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

SVHCD QUALITY COMMITTEE
AGENDA
WEDNESDAY, June 26, 2019
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 05.22.19	*Hirsch*	Action
4. ANNUAL REVIEW OF QA/PI PROGRAM	*Jones*	Inform
5. CEO DASHBOARD	*Jones*	Inform
6. POLICIES AND PROCEDURES	*Jones*	Inform/Action
7. CLOSED SESSION: a. Calif. Health & Safety Code § 32155 Medical Staff Credentialing & Peer Review Report b. Case Review/Planning § 54957.8 Root Cause Analysis	*Hirsch*	Inform
8. REPORT OF CLOSED SESSION	*Hirsch*	Inform/Action
9. ADJOURN	*Hirsch*	

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SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
May 22, 2019 5:00 PM
MINUTES
Schantz Conference Room

Members Present	Members Present cont.	Excused	Public/Staff
Carol Snyder Michael Mainardi, MD Susan Idell Howard Eisenstark, MD	Jane Hirsch Ingrid Sheets	Cathy Webber	Danielle Jones, RN Mark Kobe, CNO Leslie Lovejoy, RN Sabrina Kidd, MD Melissa Evans, RN Mike Empy, Exec Director

AGENDA ITEM	DISCUSSION	ACTION
1. CALL TO ORDER/ANNOUNCEMENTS	*Hirsch*	
	Called to order at 5:00 pm	
2. PUBLIC COMMENT	*Hirsch*	
	None	
3. CONSENT CALENDAR		Action
• QC Minutes, 04.24.19		**MOTION:** by Eisenstark to approve, 2nd by Snyder. All in favor.
4. SNF ANNUAL REPORT	*M. Evans*	
	Ms. Evans gave the annual SNF report. She spoke about the future of SNF with Ensign Management company, the addition of a sub acute care unit, staffing changes and the new patient driven reimbursement model. She also reviewed the quality metrics. Mr. Empy spoke briefly about the future state of the SNF under Ensign.	
5. PRIME GRANT UPDATE	*L. Lovejoy*	
	Ms. Lovejoy reviewed the Prime Grant update. She reported that the hospital is now within the pay for performance period. She spoke about the indicators that were not met that	

AGENDA ITEM	DISCUSSION	ACTION
	resulted in the hospital not receiving $75,000 of the grant money. She reported to date the hospital has received a net of $1.6 million.	
6. CEO REPORT AND DASHBOARD	*Jones*	
	Ms. Jones reviewed the CEO report and dashboard.	
7. CIHQ ACUTE STROKE READY SURVEY FINDINGS	*Jones*	
	Ms. Jones reviewed the CIHQ stroke ready findings. They included opportunities for improvement with documentation, timing of results with labs, CT's and EKG's, TPA mixing at the bedside by RN's. The findings have all been addressed, and were found to be primarily systems issues.	
9. QUALITY AND RESOURCE MANAGEMENT	*Jones*	
	Ms. Jones reported that she is now overseeing Medical Records. With this, the implementation of concurrent scanning of medical records will begin June 1st. The hospital is within the window for a CDPH general acute care triannual licensure survey.	
11. CLOSED SESSION	*Hirsch*	
	Called to order at 5:56:pm	
12. REPORT OF CLOSED SESSION	*Hirsch*	
	Medical Staff Credentialing reviewed.	**MOTION:** by Eisenstark to approve credentialing, 2nd by Idell . All in favor.
13. ADJOURN	*Hirsch*	
	5:59 pm	

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Quality Assurance/Performance Improvement Program Review 2018

Purpose

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

The purpose of this appraisal is to:

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

Scope and Applicability

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

Quality Assurance Performance Improvement (QAPI) Purpose Statement
The purpose of QAPI at Sonoma Valley Hospital is to take a proactive approach to continually improving the way we care for and engage with our patients, physicians and employees and other partners so that we may realize our vision to be a trusted resource for compassionate, exceptional care. To do this, all employees will participate in ongoing QAPI efforts which support our mission by continually working to restore, maintain and improve the health of everyone in our community.

QAPI Guiding Principles

1. Sonoma Valley Hospital uses quality assurance and performance improvement to make decisions and guide our day-to-day operations.
2. In Sonoma Valley Hospital, QAPI includes all employees, all departments and all services provided.
3. QAPI focuses on systems and processes, rather than individuals. The emphasis is on identifying system gaps rather than on blaming individuals.

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Findings

The Leaders devoted 2018 to refining their quality assurance performance improvement plans to provide a structure for each department to consider the complexity of their services and identify quality monitoring and performance improvement activities that promote a departmental culture of quality, patient safety and continuous improvement.

Each department identified the complexity of work flow processes and opportunities to improve based on a prioritization process that included considerations of high risk, high and low volume activities and areas that are problem prone.

Leaders have improved in their work flow process, analysis, and the identification of potential performance improvement activities by including their departmental staff in the development of QAPI plans.

The Quality Department identified that Sonoma Valley Hospital leadership has an opportunity to improve the timely submission of quality control monitoring indicators.

The Administrative Team performed a formal organization-wide Performance Improvement Project prioritization process and implemented a 100-Day Workout productivity cycle. The goal of this new process is to achieve efficient gains through rapid cycle Plan, Do, Study, Act in hospital performance while sustaining productivity and patient safety

In 2018 Sonoma Valley Hospital undertook 21 performance improvement projects with representatives from each department; both clinical and non-clinical. These projects were aligned with Sonoma Valley Hospital Strategic Priorities 2018-2020 which outlined five priorities:

1. Achieve the highest levels of health care safety, quality and value
2. Be the preferred hospital for patients, physicians, employers and health plans
3. Implement new and enhanced revenue strategies
4. Continue to improve financial stability
5. Lead progress toward being a healthier community

Hospital Acquired Pneumonia Prevention Initiative
Pneumonia is the second most common hospital acquired infection and is the most common cause of death among hospital acquired infections with a 19% mortality rate. Hospital acquired pneumonia adds 4-9 extra days per hospitalization and cost $40,000 per occurrence. Sonoma Valley Hospital has adopted a group of prevention strategies to reduce the occurrence of hospital acquired pneumonia which includes:

- Providing frequent oral care for patients, based on the Beck Scale, to reduce the amount of bacteria in the mouth

- Head of bed elevation - Keeping the patient's head of the bed at 30 degrees, when safe and appropriate, reduces the chance of germs from the patient's mouth coming in contact with the lungs.
- Clean Suction Technique and Closed Suction Catheters – when used correctly during suctioning they decrease the chances of introducing any outside germs to the patient's lungs
- Hand hygiene -prevent cross-contamination or colonization via hands of personnel

As a result of the Hospital Acquired Pneumonia Prevention Initiative, Sonoma Valley Hospital is able to demonstrate hand hygiene compliance >90%, and a decrease in hospital acquired pneumonia from 1.6 per 1000 patient days in 2017 to 0.7 per 1000 patient days in 2018.

The Care Transitions Record Project (PRIME) was a PI project implemented in response to the increasing pressure to reduce readmissions and to take more accountability in maintaining and improving the health of our community. This project, funded by a grant from the Centers for Medicare and Medicaid and administered by the California State Department of Health Services, challenges the hospital to improve the transition of care for both patients and providers. This project will continue to be an organizational focus through 2020. SVH improved the discharge instructions section to include a standardized medication reconciliation that conforms to the National Quality Forum's best practice guidelines. SVH included critical items in the nursing discharge instructions and included diagnosis related self- management plans for the nurse to go over at the time of discharge and simplified their workflow. We created and implemented the MY PLAN as the face sheet for the transition record that the patient takes home.

2018 Quality Department

Sonoma Valley Hospital was identified as a high performer in the areas of Prevention of Hospital Acquired Infections, Prevention of Falls with Injury, and Prevention of Adverse Drug Events by Health Services Advisory Group (HSAG) and Health Improvement Innovation Network (HIIN). SVH ranks in the top quartile of all hospitals nationwide. Kathy Mathews, RN, Infection Control and Chris Kutza, PharmaD and Director of SVH Pharmacy, presented at the western regional HIIN Conference at John Muir Hospital. They each shared our reduction strategies for improvement in the areas of Hospital Acquired Infection (HAI) and Adverse Drug Event (ADE).

The Quality Department with the help of Marketing, implemented the Hospital Quality Institute "Quality Transparency Dashboard" with the goal of advancing transparency in quality data between hospitals and the public through easily accessible, meaningful, shareable information about hospital quality. The standardized dashboard provides information on eight health and safety measures in comparison with state and national averages. The dashboard can be found on the Quality Care tab of the SVH website.

The Quality Department provided monthly education to leadership on the topics of CIHQ standards interpretation and compliance, and Program Beta provided an educational session on the legal implications of documentation.

The Quality Department instituted the Midas Risk/Pt Relations Committee. The expectation is that risk leaders attend twice monthly sessions to collaborate and facilitate best outcomes for organizational risk management. Sonoma Valley Hospital is moving from a silo approach to a holistic view of our systems, processes and procedures. The goal of Midas Risk/Pt Relations Committee is to recognize and mitigate unsafe conditions, patient harm and serious safety events. The Patient Relations committee reviewed grievances and complaints on a monthly basis.

The Director of Quality and Risk attended the Northern California Hospital Quality Symposium and the annual American Society for Healthcare and Risk Management Conference and brought back best practices that are in the process of being adopted.

The Quality Data Analyst attended the annual Midas conference bringing back refinements to our use of this database that have improved data gathering and reporting. The Quality Data Analyst's presentation at Midas Plus Western Regional Group was well received. The Quality Department implemented SBAR, Situation, Background, Assessment, Recommendation; a technique that can be used to facilitate prompt and appropriate communication in our event reporting and created a positive feedback loop to reporters.

An annual review of the budget for Quality, Risk Management, Infection Prevention, Peer Review and Patient Safety indicates adequate staffing and resources have been allocated to these functions.

The Quality Department helped facilitate the successful completion of the Center for Improvement in Healthcare Quality mid-cycle survey for re-accreditation. The Skilled Nursing Facility also successfully completed California Department of Public Health, Life Safety and CMS validation surveys to achieve deemed status of approval.

The Quality Department provided Anthem Blue Cross with hospital data this year for their Q-HIP program. We also provided healthcare associated infection data to the National Healthcare Safety Network and the Centers for Disease Control for surveillance and benchmarking purposes. We successfully reported quarterly data to our Patient Safety Organization. Lastly, in a combined effort, Information systems and Quality were able to successfully send Electronic Quality Measures to CMS. This data had to be mapped to portions of the electronic record so that the data could be pulled right from the record rather than manually abstracted. The current electronic measures are pay for reporting, pay for performance are in the proposed rules for possible fiscal year 2020 or 2021.

Interdisciplinary collaboration was demonstrated through the following:

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

Assessment of Performance

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

I. ***Performance Improvement Infrastructure Goals for 2018***

Performance Goal	**Outcome**
Work with department leaders and their staff to revise, refine and improve their department specific QAPI plans including development and reporting of meaningful quality and patient safety indicators	One on one meetings with department leaders to provide guidance and support of QAPI. Continued focus in 2018 with increase in new leadership over the last year.
Integrate the statistical process control software (STATIT) into data mining and display for at least three Performance Improvement Projects this year.	Planning for organizational dashboards was completed. The Emergency Department STATIT dashboard was created, implemented and reviewed by the Emergency Department Medical Director.

Define and develop the tools to build a "High Reliability" Organization through expanded use of both Lean principles and further exploration of Human Factors Design.	Not met.
Provide education to frontline staff and leaders on continuous quality improvement methods.	Provided one on one meetings with department leaders to provide guidance and support of QAPI. Attended Med/Surg staff meetings and shared Patient Experience HCAHPS data.

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

Assessment of Effectiveness

The Performance Improvement Program, in 2018, met the needs of the Performance Improvement Committee, Medical Executive Committee and Sonoma Valley Hospital.

Objectives for Next Evaluation Period

With input from the medical staff and leadership, the Administrative Team performed an assessment of potential organizational performance improvement activities for 2019 that align with the strategic plan and core strategic initiatives and reflects the scope and complexity of patient care services. In addition to departmental and interdepartmental continuous performance improvement activities, the organization will focus on the following priorities.

A. Prioritized Organizational Performance Improvement Projects for 2019 include the following:

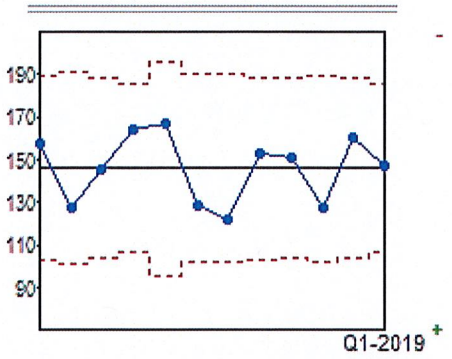
- Stroke Ready Hospital Certification: Establish stroke certification through CIHQ. Team: Mark Kobe, Danielle Jones, ED Nursing, Medical Staff. Oversight will be in the Medicine Committee.
- Patient Access Center: Establish a centralized Patient Access Center that will manage patients across the continuum of care. Team: Dawn Kuwahara, Kimberly Drummond, Fe Sendaydiego, Lisa Duarte, and Leslie Lovejoy. Oversite will be the Administrative Team.

B. Performance Improvement Infrastructure Goals 2019:

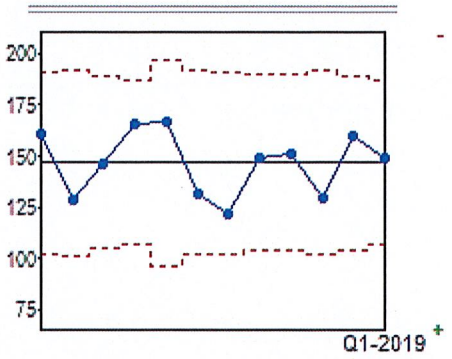
- Continue to work with department leaders and their staff to revise, refine and improve their department specific QAPI plans including development and reporting of meaningful quality and patient safety indicators.
- Create standardized organizational indicators and dashboards for medical staff committees.
- Continue to define and develop the tools to build a "High Reliability" Organization through expanded use of both Lean principles and further exploration of Human Factors Design.
- Develop and implement standardized Code Stroke dashboard to track and trend performance of process measures.
- Investigate the implementation of the NHSN procedure abstraction process in MedMined

Quality > Core Measures > Emergency Scorecard: Quality Committee SVHBOD

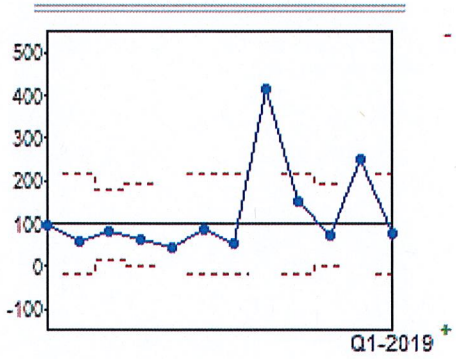
Core ED-2 - Admit Decision Time to ED Departure Time (Q)



Core ED-2b - Admit Decision Time to ED Departure Time - Reporting Measure (Q)



Core ED-2c - Admit Decision Time to ED Departure Time - Psychiatric (Q)

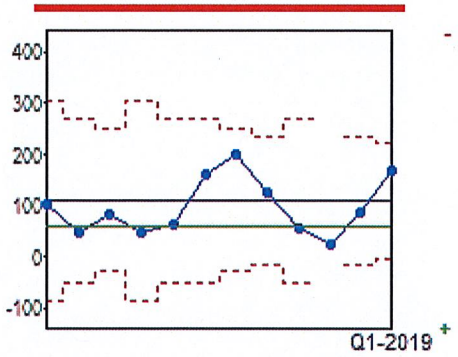


Jun 17, 2019 10:48:16

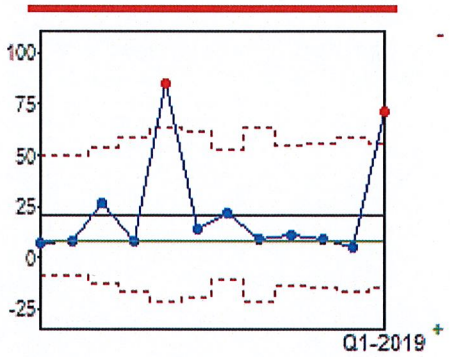
Quality > Core Measures > HOP Measures > HOP AMI_CP Scorecard: Quality Committee

SVHBOD

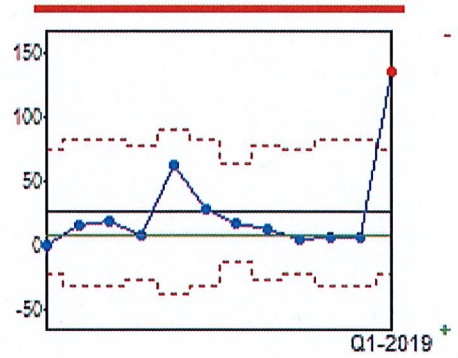
Core OP-3b - Mean Time to Txfer to Fac for Acute Coronary Intervention (Q)



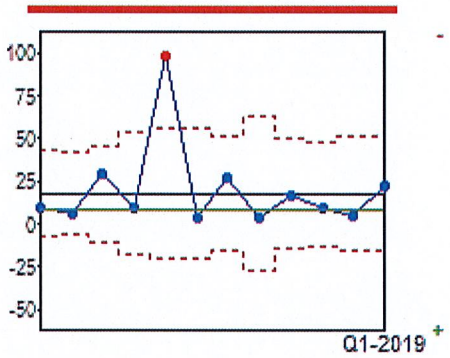
Core OP-5a - Mean Time to ECG (Q)



Core OP-5b - Mean Time to ECG - AMI (Q)



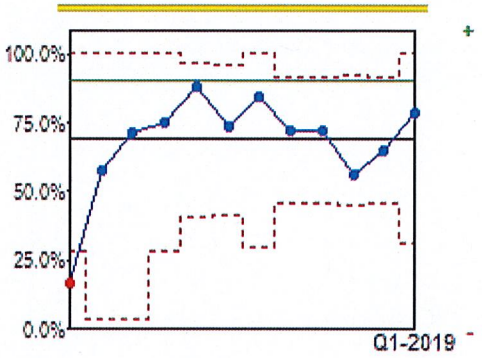
Core OP-5c - Mean Time to ECG - Chest Pain (Q)



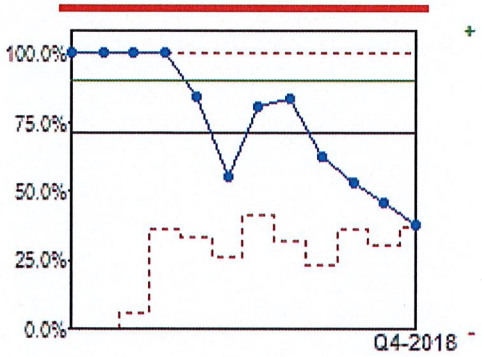
Jun 17, 2019 12:28:00

Quality > Core Measures > HOP Measures > HOP Colonoscpy Scorecard: Quality Committee SVHBOD

Core OP29/ASC9 - Colonoscopy:F/U for Avg Risk Pts (Q)



Core OP30/ASC10 - Colonoscopy:Interval for Pts w/Hx of Adenomatous Polyps (Q)

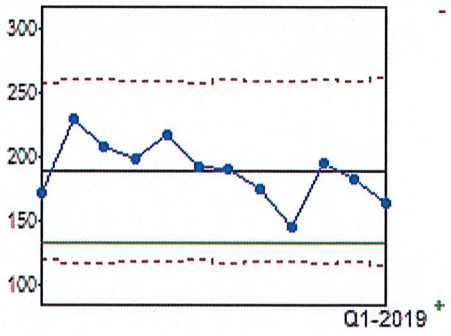


Jun 17, 2019 12:28:51

Quality > Core Measures > HOP Measures > HOP ED Throughput

Scorecard: Quality Committee SVHBOD

Core OP-18b - Mean Time ED Arrival to ED Departure - Reporting Measure (Q)

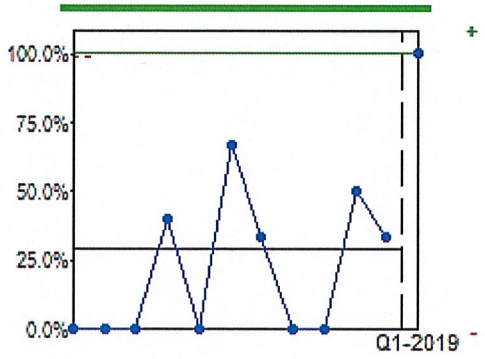


Jun 17, 2019 12:29:15

Quality > Core Measures > HOP Measures > HOP Stroke Scorecard: Quality Committee

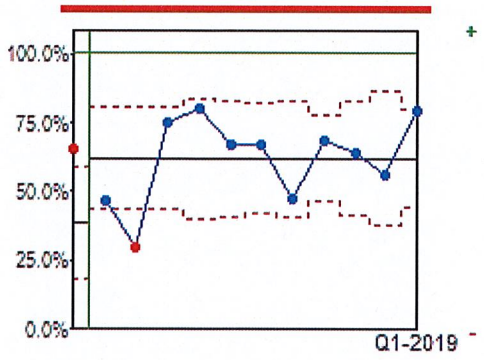
SVHBOD

Core OP-23 - Head CT/MRI Results for STK
Pts w/in 45 Min of Arrival (Q)

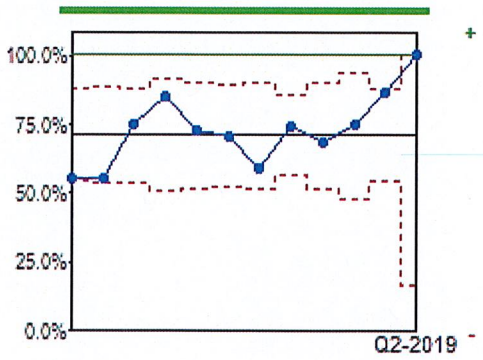


Jun 21, 2019 10:44:25

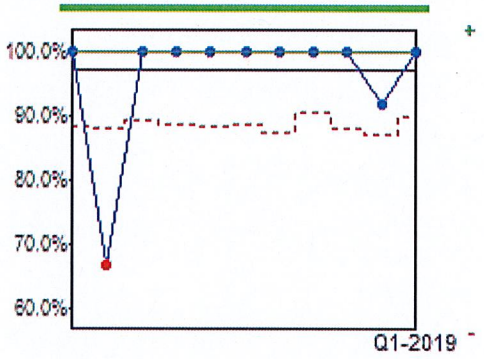
Core SEP1 - Early Management Bundle, Severe Sepsis/Septic Shock (Q)



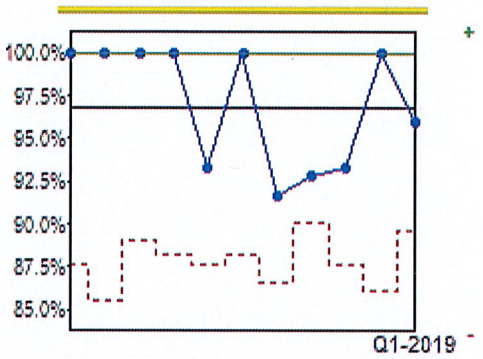
Core SEPa - Early Management , Severe Sepsis 3 Hour Bundle (Q)



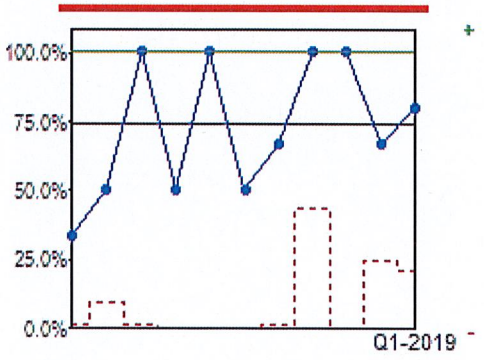
Core SEPb - Severe Sepsis 6 Hour Bundle (Q)



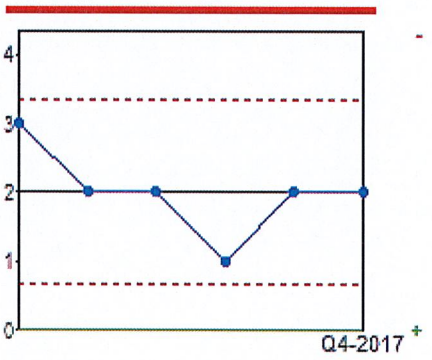
Core SEPc - Septic Shock 3 Hour Bundle (Q)



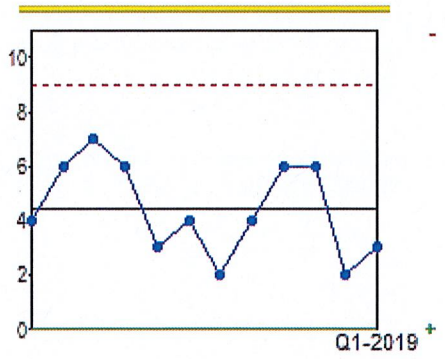
Core SEPd - Septic Shock 6 Hour Bundle (Q)



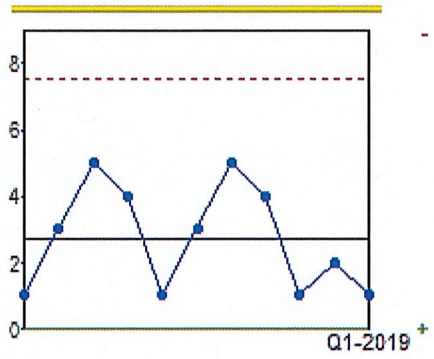
SEP1aa - severe sepsis - initial lactate management not in 3hr (Q)



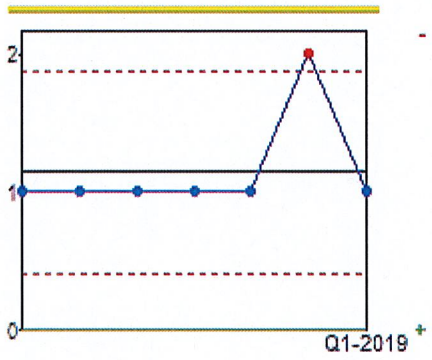
SEP1ab - severe sepsis - broad spectrum antibiotic not in 3hr (Q)



SEP1ac - severe sepsis - blood cultures not in 3hr (Q)



SEP1da - septic shock - vasopressors not in 6hr (Q)



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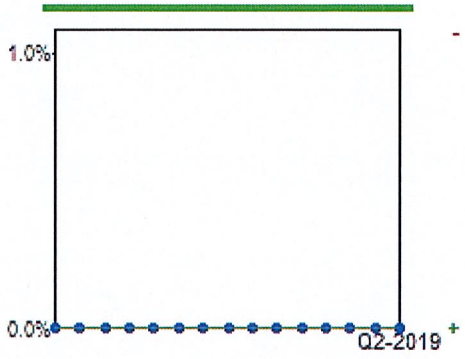
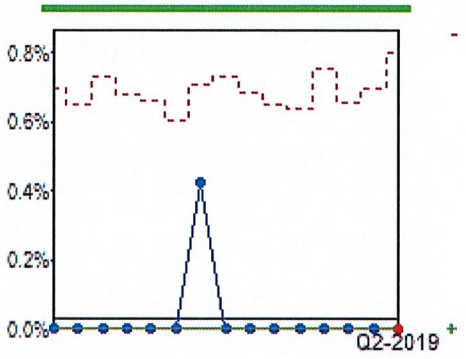
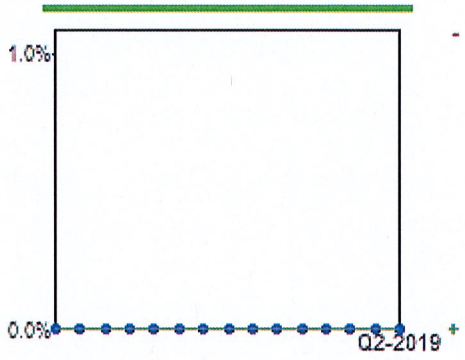
AHRQ v6.0 PSI 03 Pressure Ulcer Rate |Q|



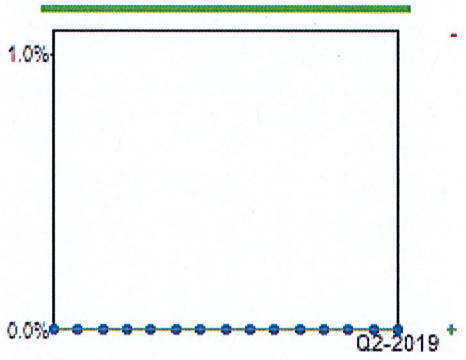
AHRQ v6.0 PSI 06 Iatrogenic Pneumothorax Rate |Q|



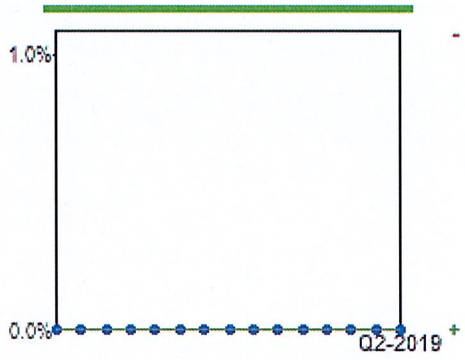
AHRQ v6.0 PSI 08 In-Hospital Fall with Hip Fracture Rate |Q|



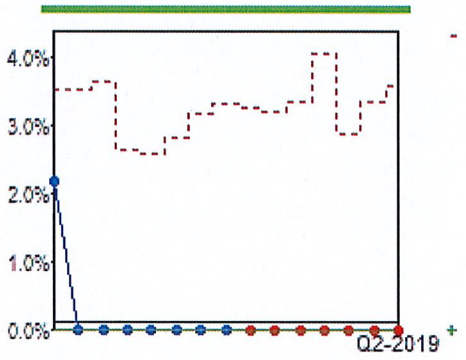
AHRQ v6.0 PSI 09 Perioperative Hemorrhage or Hematoma Rate |Q|



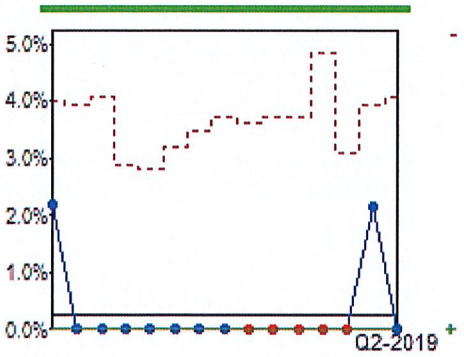
AHRQ v6.0 PSI 10 Post-Operative Acute Kidney Injury Requiring Dialysis Rate |Q|



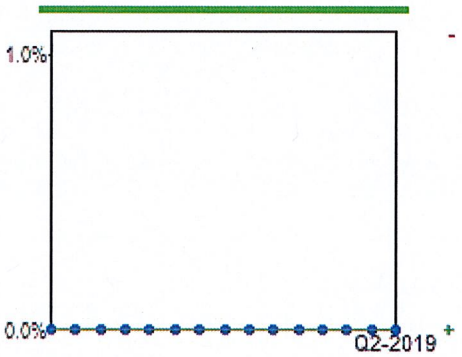
AHRQ v6.0 PSI 11 Postoperative Respiratory Failure Rate |Q|



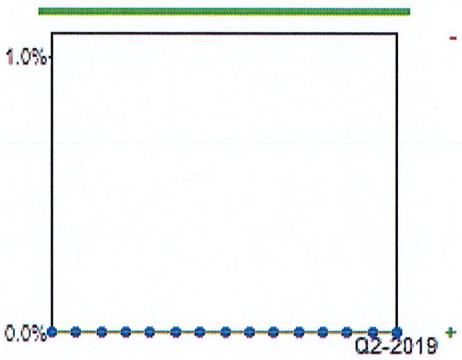
AHRQ v6.0 PSI 13 Postoperative Sepsis Rate |Q|



AHRQ v6.0 PSI 14 Postoperative Wound Dehiscence Rate|Q|



AHRQ v6.0 PSI 15 Accidental Puncture or Laceration Rate|Q|



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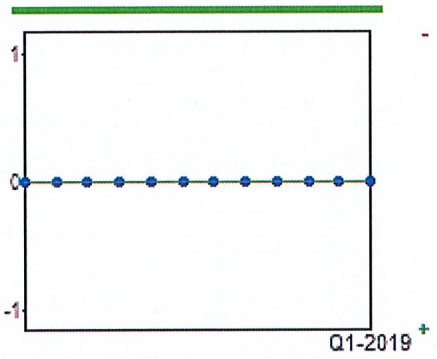
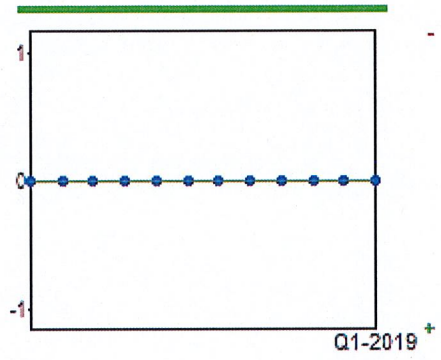
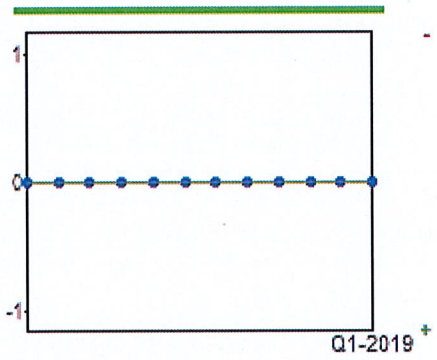
Air Embolism - Per 1000 ACA (Q)



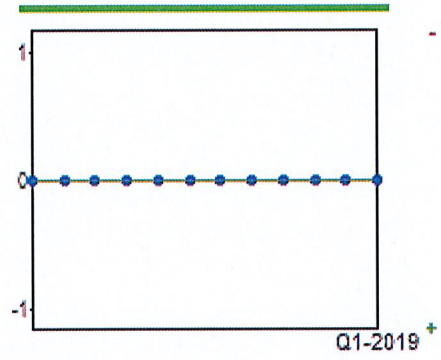
Blood Incompatibility - Per 1000 ACA (Q)



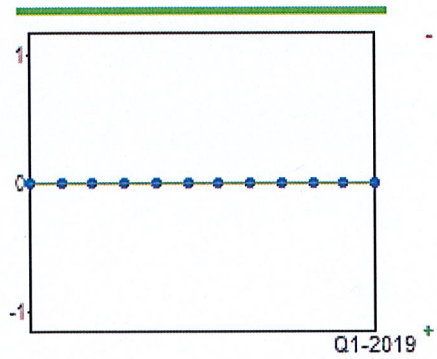
Catheter Associated UTI - Per 1000 ACA (Q)



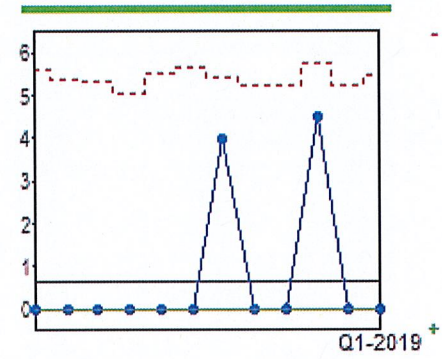
DVT/PE, Orthopedic - Per 1000 ACA (Q)



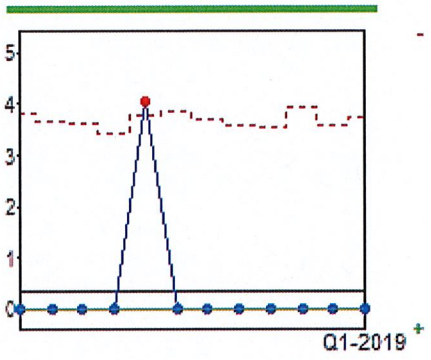
Foreign Body Left During Procedure - Per 1000 ACA (Q)



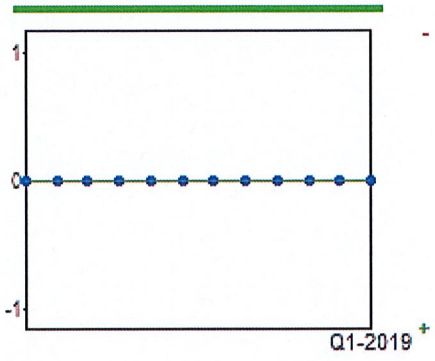
Hospital Acquired Injuries - Per 1000 ACA (Q)



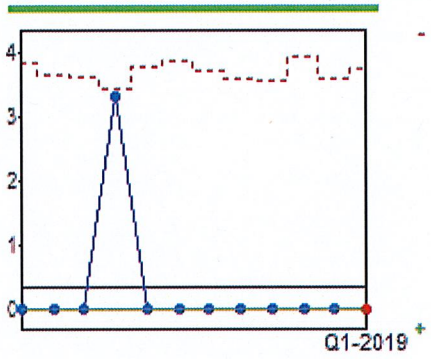
Iatrogenic Pneumothorax with Venous Cath - Per 1000 ACA (Q)



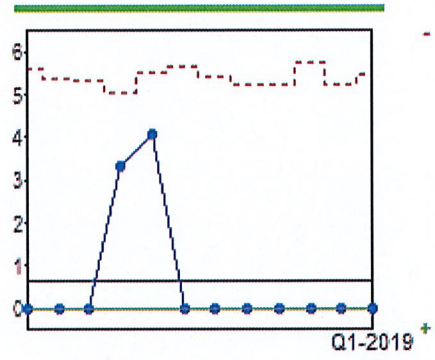
Infection from Central Venous Catheter - Per 1000 ACA (Q)



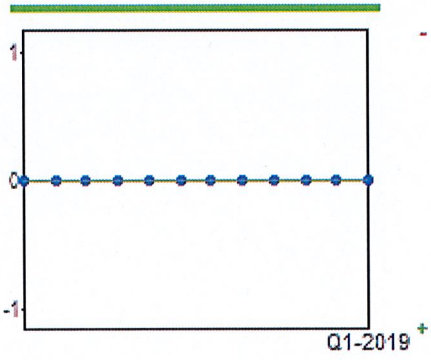
Poor Glycemic Control - Per 1000 ACA (Q)



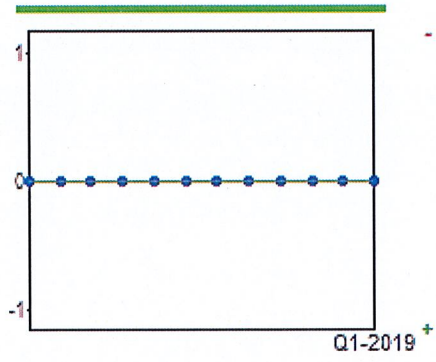
Pressure Ulcers, NPOA, All Stages - Per 1000 ACA (Q)



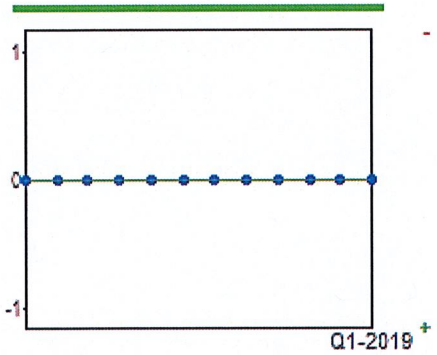
Pressure Ulcers, NPOA, Stages III and IV - Per 1000 ACA (Q)



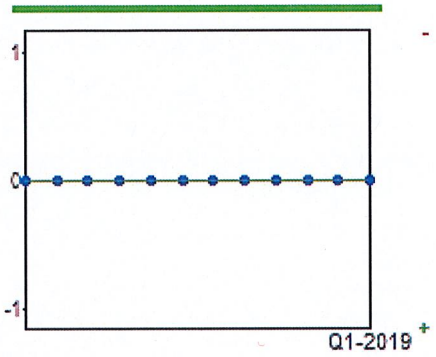
Surgical Site Infections, Bariatric - Per 1000 ACA (Q)



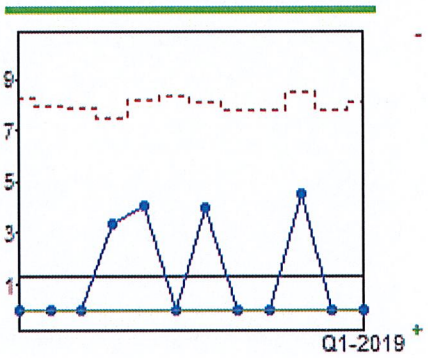
Surgical Site Infections, CIED - Per 1000 ACA (Q)



Surgical Site Infections, Orthopedic - Per 1000 ACA (Q)



Total CMS Hospital Acquired Conditions - Per 1000 ACA (Q)



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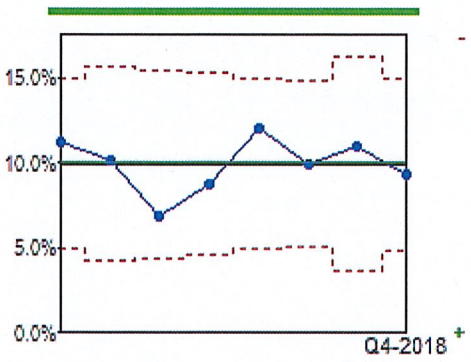
Quality > Readmissions Scorecard: Quality Committee SVHBOD

CMS: Medicare FFS Readmission Reduction
(Overall-Acute Care)



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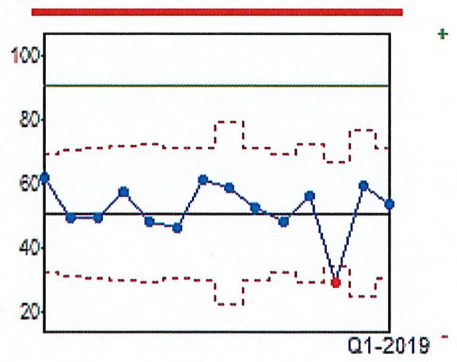
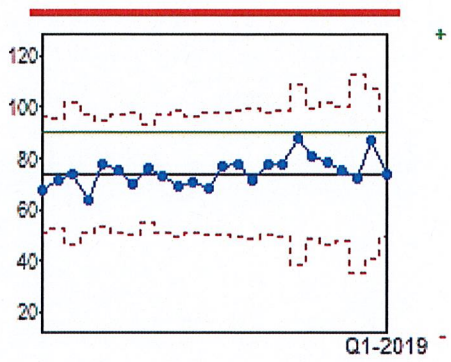
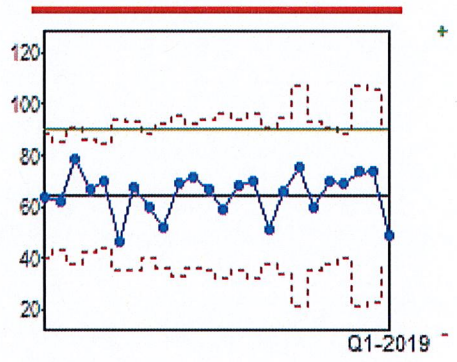
HCAHPS - Care Transitions - % Always (Q)



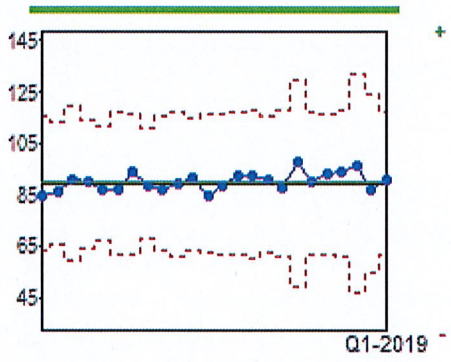
HCAHPS - Cleanliness of Hospital Environment - % Always (Q)



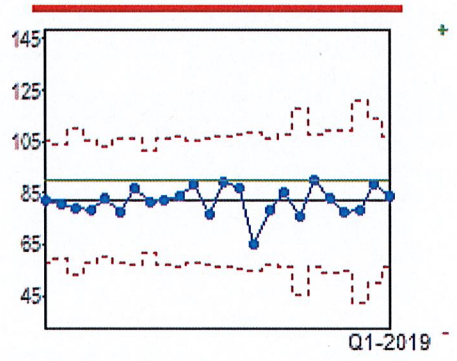
HCAHPS - Communication about Medications - % Always (Q)



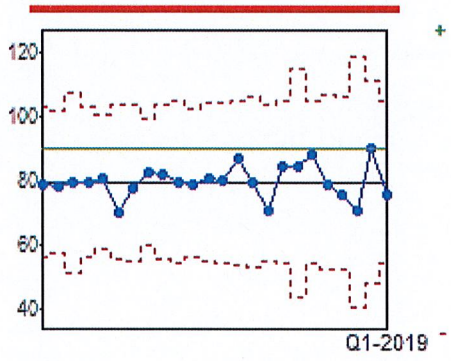
HCAHPS - Discharge Information - % Yes (Q)



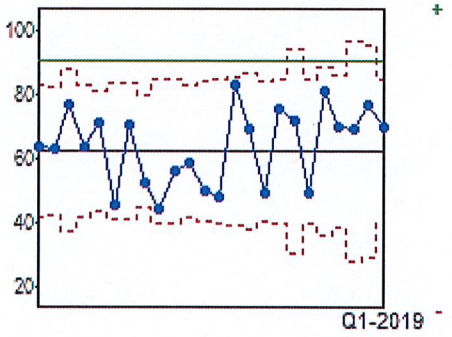
HCAHPS - Doctor Communication - % Always (Q)



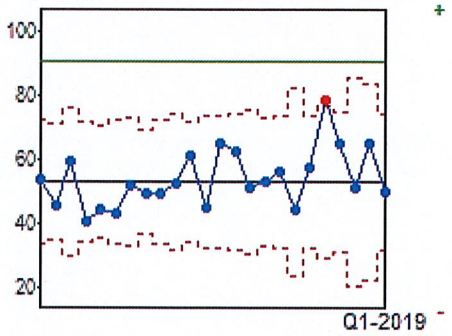
HCAHPS - Nurse Communication - % Always (Q)



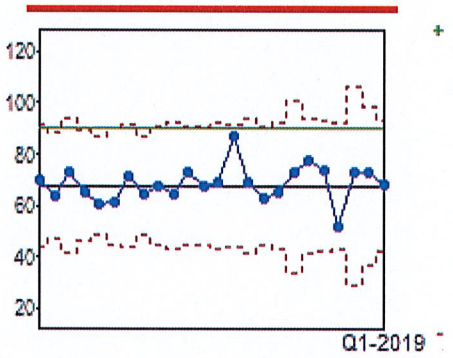
HCAHPS - Overall Rating (Q)



HCAHPS - Quietness of Hospital Environment - % Always (Q)



HCAHPS - Responsiveness of Hospital Staff - % Always (Q)



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Infection Prevention Report: 4th 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	0 0/109	0 0/138	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	0 0/906	9.2 1/1079	NHSN predicts 3.51 cases per year. 2018 total 3 cases is better than NHSN prediction. Improvement over last three years. Benchmark (MMWR) is 7.4/10,000 patient days. 2018 7.5 per 10,000 pt. 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	0 0/989	0 0/1079	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	0 0/989	0 0/1079	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	0 0/8	0 0/17	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	12.5% 2/16	0 0/8	NHSN predicts 0.28 SSIs per year. 2 SSIs /57 procedures. Annual rate 3.5%
**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	0.6% 3/470	0.8% 4/501	0.2% 1/485	NHSN predicts 1.6 SSIs per year for colon and hysterectomy surgery only, deep or organ space infections, within 30 days. 2018 rate 0.4% (8SSIs). 1 hysterectomy complication (compartment syndrome) 4th qtr, but does not appear to meet NHSN criteria for SSI. Discuss in Surgery Committee. Also, 1 superficial SSI s/p ORIF rt. hip
Class I SSI rate	<1% x 5 yrs	0 0/341	0.3% 1/338	0.5% 2/382	0.2% 1/376	No NHSN Class I (Clean Wound) rate benchmark. Superficial SSI s/p ORIF rt. Hip. Pt. was also s/p rt. Total hip replacement in the same month.
Class II SSI rate	< 1.3% x 5 yrs	0 0/69	0.8% 1/120	1.9% 2/104	0 0/84	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	10% 2/20	0 0/29	No NHSN All Total Joint SSI rate Benchmark. 0.68%-1.6% expected SSI rate for total knee (CDC 2009)
Post discharge surveillance surgeon compliance	57% 2014/ 64% 2015/ 84% 2016/ 96.5% 2017	99% Jan &Feb	99%	84.5%	99%	2014 Surgery Committee approved SSI reporting by surgeons monthly, to promote accurate SSI rates. Missing 2 surgeon's reports.

Infection Prevention Report: 4th 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	100% 21/21	100% 10/10	>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	0 0/25	0 0/7	NHSN Benchmark: 1.1 per 1,000 ventilator days.
Hospital Acquired Pneumonia (HAP) *# hospital acquired pneumonia/# pt days x 1000 pt days*	0.2/0.5/0.9/1.6	acute 1/1018 .9 SNF 1.2 2/1706	acute 0.9 1/1069 SNF 0 0/1493	0/906 0/1749	0.9 acute 1/1079 SNF 1/1022	Benchmark 1.2 cases per 1,000 pt days. HAPPI project implemented with prevention triggers in EMR and staff education. Annual rate acute 0.7, SNF 0.5 per 1000 pt. days. Improvement noted from 2017.
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 0/280	0 0/307	3.3 1/298	NHSN predicts 1.04 CAUTIs per year. 1 CAUTI in 2018 (0.85 per 1000 catheter days)
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	11.2 2/177	7.3 1/127	No NHSN SIR for SNF. Previous NHSN benchmark was 1.5 per 1000 catheter days. SNF 7.3 per 1000 catheter days. There is one hemiplegic patient that has recurrent CAUTIs.
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	2/1749	0 0/1022	Benchmark: 7.4 per 10,000 patient days. Annual rate 8.3 per 10,000 pt days in 2018.
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	o 0/142	0 0/87	Previous NHSN benchmark: 0.8 per 1,000 central line days.
Communicable Disease Exposures *Pertussis*					2	2 Pertussis exposures (Nov/Dec). 1 in ED and 1 in Medical Imaging (employee). ED did not isolate the patient and had 3 exposures. Medical Imaging resulted in 21 exposures. No pt. exposures. Both exposures had delayed reporting by lab to IP. The reporting issue has been addressed and resolved. Occ Health/ED followed up with symptomatic employees during incubation period. No secondary cases.
MRSA Active Surveillance Cultures (nares cultures only) *# positives/total screened x 100*	14% 20%/26%/9.2%	10%	3.4%	7.9%	1.9% 2/108	Nares surveillance perofrmed in accordance with California law.
% ESBL(E. coli;K. pneumoniae, K. oxytoca, P. [illegible])	2% /3%/4.2%/4.1%	4%	2.9%	3.9%	9.3%	ASP monitors antibiogram and updates annually. 31 ESBL /333 cultures 4th qtr.
# CRE cases	0/0/0/1	0	0	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.	NA	0 pts.	Water management company now in contract with SVH to assist with the water management program. Initial assessment performed.
Environmental Cleanliness Monitoring		95%	91%	81%	97%	
Total Influenza Vaccination All HCP	80%			no report	pending	CDPH benchmark 90%
Physicians, LIP, Pas	88%				65%	
Employees	78%				87%	
Volunteers				pending		
Students	100%			100%		

APRIL 2019

Patient Experience	Current Performance	FY 2019 Goal	National Benchmark
Would Recommend Hospital	64th	> 60th percentile	50th percentile
Inpatient Overall Rating	62%	>60th percentile	50th percentile
Outpatient Services	4.72	Rate My Hospital	4.5
Emergency	4.53	Rate My Hospital	4.5
Quality & Safety	**YTD Performance**	**FY 2019 Goal**	**Benchmark**
CLABSI	0	<1	<.51
CAUTI	0	<1	<1.04
SSI – Colon Surgery	0	<1	N/A
SSI – Total Joint	0	<1.5%	N/A
MRSA Bacteremia	0	<.13	<.13
C. Diff	0	3.5	7.4/10,000 pt days
PSI – 90 Composite	2	<1	<1
Heart Failure Mortality Rate	12.5%	TBD	17.3%
Pneumonia Mortality Rate	18.1%	TBD	23.6%
Stroke Mortality Rate	14.7%	TBD	19.7%
Sepsis Mortality Rate	10.2%	<18%	25%
30 Day All- Cause Readmissions	9.50%	< 10 %	< 18.5%
Serious Safety Events	0	0	0
Falls	2.7	< 2.3	2.3
Pressure Ulcers	0	<3.7	3.7
Injuries to Staff	11	< 10	17
Adverse Drug Events with Harm	0	0	0
Reportable HIPAA Privacy Events	0	0	0
SNF Star Rating	4	4	3
Hospital Star Rating	4	4	3
Our People	**Performance**	**FY 2019 Goal**	**Benchmark**
Staff Satisfaction Survey	61st percentile	75th percentile	50th percentile
Turnover	13.4%/14.6%	< 10%	< 15%
Financial Stability	**YTD Performance**	**FY 2019 Goal**	**Benchmark**
EBDA	6.8%	1%	3%
FTE's/AOB	3.84	4.3	5.3
Days Cash on Hand	9.6	20	30
Days in Accounts Receivable	38	49	50
Length of Stay	3.8	3.85	4.03
Funds raised by SVHF	$17.1 million	$20 million	$1 million
Strategic Growth	**YTD Performance**	**FY 2019 Goal**	**Benchmark**
Inpatient Discharges	871/1045	1000	1000
Outpatient Visits	45,142/54,170	53,000	51,924
Emergency Visits	8349/10,018	10,000	11,040
Surgeries + Special Procedures	2426/2911	2500	2,568
Community Benefit Hours	1025.5/1230	1200	1200

Note: Colors demonstrate comparison to National Benchmark

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

Policy and Procedures – Summary of Changes
Board Quality Committee, June 26th, 2019

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:

Code Stroke Practice Guidelines NS8610-122
Revised time stated for triage of tPA candidates and updated to latest standard of care.

Downtime Paragon Clinical Documentation MR8610-108
Per Clinical Informatics Committee direction, this police was reviewed and updated to ensure the policy is up to date, easy to understand, and communicated effectively to end users.

Emergency Operations Plan 2019 EP8610-100
Updated EOP with new Activate language to make this clearer. This Plan is required to be updated annually.

Drugs and Alcohol Free Workplace HR8610-316
Significant updates and changes by combining "Employee Testing for Suspicion of Drugs or Alcohol" and "Impaired Employee" policies into this one policy. Added post-accident testing requirement. Updated procedures for testing, added definitions, and added the Reasonable Suspicion Checklist and Consent to Employee Testing form.

Meal Breaks and Rest Periods HR8610-152
Added language for clarity related to the timing of breaks; added provisions and guidance for break times needed for lactating mothers.

MMR, Varicella, Td, TDaP, and Influenza Vaccinations HR8610-164.02
Clarification in the language about the required immunization records or serology reports indicating immunity as it pertains to measles. Updated the requirements for TDaP vaccination indicated for all personnel involved in direct patient care.

Tuberculosis Screening HR8610-164.5
Updated to reflect the change in TB testing from PPD to QuantiFERON Gold laboratory test, along with corresponding test interpretation guidance. Updated other language for clarity and organization.

Work Related Injury and Illness HR8610-174

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

Updated language to enhance explanations and bring clarity to the purpose and process of the policy reporting requirements; updated reference to newly revised Employee Work-Related Injury/Illness Report form; added guidance in regards to transitional work; added provisions for students and contract employees; added guidance for return to work. Revisions completed in response to revised reporting form, identification of important topics that needed to be included, and to ensure the addition of relevant information from previously retired Employee Health policy, #HR8610-164.12 "Work Injuries, Investigation and Return to Work Clearance" which primarily was duplicative of this HR policy.

RETIRE:

Employee Testing for Suspicion of Drugs or Alcohol HR8610-316
Content combined with revised Drug & Alcohol Free Workplace

Impaired Employees HR8610-356
Content combined with the revised Drugs & Alcohol Free Workplace, #HR9610-316

Peer Review MS8710-186
Surgical Case Review MS8710-115
Medical Staff Indicators Review MS8710-187
To be retired alongside approval of "Peer Review and Focused Professional Practice Evaluation MS8610-104"

DEPARTMENTAL

REVISIONS:
Surgery / Central Sterile

Pre-Operative Skin Preparation of Patients 7420-142
Added new policy for preoperative CHG wipe prep for all patients coming to surgery from community care facility to reduce the risk of SSI by helping to decrease patient's own bacterial load on their skin prior to making incision in surgery.

Trophon Environmental Probe Reprocessor (EPR) 7630-236
The Emergency Department (ED) has an ultrasound machine. The ultrasound probes must be disinfected according to Infection Prevention guidelines and standards. The Imagining Department disinfects ultrasound probes. The Imaging Department will process the ED's contaminated ultrasound probes. The policy was updated to maintain Infection Prevention Standards for all ultrasound probes at SVH.

REVIEWED/NO CHANGES:
Patient Accounting

Patient Refunds Overpayments 8530-01