# SVHCD QUALITY COMMITTEE
## AGENDA
## WEDNESDAY, October 23, 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@sonomavalleyhospital.org or 707.935.5004 at least 48 hours prior to the meeting. | | |
| **MISSION STATEMENT**<br>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**<br>*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**<br>• Minutes 09.25.19 | *Hirsch* | Action |
| **4. UCSF UPDATE** | *Dr. Kidd* | Inform |
| **5. CNO QUARTERLY PATIENT CARE DASHBOARD REPORT** | *Kobe* | Inform |
| **6. MEDICATION SAFETY REPORT AND PHARMACY REPORT** | *Kutza* | Inform |
| **7. QUALITY COMMITTEE CHARTER/SVH P.I. PLAN DISCUSSION** | *Hirsch* | Inform |
| **8. POLICIES AND PROCEDURES** | *Hirsch* | Inform |
| **9. CLOSED SESSION:**<br>a. Calif. Health & Safety Code § 32155 Medical Staff Credentialing & Peer Review Report | *Hirsch* | Inform |
| **10. REPORT OF CLOSED SESSION** | *Hirsch* | Inform/Action |
| **11. ADJOURN** | *Hirsch* | |

**SONOMA VALLEY HEALTH CARE DISTRICT**
**QUALITY COMMITTEE**
**September 25, 2019 5:00 PM**
**MINUTES**
**Schantz Conference Room**

| Members Present | Members Present cont. | Excused | Public/Staff |
|---|---|---|---|
| Jane Hirsch<br>Susan Idell<br>Michael Mainardi, MD<br>Ingrid Sheets<br>Howard Eisenstark, MD | | Cathy Webber<br>Carol Snyder | Danielle Jones, RN<br>Director of Quality and Risk<br>Sabrina Kidd, CMO |

| AGENDA ITEM | DISCUSSION | ACTION |
|---|---|---|
| **1. CALL TO ORDER/ANNOUNCEMENTS** | *Hirsch* | |
| | 5:01 pm | |
| **2. PUBLIC COMMENT** | *Hirsch* | |
| | None | |
| **3. CONSENT CALENDAR** | | Action |
| • QC Minutes, 08.28.19 | | **MOTION:** by Eisenstark to approve, 2nd by Idell. All in favor. |
| **4. POLICIES AND PROCEDURES** | *Jones* | |
| **REVISIONS:**<br>Injury Due to Medical Device Equipment CE8610-150<br>**DEPARTMENTAL**<br>**Surgery**<br>Pre-Operative Skin Preparation of Patients 7420-142 | | **MOTION**: by Mainardi to approve with minor revisions 2nd by Idell. All in favor. |
| **5. QUALITY DASHBOARD** | *Jones* | |
| | Ms. Jones presented the quality dashboard which is based on CMS core measures. The new dashboard is Ms. Jones recommendation for a monthly committee review. | |

| AGENDA ITEM | DISCUSSION | ACTION |
|---|---|---|
| **6. QUALITY WORK GUIDE AND PROPOSED REVISION OF THE QUALITY AGENDA** | *Jones* | |
| | Discussion of how quality metrics are gathered and will be presented to the committee.<br>Review and discussion of the proposed new agenda format and content.<br>Discussion of meeting time change to mid-day to accommodate hospital leader's attendance.<br>Ms. Jones to create a flow sheet of how information is funneled from committee to committee.<br><br>Proposed changes to the committee:<br>Meeting time change<br>Add hospital staff leadership to committee<br><br>Ms. Jones to send out a proposed charter and the current charter for the committee to compare for input at the October meeting.<br>Ms. Jones will present the quality data reporting flow sheet in November. | |
| **10. CLOSED SESSION** | *Hirsch* | |
| | Called to order at 6:05 pm | |
| **11. REPORT OF CLOSED SESSION** | *Hirsch* | |
| | Medical Staff credentialing was reviewed. | **MOTION:** by Mainardi to approve credentialing, 2nd by Eisenstark. All in favor. |
| **12. ADJOURN** | *Hirsch* | |
| | 6:06 pm | |

# Patient Care Services Dashboard 2019

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT

| Medication Scanning Rate | 2018-19 | | | | |
|---|---|---|---|---|---|
| | Q4 | Q1 | Q2 | Q3 | Goal |
| Acute | 84.0% | 82.0% | 90.3% | 94.0% | ≥90% |
| ED | 77.0% | 90.0% | 90.4% | 90.6% | ≥90% |
| Preventable med errors R/T Med Scanning | | 1 (n=48) | 0 (n=20) | 2 (n=12) | ≤2 |

| Nursing Turnover | 2018-19 RNs/Quarter | | | | |
|---|---|---|---|---|---|
| # of RNs | Q4 | Q1 | Q2 | Q3 | Goal |
| Acute (n=65) | 3 | 0 | 1 | 3 | ≤6 |

| Falls (Per 1000 days) 2018-19 | | | | | |
|---|---|---|---|---|---|
| | Q1-Q4 | Q2-Q1 | Q3-Q2 | Q4-Q1 | 50th %tile |
| Acute | 2.00 | 2.70 | 1.90 | 1.50 | 3.75 |
| ED | | 0.0 | 0.0 | 0.4 | |

| Patient Experience (CAHPS) | 2018 | | | | |
|---|---|---|---|---|---|
| | Q3 | Q4 | Q1 | Q2 | Goal |
| HCAHPS | | | | | |
| Would Recommend | | 76.5 | 87.1 | 72 | 70.0 |
| Quietness of Hosp Environment | | 51.4 | 68.3 | 61.3 | 51.0 |
| OASCAHPS | | | | | |
| Care of Patients (MD/RN respect) | 93.8 | 88.2 | 98 | 97.5 | 97.1 |
| Would Recommend | 75 | 87.5 | 83.8 | 83.5 | 88.6 |
| RATE MY HOSPITAL - ED | | | | | |
| Overall score | 4.8 | 4.8 | 4.6 | 4.7 | ≥4.5 |

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

| Nurse Staffing Effectiveness: Transfers r/t staffing/beds | | | | | |
|---|---|---|---|---|---|
| 2018-19 | Q4 | Q1 | Q2 | Q3 | 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**

# PHARMACY DEPARTMENT ANNUAL REVIEW 2019

***Introduction and Overview:*** The pharmacy is a core required service for acute care hospitals, and oversees all matters relating to inpatient and outpatient procurement and use of medications. Components of this oversight include the Pharmacy & Therapeutics Committee, medication error report management, ensuring compliance with state and federal regulations, and the annual update of the state required MERP (Medication Error Reduction Plan). In addition, the informatics pharmacist oversees the maintenance of Allscripts Paragon Pharmacy and CPOE medication-related order sets.

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

Leadership Team: Director of Pharmacy

***Statistical Overview:***

| Staff Category | Function | Total FTE's |
|---|---|---|
| Director of Pharmacy | The pharmacist in charge on the state pharmacy license, daily oversight and management of all pharmacy functions and personnel | 1FTE<br>1 full time Director of Pharmacy |
| Pharmacist Informaticist | Supports the oversight and maintenance of the pharmacy computer system (Paragon Pharmacy) as well as medication components of any CPOE order sets. Ensures that medication billing codes are functional and maintained in partnership with patient accounting. Participates in training physician and other staff on how to use Paragon. | 0.6FTE<br>1 Full-time pharmacist splitting status with staff pharmacist duties 60-40 |
| Staff Pharmacist | Provides day to day direct patient care including but not limited to medication histories, med order processing, antimicrobial stewardship, patient care rounds, collaboration with other hospital clinical staff, and supervision of pharmacy technicians. | 3.9FTE<br>2 Full time pharmacists (1 of which is also pharmacist informaticist)<br>7 per diem pharmacists |
| Pharmacy Buyer | Responsible for the management of pharmacy inventory, ordering, and management of purchasing processes. Troubleshoots and coordinates management of shortages and recalls. | 1FTE<br>1 full time pharmacy buyer |
| Pharmacy technicians | Manage the technical aspects of the pharmacy including refilling and restocking of medications within the pharmacy and patient care areas; billing; expiration date tracking; | 4FTE<br>2 Full time technicians<br>5 Per diem technicians |

| | | |
|---|---|---|
| | invoice management;<br>preparation/packaging of medications and IV's | |

Staffing decisions are made based legal minimum requirements, patient care workload, and ongoing Electronic Medical Record projects and maintenance. The pharmacy currently averages over 35,000 doses dispensed per month and performs medication histories on most of the approximately 1,000 patients admitted per year. The current total budget for the pharmacy is $3,327,162 of which $1,602,220 is medication purchases. Hospital pharmacies are typically not revenue generating departments since most of the patient care expenses relating to pharmacy are not individually reimbursed by payors. The budgeted hospital pharmacy revenue across both inpatients and outpatients is $16,269,107. The pharmacy does impact the bottom line of the hospital by ensuring that patients have the safest and most effective medication related care as possible, including antimicrobial optimization, anticoagulant management, parenteral nutrition management, thorough medication histories, counseling patients on their discharge medications, and other patient care related clinical duties. This translates to lower lengths of stay, efficient medication spending, and avoidance of readmissions.

## ***Quality Metrics***

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

*2019 QAPI Measures:*

| ***Indicator Name*** | ***Type of Indicator: Process/Outcome*** | ***Goal/Threshold*** | ***Frequency of Monitoring*** | ***# of Observations*** |
|---|---|---|---|---|
| *High risk medication errors that reach the patient per 10,000 doses dispensed* | *Outcome* | *≤1.25 errors reach the patient per 10,000 doses dispensed* | *Monthly* | *100% of error reports* |
| *Administration errors per 10,000 doses dispensed* | *Outcome* | *≤1.00 errors per 10,000 doses dispensed* | *Monthly* | *100% of error reports* |
| *Near miss error reports* | *Process* | *>75% of error reports are near misses* | *Monthly* | *100% of error reports* |
| *Pyxis Overrides* | *Process* | *<3.8% of transactions involve an override* | *Monthly* | *100% of Pyxis transactions* |
| *Pyxis Stockouts* | *Outcome* | *<1.5% of transactions result in a stockout* | *Monthly* | *100% of Pyxis transactions* |
| *Pharmacy Interventions* | *Process* | *Investigate outliers or trends for causality* | *Quarterly* | *100% of reported pharmacy interventions* |
| *Adverse Drug Reactions (ADRs)* | *Outcome* | *Investigate outliers or trends for causality* | *Quarterly* | *100% of reported ADRs* |
| *Antimicrobial stewardship: Length of Stay (LOS) by DRG* | *Outcome* | *Maintain at minimum a flat trend line for average LOS by DRG* | *Monthly* | *100% of reported LOS for DRGs related to simple pneumonia & pleurisy, septicemia, respiratory infections & inflammations, and cellulitis* |

| | | | | |
|---|---|---|---|---|
| *Antimicrobial stewardship: Antibiotic spend per pharmacy adjusted patient day (PAPD)* | *Outcome* | *Maintain at minimum a flat trend line for antibiotic spend PAPD* | *Monthly* | *100% of antibiotic spend per PAPD* |
| *Antimicrobial stewardship: Cefepime Days of Therapy (DOT)* | *Outcome* | *Maintain at minimum a flat trend line for DOT* | *Monthly* | *100% of Cefepime use per month* |
| *Antimicrobial stewardship: Ertapenem Days of Therapy (DOT)* | *Outcome* | *Maintain at minimum a flat trend line for DOT* | *Monthly* | *100% of Ertapenem use per month* |
| *Antimicrobial stewardship: Piperacillin-Tazobactam Days of Therapy (DOT)* | *Outcome* | *Maintain at minimum a flat trend line for DOT* | *Monthly* | *100% of Pipercillin-Tazobactam use per month* |
| *Inpatient controlled substance charting audit* | *Process* | *>95% of controlled substances audited are charted properly in the eMAR* | *Monthly* | *100% of controlled substance Pyxis withdrawals in a 24 hour period once per month* |
| *Anesthesia controlled substance waste reconciliation audit* | *Process* | *<4% of anesthesia controlled substance removals result in a discrepancy in the reconciliation of use, waste, and returns.* | *Monthly* | *>90% of anesthesia controlled substance transactions* |
| *Personnel glovetip testing* | *Process* | *100% pass rate per USP797 standards (<3 cfu annual; 0 cfu initial test x3)* | *Annually* | *100% of compounding personnel* |
| *Aseptic technique testing* | *Process* | *100% pass rate per USP797 standards* | *Annually* | *100% of compounding personnel* |
| *End product testing of compounded sterile solutions for sterility and pyrogens* | *Outcome* | *100% sterile and endotoxin free* | *Annually* | *1 individual sample (sample will only include non-antimicrobial agents)* |
| *Quantitative testing of compounded IV solutions* | *Outcome* | *No more than ±10% variance in intended concentration of the compounded product* | *Annually* | *1 individual sample (select sample for which reasonable quantitative test exists)* |
| *Surface testing of hoods and IV room* | *Process* | *100% pass rate per USP797 standards* | *Quarterly* | *1 sample from each IV hood; 3 samples total from IV room and anteroom* |
| *Room and hood certification* | *Process* | *100% rate of room and hoods meeting USP797 standards for ISO status and airborne particulates* | *Semi-annually* | *1 airborne particulate and 1 surface from each hood and 1 airborne from room 100%* |
| *Personnel written competencies* | *Process* | *100% pass rate for any personnel compounding or checking sterile IVs* | *Annually* | *100%* |

Below (Attachment A) please find the Year to Date 2019 results.

***Current and Future plans for Performance Improvement:***

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

* *Pharmacy inventory par level optimization:* Periodically updating the par levels of pharmacy medication stock has helped to reduce the carrying cost of our inventory and increase inventory turns.

* *Drug Utilization Optimization:* Using days of therapy (DOT) the department can track and trend utilization of targeted drugs and address changes in usage patterns in a proactive way. Identify more cost effective medication therapies for physicians to utilize.

* *CPOE order set optimization:* In order to make our CPOE system safer and more user friendly, pharmacy informatics is tasked with the ongoing project of addressing "pain points" for end users and addressing safety issues as they relate to prescribing. Most recently, most recently, nursing and pharmacy informatics have been working with physicians to significantly update CPOE order sets for sepsis and alcohol withdrawal to have them match current best practices.

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

* *Antimicrobial stewardship:* Using the MedMined software, we can assess our use of antimicrobials in an in depth and comprehensively. Both long term and current trends can be assessed in real time and discussed at the hospital Antimicrobial Stewardship Program Committee to determine actions to take. In addition, a quarterly report comparing SVH to similar hospitals across the country helps us to benchmark.

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

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

* *Medication Reconciliation:* This is multidisciplinary effort involved multiple processes and has led to multiple process changes to help improve accuracy and shorten turnaround time for completed home medication lists.

* *Discharge medication counseling:* Implementing a program in which pharmacists counsel patients being discharged home has helped improve the HCAHPS score for the question "understood purpose of taking meds at discharge.

***Conclusion:***

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

# Attachment A: All Pharmacy Indicators

| Status | Indicator | Current Value | Target | SPC Alert | Updated |
|---|---|---|---|---|---|
| **Quality > Pharmacy** | | | | | |
| | Rx-Ofirmev DOT | 33.01 | 20.00 | | Sep 2019 |
| **Quality > Pharmacy > Adverse Drug Events** | | | | | |
| | Rx-ADEs-Administration Errors Per 10,000 Doses | 0.62 | 1.00 | | Sep 2019 |
| | Rx-ADEs-Good Catches | 54% | 75% | | Sep 2019 |
| | Rx-ADEs-High Risk Med Errors Per 10,000 Doses | 0.41 | 1.13 | | Sep 2019 |
| | Rx-Adverse Drug Reactions | 0 | n/a | | Q3-2019 |
| | Rx-Adverse Drug Reactions-Antibiotics | n/a | n/a | | Q3-2019 |
| | Rx-Adverse Drug Reactions-Anticoagulants | n/a | n/a | | Q3-2019 |
| | Rx-Adverse Drug Reactions-Cardiovascular | n/a | n/a | | Jul 2019 |
| | Rx-Warfarin-Inpatient | 0.0% | 5.0% | | Mar 2019 |
| **Quality > Pharmacy > Antimicrobial Stewardship** | | | | | |
| | Rx-Antimicrobial Stewardship Cefepime DOT | 19.26 | 50.00 | | Sep 2019 |
| | Rx-Antimicrobial Stewardship Ertapenem DOT | 0.00 | 20.00 | | Sep 2019 |
| | Rx-Antimicrobial Stewardship Levofloxacin DOT | 12.38 | 15.00 | | Sep 2019 |
| | Rx-Antimicrobial Stewardship LOS-Cellulitis (Days) | 2.7 | 4.0 | | Jul 2019 |
| | Rx-Antimicrobial Stewardship LOS-Pneumonia (Days) | 1.0 | 4.0 | | Aug 2019 |
| | Rx-Antimicrobial Stewardship LOS-Resp. Infections-Inflammations (Days) | 2.0 | 4.0 | | May 2019 |

| Status | Indicator | Current Value | Target | SPC Alert | Updated |
|---|---|---|---|---|---|
| ★ ▼ | Rx-Antimicrobial Stewardship LOS-Septicemia (Days) | 3.9 | 4.5 | | Aug 2019 |
| ✗ ▼ | Rx-Antimicrobial Stewardship Pip-Tazo DOT | 31.64 | 20.00 | | Sep 2019 |
| ★ ▼ | Rx-Antimicrobial Stewardship-Antimicrobial Spend PAPD ($) | 0.87 | 8.00 | | Aug 2019 |
| **Quality > Pharmacy > Controlled Substances** | | | | | |
| | Rx-Controlled Substance Audit-Anesthesia | n/a | 2.0% | | Sep 2019 |
| | Rx-Controlled Substance Audit-Inpatient | n/a | 95.0% | | Sep 2019 |
| **Quality > Pharmacy > IV Room** | | | | | |
| ★ — | Rx-Cleanroom Aseptic Technique | 100% | 100% | | 2018 |
| ★ — | Rx-Cleanroom Certification | 100% | 100% | | Jul-Dec 19 |
| ★ — | Rx-Cleanroom Contact Plates | 100% | 100% | | Q2-2019 |
| ★ — | Rx-Cleanroom End Product Testing | 100% | 100% | | Q4-2018 |
| | Rx-Cleanroom Glovetip Testing | n/a | 100% | | Q1-2019 |
| ★ — | Rx-Cleanroom Hood Cleaning | 100% | 100% | | Jun 2019 |
| | Rx-Cleanroom Quantitative Analysis | n/a | 100% | | Q1-2019 |
| ★ — | Rx-Cleanroom Room Cleaning-Daily | 100% | 100% | | Jun 2019 |
| ★ — | Rx-Cleanroom Room Cleaning-Weekly | 100% | 100% | | Jun 2019 |
| ★ — | Rx-Cleanroom Written Competencies | 100% | 100% | | 2018 |
| **Quality > Pharmacy > Pharmacy Services** | | | | | |
| ★ ▼ | Rx-After Hours Interventions | 9.5% | 3.0% | | Sep 2019 |

| Status | Indicator | Current Value | Target | SPC Alert | Updated |
|---|---|---|---|---|---|
| | Rx-After Hours Pharmacy ED TAT | 14.13 | 10.00 | | Sep 2019 |
| | Rx-After Hours Pharmacy Errors | 0.12% | 0.00% | | Sep 2019 |
| | Rx-Clinical Interventions-Dollars Saved | $61,216 | $100,000 | | Q3-2019 |
| | Rx-Clinical Interventions-Time Spent | 301 | n/a | | Q3-2019 |
| **Quality > Pharmacy > Pyxis** | | | | | |
| | Rx-ER Pyxis Overrides | 3.19% | 2.50% | | Sep 2019 |
| | Rx-Pyxis Overrides | 3.57% | 4.00% | | Sep 2019 |
| | Rx-Pyxis Stockouts | 1.00% | 1.50% | | Sep 2019 |

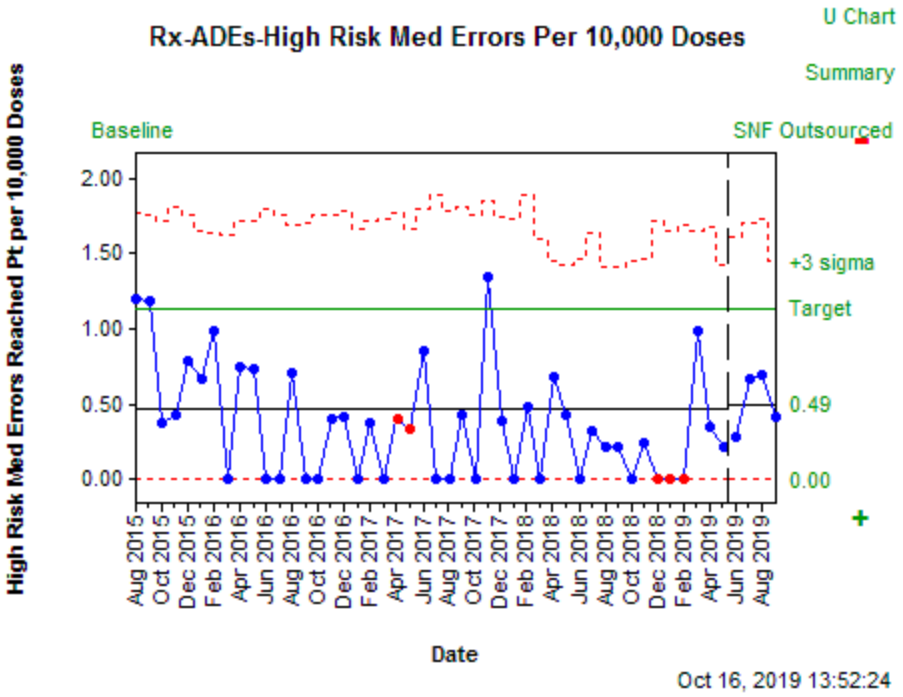
### Status Legend

- The most recent period meets or exceeds the Target
- The most recent period is between the Target and Alarm
- The most recent period violates the Target (and Alarm if applicable)
- The current value increased signifying improvement from the previous period
- The current value increased signifying deterioration from the previous period
- The current value decreased signifying deterioration from the previous period
- The current value decreased signifying improvement from the previous period
- The current value did not change from the previous period
- The indicator has not been validated
- The indicator has been validated

### Alert Legend

- Most recent period is below Lower Control Limit
- Most recent period is above Upper Control Limit
- Process shift: Most recent 8 periods are all above the Center Line
- Process shift: Most recent 8 periods are all below the Center Line
- Most recent 6 periods are all increasing
- Most recent 6 periods are all decreasing

| | |
|---|---|
| Green border: | The alert is in a positive direction |
| Red border: | The alert is in a negative direction |
| No border: | There is no target direction for the indicator |


Rx-ADEs-High Risk Med Errors Per 10,000 Doses
U Chart
Summary
Baseline
SNF Outsourced
High Risk Med Errors Reached Pt per 10,000 Doses
2.00
1.50
1.00
0.50
0.00
+3 sigma
Target
0.49
0.00
Aug 2015
Oct 2015
Dec 2015
Feb 2016
Apr 2016
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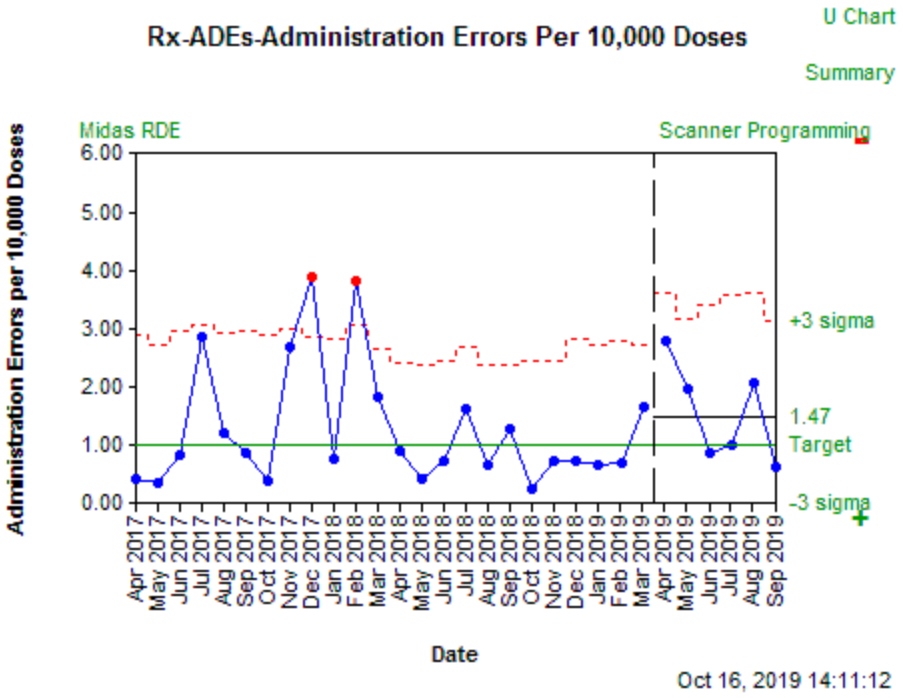
Jun 2019
Aug 2019
Date
Oct 16, 2019 13:52:24


Rx-ADEs-Administration Errors Per 10,000 Doses
U Chart
Summary
Midas RDE
Scanner Programming
Administration Errors per 10,000 Doses
6.00
5.00
4.00
3.00
2.00
1.00
0.00
+3 sigma
1.47
Target
-3 sigma
Apr 2017
May 2017
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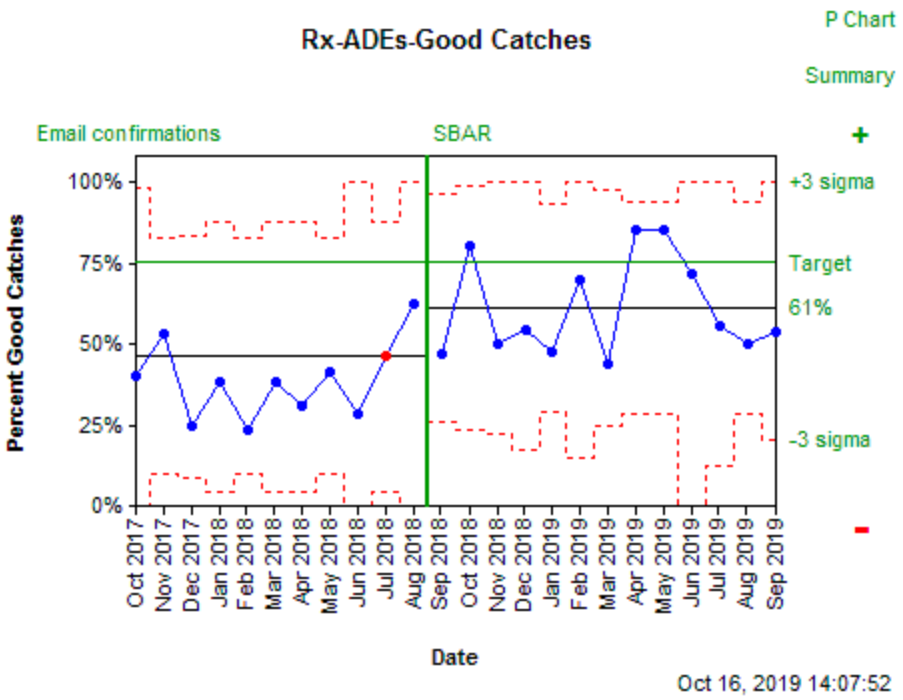
Rx-ADEs-Good Catches
P Chart
Summary
Email confirmations
SBAR
+3 sigma
Target
61%
-3 sigma
Percent Good Catches
100%
75%
50%
25%
0%
Oct 2017
Nov 2017
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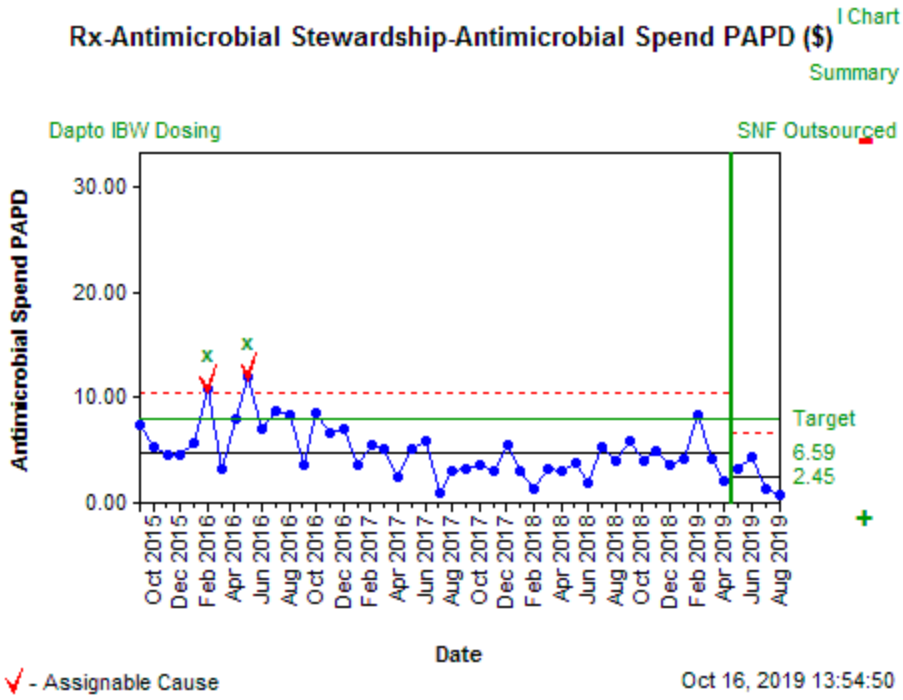
Rx-Antimicrobial Stewardship-Antimicrobial Spend PAPD ($)
I Chart
Summary
Dapto IBW Dosing
SNF Outsourced
Antimicrobial Spend PAPD
30.00
20.00
10.00
0.00
Target
6.59
2.45
Oct 2015
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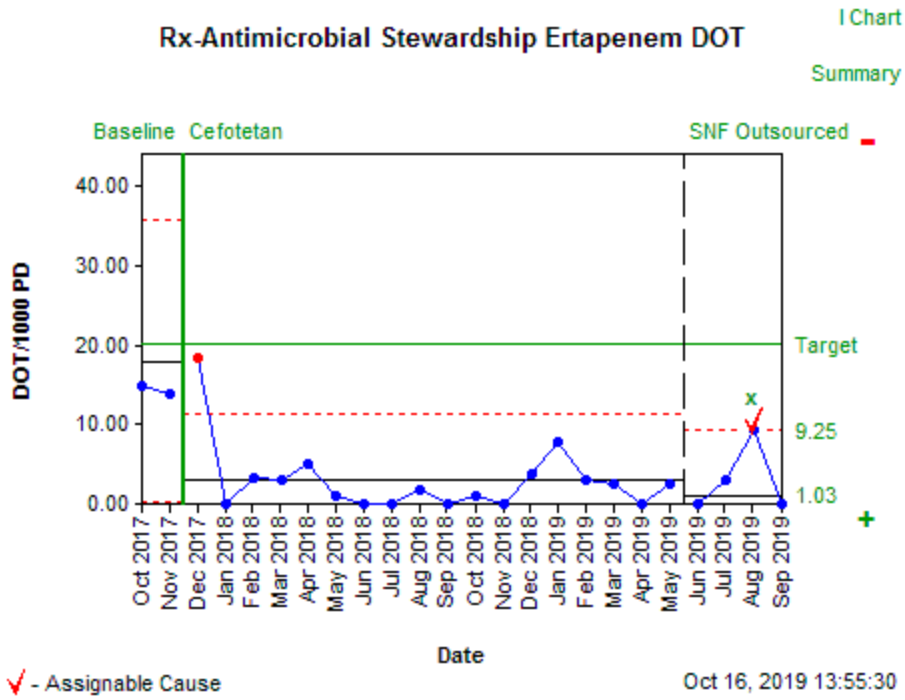
Rx-Antimicrobial Stewardship Ertapenem DOT
I Chart
Summary
Baseline
Cefotetan
SNF Outsourced
DOT/1000 PD
40.00
30.00
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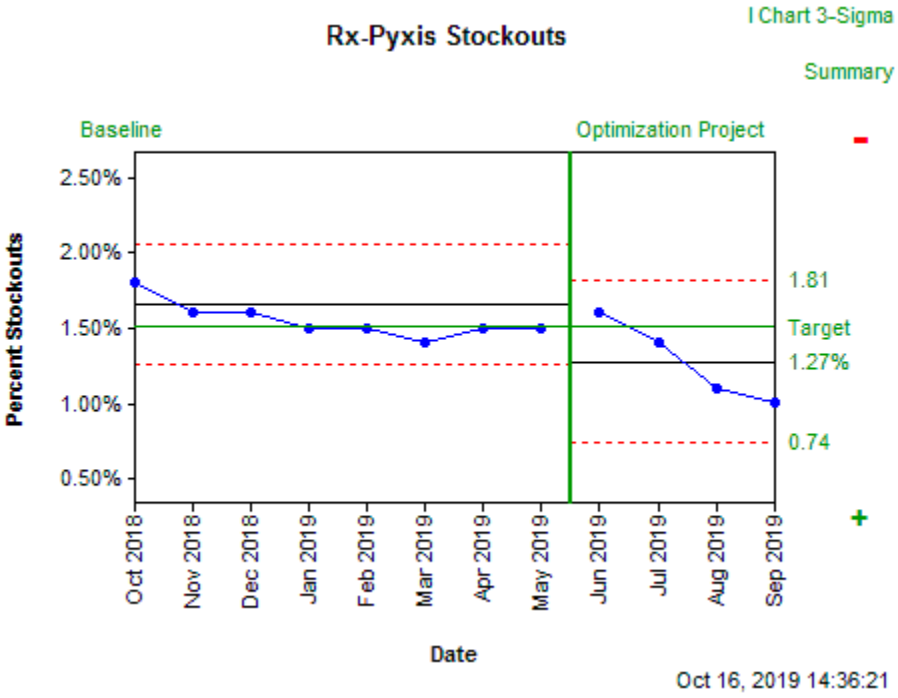
Oct 16, 2019 13:55:30


Rx-Pyxis Stockouts
I Chart 3-Sigma
Summary
Baseline
Optimization Project
Percent Stockouts
2.50%
2.00%
1.50%
1.00%
0.50%
1.81
Target
1.27%
0.74
Oct 2018
Nov 2018
Dec 2018
Jan 2019
Feb 2019
Mar 2019
Apr 2019
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Sep 2019
Date
Oct 16, 2019 14:36:21

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

SUBJECT: Quality Committee Charter



EFFECTIVE: 12/1/11

APPROVED BY: Board of Directors (12/1/11)

REVISED: 12/5/18

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

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

**Policy:**
**SCOPE AND APPLICABILITY**
This is a SVHCD Board Policy and it specifically applies to the Board, the Quality Committee, the Medical Staff, and the CEO of SVH.

**RESPONSIBILITY**

**Physician Credentialing**

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

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

**Develop Policies**

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

**Oversight**

Annual Quality Improvement Plan

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

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

Medical Staff Bylaws

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

Quantitative Quality Measures

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

2. The QC shall review all reports by and Hospital responses to accreditation organizations, e.g., Fire Marshals, Environmental Health, State Department of Health Services (DHS), and other external organizations conducting management, programmatic, physical plant audits/assessments/reviews that are directly or indirectly related to the quality of health care delivery in the Hospital (quality patient care, patient safety, and patient satisfaction). Track all uncompleted/open items until remedied/closed by the Hospital, and make recommendations and report to the Board for its action as appropriate.

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

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

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

6. The QC in collaboration with and after consultation with the Director of Human Resources, reviews systems that could adversely affect quality of care.

Hospital Policies

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

Other

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

**Annual QC Work Plan**

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

**Required Annual Calendar Activities:**

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

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

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

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

5. The QC reviews and assesses the Annual Department Reports including but not limited to: Infection Prevention, Contract Evaluations, Skilled Nursing, QAPI, Risk Management and Pharmacy.

**QC Membership and Staff**

The QC shall have at least seven and no more than nine voting members. All public members are appointed pursuant to Board policy.

1. The voting members of the QC are as follows:

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

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

   - . At least four and no more than six members of the public.

   - In the event of a tie the board chair shall decide the final vote.

2. Members of the public must be stakeholders of the District. Stakeholders have been defined by the District Board for the purposes of committee membership as:

   - Living some or all of the time in the District, OR
   - Maintaining a place of Business in the District, OR
   - Being an accredited member of the Hospital's staff

4. Staff to the QC include the Hospital's Chief Medical Officer (CMO), Chief Nursing Officer (CNO), and the Director of Quality and Resource Management who shall be the lead staff in support of the QC Chair for meetings, documents, and activities. These individuals who staff the QC are not voting members. Staff is expected to attend the QC meetings. The CEO may attend all QC and subcommittee meetings and shall be a resource at the QC meetings upon request of the QC Chair.

**Frequency of QC Meetings**

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

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

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

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

**Reference:**

**POLICY HISTORY**

December 1, 2011--Board Policy regarding the QC was first adopted.

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

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| REVISED: | |

**NEW POLICY**
Briefly state the reasons for creating a new policy.

**WHY:**

**OWNER:**
Chief Quality Officer

**AUTHORS/REVIEWERS:**
Danielle Jones, MSN, BSN, RN, HACP, Chief Quality Officer

**APPROVALS:**
Policy & Procedure Team:
Board Quality Committee:
The Board of Directors:

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| SUBJECT: Charter | POLICY: QA8610-108 |
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**PURPOSE:**

The Quality and Patient Safety Committee (Committee) is responsible for guiding and assisting the Executive Leaders, Medical Board, and the Governing Board in fulfilling their responsibility to oversee safety, quality, and effectiveness of care at Sonoma Valley Hospital; and to meet or exceed standards and regulations that govern health care organizations.

**RESPONSIBILITIES:**

The Committee has three broad sets of responsibilities. The first is to directly oversee that quality assurance and improvement processes are in place and operating in the hospital and clinics. The second is to enhance quality across and throughout the technical, patient care, and operations of the Sonoma Valley Hospital. The latter encompasses all aspects of the interface and experience between patients, families, and the community. This also includes coordination and alignment within the organization. The third is to assure continual learning and skills development for risk surveillance, prevention, and continual improvement. The committee tests all activities against the Institute of Medicine's Six Aims for Improvement: safe, effective, patient/family-centered, efficient, timely, and equitable. These aims are the drivers to the Triple Aim: Better Care, Better Health, Lower Cost. In fulfilling these responsibilities, the committee expressly relies on the confidential protections afforded by law to review activities conducted for the purpose of reducing mortality, morbidity and improving the care provided to patients.

**POLICY:**

**Oversight**
As the governing body, the Governance Board is charged by law and by accrediting and regulatory organizations (e.g., CIHQ) with insuring the quality of care rendered by hospital and clinics through its various divisions and departments. To help meet this responsibility, the Quality Committee exists to:

- Develop the quality goals and blueprint (priorities and strategies) for Sonoma Valley Hospital, using an inclusive and data driven-process.

- Review and monitor patient safety, risk mitigation, quality assurance, and improvement plans and progress.

- Have the authority to initiate inquiries, studies, and investigations within the purview of duties assigned to the Committee.
- Perform, on behalf of the Governance Board and Medical Leadership, such other activities as are required by the TJC, Centers for Medicaid and Medicare Services (CMS), National Committee for Quality Assurance (NCQA) and other external accrediting and regulatory bodies.

- Perform such other activities as requested by the Executive Leadership of Sonoma Valley Hospital.

- Render reports and recommendations to the Executive Leadership Committee of Sonoma Valley Hospital, and Medical Board on its activities.

- The Committee has the delegated authority to establish accountability in medical staff and management to assure improvement is occurring and targeted outcomes are achieved.

**Quality Integration**

1. The Committee monitors the quality assurance and improvement activities of Sonoma Valley Hospital's entities to enhance the quality of care provided throughout the hospital or medical center system and encourage a consistent standard of care. Monitored activities include but are not limited to:
   *(List as relevant to the organization)*

2. The Committee assures the coordination and alignment of quality initiatives throughout Sonoma Valley Hospital.

3. The Committee may initiate inquiries and make suggestions for improvement.

4. The Committee conducts annual reviews of the following key areas:
   a. Improvement goal achievement
   b. Clinical outcomes (priorities and improvement)
   c. Patient Safety/Event Analysis/Risk Trending
   d. Culture of Patient Safety
   e. Accreditation and Regulatory Reviews
   f. Environment of Care and Disaster Management plans

5. The Committee monitors the progress of quality assurance and improvement processes and serves as champion of issues concerning quality to other committees.

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6. The Committee identifies barriers to improvement for resolution and systematically addresses and eliminates barriers and excuses.

**PROCEDURE:**

**Guidelines**
Guidelines are designed to govern the operations of the Committee. They will be developed over time as the Committee functions and performs its responsibilities.

1. Handling of Confidential Documents Absent a specific request, confidential documents will not be forwarded to Committee members who have indicated they will not be attending a meeting. Confidential documents will be distributed ahead of meetings with the standard agenda package. They will be separately identified, numbered and logged. They will be collected following review at meetings. A return envelope will be forwarded to Committee members unexpectedly unable to attend a meeting so they will have a convenient method of returning these materials. If sent electronically, appropriate security will be used.

2. Standard Agenda
   The standard Agenda for the council will include:
   - Quality Performance Indicator Set
   - Clinical Priorities (clinical outcomes/process improvement), including:
   - *(List relevant services)*
   - Patient harm
   - Patient safety (adverse event reduction, healthcare acquired infection reduction, risk mitigation)
   - Performance to accreditation and regulatory standards and requirements
   - Environmental safety and disaster management

**Rules**

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|---|---|
| Authority to Act | Yes, within charter and as directed by Executive Leadership and Board |
| Composition | Medical and Clinical Staff Leadership appointments; Operations, Executive<br>Staff, and Board Members<br>Patient/ Families membership should be considered |
| Meeting Schedule | Ten meetings per year |

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| Recommend Size: | Based on organization |
| Quorum Requirement: | Based on organization |
| Chair | Board Chair or Chief Executive Officer (CEO) |
| Major Staff Support | Chief Quality and Patient Safety Officer, Quality Staff |
| Notices Forwarded To | Committee Members, Presenters, CEO, Chief Medical Officer (CMO) and Chief Nursing Officer (CNO) |
| Non-member attendees | Staff resources as requested<br>Subject matter experts as requested |

**Summary of Quality and Patient Safety Committee Roles and Responsibility**
Provides the operational oversight to assess that quality and its measurement are anchored Sonoma Valley Hospital's Vision and Mission; and to assess the ability of Sonoma Valley Hospital to execute against identified Quality and Safety strategies. The Board is ultimately responsible for the work of Sonoma Valley Hospital and quality of that work and is assisted by the work of the Quality and Patient Safety Committee.

The Quality and Patient Safety Committee has the following specific responsibilities:

1. Inspiring top-tier outcome performance in all clinical programs.
2. Requiring consistency of purpose in achieving best practice in clinical outcome and safety.
3. Keeping improvement as the focus against the theoretical limits of what is possible: aiming for zero defect care.
4. Evaluating whether or not processes are in place and operating to demonstrate improvement is occurring.
5. Reviewing key initiatives.
6. Requiring measures.
7. Focusing on performance results.
8. Escalating barriers to progress to appropriate forums for resolution.
9. Evaluating if community needs are met, which includes public accountability and regulatory
10. compliance.
11. Leading celebration of gains made.

12. Improving its own methods.

**REFERENCES:**
www.hginstitute.org

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| SUBJECT: Quality Assessment/Performance Improvement Plan | POLICY # QA8610-102 |
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| DEPARTMENT: Organizational | EFFECTIVE: 1/2011 |
| REVIEW/REVISED: 1/11 6/12, 4/13, 2/16 | |

☐ Revised ☐ Reviewed/No Changes ☐ Retired

**CHANGE SUMMARY:**
Briefly state changes and include reasons for making change(s).

**What:**

**Why:**

**OWNER:**
Chief Quality Officer

**AUTHORS/REVIEWERS:**
Danielle Jones, Chief Quality Officer

**APPROVALS:**
Policy & Procedure Team:
Medicine Committee:
Medical Executive Committee:
Board Quality Committee:
The Board of Directors:

| SUBJECT: Quality Assessment/Performance Improvement Plan | POLICY # QA8610-102 |
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| DEPARTMENT: Organizational | EFFECTIVE: 1/2011 |
| REVIEW/REVISED: 1/11 6/12, 4/13, 2/16 | |

**PURPOSE:**

This Performance Improvement (PI) Program promotes the mission of Sonoma Valley Hospital (SVH) by establishing a formal, organization-wide system to monitor and continuously improve patient outcomes and client services. The purpose(s) of this plan is to: develop, implement, and maintain an effective, ongoing, organization-wide, data-driven quality assessment and performance improvement program and to establish a planned, systematic, and interdisciplinary approach to improving the care, treatment and services provided.

**POLICY:**

Quality is defined as the degree to which care meets or exceeds the standards set by the Board of Directors and the Administrative Leaders of SVH. The standards will be based on one or more of the following: input from our clients, current expert knowledge, literature review, internal and external comparison, and benchmarking.

**SCOPE & APPLICABILITY:**

This is an organization-wide plan. It applies to all departments, care, treatment, and service settings including those services furnished under contract or arrangement. See policies: QA 8610-101; QA 8610 - 102 for additional information regarding the structure of this program.

**AUTHORITY AND RESPONSIBILITY:**

## Governing Body

The Governing Body authorizes the establishment of this performance improvement program. The Governing Body is responsible for assuring:

- That an ongoing program for quality improvement is defined, implemented, and maintained.
- That an ongoing program for patient safety, including the reduction of medical errors, is defined, implemented, and maintained.
- That the organization-wide quality assessment and performance improvement efforts address priorities for improved quality of care, and patient safety and that all improvement actions are evaluated
- That clear expectations for safety are established
- That adequate resources are allocated for measuring, assessing, improving, and sustaining the hospital's performance and patient safety
- That a determination of the number of distinct improvement projects is conducted annually

## Medical Executive Committee / Performance Improvement Committee

The Governing Body delegates the development, implementation, and evaluation of this program to the Medical Executive Committee (MEC). The MEC is responsible for monitoring and improving, the quality of care, safety and service provided its medical staff. The MEC has formed a Performance Improvement Committee to carry out this responsibility.

## Administration & Management

The Governing Body also delegates the development, implementation, and evaluation of this program to the organization's Administration and Management team. Administration and Management are responsible for improving the quality of care, safety, and service provided by organization staff. The Administration and Management team have developed structures and processes to carry out this responsibility.

## Further Delegation of Authority and Responsibility

The MEC and/or Administration & Management may further delegate aspects of this program as necessary to discharge their responsibilities. As such, either body may delegate to existing entities in their respective organizational structure(s), or may formulate entities to achieve specific aims.

## Quality and Resource Management

The MEC and/or Administration delegate structural, reporting, and facilitation functions of this program to the Chief Quality Officer. The Quality and Resource Management department provide education, data aggregation and reporting, team facilitation and training in order to support the success of the program. This department is also responsible for mandated reporting of quality measures and communicating the results of that reporting.

## Employees

Employees are responsible for: learning the principles of quality assessment and performance improvement; reporting any potential quality issues to their department manager or supervisor, or directly to the Quality Department; and serving on PI Teams when requested and assisting in carrying out the functions of the team.

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**PROCEDURE:**

A. **Collecting Data on Performance: Scope of Data Collection**
At a minimum, the organization will collect data in the following areas:

- Performance improvement priorities identified by leaders.
- Department specific quality monitoring/quality control systems and process indicators
- All significant discrepancies between preoperative and postoperative diagnoses, including pathologic diagnoses.
- Medical errors and adverse patient events
- Adverse events related to using moderate or deep sedation or anesthesia.
- Adverse events related to the performance of operative and/or invasive procedures
- The use of blood and blood components.
- All confirmed hemolytic blood transfusion reactions. .
- Significant medication errors and significant adverse drug reactions.
- Patient perception of the safety and quality of care, treatment, and services.
- Processes that improve patient outcomes and/or prevent and reduce medical errors.
- Processes as defined in the organizations Infection Control Program and Utilization Review Program
- Inpatient and outpatient CMS core measure data, patient safety measure data; readmission data
- The organization may also consider collecting data on the following:
  - Staff opinions and needs
  - Staff perceptions of risk to individuals
  - Staff suggestions for improving patient safety
  - Staff willingness to report adverse events

Measurement of the above areas may be organization-wide in scope, targeted to specific areas, departments and services, or focused on selected populations.

B. **Frequency of Data Collection**
By acceptance of this program, the Governing Body has defined the frequencies of data collection to be ongoing, time limited, episodic, intensive, or recurring. The duration, intensity, and frequency of data collection to measure a specific indicator shall be based on the needs of the organization, external requirements, and the result of data analysis.

C. **Detail of Data Collection**
By approval of this program, the Governing Body has determine that data shall be collected in sufficient detail to provide the user of that data with sufficient information to make timely, accurate, and data-driven decisions.

D. **Aggregation and Analysis of Data**

1. **Purpose:**
   The purpose of data aggregation and analysis is to:
   - Establish a baseline level of performance
   - Determine the stability of process
   - Determine the effectiveness of a process or desirability of an outcome as compared to internal or external targets (benchmarks)
   - Identify opportunities for improvement
   - Identify the need for more focused data collection
   - Determine whether improvement has been achieved and/or sustained.

2. **Construct:**
   Performance measures should have a construct to assure that data is appropriately identified, collected, aggregated, displayed, and analyzed. In general, the construct should consist of:
   - A definition of the measure
   - The population to be measured (including, when appropriate, criteria for inclusion and/or exclusion)
   - The type of measurement (i.e. rate based or event based)
   - If rate based, a calculation formula (i.e. defined numerator / denominator)
   - The minimum sampling size (where appropriate) to assure statistical validity
   - The frequency of data collection / aggregation
   - The methodology by which data will be collected.
   - The entity primarily responsible for data collection.
   - The manner in which aggregated data will be displayed.
   - The entity(s) to which the aggregated data will be reported to for analysis and action.

3. **Compilation of Data:**
   Data shall be compiled in a manner that is usable to those individuals and entities charge both with analyzing the data, and taking action on the information derived from data analysis. Where appropriate, statistical tools and techniques are used in data display, to assist in appropriate analysis.

4. **Analysis of Data:**
   Data on performance measures will be analyze to:
   - Monitor the effectiveness and safety of services and quality of care
   - Identify opportunities for improvement and changes that will lead to improvement

5. **Analysis of Aggregated Data:**
   Data on rate based performance measures are aggregated to determine patterns, trends, and variation (common or special cause). Data may be aggregated for a single point in time or over time, depending on the needs of the organization and the reason for monitoring performance. In general, measurement designed to establish the desired stability of a process or a desired outcome will be measured over time until target levels of performance are met.

   Once a process is considered stable, and/or a desired level of performance has been achieved, then an analysis of performance measures may be conducted in a more episodic fashion.

   Data that is event based is analyzed in singular or aggregated form depending on the number of data elements in the performance measure. In general, event based measurements are monitored on an ongoing basis. When possible, data is compared against internal and/or external benchmarks to allow for comparative performance over time.

6. **Intensive Assessments:**
   Data will be intensively assessed when the organization detects or suspects a significant undesirable performance or variation. Intense analysis is called for when:

   - Levels of performance, patterns, or trends vary significantly and undesirably from those expected
   - Performance varies significantly and undesirably from that of other organizations or recognized standards
   - An Adverse Event has occurred (root cause/intense analysis)

E. **Improving Performance:**

1. **Performance Mode**l: The organization will undertake efforts to improve existing processes and outcomes and then sustain the improved performance. To accomplish this, Sonoma Valley Hospital has adopted the following performance improvement model:

   *FOCUS PDSA: Plan Do Study Act to be used for complex processes involving more than one department where the root cause and processes steps are not well known. Example: Patient Throughput.*

*Rapid Cycle PDSA to be used when the process problem is well known and can be addressed more rapidly or when the improvement process will involve cycle of quick changes towards a clear outcome. Example: Improving patient satisfactions scores in a specific department.*

This model is used – formally or informally – in improvement efforts throughout the organization. In addition, LEAN principles may be employed as part of the PDSA model to ensure a more robust methodology and more effective improvement outcome.

2. **Prioritizing Performance Improvement Activities:** Sonoma Valley Hospital Senior Leadership prioritizes organization-wide performance improvement activities that address processes that:

   - Focus on high-risk, high or low-volume, or problem-prone areas
   - Consider the incidence, prevalence, and severity of problems in those areas
   - Affect health outcomes, patient safety, quality of care, and fiscal stewardship
   - New services or programs

   Departmental Leaders use the same process to identify those activities within their department.

3. **Performance Improvement Projects:** As part of its quality assessment and performance improvement program, the organization must conduct performance improvement projects.

   - The number and scope of distinct improvement projects conducted annually shall be proportional to the scope and complexity of the hospital's services and operations.
   - The organization shall document what quality improvement projects are being conducted, the reasons for conducting these projects, and the measurable progress achieved on these projects.
   - While the organization is not required to participate in a CMS Quality Improvement Organization (QIO) cooperative project, its own projects shall be of comparable effort.

4. **Improving Performance:** Performance improvement activities shall – at a minimum – track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the organization.

The organization shall take actions aimed at performance improvement and after implementing those actions, the organization shall measure its success and track performance to ensure that improvements are sustained.

When planned improvements are not achieved or sustained, the process will undergo an intense analysis to gain an understanding of why planned improvements have not worked and a new plan will be developed, implemented and monitored.

5. **Reporting of Performance Improvement Activities:** Regular reports on the status and effectiveness of performance improvement activities shall be made to the Governing Body as well as the leadership of the organization and its medical staff.

**REFERENCES**

CIHQ Standard QA-1
CMS Conditions of Participation for Acute Care Hospitals, 482.21

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| SUBJECT: Performance Improvement | POLICY: QA8610-110 |
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| DEPARTMENT: ORGANIZATIONAL | EFFECTIVE: |
| REVISED: | |

**NEW POLICY**
This is an example Performance Improvement Plan from the Hospital Quality Institute Quality Work Guide.

**WHY:**

**OWNER:**
Chief Quality Officer

**AUTHORS/REVIEWERS:**
Danielle Jones, MSN, BSN, RN, HACP, Chief Quality Officer

**APPROVALS:**
Policy & Procedure Team:
Board Quality Committee:
The Board of Directors:

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| SUBJECT: Performance Improvement | POLICY: QA8610-110 |
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**PURPOSE:**

The purpose of the Quality and Patient Safety Performance Improvement Plan is to improve outcomes of care, establish reliability in delivering care, and advance patient safety, by creating a culture that facilitates:

- Recognition and acknowledgement of risks and adverse events;
- Analysis of reported risks to identify underlying causes and systems changes needed to reduce the likelihood of recurrence;
- Analysis of contributing factors to adverse events and near misses;
- Initiating actions to recover, reduce risk, and prevent recurrence;
- Reporting internally on risk reduction initiatives and their effectiveness;
- Supporting transparency of that knowledge to affect positive change in culture and behavioral
- changes in health care practice both internally and with other organizations;
- Focusing on processes and systems in a context of Just Culture;
- Prospective review of selected clinical programs or services before an adverse event occurs to identify system design to error proof the system;
- Organizational learning about the epidemiology of error and performance improvement principles and processes;
- Integration of Quality and Patient Safety Improvement priorities into the new design and redesign of all relevant processes, functions and services;
- Systematic planning, analysis and monitoring of performance to improve and sustain advances in processes and outcomes of patient care through interdisciplinary teamwork;
- Regular establishment and reassessment of organizational Quality and Patient Safety Improvement priorities;
- Meeting and exceeding patient / family (customer) needs and expectations;
- Research into ways to improve patient safety and quality;
- Use of evidence-based practice and decision support; and
- Public transparency of reportable performance measures.

The approach to improving quality and patient safety delineated in this plan is based on the Sonoma Valley Hospital Quality and Patient Safety Strategy and requires a coordinated and collaborative effort to operationalize. Multiple departments and disciplines are involved in establishing the plans, processes and mechanisms that comprise health care safety and quality activities throughout Sonoma Valley Hospital. The Quality and Patient Safety Performance Improvement Plan has been developed with broad interdisciplinary input, Quality and Patient

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Safety Committees and Forums and is approved by the relevant committees, and Executive and Governance
Leadership.

Sonoma Valley Hospital endorses the six aims that the Institute of Medicine's (IOM) Advisory Commission on Consumer Protection and Quality in the Health Care Industry delineates in the report, *Crossing the Quality Chasm*. Specifically, health care should be:

- Safe – eliminating injuries to patients from the care that is intended to help them
- Effective – providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse, inappropriate use, and overuse)
- Patient[/family]-centered – providing care that is respectful of and responsive to individual patient preferences, needs and values and ensuring that patient values guide clinical decisions
- Timely – reducing waits and delays for both those who receive care and those who give care
- Efficient – avoiding waste, in particular waste of equipment, supplies, ideas and energy.
- Equitable – providing care that does not vary in quality because of personal characteristics such as gender identity, ethnicity, sexual orientation, geographic location and socioeconomic status.

**RESPONSIBILITIES:**

- All staff from every hospital department are responsible to report patient safety events, risks, and near misses.
- Infection Control and Prevention aggregates and analyzes data related to health care associated infection, infectious disease exposure, contact tracing, and multi-drug resistant organisms.
- The Safety Officer aggregates and analyzes data related to environment of care surveillance and risks, including: safety, security, hazardous materials, and fire prevention.
- Clinical Engineering aggregates, analyzes and reports data related to medical equipment preventive maintenance, incidents, and risks.
- Pharmacy aggregates, analyzes and reports data related to pharmacist interventions, pharmaceutical inspections, and medication use.
- Risk Management aggregates, analyzes and reports data related to actual potential risk management issues and patterns.

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**POLICY:**

**Scope and Activities**
This plan applies to all service and sites of care provided at Sonoma Valley Hospital. The Quality and Patient Safety Performance Improvement Plan establishes a system that includes an ongoing assessment, using internal and external knowledge and experience, to prevent errors and maintain and improve health care safety and quality. Sonoma Valley Hospital recognizes that patients, physicians and staff, visitors and other customers have the right to expect the best possible clinical outcomes, a safe environment and an error/failure-free care experience. Therefore, Sonoma Valley Hospital commits to continuously analyzing data, and designing, monitoring, improving and sustaining performance while undertaking a proactive approach to identify and mitigate health care risk and error. The organization responds quickly, effectively, and appropriately when errors occur. We recognize that the patient has the right to be informed of the results of treatments or procedures whenever those results differ from anticipated results. [disclosure]

The Quality and Patient Safety Performance Improvement System, as described in this plan, includes the activities of relevant committees/teams, including, but not limited to: [list as relevant to organization].

Additional program specifics include:

1. All departments within the organization (patient care and non-patient care departments) are responsible for on-going performance improvement and quality assurance activities. These efforts are monitored through the organizational leadership structure and key indicators are reported via the *Quality Performance Indicator Report*, condition specific dashboards and other methods.

2. All departments within the organization (patient care and non-patient care departments) are responsible to report health care safety events, near-misses, risks and hazards. Sonoma Valley Hospital has an event reporting system, to report unexpected events and near misses. Summary data from the event reporting system is aggregated and presented periodically to the Quality and Patient Safety Committee and other appropriate forums that determine further safety (risk reduction) activities as appropriate.

3. The organization selects at least one high-risk safety process for proactive risk assessment (FMEA) annually. This is accomplished through review of internal data reports and reports from external sources (including, but not limited to reports from evidence-based medicine, the Agency for Healthcare Research and Quality (AHRQ), Centers for Medicaid & Medicare Services (CMS) Hospital Compare and other federal

and state organizations, CIHQ and Current Literature).

4. Upon identification of a medical/health care error, the patient care provider will immediately:
   - Perform necessary health care interventions to protect and support the patient's clinical condition.
   - Perform necessary health care interventions to contain the risk to others, as appropriate to the event.
   - Contact the patient's attending physician and other physicians, as appropriate, to report the event, carrying out any physician orders as necessary.
   - Preserve any information related to events, including physical evidence (e.g., removal and preservation of a blood unit for a suspected transfusion reaction, preservation of IV tubing, fluids bags and/or pumps for a patient with a severe drug reaction from an IV medication, preservation of any medication labels for medications administered to the incorrect patient). Preservation of information includes documenting the facts regarding the event to the immediate supervisor, and to the organization using the event reporting system, and reporting algorithm to Risk Management.

5. An effective Quality and Patient Safety Performance Improvement Plan must exist within an environment of reporting of medical/health care errors and events. Sonoma Valley Hospital adopts the principles of a Just Culture in management of errors and events. All physicians and staff are expected to report suspected and identified medical/health care errors and should do so without the fear of reprisal in relationship to their employment. Sonoma Valley Hospital supports the concept that errors occur due to a breakdown in systems and processes, and focuses on improving systems and processes. An accountable, Just Culture approach will be used with involved physicians and staff.

6. Quality and Patient Safety Improvement includes a periodic assessment of patients, families, physicians, and staff perceptions and suggestions for improving patient safety and clinical outcomes.

7. Patients, and when appropriate, their families are informed about the outcomes of care, including unanticipated outcomes, or when the outcomes differ from the anticipated outcomes. Guidelines and training for disclosure are provided through the organization using expert resources.

8. New employee and leadership orientation provides initial education and training, including the need and methods to report, PDSA cycles of improvement, and Quality goals. Training, such as provision of health care through interdisciplinary teamwork, is

coordinated throughout the Sonoma Valley Hospital educational resources. Clinical programs and workshops are identified for an emersion in quality improvement and safety science. Ongoing offerings to managers, leaders, physicians, and staff are provided as well.

9. Medical/health care events, including sentinel events, are reported in accordance with all state, federal and regulatory body rules, laws and requirements.

10. Education and orientation is provided to patients to partner for safety through the admission process and distributed materials. Patient/Family Advisory Committees are engaged to help create strategies and tools for Sonoma Valley Hospital.

11. Systematic feedback is an aim for leaders to recognize staff when they have advanced a safety issue.

**Example**
[Organization can define its own methods]

**Quality Improvement Methodology**
The evaluation, monitoring, and improvement methodology utilized by Sonoma Valley Hospital is the DMAIC and/or PDSA process. The steps are:

- **D**efine
- **M**easure
- **A**nalyze
- **I**mprove
- **C**ontrol

- **P**lan the improvement and continued data collection
- **D**o Improvement, data collection and analysis
- **S**tudy the results to inform the next test of change
- **A**ct to hold the gain and to continue to improve the process

Sonoma Valley Hospital also employs tools for process improvement and/or system design that incorporate elements of Statistical Process Control, Six Sigma; and Lean Systems Thinking and Operations Engineering to reduce system variation, delays, and unnecessary complexity that are barriers to optimal patient care.

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**PROCEDURE:**

**Quality Improvement Priorities**
Leaders plan and ensure implementation of the Quality and Patient Safety Improvement System. The criteria used to prioritize opportunities for improvement include, but are not limited to:

- Vision and Mission
- Clinical quality outcomes
- Patient safety assessments and event analysis findings
- Patient Safety Climate Survey
- Benchmarking and identification of opportunity
- Participation in improvement collaboratives
- National Patient Safety Goals and other regulatory/accrediting standards
- Customer satisfaction
- Aspirational aims for the future of health care
- IOM six aims of care that is safe, timely, efficient, effective, patient[/family]-centered, equitable

Quality improvement priorities and activities may be reprioritized based on significant organizational performance findings or changes in regulatory requirements, patient population, environment of care, and expectations and needs of patients and communities served. Priorities are identified each year in Sonoma Valley Hospital quality goals and cascaded throughout the organization. Sub goals or drivers of the goals that are locally relevant, conceptually linked, and contribute to achieve the desired outcomes are identified.

Previously prioritized activities are evaluated and are incorporated into standard practice, based on positive findings from these evaluations. Further tracking and trending of these measures are continued if overall quality surveillance measures suggest that formal reevaluation is warranted.

**Tools to Guide Clinical Practice**
Tools to improve quality of care and reduce unintended variation exist throughout Sonoma Valley Hospital. These tools include evidenced-based guidelines, standardized order sets, protocols and clinical pathways in addition to improvement methodologies described above. There are other activities that are not part of this Quality and Patient Safety Improvement Plan that are carried out throughout the organization where algorithmic approaches exist. Research and experimental study design oversight is conducted by the [designated review board]. Research in safety systems and improvement exists throughout Sonoma Valley Hospital. [*optional text, based on type of organization:* Medical resident quality improvement projects and a developing maintenance of certification program contribute to an enriching environment.]

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***Confidentiality***
Confidentiality and peer review protections are essential to a successful quality and patient safety improvement process. Deliberations of quality committees and teams where quality and patient safety improvement issues are discussed are protected. Additionally, names of specific individuals (patients, physicians, staff, etc.) are deindentified. Quality and patient safety improvement data, reports, and other work products are maintained in secure files and databases.

***Evaluation***
The effectiveness of the Quality and Patient Safety Improvement Plan is evaluated and reported annually to the senior leaders, Medical Board, and Governance Board. This evaluation is based on comparisons of annual goals and objectives with program activities and achievements.

***Accountability***
The executive responsibility for the Quality and Patient Safety Performance Improvement Plan is through the CEO. The Medical Board, Hospital-Clinic Systems, senior leaders, and the Quality and Patient Safety Council ensure implementation of an integrated program throughout the organization. A qualified Chief Quality and Patient Safety Officer reports to the CEO to oversee the portfolio of activity and ensure the system of improvement is operating and effective.

The office of Quality and Patient Safety, led by Chief Quality and Patient Safety Officer, is responsible for advancing strategy and guiding implementation with operations leaders.

***Medical Board***
The Medical Board has responsibility for the oversight of the safety and quality of medical and patient care rendered by the medical center. It regularly reviews and evaluates performance data and makes recommendations for further action or commissions studies when needed. The Medical Board shares responsibility with the Sonoma Valley Hospital Administration for developing and reviewing policies and recommending standards for other Sonoma Valley Hospital staff whose conduct directly influences the safety and quality of patient care.

***Quality and Patient Safety Committee***
The Quality and Patient Safety Committee (Committee), which represents leadership across Sonoma Valley Hospital, is responsible and accountable for the success of the Sonoma Valley Hospital's performance in quality and patient safety activities. The Committee synthesizes and coordinates quality and patient safety activities of the Sonoma Valley Hospital. The Committee ensures that activities throughout the organization are consistent with the priorities established by leadership. The Committee systematically reviews reports from patient safety and quality related committees and subcommittees to identify key areas of opportunities. The Committee

identifies specific high volume, high risk and problem-prone aspects of care, instructing the appropriate committee(s), as delineated in the Medical Staff Bylaws, to prioritize their efforts accordingly. Intradepartmental performance improvement activities, when appropriate, are shared with the Committee to assure coordination of efforts. The Committee evaluates progress in achieving quality goals and recommends priorities to senior leaders for goal setting.

The Committee provides quality and patient safety improvement leadership, including but not limited to:

1. Assuring compliance with national recommendations for patient safety, including the National Patient Safety Goals.
2. Overseeing and setting/resetting priorities for Sonoma Valley Hospital comprehensive, interdisciplinary improvement efforts.
3. Developing an environment that encourages and empowers staff to identify and address issues through the performance improvement process in a collegial, non-punitive manner.
4. Empowering committees to identify opportunities, design performance improvement activities and resolve issues.
5. Monitoring patient safety and quality-related functions.
6. Reviewing reports from organizational committees and making recommendations regarding safety and quality of care issues.
7. Overseeing performance measures that are required by accrediting and licensing agencies related to patient safety and quality.
8. Obtaining input for improvement opportunities from committee representatives, department heads or representatives, administrative reports including third-party reports, survey findings from professional organizations such as TJC, departmental quality assessment reports, and continuous hospital-wide trend reports on mortality and readmission.
9. Identifying opportunities for interdisciplinary approaches as needed to resolve problems efficiently and effectively.
10. Chartering performance improvement teams and program evaluations, addressing organizational priorities and reviewing their activities.
11. Referring issues to appropriate improvement teams, clinical services, departments or committees.
12. Facilitating dissemination, discussion and understanding of clinical Performance Improvement and Patient Safety data.
13. Reporting to the Executive Leadership and Board on significant issues.
14. Assuring compliance with accreditation standards and regulatory agency requirements.
15. Monitoring sentinel events and event analysis findings and action plans.

16. Selecting, approving, and reviewing Failure Mode and Effects Analyses (FMEA) performed by the organization.
17. The Medical Board will receive minutes and Quality Performance Indicator Reports.

***Executive Steering Committee***
The Executive Steering Committee is composed of organizational leaders who are responsible for establishing expectations and priorities in order to manage the clinical performance and patient safety improvement system. They remove barriers and/or assign resources as needed. They ensure that processes are in place to measure, assess, and improve the hospital's patient care/safety functions. The key charge of this group is to ensure that the appropriate quality and safety priorities are identified and addressed, remove barriers to progress, and to approve strategies for quality communication inside and outside the hospital.

**REFERENCES:**
www.hginstitute.org

**Policy and Procedures – Summary of Changes**
Board Quality Committee, October 17th, 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:**

Compounding Drug Products MM8610-137
Updated section on beyond use dates to match current requirements of USP 795. USP 795 is enforceable and has been updated, requiring the policy to be updated to match.

Compounding Policies, Annual Review of MM8610-160
Changed the methodology for documenting annual review of policies and documentation of staff acknowledgement of revisions. Previous methods were difficult to maintain. New method involves central document updated on an annual basis instead of signing each policy separately.

IV Compounding Outside of the Pharmacy MM8610-118
Updated the section on beyond use dating that has change from 1 hour to 4 hours. Added a section describing immediate use compounding from the updated version of USP 797. USP 797 has undergone extensive revisions and is enforceable in December 2019.

Lipid Rescue for Local Anesthetic Toxicity MM8610-104
Added line stating that pharmacy department is responsible for restocking and maintaining the kit. This is a regulatory requirement to be in the policy.

Malignant Hyperthermia Management of Patient with MM8610-105
Added language stated what personnel is responsible for maintaining and restocking the components of the MH cart. Pharmacy manages the medication and nursing manages the supplies. This is a requirement of title 22 and in response to a finding during GACH survey by CDPH.

Multi-Dose and Single-Dose Vials MM8610-127
Updated the storage beyond use date and handling instructions for single use vials. USP 797 has undergone extensive revision and is enforceable in December 2019. Policies require updating to ensure compliance.

Self Administration of Medications MM8610-115
Removed reference to Skilled Nursing Facility requirements. SNF is no longer managed by the hospital.

Sterile Compounding MM8610-117
Significant revisions made to majority of document. Includes changes to beyond use dating, risk level categories, immediate use definition, environmental sampling procedures, personnel competency procedures, action levels for QA, removal of procedures for tasks not done at SVH, consolidating repetitive or duplicate verbiage. A significant revision to USP 797 was released in 2019 which becomes enforceable in December 2019. Policy updated to account for changes in this revision.

**RETIRE:**

Drug Regimen Review for Skilled Nursing Facility MM8610-107
SVH pharmacy is no longer participating in multidisciplinary rounds as Ensign now oversees Valley of the Moon Skilled Nursing Facility.

Pharmaceutical Care Consulting for Skilled Care Facility MM8610-109
No longer necessary with the transfer of SNF

**REVIEWED/NO CHANGES:**

Fentanyl Patch MM8610-130
Pharmaceutical Waste Management MM8610-155

**DEPARTMENTAL**

**PHARMACY DEPARTMENT**
**REVISIONS:**

Updated to current protocol:
Antimicrobial Stewardship Monitoring Procedure 8390-01
QAPI Procedures Sampling Plan-IV Room 8390-02
Sterile Compounding Procedures 8390-03
Fentanyl Patch Pharmacist Verification 8390-13

Reviewed, No changes:
C-II Controlled Substance Wholesaler Invoice Management Procedure 8390-04
Body Fluid Exposure Prophylaxis Kit Preparation 8390-06
Clozapine REMS Procedure 8390-08
Pharmacy Staff Competency Assessment 8390-09
Maintenance of Pharmacy Equipment 8390-10
Pharmacist Patient Discharge Medication Counseling 8390-11
Medication History Review Standard Work 8390-12