SVHCD QUALITY COMMITTEE
AGENDA
WEDNESDAY, December 19, 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 11.28.18	*Hirsch*	Action
4. 2018 QUALITY COMMITTEE WORK PLAN REVIEW	*Jones*	Inform
5. ORTHOPEDIC SERVICES PRESENTATION	*Dr. Brown*	Inform
6. POLICIES AND PROCEDURES	*Jones*	Inform/Action
7. CLOSED SESSION: a. Calif. Health & Safety Code § 32155 Medical Staff Credentialing & Peer Review Report	*Hirsch*	Inform
8. REPORT OF CLOSED SESSION	*Hirsch*	Inform/Action
9. ADJOURN	*Hirsch*	

SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
November 28,2018 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 Michael Brown, MD Ingrid Sheets Dr. Brown	*Susan Idell*	Danielle Jones, RN Mark Kobe, RN Leslie Lovejoy, DPRN

**Italisized names indicate voting member*

AGENDA ITEM	DISCUSSION	ACTION
1. CALL TO ORDER/ANNOUNCEMENTS	*Hirsch*	
	Meeting called to order at 5:03 pm	
2. PUBLIC COMMENT	*Hirsch*	
3. CONSENT CALENDAR	*Hirsch*	Action
• QC Minutes, 10.24.18		**MOTION:** by Mainardi to approve, 2nd by Eisenstark. All in favor.
4. PRIME GRANT UPDATE	*Lovejoy*	Inform
	Ms. Lovejoy reviewed the five indicators of the Prime grant. All of the benchmarks were met, but the achievement goal was not met for the Care Transition metric.	
5. INFECTION PREVENTION REPORT	*Jones*	Inform
	Ms. Jones reviewed the infection prevention report for the third quarter in Ms. Matthews absence. She reported there were no c. diff cases in the third quarter. She also spoke about four deep organ space infections, and two GI case infections.	
6. GOOD CATCH REPORT	Jones	
	Ms. Jones reviewed the good catch report.	

AGENDA ITEM	DISCUSSION	ACTION
7. BOARD QUALITY CHARTER	*Hirsch/Jones*	Inform/Action
	Ms. Hirsch recommended an edit be made to the amount of voting members to reflect that every member of the committee be a voting member (8). With the committee Chair person being the tie breaking vote. The committee discussed further changes and clarifications.	**MOTION:** by Mainardi to approve changes. 2nd by Eisenstark. All in favor
8. POLICIES AND PROCEDURES	*Jones*	
	New Surge Policy to Manage Patient Infllux EP8610-102 CMS 1135 Waiver for Disaster Conditions EP8610-103 Delegation of Authority EP8610-104 (edit page numbers) **Revisions** DVT-PE Prophylaxis and Treatment Protocol MM8610-152 Medication Reconcilliation MM8610-144	**MOTION:** by Eisenstark to approve, 2nd Mainardi by . All in favor.
9. CLOSED SESSION	*Hirsch*	
	Called to order at 6:10 pm	
10. REPORT OF CLOSED SESSION	*Hirsch*	
	Medical Staff credentialing was reviewed as well as the plan of correction from the Pharmacy and SNF surveys.	**MOTION:** by Eisenstark to approve credentialing, 2nd by Mainardi. All in favor.
11. ADJOURN	*Hirsch*	
	6:25pm	

2018 Quality Committee Work Plan

January 1/24	February 2/28	March 3/28	April 4/25
▪ Review and Approval of 2018 Work Plan ▪ IT Departmental Report Fe Sendaydiego	• Annual Infection Control Report* Kathy Mathews	▪ CEO Strategic Plan & Financial Stability ▪ PI Clinical Project Review	▪ Patient Care Services Report Medical-Surgical Department Report Mark Kobe& Lisa Miklos ▪ Foundation Report Dave Pier
May 5/23	**June 6/27**	**July 7/25**	**August 8/22**
▪ Annual review of QA/PI Program* ▪ OB/Women's Place Sally Staples & Dr. Amara	▪ Perioperative Services Report Janine Clark & Dr. Sawyer ▪ Annual Risk Management Report*	▪ Pain Team Dr. Lee ▪ 2018 Contract Evaluation Report*	• Medication Safety Report & Department Report* Chris Kutza ▪ PI Support Services Project Review
September 9/26	**October 10/24**	**November 11/28**	**December 12/19**
▪ Orthopedic Services Report Dr. Brown ▪ PI Clinical Project Review *(to Oct per DJ)*	▪ Patient Safety/Quality education session ▪ Skilled Nursing Report* Melissa Evans ▪ PI Clinical Project Review	• Annual Culture of Safety AHRQ Report	▪ Evaluation of the Quality Committee Work Plan ▪ PI Support Services Project Review

*Required

Orthopedic Services Annual Report 2018
Quality Committee

ADULT RECONSTRUCTION

- TOTAL JOINT PRESENTATION
- CMS
- JOINT PROGRAM
- CURRENT TRENDS

CMS

- 1/1/2018---CMS REMOVED TOTAL KNEE REPLACEMENT FROM INPATIENT ONLY STATUS
- RESULTS IN DECREASED REIMBURSEMENT
- CMS DETERMINED 18% DECREASE
- OUTPATIENT DETERMINED AS “TWO MIDNIGHT STAY”
- LONGER STAYS REQUIRE DOCUMENTATION

CMS

- RESULTS---
- SHIFT AWAY FROM SNF
- TSR AND THR SOON TO FOLLOW
- ASC APPROVAL EXPECTED IN THE FUTURE

TOTAL JOINT PROGRAM

MERCY HOSPITAL---PRE-OP CLASSES, “COACH”

PEACE HEALTH—HOME PREPARATION

HSS—TELEHEALTH

SALEM –TRACK ONE PROGRAM

NASSAU COMMUNITY—IMAGE GUIDED TECHNOLOGY

SONOMA VALLEY HOSPITAL

- NURSE NAVIGATOR
- PRE-OP PHYSICAL THERAPY
- PRE-OP MEDICAL EVALUATION
- “VIDSCRIPTS”
- IMPROVED TECHNOLOGY

PRO-ROLLER

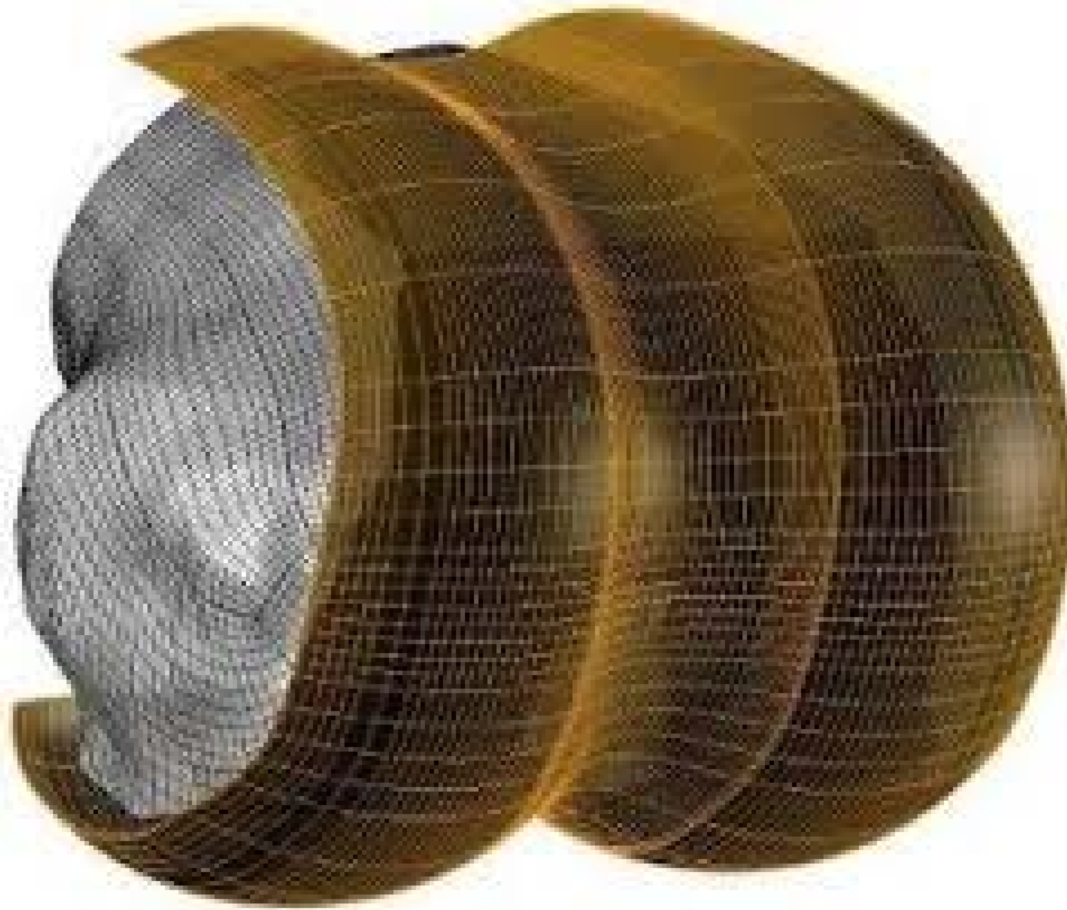
VIDSCRIPTS

PRE –OP EVALUATION

CONFORMIS

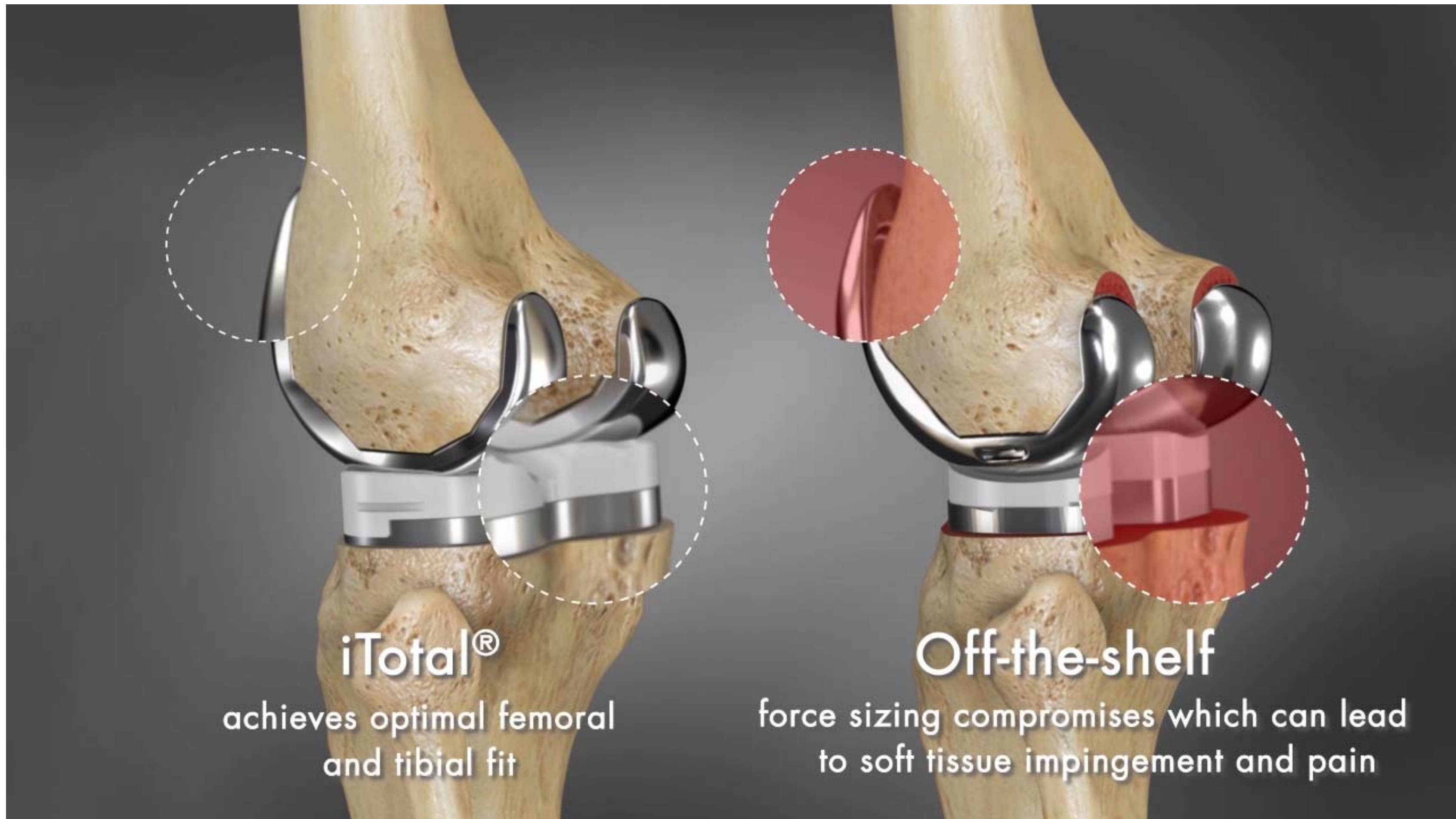
FORM · FIT · FUNCTION

3-D TECHNOLOGY



PERSONALIZED CUTTING GUIDES

CONFORMIS



ANTERIOR TOTAL HIP REPLACEMENT

- ORIGINATED IN 1970’S
- RE-INTRODUCED IN 2004
- HANA TABLE
- IMPLANT TECHNOLOGY
- DECREASED PAIN, EARLIER FUNCTION. DECREASED DISLOCATION RATE

ANTERIOR HIP

VOLUMES

- 1-1-2018 to 12-10-2018, EXCLUDING FRACTURES
- TOTAL HIP---------18
- ANTERIOR------11
- REVISION TOTAL HIP---3
- TOTAL KNEE-----52
- REVISION KNEE----8
- TOTAL SHOULDER---12
- REVISION SHOULDER---2

CURRENT TRENDS—WHAT IS ON THE MENU

- NATURALS
- ANTIINFLAMMATORIES
- CORTISONE INJECTIONS
- HYALURONIC ACID INJECTIONS
- PRP
- MESENCHYMAL CELL INJECTIONS

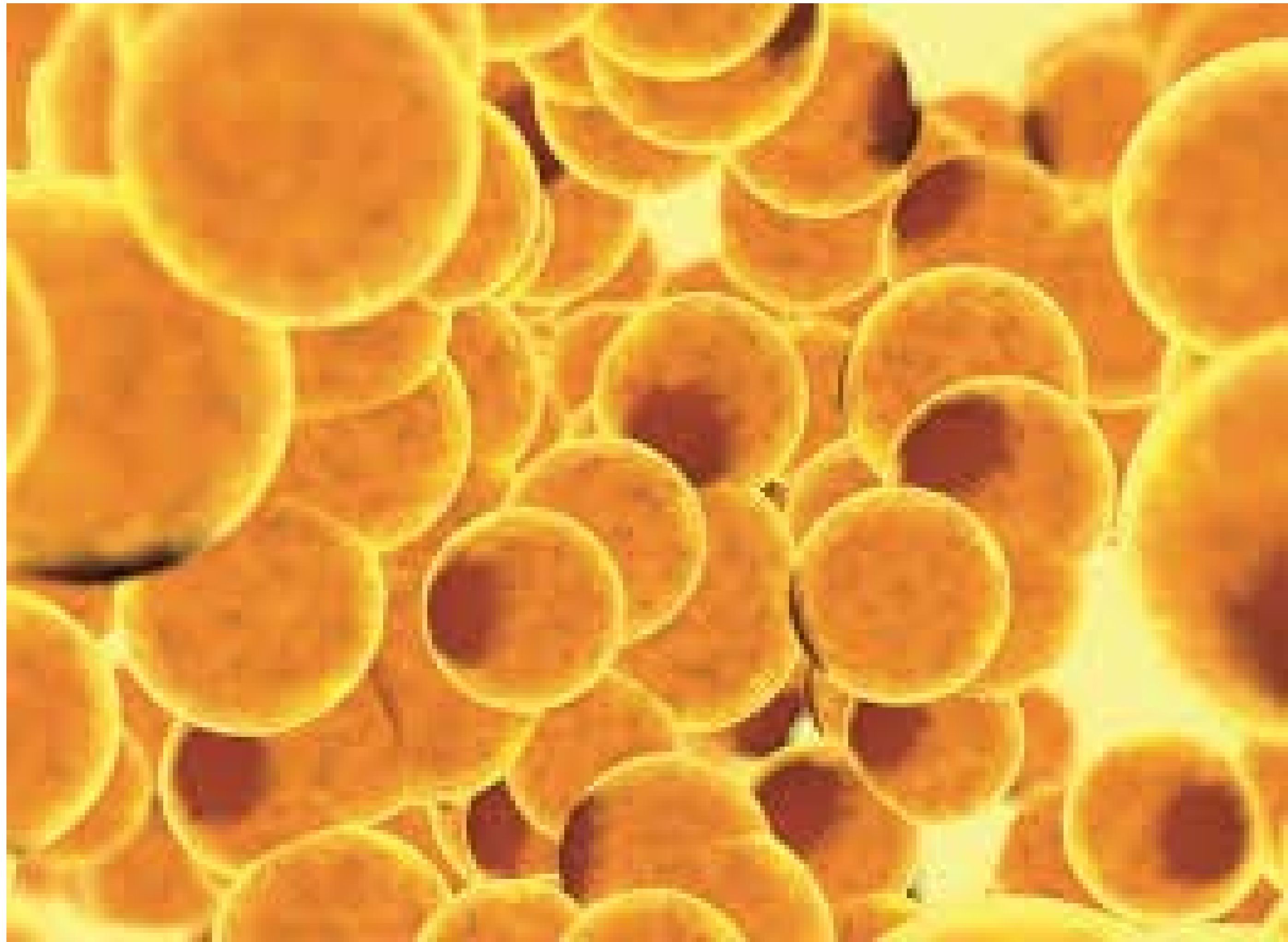
NATURALS

- TUMERIC—FROM THE GINGER FAMILY
- CURCUMIN—THE MAIN ACTIVE INGREDIENT IN TUMERIC.
- GLUCOSAMINE/CHONDROITIN SULFATE

HA INJECTIONS

PRP

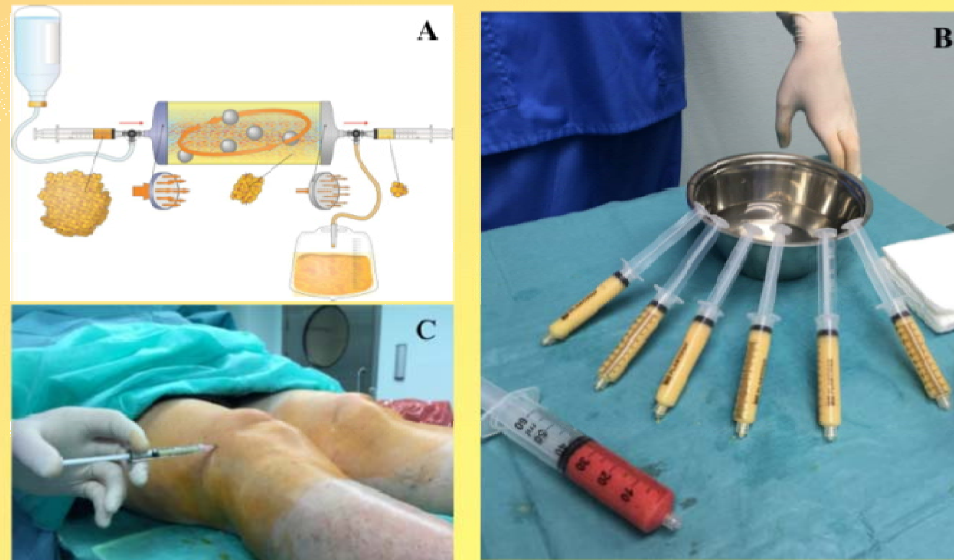
LIPOGEMS



Material and Methods

LIPOGEMS® SYSTEM

Lipogems® is a single-use medical device for the processing of lipoaspirated adipose tissue. The unit consists of a transparent plastic cylinder with filters and beads for the micro-fragmentation of adipose tissue; tubes that guarantee the constant flow of saline solution and the elimination of waste products are connected to the cylinder. Lipogems® progressively reduces the size of adipose tissue clusters, washing pro-inflammatory oil and blood debris through an "enzyme free" minimal manipulation in an aseptic closed system. The entire process, carried out in one surgical step, is performed in immersion in a saline solution, which minimizes any trauma to the cellular products.



A) Lipogems® system; **B)** Unprocessed (60 mL syringe) and Lipogems® microfragmented fat (10 mL syringe); **C)** Lipogems® (10 mL) injection through lateral suprapatellar approach.

STUDY DESIGN

The study included 60 patients aged from 18 to 83 with osteoarthritis in the knee. In all the patients, the presence of osteoarthritis symptoms was confirmed by clinical examination, X-ray and MRI. Patients underwent a three-step procedure of lipoaspiration, Lipogems® fat micro-fragmentation and 10 mL re-injection into the knee through lateral suprapatellar approach. All fat aspirations were performed by orthopedic surgeon and orthopedic resident without any technical problems and learning curve for this procedure was very short. Results were assessed using KOOS questionnaire before the procedure (time zero), at 1 , 3, 6, 9 and 12 months follow-up. X-rays and MRI were also collected. Student's t test was used to determine statistical significance: results are expressed as the mean ± SEM. $P \leq 0.05$ was considered statistically significant as indicated in the figures.

2019 Goals

- COMMUNITY PRESENTATIONS ----FOCUS ON NEW TECHNOLOGY
- MARKETING---WITH HELP FROM PRIMA AND VENDORS
- PATIENT TESTAMONIAL

Policy and Procedures – Summary of Changes
Board Quality Committee, December 19th, 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:

Surge Policy to Manage Patient Influx EP8610-102
The former surge policy was imbedded in the Emergency Operations Plan and new CMS regulation requires it to be a separate policy.

CMS 1135 Waiver for Disaster Conditions EP8610-103
Delegation of Authority EP8610-104
These policies are required to be in compliance with CIHQ Disaster Management regulations

REVISIONS:

Alcoholic Beverages Policy PC8610-101
Raised the limit on the number of servings of alcohol given to select patients to three servings at both lunch and dinner. This limit was raised to help prevent patients who admit to regular consumption from experiencing withdrawal symptoms. An MD order will precede the serving of alcohol (wine/beer) to patients.

DEPARTMENTAL

NEW:

Skilled Nursing Facility
Alcoholic Beverages in SNF 6580-105
To distinguish between the guidelines for consuming alcohol on the acute care units of the hospital and the Skilled Nursing Facility.

Emergency Department
Resources Available for Managing the Labor and Delivery Patient in the ED 7010-22
To help guide Emergency Department Physicians and Nurses in early management of the presentation of a laboring mom. With the closure of our Obstetrics Department, ED personnel no longer have the ability to draw upon Labor and Delivery nurses for backup. The first order of business should be immediate consideration for transfer as any delay will only prolong the transfer if appropriate.

REVISIONS:

Nutrition

<u>Thawing of Food 8340-104</u>

Changed title to include all foods, not just meats. Added a purpose as it was not previously included. Added procedure for food thawing storage order as it did not previously specify this. Added process for labeling and when foods expire after thawing per CMS findings. Added references.

<u>Food & Nutrition Disaster Plan 8340-109</u>

Updates made to the policy outline what food will be kept on hand, how therapeutic diets will be followed, and in what order food will be mobilized during an emergency. A reference was added for meal planning guidelines in order to ensure that patient's nutritional needs are met during a natural disaster. How food will be stored and monitored for expiration dates per CMS survey findings was added.

SUBJECT: Surge Policy to Manage Patient Influx	POLICY #EP8610-102
DEPARTMENT: Organizational	EFFECTIVE:
REVISED:	

PURPOSE:

To provide guidelines and identify a process to manage a disaster involving an influx of patients that cannot be managed effectively with routine procedures or resources within the hospital environment.

POLICY:

Sonoma Valley Hospital will provide a guide for prompt mobilization and coordination of personnel and facilities in time of disaster involving an influx of patients that cannot be managed effectively with routine procedures or resources within the hospital. Hospital systems are assumed to be overwhelmed and efforts to coordinate with community agencies will be enacted (EMS, SVFA, MOHAC, local police).

PROCEDURE:

1. Plan initiation:

   Notification- Call received by hospital of anticipated influx of patients via EMS radio and/or notification from Sonoma County Department of Public Health Medical Health Operational Area Coordinator (MHOAC). ED MD on duty will assess anticipated number of patients and severity of illness/injury and determine departments' ability to function or determine if volume is beyond departments' normal capacity to safely care for patients.

2. Activation:

   Disaster Code will be initiated and Incident Command Center established.

3. Stages of Surge :

   a. Stage One: can be handled by ED and appropriate ancillary departments. If majority of patients are urgent or emergent, may elevate to stage two.
   b. Stage Two: additional staffing is anticipated to handle the influx of patients. Department call lists are activated
   c. Stage Three: Influx of patients is greater than expected and overwhelming available resources can safely handle.

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4. Alternate Care Sites:

   A. Initiate plan to erect auxiliary tent structure in suitable location (Old ED parking lot, Main entrance parking lot).
   B. Contact Hospitalist and SNFist to discharge or transfer any appropriate patients.
   C. Contact Redcomm and update hospital status and need for potential transportation
   D. Begin contact with facilities SVH has transfer agreements (St. Joes Transfer Center, Sutter transfer Center).
   E. See Emergency Operations Plan for listing of Alternate Care Sites (Attachment A of EOP)

5. Rapidly reduce routine hospital patient activity

   A. Cancel elective procedures and surgeries
   B. Discharge all appropriate patients
   C. Transfer appropriate SNF patients to local Alternate Care Sites
   D. Consider utilization of Home Health agencies
   E. Follow further instruction and guidance from Incident Command Center

REFERENCE:
CIHQ 42 CFR 482.15 Emergency Preparedness Policies and Procedures

OWNER:
Emergency Management Committee

AUTHORS/REVIEWERS:
Mark Kobe, Chief Nursing Officer
Dawn Kuwahara, Chief Ancillary Services Officer
Gregory Gatenian, Engineering Manager
Celia Kruse de la Rosa, Marketing & Public Relations Coordinator

APPROVALS:
Policy & Procedure Team: 11/20/18
Board Quality Committee:
The Board of Directors:

DRAFT

SUBJECT: CMS 1135 Waiver for Disaster Conditions	POLICY #EP8610-103
	PAGE 1 OF 4
DEPARTMENT: Organizational	EFFECTIVE:
REVISED:	

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PURPOSE:

To provide guidelines and identify a process to access and acquire Federal waiver for CMS Conditions of Participation in times of disaster response.

POLICY:

Under Section 319 of the PHS Act, the HHS Secretary may declare a public health emergency if — after consulting with public health officials as necessary — he or she determines that a disease or disorder presents an emergency or an emergency otherwise exists, such in cases of significant infectious disease outbreaks or bioterrorist attacks.

Declaring a public health emergency allows the Secretary to take certain actions in response, and can be necessary to authorize a variety of discretionary response actions under the statutes HHS administers.

When the President declares a major disaster or emergency under the Stafford Act and the HHS Secretary declares a public health emergency under Section 319 of the Public Health Service Act, Section 1135 of the Social Security Act authorizes the Secretary to waive or modify certain federal laws, including:

- Conditions of participation or other certification requirements under Medicare, Medicaid and the Children's Health Program (CHIP)
- Preapproval requirements under Medicare, Medicaid and CHIP
- State licenses for physicians and other health care professionals, for purposes of Medicare, Medicaid and CHIP reimbursement only. The state determines whether a non-federal provider is authorized to provide services in the state without state licensure.
- Emergency Medical Treatment and Labor Act (EMTALA) requirements for redirecting individuals to another location, if the transfer arises out of emergency circumstances. This waiver is effective only if actions under the waiver do not discriminate based on a patient's source of payment or ability to pay.
- Stark self-referral sanctions
- Performance deadlines and timetables
- Limitations on payment for health care items and services furnished to Medicare Advantage enrollees by non-network providers

In addition to this authority, referred to as the 1135 waiver authority, Section 1812(f) of the Social Security Act authorizes the Secretary to provide for skilled-nursing facility coverage in the absence of a qualifying hospital stay, as long as this action does not increase overall program payments and does not alter the facility's "acute care nature" (that is, its orientation toward relatively short-term and intensive care).

Duration of a Section 1135 Waiver

Waivers under Section 1135 of the Social Security Act typically end with the termination of the emergency period or 60 days from the date the waiver or modification is first published, unless the Secretary extends the waiver by notice for additional periods of up to 60 days.

For public health emergencies that do not involve a pandemic disease, EMTALA and Health Insurance Portability and Accountability Act of 1996 requirements are limited to a 72-hour period beginning upon implementation of a hospital disaster protocol. Waiver of EMTALA requirements for emergencies that involve a pandemic disease last until the pandemic-related public health emergency is terminated. The 1135 waiver authority applies only to federal requirements for licensure or conditions of participation, not state.

Implementation of 1135 Waiver Authority

Once an 1135 waiver has been authorized, health care providers can submit requests to operate under that authority to the state survey agency or Centers for Medicare & Medicaid Services (CMS) regional office. These requests generally include a justification for the waiver and expected duration of the modification requested. Providers and suppliers have been asked to keep careful records of beneficiaries to whom they provide services to ensure that proper payment is made. The state survey agency and regional office review the provider's request and make appropriate decisions, usually on a case-by-case basis. Providers are expected to return to compliance with any waived requirements prior to the end of the emergency period.

Federally certified or approved providers must operate under normal rules and regulations, unless they have sought and have been granted modifications for specific requirements under the 1135 waiver authority.

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1135 Waiver Request Format

Though there is no specific form or format required to request a waiver, impacted providers should provide the California Department of Public Health (CDPH) with certain information, including:

Provider name/type

Full address (including county/city/town/state)

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SUBJECT: CMS 1135 Waiver for Disaster Conditions	POLICY #EP8610-103
	PAGE 1 OF 4
DEPARTMENT: Organizational	EFFECTIVE:
REVISED:	

CMS Certification Number (Medicare provider number)

Contact information for follow-up questions, should the regional office need additional clarification

A brief summary of why the waiver is needed that clearly states the issue's scope and impact. For example: Critical access hospital is sole community provider without reasonable transfer options at this point during the specified emergent event (e.g. flooding, tornado, fires, or flu outbreak). Facility needs a waiver to exceed its bed limit by X number of beds for Y days/weeks (be specific).

The type of relief or regulatory requirement waiver sought

Providers should send this information to the San Francisco Regional Office at rosfoso@ cms.hhs.gov and copy CDPH. This will ensure the waiver request does not conflict with any state requirements and that all concerns are addressed in a timely fashion.

For more information on the 1135 waiver process, visit the CMS website.

REFERENCE:
CIHQ 42 CFR 482.15 Emergency Preparedness Policies and Procedures

OWNER:
Emergency Management Committee

AUTHORS/REVIEWERS:
Mark Kobe, Chief Nursing Officer
Dawn Kuwahara, Chief Ancillary Services Officer
Gregory Gatenian, Engineering Manager
Celia Kruse de la Rosa, Marketing & Public Relations Coordinator

APPROVALS:
Policy & Procedure Team: 11/20/18
Board Quality Committee:
The Board of Directors:

DRAFT

SUBJECT: Delegation of Authority	POLICY #EP8610-104
	PAGE 1 OF 4
DEPARTMENT: Organizational	EFFECTIVE:
REVISED:	

PURPOSE:

To provide guidelines to the organization to identify which staff would assume specific roles in another's absence through succession planning, delegations of authority and who is authorized to act in the absence of the administrator or person legally responsible for the operations of the organization.

POLICY:

The emergency preparedness plan addresses the continuity of operations, including delegations of authority and succession plan when indicated.

1. In the event that the Administrator of SVH (Chief Executive Officer, CEO) is unavailable in an emergency situation, authority is delegated to the Chief Nursing Officer (CNO).

2. In the event that the CEO becomes deceased, the Chief Financial Officer (CFO) is delegated authority for the organization. Clinical operations would be delegated to the CNO.

3. In the event the CNO is unavailable or deceased, the Director of Patient Care Services is delegated authority for clinical operations.

REFERENCES:
CIHQ 42 CFR 482.15 Emergency Preparedness Policies and Procedures

OWNER:
Emergency Management Committee

AUTHORS/REVIEWERS:
Mark Kobe, Chief Nursing Officer
Dawn Kuwahara, Chief Ancillary Services Officer
Gregory Gatenian, Engineering Manager
Celia Kruse de la Rosa, Marketing & Public Relations Coordinator

APPROVALS:
Policy & Procedure Team: 11/20/18
Board Quality Committee:
The Board of Directors:

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SUBJECT: Alcoholic Beverages in SNF	POLICY: 6580-105
	PAGE 1
DEPARTMENT: Skilled Nursing Facility	EFFECTIVE:
REVISED:	

PURPOSE:

The purpose of this policy is to establish uniform guidelines concerning the consumption of alcoholic beverages in the Skilled Nursing Facility.

PROCEDURE:

1. A physician's order must be received before any alcoholic beverage may be administered to a patient through the dietary department.
2. Skilled Nursing patients have the right to consume alcohol in modest amounts.
3. If wine is ordered through the dietary department, 4 oz. of red or 4 oz. of white wine will be sent on the lunch and /or dinner tray *or* 12 oz. of beer will be provided for lunch and/or dinner.
4. Long term residents have the right to keep wine in their rooms or the beverage of their choice with a physician's order. Alcoholic beverages must be kept out of the reach of other patients/ residents.
5. Should you have any doubt concerning the administration of the alcoholic beverage to the resident, contact the Director of Nursing Services and or the Medical Director.

REFERENCES;
California Department of Public Health. Residents Rights, (n.d.). Retrieved from cdph.ca.gov.

Long Term Care Ombudsman, "Thinking Outside the Box (of Wine): Alcohol Use In Long Term Care Facilities (n.d.) Resident Rights. Retrieved from ltcombudsman.org

OWNER:
Medical Director SNF

AUTHORS/REVIEWERS:
Melissa Evans, SNF Director of Nursing

APPROVALS:

DRAFT

SUBJECT: Alcoholic Beverages in SNF	POLICY: 6580-105
	PAGE 1
DEPARTMENT: Skilled Nursing Facility	EFFECTIVE:
REVISED:	

Policy & Procedure Team: 11/20/18
Medicine Committee: 12/13/18
Board Quality Committee:
Medical Executive Committee:
The Board of Directors:

DRAFT

SUBJECT: Resources available for Managing the Labor and Delivery Patient in the ED	POLICY #7010-22
	PAGE 1 OF 2
DEPARTMENT: Emergency	EFFECTIVE: 11/18
REVISED:	

PURPOSE:

Obstetric emergencies are standard competency for emergency department physicians and are not covered in this policy. The purpose of this policy is to guide emergency department staff in the management and resources available for the care of the pregnant patient with imminent delivery.

POLICY:

In the event of a presentation of laboring mom in the ED, the ED physician shall assess the patient for safe transfer within the EMTALA guidelines to facility with a labor and delivery department.

PROCEDURE:

1. First priority by ED MD is to consider immediate transfer, if appropriate

2. Call the OB/GYN on call for the emergency department for consultation

3. Assess the need to transfer the patient to one of the following organizations that SVH holds valid transfer agreements with:
   a. Sutter Santa Rosa (Sutter Transfer Center 888 637-2762)
   b. Petaluma Valley Hospital (St. Joe's Transfer Center 800 200-7764)
   c. Queen of the Valley Hospital (St. Joe's Transfer Center)
   d. Santa Rosa Memorial Hospital (St. Joe's Transfer Center)

4. If indicated, call a local pediatrician to assist (no on call agreement)

5. Notify nursing supervisor to assist and locate available L & D competent staff

REFERENCE:
EMTALA- A Guide to Patient Anti-Dumping Laws, 9th Ed. 2018 section 1.10

OWNER:
Chief Nursing Officer

AUTHORS/REVIEWERS:

DRAFT

Mark Kobe, Chief Nursing Officer

APPROVALS:
Policy & Procedure Team: 11/20/18
Medicine Committee: 12/13/18
Board Quality Committee:
Medical Executive Committee:
The Board of Directors:

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