SVHCD QUALITY COMMITTEE

AGENDA

WEDNESDAY, January 22, 2020
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 District meeting, please contact the District Clerk, Vivian Woodall, at vwoodall@sonomavalleyhospital.org or 707.935.5005 at least 48 hours prior to the meeting.		
MISSION STATEMENT *The mission of the SVHCD is to maintain, improve, and restore the health of everyone in our community.*		
1. CALL TO ORDER/ANNOUNCEMENTS	*Hirsch*	
2. PUBLIC COMMENT SECTION *At this time, members of the public may comment on any item not appearing on the agenda. It is recommended that you keep your comments to three minutes or less, Under State Law, matters presented under this item cannot be discussed or acted upon by the Committee at this time For items appearing on the agenda, the public will be invited to make comments at the time the item comes up for Committee consideration.*	*Hirsch*	
3. CONSENT CALENDAR • Minutes 11.20.19	*Hirsch*	Action
4. VALLEY OF THE MOON POST ACUTE SEMI-ANNUAL REPORT	*Empey*	Inform
5. SVH QUALITY INDICATOR PERFORMANCE AND PLAN	*Jones*	Inform
6. PROPOSED QUALITY COMMITTEE CHARTER	*Jones*	Inform
7. POLICIES AND PROCEDURES	*Jones*	Action
7. CLOSED SESSION: a. Calif. Health & Safety Code § 32155 Medical Staff Credentialing & Peer Review Report	*Hirsch*	Inform
8. REPORT OF CLOSED SESSION	*Hirsch*	Inform/Action
9. ADJOURN	*Hirsch*	

SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
November 20, 2019 5:00 PM
MINUTES
Schantz Conference Room

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

AGENDA ITEM	DISCUSSION	ACTION
1. CALL TO ORDER/ANNOUNCEMENTS	*Hirsch*	
	5:00 pm	
2. PUBLIC COMMENT	*Hirsch*	
	None	
3. CONSENT CALENDAR		Action
• QC Minutes, 10.23.19	The minutes should reflect Danielle Jones as excused.	**MOTION:** by Mainardi to approve with correction, 2nd by Sheets. All in favor.
4. 2018 ANNUAL CULTURE OF SAFETY REPORT	*Jones*	
	Ms. Jones reviewed the Annual Culture of Safety Report from AHRQ. The report measured number of events reported and overall patient safety grade across 12 dimensions.	
5. CMS STAR RATING	*Jones*	
	Ms. Jones explained the CMS 5 star rating based on seven measure groups, keeping in mind that this data is two years old. SVH outperformed other hospitals in safety of care and readmissions, which together account for 44% of SVH's 4 star rating. Becoming a 5 star hospital is a goal of SVH's strategic plan.	
6. QUALITY AND SAFETY ACCOUNTABILITY REPORTING	*Jones*	

AGENDA ITEM	DISCUSSION	ACTION
	Ms. Jones shared the quality and safety reporting flow. A key committee is Performance Improvement staffed by clinicians and reporting to the Medical Executive Committee, since physicians are responsible for patient safety.	
7. HQI QUALITY DASHBOARD	*Jones*	
	The HQI dashboard is real time data. Again, SVH outperformed other State and national hospitals in most areas.	
8. BOARD QUALITY RESTRUCTURE	*Jones*	Inform/Action
	A brief discussion was held, and the topic was put over to the December meeting. Committee member requests included: viewing a sample standardized agenda (including core measures, risk events, harm events, and other indicators); seeing current data around clinical indicators, including any fallouts and why, what is being done to resolve the issue; and review of the prior Jaffe presentation categories.	
9. CLOSED SESSION	*Hirsch*	
a. Calif. Health & Safety Code § 32155 Medical Staff Credentialing & Peer Review Report	Called to order at 6:07 pm	
10. REPORT OF CLOSED SESSION	*Hirsch*	
	Medical Staff credentialing was reviewed.	**MOTION:** by Mainardi to approve credentialing, 2nd by Sheets. All in favor.
11. ADJOURN	*Hirsch*	
	6:11 pm	

JANUARY 2020

SVH - ENSIGN PARTNERSHIP UPDATE

VALLEY OF THE MOON
POST ACUTE

SUMMARY OF TRANSITION

- **OCCUPANCY SINCE JULY 1st, 2019**
  - AVERAGE DAILY CENSUS = 21.95 OR 81.3%
  - 45% LONG TERM CARE
  - 114 ADMISSIONS
  - 104 DISCHARGES
  - AVG. LENGTH OF STAY FOR SKILLED RESIDENTS IS 21.45 DAYS
- **PRIMARY REFERRAL SOURCE: SONOMA VALLEY HOSPITAL, (ALSO SANTA ROSA MEMORIAL, AND QUEEN OF THE VALLEY)**
- **PRIMARY PAYERS: MEDICARE, MEDICAID, PARTNERSHIP, HMO, HOSPICE, PRIVATE**
- **PRIMARY SERVICES OFFERED: SKILLED NURSING, IV THERAPY, PT, OT, ST**
- **SEEMLESS MEDICARE CONVERSION TO PATIENT DRIVEN PAYMENT MODEL (PDPM) OCT 1, 2019 – IMPROVED PERFORMANCE**

VALLEY OF THE MOON POST ACUTE
ENSIGN GROUP

SUMMARY OF TRANSITION CONTINUED…

- **SUCCESSFUL SHARED SERVICES WITH HOSPITAL INCLUDE:**
  - DIETARY/FOOD SERVICES
  - LAB/RADIOLOGY
  - HOUSEKEEPING
  - PHYSICAL FACILITY/ENGINEERING
  - COMMON SPACES/OFFICES
  - LAUNDRY
- **NEW MEDICAL DIRECTOR (GAPS HEALTH)**
  - JAMISON FERAMISCO
- **PRIMARY LOCAL REFERRING AND FOLLOWING PHYSICIANS FROM SONOMA COMMUNITY:**
  - DR. VERDUCCI
  - DR. CAMPBELL
  - DR. STREETER

VALLEY OF THE MOON POST ACUTE

ENSIGN GROUP

CENSUS DETAIL

Period Ending	Jul/19	Aug/19	Sep/19	Oct/19	Nov/19	Dec/19	AVG	YTD
Sonoma Valley Hospital								
	27	27	27	27	27	27	27	27
Managed Care	2.52	2.00	2.87	3.61	3.33	1.90	2.70	2.70
Medicaid	2.13	5.84	7.77	9.19	11.10	11.84	7.96	7.96
Medicare A	10.52	9.29	11.53	9.10	9.23	6.81	9.40	9.40
Other	0.06	4.23	3.30	1.77	1.00	0.29	1.77	1.77
Private	-	-	-	0.45	-	0.23	0.11	0.11
TOTAL	**15.23**	**21.35**	**25.47**	**24.13**	**24.67**	**21.06**	**21.95**	**21.95**
Occupancy %	56.39%	79.09%	94.32%	89.37%	91.36%	78.02%	81.30%	81.30%
Admissions	26	22	15	19	14	18	19.00	114
Discharges/Deaths	22	14	15	18	13	22	17.33	104
Leaves/Room Reserves	0	1	1	8	0	1	1.83	11
Return from Leaves	0	1	0	7	0	1	1.50	9

KEY QUALITY METRICS

SONOMA VALLEY HOSPITAL

Skilled Nursing Facility Quality Dashboard Q4 2019

PERFORMANCE GOAL	OBJECTIVE	METRIC	ACTUAL RESULT	GOAL LEVEL
1	Highly Satisfied Patients 90% or > highly satisfied	Per Questionnaire, Would recommend facility	Total 53 Q4 Discharges Result= 43 Highly Satisfied 81%	5 is 90 and above 4 is 85 to 89 3 is 81 to 88 2 is 75 to 80 1 is 74 and below
2	Falls reduction	Falls/patient days	CA Average 1.7 Natl Average 3.3 **Result= 4 Falls/2,246 days =<1%**	5 is 1.7 or less 4 is 1.8-2.5 3 is 2.6-3.3 2 is 3.4-3.9 1 is >3.9
3	Restraint Free Environment	Restraint utilization	CA Average 0.5% Natl Average 0.3% **Result= 0%**	5 is 0.5% or less 4 is 0.4-0.3% 3 is 0.31-0.35 4 is 0.36-0.40 5is >0.41
4	Pressure Ulcer prevention	CMS report	CA Average 1.0% (6.87%) Natl Average 1.7% (7.32%) **Result= 0%**	5 is 1.0 or less 4 is 1.1-1.5% 3 is 1.6-1.8% 2 is 1.9-2.1% 1 is >2.1%
5	Antipsychotic Medication	CMS report	CA Average 1.4% (9.67%) Natl Average 1.8% (12.78%) **Result= 11.11%**	5 is 1.4% or less 4 is 1.5-1.7% 3 is 1.8-2.0% 2 is 2.1-2.5% 1 is > 2.6 %

VALLEY OF THE MOON POST ACUTE

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KEY QUALITY METRICS CONTINUED…

PERFORMANCE GOAL	OBJECTIVE	METRIC	ACTUAL RESULT	GOAL LEVEL
6	% Patients successfully returned home	CMS report	CA Average 48.5% Natl Average 48.6% **Result= 83.19%**	5 is >48.6% 4 is 48.5-48.3% 3 is 48.2-47.9% 2 is 47.8-46.5% 1 is ≤ 46.6%
7	Re-hospitalized within 30 days after SNF admission	CMS report	CA Average 22.8% Natl Average 22.9% **Result= 9.62%**	5 is <22.8% 4 is 22.9-23.5% 3 is 23.6-24.0% 2 is 24.1-24.6% 1 is >24.6
8	Residents who self-report moderate to severe pain	CMS report	CA Average 6.2% Natl Average 14.7% **Result= 6.49%**	5 is 6.2% or < 4 is 6.3-9.0% 3 is 9.1-14.0% 2 is 14.1-18% 1 is ≥ 18%
9	Discharged residents with Emergency Room visit within 30 days	CMS report	CA Average 10.1% Natl Average 10.7% **Result= 6.41%**	5 is ≤ 10.1% 4 is 10.2-10.5% 3 is 10.6-10.8% 2 is 10.9-11.1% 1 is ≥ 11.2%
10	Catheter Associated Urinary Tract Infection	CMS Report	Natl Average <1.04 **Result= 0%**	5 is <0.95 4 is <1.00 3 is <1.04 2 is <1.06 1 is <1.08
11	Central Line Bloodstream Infection	CMS Report	Natl Average <0.51 **Result= 0%**	5 is <0.44 4 is 0.45-0.50 3 is 0.51-0.55 2 is 0.56-0.60 1 is <0.60
12	C-Difficle Infection	CMS Report	Natl Average 7.4/10k pt days **Result= 0%**	5 is <6.9 4 is 6.8-7.0 3 is 7.1-7.4 2 is 7.5-7.9 1 is >7.9

VALLEY OF THE MOON
POST ACUTE
ENSIGN GROUP

STATUS UPDATE

UPDATE ITEMS	STATUS	NEXT STEPS	TIMELINE	NOTES
1. SUBACUTE PLANS	OSHPD FINISHED 2ND REVIEW.	COMPLETE APPROVAL PROCESS	2020	
2. STAFFING	CURRENTLY FULLY STAFFED.	CONTINUE TRAINING AND IMPLEMENTATION OF SYSTEMS.	IN PROCESS	INITIAL TURNOVER RATE WAS 0VER 95%. 6 ORIGINAL EMPLOYEES REMAIN. -3 CNA'S -1 RN -ACTIVITIES DIRECTOR
3. RESIDENT SATISFACTION	2 SYSTEMS: 1. GUARDIAN ANGEL PROGRAM (ONGOING DURRING RESIDENT STAY) 2. QUESTIONAIRE DURRING DISCHARGE.	WE CONTINUE TO MONITOR AND COLLECT FEEDBACK FROM RESIDENTS. WE ALSO CONTINUE TO EDUCATE STAFF WITH REGARDS TO CUSTOMER SERVICE AND COMMUNICATION.	ONGOING PROCESS	

VALLEY OF THE MOON
POST ACUTE
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STATUS UPDATE CONTINUED…

UPDATE ITEMS	STATUS	NEXT STEPS	TIMELINE	NOTES
4. CDPH ANNUAL SURVEY FOR LIFE SAFETY, CMS RE-CERTIFICATION, AND STATE LICENSURE COMPLETE AS OF DECEMBER.	SEVERAL ITEMS CORRECTED. MOST ISSUES WERE ADMINISTRATIVE AND FOCUSED ON SYSTEMS, AND PROCESSES AS WELL AS EDUCATION AND TRAINING.	ONGOING PLAN OF CORRECTION WITH REGARDS TO ITEMS IDENTIFIED IN SURVEY PROCESS	IMMEDIATE AND ONGOING AS OF OCTOBER 16, 2019	WE HAVE MUCH TO DO WITH OUR STAFF BECAUSE OF THE AMOUNT OF TRANSITION IN JULY AND TURNOVER. WE ARE MUCH FARTHER ALONG NOW THAN IN EARLY OCTOBER, AND OUR CORPORATE EXPECTATION IS 5 STAR FACILITIES.
5. SHARED SERVICES	EXCELLENT COOPERATION WITH HOUSEKEEPING, PLANT, LAUNDRY, DIETARY, LAB, RADIOLOGY WHICH ARE ALL CURRENTLY SHARED SERVICES.	CONTINUE WITH GREAT COMMUNICATIO N		

VALLEY OF THE MOON POST ACUTE

ENSIGN GROUP

FINANCIAL OVERVIEW

	FINAL	FINAL	FINAL	FINAL	FINAL	FINAL
	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	YTD
TOTAL NET REVENUE	321,724.29	430,678.87	488,721.11	583,852.66	549,574.58	2,374,551.51
TOTAL OPERATING EXPENSES	320,597.59	328,834.66	414,227.11	475,276.80	422,354.70	1,965,909.88
EBITDAR	1,126.70	101,844.21	74,494.00	108,575.86	127,219.88	408,641.63
EBITDAR Margin %	0.35%	23.65%	15.24%	18.60%	23.15%	17.21%

FINANCIAL OVERVIEW

KEY SNF COSTS

	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	TOTAL YTD
THERAPY	$33,493.18	$40,202.16	$48,865.50	$56,181.36	$45,880.19	$224,687.89
PHARMACY	$15,039.00	$11,848.87	$17,416.90	$26,701.48	$15,043.93	$86,050.18
NURSING	$153,858.53	$148,216.96	$191,692.71	$183,980.69	$200,792.64	$879,331.40

KEY SNF COSTS USING SVH CONTRACTED SERVICES

	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	TOTAL YTD
LAB	$1,138.20	-$507.80	$1,786.61	$1,080.54	$2,477.71	$5,975.26
RADIOLOGY	$2,185.00	-$1,677.04	$457.47	$2,223.00	$857.92	$4,046.35
PLANT/FACILITY	$13,886.95	$15,954.66	$14,250.00	$16,673.90	$14,925.83	$75,691.34
HOUSEKEEPING	$12,199.70	$9,608.46	$9,891.54	$8,306.29	$8,166.66	$48,172.65
LINENS		$3,837.40	-$1,569.27	$4,002.71	$2,976.74	$9,247.58
DIETARY	$14,248.68	$19,934.54	$24,680.00	$22,480.00	$22,290.00	$103,633.22

VALLEY OF THE MOON TEAM

Name	Position	Email
Mike Empey	Administrator	mempey@ensignservices.net
Angie Macaraeg	Dir. Of Nursing	amacaraeg@ensignservices.net
Shobha Neupane	Director of Rehab	Sneupane@ensignservices.net
Jennifer Raymond	Therapy Resource, Flagstone North	jraymond@ensignservices.net
Claudia Alexander	MDS Resource, Flagstone North	cbalexander@ensignservices.net
Teresa DeGuzman	Clinical Resource, Flagstone North	tdeguzman@ensignservices.net
Cason Bush	Cluster Leader, Flagstone North	cbush@ensignservices.net
Mira Jensen	Director of Clinical Services, Flagstone	mjensen@ensignservices.net
Adam Willits	President, Flagstone	awillits@ensignservices.net

Quality Indicator Performance & Plan

January 2020

Data for November 2019

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MORTALITY

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Scorecard Summary
Mortality

All Indicators View: PI Committee Mortality EDIT

Status	Indicator	Current Value	Target	SPC Alert	Updated
Quality > Autopsies Mortalities					
▼	Acute Care Mortality Rate (M)	3.5%	n/a		Dec 2019
▲	DV Inpatients - Percent Transferred to Hospice (M)	1.1%	n/a		Dec 2019
Quality > Process of Care > Sepsis Care					
▼	Sepsis, Any Diagnosis - Mortality Rate (M)	4.8%	0.0%		Dec 2019
▼	Sepsis, Principal Diagnosis - Mortality Rate (M)	5.0%	0.0%		Dec 2019
–	Sepsis, Secondary Diagnosis - Mortality Rate (M)	0.0%	0.0%		Dec 2019
▼	Sepsis, Severe - Mortality Rate (M)	0.0%	0.0%		Dec 2019
–	Sepsis, Simple - Mortality Rate (M)	0.0%	0.0%		Dec 2019
▲	Septic Shock - Mortality Rate (M)	50.0%	0.0%		Dec 2019
▼	Severe Sepsis or Septic Shock - Mortality Rate (M)	16.7%	0.0%		Dec 2019

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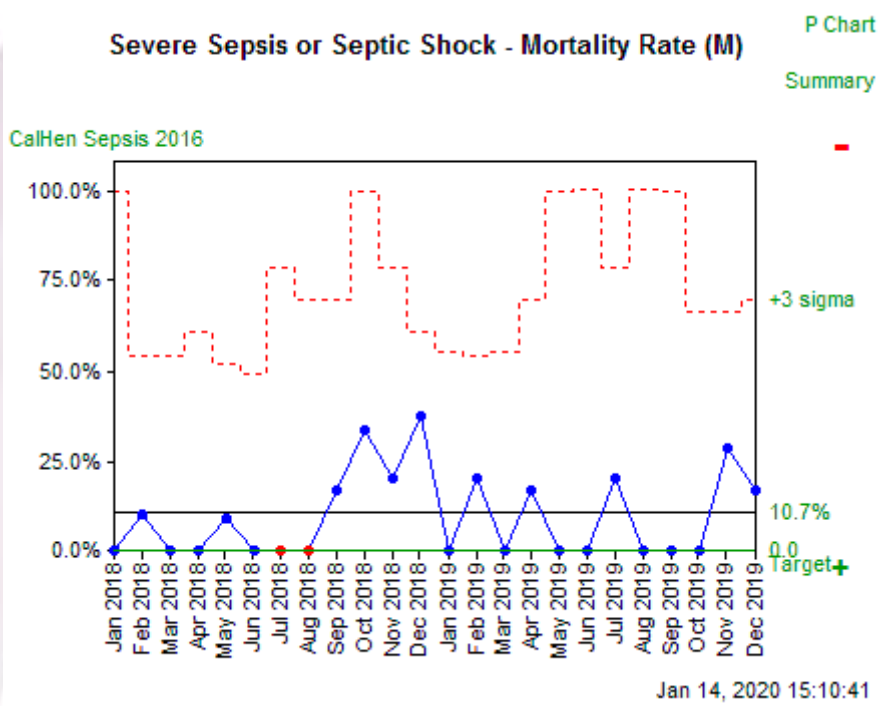
Sepsis Mortality Rate



Mortality rate among acute care inpatient encounters with a principal or secondary discharge diagnosis of severe sepsis or septic shock

- **Opportunities for Improvement**
  - December 2019
    - 1 of 6 (16.7%)
    - Hospice patient
- **Plan of Action**
  - Acute patients requiring Hospice service need to be discharged from acute care then readmitted to Hospice services
  - Continue to monitor

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PREVENTABLE HARM EVENTS

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Scorecard Summary

AHRQ Patient Safety Indicators

Preventable Harm

All Indicators View: PI Committee AHRQ PSI EDIT

Status	Indicator	Current Value	Target	SPC Alert	Updated
Quality > Patient Safety > AHRQ Patient Safety Indicators_PSI					
—	AHRQ v6.0 PSI 03 Pressure Ulcer Rate |M|	0.0%	0.0%		Dec 2019
—	AHRQ v6.0 PSI 06 Iatrogenic Pneumothorax Rate |M|	0.0%	0.0%		Dec 2019
—	AHRQ v6.0 PSI 08 In-Hospital Fall with Hip Fracture Rate |M|	0.0%	0.0%		Dec 2019
—	AHRQ v6.0 PSI 09 Perioperative Hemorrhage or Hematoma Rate |M|	0.0%	0.0%		Dec 2019
—	AHRQ v6.0 PSI 10 Post-Operative Acute Kidney Injury Requiring Dialysis Rate |M|	0.0%	0.0%		Dec 2019
—	AHRQ v6.0 PSI 11 Postoperative Respiratory Failure Rate |M|	0.0%	0.0%		Dec 2019
—	AHRQ v6.0 PSI 12 Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate |M|	0.0%	0.0%		Dec 2019
—	AHRQ v6.0 PSI 13 Postoperative Sepsis Rate |M|	0.0%	0.0%		Dec 2019
—	AHRQ v6.0 PSI 14 Postoperative Wound Dehiscence Rate|M|	0.0%	0.0%		Dec 2019
—	AHRQ v6.0 PSI 15 Accidental Puncture or Laceration Rate |M|	0.0%	0.0%		Dec 2019

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Scorecard Summary

Patient Falls

Preventable Harm

All Indicators View: PI Committee Falls EDIT

Status	Indicator	Current Value	Target	SPC Alert	Updated
Quality > Patient Safety > Falls					
▼	RM ACUTE FALL- NO INJURY (M) per 1000 patient days	0.00	0.00		Dec 2019
—	RM ACUTE FALL- WITH INJURY (M) per 1000 patient days	0.00	0.00		Dec 2019
—	RM ED FALL- NO INJURY (M) per 1000 patient days	0.00	0.00		Dec 2019
▲	RM ED FALL- WITH INJURY (M) per 1000 patient days	1.13	0.00		Dec 2019

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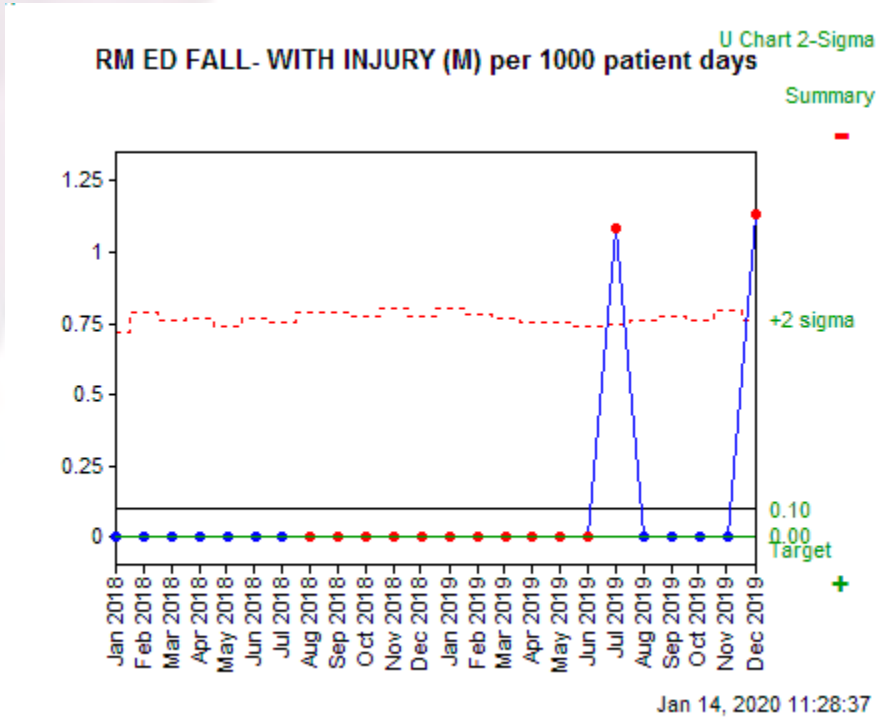
ED Falls with Injury per 1000 patient days

Champion: Mark Kobe
Leader: Mark Kobe



- **Opportunities for Improvement**
  - December 2019
  - One fall
    - Patient presented to emergency department for evaluation and treatment of mental health disorder

Frequency of incidents of emergency department patient falls per 1,000 encounters

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Scorecard Summary

Coded Complications of Care

Preventable Harm

All Indicators View: PI Committee Coded Complications of Care EDIT

Status	Indicator	Current Value	Target	SPC Alert	Updated
Status	Indicator	Current Value	Target	SPC Alert	Updated
Quality > Patient Safety > AHRQ Patient Safety Indicators_PSI					
● —	AHRQ v6.0 PSI 12 Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate (M)	0.0%	0.0%		Dec 2019
Quality > Patient Safety > CMS HAC Reduction					
● —	Air Embolism - Per 1000 ACA (M)	0.00	0.00		Dec 2019
Quality > Patient Safety > Coded Complications of Care					
● —	Acute Postop Respiratory Insufficiency NPOA - Per 1000 ACA (M)	0.00	0.00		Dec 2019
● —	Acute Postop Respiratory Insufficiency, NPOA - Per 1000 ACA w/ Surgical Proc (M)	0.00	0.00		Dec 2019
● —	Air Embolism NPOA - Per 1000 ACA (M)	0.00	0.00		Dec 2019
▲	Cardiac Arrest- per 1000 ACA (M)	11.76	n/a		Dec 2019
● —	Cardiac Arrest-NPOA per 1000 ACA (M)	0.00	0.00		Dec 2019
● —	Cardiac Complications NPOA per 1000 ACA (M)	0.00	0.00		Dec 2019
● —	Cardiogenic Shock NPOA per 1000 ACA (M)	0.00	0.00		Dec 2019
● ▼	Deaths per 1000 ACA Elective Admission (M)	0.00	0.00		Dec 2019

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Scorecard Summary

Coded Complications of Care

Preventable Harm

All Indicators View: PI Committee Coded Complications of Care EDIT

Status	Indicator	Current Value	Target	SPC Alert	Updated
—	Device/Implant Complications, Cardiac Incl. Valve, NPOA - Per 1000 ACA (M)	0.00	0.00		Dec 2019
—	Device/Implant Complications, Genitourinary/Urologic NPOA - Per 1000 ACA (M)	0.00	0.00		Dec 2019
—	Device/Implant Complications, Nervous System NPOA - Per 1000 ACA (M)	0.00	0.00		Dec 2019
—	Device/Implant Complications, Orthopedic Device NPOA - Per 1000 ACA (M)	0.00	0.00		Dec 2019
—	Device/Implant Complications, Other/NEC Device NPOA - Per 1000 ACA (M)	0.00	0.00		Dec 2019
—	Device/Implant Complications, Vascular Device NPOA - Per 1000 ACA (M)	0.00	0.00		Dec 2019
—	Device/Implant Complications, Vascular NPOA - Per 1000 ACA (M)	0.00	0.00		Dec 2019
—	Device/Implant Functional Complications NPOA - Per 1000 ACA (M)	0.00	0.00		Dec 2019
—	Device/Implant Other Complications NPOA - Per 1000 ACA (M)	0.00	0.00		Dec 2019
—	Device/Implant, Inflammatory Reaction NPOA - Per 1000 ACA (M)	0.00	0.00		Dec 2019
—	Digestive System Complications NPOA - Per 1000 ACA (M)	0.00	0.00		Dec 2019
—	Disruptions of Operative Wound, NPOA - Per 1000 ACA (M)	0.00	0.00		Dec 2019
—	DVT/PE, Orthopedic, NPOA - Per 1000 Inpatients w/ Total Knee/Hip Replacement (M)	0.00	0.00		Dec 2019

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Scorecard Summary

Coded Complications of Care

Preventable Harm

All Indicators View: PI Committee Coded Complications of Care EDIT

Status	Indicator	Current Value	Target	SPC Alert	Updated
	Iatrogenic Pneumothorax NPOA - Per 1000 ACA (M)	0.00	0.00		Dec 2019
	Iatrogenic Pulmonary Embolus NPOA - Per 1000 ACA (M)	0.00	0.00		Dec 2019
	Infection from Central Venous Cath, NPOA - Per 1000 Inpatients w/ CV Cath (M)	0.00	0.00		Dec 2019
	Intraoperative Injuries NPOA- Per 1000 ACA with a Surgical Procedure (M)	0.00	0.00		Dec 2019
	Nervous System Complications NPOA- Per 1000 ACA (M)	0.00	0.00		Dec 2019
	Other Complications NPOA- Per 1000 ACA (M)	0.00	0.00		Dec 2019
	Peripheral Vascular Complications NPOA - Per 1000 ACA (M)	0.00	0.00		Dec 2019
	Postoperative Hemorrhage_Hematoma NPOA - Per 1000 ACA with surgical procedure (M)	0.00	0.00		Dec 2019
	Postoperative Infection - Per 1000 ACA (M)	0.00	0.00		Dec 2019
	Postoperative Pulmonary Edema - Per 1000 ACA (M)	0.00	0.00		Dec 2019
	Postoperative Pulmonary Edema NPOA with Surgical Procedure- Per 1000 ACA (M)	0.00	0.00		Dec 2019
	Postoperative Shock NPOA with Surgical Procedure- Per 1000 ACA (M)	0.00	0.00		Dec 2019
	Respiratory Complications NPOA- Per 1000 ACA (M)	0.00	0.00		Dec 2019

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Scorecard Summary
Blood Utilization

All Indicators View: PI Committee Blood Utilization EDIT

Status	Indicator	Current Value	Target	SPC Alert	Updated
Quality > Blood Utilization					
● ▼	Blood Cultures -Contamination Rate |LAB| (M)	1%	3%		Dec 2019
● ▼	Blood Cultures -Contamination Rate|RN| (M)	8%	3%		Dec 2019
● ▼	Blood Cultures -Total Contamination Rate (M)	5%	3%		Dec 2019
● ▲	Blood Transfusion Justified (M) percentage	43.3%	100.0%		Dec 2019
● —	Blood Transfusion Reaction (M) percentage	0.0%	0.0%		Dec 2019
● —	Blood Units Wasted (M) volume	0	0		Dec 2019
Quality > Patient Safety > CMS HAC Reduction					
● —	Blood Incompatibility - Per 1000 ACA (M)	0.00	0.00		Dec 2019

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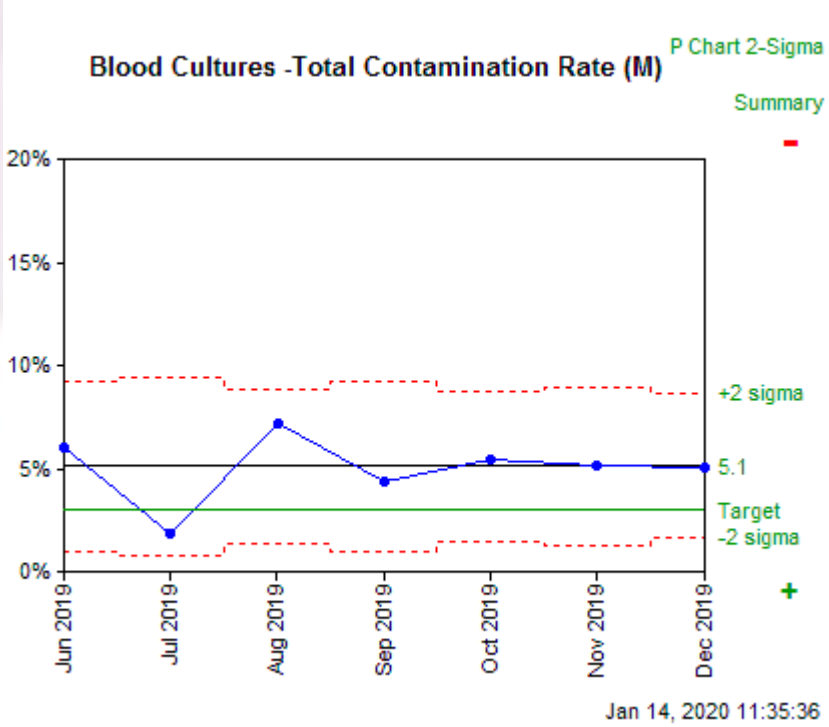
Blood Culture Contamination Rate

Champion: Dr. Kretzchmar
Leader: Mark Kobe



- **Opportunities for Improvement**
  - December 2019
  - 8 contaminated cultures
    - 7 RN contaminated cultures
- **Plan of Action**
  - New protocol implemented mid-November where new IVs will be started for blood cultures in ED
  - Continued counseling and coaching

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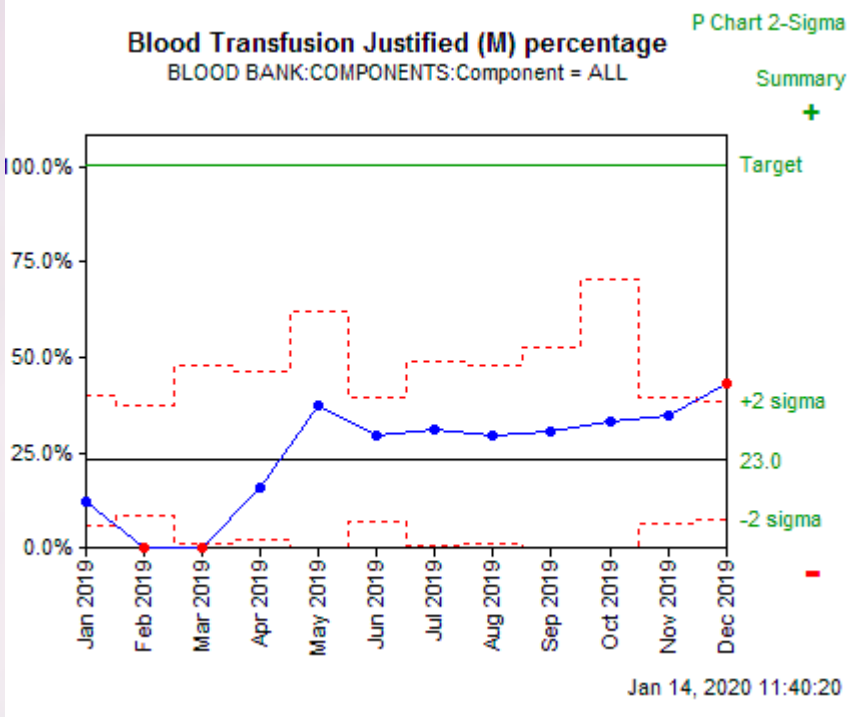
Blood Transfusion Practice

Champion: Dr. Kretzchmar
Leader: Nic Hadjiyanni



- **Opportunities for Improvement**
  - December 2019
    - 13 of 30 (43.3%) blood transfusions were identified as meeting SVH policy
    - System issues
      - CLS only uses hemoglobin as indicator and does not have access to needed data points to determine justification such as cardiac history, active bleeding, etc.
- **Plan of Action**
  - Determine organizational criteria for transfusion and train CLS for data input.

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HEALTHCARE ACQUIRED INFECTION

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Scorecard Summary
Hospital Acquired Infections

Infection Prevention Report: 3rd Quarter 2019					
Indicator	**Comparison Rates: 2013–2018**	**Q1 2019**	**Q2 2019**	**Q3 2019**	**Q4 2019**
Quarterly reporting of National Healthcare Safety Network (NHSN) indicator data is required by CDPH. NH Indicates public reporting on CDPH website. Green indicates no action indicated, yellow indicates abov					
"CLABSI (NHSN) (CMS Never Event) *# Central Line Associated Bloodstream Infections (CLABSI)/1000 central line days*	**0 since 2011**	**0** 0/108	**0** 0/89	**0** 0/51	
"CDI (NHSN) *#Inpatient Hospital Acquired infections due to C. difficile per 10,000 patient days*	**2.1/7.2/12 15/21.7/7.5**	**0** 0/872	**0** 0/901	0 **0/821**	
"MRSA Bloodstream Infections (NHSN) *#bloodstream infections due to MRSA per 1000 pt. days*	**1.3/0/0 0/ 0/0**	**0** 0/872	**0** 0/901	**0** 0/821	
"VRE Bloodstream Infections (NHSN) *#Hospital Acquired bloodstream infections due to VRE per 1000 pt. days*	**0 x 6 yrs**	**0** 0/872	**0** 0/901	**0** 0/821	
"Hip: Deep or Organ Space Surgical Site Infections (NHSN) *# infections/ # Total Hip Cases x 100*	**0 / 1.8% / 0 1.6% / 0**	**0** 0/11	**0**	**0** 0/12	
"Knee: Deep or Organ/Space Surgical Site Infections (NHSN) *# infections/ # Total Knee Cases x 100*	**0 / 1.7% / 2 1.4% /**	**0** 0/17	**0**	**0** 0/14	
"Overall Surgical Site Infections (SSI) *Total # SSI/Total # surgeries x 100*	**0.2%/0.7%** (12)/ **0.4% (6)/ 0.5% (8)/**	0.4% 2/473	**0.8%** **5/586**	**0** 0/462	
Class I SSI rate	**<1% x 5 yrs**	0.2% 1/409	**0.9%** **4/420**	0 0/373	
Class II SSI rate	**< 1.3% x 5 yrs**	0 0/56	**0 0/54**	0 0/61	
Total Joint SSI rate	**0 / 0.8%/1.9%/1.4%/1.4%**	**0**	**0**	0 0/23	
Post discharge surveillance surgeon compliance	**57%, 64%, 84%, 96.5%, 95.3%**	92% Jan sample	**90.5% Apr/May**	80% Jul/Aug	
Hand Hygiene Compliance *hand hygiene observations: # opportunities/# hand hygiene procedure observed*	**2017 98.7%** **2018 92.7%**	**95%** **19/20**	**100&** **19/19**	**100%** 23/23	

"Ventilator Associated Event (VAE): Pneumonia *# Ventilator Associated Pneumonias or events/ # vent days x 1000*	**0 x 4 yrs.**	**0** 0/7	**0** **0/23**	**0/0**	
"Hospital Acquired Pneumonia (HAP) *# hospital acquired pneumonia/# pt days x 1000 pt days*	**0.2/0.5/0.9/1.6/ 0.7**	acute 0/872 SNF 0/988	1.1 1/901	0 0/821	
"Inpatient Hospital Acquired Catheter Associated Urinary Tract Infections (CA-UTI) (CMS Never Event) *# inpatient CAUTI/# catheter days x 1000*	**0.7 /0 / 1.7 1.4/1.6/0.85**	**0** 0/197	**4.6** 1/217	**0** **0/221**	
Communicable Disease Exposures		1	1	**0**	
MRSA Active Surveillance Cultures (nares cultures only) *# positives/total screened x 100*	**14%, 20%, 26% 9.2%/5.8%**	**9.5%** 10/105	15.1% 5/33	**4.2%** 1/24	
% ESBL(E. coli;K. pneumoniae, K. oxytoca, P. mirabilis)	**2% /3%/4.2%/4.1%**	7%	31.3%	7.7%	
# CRE cases	**0/0/0/1**	1	0	0	
Legionella Monitoring: water samples and patients with HA pneumonia		0	0	0	
Environmental Cleanliness Monitoring	95%	97%	96%	100%	

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MEDICATION EVENTS

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Scorecard Summary
Adverse Drug Events

Status	Indicator	Current Value	Target	SPC Alert	Updated
Quality > Pharmacy > Adverse Drug Events					
▼	Rx-ADEs-Administration Errors Per 10,000 Doses	0.23	1.00		Dec 2019
▲	Rx-ADEs-Good Catches	33%	75%		Dec 2019
▼	Rx-ADEs-High Risk Med Errors Per 10,000 Doses	0.47	1.13		Dec 2019
▲	Rx-Adverse Drug Reactions	4	n/a		Q4-2019
	Rx-Adverse Drug Reactions-Antibiotics	25%	n/a		Q4-2019
	Rx-Adverse Drug Reactions-Anticoagulants	0%	n/a		Q4-2019
	Rx-Adverse Drug Reactions-Cardiovascular	25%	n/a		Oct 2019
–	Rx-Warfarin-Inpatient	0.0%	5.0%		Dec 2019

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ADVERSE EVENTS

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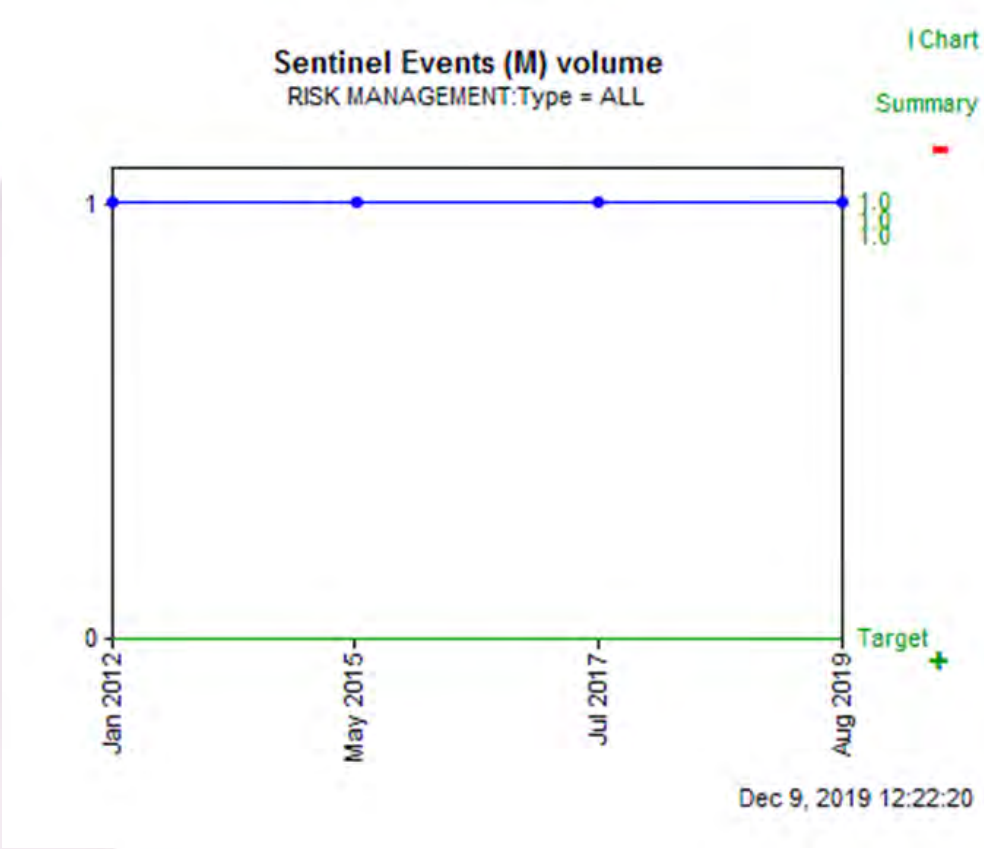
Adverse Events



- Opportunities for Improvement
  - August 2019
    - Wrong site surgery
  - July 2017
    - Retained foreign body
  - May 2015
    - Retained foreign body
  - January 2012
    - Retained foreign body
- Plan of Action
  - Completed a root cause analysis, consent and OR whiteboard audits, in-service on time out procedure, BETA presentation on medical/legal implications of documentation

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CORE MEASURES

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Scorecard Summary
Core Measures

All Indicators View: Core Measures -Monthly- Chart abstracted EDIT

Status	Indicator	Current Value	Target	SPC Alert	Updated
Quality > Core Measures					
	Core ED-2b - Admit Decision Time to ED Departure Time - Reporting Measure (M)	n/a	132.00		Dec 2019
	Core ED-2c - Admit Decision Time to ED Departure Time - Psychiatric (M)	n/a	n/a		Dec 2019
	Core OP-18b - Median Time ED Arrival to ED Departure - Reporting Measure (M)	n/a	140.00		Dec 2019
—	Core OP-23 - Head CT/MRI Results for STK Pts w/in 45 Min of Arrival (M)	100.0%	100.0%		Nov 2019
Quality > Core Measures > HOP Measures > HOP Colonoscpy					
▼	Core OP29/ASC9 - Colonoscopy:F/U for Avg Risk Pts (M)	64.3%	90.0%		Oct 2019
Quality > Core Measures > Sepsis					
▲	Core SEP1 - Early Management Bundle, Severe Sepsis/Septic Shock (M)	75.0%	100.0%		Dec 2019
▲	Core SEPa - Early Management , Severe Sepsis 3 Hour Bundle (M)	100.0%	100.0%		Dec 2019
▼	Core SEPb - Severe Sepsis 6 Hour Bundle (M)	75.0%	100.0%		Dec 2019
—	Core SEPc - Septic Shock 3 Hour Bundle (M)	100.0%	100.0%		Dec 2019
—	Core SEPd - Septic Shock 6 Hour Bundle (M)	100.0%	100.0%		Oct 2019
Quality > Core Measures > Stroke					
—	Core STK-4-Thrombolytic Therapy (M)	100.0%	100.0%		Jul 2019

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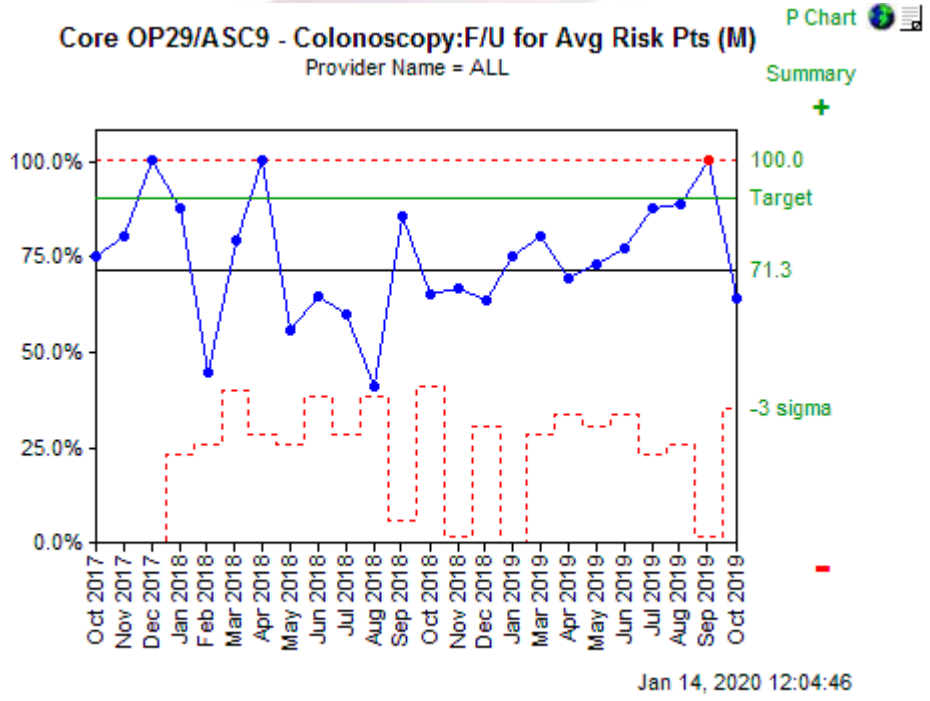
OP29 Colonoscopy



Percentage of patients aged 50 to 75 years of age receiving a screening colonoscopy without biopsy or polypectomy who had a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report.

- **Opportunities for Improvement**
  - **October 2019**
  - 5 patients did not receive the appropriate follow up interval for normal colonoscopy in the average risk patient population
  - All fallouts are attributed to one surgeon
- **Plan of Action**
  - Documentation of medical reasons for not recommending at least a 10-year follow-up interval
    - inadequate prep, familial or personal history of colonic polyps, patient had no adenoma and age is ≥66 years old, or life expectancy is <10years

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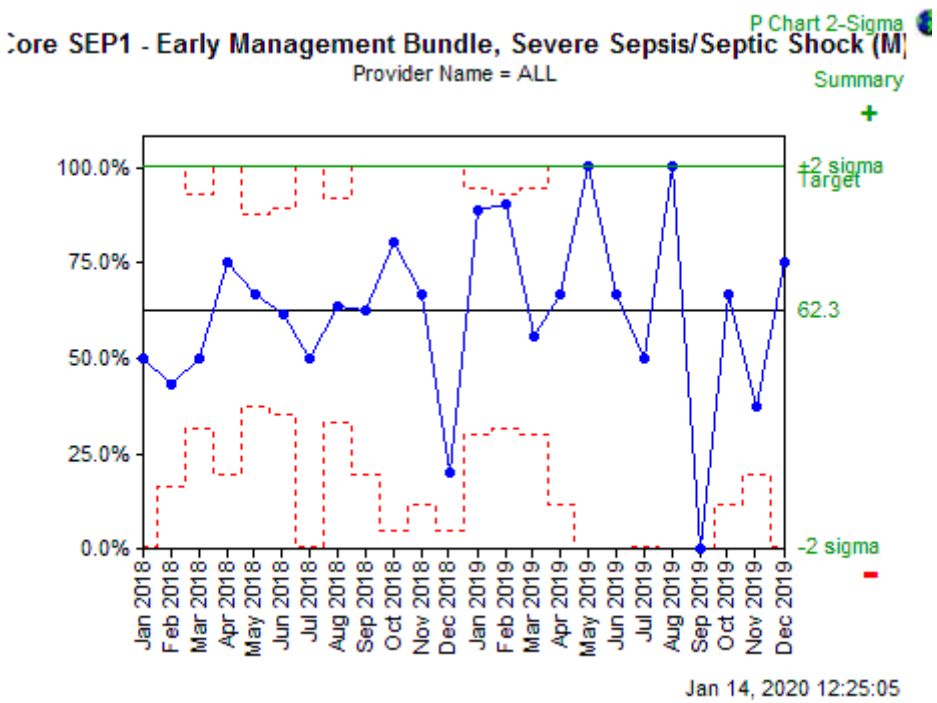
Sepsis



Consistent with Surviving Sepsis Campaign guidelines, it assesses measurement of lactate, obtaining blood cultures, administering broad spectrum antibiotics, fluid resuscitation, vasopressor administration, reassessment of volume status and tissue perfusion, and repeat lactate measurement. As reflected in the data elements and their definitions, the first four interventions should occur within 3 hours of presentation of severe sepsis, while the remaining interventions are expected to occur within 6 hours of presentation of septic shock.

- **Opportunities for Improvement**
  - November 2019
    - Lactate completed > 3 hours after sepsis presentation
    - Severe sepsis diagnosis without lactate or blood culture
  - December 2019
    - Repeat lactate not ordered
- **Plan of Action**
  - Review sepsis fall out cases with Emergency Department & Hospitalists Medical Directors
  - Present cases to Peer Review Committee

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Scorecard Summary
Electronic Clinical Quality Measures (eCQM)

Quarter	Category	Measure Title	Performance Rate
Q3 2019	STK-10	Assessed for Rehabilitation	100.00%
Q3 2019	STK-02	Discharged on Antithrombotic Therapy	100.00%
Q3 2019	STK-06	Discharged on Statin Medication	100.00%
Q3 2019	STK-08	Stroke Education	100.00%
Q3 2019	STK-03	Anticoagulation Therapy for Atrial Fibrillation/Flutter	100.00%
Q3 2019	STK-05	Antithrombotic Therapy By End of Hospital Day 2	100.00%
Q3 2019	VTE-1	Venous Thromboembolism Prophylaxis	92.52%
Q3 2019	VTE-2	Intensive Care Unit Venous Thromboembolism Prophylaxis	98.21%

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READMISSION

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Scorecard Summary
Readmissions
Emergency Department

Quality > Emergency View: PI Committee Readmissions EDIT

Status	Indicator	Current Value	Target	SPC Alert	Updated
▲	Emergency Department, Treated/Released - % Readmit w/in 48 hours to ED (M)	4.3%	0.0%		Dec 2019
▼	Emergency Department, Treated/Released - % Readmit w/in 48 hours to IP (M)	0.5%	0.0%		Dec 2019
▲	Emergency Department, Treated/Released - % Readmit w/in 48 hours to OBS (M)	0.1%	0.0%		Dec 2019

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Scorecard Summary

Readmissions

Sepsis

All Indicators View: PI Committee Readmissions EDIT

Status	Indicator	Current Value	Target	SPC Alert	Updated
—	Sepsis, Severe - % Readmit within 30 Days (M)	0.00%	0.00%		Dec 2019
▲	Sepsis, Simple - % Readmit within 30 Days (M)	0.07%	0.00%		Dec 2019
—	Septic Shock - % Readmit within 30 Days (M)	0.00%	0.00%		Dec 2019

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Scorecard Summary Readmissions

All Indicators View: PI Committee Readmissions EDIT

Status	Indicator	Current Value	Target	SPC Alert	Updated
Quality > Readmissions					
● ▲	07-DV Inpatients - Percent Readmit to Acute Care within 07 Days (M)	2.4%	8.0%		Dec 2019
● ▲	14-DV Inpatients - Percent Readmit to Acute Care within 14 Days (M)	3.6%	8.0%		Dec 2019
● ▼	30-DV Inpatients - Percent Readmit to Acute Care within 30 Days (M)	4.8%	8.0%		Dec 2019
● –	COPD, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)	0%	0%		Dec 2019
● –	HF, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)	0%	0%		Dec 2019
● ▼	Medicine, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)	5%	0%		Dec 2019
● ▲	PNA, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)	25%	0%		Dec 2019
● ▲	Sepsis, Any Diagnosis - % Readmit within 30 Days (M)	0%	0%		Dec 2019
● –	Surgery, CMS Readm Rdctn -% Readmit within 30 Days_ ACA |M|	0.00%	8.00%		Dec 2019
● –	TJP, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)	0.00%	0.00%		Dec 2019

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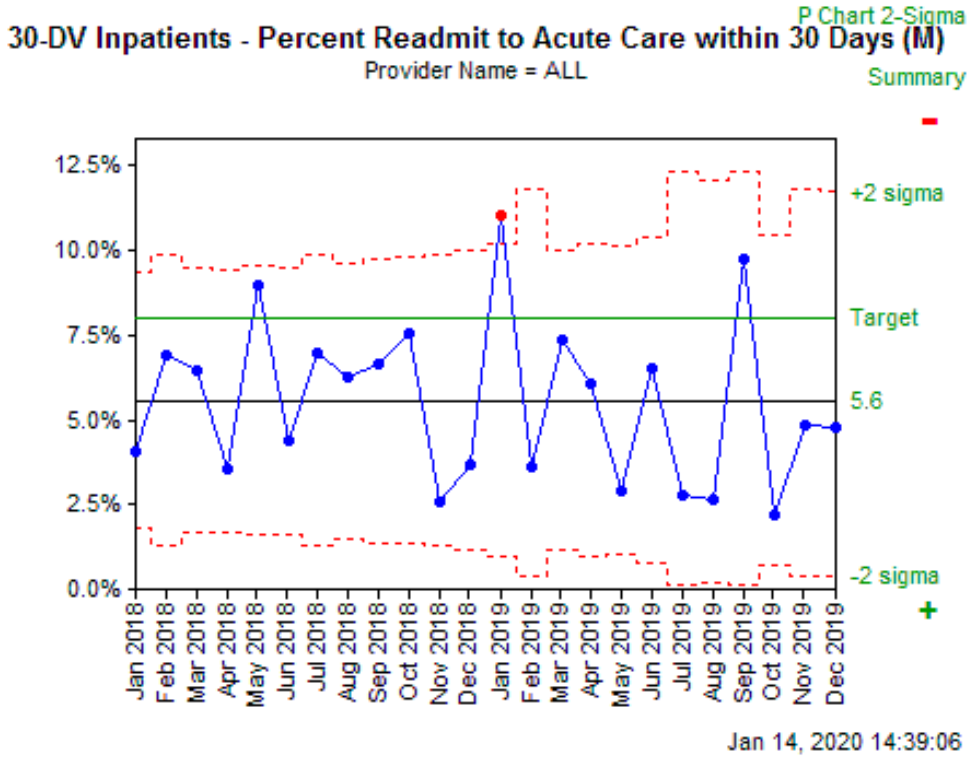
Medicine All Cause Admission 30 day readmission



Percentage of encounters with an unplanned readmission to the same facility within 30 days for any cause among encounters for acute care inpatients with a principal discharge diagnosis for a clinical classification category in the Medicine cohort

Opportunities for Improvement

- December 2019
  - 4 readmissions
  - One patient will be represented in January readmission data as she returned to ED the same day as inpatient discharge citing medication noncompliance
  - One patient transferred to another facility for gastroenterology and need for MRCP, patient discharged from facility and immediately returns to SVH
  - One patient end of life care with multiple Hospice admissions and discharges
  - One patient readmitted for stabilization of chronic GI symptoms

Plan of Action

- Report to Performance Improvement Medical Staff Committee
- Continue to monitor

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PATIENT EXPERIENCE

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Patient Experience

CAHPS	Sep '19	Oct '19	Nov '19	Dec '19
	Top Box	Top Box	Top Box	Top Box
Rate hospital 0-10	66.7 ▼	55.6 ▼	100 ▲	-
Recommend the hospital	63.6 ▼	62.5 ▼	100 ▲	-
Cleanliness of hospital environment	45.5 ▼	77.8 ▲	100 ▲	-
Quietness of hospital environment	27.3 ▼	44.4 ▲	100 ▲	-
Comm w/ Nurses	66.7 ▼	70.4 ▲	83.3 ▲	-
Response of Hosp Staff	63.6 ▼	85.7 ▲	75.0 ▼	-
Comm w/ Doctors	70.1 ▼	70.4 ▲	83.3 ▲	-
Hospital Environment	36.4 ▼	61.1 ▲	100 ▲	-
Communication About Pain	50.0 ▼	-	-	-
Comm About Medicines	36.7 ▼	42.9 ▲	100 ▲	-
Discharge Information	83.3 ▼	83.3	100 ▲	-
Care Transitions	26.0 ▼	46.8 ▲	50.0 ▲	-

Plan of Action

- We have partnered with a consultant to begin a project to elevate our Human Experience across Sonoma Valley Hospital. Over the next couple of months we will be conducting interviews, focus groups, data analysis, and surveys to help us to:
  - Understand factors driving our current experience, both the strengths and the opportunities.
  - Define a shared vision of the Sonoma Valley Hospital Human Experience and core strategies to help achieve it.
  - Identify innovative operating systems, team structures, cultural attributes, and tactics to elevate patient, family, and staff experience.

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ACCREDITATION & REGULATORY

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GACH CDPH Survey Deficiencies

E 474	Pharmacy and Therapeutics Committee Composition
E 475	Elimination of "No Alternative" Choice from Applicable Order Sets Verification
E 479	Medication trays w/ updated contents present in Broselow Carts Verification
E 480	Policy Updates (Kit Stocking, Malignant Hypothermia, Broselow Carts) Verification
E 481	RSI Kit and Broselow Cart Proper Labeling
E 500	Policy Update (Investigational Drugs) Verification
E 516	Monitor Compounding logs for medium risk compounding of banana bags
E 521	Monitor for presence of out of date drug references in the ED Med Room
E 347	Develop written policies for surgical side and site marking

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QUALITY ASSURANCE PERFORMANCE IMPROVEMENT (QAPI)

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Quality Assurance Performance Improvement (QAPI)

Patient Access to Medical Imaging

Leslie Lovejoy, Dawn Kawahara, Fe Sendaydiego, Kimberly Drummond, Lisa Duarte, Ron Schwartz
Quality, Administration, Information Systems, Facilities, Admitting, and Medical Imaging

Introduction Smart Goal

Background – Prior to this project, the existing patient scheduling process was a decentralized model that was disjointed, inefficient, and left the providers and patients with unsatisfactory experiences in scheduling services with Sonoma Valley Hospital. Scheduling, authorizations, and pre-registrations were being done in multiple departments that was contributing to unnecessary high volume of phone calls. A decentralized patient access was also causing a poor patient flow where they were sent back to the back of the hospital to obtain copies of their medical records. Patients getting lost in that system created an increase in patient and physician office complaints.

Smart Goal- By June 2019, we wanted to see

- a decrease in patient complaints regarding "ability to schedule an appointment" by less than three per month
- a decrease in physician office complaints to less than three per month and
- collect ninety percent (90%) of collectable accounts.

Plan

Establish a centralized patient access model that will manage our patients across the continuum of care. We aimed to increase patient, physician and employee satisfaction by streamlining the existing process and implement best practice technology and work flow processes.

Outcome: Improved Physician, Patient, and Employee Satisfaction

Do

- Created the Patient Access team that included representatives from multiple key departments.
- The team conducted a site visit to Tahoe Forest Hospital to gain insights from their own experience in implementing a centralized scheduling process.
- Identified numerous measures of success and vision.
- Created a driver diagram to identify the key concepts that contributes to a successful centralized scheduling process.
- Developed an effective implementation plan and roll out strategy that empowered team members within the organization.
- Identified the existing workflow processes and scheduling parameters.
- Implemented staffing, budget, and training to meet the key drivers identified.
- Medical Imaging was selected to be the pilot for Patient Access since it has the most complicated workflow.

Study

Dashboard

Indicator	Goal	May	Jun. Jul.	Aug Sept
1. Total Inbound Visitors by Mo	[illegible]			
2. Completed Appointments	[illegible]			352 434
3. % cancelled/rescheduled	[illegible]			7% 5%
4. Registration Accuracy (%) QD	[illegible]	[illegible]	[illegible]	99% 99%
5. Total number of non-compliant authr	[illegible]			1 2
6. Percentage of Collectable Accounts Captured	[illegible]			78% 80% 85%
7. Rate of Physician Office complaints	[illegible]	1	0 1	1 0
8. Score of 1 or 2, Ability to Schedule an appt. Goal=1, 100% of the time	[illegible]	1	2 2	2 1

What did we learn?

We were able to meet goal for the number of complaints and registration accuracy.

What did not work?

Starting the pilot in a non dedicated space had its challenges. The process improved when the team moved into their current space. We also realized that Patient Access is more than scheduling and registration, it is wayfinding, addressing inquiries, and providing medical records. The team have started addressing these opportunities during Fall 2019. Last but not the least, we were able to improve the processes without having to purchase and implement a separate scheduling platform. We were able to utilize what we already have in Paragon Resource Scheduling.

Act/Next Steps

As part of existing plans for the hospital phone system upgrade, additional features will also become available that will capture wait times, volumes of calls per month, total number of appointments scheduled and percentage of cancelled/rescheduled appointments. The additional information will provide us the insight on future improvements. This project will also expand to add other departments such as Wound Care, Speech Therapy, Cardiology Testing, Nutritional Services, and Pre Op Surgery Testing. This will be an ongoing project in 2020.

Patient Access Team at Work in their new space

References:

Advisory Board. Streamlining Imaging Access. 2015. Advisory Board Outpatient Imaging Access Survey.

Aye, Jejong and Williams, Michelle Betiong. Building a Partnership between Scheduling and Pre-Registration. 2016. Dignity Health

Branderburg, Lisa, Gabow, Steele, Glenn, Toussaint, John, and Tyson Bernard J. Innovation and Best Practices in Health Care Scheduling. February 2015. Institute of Medicine, Of The National Academies.

Perioperative Services Optimization Project

Leslie Lovejoy, Janine Clark
Perioperative Services, Medical Staff

Introduction SMART goal

Background. In light of a dramatic shift from inpatient to outpatient surgical procedure volumes, Leadership determined the need to once again look at the current perioperative services model and determine its overall efficiency.

Goal: Increase the efficiency and direct margin in Perioperative Services by developing and implementing best practice strategies that maximize efficiencies in both the scale of services provided and in operations.

Phase One: **Late first case start times**

Late case start times, especially when it is the first case of the day can lead to disruption of the schedule for the whole team and may result in pushing elective cases into after hours. Consequently the cost of doing the surgery increases due to the necessity of staffing overtime hours and the use of premium pay..

To improve the "on-time" rate for the first case of the day. Base line data indicated that the first case of the day started on time 3% of the time in FY 2018. The national benchmark is 76%.

What we planned to do:

1. Develop a format for tracking cases by surgeon;
2. Define the parameters for designating that a case was late;
3. Develop a coding system for determining the reasons for first case delays; and
4. Analyze the reasons for patterns and created a monthly reporting tool for discussion in Surgery Committee.

Plan

Do

We collected data for FY2019; analyzed the reasons for the late case start and created a perioperative metrics dashboard that included % of late first cases, the reason codes for lateness and performance by surgeon. The data was presented in Surgery Committee in July, who asked for refinement of the data to make sure that their performance was accurately reflected.

Once refinement was completed, monthly reporting of late first cases prompted improvement by most surgeons. And performance is moving closer to the 76% national benchmark.

We refined the metric dashboard creating two metrics:

1. % of first cases late due to surgeon lateness; and
2. % total late first cases which includes other reasons for lateness.

Study

After analyzing the reasons codes, it was found that the majority of the reasons for lateness is surgeon lateness.

The Committee agreed to the current definitions of " late" to be 7 minutes past the in-room time. This would mean that the surgeon arrives to the pre-op area for patient site marking, History & Physical updates, etc., so that "wheels in', (the time that the patient enters the operating room), occurs on or before scheduled start time – 7 minutes. Anytime thereafter is deemed to be late.

We also are looking at any patterns within the "other" reasons for a late start to identify any process flow issues that can also be addressed.

Act

This metric will be monitored and reported monthly. The committee's next process is to decide at what point in time and at what percentage does that result in the surgeon losing the privilege of having the "first case of the day" or other measures. This will be added to current perioperative policies and taken through committees.

Surgeons will be notified of the changes in policy and their first case of the day timeliness data .

Phase Two: One Medical Passport implementation

Goal: to reduce the manual pre-operative preparation process by implementing an electronic platform

References

Healthcare Advisory Board
AORN

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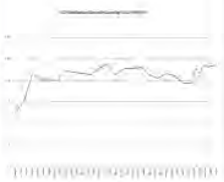
Quality Assurance Performance Improvement (QAPI)

MEDICATION ADMINISTRATION ELECTRONIC SCANNING

Mark Kobe, Jessica Winkler, Chris Kutza, Andrea O'Donnell
Emergency Department, Pharmacy, Information Systems, Nursing Informatics & Quality

Introduction SMART goal

By April 1, 2019 compliance to medication administration scanning by Emergency Department RNs will be 90% or greater.



Plan

Quarter 4 2018 medication administration scanning by Emergency Department RNs had fallen to 77% compliance. To improve performance we plan to:

1. Publish scanning compliance by RN in the Emergency Department
2. Re-validate compliance expectations with Emergency Department RNs
3. Solicit information from ED RNs as to obstacles/barriers to successful compliance to medication scanning.

Do

We published scanning compliance by RN in the Emergency Department and solicited perceived barriers to successful compliance from the RNs.

What did you observe? We immediately learned there were many barriers related to successful scanning of medications that were related to the pharmacy and information system protocols:

1. Monthly downtime protocols from IS lasting 5 hours where RN is unable to scan medications, but medications given during that time were counted against their compliance.
2. Immediately identified 4 medications that would never scan properly and Pharmacy unable to correct due to manufacturer: Tylenol, Solumedrol, Saline Flushes & 500 milliliter bags of Normal Saline.

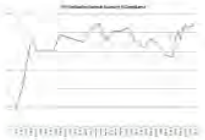
Study

What did you learn?

1. Night pharmacy response times were frequently well beyond contract obligations (>10 minutes) causing Emergency Department RNs to override scanning in order to give meds for safe patient care
2. New hires in Emergency Department without adequate medication administration scanning training
3. Medications ordered in the Emergency Department not available in the department's Pyxis
4. Pharmacy process for changing medication vendors and not upgrading bar codes
5. Bar code scanning programming in the Pharmacy differed from programming on Emergency Department computers causing errors for RNs
6. More medications routinely not scanning properly: Probiotics, Bentyl, Tramadol, Magnesium oxide

Did you meet your measurement goal?

Yes, January scanning compliance increased to 88% overall, February increased to 91% and March showed a dip back to 89%. Further investigation warranted. Current overall compliance is 93.5%.



Act

What will you put into place?

1. We continued to gather information from RNs on obstacles to successful scanning
2. Increased monitoring of offsite pharmacy contract compliance
3. Created generic barcode for Probiotics to scan successfully
4. Pharmacy re-designed process for upgrading bar codes with vendor changes.
5. Roll out of learnings from this to Inpatient Nursing experiencing same issues

What did not work?

1.Some medication bar codes will not scan
2.Downtime protocols lasting 5 hours and not able to decrease length at this time
3. After hours pharmacy continues to need frequent monitoring
4. When a medication is held because of parameters and medication charted as not given, this creates non-compliance for RN. Currently working on a fix for this.
5.When we administer a patient's own meds, there is no bar code to scan.

Acknowledgments

Chris Kutza, Director of Pharmacy
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Ernie Torrento, Information Systems
Andrea O'Donnell, Nurse Informatics
Laura Gallmeyer, Quality

Emergency Food & Water Storage

Anna Harleman, Kimberly Drummond, Grigory Gatenian, Joy Ni, Nufo Alvarez, Scott Larson
Nutritional Services, Facilities and Environmental Services

Introduction Smart Goal

Background - We have two separate rooms for emergency food and water. The room used for water and other beverages is too small and not temperature controlled. Existing shelving could not support the product

We have identified that USE BY dates are difficult to access or not in place. Product is stored in front of other product and is challenging to rotate as all product must be moved to access product in back of it.

Smart Goal - By February 2019, we will have Emergency Food & Water in one temperature controlled room near Nutritional Services. Products will be accessible on carts with casters to facilitate stock rotation and ease of cleaning storage room. 100% of product will have visible expiration dates. Floors will be cleaned on a weekly schedule.

Plan

We are going to establish a centralized temperature controlled storage room. Product will be stored on movable carts to facilitate inventory, rotation and USE BY date tagging of the stock.

Outcome: Improved Emergency Preparedness and Staff Satisfaction for easier maintenance of room.

Do

- Meeting with Nutritional Services and Facilities to define needs.
- Calculate cart storage needs, configurations and room layout. Calculate weight and height per cart to meet compliance standards.
- Clean out storage room from previous use to make room for new carts.
- Deep clean floors.
- Order NSF certified carts and build them to meet compliance per Title 22-CDPH and Title 24-OSHPD.
- Stock carts and label products with uniform and visible USE BY date labels.

Completion: Project completed but took longer than anticipated. More carts were needed and some reconfiguration was necessary after carts built/stocked.

New Water Storage Carts

Study

The Hospital is required to maintain a 4-day supply of food. By having a well organized, temperature controlled and accessible room the food & water supply is easier to maintain. The ability to read all of the USE BY dates allows the product to be used and replaced when close to USE BY dates to avoid waste.

New Food Storage Carts

What did not work?

We found that we did not have enough carts to accommodate all the water required. Additional carts were deployed and pallets of water offloaded onto carts.

Cleaning needed to be captured on the regular weekly duty schedule for the Floor Tech.

Cart distances and separation needed to be maintained as this is a shared storage room.

CDPH survey – Code required 12" shelf separation from the floor. Carts were adjusted to meet code requirements.

Act/Next Steps

Maintain the room - Quarterly inspections
Cans inspected for rust, bulging, leaking, and dents. Water bottles inspected for leaks. Boxes inspected for any damage from insects, rodents or water damage. Any food items compromised will be discarded immediately and replaced.

New Nutritional Supplement Cart

References

CIHQ Standard NU-01

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Dietary Guidelines for Americans [Internet]. 8th ed. 2015 Dec [cited 2017 Dec 5]

United States Department of Agriculture, Food Safety and Inspection Service. (2014).Shelf-Stable Food Safety.

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Quality Assurance Performance Improvement (QAPI)

RENOVO Clinical Engineering Program Renewal

Grigory Gatenian, Kimberly Drummond, Jessica Winkler, Janine Clark, Mark Kobe

Facilities, Surgery, Med/Surg, Emergency Department, Lab, Skilled Nursing Facility & Medical Offices

Introduction SMART goal

Background - In 2019, the hospital reinvented itself and refocused its services based on Community needs. The closure of OB and transferring the management of the Skilled Nursing and Home Health reduced the amount of clinical equipment in the hospital inventory.

The hospital also consolidated nursing services onto the 3rd Floor with ICU. Med/Surg, Respiratory Therapy, Physical Therapy, Case Management and Satellite Pharmacy departments were moved to the 3rd Floor from different locations in the hospital. With all clinical services located on the same floor it increased efficiency, improved communication and patient care coordination and allowed for a consolidation of clinical equipment.

These major changes coincided with the renewal of RENOVO Clinical Engineering contract. The RENOVO renewal was presented to the hospital at $235,133 and was based on previous full operations.

Goal - Reduce the cost of Clinical Engineering program and right size the inventory based on current operations in FY2020.

Plan

1. Reduce overall cost of the Clinical Engineering program
2. Reduce (right size) the clinical equipment inventory in each department.
3. Reduce on site presence of biomedical engineer based on reduced inventory.
4. Renegotiate biomed services contract with Renovo based on the new hospital structure.

Do

We worked with several department managers (Med/Surg, Emergency Department, Lab, Skilled Nursing Facility, Medical Offices) to review the inventory and determine which equipment can be removed due to reduced services. As a result, some of the equipment was completely removed from inventory, some was re-assigned to Plant Operations to maintain and some specialty equipment was replaced with equipment that could be maintained as routine Biomed equipment.

We worked with RENOVO to bid on 3 different Clinical Engineering platforms.

Full Clinical Engineering – Existing full service, scheduling & documentation program. After hours calls – Labor included.

Hybrid Clinical Engineering – Same as Full CE but SVH to maintain Beds/Gurneys, After hours calls and Time &Materials.

Biomed/Specialty Engineering w/documentation – Same as Hybrid – but SVH take over scheduling for Preventative Maintenance on Facility Direct Contract equipment (i.e. CT, MRI, etc.)

We met with our Financial Department to review contract options presented by RENOVO.

Full Clinical Engineering – $148,425.15

Hybrid Clinical Engineering – $129,984.35

Biomed/Specialty & data base documentation – $125,954.35

After extensive study of presented option details we selected **Hybrid Clinical Engineering** as it provided the best value with Renovo still retaining documentation of all Clinical Equipment included the beds/gurneys. Savings of **$105K annually** comparing to the original renewal proposal.

Study

We right sized the physical inventory of the equipment covered by the Renovo contract from 856 to 715 units.

We reduced the on-site presence of the Biomedical Engineer from 5 to 3.6 days per week on average.

Changing After hour call coverage to time & materials reduced the monthly premium and allows us to pay for the Biomed Engineers time as used.

Some equipment in the Specialty Equipment category was switched to time and materials based on the age of the equipment. Full-service coverage was no longer necessary as the equipment will be replaced if significant repairs (over 50% of its value) are required. By switching to time & materials, we achieved a significant price reduction for specialty equipment supported by Renovo.

The new contract was signed mid-July. We received a credit in August of 2019 as the previous contract pricing had been billed. The graph below illustrates the reduction in monthly payments after implementing the changes to the program.

Act/Next Steps

In the Hybrid Clinical Engineering program, Plant Operations is maintaining patient beds/gurneys, which were removed from Renovo contract. Renovo continues to document service in our Clinical Engineering database.

Some equipment from Skilled Nursing Facility, OB and the Home Care was completely removed from the inventory, some was re-assigned to other departments. Equipment that was not re-assigned is being evaluated for sale, donation or disposal based on its age and condition.

A monthly meeting has been established with Plant Operations, Biomed Engineer and Materials Management. The goals for this meeting are to monitor the inventory, review service contract needs for equipment that is maintained by the manufacturer, trending repairs on equipment and make replacement plans for equipment deemed end of life by the manufacturer.

Next steps – Review all service contracts for equipment that is being maintained by the Manufacturer. Determine overall spend for this equipment and evaluate areas to reduce costs.

Respiratory Therapy Supply Reorganization

Ellen Shannahan, Kimberly Drummond, James Dugger & Jessica Winkler

Materials Management, Facilities, Respiratory Therapy, Medical/Surgical and ICU

Introduction SMART goal

RT Supplies were scattered in multiple locations and were not managed by one person. This lead to over stocking of supplies, expired product, and next-day shipping costs due to expired/lost supplies.

Specific: Eliminate expired product in RT's active inventory.

Measurable: 100% reduction of outdated products.

Achievable: With buy-in from all stakeholders.

Relevant: $885 worth of expired product located in RT supplies.

Time-Bound: 4-months

Plan

Create an automated process to reorder RT supplies, reduce supply locations, reduce supplies, gain buy-in from stakeholders, and improve supply management by eliminating hoarding.

Outcome: No expired product located in supplies.

Do

- Meet with key stakeholders.
- Identify supplies and locations
- Update Item Files in Paragon
- Update Min/Max levels for reordering
- Eliminate old locations
- Create Barcodes for scanning
- Stock high moving supplies in Materials to reduce supplies on floors (consolidation).
- Install new shelving units for supplies
- Label, barcode, and begin new system.

The work to setup this system took longer than anticipated because of preparatory work in Paragon database.

RT's input was vital to the success and identification of supplies to keep, to eliminate, and usage.

Study

Organizing the RT supplies created efficiency, improved workflow, eliminated waste, and improved patient care by allowing RT's to focus on patients rather than supplies.

- RT Supply locations have been reduced down to 2 nursing locations on the 3rd floor.
- Materials Management is now scanning RT supplies.
- Supply usage and flow is easier to track.
- Expirations not occurring
- Overnight shipping cost reduced.
- Supplies reduced for RT by 40%
  - **171 items down to 104**

Act

We now have a well established system for ordering and stocking RT supplies. Supply outdates are checked on a regular basis. Over ordering has been dramatically reduced. This system replenishes stock as needed in specified area that is easily maintained.

By engaging clinical staff, we were able to establish cost-saving habits, discourage hoarding, and empower providers by allowing them to focus on patient care rather than supplies.

Supply Area 1 - ICU

Supply Area 2 – Med/Surg

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Quality Assurance Performance Improvement (QAPI)

Using SBAR for Risk and Patient Relation

Cindi Newman & Danielle Jones
Quality & Risk Management

Aim Statement

Our Aim is to increase the quantity and quality of patient safety Good Catches, risk event reports and California Hospital Patient Safety Organization (CHPSO) extractions and uploads.

One indicator of the effectiveness of any risk management program is the willingness of frontline staff to report unusual occurrences and concerns through the notification system.

Risk Management identified an opportunity related to the reporting of risk events. Our feedback from the frontline staff uncovered:

- event entry forms were intimidating and time consuming.
- too many data fields that required specific entry.
- don't understand why it is important to report or how their reporting can impact change.
- no real sense of inclusion or empowerment in the risk event reporting practice or process improvement.

Plan

In response to this valuable feedback, Risk Management implemented free text SBAR formatting to the risk event reporting:

S = Situation: a brief statement of the problem, why are you reporting this event?

B = Background: Brief and important information related to the situation that is not further explained in the assessment section.

A = Assessment: Describe what occurred. Include only factual information that is critical to the incident.

R = Recommendation: Identify potential actions to take that would avoid a problem in the future or that will improve the current process.

Do

Process Change One

Staff wanted to tell a story

- The narrative SBAR format guides staff through reporting events in a thoughtful way AND in a format that is well known by clinical staff. SBAR asks for recommendations to improve current processes.

Process Change Two

Staff wanted to be acknowledged

- The reporter of every event receives an acknowledgement email within 2 business days.

Process Change Three

Staff wanted to see the system changes from the Good Catches

- Safety Committee reviews every Good Catch and reports out system or process changes.

Study

Process Change 1 (SBAR)

The event comes to life when we let staff tell the story in a structured way.

- Not as much blame
- Not as many vague descriptions
- Great process improvement suggestions
- Dept. Managers and Director of Quality/Risk Management work together to complete event detail for accurate PSO reporting.

Results

Process Change 2 (Email the reporter)

The staff know that their event has been received and is being investigated.

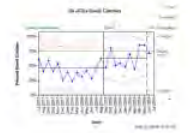
- They receive event number
- They know who is leading the investigation
- They are more likely to receive outcomes from the manager
- The lead investigator(s) are now accountable. No more anonymity.

Process Change 3 (Good Catch)

The staff know that their event was reviewed by leaders at the Safety Committee

- They are acknowledged at an organizational level by receiving a Good Catch award and letter of thanks from our Board Chair, CEO and the President of the Medical Staff
- They understand how their engagement led to positive change for patient or employee safety
- Encourages more staff to think more critically and report their recommendations

Act



The graph above reflects the increase in Good Catch reporting for Medication Adverse Drug Events (ADE) after SBAR was initiated.

Project Phase Two

Safety event reporting by telephone gives front line staff, providers and visitors a convenient method to participate in our culture of safety. To be implemented in 2020.

Verigene®

Nicolaos Hadjivanni CLS (MT-ASCP), Dawn Kuwahara RN BSN, and David Long CLS (MT-ASCP)
Laboratory

Introduction SMART goal

Background

Enteric diseases are infections caused by viruses and bacteria; primarily as a result of eating, drinking and digesting contaminated foods or liquids. Cholera, typhoid fever, salmonella and Escherichia coli, infections are some of the most common enteric diseases.

Stomach pain, diarrhea, nausea and vomiting are the typical side effects of enteric diseases. Diarrhea and nausea could cause severe dehydration. An enteric disease could last for days, weeks, months or even years, leading to constant malnutrition and poor absorption of medicines.

Plan

In an effort to identify Enteric Pathogen (EP) organisms faster, the Laboratory is recommending implementing a rapid direct detection system. This will allow us to identify these organisms and drug resistant markers in a 2 to 5 hour process instead of the traditional culture and sensitivity (C&S) process of 2 days (or more) resulting in faster patient treatment and improved outcomes.

Traditional C&S Process:

Rapid detection and molecular technology is found to be the standard of practice in most hospitals. It enables physicians to make decisions about timely, targeted therapy.

Do

Contacting various molecular testing vendors, SVH Laboratory choose and contracted with Verigene® to implement their system. The contract was signed in August 2018, the equipment was delivered a month later. A "go live" date targeted for Nov. 5, 2018 for Enteric Pathogens.

Propose Verigene® Molecular Process:

The testing process with Verigene® takes about 2 hours with positive genera identification. With this faster testing time should result in faster patient treatment and improved outcomes. There are possible net revenue gains of $5-6,000.00 due to shorten length of stay, pharmaceutical costs, and lower testing costs.

To execute the project, the laboratory did the following to meet regulatory requirements for new tests.

- Validation of instrument
- Writing policy and procedures
- Staff Training
- Proficiency and parallel testing
- Communication with Physicians & Pharmacy

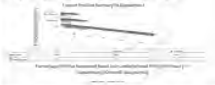
Progress will be measured by monitoring patient outcomes, length of stay, and pharmaceutical costs

Study

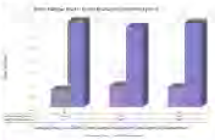
What was observe?

As shown above, recovery rates for the bacterial culture method are low. Compared with the Verigene® that detects bacteria, viruses, and toxins recovery rates improved.

Comparing the recovery rate percentages:



Finally, results are available much sooner, within less than 1 day as compared with traditional stool diagnostics that require an incubation time of 3-4 days.



Act

The Laboratory found that since implementation of molecular testing for Enteric Pathogens that the recovery rate of the causative organism did increase as well as the turn-around-time (TAT) did decreased as expected.

At this time the lab is unable to determine cost savings by length-of-stay or pharmacology improvement due to the low number of positive patients. Further review will be needed to verify those parameters.

Additional training of staff should help in to decrease the TAT, especially with ED and In-patient areas.

Results

Results were as expected showing improved recovery rate and lower TATs.

2nd Phase

Verigene® offers additional molecular testing platforms for direct testing of blood cultures (recovery of gram positive and negative organisms) as well for C difficile. The lab will be adding this capability to their test menu.

Additional staff training with emphasis on ED and In-patient specimens should even further reduce the TAT for those patients.

Acknowledgements:

Nicolaos Hadjivanni, CLS Laboratory Manager; Dawn Kuwahara BSN, RN, Chief of Ancillary Services; Dan Ryan, CLS and Dennis Mangan CLS, for the man hours to implement, parallel study; to bring the methodology to SVH. David Long CLS, & Danielle Jones for design work

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Quality Assurance Performance Improvement (QAPI)

Broadcast & Notification System

Fe Sendaydiego, Lynn McKissock, Celia Kruse de la Rosa, Veronica Loza

Information Systems, Human Resources, Community Outreach, Mammography

Introduction SMART goal

During the North Bay Fires of 2017, we realized we did not have a system in place to contact all hospital staff with important information pertaining to the condition of the hospital and/or staffing needs (similar to the county-wide Nixle system). Simultaneously, we saw an opportunity to improve our appointment reminder process utilizing available technology to remind patients of their appointments via text, email and/or phone call.

GOAL: Implementation of a notification system capable of various methods of reaching both staff and patients with important communication before the end of the 2019 calendar year.

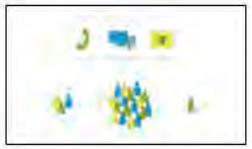
Plan

Upon identification of a system that meets our needs, we will run a pilot with a small group first, and upon success will expand use for other purposes.

Do

Identified One Call Now as the cost-effective system that met our needs.

Selected Mammography as the pilot program for appointment reminders. Working with the scheduler, created a report to capture appointments by patient within the scheduling system. Implemented a process to import the electronic report into the One Call Now system and began testing the various contact methods. After a week of successful testing, the appointment reminder portion of the system was activated.



After a successful pilot program, we began research and testing for employee notifications. Again, utilizing a small group for piloting, we tested various rounds of notifications and developed training materials for employees to follow for self-enrollment. After three weeks of successful testing, we introduced the new notification system to all employees in October, 2019.

As each employee enrolls, we assign them to a "sub-group" for targeted message distribution. The primary sub-groups include All Staff, Leadership, Administrative Team, and Emergency Preparedness Team. We also created a couple of additional distribution groups for community organizations and specific departments within this hospital.

Study

Appointment Reminders: Within the pilot group we observed that there did seem to be a reduction in "no shows" for appointments and an increase in patients calling in to reschedule appointments they were no longer able to meet. We believe the appointment reminders prompted the individuals to reschedule, rather than just not showing.

Employee Notifications: While some employees reported enthusiasm for having such a system in place and found the self-enrollment instructions very easy to follow, there remains a majority of staff that have not yet registered (as of November 2019, only 16% of our total population have registered).

Upon further research, we learned that some employees have concerns of getting inundated with messages on their personal phones – particularly messages that are not emergency-related. Additional feedback also included responses indicating a lack of urgency in the need of signing up – it appeared to be presented more as an option, if desired.

So, while we met our implementation goal, we have yet to reach our goal of having all staff enrolled.

Act

Appointment Reminders: With the pilot program being successful, we feel ready to expand this functionality to additional departments, such as Patient Access. We will target this to begin after the first of the new year.

Employee Notifications: We see an opportunity to further promote and better communicate the importance of this notification tool. We will enhance our communication to stress the emergency aspect and benefits of receiving notifications and alleviating the perception of message inundation.

Overall, we see this as an excellent additional method of reaching a greater population with important messages, alerts, and notifications that we should continue to grow.

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RISK EVENT REPORTING

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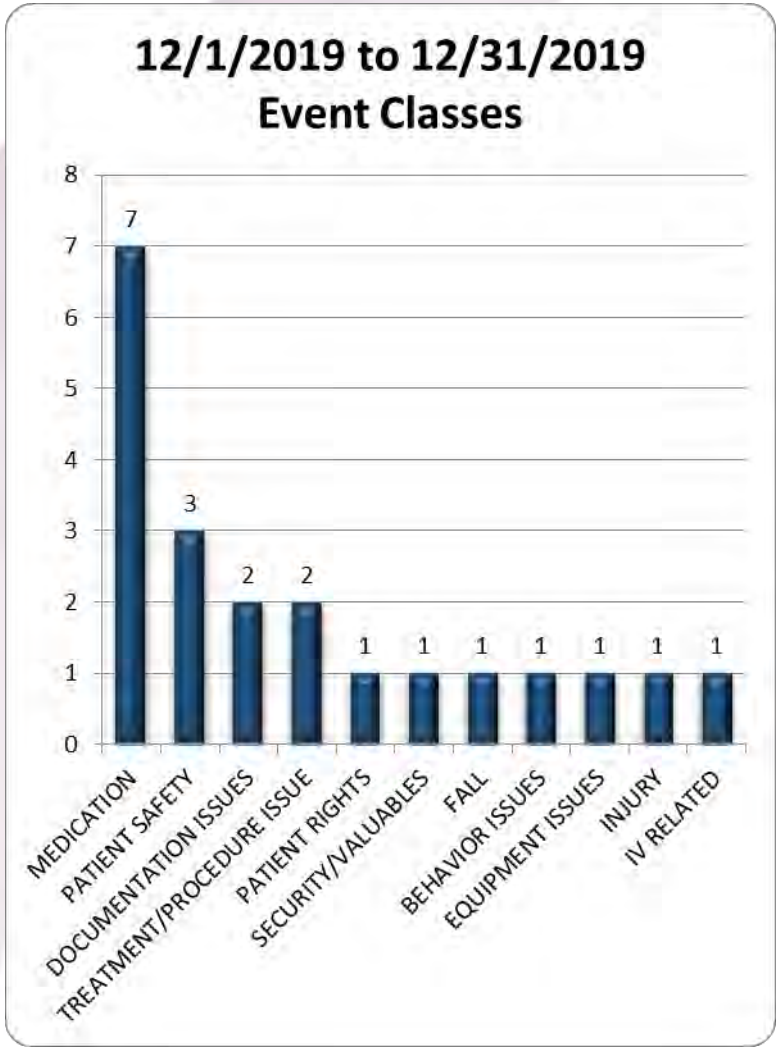
Risk Event Reporting



- **Opportunities for Improvement**
  - November 2019
    - No Good Catches reported in November
    - Last Good Catch reported in September
      - Risk event reporting decreased post SNF restructure
- **Plan of Action**
  - Laboratory training on event reporting in January
  - 5494 Call for Safety

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Hospital Quality Institute

Leadership in quality and patient safety

CEO, Leader, and Governance

Quality Work Guide

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Hospital Quality Institute
Leadership in quality and patient safety

Quality Work Guide

For CEO & Board Governance

From: Julie Morath, RN, MS, President/CEO

Hospital Quality Institute (HQI) is pleased to provide these materials for your review and use. These materials are intended to provide guidance in the development of a system of continued improvement and safety system for an organization, specifically focused on executive and governance oversight. The materials provide examples or a template that an organization can adapt for its use to fulfill Quality and Patient Safety requirements.

HQI Blueprint for Advancing Quality and Patient Safety

California Hospital Patient Safety Organization Membership Brochure

"Becoming a Patient Safety Organization" by Rory Jaffe, MD, MBA, Executive Director of CHPSO; Published in the AHRQ *Perspective*, July 2011.

HQI Improvement Pocket Guide: DMAIC

Board Leadership: A Driver of Health Care Quality

Quality as a System

Questions a Board Needs to Ask

Example: Quality and Patient Safety Committee Charter

Example: Operational Quality and Patient Safety Performance Improvement Plan (QAPI)

Example: Quality and Patient Safety Accountability and Reporting Flows

Cascade of Alignment: Connecting the Dots of Specific Initiatives to Overarching Quality and Patient Safety Aims to Move the Dial for Better Care

Governance and Board Readiness Assessments

We look forward to working with you as you develop your quality improvement and patient safety plan. For editable/electronic files, please contact HQI at HQIOperations@HQInstitute.org or (916) 552-7600.

A collaboration of the California Hospital Association, Hospital Council of Northern and Central California, Hospital Association of Southern California, and Hospital Association of San Diego and Imperial Counties

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Board Leadership:
A Driver of Health Care Quality

The Developing Requirements and How to Meet Them

The purpose of this brief is to provide an overview of the evolving role and expectations for hospital Boards in achieving higher levels of clinical quality and patient safety.

Situation

It is well established that hospital governing Boards have responsibility for the quality of care provided in their institutions.[1] Historically, how Boards fulfilled this responsibility has been open to interpretation and varying practices. In recent years, the changing social, political and economic environment has led to a new era of publicly reported comparative quality measures, transparency, and new reimbursement models that reward performance. The role of hospital Boards in assuring quality of care in this context is more focused that ever before.[2] A challenge in meeting these evolving expectations was framed in a recent study that raised questions about whether hospital Boards are sufficiently educated about and engaged in oversight of quality.[3] Hospital Boards that have met this challenge, however, demonstrate great positive impact on institutional and patient outcomes.

Background

Momentous events occurred during the course of the last decade that are an impetus for today's heightened expectation that hospital Boards exercise active oversight of the quality of care delivered by their organizations. First, the Institute of Medicine (IOM) published two seminal reports, *To Error is Human*[4] and *Crossing the Quality Chasm*[5], in 2001 and 2002, respectively. These reports documented the serious and pervasive nature of the nation's overall quality problem, finding nearly 100,000 deaths per year from medical errors, as well as systemic failure to provide evidence-based care nearly half of the time. Second, concurrent with the release of the IOM reports, the for-profit business sector experienced a series of ruinous accounting fraud scandals leading to the bankruptcies of Enron and WorldCom, and the related demise of Arthur Anderson. Additionally, the notorious $1.3 billion bankruptcy of the Allegheny Health, Education and Research Foundation reverberated with many of the issues

Key Points

- Engaged Boards improve quality outcomes
- The nation has a serious quality and patient safety problem
- There are new expectations for governance oversight of quality
- Quality is at the center of healthcare reform
- Best practices for Boards are available

demonstrated by the infamous commercial failures, but within non-profit healthcare. These examples mark unconscionable lapses in corporate integrity and governance oversight leading to an increased scrutiny of Boards and higher standards of accountability. In 2002, Congress responded by passing the Sarbanes-Oxley legislation which introduced major changes to the regulation of corporate governance and public finance.[6] While charitable organizations are largely not covered by its provisions, the law has affected and strengthened Board practices in not-for-profit organizations. Some predict, however, that a direct ". . . Sarbanes-Oxley for quality is around the corner."[7] Third, while many aspects of the US healthcare system are exceptionally advanced, the care provided is too often unsafe and inefficient. Exacerbating the patient safety issues are federal forecasts that predict US healthcare spending will exceed $4.1 billion by 2016, representing 20% of the gross national product.[8] In response to the demand for better quality, patient safety, and cost efficiency, policy leaders and patient organizations have called governing Boards to enhance their oversight function on quality of care. In March 2010 Congress passed the Patient Protection and Affordable Care Act[9] which addressed multiple changes to the current healthcare delivery system. Payors are moving into value-based purchasing models using financial incentives targeted at providers, consumers, or both, linked to measures of health care quality and efficiency.

These events usher in a new era of accountability for health system Boards. The change is welcomed as evidence shows that highly engaged Boards focused on quality of care can impact outcomes in very positive ways.

Assessment

Boards face important new issues related to how quality of care affects matters of reimbursement and payment, efficiency, cost controls, and collaboration between organizational providers and individual and group practitioners. "These new issues are so critical to the operation of health care organizations that they require attention and oversight, as a matter of fiduciary obligation, by the governing Board."[10]

Historically, Boards delegated to medical staff and management the operational responsibility for safe care. Hospital Boards are beginning to realize that they can no longer regard the quality and safety of care in the hospital as the sole responsibility of the doctors, nurses and executives. Even though most hospital Board members are not clinically trained, they are nevertheless ultimately responsible for everything that goes on in the hospital, including the quality of clinical care.[11] Training in quality principles and methods, as well as attuned organizational structures and processes are critical to enable Board effectiveness.

Recent studies show that the majority of hospital Boards are not prepared to meet the new level of expectations and accountabilities for quality of care. In a national survey of Board chairs, a study conducted by researchers at the Harvard School of Public Health found that fewer than half of the Boards rated quality of care as one of their top two priorities. Few reported receiving training in quality. Moreover, using publically reported quality data, the researchers assessed Board engagement relative to high-performing and low-performing hospitals. They identified large differences in Board activities and engagement between high-performing and low performing hospitals. Highly engaged and trained Boards who exercised active oversight of quality realized significantly higher quality performance.[12]

Recommendations

Many excellent resources are available to suggest potential strategies to support Boards in meeting their oversight of quality.[13] Most of these resources share common themes in their recommendations. A succinct statement of recommended Board activities was advanced in a recent study by researchers at the Johns Hopkins Quality and Safety Research Group.[14] The recommendations include:

1. Boards should have a separate quality and patient safety committee that meets regularly and reports to the full Board. Evidence suggests Boards with such a committee spend more time on improvement activities, and their hospitals may have better outcomes.

2. Boards should ensure the existence and annual review of a written quality improvement and patient safety plan that reflects systems thinking, contains valid empirical measures of performance, and is consistent with national, regional, and institutional quality and safety goals.

3. Boards should have an auditing mechanism for quality and safety data, just as they do for financial data. While data quality control principles apply to clinical research and apply to financial data through generally accepted accounting principles, data quality in measuring quality and patient safety has received little to no attention in most health-care organizations.

4. Boards should routinely hear stories of harm that occurred at the hospital, putting a face on the problem of quality and patient safety. Stories may be case reviews presented by staff or interactions with patients or families who suffered harm.

5. In conjunction with the CEO and medical staff leaders, boards should identify specific, measurable, valid quality indicators consistent with strategic goals and hospital services, and review performance against the indicators no less than quarterly. Such review should include:

    a. Regular quantitative measurement against benchmarks;
    b. Reported compliance with rigorous data quality standards;
    c. Performance transparency;
        i. Weekly or monthly reports of harm;
        ii. Sentinel event and claims review for quality and safety problems;
    d. Methods for active intervention to improve care;
        i. Survey of quality and safety culture;
        ii. Use of survey results to shape improvement efforts;
        iii. Routine mechanism to tap the wisdom of bedside caregivers.

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[1] Lister E, Cameron DL. The role of the Board in assuming quality and driving major change initatives – part 1: maintaining organizational integrity. *Group Practice Journal*. 2001;50:13-20.

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[3] Jha, A and Epstein, A, "Hospital Governance and the Quality of Care," *Health Affairs 29 (1):182-187*.

[4] To Err is Human: Building a Safer Health System (2000), Institute of Medicine

[5] In Crossing the Quality Chasm: A New Health System for the 221st Century (2001), the Institute of Medicine (IOM) identifies six aims of the healthcare quality system: that it should be safe, effective, efficient, timely, patient centered, and equitable.

[6] Sarbanes-Oxley Act of 2002, PL 107-204, 116 Stat 745

[7] Nash DB, Medical Executive Post, March 9, 2008. See also, Royo MB, Nash DB. 2008. "Sarbanes-Oxley and Not-for-Profit Hospitals: Current Issues and Future Prospects," *American Journal of Medical Quality*, 23(1):70-72

[8] Poisal JA, et al, "Health Spending Projections Through 2016: Modest Changes Obsure Part D's Impact," Health Affairs 26 (2):w242-w253 (2007)

[9] Patient Protection and Affordable Care Act, PL 111- 148

[10] Callendar et al, Corporate Responsibility and Health Care Quality: A Resource for Health for Health Care Boards of Directors, American Health Lawyers Association, 2007

[11] National Quality Forum, Hospital Governing Boards and Quality of Care: A Call to Responsibility, 2004

[12] Jha, A and Epstein, A, "Hospital Governance and the Quality of Care," *Health Affairs 29 (1):182-187*.

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[13] See:
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Conway J, Getting Boards on Board: Engaging Governing Boards in Quality and Safety, The Joint Commission Journal on Quality and Patient Safety, Volume 34 Number 8, April 2008

[14] Goeschel CA, Wachter RM, Pronovost PJ, "Responsibility for Quality Improvement and Patient Safety: Hospital Board and Medical Staff Leadership Challenges," Chest 2010;138;171-178

Quality and Safety as a System:

Escalation of Concern When Complaint or Failure is Evaluated:

1. Is this an ISOLATED Event?
2. Is there a PATTERN of failure(s) in this area?
3. Are there organizational SYSTEMIC ISSUE(s) related to quality performance and oversight?

A system of performance and oversight must demonstrate iterative cycles of:

Hospital Quality Institute
Leadership in quality and patient safety

Governance Oversight of Quality

Key Questions for Boards

1. Is there a systemic view for strategy, e.g. planning process and strategic plan?
2. Are there measures that answer whether or not strategy is advancing, i.e.: Is care getting better or worse?
3. How were the measures selected? What are the criteria?
4. Are there contexted measures and metrics? For example:
   - upper/lower control limits if appropriate
   - target
   - actual absolute numbers, not percentages; or both
   - comparison to history and targets
5. Is there a coordinated process? Is there conformance and predictability in presentations, data displays, etc.?
6. Is the focus on the core product(s) of clinical care, such as core measures, eliminating harm, other specific and relevant topics?
7. Can all staff leaders answer the following questions?
   - how does "this" compare to past?
   - how does "this" compare to best-of-class?
   - what are we doing to improve and close the performance gap?
   - what can we predict from what we know?
   - what might be unintended consequences of our improvement efforts?
8. What is the relevance to the front line caregivers and providers? Where is street level example that ties "front office to front line?"

Hospital Quality Institute
Leadership in quality and patient safety

Quality and Patient Safety Committee

[ORGANIZATION]

Organization and Policy Statement

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 [ORGANIZATION]; 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 [ORGANIZATION]. 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.

A. Oversight

As the governing body, the Governance Board is charged by law and by accrediting and regulatory organizations (e.g., The Joint Commission [TJC]) 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 [ORGANIZATION], 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 [ORGANIZATION].

- Render reports and recommendations to the Executive Leadership Committee of [ORGANIZATION], 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.

B. Quality Integration

1. The Committee monitors the quality assurance and improvement activities of [ORGANIZATION]'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 [ORGANIZATION].
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.
6. The Committee identifies barriers to improvement for resolution and systematically addresses and eliminates barriers and excuses.

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[1]
   The standard Agenda for the council will include:
   - Quality Performance Indicator Set
   - Clinical Priorities (clinical outcomes/process improvement), including: *(List relevant services)*
   - Patient harm

[1] Reports are not made on each agenda item in each meeting.

- 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

Authority to Act	Yes, within charter and as directed by Executive Leadership and Board
Composition	Medical and Clinical Staff Leadership appointments; Operations, Executive Staff, and Board Members Patient/ Families membership should be considered
Meeting Schedule	Ten meetings per year
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 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 [ORGANIZATION]'s Vision and Mission; and to assess the ability of [ORGANIZATION] to execute against identified Quality and Safety strategies. The Board is ultimately responsible for the work of [ORGANIZATION] 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:

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

Operational Quality and Patient Safety Performance Improvement Plan

[Organization]

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 [Organization] 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 [ORGANIZATION]. The Quality and Patient Safety Performance Improvement Plan has been developed with broad interdisciplinary input, Quality and Patient

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

[Organization] 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.

SCOPE AND ACTIVITIES

This plan applies to all service and sites of care provided at [ORGANIZATION]. 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. [ORGANIZATION] 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, [ORGANIZATION] 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. [ORGANIZATION] 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, The Joint Commission 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. [ORGANIZATION] 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. [ORGANIZATION] 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 [ORGANIZATION] 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 [ORGANIZATION].
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 [ORGANIZATION] 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

[ORGANIZATION] 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.

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 [ORGANIZATION] 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 [ORGANIZATION]. 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 [ORGANIZATION]. [*optional text, based on type of organization:* Medical resident quality improvement projects and a developing maintenance of certification program contribute to an enriching environment.]

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 [ORGANIZATION] Administration for developing and reviewing policies and recommending standards for other [ORGANIZATION] 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 [ORGANIZATION], is responsible and accountable for the success of the [ORGANIZATION]'s performance in quality and patient safety activities. The Committee synthesizes and coordinates quality and patient safety activities of the [ORGANIZATION]. 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 qoals 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 [ORGANIZATION] 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.

STAFF RESPONSIBILITIES FOR SPECIFIC INFORMATION

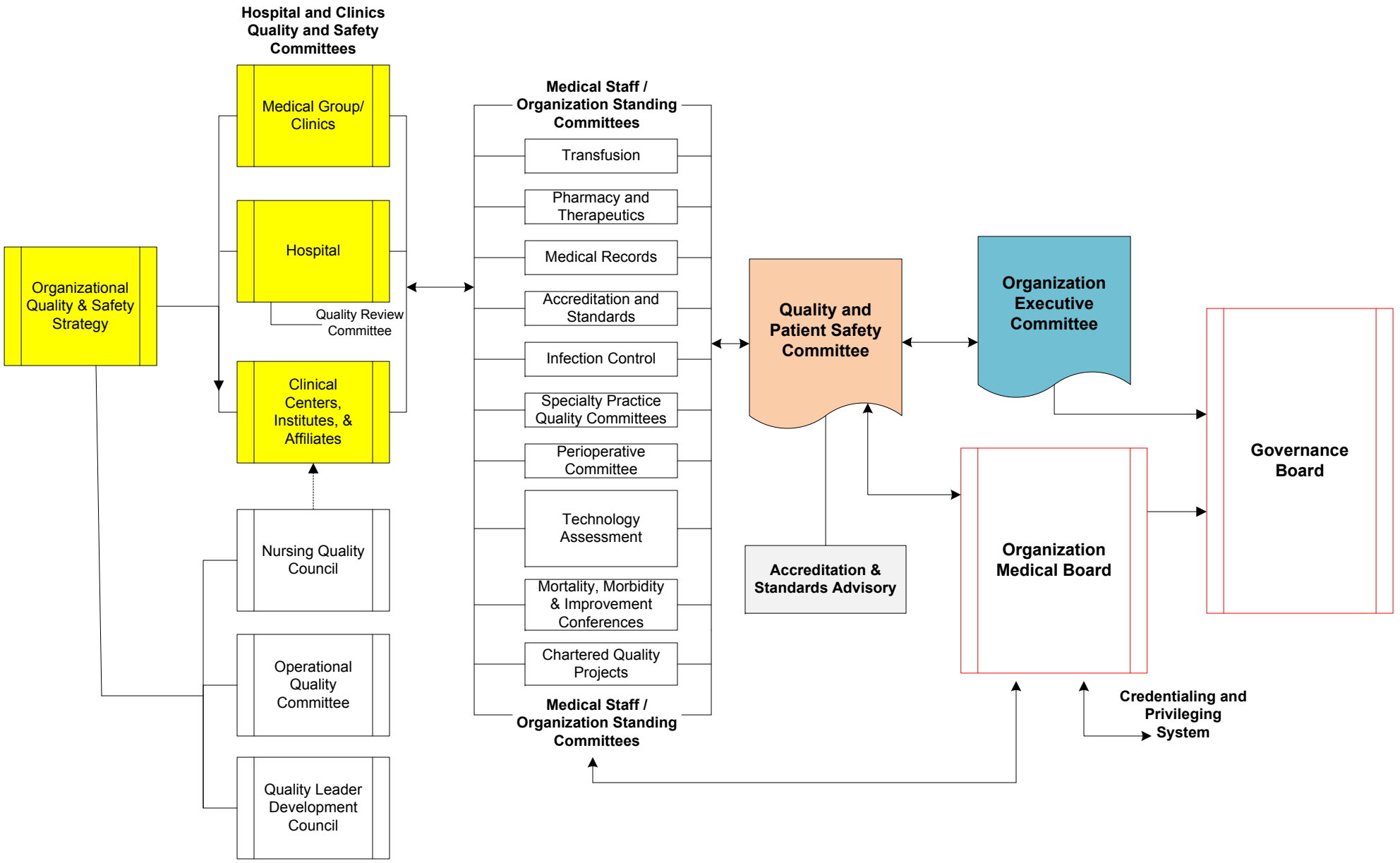
- All staff from every hospital department are responsible to report patient safety events, risks, and near misses.
- Infection Control and Prevention aggregates and analyzes data related to health care associated infection, infectious disease exposure, contact tracing, and multi-drug resistant organisms.
- 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.

[Refer to Organizational Quality & Patient Safety Accountability Flow]

Roles and Responsibilities of Committees for Quality

Hospital, Clinics and Medical Specialties	Organization-wide	Executive Oversight	Medical Staff Governance	Governance
Local Quality Committees • Develops tactics and aligns improvement efforts to achieve organizational quality goals • Identifies local trends and patterns to inform improvement efforts • Develops relevant quality assurance and improvement plans and priorities • Assures follow up to close identified gaps in care from event analysis and safety reports • Monitors progress and speed and removes barriers to effective action • Engages providers and frontline staff in improvement, using standard methods, tools, and techniques. • Uses survey data and other listening posts to create a culture of safety • Monitors NQF best practice implementation and compliance to regulatory and accreditation standards • Fosters continual learning and skills for risk prevention and improvement • Produces reports and tracks performance • Recognizes accomplishments and celebrates gains made	*Quality and Patient Safety Committee* • Facilitates development of quality goals and initiatives • Establishes priorities and plans • Oversees quality assurance and improvement processes of organization through standard reports and presentations • Provides quality alignment and integration • Monitors measured performance against goals and priorities • Reviews event analysis outcomes and risk trending • Monitors NQF best practice implementation and compliance to regulatory and accreditation standards • Recommends actions to close gaps in care/performance • Fosters culture of safety and habitual excellence • Assures continual learning and skills for risk prevention, improvement, and outcomes management • Identifies need for policies and procedures • Recognizes and celebrates gains made	*Executive Leadership* • Endorses quality goals and plans • Endorses metrics for external and internal reporting • Systematically reviews quality improvement measures, metrics, and processes • Monitors NQF best practice implementation and compliance to regulatory and accreditation standards • Provides resources and support • Removes barriers and excuses from progress • Catalyzes action • Commissions studies and reports • Accepts standard quality performance indicator reports and annual patient safety report	*Medical Board* • Provides oversight of the quality of care • Assures credentialing and privileging process and actions • Approves clinical policies and procedures • Monitors NQF best practice implementation and compliance to regulatory and accreditation standards • Accepts reports: CME, medical staff committees and departments, patient safety, quality performance indicators • Reviews risk prevention report and directs action • Acts on quality matters as referred/identified • Improves its own methods	*Governance Board* • Assumes responsibility and accountability for patient safety and quality performance • Assures improvement is occurring • Requires constancy of purpose in the quality journey • Holds Senior Leadership accountable for results • Assures community needs are met through compliance to regulatory and accreditation standards • Leads celebrations of gains made • Improves its own methods

Example
Quality & Safety Accountability & Reporting Flows



Courtesy of Hospital Quality Institute,
www.hqinstitute.org

Cascade of Alignment:

Connecting the Dots of Specific Initiatives to Overarching Quality and Patient Safety Aims to Move the Dial for Better Care

Hospital Quality and Safety areas of focus generate multiple individual measures and initiatives, but sum to five broad strategic aims.

They are:

1. Increase the survival of patients cared for in the hospital environment to levels that meet or exceed the best care in the U.S.
2. Provide harm free care through reliable performance and elimination of defects that harm or have the potential to harm our patients.
3. Demonstrate top performance in clinical care, by achieving 100% compliance to evidence-based practices.
4. Create value through efficient, integrated systems of care that reduce the utilization of resources and costs associated with poor quality and preventable readmissions.
5. Advance hospital performance to achieve high reliability to take excellence to scale with zero defect in care delivery.

Quality and Safety Focus: Rationale and Actions*

Strategic Aim: INCREASE THE SURVIVAL OF PATIENTS CARED FOR IN THE HOSPITAL ENVIRONMENT TO LEVELS THAT MEET OR EXCEED BEST CARE IN THE US

Definition	Rationale	Highlights of Actions / Strategies in Place for Success
Index of Observed Inpatient Deaths divided by Expected Inpatient Deaths. Emphasis is on reducing observed mortality.	• Key outcome indicator of survival. • Lives saved • Used as indicator of overall excellence for complex, tertiary/quaternary organizations caring for the sickest patients as well as teaching and community hospitals. • Indicator for rankings in Hospital Compare, UHC , US News World Report, Consumer Portals.	• Sepsis Protocol and training • Obstructive sleep apnea protocol / screening / management • General Unit monitoring capabilities • Handovers / escalation of chain of command / critical communications • Rapid Response Teams • Transfer management (Care Transitions throughout continuum) • Opiod administration monitors • Trauma Extravasation Protocol (TEP), Massive Transfusion Protocol (MTP). • Planning for ICD—IO Coding optimization • Case review of deaths • Palliative Care and Hospice programs and referrals • Use of PEWS/MEWS as an anticipatory care model
Actual mortality rate	• Real time • Internal monitor • Deaths / patient days or deaths / discharges • Complement external comparison • Already collected by most	

Quality and Safety Focus: Rationale and Actions

Strategic Aim: DEFECT-FREE CARE

Provide harm free care through reliable performance and elimination of defects that harm or have the potential to harm our patients

Definition	Rationale	Highlights of Actions / Strategies in Place for Success
Preventable Patient Harm Metric: A composite metric of the monthly rate from CMS definitions, includes CDC, and others **Healthcare Acquired Condition:** 1. Pressure ulcer 2. Falls / Trauma 3. EED and maternity measures **Healthcare Acquired Infection:** 1. CLABSI 2. Catheter-associated UTI 3. VAC (formerly VAP) 3. Surgical site infection 4. Immunization rates workforce 5. Hand hygiene	• Harm events and healthcare acquired definitions is based on standard definitions of the 10 CMS-defined "Healthcare Acquired Conditions" • **Aligns with NQF Safe Practices: 22, 25, 26, 27, 28, 32, 33** • This metric can be generated in real time. • These metrics are already being produced. • The falls and pressure ulcer metrics correspond to those provided to the Leapfrog survey; NDNQI • Publically reported elements / greater transparency; HEN participation • Patient Safety Performance affects risk profile / claims and lawsuits • Adds to cost burden • Pay for performance implications ♦ CMS penalties and rewards in reimbursement ♦ Payor / contracting focus • Affects reputation and ranking • Safety indicators gaining greater weight in quality assessments • Affects pain, suffering of patients, families, and staff • TJC scrutiny and standards in development • Competitors / best performers mandatory measures	**HAC Pressure Ulcer** • CalHEN membership (179 hospitals) • Children's Ohio HEN (OCHCN) 7 Children's Hospitals • Aggressive Awareness Campaign • Education emphasis shift from staging to prevention • Focused, intentional rounding • Prediction / screening tools • Medical staff involvement and education for POA documentation **Falls** • CalHEN and OCHCN participation • Aggressive Awareness Campaign • Rounding • Prediction / screening tools • Environmental risk mitigation (lighting) and use of devices (lifts, raised toilet seats, alarms) **EED and Maternity Measures** • CalHEN • Patient Safety First Includes physican education and and "hard stop" policy • CMQCC • ACOG participation • Community partnership—March of Dimes **HAI Prevention** • CalHEN and OCHCN • HQI and HAI State Committees; APIC partnership • Robust implementation evidence with CLABSI to spread outside of ICUs • New CDC definitions and measures for (VAP) VAC • Mandatory Immunizations emerging; 2020 TJC standard for immunization rates • Hand hygiene accountability model • California Joint Replacement Registry (CJRR) • American College of Surgeon NISQIP, SCIP, SSI

Quality and Safety Focus: Rationale and Actions

Continued from page 3

Definition	Rationale	Highlights of Actions / Strategies in Place for Success
Medication Events 1. Definitions remain in development	Participate in national definition through CalHEN work	Medication Events and Near Misses • Medication Safety Committee • High risk medication improvement focus: ♦ Opiods ♦ Vancomycin ♦ Anticoagulants ♦ Insulin ♦ Medication reconciliation • Increase profile and leadership of PharmD content experts • Process mapping, FMEA, of medication management system • Focus on pharmacy processes and nursing administration processes • Double check for high risk drugs • California Association of Health System Pharmacists
Other areas of Preventable Harm in study / actions 1. Retained surgical items (RSI) 2. Air embolism 3. Blood type incompatibility 4. Manifestation of poor glycemic control 5. DVT ,VTE, or PE associated with knee or hip surgery; obstetrical care Never Events are enduring areas of focus: 1. Wrong site, wrong procedure, wrong patient	CMS metrics with same consequences as HAC, HAI. Publically reportable for retained objects, blood transfusion event	• Instrument and sponge count procedures • Intraoperative handovers for relief in cases, and multi-surgical teams • Line management • Reliable system design for blood management • Robust glycemic control process, informatics alert, consulting team, quality metrics and reporting • DVT /VTE/PE tracking added to CalHEN • Universal Protocol / Time out expanding to outpatient procedural areas of high volume and high risk from surgical operating rooms as well as bedside procedures • Surgical debriefs

Quality and Safety Focus: Rationale and Actions

Strategic Aim: TOP PERFORMANCE IN CLINICAL CARE

Aim: Demonstrate top performance in clinical care, by achieving 100% compliance to evidence-based practices

Definition	Rationale	Highlights of Actions / Strategies in Place for Success
Inpatient Core Process Quality Metric: An aggregate score, based on compliance with multiple CMS inpatient core measures in these areas: AMI, Heart Failure, Pneumonia, Surgical Care (SCIP). Core measures. Anticipate addition of chronic obstructive pulmonary disease and stroke Asthma care for children	• This aggregate metric samples care quality across four important clinical areas. • The individual inpatient care measures are based on CMS Proposed Rule (Issued Jan, 2011. Amended April 29, 2011) on Value Based Purchasing (VBP) for Medicare Patients; TJC for all patients. • The aggregate metric ("VBP Process Domain Score") is available for monthly tracking of performance. • Measures are publically reported, impacting payment (revenues and penalties) as well as ratings and reputation. • This single numeric score (a percentage of achieved vs. potential) reflects both current level performance and improvement during the time interval of reporting. • Note: This metric does not include the HCAHPS portion of VBC points.	• Opportunities for core measures • Define issue and scope of any gaps • Is Pneumonia discharge trigger and immunization protocol in place? ♦ Implement discharge advisor to deliver pneumococcal and influenza vaccines. • Status of Asthma care for pediatrics • SCIP opportunity is typically acute pain service and surgery service coordination in management • ED to inpatient identification is operational • Psychiatry/mental health emerging

Quality and Safety Focus: Rationale and Actions

Strategic Aim: TOP PERFORMANCE IN CLINICAL CARE

Continued from page 5

Definition	Rationale	Actions / Strategies in Place for Success
Outpatient Core Process Quality Metric: A composite score based on compliance with four primary care prevention measure for diabetes care (LDL & A1C outcome measures) and cancer prevention (breast &, colon cancer screening). Outpatient OPPS is a core measure relating to ambulatory surgical population Measures of prevention are still in consideration Status of ambulatory measures are being released	• This aggregate metric samples primary care quality across important prevention areas • The individual metrics are already being tracked. • These metrics are consistent with those used for TJC, NCQA, and CMS reporting, and payer contracting. • Consistent with Meaningful Use • Implications for differential payment	**Hospitals /Hospital Systems** • Meaningful Use is an enabling platform • OPPS focus in antibiotic selection and administration in outpatient procedures • Status of ambulatory quality measures in early stages of development • Readmission measures

Quality and Safety Focus: Rationale and Actions

Strategic Aim: REDUCE COSTS OF CARE

Through efficient, integrated systems of care that reduce the utilization of resources and costs associated with poor quality and preventable readmissions

Transitions of care across continuum

Definition	Rationale	Highlights of Actions / Strategies in Place for Success

Optimizing Care Transitions / Continuity of Care
 	
Metric: Rate of Readmissions within 30 days (based on CMS definition of readmission for HF, AMI and Pneumonia).
 	
All readmissions for all reasons in definition; focus on unplanned, related readmissions for AMI, HF, PN populations.
 	
COPD is being added.
	• Readmission rate reflects important coordination of care across inpatient / outpatient boundaries.
	• Indicator for effectiveness in continuum of care development and partnerships
	• Driver for differential reimbursement.
	• Consistent with goal for Optimizing Care Transitions.
	• Data are generated and can be reported daily, weekly, and monthly.
	• Studies are in process for predictive models to identify and mitigate risk for readmissions.
	• Programs for continuing care identified and in process
	  ♦ Post-Acute Care
	  ♦ Medical Home
	  ♦ Skilled Nursing Facility (SNF) capacity/partnerships/access
	  ♦ Transition clinics
	• Home Care Services are part of care continuum
	• Case management program and services track at risk patients/populations
		• Measure in CalHEN, OCHCN
		• Explore predictive model intended to trigger protocol for patients at high risk for readmission for more focused discharge plans and resources
		• Optimal discharge planning teams
		• Patient education for discharge instruction / patient – centered plan
		• Post D/C follow up phone calls to include continuing care assessment
		• PharmD participation in discharge process for medication reconciliations to reduce readmission through appropriate medication management
		• Meaningful Use implications support this goal
		• Daily, weekly, monthly readmit reports with chart reviews to understand interconnections of discharge status to reason for readmission.
		• Readmission for psychiatry needs definition
		• View patient flow as a value stream
		• Work with Post-Acute care and Continuing Care agencies and facilities to effectively achieve transitions, especially access
		• Mental health not yet well understood
		• Readmissions collaboratives
		• Why admission in the first place?

Quality and Safety Focus: Rationale and Actions

Advance Culture of Safety, Improvement, Reliability with a Learning and Improvement System

Advance hospital performance to achieve high reliability to take excellence to scale with zero defect in care delivery.

Definition	Rationale	Highlights of Actions / Strategies in Place for Success
HealthCare Reliability Organizing (HCRO) provides knowledge, structure and process consistent with and in support of reliable performance in care delivery.	• Aligns with NQF Safe Practice 4: "Systematically identify and mitigate patient safety risks." • Leadership and reporting is foundational to a culture of safety. • Knowledge, skills, tools are required for improvement at frontlines of care • Leapfrog / TJC/QAPI	**Patient Safety First** • Mobile Simulation Center Sepsis Project and Team Training • TeamSTEPPS **CHPSO** • Curriculum and mentors to the programs identified and being recruited • Structures: ♦ Purposeful rounding, disciplined and intentional ♦ Handovers ♦ Universal protocol and timeouts ♦ Huddles and debriefs ♦ Escalation in chain of command • HCRO curriculum in final development • Human factors expertise • Culture of safety survey opportunity • NPSF certification program • PSO feedback and engagement • Attention of Leadership: fluency in performance, inquiry, recognition • Alignments in HR partnerships, peer review models, mortality and morbidity review formats and conduct • Codes of conduct **Transforming Concept from Lucian Leape Institute** • Through the Eyes of the Workforce—Creating Workforce and Patient Safety • Transparency
Culture survey results create data base for understanding and targeting improvements.	• Results can affect HCAHPS results that roll up into the Value Based Purchasing scores.	
Create psychological safety for reporting and improvement. Engage and align leaders, faculty, staff and residents in continual learning and improvement within defined clinical microsystems. Create cultural tipping point for reliability, and resilience in frontlines of care and with clinical leaders.	• Survey is required for Leapfrog submission • Handovers and reliable communication are causal variables in events of harm and near misses and central to this goal. • Readiness / demand has been expressed by stakeholders • Capability / capacity of frontline essential to advance habitual excellence • 353 member PSO with data to inform areas of focus • Learning Management System (LMS) and Reliability Management System with Gateway Practices, Support Person-Centered Care and the Triple (Quadruple) Aim	

Governance Board Readiness Assessments:

QI and Patient Safety in Health Care Organizations

Claire Manneh, MPH

Director of Programs

22 April 2014

Contents

ABSTRACT

This review is an attempt to conduct a survey of relevant board readiness instruments used to assess the work of health care organizations on quality improvement and patient safety for California hospitals and health systems. While research on the usefulness of these assessment tools is limited, adopting assessments ensures sustainability, meets patient needs, and restores the values and mission of the organizations. A copy of each these instruments are available in the appendix.

INTRODUCTION

California is home to the most hospitals and healthcare facilities in the nation, each healthcare organization equipped with a board of directors. More than ever, hospital trustees, executives, and clinicians face a multitude of challenges. They are met with legislative pressures coupled with transformations to the healthcare system, and competition to keep up with those demands, particularly in the patient safety and quality improvement spaces. Board members' use of self-assessment tools can help the organization understand where their opportunities lie and areas of improvement.

A variety of organizations and researchers have come up with instruments for governance boards to understand how they tackle patient safety efforts. Although errors in hospitals exist, the failures in the process may be harmful to patients. Changing the culture to reduce error and improve quality in the healthcare system is an underlying goal in these assessments.

ASSESSMENTS

American Governance Center

In a recent study by the American Governance Center, Governance Practices in an Era of Health Care Transformation, researchers found that these tools are beneficial to both hospital and health system boards, particularly in the adoption governance practices to lead their organizations through the significant changes in care delivery. The Center's Readiness Assessment is available for free. The assessment is a high-level survey to help boards determine how their current practices compare with key transformational governance practices identified in the study. Board members have the option to complete the assessment either manually or electronically. Results can be used for discussion about board strengths and opportunities to further improve governance.

HQLAT

In 2004, the University of Iowa and the Oklahoma Foundation for Medical Quality led a major national initiative, under contract with the Centers for Medicare & Medicaid Services (CMS), to align health care leadership with clinical performance improvement. Advisors from 96 industry organizations and over 600 supporting partners created the Hospital Leadership and Quality Assessment Tool (HLQAT), to help health care organizations identify and adopt quality-oriented leadership systems and ultimately improve clinical care processes and

outcomes. According to the research, respondent groups of hospitals (Board members, C-Suite, Clinical Managers) who on average had positive perceptions on the HLQAT domains also had higher quality scores. Further, "differences in the average domain responses between Board, C-Suites and Clinical Managers were smaller for high performing hospitals than for low performing hospitals" (HLQAT). The instrument is available online and free for hospitals. At least 13 surveys per hospital are required to receive a HQLAT report: three board members, four members of the executive team, and six to ten clinical managers. (Case-by-case exceptions to the minimum threshold can be made for small hospitals). Hospitals will have access to view reports as well as evidence based resources. Earlier versions of the survey were pretested over a variety of hospitals and in 2008, Westat conducted a pilot test to determine the association between hospital leadership attributes and hospital performance by comparing the high-performing hospitals with lower performers. Their findings led to a revision based on psychometric analysis results with high reliability (WeStat).

IFC – International Finance Corporation

An international level tool, the Self-Assessment Guide for Health Care Organizations, provides practical advice to organizations and companies that aim for international standards, including those who may wish to achieve some form of international accreditation. The guide uses a structured self-scoring methodology to lead management teams through a comprehensive assessment of their organizations. It focuses on 31 key standards based on accreditation standards of the foremost international health care accreditation body, the Joint Commission International.

The guide was developed by IFC health sector specialists with support from the Joint Commission Institute and international medical experts. It includes references to free online resources, including reputable sources of evidence-based medical practices.

IHI

The IHI's "Protecting 5 Million Lives from Harm: Governance Leadership – Boards on Boards (2008)" report provides samples of good practice to improve quality and reduce harm. Instead of using an automated system like the HLQAT or the American Governance Center's self-evaluation tools, the IHI's approach revolves around discussions and patient narratives, recommending boards to devote a quarter of the board meeting time on quality and safety issues. Further, the IHI recommends the entire board to conduct a patient interview on an individual who has experience serious harm within the past year. Six aims the Million Lives campaign asks leadership to focus on are: setting aims; getting data and hearing stories; establishing and monitoring system-level measures; changing the environment, policies, and culture; learning, starting with the board; and establishing executive accountability. The holistic approach of the IHI instrument focuses on qualitative aspects presented at board meetings using the hospital's existing metrics or dashboard, as opposed to a measurable, survey instrument.

The Monitor Group

Another international and UK-based level tool was created by the Monitor Group, who developed a Framework in 2010. The Framework can be relevant and translated to patient safety and quality improvement efforts for California. Assessing themselves against this framework allows boards to continuously monitor and improve the quality of health care provided and that areas highlighted through the process as requiring further work are effectively addressed. Questions include, Does the board provide a clear steer on the strategic and operational quality outcomes it expects the organization to achieve? Or Do you know that a quality culture exists across the different layers of clinical and non-clinical leadership. What is your evidence for this? The tool also encourages participation from patients, such as children, older people those with mental health conditions. A good patient story will strengthen the footprint on the hospital's effort to improve quality and safety. This guidance lays out one way of gaining assurance that such requirements have been met effectively and comprehensively.

RECOMMENDATIONS

The HQLAT will provide hospitals the opportunity to bring their Board members over a discussion on quality, identify the differing viewpoints of quality between all stakeholders, and recognize opportunities for process improvements. The benefit to using either the American Governance Center's or the HQLAT's instruments are the post-assessment resources they make available. Further, both tools are available electronically, allowing for convenient data collection and synthesis. The HQLAT also has a benchmarking tool hospitals can use to compare with other systems, a benefit the other instruments do not measure. The IFC, IHI, and Monitor tools may be used electronically if one were to enter the questions into an online survey database, such as Survey Monkey. While these resources are limited, there is a tool used for a study by Bataldan and Stoltz as well as one by Kane et al, which are both available with a PubMed subscription.

APPENDIX

American Governance Center Tools

AHA_Governance Tools for Transformat

HQLAT: Sample Senior Manager Survey

HLQAT-Senior-Manager-Survey_Final.pdf

IFC: Promoting Standards – Quality Measurement and Improvement, Patient Safety, and After the Assessment Modules

IFC_4QltyMsurImprv.pdf

IFC_5PtntSfty.pdf

IFC_7AftrSlfAssem.pdf

IHI Guide

IHIboardhowtoguide.pdf

Monitor Group Guide – refer to page 38

Monitor_QualityGovGuide22April13FINAL.p

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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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REVISED:	

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~~ Quadruple Healthcare Aim: Better Care for patients and providers, 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., Center for Improvement in Healthcare Quality CIHQ) with insuring the quality of care rendered by hospital ~~and clinics~~ through its various divisions and departments. To help meet this responsibility, the Board Quality Committee exists to:

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- 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~~CIHQ, 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~~)

1. Quality Performance Indicator Set
   a. Mortality
   b. Preventable Harm Events
   c. Healthcare Acquired Infection
   d. Medication Events
   e. Never Events
   f. Core Measures
   g. Readmissions
2. Patient Experience
3. Accreditation & Regulatory Standards

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4. *Quality Assurance Performance Improvement*
5. *Culture of Safety*
6. *Risk Event Reports*
7. *Policies & Procedures*

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.

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~~[DJ1] ~~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

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The standard Agenda for the council will include:

- Quality Performance Indicator Set
- Clinical Priorities (clinical outcomes/process improvement), including:
- ~~*(List relevant services)*~~Quality Assurance Performance
- ~~Patient~~Improvement
- Patient harm
- Patient safety (adverse event reduction, healthcare acquired infection reduction, risk mitigation)
- Performance to accreditation and regulatory standards and requirements
- Patient Experience
- Culture of Safety
- Policies and Procedures
- Environmental safety and disaster management

Rules

Authority to Act	Yes, within charter and as directed by Executive Leadership and Board
Composition	Medical and Clinical Staff Leadership appointments; Operations, Executive Staff, and Board Members Patient/ Families membership should be considered
Meeting Schedule	Ten meetings per year
Recommend Size:	~~Based on organization~~ The Quality Committee shall have at least seven and no more than nine voting members. Two Board members, one of whom shall be the QC chair, the other the vice-chair. One designated position from the Medical Staff leadership, i.e., the Chief or the Vice Chief. At least four and no more than six members of the public
Quorum Requirement:	Based on organization
Chair	Board Chair ~~or Chief Executive Officer (CEO)~~
Major Staff Support	Chief Quality Officer ~~and Patient Safety Officer, Quality Staff~~

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Notices Forwarded To	Committee Members, Presenters, CEO, Chief Medical Officer (CMO) and Chief Nursing Officer (CNO)
Non-member attendees	Staff resources as requested 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

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.

Policy and Procedures – Summary of Changes
Board Quality Committee, January 22nd, 2020

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:

Management of the Social Needs Patients MS8610-105
Created to outline the management of patients who present to the hospital with social needs which prevent them from returning to their previous living environment and do not met inpatient admission criteria for medical necessity. This policy will assist medical staff in the management of the social needs of a patient who does not meet inpatient admission criteria.

Rapid Sequence Intubation (RSI) Kit MM8610-161
Required as part of the Plan of Correction due to CDPH finding.

Sewage Overflow Response Plan CE8610-188
The Hospital experienced one major sewage flood and several minor sewage overflows in 2019. CDPH was present during a sewage overflow in Skilled Nursing and requested to see the policy for accessing sewage pipes in that unit. This policy is in response to a Skilled Nursing plan of correction. This policy was created as an organizational wide policy as flooding and sewage overflow can occur anywhere in the Hospital. It is important to document flood and sewage overflow response steps in order to adhere to Infection Prevention protocols during containment, clean-up and repair. This policy outlines communication, responsibilities, and procedures for a rapid response in order to protect patients, visitors and staff during a potentially hazardous event.

REVISIONS:

Creutzfeldt-Jakob Disease Human Prion Disease IC8610-118
Hospital did not have a screening process for suspected CJD and Medical Imaging was used for lumbar puncture for patient with unspecified encephalopathy with CJD in the differential diagnosis. It has been determined that patients with suspected or confirmed CJD or other human prion disease require a higher level of care and therefore should be referred to a CJD treatment center e.g., UCSF. This includes screening patients with diagnostic tests e.g., lumbar puncture for 14-3-3 protein testing or for surgery. Patients who are admitted and have or may have risk factors for CJD that are recognized during the course of their hospitalization, will be cared for in a manner that minimizes the risk of transmission of CJD until transfer to a higher level of care can occur.

Investigational Drug Use MM8610-135
Added the language: “Basic information concerning the dosage form, route of administration, strength,

actions, uses, side/adverse effects, interactions, and symptoms of toxicity of the investigational medication needed to safely administer the medication is obtained and made available for nursing staff on the unit in which the patient receiving the investigational drug is located."This language in the policy is a requirement of Title 22 DIV5 CH1 ART3-70263(o).

Pharmacy and Therapeutics Committee MM8610-129
Clarified membership and voting as part of the Plan of Correction due to CDPH finding.

Sterile Compounding MM8610-117
Revisions were made to ensure compliance with CCR 1751.4(j) and USP 797 2012 revision due to findings during most recent Board of Pharmacy inspection.

Warming Fluids for IV and Irrigation Purposes, Storage and Handling of MM8610-112
Changed the maximum storage temperatures and times and updated attachment A. An updated manufacturer letter defining how long fluids may be stored at elevated temperatures was obtained and the policy needs to match it.

Emergency Operations Plan 2019 EP8610-100
Clarified the role the SNF plays in Emergency Operations Management at SVH. Review completed to fulfill annual update requirement and to meet the requirements of Title 22 for Skilled Nursing Facilities attached to an Acute Care Hospital.

Hospital Evacuation during Disaster EP8610-101
Revised to include language codifying Skilled Nursing Unit role in Evacuation. Updated to fulfill Title 22 Life Safety requirement.

Surge Policy to Manage Patient Influx EP8610-102
Revised to include language codifying Skilled Nursing Unit role in disaster management. Updated to fulfill Title 22 regulation.

Tracking of On-duty Staff during a Disaster EP8610-104
Revised to include language codifying Skilled Nursing Unit role in disaster management. Updated to fulfill Title 22 regulation.

Fire Watch Policy CE8610-139
Additional NFPA requirements to the policy, CDPH contact update. Revised Fire Alarm out of service timeframe from 10 hours to 4 hours in a 24 hr. period.

Acuity Ratio and Staffing Plan-Nursing NS8610-102
Updating policy to reflect changes in departments and practice. Birth Center is no longer open.

Admission and Discharge Criteria By Unit PC8610-102
Elimination of SNF and Birth Center. Triannual review and these services no longer part of SVH.

Autotransfusion PC8610-109
Revisions were made to Addendum A per 3T Medical Systems Instructions for Use dated 8/2018. Previous instructions were from Stryker's Instructions for Use dated 2011. Distributer changed from Stryker to 3T Medical. Reviewed 3T Medical's current instructions for use.

Chain of Command GL8610-120
Policy language clarified and updated. SVH does not employ Charge Nurses or a Director of Nursing.

Clinical Nursing Procedures PC8610-124
We've changed vendors from Lippincott to EBSCO. Better product.

Code Blue-Broselow Carts and Emergency Medications QS8610-104
Removed vacutainers from Code Cart Drawer #2. Moved IV fluids for Broselow cart to drawer 9; updated contents of medication tray for Broselow Carts; added language stating who is responsible for the stocking and management of the different drawers in the crash carts and Broselow carts. Vacutainers frequently outdate and are not necessary in Codes due to abundance of vacutainers stocked in all nursing departments. It was a finding during CDPH survey that the pediatric drug tray contents were not adequate and the policy did not define who managed restocking each drawer of the carts.

Code Stroke Paging NS8610-124
Stroke paging protocol is being revised to delete 'stroke cleared' announcement. Rationale for stroke cleared announcement was to notify the Pharmacy to stand down on mixing tPA for infusion. Since tPA is now mixed by ED RNs, no need for additional overhead announcement.

Death-Fetal or Newborn PC8610-130
Very minimal/minor changes. Triannual review.

Falls-Management QS8610-116
Removed language pertaining to SNF Added CIHQ reference. SNF no longer part of SVH.

Nursing Staffing Floating and Call-Off NS8610-108
Revision of language including floating to SNF. SNF staff no longer SVH employees.

Orientation and Evaluation of Registry Personnel NS8610-110
Minimal language changes from Administrative Coordinator to Nursing Supervisor. Changed evaluation of registry to annual from quarterly. Triannual review.

Plan for the Provision of Nursing Care NS8610-112
Removal of verbiage r/t: Birthing Center, Skilled Nursing Facility and Home Care. Triannual review. The above services discontinued at SVH.

Pressure Ulcer Wound Care Assessment and Management PC8610-162
Removal of SNF language. Triannual review SNF no longer part of SVH nursing service.

Safe Baby Surrender Policy PC8610-164
Very minimal change. Triannual review.

Transporting of Monitored Patients PC8610-168
Minor removal of language around standard of practice that clearly includes documentation and use of oxygen if indicated. Triannual review.

Treat and Transfer of Patients GL8610-194
Cleaned up language regarding transfer of patients for services unavailable at SVH and/or staffing. Triannual review.

Weekend Coverage NS8610-118
Cleaned-up language around weekend shift coverage and per diem requirements. Bring to current practice and HR policy. Triannual review.

REVIEWED/NO CHANGES:

Controlled Substance Distribution for Anesthesia MM8610-108
Drug Supply Chain Security MM8610-157
Floorstock Medications MM8610-121
High Alert Medications MM8610-131
Adult Hypoglycemia Protocol PC8610-108
Audibility of Clinical Monitoring Intervention Alarm Systems QS8610-102
Declotting Central Venous Access Devices PC8610-132
Pain Management QS8610-120
Patient Identification QS8610-122
Scheduling of Staff Nursing NS8610-114
Universal Protocol PC8610-170
Urinary Catheter Insertion-Maintenance Removal PC6810-172
Verbal Telephone Order Policy QS6810-130

RETIRE:

Car Seat Safety PC8610-110
Nursing Education Reimbursement NS8610-104
Pediatric Informed Consent PR8610-168
Pediatric-Family Issues PC8610-152
PICC Line Insertion Peripherally Inserted Central Catheter PC8610-156
Standardized Procedure for Med Screening Exam for the Obstetrical Patient Performed by RN PC8610-166

DEPARTMENTAL

REVISIONS:

Nutritional Services
Diet Manual 8340-151
Organization has updated to a new diet manual. Removed reference to old diet manual. Removed reference to online diet manual from the Academy of Nutrition and Dietetics. Changed review of diet manual from every 3 years to annually with revision and approval at least every 5 years per regulations. Online diet manual does not match official approved diet manual to be used.

Emergency Department
Emergency Initial Assessment Triage 7010-01
Patients arriving via EMS ambulance may potentially be placed in the waiting room after a hand-off has been accomplished between the nurse and the EMS personnel and triage by a qualified RN (ESI levels 3-5 only).

SUBJECT: Management of Social Needs Patients	POLICY: MS8610-105
	PAGE 2
DEPARTMENT: Organizational	EFFECTIVE:
REVISED:	

PURPOSE:

To outline the management of patients who present to the hospital with social needs which prevent them from returning to their previous living environment and do not meet inpatient admission criteria for medical necessity.

POLICY:

To follow the Management of Social Needs Patients flow chart.

PROCEDURE:

Refer to Management of Social Needs Patients flow sheet (Appendix A).

APPENDICES:
Appendix A: Management of Social Needs Patients

OWNER: Chief Medical Officer

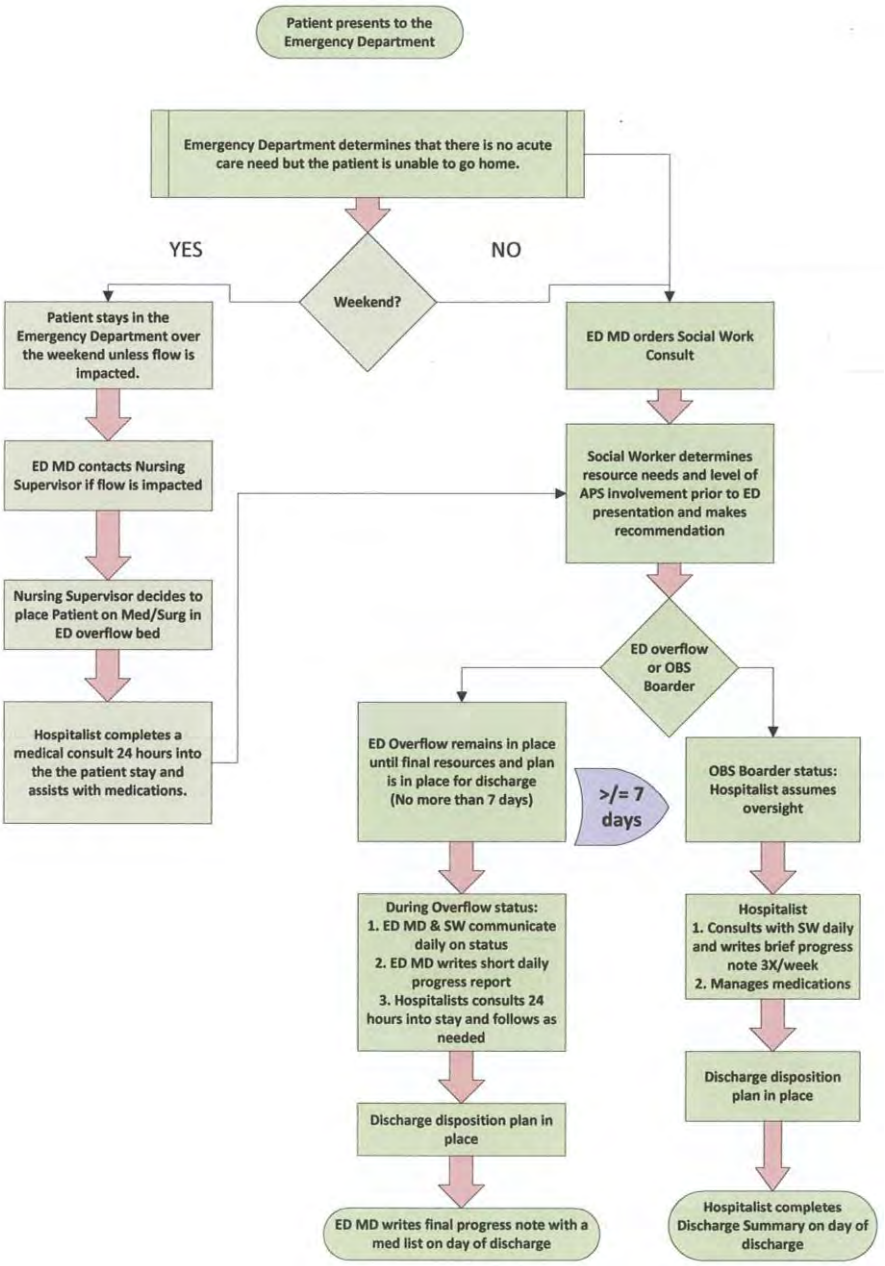
AUTHORS/REVIEWERS:
Sabrina Kidd, MD, Chief Medical Officer
Leslie Lovejoy, RN, Director, Clinical Care Transitions

APPROVALS:
Medicine Committee: 11/14/19
Surgery Committee: 11/14/19
Policy & Procedure Team: 12/4/19
Medical Executive Committee: 12/19/19
Board Quality Committee:
The Board of Directors:

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

SUBJECT: Management of Social Needs Patients	POLICY: MS8610-105
	PAGE 2
DEPARTMENT: Organizational	EFFECTIVE:
REVISED:	

Appendix A: Management of Social Needs Patients



PROCEDURE: Rapid Sequence Intubation (RSI) Kit	POLICY #: MM8610-161
	PAGE 1 OF 3
DEPARTMENT: Organizational	EFFECTIVE:
REVIEWED/REVISED:	

PURPOSE:

The purpose of this policy is to provide procedures for stocking a kit of medications commonly used during emergent rapid sequence intubation (RSI) to allow for timely access to these medications when needed.

POLICY:

The pharmacy will maintain and stock an "RSI Kit" of medications commonly used for RSI. This kit will be stored in the ICU and Emergency Department (ED).

PROCEDURE:

1. The pharmacy department will prepare and maintain 3 kits consisting of a sealed tray containing medications intended for use in RSI, and a virtual Pyxis kit of controlled substances.
    a. The trays will have the contents posted on the outside cover.
    b. The trays will be stocked as follows:
        i. 2 trays in the Emergency Department Pyxis
        ii. 1 tray in the ICU Pyxis
2. When a kit is needed, the healthcare provider will retrieve the kit from Pyxis.
    a. If controlled substances are needed, the provider will access the "virtual" RSI kit in Pyxis to access the appropriate controlled substances per hospital policy.
3. When finished using the tray, the provider will apply a patient sticker to the charge sheet contained in the RSI kit and indicate what items were used, and then seal the tray using the breakaway locks provided in the kit.
    a. Unused controlled substances will be returned to Pyxis or wasted per hospital policy.
4. The Pharmacy Department will be notified of the kit usage so that pharmacy personnel can retrieve the kit to replenish and restock the kit to the appropriate area(s).

REFERENCES:

- Up To Date Online: Rapid sequence intubation for adults outside the operating room; accessed 9/27/2019
- Up To Date Online: Rapid sequence intubation (RSI) outside the operating room in children: Approach; accessed 9/27/2019
- Pyxis Medstation, Management and Use of MM8610-147

- Controlled Substance Management MM8610-102

Attachments:

- Attachment A: RSI Kit Contents List

OWNER:
Director of Pharmacy

AUTHORS/REVIEWERS:
Chris Kutza, Director of Pharmacy

APPROVALS:
Policy & Procedure Team: 11/06/19
PI Committee: 12/12/19
Medical Executive Committee: 12/19/19
Board Quality Committee:
The Board of Directors:

Attachment A: RSI Kit Contents List

RSI Kit	Par Level
Atropine 1mg/10ml syringe (0.01mg/kg)	1
Etomidate 20mg/10ml injection (0.3mg/kg)	2
Lidocaine 100mg/5ml syringe (1mg/kg)	1
Propofol 200mg/20ml injection (1-2mg/kg)	1
Succinylcholine 200mg/10ml injection (1-1.5mg/kg)	1
Vecuronium 10mg injection (0.1mg/kg)	2
Yellow lock	1
Stored in Pyxis	
Fentanyl 100mcg/2ml injection (1-3mcg/kg)	2
Ketamine 500mg/10ml injection (1-2mg/kg)	1
Midazolam 5mg/5ml injection (0.1mg/kg)	2

SUBJECT: Water/Sewage Overflow Response Plan	POLICY: CE8610-188
	PAGE 1 OF 3
DEPARTMENT: Organizational	EFFECTIVE:
REVIEW/REVISED:	

PURPOSE:

This response plan establishes procedures and safety measures to be followed during a sewage/waste water overflow and remediation efforts to prevent the transmission of infectious organisms contained in sewage and wastewater.

POLICY:

It is the policy of Sonoma Valley Hospital to protect patients, staff, visitors and the environment from potentially harmful effects e.g., infections, associated with contact with sewage/waste water overflows. Flooding or large sewage spills constitute a disaster level emergency as determined by Nursing Supervisor or Engineering.

RESPONSIBILITIES:

All staff shall immediately report flooding or sewage/waste water overflows including the location and size to the Engineering Department 7:00 a.m.-5:00 p.m. or after-hours to the Nursing Supervisor. Engineering and/or Nursing Supervisor will report the event to the Infection Preventionist. All staff shall take measures to remove patients and visitors from the area.

For large scale sewage/wastewater overflows and flooding, a professional restoration service shall be engaged by the Plant Operations Manager. The Administrator on Call ("AOC") and Infection Preventionist shall be notified. The Nursing Supervisor or AOC will activate the Incident Command protocol as necessary.

Response team: Engineering and EVS Departments are the primary responders 7:00 a.m. to 5:00 p.m. and the Nursing Supervisor for after-hours events. Infection Preventionist will respond in person or by phone if unavailable in the hospital.

Spill supplies: Bulk mitigation supplies and PPE are located in the Housekeeping closets on each floor. Supplies include: spill socks/pads, waterproof gloves, face shields, shoe covers, waterproof boots and water resistant cover suits.

PROCEDURES:
All parties shall don PPE prior to entering the work area and doff PPE upon exiting.

SUBJECT: Water/Sewage Overflow Response Plan	POLICY: CE8610-188
	PAGE 2 OF 3
DEPARTMENT: Organizational	EFFECTIVE:
REVIEW/REVISED:	

Initial Response:

1. Engineers will:
    a. Determine cause of and take action to stop active sewage overflow
    b. Contain the spill in the smallest possible area and protect floor below if needed
    c. Isolate and secure area
    d. Post signage to stop unauthorized entry
    e. Assess electrical in flooded areas to determine if power shutdown necessary
    f. Assess area to determine if drywall or furniture has been saturated. Mark all affected items.
    g. Call sewer service vendor to clear any blockages
    h. Communicate with Infection Preventionist and staff regarding repair duration, noise and other impacts

2. EVS will:
    a. Set-up PPE station just outside spill area to include booties, gloves, face shields, gowns, bleach wipes & trash can.
    b. Post signage identifying PPE required to enter affected area.
    c. Post signage inside zone requiring PPE to be removed prior to leaving affected area.
    d. Remove any standing water with spill pads, wet/dry vacuum or water extractor. Clean and disinfect any equipment immediately after use.

3. Nursing Supervisor will:
    a. Secure the area and coordinate removal of patients as needed
    b. Contact Engineer on call
    c. Contact EVS
    d. Contact Infection Preventionist.
    e. Contact AOC for large scale events.

Repair and Clean-up Procedure:

All parties shall don PPE prior to entering the work area and doff PPE upon exiting. All parties shall practice thorough hand washing hygiene immediately after clean-up work.

1. Engineers will:
    a. Supervise vendor work area prior to work to verify area is protected using drapes and/or barricades to prevent splatter in the surrounding area.
    b. All machinery must be protected from splatter and the wheels and visible soil cleaned with disinfectant prior to its removal from work area.
    c. Work with Housekeeper to dispose of spill containment/disposable barricade material.

2. EVS will:
    a. Immediately following repair work, the Housekeeper will follow directions provided by the Infection Preventionist and utilize appropriate equipment to clean and disinfect all surfaces with 1:10 bleach solution that came in contact with sewage and/or waste water in the work area and surrounding area.
    b. After 5 min. dwell time is complete, all surfaces will be rinsed with water and allowed to air dry.
    c. Mop floor with disinfectant allowing for 5 min. dwell time. Final clean-up with regular mopping using the neutral floor cleaner.
    d. Clean and disinfect tools used in the clean-up, mops, dust pans, tongs, wet/dry vacuums or water extractors, reusable barricades, etc.
    e. Remove PPE station

Exposure and First Aid:

Patients, staff or visitors who believe that raw sewage has come into direct contact with your eyes, mouth, ears, nose or a cut, abrasion or puncture, etc. shall immediately and thoroughly wash the exposed area with copious amounts of soap and water. Staff shall seek follow-up care with Occupational Health or the Emergency Department if after-hours.

REFERENCES:
CDC - Guidelines for Environmental Infection Control in Health-Care Facilities

OWNER:
Director of Facilities

AUTHORS/REVIEWERS:
Kimberly Drummond, Director of Facilities
Kathy Mathews, Infection Preventionist
Danielle Jones, Chief Quality Officer
Michael Empey, Director, Skilled Nursing
Mark Kobe, Chief Nursing Officer
Grigory Gatenian, Plant Operations Manager

APPROVALS:
Policy & Procedure Team: 1/8/20
Board Quality Committee:
The Board of Directors: