SVHCD QUALITY COMMITTEE
AGENDA
WEDNESDAY, September 26, 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 08.22.18	*Hirsch*	Action
4. POLICIES & PROCEDURES	*Kobe*	Inform/Action
5. QUALITY COMMITTEE CHARTER	*Hirsch*	Inform/Action
6. CLOSED SESSION: a. Calif. Health & Safety Code § 32155 Medical Staff Credentialing & Peer Review Report	*Hirsch*	Inform
7. REPORT OF CLOSED SESSION	*Hirsch*	Inform/Action
8. ADJOURN	*Hirsch*	

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SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
August 22, 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 Kelsey Woodward	*Susan Idell* Michael Brown, MD	Danielle Jones Mark Kobe Chris Kutza

**Italisized names indicate voting member*

AGENDA ITEM	DISCUSSION	ACTION
1. CALL TO ORDER/ANNOUNCEMENTS	*Hirsch*	
	Meeting called to order at 459 pm Ms. Hirsch announced this will be Ms. Woodward's last meeting due to relocation.	
2. PUBLIC COMMENT	*Hirsch*	
3. CONSENT CALENDAR	*Hirsch*	Action
• QC Minutes, 07.25.18		**MOTION:** by Eisenstark to approve, 2nd by Mainardi. All in favor.
4. PAIN MANAGEMENT PROGRAM	*Yang*	Inform
	Dr. Yang and Dr. Hau gave an overview of their pain management practice. The care they provide is comprehensive and includes interventional pain modalities. This includes both chronic and acute pain conditions. Varying interventional modalities have supported a decrease in their opioid prescribing.	
5. 2018 PHARMACY ANNUAL REPORT	*Kutza*	Inform
	Mr. Kutza reviewed the 2018 annual report. One of the major changes from last year was that SVH is no longer part of the 340b program. He reviewed the quality metrics for 2017-2018.	

AGENDA ITEM	DISCUSSION	ACTION
	Past and future plans include: The use of Statit, CPOE order set optimizations, Pyxis stock optimization, antimicrobial stewardship, medication safety, and medication reconciliation.	
6. QUALITY COMMITTEE CHARTER	*Jones*	
	Ms. Jones reviewed the revisions to the charter. Request by the committee for the redline version to be brought back to the next meeting for review and approval.	
6. INFECTION PREVENTION Q2 DATA	*Jones*	Inform
	Ms. Jones gave the Infection Prevention Q2 data review. There is an opportunity in improvement in C. difficile infections.	
7. POLICIES AND PROCEDURES	*Jones*	Inform/Action
	Policies: Aminoglycoside Protocol MM8610-111 Controlled Substance Management MM8610-102 Dispensing of Medication MM8610-148 Automatic Stop Orders MM8610-138 Look Alike Sound Alike MM8610-101 Ordering and Prescribing Medications MM8610-133 Healing at Home Administrative and Clinical policies	**MOTION:** by Mainardi to approve 2nd by Eisenstark. All in favor
8. REPORT OF CLOSED SESSION	6:10-6:20 pm	Action
	Adverse Drug Event reviewed. Credentialing report was reviewed and approved.	**MOTION:** by Mainardi to approve, 2nd by Eisenstark. All in favor.
9. ADJOURN	*Hirsch*	
	Meeting adjourned at 6:33 pm	

Policy and Procedures – Summary of Changes
Board Quality Committee, September 26th, 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:

Ventilator Associated Pneumonia (VAP) and Nonventilator Pneumonia Prevention IC8610-179
This Organizational policy was developed to replace ICU Departmental Policy, Ventilator Associated Pneumonia (VAP) Prevention 6010-17

REVISIONS:

Hiring Process Recruitment and Selection HR8610-325
Removed a significant amount of language that was redundant in other policies and added more specific and relevant language associated with the current recruitment and selection process. Revised to reflect best practices and ensure compliance with applicable employment laws and strengthen our success rate in hiring qualified candidates. Added information about the newly developed Signing & Retention Bonus Agreement designed to attract and retain clinical new hires and new nursing graduates (with six months of work experience or less) in hard-to-fill nursing and clinical positions.

References HR8610-196
Removed language referring to how SVH conducts references for potential new hires and clarified language of how SVH responds to requests for reference checks and employment inquires. The process of how SVH conducts references for potential new hires is now covered under separate policy: Hiring Process: Recruitment and Selection #HR8610-325

RETIRED:

Requisition for Employee HR8610-101
Information included in revised Hiring Process: Recruitment & Selection, #HR8610-325

DEPARTMENTAL

NEW:

Scribes in the Emergency Department 7010-21
This is a policy for Medical Staff. The ED MDs will be using Scribes for documentation and this policy outlines the Scribes scope of practice.

Scheduling Per Diem Policy 8560-01
To provide a scheduling guideline to any per diem status employee.

REVIEWED/NO CHANGES:
Medical Imaging Departmental Policies - Table of Contents Attached

RETIRED:
Ventilator Associated Pneumonia (VAP) Prevention 6010-17
Replaced ICU department policy with organizational policy: Ventilator Associated Pneumonia (VAP) and Nonventilator Pneumonia Prevention IC8610-179

SUBJECT: Ventilator Associated Pneumonia (VAP) and Nonventilator Hospital-Acquired Pneumonia Prevention	POLICY #IC8610-179 PAGE 1 OF 2
DEPARTMENT: Organizational	EFFECTIVE:
REVIEW/REVISED:	

POLICY:

Healthcare providers will implement measures for the prevention of ventilator associated events (VAE) and pneumonia (VAP) and nonventilator hospital-acquired pneumonia (NV-HAP).

Background
Ventilator-associated pneumonia (VAP) is a nosocomial lung infection that occurs in patients receiving mechanical ventilation. NHSN reports that the incidence of VAP is from 0.0-4.4 per 1000 ventilator days. VAP and ventilator associated events (VAE) are identified according to the Centers for Disease Control (CDC) definitions by using a combination of radiologic, clinical, and laboratory criteria. VAP/VAE are suspected when a patient receiving mechanical ventilation develops a new or progressive pulmonary infiltrate with fever, leukocytosis, and purulent tracheobronchial secretions. VAP is considered as ventilator associated if the patient was intubated and ventilated at the time or within 48 hours before the onset of infection. Although a serious infection, VAP represents only 38% of total hospital-acquired pneumonia cases. Although it carries the same mortality as VAP (recent meta-analysis reports rates at 4.4-13%), the incidence of NV-HAP is higher, and therefore associated costs and deaths are higher. NV-HAP patients are at greater risk for readmission within 30 days than patients without HAIs.

PROCEDURE:

- **Clean hands** with soap and water or an alcohol-based hand rub before and after touching the patient or the ventilator.
- **Assess the patient's risk for aspiration.** Utilize Speech Therapy consultation as indicated.
- **Implement oral care for ALL patients in accordance with the Oral Care procedure**
- **Collaborate** to identify patients where implementation of noninvasive positive pressure ventilation may be appropriate to prevent the need for intubation
- **Keep the head of the patient's bed raised** between 30 and 45 degrees unless clinically contraindicated in ventilated and nonventilated patients at high risk for aspiration
- **Assess readiness to extubate ventilated patients daily** through combined spontaneous awakening trials (SATs: sedation interruption/minimization) and spontaneous breathing trials (SBTs), unless clinically contraindicated.

SUBJECT: Ventilator Associated Pneumonia (VAP) and Nonventilator Hospital-Acquired Pneumonia Prevention	POLICY #IC8610-179 PAGE 2 OF 2
DEPARTMENT: Organizational	EFFECTIVE:
REVIEW/REVISED:	

- **Minimize pooling of secretions above the endotracheal tube cuff** by using an endotracheal tube with subglottic suction capability in patients with anticipated intubation greater than 48-72 hours.
- **Maintain and improve physical conditioning** through early exercise and mobility.
- **Change ventilator circuits only if visibly soiled.**
- **Promote lung expansion (pulmonary toilet)** for non-ventilated patients

REFERENCES:

CDC. Guidelines for the Management of Adults with Hospital-acquired, Ventilator-associated, and Healthcare-associated Pneumonia, 2005.
Lippincott: http://procedures.lww.com/lnp/procedureselect.do
AACN: http://www.aacn.org/wd/practice/docs/130300-standards_for_acute_and_critical_care_nursing.pdf
AACN Practice Alert, Critical Care Nurse, Vol 37, No. 3, June 2017

OWNER:
Chief Nursing Officer

AUTHORS/REVIEWERS:
Kathy Mathews, Infection Preventionist

APPROVALS:
Policy & Procedure Team: 6/19/18
Performance Improvement Committee: 8/23/18
Medical Executive Committee: 9/20/18
Board Quality Committee:
The Board of Directors:

SUBJECT: Scribes in the Emergency Department	POLICY: 7010-21
	PAGE 1 OF 4
DEPARTMENT: Medical Staff	EFFECTIVE:
REVIEWED:	

PURPOSE:

This Policy is to establish the requirements and scope of duties for the use of Scribes by physicians in the Emergency Department at Sonoma Valley Hospital.

POLICY:

Scribes work under the direction of the Provider to record information into the medical record with the goal of allowing the provider to spend more time with the patient and improve accuracy and detail of documentation. The scribe never performs clinical or medical tasks.

PROCEDURE:

I. **Qualifications of a Scribe**:

a. Minimum of a high school diploma or equivalency.

b. The scribe must be employed, in good standing, with ScribeConnect who contracts with Valley Emergency Physicians Healthcare (VEP).

c. Successful completion of an approved scribe training course specific to Emergency Medicine.

II. **Scribe Training, Requirements and Employment**:

a. Scribes will be oriented to information necessary for compliance with all Policies of Sonoma Valley Hospital (including Human Resources, Information Services, and Rights and Responsibilities).

b. Scribes will complete a comprehensive orientation and training course through ScribeConnect - specific to Emergency Medicine - that includes didactic classroom training, Electronic Medical Record (EMR) training and bedside training.

c. Scribes must pass a comprehensive competency exam prior to working independently with the Provider.

d. As Employees of ScribeConnect, all scribes are paid by ScribeConnect, are

covered under ScribeConnect's Worker's Compensation Policy and receive benefits based on their employment status. Scribes are required to take a meal period and rest breaks per California law.

e. All Scribes must sign a job description that recognizes the Scribe's unlicensed status and clearly defines the qualifications and extent of their responsibilities.

f. Scribes must meet all information management, HIPAA, HITECH, confidentiality and patient rights standards, as do other hospital personnel.

III. **Scope of Service:**

a. Scribes assists the physician or provider with chart documentation by entering data into the electronic medical record information system as the licensed provider collects it during the ED encounter.

b. Scribes may document ONLY at the direction of the provider any dictations of medical decision-making, treatment plan and/or activities (i.e. family meetings, patient counseling, re-evaluations, etc.)

c. A Scribe must document ONLY under his or her own log-in credentials and password. Sharing of credentials and password information is not permitted.

d. Notifies physician or provider of pending or completed lab, x-ray, EKG results, nursing orders and any other recommendations noted in the patient's medical record.

e. Scribes perform no clinical duties, do not provide direct patient care, and do not discuss care or results with patient or family at any time.

f. Scribes may assist the provider as he or she rounds on their patients and may update patients and family members with the status of pending tests at the direction of the provider. Scribes may not discuss results, values or independently (out of the presence of the provider) elicit/obtain information from patients or family.

g. Scribes do not transcribe, enter orders, or write prescriptions.

h. Verbal orders cannot be given to nor entered by Scribes.

i. The physician or provider is responsible for introducing the Scribe to the patient

and obtaining consent for the presence of a Scribe.

j. The physician or provider is responsible for the accuracy of the documentation by the Scribe performing this duty.

k. Scribe must sign, including their name and title, date and time of all entries into the medical record-electronic or manual. The role and signature of the Scribe must be clearly identifiable and distinguishable from that of the Physician or Provider or of other staff.
Example: "Scribed for Dr. X by name of the scribe and title" with the date and time of the entry.

IV. **Provider Responsibilities:**

a. The physician or provider must complete a scribe attestation for every medical record in which the Scribe made an entry on behalf of the physician or provider.

b. The physician or provider must sign and date the attestation through the clinical information system.

c. The attestation must take place before the physician or provider and scribe leave the patient care area since other providers may be using the documentation to inform their decisions regarding care, treatment and services.

d. The attestation, physician signature and date cannot be delegated to another physician or provider or the scribe.

V. Scribe Supervision & Reappraisal:

a. The “Site Manager” (SM) will oversee the scribe program in the Emergency Department at Sonoma Valley Hospital. The SM is an employee of ScribeConnect and will collaborate with Sonoma Valley Hospital and VEP staff to ensure compliance with all facility requirements, scribe performance and any other scribe-related topics.

b. The Physician/Provider who is utilizing a Scribe is responsible to ensure that the Scribe is not acting outside of his/her job description, that authentication is occurring as required and that no orders are being entered into the medical record by Scribes. The Provider is responsible for the accuracy of the documentation by the Scribe performing this duty.

c. ScribeConnect will verify the competency of the Scribe in writing to the designated department at Sonoma Valley Hospital within 90 days of hire, and then at least every two (2) years.

REFERENCES:
CIHQ 482.12 GL-6 Directing Medical Care of the Patient

OWNER:
Chief Executive Officer

AUTHORS/REVIEWERS:
Mark Kobe, Chief Nursing Officer

APPROVALS:
Policy & Procedure Team: 6/19/18
Medicine Committee: 9/13/18
Medical Executive Committee: 9/20/18
Board Quality Committee:
The Board of Directors:

SUBJECT: Scheduling Policy for Per Diem Status Employees	POLICY # 8560-01
	PAGE 1 OF 2
DEPARTMENT: Admitting	EFFECTIVE:
REVISED:	

PURPOSE:

To clarify the structure and requirements of Per Diem staff according to the needs of the Admitting department.

POLICY:

Employees hired on as Per Diem status are done so with the understanding that they are scheduled according to the needs of the department in either Admitting, Concierge, PBX or Emergency Department Registration. Likewise they are hired with the knowledge that we are a 24 hour operation and shifts vary from AM, PM, nights (NOC), weekdays, weekends and holidays.

Employees hired as Per Diem are required to give one month of availability submitted to the Admitting Manager no later than the Thursday before the last week of the schedule. Schedules are made for one month at a time. Availability may only consist of either unavailable days, or specify availability on days just for the AM (5:30 AM – 5:30 PM), PM (1:00 PM – 10:30 PM), or NOC (10pm – 630am) timeframes. Availability may not specify specific shifts.
Per Diem employees are required to be available at least 2 weekends out of each schedule period and at least 2-3 shifts each week of a 4-week schedule. They must make themselves available for at least 4 of the 11 holidays (8 of which are recognized SVH holidays plus Easter, Christmas Eve and New Year's Eve).

Per Diem employees must notify the Admitting Manager in advance of required prolonged periods of unavailability. Total unavailability may not exceed eight (8) weeks in a calendar year (56 days).

PROCEDURE:

It is the responsibility of the Per Diem employee to give the Admitting Manager one month of availability either by email or written calendar. This is due no later than the Thursday before the last week of the current schedule.

The Admitting Manager will provide a yearlong calendar in the Admitting Department where each employee (benefitted and per diem) will write down dates that are being requested off. Requests for time off will not be approved for any day or week where there are already two people scheduled off. Per Diem employees are asked to consider this posted calendar when providing their availability and make every effort to be available to help cover the absences. In the event of extenuating circumstances, every effort will be made to accommodate such request if the needs of the department can still be met, at the discretion of the manager.

SUBJECT: Scheduling Policy for Per Diem Status Employees	POLICY # 8560-01
	PAGE 2 OF 2
DEPARTMENT: Admitting	EFFECTIVE:
REVISED:	

REFERENCES:
Organizational Policy – Classification of Employees, Per Diem section with guidance from example of Nursing per diem requirements.

OWNER:
Lisa Duarte, Admitting Manager

AUTHORS/REVIEWERS:
Lisa Duarte, Admitting Manager
Lynn McKissock, Director of Human Resources
Cynthia Denton, Director of Admitting and Patient Financial Services

APPROVALS:
Policy & Procedure Team: 9/18/18
Board Quality Committee:
The Board of Directors:

Medical Imaging Department Policies and Procedures
Table of Contents

7630-173 MRI Screening Procedure
7630-169 MRI Code Blue Procedure
7630-157 Intravenous Administration of Radiopharmaceuticals Policy
7630-155 Infection Control during Imaging Procedures Procedure
7630-199 Physician Orders - Verbal and Written Policy
7630-137 ED and Radiologist Discrepancy

4. Safety

7630-102 MRI, Patient Preparation
7630-135 Departmental Safety Measures
7630-197 Personal Protective Equipment Technologist Safety Procedure
7630-195 Patient Transport Procedure
7630-145 Fire Safety - Imaging Department Procedure
7630-147 Fire Safety - MRI
7630-171 MRI Safety
7630-229 Routine Department Disinfection Procedure

5. Radiation Safety

ALARA (As Low As Reasonably Achievable)
7630-216 Radiation Protection for Patients Policy
7630-217 Radiation Safety Post Injection of Radioisotopes
7630-210 Portable Fluoroscopy Usage Policy and Procedure
7630-211 Radiation and Decontamination Procedure
7630-179 Nuclear Medicine Emergency Procedure
Radiation Contamination Telephone List
7630-213 Radiation Physicist Policy
7630-139 Dosimetry Procedure
7630-151 General Rules for the Safe Use of Radioactive Material
7630-153 Hot Lab Requirements Procedure
7630-167 Misadministration of Radioisotopes Procedure
7630-177 Nuclear Medicine Department Security Procedure
7630-185 Nuclear Medicine Safety Measures
7630-235 Sign Posting Requirements Procedure
7630-219 Radiation Safety- Staff
7630-215 Radiation Safety Instructions
7630-205 Pregnant Worker in a Radiation Environment
Procedure Declaration of Pregnancy
Undeclaration of Pregnancy
7630-175 Non Radiologist and Fluoroscopic Procedures Procedure

6. Procedures/Preps

7630-149 Gastrograffin Oral Prep for Adult ED Patients Prior to CT Scans of the Abdomen and/or Pelvis
7630-232 Scheduling Procedures
7630-231 Scheduling Biopsies Procedure
7630-183 Nuclear Medicine Procedures

7630-187 Nuclear Medicine Studies
7630-239 Virtual Radiology Services Procedure (Nighthawk)
7630-131 CT Oral Preparation ProcedureInpatient Abdomen and/or Pelvis CT Preps
Prep Instructions for an Abdominal-Pelvic (or Pelvic Only) CT Scan Examination Form
Abdominal-Pelvic CT Exam Appointment Form with Prep Kit Warnings
7630-221 Radiography in the Surgical Suite
7630-236 Trophon Environmental Probe Reprocessor (EPR) Quality Control

7. Quality Control Procedure

7630-161 Mammographic Compliance
7630-209 Routine QC Procedures in Nuclear Medicine
7630-133 CT Scanner Quality Control Procedure
Quality Control Indicators for Radiology, Mammography, Nuclear Medicine, Ultrasound, CT Scan
7630-181 Nuclear Medicine Equipment Calibrations

8. Personnel

7630-141 Duties of Medical Director of Imaging Department
7630-223 Radiologist Availability Procedure
7630-189 Paid Time Off (PTO) Procedure
7630-237 Venipuncture by Technologists
7360-238 Certification of Technologists Procedure
7630-109 Medical Imaging Operational Hours and Support Services

APPROVALS:
Policy & Procedure Team: 7/17/18
Surgery Committee: 9/13/18
Medical Executive Committee: 9/20/18
Board Quality Committee:
The Board of Directors:

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 Audit Committee~~, the Medical Staff, and the CEO of SVH. (ok with me)

RESPONSIBILITY

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 ~~CEO resulting 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. (ok with me)

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.

(Danielle, good to include with the individual dept reports, but seem that in the Hospital's plan, which this refers to, that it would be good to continue to include as an important element for improving quality and safety….)

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Commented [DJ1]: We have not provided professional education updates to the BQ. This is a component of the individual department specific reports. This has now been added to the annual department report template given to leaders.

~~Medical Staff Bylaws~~

1. ~~The QC shall assure that the Medical Staff's Bylaws are reviewed and approved by the Board and are consistent with the District and Hospital Mission, Vision and Values, Board policy, and accreditation standard, prevailing standards of care, and evidence-based practices.~~

2. ~~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~~. (I agree with #1, but wonder if #2 should stay. If, for example, during a survey, a problem was identified around a medical staff issue….or if an HCAHPS question around physician communication arose…wouldn't BQC be responsible for overseeing that?)

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. (I agree it's covered in the dept annual reviews, but seems that the BQC should include in a report to the Board…so I'd leave in)

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 ~~Audit Committee~~ Finance Committee shall refer the audit to the QC for its review and recommendations to the Board. (ok)

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

Commented [DJ2]: Rules and Regulations go to the Board Governance Committee not BQC. They are reviewed every three years and any changes go to Board Governance. Medical Staff is an independent organization from the hospital. They have the responsibility of oversight of the quality of patient care and outcomes and any projects they do can go through BQC, hence the departmental reports and credentialing go there.
Board oversight of medical staff governance and structure is under the purview of the Governance Committee in the same way that the Boards By-laws and policies are reviewed in Governance committee.

Commented [DJ3]: I believe this is coverd with the medical director report for the required department annual reviews.

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; ~~Press Ganey~~ Patient Satisfaction Survey Vendor~~surveys~~; reports and comparisons to other hospitals, state and national standards; and patient and/or family compliments and complaints. (good)

6. The QC shall review and assess the system for resolving interpersonal conflicts among individuals working within the Hospital environment that could adversely affect quality of care, patient safety or patient satisfaction, and make recommendations to the Board. If there are adverse Add HR to annual review list. (How about "The QC, in collaboration with and after consultation with the Director of HR, reviews situations and systems that could adversely affect quality of care…..and yes, let's ask Lynn to do a quality/safety focused annual report to QC)

Commented [DJ4]: Add annual HR report to BC calendar? Lynn

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 ~~CEO's~~Hospital's work plan to support the QC. (ok)

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 April,~~ in advance of the annual budget process and provide an assessment to the Board and CEO with recommendations for action. (are you suggesting leaving this as is, with the addition of an HR annual plan…..or deleting it? Can't tell….I do recall that in years past when Leslie has done a report, she included a specific statement that the current quality/safety resources are adequate, so that it's in the minutes. I think this might be something CIHQ looks for?)

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, (agree)

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.

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

- Three 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

Commented [DJ5]: Add HR to required department annual plan

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Commented [DJ6]: These 5 are the only required reports to be presented to QC. I recommend that we add lab, periop, ED, ICU, Med/Surg and HR. There have been inconsistencies in annual department report requirements.

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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.

Reference:

~~**POLICY HISTORY**~~

~~December 1, 2011~~

~~Board Policy~~

~~regarding the QC~~

~~was first adopted.~~

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.

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