inpatient CAUTI/# catheter days x 1000*	**0.7 /0 / 1.7 1.4/1.6**	**0** 0/283	**0** 0/28			**NHSN predicts 1.04 CAUTIs per year.**
SNF Hospital Acquired Catheter Associated Urinary Tract Infections (CA-UTI) # *SNF CAUTI/# catheter days x 1000*	**2.6 / 3.3/ 5.7/ 7.6/2.6**	**9.5** 1/105	**0** 0/133			**No NHSN SIR for SNF. Previous NHSN benchmark was 1.5 per 1000 pt days**
SNF Hospital Acquired *C. Difficile* Infections (CDI) # *SNF CDI/# patient days x 10,000*	**20 /11.7 /2/2/ 3.6**	**11.7** 2/1706	**6.7** 1/1493			**Benchmark: 7.4 per 10,000 patient days. 3/24 and 4/2. 1 pt. had reoccurring CDI. Expired at home with CDI.**
SNF Central line associated bloodstream infections (CLABSI) # *Central Line Associated Bloodstream Infections (CLABSI)/central line days x 1000*	**1 / 0/ 0 /0 /2.7**	0 0/93	0 0/101			**Previous NHSN benchmark: 0.8 per 1,000 central line days.**
Healing at Home Associated Infections # *of infections/Total visits x 1000*	**0.3 / 0.6 / 0/0 0.1**	**0.9 UTI** 0.4 CDI	0.9 UTI not CAUTI			**SVH Benchmark: 1.5 per 1,000 home care visits**
MRSA Active Surveillance Cultures (nares cultures only) # *positives/total screened x 100*	**14%** **20%/26%/9.2%**	**10%**	3.4%			**Nares surveillance perofrmed in accordance with California law.**
% ESBL(E. coli;K. pneumoniae, K. oxytoca, P. mirabilis)	**2%**	4%	2.9%			**ASP monitors antibiogram and updates annually.**
# CRE cases	**0/0/0/1**	0	0			**Track and trend**
Legionella Monitoring: water samples and patients with HA pneumonia		0 pts./ 3 cfu/ml water	0 pts/ water cx neg.			**No L. pneumophilia recovered on repeat environmental cultures from 2 South (previously positive).**
Environmental Cleanliness Monitoring		95%	91%			**169 areas with illumination /184 areas assessed with florescent marker**
Total Influenza Vaccination All HCP	80%					CDPH benchmark 90%
Physicians, LIP, Pas	88%					
Employees	78%					
volunteers	86%					
Students	100%					

Policy and Procedures – Summary of Changes
Board Quality Committee, August 22nd, 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

REVISIONS:

Aminoglycoside Protocol MM8610-111
Removed text referencing "Kinetidex" software. Delete attachment "Aminoglycoside Protocol Order Sheet" and instead placed it on the intranet as a printable form for use in downtime. Kinetidex is no longer an available software. Paper order form no longer used.

Controlled Substance Management MM8610-102
Added verbiage describing quarterly C-II inventory reconciliation as required by California state regulation CCR 1715.65 and updated references to add this new regulation to ensure compliance with applicable state law.

Dispensing of Medication MM8610-148
Added verbiage to clarify when a pharmacist must supervise medication preparation by non-pharmacy personnel. Prior verbiage was too ambiguous and may have led to confusion.

REVIEWED/NO CHANGES:

Automatic Stop Orders MM8610-138
Look Alike Sound Alike MM8610-101
Ordering and Prescribing Medications MM8610-133

DEPARTMENTAL

REVIEW & REVISIONS:

Healing at Home Departmental Policies

Summary Sheet 2018 Healing at Home Administrative Policies is attached
Summary Sheet 2018 Healing at Home Clinical Policies is attached

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

Policy Submission Summary Sheet

Title of Document: **Healing at Home Clinical Policies**

New Document or Revision written by: **Barbara Lee, RN**

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

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

Chapter 1 Leadership

7290-100 Administrative Structure/Leadership Relationships – Reviewed; no changes
7290-120 Leadership Compliance – Reviewed; no changes
7290-130 Organizational Planning-Mission and Ethics – Reviewed; no changes
Attachment 1B- Mission & Vision Statements – Reviewed; no changes
7290-141 Organizational Planning and Management – Reviewed; no changes
7290-142 Organizational Planning-Organizational Chart – Reviewed; no changes
7290-143 Organizational Planning-Service Area – Reviewed; no changes
7290-144 Organizational Planning-Scope of Service – Reviewed; no changes
Addendum E- Services Provided Directly and By Arrangement – Reviewed; no changes
7290-145 Organizational Planning- Contracted Personnel – Reviewed; no changes
7290-150 Professional Advisory Group – Reviewed; no changes
7290-160 Organization Culture and System Performance – Reviewed; no changes
7290-170 Patient Safety Program – Reviewed; no changes

Chapter 2 Human Resources Management

Personnel Policies

7290-211 Personnel Policies – Reviewed with HR Director, deleted this policy, not necessary.
7290-212 Employee Grievance Procedure – Reviewed with HR Director, deleted this policy: redundant to SVH Policy HR8610-186.
7290-213 Receiving of Gifts/Gratuities – Reviewed with HR Director, deleted this policy: redundant to SVH Policy HR8610-143
7290-214 Flexing for Increase/Decrease in Census – Reviewed and updated to current practice and standards.
7290-215 Employee's Phone Numbers – Reviewed and updated to current practice and standards.
7290-216 Dress and Conduct Code – Reviewed; references added to SVH Policies: Dress Code and Code of Conduct

Job Descriptions

7290-220 Job Descriptions – Reviewed; updated with reference to Medicare CoP 484.115 and SVH Policy HR 8610-108

Employee

7290-231 Selection Process – Reviewed; updated with reference to Medicare CoP 484.115 and SVH Policy HR 8610-102
7290-232 Orientation – Reviewed; updated with reference to SVH Policy 8610-112
7290-233 Performance Evaluation – Reviewed; updated with annual joint supervisory visits and time frames.
7290-234 Employee Termination – Reviewed with HR Director, deleted this policy: redundant to SVH Policy HR8610-184: Termination of Service
7290-235 Personnel Files – Reviewed; updated and referenced to SVH Policy HR8610-198 Personnel Records

7290-236 Paid Time Off – Reviewed; updated with reference to SVH Policy PTO

Competency Program

7290-240 Competency – Reviewed, updated to 2018 Medicare CoPs, simplified language, removed redundancies, included HHA in-service requirements.

Supervision

7290-251 Supervision – Reviewed; revised to 2018 Medicare CoPs, simplified language, removed redundancies, and incorporated 7290-252

7290-252 Home Health Aide Supervision – incorporated into 7290-251, deleted this policy

Continuing Education

7290-261 Continuing Education/In-services/Training – Reviewed; streamlined language and removed redundancies.

Addendums/Exhibits

Addendum A Nursing Practice Act – Reviewed; no changes

Chapter 3 Records Management

7290-310 Contents of the Medical Record – Reviewed; added Face to Face and Discharge Summary and made minor word changes. Added section on Physician Orders in reference to signing.

7290-311 Standardized Formats – Reviewed; added reference to Medicare regulation regarding Clinical Records.

7290-312 Patient Billing Information – Reviewed; added references to regulations, OASIS submission and collaboration to obtain and track insurance authorizations.

7290-320 Entries into the Clinical Record – Reviewed; updated Mistaken Entries section to reflect computerized documentation, reorganized Medications section to include medication reconciliation and comprehensive medication profile.

7290-330 Agency Discharge/Transfer Documentation – Reviewed; renamed to Agency Discharge/Transfer, clarified time frame to business days.

7290-350 Facsimile (Fax) Entries/Transmissions – Reviewed; updated with reference to SVH Policy 8700-133

7290-361 Review of Clinical Records – Reviewed; minor wording changes.

7290-362 Quarterly Clinical Record Review– Reviewed; updated to QAPI and new Medicare Conditions of Participation regarding Organization and Administration of Services.

7290-370 Retention of Records – Reviewed; changed retention time frame in accordance with SVH Medical Records Policy. Deleted use of microfilming or miniaturizing records. Added reference to SVH Policy 8700-157 Records Retention.

7290-380 Protection of Records – Reviewed; updated with new references and added Retrieval of clinical records.

7290-390 Data Collection and Transmission – Reviewed; no changes

Addendum :

Addendum A: Patient Care Documentation-Definitions and Requirements- reviewed, minor word changes

Attachments

A. Unacceptable Abbreviations – Reviewed; no changes
B. In-House Presentation Folder – Reviewed; updated Privacy Notices and reorganized list.
C. Records Retention Policy, (SVH Policy 8700-157, revised 5/2015) – Reviewed
D. Facsimile Transmission of Patient Information (SVH Policy 8700-133, revised 5/2015) – Reviewed
E. Clinical Record Review Tool – Reviewed; updated to 2015 revision
F. Home Care Business Continuity Plan – Reviewed; no changes
G. Mobile Device User Agreement – Reviewed; updated #3, 6, and 10.

Chapter 4 Records Surveillance, Prevention and Control of Infection

7290-410 Exposure/Infection Control Program – Reviewed; updated to 2018 Medicare CoP 484.70, added references.

7290-411 Monitoring Staff Compliance – Reviewed; updated to 2018 Medicare CoP 484.70, added reference.

7290-412 Equipment Cleaning Protocol – Reviewed; no changes.

7290-420 Reporting and Tracking Exposure – Reviewed; updated to 2018 Medicare CoP 484.70, added references.

7290-430 Evaluation of Exposure/Infection Control Procedures – Reviewed; updated to 2018 Medicare CoP 484.70, added references

Chapter 5 Management of the Environment of Care

7290-510 In-Office Environmental Safety Program – Reviewed; updated references.
7290-520 Patient Environmental Safety Program – Reviewed; simplified language, removed redundancies.
7290-521 Fire and Long Term Oxygen Use in the Home – Reviewed; simplified language and removed redundancies.
7290-530 Reporting and Documenting an Incident – Reviewed; simplified language
7290-540 Management of Supplies and Equipment – Reviewed; no changes
7290-550 Emergency Management – Reviewed; updated to 2018 Medicare CoP 484.102
Prioritized Emergencies Identified Through Hazard Vulnerability Analysis – Updated to 2017 HVA

Chapter 6 Performance Improvement
7290-610 Quality Management Plan – Rewritten to QAPI to meet new Medicare Conditions of Participation.

Chapter 7 Rights, Responsibilities, and Ethics
7290-710 Patient Rights and Responsibilities – Reviewed; updated to Medicare CoPs effective 2018, added reference.
7290-720 Advance Directives – Reviewed; added #2 under "Patients who Lack Decision Making Capacity" to update to new Medicare CoPs.
7290-730 Communications – Reviewed; added #3 and 4 in Procedure to conform with new Medicare CoPs, added reference.
7290-740 Ethics – Reviewed; updated to Medicare CoPs effective 2018, added reference.
7290-750 Confidentiality – Reviewed; updated to Medicare CoPs effective 2018, added reference.
7290-760 Grievance Process – Reviewed; updated to Medicare CoPs effective 2018, added reference.
7290-770 Experimental Treatment – Reviewed; added #2 in Procedure
7290-780 Financial Responsibility – Reviewed; added second bullet point under Policy to update to 2018 Medicare CoPs, added reference.
7290-790 Pain Management – Reviewed; simplified language
7290-791 Informed Consent – Reviewed; no changes
Addendums
Addendum A- Patient Bill of Rights and Responsibilities – Reviewed; no changes
Addendum B- Patient Treatment Agreement Form #323 – Reviewed; no changes
Attachments
Mission Statement/after Hours/Complaints 7-A – Reviewed; no changes
Pain Scale Assessment Tool 7-B – Reviewed; no changes

Chapter 8 Patient Assessment
7290-810 Initial Assessment – Reviewed; updated to Medicare CoPs effective 2018, added reference.
7290-811 OASIS Assessments – Reviewed; updated language to conform to Medicare CoPs effective 2018.
7290-820 Significant Change in Condition – Reviewed; no changes
7290-821 Reassessment – Reviewed; updated language to conform to Medicare CoPs effective 2018.
7290-830 Functional Assessment – Reviewed; updated to Medicare CoPs effective 2018, added reference.
7290-840 Maternal/Infant Assessment – Reviewed; removed CMS reference, simplified language.
7290-850 Children and Adolescent Assessments – Reviewed; simplified language and removed redundancies.
7290-860 Nutritional Assessment – Removed this policy; not necessary, included in comprehensive assessment.
7290-870 Assessment and Reporting of Abuse – Reviewed; updated to Medicare CoPs effective 2018
Attachment
SVH Policy: PR8610-140 Abuse Reporting – Reviewed; no changes

Chapter 9 Continuum of Care
7290-910 Admission – Reviewed; updated to 2018 Medicare CoPs including patient rights and complaint process,
7290-920 General Transfer Referral – Reviewed; updated to 2018 Medicare CoPs 484.50, Patient Rights, added reference
7290-921 Transfer of Out of Service Area – Reviewed; added purpose and policy sections
7290-922 Withdrawing from a Case – Reviewed; updated to 2018 Medicare CoPs, 484.50, Patient Rights
7290-923 Discharge/Referral – Reviewed; no changes
7290-930 Coordination of Services – Reviewed; Changed Patient Care Coordinator to Clinical Manager; updated to 2018

Medicare CoPs, added reference.
7290-931 Case Management – Reviewed; updated to 2018 Medicare CoPs, added reference.
7290-932 Therapy Service Considerations-PT, ST, OT – Reviewed; added licensure requirements for PT, ST, OT; added reference; deleted Medicare Part B Outpatient.
7290-933 Special Services Considerations-MSW – Reviewed; updated to 2018 Medicare CoPs, added reference
7290-934 Communication- Coordination of Services – Reviewed; no changes
7290-935 60 Day Summary- Reviewed; Changed name from "Coordination of Services/Communication/Progress Summary" and simplified language-removed reference to Case Conference documentation.
7290-940 Coordination of Medical Supplies – Reviewed; minor wording changes.
7290-941 Coordination of Medical Supplies-DME – Reviewed; changed "discipline" to "clinician".
7290-942 Coordination of Medical Supplies-PPE – Reviewed; minor wording changes.
7290-950 After Hours Care of Patient – Reviewed; Changed Patient Care Coordinator to Clinical Manager
7290-951 After Hours Care of the IV Patient – Reviewed; Changed Patient Care Coordinator to Clinical Manager

Chapter 10 Care, Treatment, and Service
7290-1010 Physician-Verification of Physician Licensure – Reviewed; removed UPIN, specified California license, added PECOS
7290-1011 Physician Responsibilities – Reviewed; removed reference to Face to Face for Medicare only.
7290-1020 Treatment Consent – Reviewed; added reference
7290-1021 Patient Identifier – Reviewed; minor format changes
7290-1030 Plan of Care – Reviewed; updated to 2018 Medicare CoPs and reference added
7290-1031 Revision to the Plan of Care (485) – Reviewed; updated to 2018 Medicare CoPs and reference added
7290-1032 Recertification – DELETED THIS POLICY; REDUNDANT TO REASSESSMENT POLICY IN CHAPTER 8
7290-1040 Specific Patient Population: Nutritional Needs – Reviewed; minor formatting changes
7290-1050 Frequency of Review/Revision – DELETED THIS POLICY, REDUNDANT TO REASSESSMENT POLICY IN CHAPTER 8
7290-1060 Clinical Laboratory Services – Reviewed; minor changes in wording, removed references to specific places to chart quality controls.
7290-1061 Critical Results and Values – DELETED THIS POLICY, NOT REQUIRED
7290-1070 Medication and Infusion Therapy – Reviewed; minor wording changes
7290-1071 Drug Regimen Review – Reviewed; added reference to 2018 Medicare CoPs
7290-1080 Patient Education – Reviewed; simplified language

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

Policy Submission Summary Sheet

Title of Document: **Healing at Home Clinical Policies**

New Document or Revision written by: **Barbara Lee, RN**

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

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

PC7290-107 Indwelling Urinary Catheter Irrigation- Reviewed; no changes
IC7290-101 Bag Technique and Personal Protective Equipment- Reviewed, combined 2 policies (Bag and PPE and Clean Vs Dirty Section of Employee Vehicle
PR7290-121 Reporting of Abuse, Neglect, and Suspicious Injuries- Reviewed, validated against law and regulation, updated with current Key Definitions
IC7290-102 Equipment Cleaning Protocol-Field Staff- Reviewed; updated with changes to specific cleaning products in table.
IC7290-103 Equipment Cleaning Protocol-Office- Reviewed; updated by referring to cleaning product instructions for contact time.
IC7290-104 Infection Control Precautions to Prevent Transmission of MDROs in the Home- new policy created by updating former Guidelines
IC7290-105 Storage of Medical Supplies in the Home- Reviewed, no changes
PR7290-108 Do Not Resuscitate- Reviewed, updated to current law and forms, combined 3 old policies: "Do Not Resuscitate", "Full Code in the Event of an Arrest in the Home", and "Death of a Patient at Home".
IC7290-106 Infectious Waste and Sharps Disposal- Reviewed and updated to current regulation
MM7290-109 Drug Regimen Review- Reviewed and added to Clinical Policies from Administrative Policies
MM7290-110 Medication Administration- Reviewed, updated and added from Administrative Policies, Replaces old clinical policies: "Medication Administration, Oral Medication" "Anaphylactic Reaction to IM/SQ Medication", "Adverse Drug Reactions", and "Anticoagulant Therapy in the Home"
LB7290-111 Venipuncture- Reviewed, updated according to Lippincott and SVH P&P
LB7290-112 Occult Blood Testing of Feces- Reviewed, updated references
LB7290-113 Wound Culture – Reviewed, updated according to Lippincott
PC7290-114 Ankle-Brachial Index- Reviewed, updated according to Lippincott
PC7290-115 Wound Management and Wound Management Chart- New policy consolidating separate policies for wound dressing products
PC7290-116 Urinary Catheter Insertion and Removal: Female and Male- Reviewed, updated, and consolidated the following policies: Catheter Insertion – Indwelling, Male and Female; Catheter Removal; Suprapubic Catheter Care, Suprapubic Catheter: Removal and Replacement.
PC7290- 117 Clean Technique in Wound Care- Reviewed and updated.
CE7290-118 In-Office Environmental Safety Program-Reviewed and updated
CE7290-119 Patient Environmental Safety Program- Reviewed and updated
PC7290-120 Urinary Catheter Insertion and Removal: Female and Male: Reviewed, revised and updated to current best practice.
PC7290-122 Blood Draw from Central VAD- Revised and updated to current best practice
PC7290-123 Central Venous Tunneled Catheter Management (Hickman, Broviac, and Groshong catheters) Updated to current best practice and consolidated three old policies into one.

PC7290-124 Implanted Port Access and Management- Revised and updated to current best practice.
PC7290-125 Peripherally Inserted Central Catheter (PICC) Care and Management- Revised to current best practice. Consolidated old polices.
Vascular Access Device Adult Quick Access Guidelines- Revised hospital guidelines to current best practice in home health setting