SVHCD QUALITY COMMITTEE
AGENDA
WEDNESDAY, July 24, 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 06.26.19	*Hirsch*	Action
4. PATIENT CARE SERVICES ANNUAL REPORT	*Kobe*	Inform
5. CNO QUARTERLY PCS DASHBOARD	*Kobe*	Inform
6. GOOD CATCH REPORT	*Jones*	Inform
7. QUALITY AND RESOURCE MANAGEMENT REPORT	*Jones*	Inform
8. CEO DASHBOARD	*Jones*	Inform
9. POLICIES AND PROCEDURES	*Jones*	Inform/Action
10. 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
11. REPORT OF CLOSED SESSION	*Hirsch*	Inform/Action
12. ADJOURN	*Hirsch*	

SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
June 26, 2019 5:00 PM
MINUTES
Schantz Conference Room

Members Present	Members Present cont.	Excused	Public/Staff
Jane Hirsch Carol Snyder Michael Mainardi, MD Cathy Webber Ingrid Sheets	Jane Hirsch	Susan Idell Howard Eisenstark, MD	Danielle Jones, RN Sabrina Kidd, MD

AGENDA ITEM	DISCUSSION	ACTION
1. CALL TO ORDER/ANNOUNCEMENTS	*Hirsch*	
	Called to order at 5:01pm (closed session) and 5:14 pm (regular session)	
2. PUBLIC COMMENT	*Hirsch*	
	None	
3. CONSENT CALENDAR		Action
• QC Minutes, 05.22.19		**MOTION:** by Mainardi to approve, 2nd by Snyder . All in favor.
4. ANNUAL RVIEW OF QA/PI PROGRAM	*D. Jones*	
	Ms. Jones presented the annual QA/PI program. She said that in 2018 the SVH leaders refined their quality assurance and performance improvement plans to provide a structure for each department and to identify quality monitoring and performance improvement activities that promote a departmental culture of quality, patient safety and continuous improvement. SVH was identified as a high performer in areas of Prevention of Hospital Acquired Infections, Prevention of Falls with Injury, and Prevention of Adverse Drug Events by HSAG and HIIN. The Quality Department also implemented the Hospital Quality Institute "quality	

AGENDA ITEM	DISCUSSION	ACTION
	transparency dashboard." This promotes transparency between hospitals and the public regarding quality data. She also spoke about the importance of high reliability culture and how to work towards that. The Performance Improvement goals for 2019 were to continue to work with department leaders and staff to revise, refine and improve their QAPI plans, create standardized organizational indicators and dashboards, continue to define and develop the tools to build a "high reliability" organization, develop and implement standardized Code Stroke dashboard, and to investigate the implementation of the NHSN procedure abstraction process in MedMinded. She then reviewed the Quality core measures and data.	
5. CEO DASHBOARD	*D. Jones*	
	Reviewed	
6. POLICIES AND PROCEDURES	*Jones*	
Code Stroke Practice Guidelines NS8610-122 Downtime Paragon Clinical Documentation MR8610-108 Emergency Operations Plan 2019 EP8610-100 Drugs and Alcohol Free Workplace HR8610-316 Meal Breaks and Rest Periods HR8610-152 MMR, Varicella, Td, TDaP, and Influenza Vaccinations HR8610-164.02 Tuberculosis Screening HR8610-164.5 Work Related Injury and Illness HR8610-174 **RETIRE:** Employee Testing for Suspicion of Drugs or Alcohol HR8610-316 Impaired Employees HR8610-356 Peer Review MS8710-186 Surgical Case Review MS8710-115 Medical Staff Indicators Review MS8710-187 **DEPARTMENTAL** **REVISIONS:**	Discussion and review of revisions.	**MOTION**: by Webber 2nd by Snyder. All in favor.

AGENDA ITEM	DISCUSSION	ACTION
Surgery / Central Sterile Pre-Operative Skin Preparation of Patients 7420-142 Trophon Environmental Probe Reprocessor (EPR) 7630-236 **REVIEWED/NO CHANGES:** **Patient Accounting** Patient Refunds Overpayments 8530-01		
11. CLOSED SESSION	*Hirsch*	
	Called to order at 5:01 pm	
12. REPORT OF CLOSED SESSION	*Hirsch*	
	Medical Staff Credentialing reviewed. Root cause analysis reviewed.	**MOTION:** by Mainardi to approve credentialing, 2nd by Sheets. All in favor.
13. ADJOURN	*Hirsch*	
	5:13pm (closed session) and 6:12 pm (regular session)	

Patient Care Services

Annual Report 2019

Prepared by: Mark Kobe, RN MPA Chief Nursing Officer

Introduction and Structure

Patient Care Services is comprised of 7 major service areas: Intensive Care, Emergency, Surgery, Inpatient, Skilled Nursing, Pharmacy and Respiratory Therapy. These areas are staffed by 109 Registered Nurses, 10 Respiratory Therapists, 10 Pharmacists, 7 Pharmacy techs and 42 Certified Nurses Assistants, Scrub techs, ED techs and unit assistants. The areas are managed individually by 2 nursing directors, 1 Pharmacy Director and 1 nursing manager who report directly to the Chief Nursing Officer.

Category	Function	Staff Oversight
Chief Nursing Officer	The CNO is involved at the executive level in collaborative leadership of the organization. Provides leadership, management, consultation and oversight for the department of nursing in both the clinical and Administrative setting and assumes administrative responsibility for the Skilled Nursing Facility. Responsible for the day to day operations of all clinical functions. Pro-actively maintains high level internal customer, physician and Board of Trustee relationships and satisfaction. Responsible for management of federally-mandated grievance process, management of emergency physician and hospitalist group contracts and oversight, direct oversight and responsibility for service excellence initiatives and performs daily clinical role as Interim Emergency Department Director and Administrative Nursing Supervisor.	Director of SNF Director of Pharmacy Director Inpatient Manager Surgery 12 Nursing Supervisors
Director of Nursing, Skilled Nursing Facility	The Director of Skilled Nursing Facility is responsible for daily oversight ensuring high quality care in high acuity environment. The Director is responsible for all regulatory requirements from multiple regulators and recruits/hires qualified staff, participates in marketing activities, assures that the QAPI program is implemented and maintained. In addition, oversees admissions based on the units' ability to care for patients safely Oversees staff development needs, manages the SNF budget, participates in surveys and responds to regulatory deficiencies. The Director assures patient's rights and acts as a liaison between physicians, families, staff, and the community.	8 Registered Nurses 14 Certified Nurse Assistants 3 Unit Assistants
Director of Patient Care Services	The Director of Patient Care Services provides leadership for the clinical operations and coordinated activities of the Medical-Surgical Inpatient department, Outpatient Infusion Services and Intensive Care Unit. Ensures accountability for administrative responsibilities that include staffing, leading, morale, customer satisfaction, quality patient care, organizing and role modeling for critical care nursing. Maintains positive relationships with Hospitalists and Surgeons. Primary responsibility for Inpatient satisfaction (HCAHPS).	31 Registered Nurses 7 C N As 4 telemetry technicians
Manager Surgery	Direct daily oversight of Surgical Care Unit, comprised of 3 operating suites and a pre- and post-operative patient care/ recovery area. Manages daily staffing needs based on surgical case load and responsible for management of surgeon block assignment and utilization. Seeks out new surgical opportunity for organization. Primary responsibility for OASCAHPS	2 Clinical Coordinators 16 Registered Nurses 5 Scrub Techs 2 Central Sterile Techs 3 Housekeepers

Quality Dashboard

Ultimately, Patient Care Services are involved and directly responsible for results in virtually all Quality measures of the organization: CMS core measures, infection prevention monitoring, to name a few. As a Board Committee, you view many, if not all measures in your dashboards. As you know, most quality measures are a collaborative effort from a multidisciplinary perspective. Some, however are under direct nursing control. The Patient Care Services Dashboard represents these measures and is presented below.

Medication Scanning Rate	2018-19				
	Q2	Q3	Q4	Q1	Goal
Acute	83.0%	85.0%	84.0%	82.0%	≥90%
ED	84.0%	78.0%	77.0%	90.0%	≥90%
Preventable med errors				1 (n=48)	

Nursing Turnover	2018-19 RNs/Quarter				
# of RNs	Q2	Q3	Q4	Q1	Goal
Acute (n=65)	5	2	3	0	≤6
					-

Falls (Per 1000 days) 2018-19					
	Q3-Q2	Q4-Q3	Q1-Q4	Q2-Q1	50th %tile
Acute	2.80	2.90	2.00	2.70	3.75
ED				0.0	

Patient Experience (CAHPS)	2018				
	Q1	Q2	Q3	Q4	Goal
HCAHPS					
Would Recommend				76.5	70.0
Quietness of Hosp Environment				51.4	51.0
OASCAHPS					
Care of Patients (MD/RN respect)	97	94.6	93.8	88.2	97.1
Would Recommend	85.4	77.6	75	87.5	88.6
RATE MY HOSPITAL - ED					
Overall score	4.7	4.7	4.8	4.8	≥4.5

Hospital Acquired Pressure Ulcer Incidents (Per 1000 admissions)	2018-19				
	Q2	Q3	Q4	Q1	National
Acute	0.0	0.0	1.2	0.0	3.68

Nurse Staffing Effectiveness: Transfers r/t staffing/beds					
2018-19	Q2	Q3	Q4	Q1	Goal
	0	0	0	0	≤0

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

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

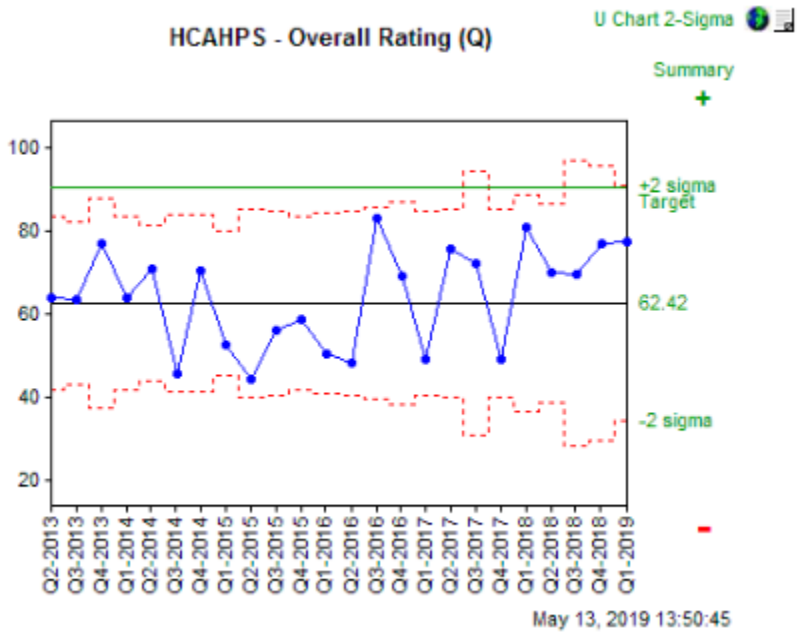
Service Excellence

Patient satisfaction is an extremely high priority for Patient Care Services. HCAHPS scores are a significant determinant in awarding of the CMS 5 Star status. All Patient Care Services staff embrace and employ many of the early tenants of the Studor model (AIDET, White Boards, Rounding, Call backs) as well as more contemporary initiatives like, "What Matters to You." Staff are expected to work and deliver patient care in a manner consistent with these initiatives. We measure patient satisfaction in a number of areas using different modalities.

HCAHPS is the primary measurement tool for Inpatient satisfaction. It is a CMS-mandated survey tool that was administered through Press Ganey via mailed paper survey. Inpatient volume is very low and only inpatients <u>discharged directly home</u> qualify for survey. Observation patients and patients transferred to Skilled Nursing or discharged home with Home Care do not qualify for survey.

OASCAHPS is the primary measurement tool for Outpatient Ambulatory Surgery. CMS expects to mandate this survey for organizations beginning January 1, 2020. Press Ganey will be distributing this survey also via mailed survey methodology.

We measure satisfaction in our Outpatient service areas using a service called Rate My Hospital. It is a texting service that sends text message survey tool links to patients discharged from the ED, Imaging, Cardiopulmonary, Outpatient Physical Therapy and Outpatient Surgery.



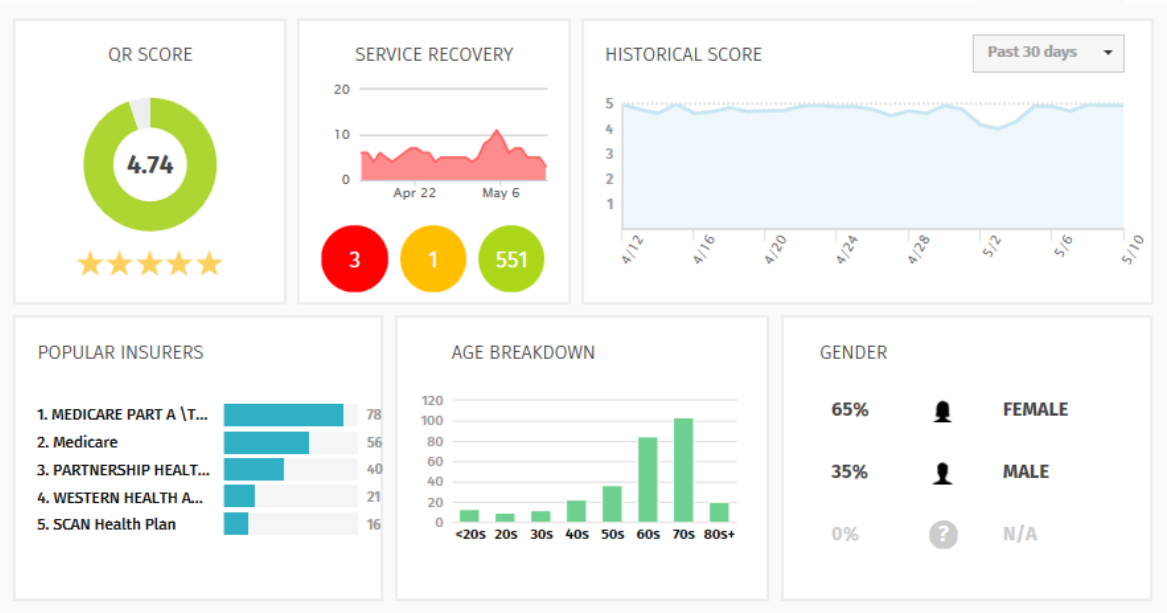
OASCAHPS Q1 2019

Question	Mean
Std Overall	93.2
Std Nursing	92.9
Nurses concern for comfort	95.1
Info N gave to prepare for proc	92.7
Nurse response to questions	94.0
Std Physician	91.1
Explanations prior to surgery	93.0
Information re what was done	89.2
Doctor response to questions	92.7
Doctor expln why proc important	90.3
Std Overall Assessment	95.7
Degree staff worked together	95.7

RATE MY HOSPITAL

5 departments, 5 surveys, 5189 responses since July 19, 2017

Since April 12, 2019 **Sent:** 1409 **Responded:** 293 (20.79%) **Median resp. time:** 1 hr 2 mins



RATE MY HOSPITAL (cont.)

Survey	Avg.Score	Score Trend	At Risk
Cardiopulmonary Department Patient Survey Sonoma Valley Hospital Providers | Patients | Questions | Analytics | CSV	4.85		0 /214
Emergency Department Patient Survey Sonoma Valley Hospital Providers | Patients | Questions | Analytics | CSV	4.53		0 /1407
Hand and Physical Therapy Patient Survey Sonoma Valley Hospital Providers | Patients | Questions | Analytics | CSV	4.85		0 /412
Medical Imaging Patient Survey Sonoma Valley Hospital Providers | Patients | Questions | Analytics | CSV	4.76		3 /1569
Outpatient Surgery Patient Survey Sonoma Valley Hospital Providers | Patients | Questions | Analytics | CSV	4.80		0 /679

Financial Performance FY 2019 YTD

The following is a rollup report of all Patient Care Service areas combined.

CNO ROLLUP FINANCIALS

TOTAL EXPENSES MTD-May

ACTUAL	FLEX	BUDGET	VARIANCE
412,816	396,745	407,527	5,289

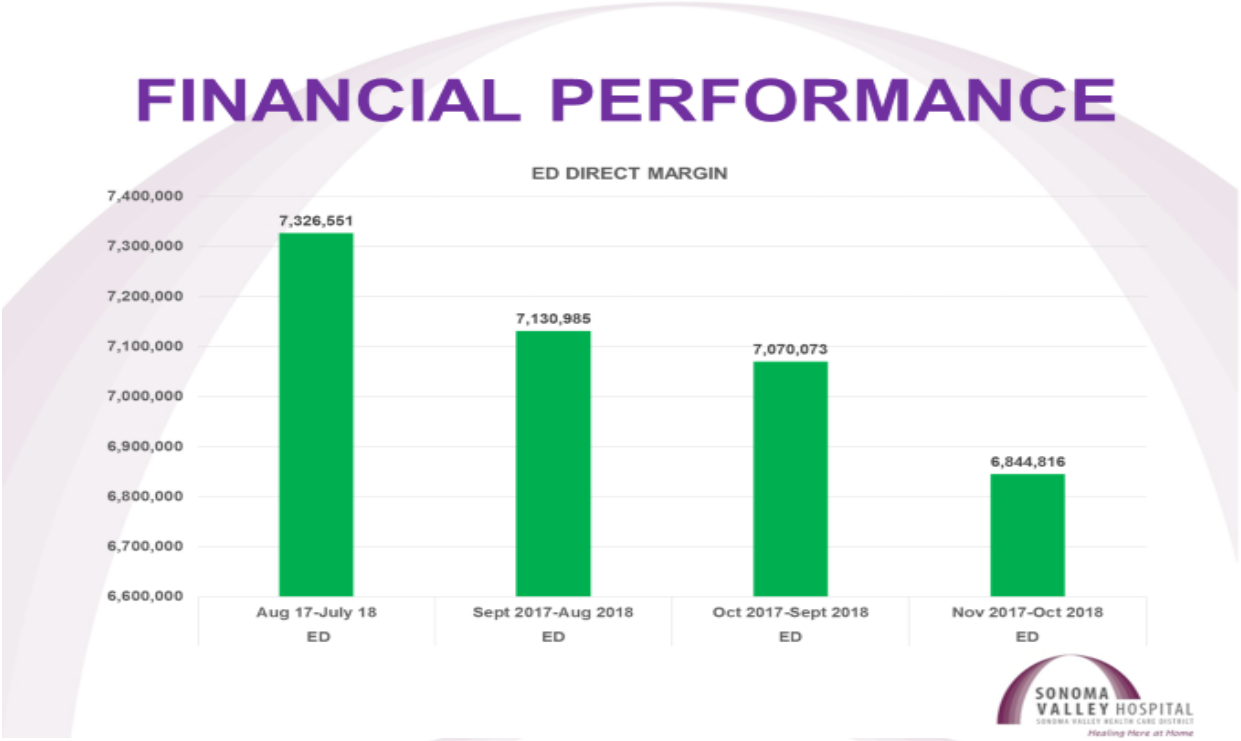
		FYTD	
ACTUAL	FLEX	BUDGET	VARIANCE
4,172,589	3,948,202	4,101,260	71,329

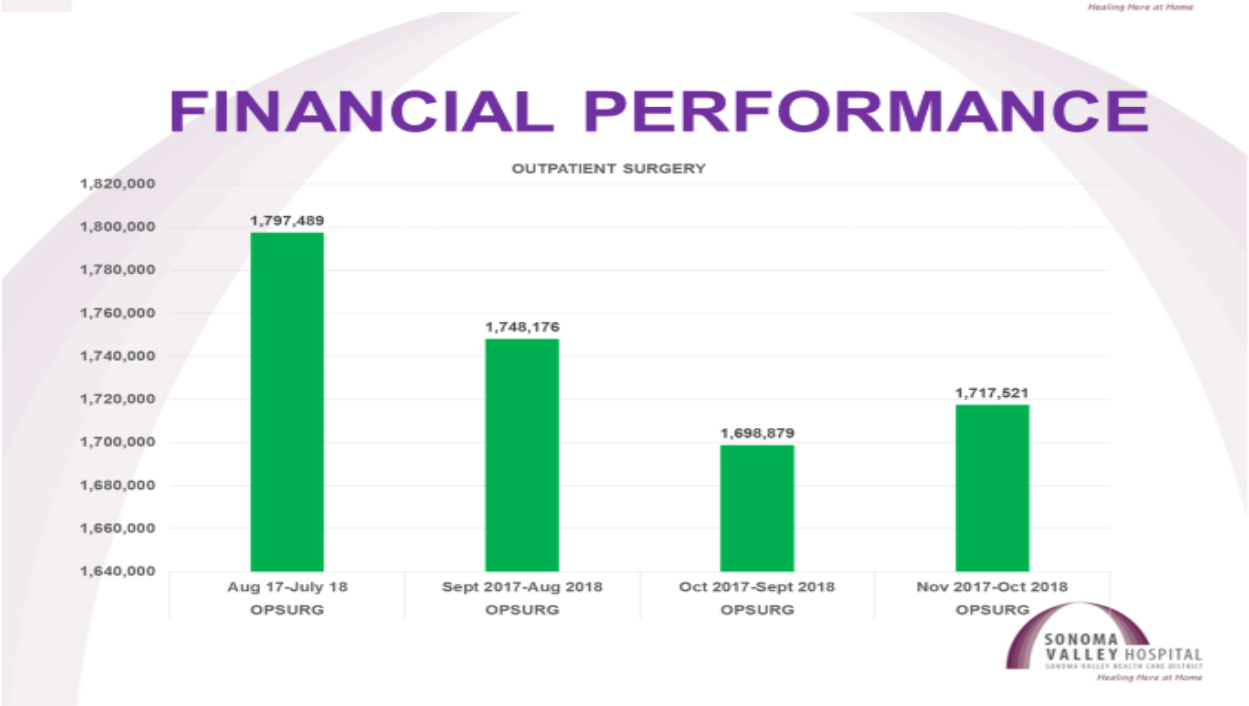
Rollup May variances:

Patient Chargeables, i.e implant costs (10k) (129k ytd) and Supplies (14k) for Spec Proc and Surgery
Registry 7.8k

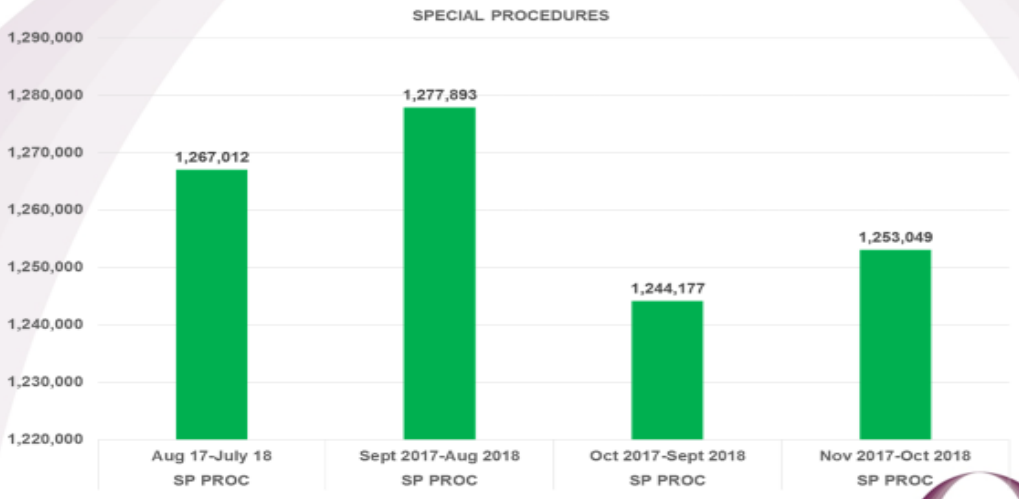
Direct Margins

Patient Care Services is a significant contributor to SVH's bottom line.

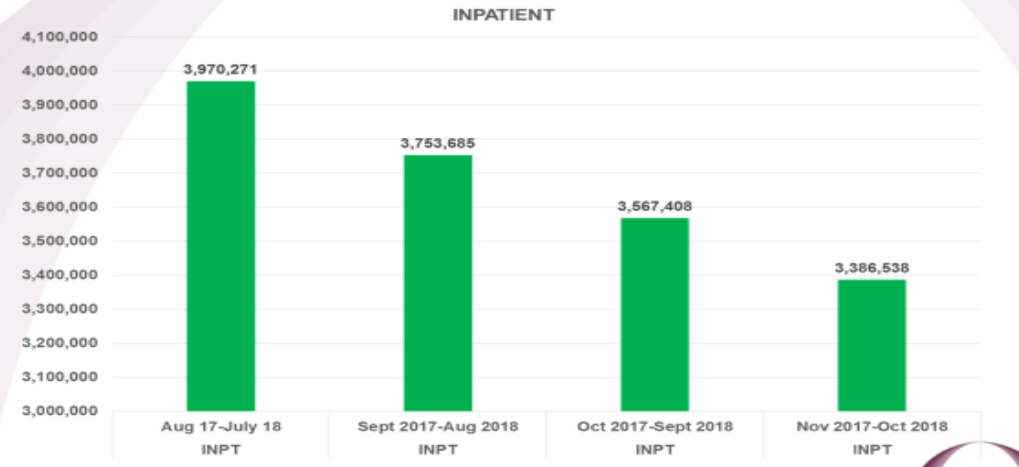




FINANCIAL PERFORMANCE



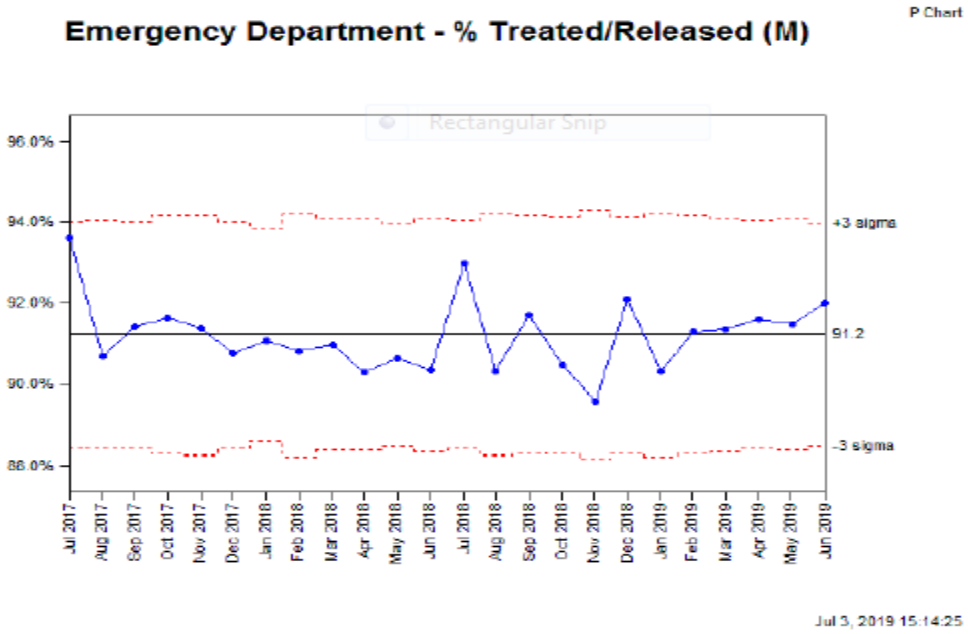
FINANCIAL PERFORMANCE

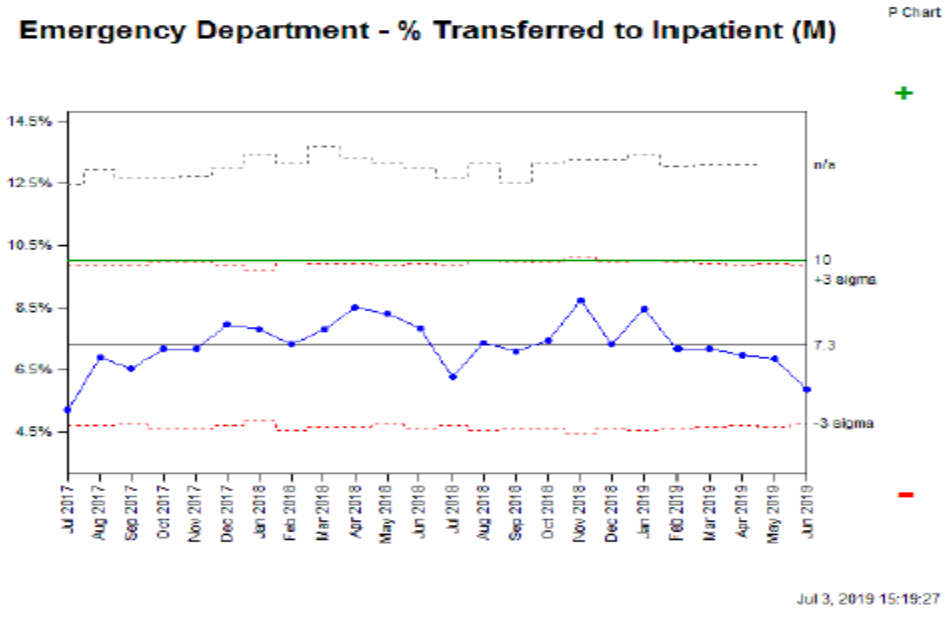


Growth

ED

Total visits for calendar 2018 (10,359) dropped 7.5% over 2017. The organization Strategic Plan calls for increased community awareness and marketing of the Emergency Department. The ED continues to generate the largest Direct Margin at SVH.





The Department became Stroke Ready Certified in April of this year. The ED sees approximately 22 patients each month presenting with potential signs of stroke. Of those, only a small percentage are actual strokes and an even smaller percentage quality for the clot-busting drug tPA. We administer tPA to approximately 6 patients per year.

Outpatient Surgery

Fiscal year 2019 the number of surgical cases increased with pain management, endoscopy and ophthalmology demonstrating the greatest increases. FY 2020 was budgeted lower due to the loss of a pain management group.

SURGICAL VOLUME

	FY 2018	FY 2019	BUDGET 2020
Inpatient	334	344	330
Outpatient	1515	1611	1573

PEOPLE

Staff Satisfaction

Staff satisfaction scores have just come in and are currently being analyzed. Participation rates for Patient Care Services are as follows:

Department	Responses	Staff	%Participation
Emergency Room	8	29	28%
ICU	2	18	11%
Med/Surg	12	25	48%
Nursing Administration	6	13	46%
Skilled Nursing Facility	5	31	16%
Surgical Services	11	32	34%

Turnover

2018 ended with 28.7% overall turnover. The Emergency Department and Inpatient experienced a higher than usual turnover in the first three Quarters of 2018. The SNF has experienced turnover in recently trained staff now seeking employment closer to home after being trained by SVH. There has been some retirement of SNF staff also.

TURNOVER CY 2018

	Regular (>=.5 FTE)		
	Active	**Terms**	**Turnover Rate**
SNF	17	7	40.8%
Acute Care	53	13	24.7%
Total:	**70**	**20**	**28.7%**

2019 has seen stabilization of turnover across the Patient Care Services Domain after 3rd and 4th Quarter 2018 hiring in the ICU and ED.

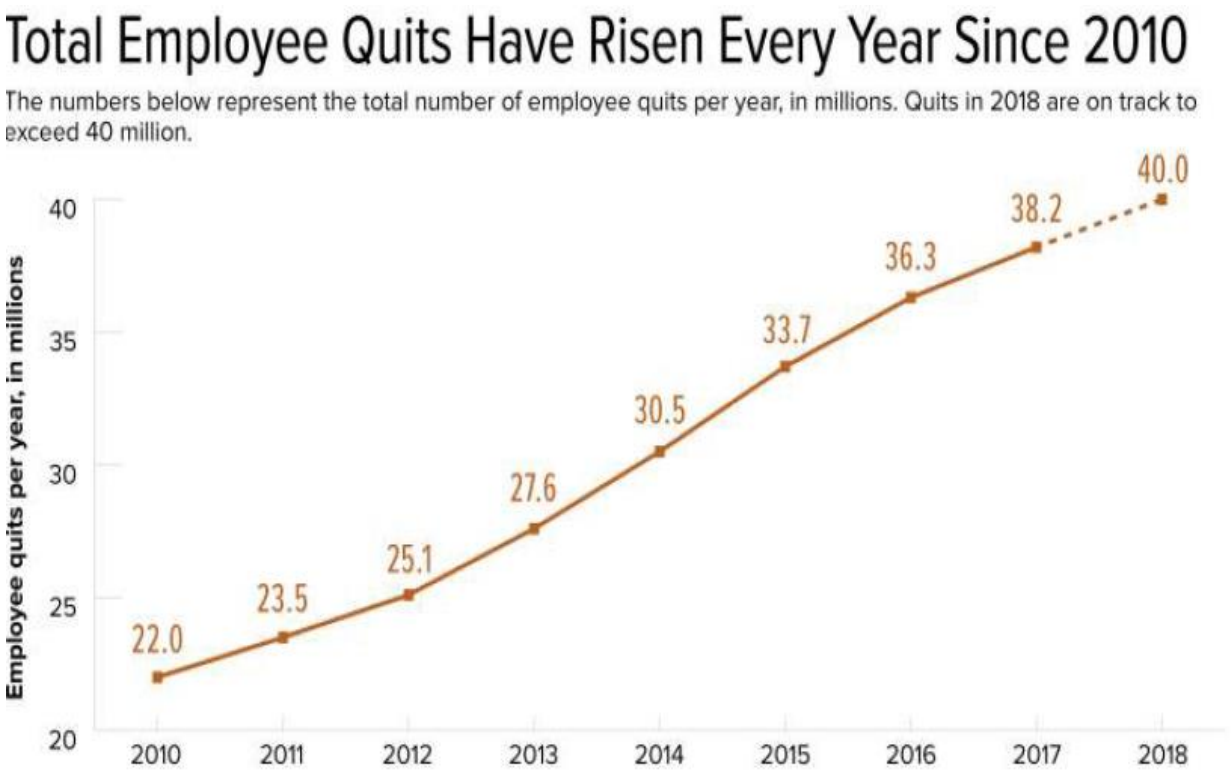
TURNOVER Q1 2019

	Regular (>=.5 FTE)		
	Active	**Terms**	**Turnover Rate**
SNF	14	0	0.0%
Acute Care	50	0	0.0%
Total:	**64**	**0**	**0.0%**

PATIENT CARE SERVICES 2019 GOALS

1. Staff Satisfaction participation rate ≥80%
2. HCAHPS 5 of 10 domains ≥ 70th %tile; Rate My Hospital overall ≥ 4.5; OASCAHPS TBD
3. Budgetary compliance in all service areas
4. Acute Care annual turnover rate < 10%
5. Acute Care and ED Medication Scanning compliance ≥90%
6. Develop evidenced-based standards of care for treatment of patients in alcohol detox per new evidenced-based phenobarbital protocol
7. Maintain ≥ 20% growth in surgical services

CONCERNS


Total Employee Quits Have Risen Every Year Since 2010
The numbers below represent the total number of employee quits per year, in millions. Quits in 2018 are on track to exceed 40 million.
Employee quits per year, in millions
40
35
30
25
20
22.0
23.5
25.1
27.6
30.5
33.7
36.3
38.2
40.0
2010
2011
2012
2013
2014
2015
2016
2017
2018

12

Patient Care Services Dashboard 2019

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT

Medication Scanning Rate	2018-19				
	Q3	Q4	Q1	Q2	Goal
Acute	85.0%	84.0%	82.0%	90.3%	≥90%
ED	78.0%	77.0%	90.0%	90.4%	≥90%
Preventable med errors R/T Med Scanning			1 (n=48)	0 (n=20)	

Falls (Per 1000 days) 2018-19					
	Q4-Q3	Q1-Q4	Q2-Q1	Q3-Q2	50th %tile
Acute	2.90	2.00	2.70	1.90	3.75
ED			0.0	0.0	

Hospital Acquired Pressure Ulcer Incidents (Per 1000 admissions)	2018-19				
	Q3	Q4	Q1	Q2	National
Acute	0.0	1.2	0.0	0.0	3.68

Nursing Turnover	2018-19 RNs/Quarter				
# of RNs	Q3	Q4	Q1	Q2	Goal
Acute (n=65)	2	3	0	N/A	≤6

Patient Experience (CAHPS)	2018				
	Q2	Q3	Q4	Q1	Goal
HCAHPS					
Would Recommend			76.5	87.1	70.0
Quietness of Hosp Environment			51.4	68.3	51.0
OASCAHPS					
Care of Patients (MD/RN respect)	94.6	93.8	88.2	98	97.1
Would Recommend	77.6	75	87.5	83.8	88.6
RATE MY HOSPITAL - ED					
Overall score	4.7	4.8	4.8	4.6	≥4.5

Nurse Staffing Effectiveness: Transfers r/t staffing/beds					
2018-19	Q3	Q4	Q1	Q2	Goal
	0	0	0	0	≤0

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

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

GOOD CATCH AWARDS

The following employees were recognized for identifying and reporting potential safety issues affecting patient care or employee/visitor safety.

Employee	*Safety Issue Identified*	*Actions Taken to Prevent Harm*
Cathy Noh (Pharmacy) RM 19-613	Unusual telephone order to refill many vials of weight based medication. Pharmacist questioned the amount ordered (60 Mg {6x10mg vials}). After clarification with MD, MD stated that he wanted 0.6mg/kg with 10 mg max dose as the CPOE order read from his order screen. There was no warning for a Max dose of 10 mg in case of entry error.	***System changed to show a warning when amounts over 10 mg are entered. We are researching if the EHR Vendor can create a "hard stop" and weight base dose maximums.***
Corey Gonsalves (Emergency) RM 19-693	Corey was organizing and finalizing charts from the previous shift and noted that important COBRA Authorization and moderate sedation documentation was missing from medical chart.	***After searching the confidential shred bin, she found the missing documentation.*** ***Reminder to clinical staff to keep all documents for ER Assistants to complete visit documentation.***
Theresa Piller (Skilled) RM 19-565	While pulling medication, noticed 2 different drugs in same bin.	***Notified Pharmacy and corrected. Pt received correct medication.*** ***Pharm staff reminded to review meds placed in Pyxis bin.***
Loise Kilonzo-Cullen (Skilled) RM 19-415	Wrong formulation matched to medication order. Terazosin 4mg QHS ordered. The e-MAR showed “give 4mg from a 5mg capsule.” Apparent Rph processing error.	***Item was corrected to 4x1mg terazosin.*** ***Pharm staff reminded to review order processing.***
Melanie Pasion (Skilled) RM 19-485	Pharmacy received a Medication Barcode Scanning Issue Form from Melanie regarding oxycodone concentrate not scanning.	***Inventory system updated.*** ***C-II items require more complex receiving and documentation when updated. Ensure new NDC codes are entered into Paragon Inventory.***

MAY 2019

Patient Experience	Current Performance	FY 2019 Goal	National Benchmark
Would Recommend Hospital	67th	> 60th percentile	50th percentile
Inpatient Overall Rating	62.5%	>60th percentile	50th percentile
Outpatient Services	4.71	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	15	< 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	14.5%/15.8%	< 10%	< 15%
Financial Stability	**YTD Performance**	**FY 2019 Goal**	**Benchmark**
EBDA	6.8%	1%	3%
FTE's/AOB	3.8	4.3	5.3
Days Cash on Hand	39	20	30
Days in Accounts Receivable	37	49	50
Length of Stay	3.8	3.85	4.03
Funds raised by SVHF	$17.2 million	$20 million	$1 million
Strategic Growth	**YTD Performance**	**FY 2019 Goal**	**Benchmark**
Inpatient Discharges	1003/1094	1000	1000
Outpatient Visits	50,160/54,720	53,000	51,924
Emergency Visits	9240/10,080	10,000	11,040
Surgeries + Special Procedures	2691/2935	2500	2,568
Community Benefit Hours	1124/1226	1200	1200

Note: Colors demonstrate comparison to National Benchmark

Policy and Procedures – Summary of Changes
Board Quality Committee, July 24th, 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

NEW:

Patient Safety Program GL8610-202
This policy was created to establish a written patient safety program for Sonoma Valley Hospital

REVISIONS:

Adverse Event Reporting GL8610-184
Changes have been made to reflect the current Health and Safety code from the Department of Public Health regarding Sentinel Events and reporting.

Code Blue-Broselow Carts and Emergency Medications QS8610-104
Removing Broselow Resuscitation Bags from Adult Crash Carts and updating Broselow Cart drawer contents list. There have been no pediatric resuscitations in recent or distant memory. These bags contain expensive product that expires each month. These bags are very high risk for regulator violations of policy due to difficulty in examining contents monthly. SVH does not admit pediatric patients but sees pediatric patients in the ED and OR. ED and OR will maintain a Broselow Emergency Cart.

Code Management for DP SNF
On July 1, 2019, the SNF became managed by an outside vendor. Our Hospitalists and ED MDs will no longer contractually respond to the SNF. The SNF will handle code blues and rrts like other SNFs and call 911 for these emergencies. Because the SNF is physically attached to SVH, life safety code regulations still apply and therefore, Code Red for fire and Code Disaster, remain in effect

REVIEWED/NO CHANGES:

Influenza Vaccination Program for Staff and LIPs IC8610-142

DEPARTMENTAL

REVISIONS:
Nutritional Services

Diet Orders and Diet Changes 8340-153
Added allowance for registered dietitian to accept and transmit medical nutrition therapy orders from the doctor. Deleted that the unit clerk will process these orders. Added licensed nurse can be notified as well if

question regarding diet order. Expanded to encompass Registered Dietitian scope of practice, to enhance patient satisfaction, and due to change in work flows.

Fluid Restriction Allowance 8340-155
Changed policy to define how many ounces the kitchen will send on each tray based on the fluid restriction written by the doctor. Removed that nursing will deduct supplement fluid from total allowance. Added Purpose and Responsibility. Added attachment A with defined allowances. Added what is included in a fluid restriction and what is not. Defined what to do if fluids exceed limits prescribed by the physician. Previous policy stated that when patients are placed on a physician ordered daily fluid restriction the kitchen will always send only 4 ounces of any fluid per tray. Nutritional Services staff to account for supplement fluid being sent. Purpose and Responsibility was missing on previous policy. Added attachment A to specify allowances. Defined process will ensure staff gives correct amounts of fluids and instructs staff as to what to do if fluids exceed limits.

Food Nutrition Disaster Plan 8340-109
Added location of the Emergency Supply by addition of map. Grammatical changes. Updated Appendix D-Emergency Menu Food Items List.

Registered Dietitian Nourishment Modifications 8340-173
The kitchen will not send nourishments if patient is NPO but will allow nourishments to be resumed when NPO no longer valid. Made changes in nutrition supplements and need for patient-centered care.

Responsibilities of the Dietitian 8340-171
Addition of RD responsibility of allergy/intolerance related menu modifications. Change of wording in meeting participation to allow for flexibility. Deleted RD responsibility over FNS manager as this is no longer necessary.

Medical Staff Departmental Policies
Table of Contents listing changes is attached

SUBJECT: Patient Safety Program	POLICY # GL8610-202
	PAGE 1 OF 5
DEPARTMENT: Quality	EFFECTIVE:
REVISED:	

PURPOSE:

This is an organization-wide program. It applies to all sites, services, and care settings. The scope of the patient safety program includes the full range of safety issues, from potential or no harm errors, to hazardous conditions and sentinel events.

The organization recognizes that a patient has the right to a safe environment, and an error free care experience. Therefore, the organization commits to undertaking a proactive approach to the identification and mitigation of medical errors.

The organization also recognizes that despite our best efforts, errors can and will occur. Therefore, it is the intent of the organization to respond quickly, effectively, and appropriately, when an error does occur.

The organization also recognizes that the patient has the right to be informed of the results of treatments or procedures whenever those results differ significantly from anticipated results.

RESPONSIBILITY:

1. Governing Body
The Governing Body, through the approval of this document, authorizes the establishment of a planned and systematic approach to preventing and addressing patient safety. The Governing Body delegates the implementation and oversight of this program to Medical Staff Performance Improvement Committee.

2. The Performance Improvement Committee
The Performance Improvement (PI) Committee is responsible for the oversight of the development, implementation and evaluation of the Patient Safety Program. This includes monitoring of corrective actions for patient safety events and to make recommendations to eliminate future patient safety events. The PI Committee will review and revise patient safety plans, annually or more often, if necessary. Ad hoc Patient Safety Subcommittees are formed as needed. The PI Committee delegates' responsibility of the actual implementation of the program to the Chief Executive Officer or designee (hereinafter referred to as the "Senior Leader").

3. Senior Leader
The Senior Leader is responsible for assuring that this program is implemented and evaluated throughout the organization. As such, the Senior Leader will establish the

structures and processes necessary to accomplish this objective. The Senior Leader delegates the day to day implementation and evaluation of this program to the Medical Staff and Clinical Leadership (hereinafter referred to as the "Management Team" of the organization.

4. Medical Staff & Management Team
Consistent with its bylaws, policies, and rules and regulations, the Medical Staff and Risk Manager are responsible for the day- to- day implementation and evaluation of the processes and activities noted in this program.

POLICY:

1. Designing or Re-designing Processes
When a new process is designed (or an existing process is modified) the organization will use information from both internal and external sources on reducing medical errors, and incorporate this information into its design or re-design strategies.

2. Identification of Potential Patient Safety Issues
As part of its planning process, the organization regularly reviews the scope and breadth of its services. Attendant to this review is an identification of care processes that, through the occurrence of an error, would have a significant negative impact on the health and well-being of the patient. Areas of focus may include:

- Processes identified through a review of the literature
- Processes identified through the organization's performance improvement program
- Processes identified through occurrence reports and adverse events
- Processes identified as the result of findings by regulatory and/or accrediting agencies
- Patient safety goals as recommended by the annual Joint Commission National Patient Safety Goals.

3. Performance Related to Patient Safety

a. Once potential issues have been identified, the organization will establish performance measures to address those processes that have been identified as "high risk" to patient safety.

b. Performance measurement data will be collected, aggregated, and analyzed – as necessary – to determine if opportunities to improve safety and reduce risk are identified. If so, the organization will prioritize those processes that demonstrate significant variation from desired practice, and allocate the necessary resources to mitigate the risks identified.

c. Opportunities to reduce errors that reflect system issues are addressed through the organization's performance improvement program.

d. Opportunities to reduce errors that reflect the performance of the individual care provider are addressed, as appropriate, through the Medical Staff peer review process or through the organization's human resource policy(s).

Responding to Errors:
The organization is committed to responding to errors in care in a manner that supports the rights of the patient, the clinical and emotional needs of the patient, protects the patient and others from any further risk, and preserves information critical to understanding the proximal and – where appropriate – root cause(s) of the error. To that end, the organization has established a variety of policies and procedures to address these issues.

1. Levels of Response to Errors
There are three major levels of response by the organization to an error. Response is based on the severity of the error.

a. Errors that are minor in nature and result in no harm (or risk of harm) to the patient may be aggregated and analyzed to see if there are any patterns or trends that would indicate process improvement opportunities. It is generally not necessary to address each error singularly.
b. Errors that are near misses or have some sort of untoward effect on the patient, but are not considered adverse as defined by the organization's adverse event policy, will be addressed through the organization's incident reporting and risk management process. An intensive assessment or root cause analysis may or may not be performed.
c. Errors that meet the organization's definition of a sentinel event will be subjected to an intensive assessment or root cause analysis. Management of these types of errors is described in the adverse event policy.

2. Supporting Staff Involved in Errors
The organization recognizes that individuals involved in an error may need emotional and psychological support. To that end, the organization has defined processes to assist employees and members of the Medical Staff.

a. Employees can be referred to the organization's "Employee Assistance Program" for assistance.
b. Members of the Medical Staff can be referred to the "Well-Being Committee" for assistance.

3. Educating the Patient on Error Prevention

The organization recognizes that the patient is an integral part of the healthcare team. Therefore, patients will be educated about their role and responsibility in preventing medical errors.

4. Informing the Patient of Errors in Care

The organization recognizes that a patient has the right to be informed of results of care that differ significantly from that which was anticipated. The Licensed Independent Practitioner (LIP) is responsible for assuring that the patient is informed of errors in care.

Reporting Errors:

The organization has established mechanisms to report the occurrence of medical errors both internally and externally.

1. Errors will be reported internally to the appropriate administrative or medical staff entity.

a. Errors will be reported to external agencies in accordance with applicable local, state, and federal law, as well as other regulatory and accreditation requirements.

2. Dissemination of Information

Lessons learned from root cause analyses, system or process failures, and the results of proactive risk assessments shall be disseminated to appropriate staff that provide care, treatment, and service pertinent to the specific issue.

3. Report to the Governing Body

Reporting of adverse events must be part of the organization's quality assessment and performance improvement program.

At least once a year, the organization will provide the governing body with a written report on the following:

b. All system or process failures
c. The number and type of sentinel events
d. Whether the patients and the families were informed of the events
e. All actions taken to improve safety, both proactively and in response to actual occurrences

REFERENCES:

CMS Conditions of Participation for Acute Care Hospitals, §482.21
CMS Conditions of Participation for Critical Access Hospitals §485.635(a)(3)(v)
Center for Improvement in Healthcare Quality, Standard QA-3

OWNER:

Director of Quality & Risk Management

SUBJECT: Patient Safety Program	POLICY # GL8610-202
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DEPARTMENT: Quality	EFFECTIVE:
REVISED:	

AUTHORS/REVIEWERS:
Danielle Jones, Director of Quality & Risk Management

APPROVALS:
Policy & Procedure Team: 6/18/19
Performance Improvement Committee: 6/27/19
Medical Executive Committee: 7/18/19
Board Quality Committee:
The Board of Directors:

POLICIES/PROCEDURES MANUAL
Medical Staff
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Governance	
Rules and Regulations	Medical Staff Rules and Regulations (revisions not due until 3/2020)
Bylaws	Medical Staff Bylaws (revisions not due until 3/2020)

APPROVALS:
Policy & Procedure Team: 5/21/19
Medical Executive Committee: 6/20/19
Board Quality Committee:
The Board of Directors:

To: Sonoma Valley Healthcare District Board Quality Committee
From: Danielle Jones
Date: 7/24/19
Subject: Quality and Resource Management Report

Community Stroke Education

Let's Talk about Stroke, a panel discussion was presented at Vintage House on July 18.#7ª˘# ⌀˚ı˘❡ı˝∞ ˛˘˛#Jasper Schmidt, MD, SVH Medical Director of Emergency Medicine; Danielle Jones, BSN, RN, HACP, SVH Director of Quality and Risk Management; and Maryanne Mahoney, RN, SVH Stroke Coordinator. Topics included; SVH's recent Acute Stroke Ready Hospital Certification, stroke statistics, anatomy and physiology, types of strokes, how to recognize a stroke, treatment, risk factors and preventative measures. 46 members of the public attended and shared that the presentation was "excellent, concise, informative, and really good!" We look forward to a second presentation on Thursday, August 8 at the Vintage House.

Department QAPI plans & quality monitoring

Completed quarterly review of department QAPI indicators. See the attached report.

Quality & Risk Management Oversight 2019

Quality Monitoring Reporting:

	Due Dates	4/15/2019	7/15/2019	10/15/19	1/15/20	
	Data Collection Period	Q1 2019	Q2 2019	Q3 2019	Q4 2019	QAPI 19/21
1	Acc/PtAcct	No	No			No
2	Admitting	No	No			Yes
3	Cardiopulm	No	No			Yes
4	Case Management	Yes	Yes			Yes
5	Emergency	Yes	Yes			Yes
6	EVS	Yes	Yes			Yes
7	Facilities	No	No			Yes
8	HIM	Yes	No			Yes
9	HR	Yes	No			Yes
10	ICU	Yes	Yes			Yes
11	Infection Prevention	Yes	Yes			Yes
12	IT	Yes	Yes			No
13	Lab	Yes	No			Yes
14	Materials Management	No	Yes			No
15	Med Staff	No	No			No
16	Med-Surg	Yes	Yes			Yes
17	Med Imaging	Yes	Yes			Yes
18	Nutritional Services	Yes	No			Yes
19	Occupational Health	Yes	Yes			Yes
20	Pharmacy	Yes	Yes			Yes
21	Quality	Yes	Yes			Yes
22	Rehab Ser IP	Yes	No			Yes
23	Rehab Ser OP	Yes	No			Yes
24	SNF	Yes	N/A			Yes
25	Surgery	Yes	Yes			Yes
26	Wound Care	Yes	Yes			Yes
27	Patient Financial Services	Yes	No			No
28	Respiratory Therapy	No	No			Yes
29	Risk	Yes	Yes			Yes
	Completion Rate	76%	54%			