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SONOMA VALLEY HEALTH CARE DISTRICT
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SVHCD QUALITY COMMITTEE
AGENDA
WEDNESDAY, February 26, 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 01.22.20	*Hirsch*	Action
4. SVH QUALITY INDICATOR PERFORMANCE AND PLAN	*Jones*	Inform
5. PROPOSED QUALITY COMMITTEE CHARTER	*Jones*	Inform
6. 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
January 22, 2020 5:00 PM
MINUTES
Schantz Conference Room

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

AGENDA ITEM	DISCUSSION	ACTION
1. CALL TO ORDER/ANNOUNCEMENTS	*Hirsch*	
	The meeting was called to order at 5:00 pm. The CNO Quarterly Patient Care Dashboard and the 2020 Work Plan were added to the agenda.	
2. PUBLIC COMMENT	*Hirsch*	
	None	
3. CONSENT CALENDAR		Action
• QC Minutes, 11.20.19		**MOTION:** by Mainardi to approve, 2nd by Sheets. All in favor.
4. VALLEY OF THE MOON POST ACUTE SEMI-ANNUAL REPORT	*Empey*	Inform
	Mr. Empey handed out a dashboard for the 4th quarter 2019 Skilled Nursing Facility results and discussed the metrics. The Committee asked if he would differentiate new antipsychotic medication orders vs. established orders on future reports, as well as break out hospice patients. The facility is in final review for sub-acute status, still probably six months away.	
5. CNO QUARTERLY PATIENT SERVICES DASHBOARD	*Kobe*	Inform
	Mr. Kobe reported that patient falls continue to decrease. Patient experience may be reported differently in the future	

AGENDA ITEM	DISCUSSION	ACTION
	based on the hospital's new human experience program. Texting patients after visits began in the 4th quarter 2019.	
6. 2020 QUALITY COMMITTEE WORK PLAN REVIEW	*Jones*	Inform/Action
	Ms. Jones felt there was no need for a work plan since the Committee would work off a standard agenda in the future.	No action
7. SVH QUALITY INDICATOR PERFORMANCE AND PLAN	*Jones*	Inform
	Ms. Jones gave a presentation on the new quality data reporting she planned to bring to the Committee each month. Scores were provided for all indicators in several dimensions; opportunities for improvement and plans of action were also identified.	
8. PROPOSED QUALITY COMMITTEE CHARTER	*Jones*	Inform
	In the interests of time, the Chair moved discussion of the Committee charter to February.	
9. POLICIES AND PROCEDURES	*Jones*	Action
	New: Management of the Social Needs Patients MS8610-105 Rapid Sequence Intubation (RSI) Kit MM8610-161 Sewage Overflow Response Plan CE8610-188 **Revisions:** Creutzfeldt-Jakob Disease Human Prion Disease IC8610-118 Investigational Drug Use MM8610-135 Pharmacy and Therapeutics Committee MM8610-129 Sterile Compounding MM8610-117 Warming Fluids for IV and Irrigation Purposes, Storage and Handling of MM8610-112 Emergency Operations Plan 2019 EP8610-100 Hospital Evacuation during Disaster EP8610-101 Surge Policy to Manage Patient Influx EP8610-102 Tracking of On-duty Staff during a Disaster EP8610-104 Fire Watch Policy CE8610-139 Acuity Ratio and Staffing Plan-Nursing NS8610-102 Admission and Discharge Criteria By Unit PC8610-102	**MOTION:** by Mainardi to approve, 2nd by Sheets. All in favor.

AGENDA ITEM	DISCUSSION	ACTION
	Autotransfusion PC8610-109 Chain of Command GL8610-120 Clinical Nursing Procedures PC8610-124 Code Blue-Broselow Carts and Emergency Medications QS8610-104 Code Stroke Paging NS8610-124 Death-Fetal or Newborn PC8610-130 Falls-Management QS8610-116 Nursing Staffing Floating and Call-Off NS8610-108 Orientation and Evaluation of Registry Personnel NS8610-110 Plan for the Provision of Nursing Care NS8610-112 Pressure Ulcer Wound Care Assessment and Management PC8610-162 Safe Baby Surrender Policy PC8610-164 Transporting of Monitored Patients PC8610-168 Treat and Transfer of Patients GL8610-194 Weekend Coverage NS8610-118 **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	

AGENDA ITEM	DISCUSSION	ACTION
	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 **Emergency Department** Emergency Initial Assessment Triage 7010-01	
10. CLOSED SESSION	*Hirsch*	
a. Calif. Health & Safety Code § 32155 Medical Staff Credentialing & Peer Review Report	Called to order at 6:27 pm	
11. REPORT OF CLOSED SESSION	*Hirsch*	Inform/Action
	Medical Staff credentialing was reviewed.	**MOTION:** by Mainardi to approve credentialing, 2nd by Eisenstark. All in favor.
12. ADJOURN	*Hirsch*	
	6:28 pm	

Quality Indicator Performance & Plan

February 2020

Data for January 2020

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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)	2.5%	n/a		Jan 2020
▲	DV Inpatients - Percent Transferred to Hospice (M)	2.5%	n/a		Jan 2020
Quality > Process of Care > Sepsis Care					
▲	Sepsis, Any Diagnosis - Mortality Rate (M)	5.3%	0.0%		Jan 2020
▲	Sepsis, Principal Diagnosis - Mortality Rate (M)	6.2%	0.0%		Jan 2020
–	Sepsis, Secondary Diagnosis - Mortality Rate (M)	0.0%	0.0%		Jan 2020
▲	Sepsis, Severe - Mortality Rate (M)	14.3%	0.0%		Jan 2020
–	Sepsis, Simple - Mortality Rate (M)	0.0%	0.0%		Jan 2020
▼	Septic Shock - Mortality Rate (M)	0.0%	0.0%		Jan 2020
▼	Severe Sepsis or Septic Shock - Mortality Rate (M)	9.1%	0.0%		Jan 2020

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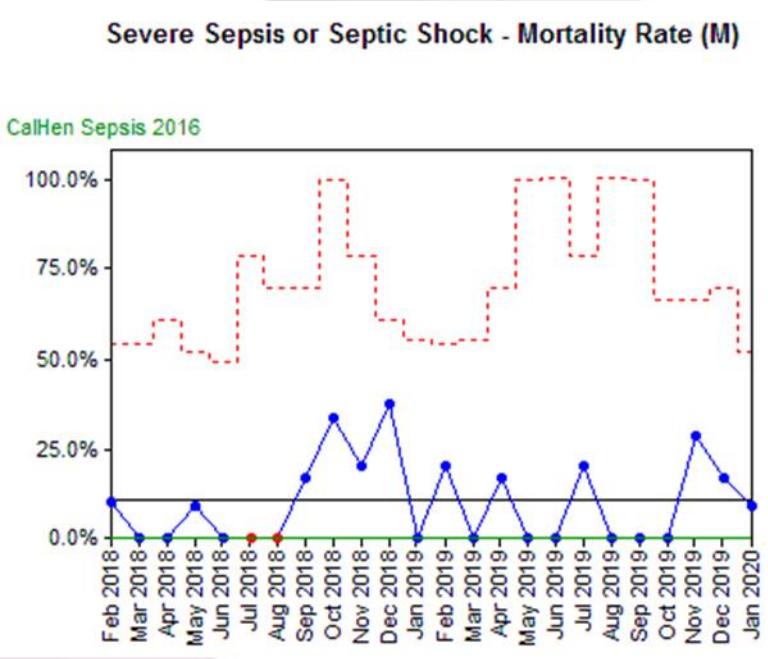
Sepsis Mortality Rate



Period	Numerator	Denominator	Percent
Jan 2020	1	11	9.1%
Dec 2019	1	6	16.7%
Nov 2019	2	7	28.6%
Oct 2019	0	7	0.0%
Sep 2019	0	3	0.0%
Aug 2019	0	1	0.0%
Jul 2019	1	5	20.0%
Jun 2019	0	2	0.0%
May 2019	0	3	0.0%
Apr 2019	1	6	16.7%
Mar 2019	0	9	0.0%
Feb 2019	2	10	20.0%
Jan 2019	0	9	0.0%
Dec 2018	3	8	37.5%
Nov 2018	1	5	20.0%
Oct 2018	1	3	33.3%
Sep 2018	1	6	16.7%
Aug 2018	0	6	0.0%
Jul 2018	0	5	0.0%
Jun 2018	0	12	0.0%
May 2018	1	11	9.1%
Apr 2018	0	8	0.0%
Mar 2018	0	10	0.0%
Feb 2018	1	10	10.0%

- **Case Review**
  - Extensive bilateral pneumonia, acute respiratory distress syndrome, cardiomyopathy
  - Expected death

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

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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%		Jan 2020
	AHRQ v6.0 PSI 06 Iatrogenic Pneumothorax Rate |M|	0.0%	0.0%		Jan 2020
	AHRQ v6.0 PSI 08 In-Hospital Fall with Hip Fracture Rate |M|	0.0%	0.0%		Jan 2020
	AHRQ v6.0 PSI 09 Perioperative Hemorrhage or Hematoma Rate |M|	0.0%	0.0%		Jan 2020
	AHRQ v6.0 PSI 10 Post-Operative Acute Kidney Injury Requiring Dialysis Rate |M|	0.0%	0.0%		Jan 2020
	AHRQ v6.0 PSI 11 Postoperative Respiratory Failure Rate |M|	0.0%	0.0%		Jan 2020
	AHRQ v6.0 PSI 12 Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate |M|	0.0%	0.0%		Jan 2020
	AHRQ v6.0 PSI 13 Postoperative Sepsis Rate |M|	0.0%	0.0%		Jan 2020
	AHRQ v6.0 PSI 14 Postoperative Wound Dehiscence Rate|M|	0.0%	0.0%		Jan 2020
	AHRQ v6.0 PSI 15 Accidental Puncture or Laceration Rate |M|	0.0%	0.0%		Jan 2020

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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	3.12	0.00		Jan 2020
—	RM ACUTE FALL- WITH INJURY (M) per 1000 patient days	0.00	0.00		Jan 2020
—	RM ED FALL- NO INJURY (M) per 1000 patient days	0.00	0.00		Jan 2020
▼	RM ED FALL- WITH INJURY (M) per 1000 patient days	0.00	0.00		Jan 2020

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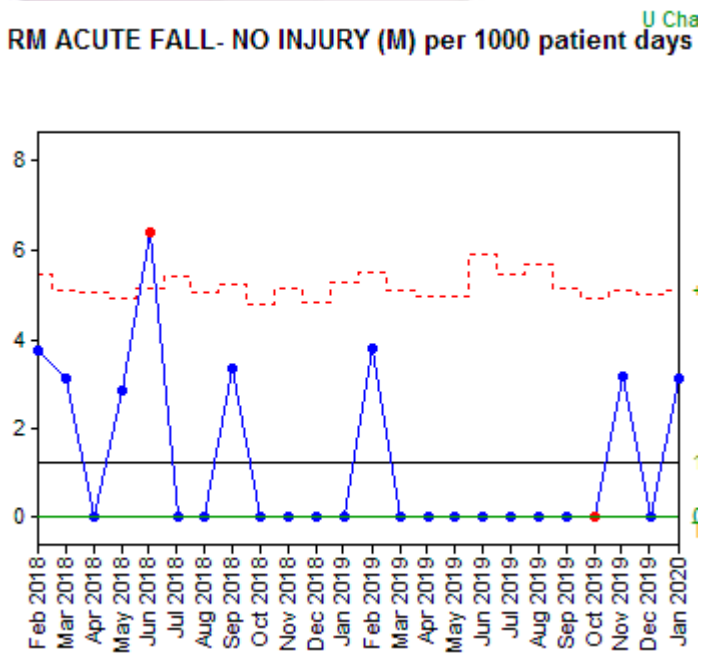
Acute Falls No Injury per 1000 patient days

Champion: Jessica Winkler
Leader: Mark Kobe



Period	C-RM Event: Fall-NO Injury: Acute only (numerator)	S-FS-SVH ADJUSTED PATIENT DAYS: Acute	Rate
Jan 2020	1	321	3.12
Dec 2019	0	336	0.00
Nov 2019	1	319	3.13
Oct 2019	0	351	0.00
Sep 2019	0	312	0.00
Aug 2019	0	240	0.00
Jul 2019	0	269	0.00
Jun 2019	0	220	0.00
May 2019	0	340	0.00
Apr 2019	0	341	0.00
Mar 2019	0	317	0.00
Feb 2019	1	265	3.77
Jan 2019	0	290	0.00
Dec 2018	0	370	0.00
Nov 2018	0	315	0.00
Oct 2018	0	375	0.00
Sep 2018	1	300	3.33
Aug 2018	0	325	0.00
Jul 2018	0	273	0.00
Jun 2018	2	314	6.37
May 2018	1	354	2.82
Apr 2018	0	327	0.00
Mar 2018	1	321	3.12
Feb 2018	1	267	3.75

- **Case Review**
  - January 2020
  - One fall
    - Acute ischemic cerebral vascular accident, acute metabolic encephalopathy

Frequency of incidents of patient falls per 1,000 patient days.

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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%		Jan 2020
Quality > Patient Safety > CMS HAC Reduction					
● —	Air Embolism - Per 1000 ACA (M)	0.00	0.00		Jan 2020
Quality > Patient Safety > Coded Complications of Care					
● —	Acute Postop Respiratory Insufficiency NPOA - Per 1000 ACA (M)	0.00	0.00		Jan 2020
● —	Acute Postop Respiratory Insufficiency, NPOA - Per 1000 ACA w/ Surgical Proc (M)	0.00	0.00		Jan 2020
● —	Air Embolism NPOA - Per 1000 ACA (M)	0.00	0.00		Jan 2020
▲	Cardiac Arrest- per 1000 ACA (M)	12.50	n/a		Jan 2020
● ▲	Cardiac Arrest-NPOA per 1000 ACA (M)	12.66	0.00		Jan 2020
● —	Cardiac Complications NPOA per 1000 ACA (M)	0.00	0.00		Jan 2020
● —	Cardiogenic Shock NPOA per 1000 ACA (M)	0.00	0.00		Jan 2020
● —	Deaths per 1000 ACA Elective Admission (M)	0.00	0.00		Jan 2020
● —	Device/Implant Complications, Cardiac Incl. Valve, NPOA - Per 1000 ACA (M)	0.00	0.00		Jan 2020
● —	Device/Implant Complications, Genitourinary/Urologic NPOA - Per 1000 ACA (M)	0.00	0.00		Jan 2020

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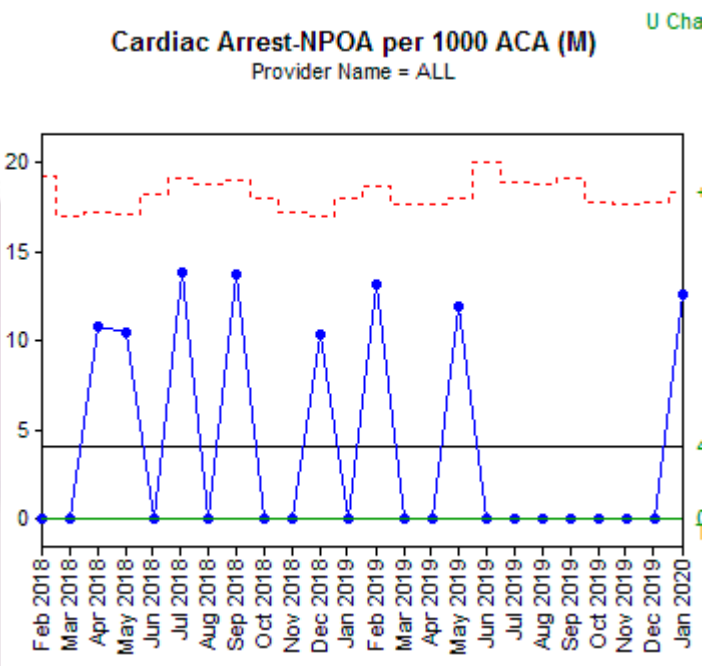
Cardiac Arrest Not Present on Admission



Period	CDB1334 - Cardiac Arrest, NPOA - Per 1000 ACA (numerator)	CDB1334 - Cardiac Arrest, NPOA - Per 1000 ACA (denominator)	Rate
Jan 2020	1	79	12.66
Dec 2019	0	86	0.00
Nov 2019	0	88	0.00
Oct 2019	0	86	0.00
Sep 2019	0	71	0.00
Aug 2019	0	75	0.00
Jul 2019	0	74	0.00
Jun 2019	0	64	0.00
May 2019	1	84	11.90
Apr 2019	0	87	0.00
Mar 2019	0	87	0.00
Feb 2019	1	76	13.16
Jan 2019	0	83	0.00
Dec 2018	1	97	10.31
Nov 2018	0	94	0.00
Oct 2018	0	83	0.00
Sep 2018	1	73	13.70
Aug 2018	0	75	0.00
Jul 2018	1	72	13.89
Jun 2018	0	81	0.00

- **Case Review**
  - Final diagnosis terminal cardiopulmonary arrest secondary to acute respiratory distress syndrome.
- **Plan of Action**
  - Consider Advanced care planning earlier during hospitalization.

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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, Orthopedic Device NPOA - Per 1000 ACA (M)	0.00	0.00		Jan 2020
	Device/Implant Complications, Other/NEC Device NPOA - Per 1000 ACA (M)	0.00	0.00		Jan 2020
	Device/Implant Complications, Vascular Device NPOA - Per 1000 ACA (M)	0.00	0.00		Jan 2020
	Device/Implant Complications, Vascular NPOA - Per 1000 ACA (M)	0.00	0.00		Jan 2020
	Device/Implant Functional Complications NPOA - Per 1000 ACA (M)	0.00	0.00		Jan 2020
	Device/Implant Other Complications NPOA - Per 1000 ACA (M)	0.00	0.00		Jan 2020
	Device/Implant, Inflammatory Reaction NPOA - Per 1000 ACA (M)	0.00	0.00		Jan 2020
	Digestive System Complications NPOA - Per 1000 ACA (M)	0.00	0.00		Jan 2020
	Disruptions of Operative Wound, NPOA - Per 1000 ACA (M)	0.00	0.00		Jan 2020
	DVT/PE, Orthopedic, NPOA - Per 1000 Inpatients w/ Total Knee/Hip Replacement (M)	0.00	0.00		Jan 2020
	Iatrogenic Pneumothorax NPOA - Per 1000 ACA (M)	0.00	0.00		Jan 2020
	Iatrogenic Pulmonary Embolus NPOA - Per 1000 ACA (M)	0.00	0.00		Jan 2020
	Infection from Central Venous Cath, NPOA - Per 1000 Inpatients w/ CV Cath (M)	0.00	0.00		Jan 2020
	Intraoperative Injuries NPOA- Per 1000 ACA with a Surgical Procedure (M)	0.00	0.00		Jan 2020
	Nervous System Complications NPOA- Per 1000 ACA (M)	0.00	0.00		Jan 2020
	Other Complications NPOA- Per 1000 ACA (M)	0.00	0.00		Jan 2020

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Scorecard Summary
Coded Complications of Care
Preventable Harm

Peripheral Vascular Complications NPOA - Per 1000 ACA (M)	0.00	0.00		Jan 2020
Postoperative Hemorrhage_Hematoma NPOA - Per 1000 ACA with surgical procedure (M)	0.00	0.00		Jan 2020
Postoperative Infection - Per 1000 ACA (M)	0.00	0.00		Jan 2020
Postoperative Pulmonary Edema - Per 1000 ACA (M)	0.00	0.00		Jan 2020
Postoperative Pulmonary Edema NPOA with Surgical Procedure- Per 1000 ACA (M)	0.00	0.00		Jan 2020
Postoperative Shock NPOA with Surgical Procedure- Per 1000 ACA (M)	33.33	0.00		Jan 2020
Respiratory Complications NPOA- Per 1000 ACA (M)	0.00	0.00		Jan 2020
Retained Foreign Body NPOA- Per 1000 ACA (M)	0.00	0.00		Jan 2020
Transfusion Reaction, all types NPOA- Per 1000 ACA (M)	0.00	0.00		Jan 2020
Urinary Complication NPOA- Per 1000 ACA (M)	0.00	0.00		Jan 2020

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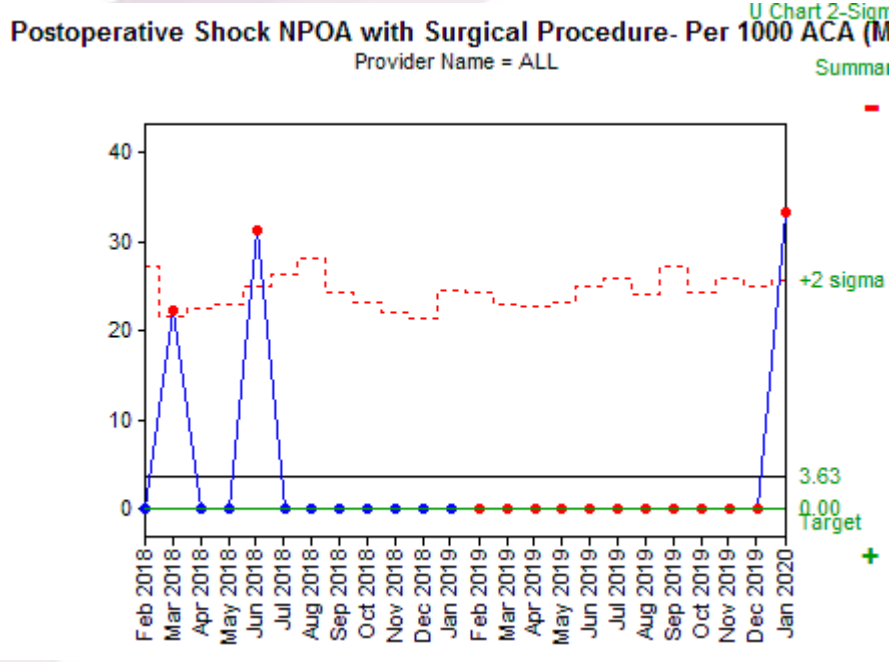
Post Operative Shock



Population of patients with a discharge diagnosis of postoperative shock with a POA status of "not present on admission"

- **Case Review**
  - Subtotal cholecystectomy secondary to severe inflammation. Bleeding due to disseminated intravascular coagulation. Patient was transferred to higher level of care.

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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)	0%	3%		Jan 2020
● ▼	Blood Cultures -Contamination Rate|RN| (M)	2%	3%		Jan 2020
● ▼	Blood Cultures -Total Contamination Rate (M)	1%	3%		Jan 2020
● ▼	Blood Transfusion Justified (M) percentage	39.6%	100.0%		Jan 2020
● –	Blood Transfusion Reaction (M) percentage	0.0%	0.0%		Jan 2020
● –	Blood Units Wasted (M) volume	0	0		Jan 2020
Quality > Patient Safety > CMS HAC Reduction					
● –	Blood Incompatibility - Per 1000 ACA (M)	0.00	0.00		Jan 2020

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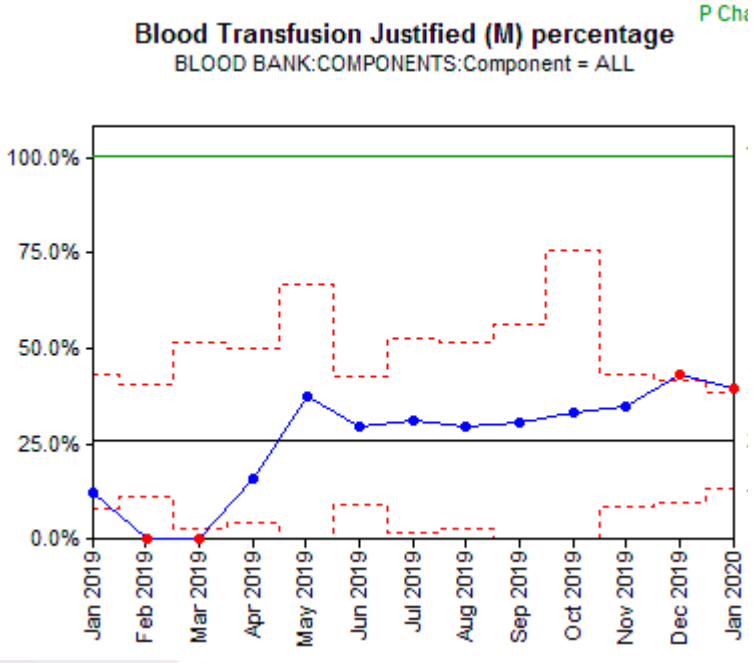
Blood Transfusion Practice

Champion: Dr. Kretzchmar
Leader: Nic Hadjiyanni



Period	C-BB-Blood Transfusion Justified	S-BB-Blood Units Transfused	Percent
Jan 2020	19	48	39.6%
Dec 2019	13	30	43.3%
Nov 2019	9	26	34.6%
Oct 2019	2	6	33.3%
Sep 2019	4	13	30.8%
Aug 2019	5	17	29.4%
Jul 2019	5	16	31.2%
Jun 2019	8	27	29.6%
May 2019	3	8	37.5%
Apr 2019	3	19	15.8%
Mar 2019	0	17	0.0%
Feb 2019	0	35	0.0%
Jan 2019	3	25	12.0%

- **Opportunities for Improvement**
  - January 2020
    - 19 of 48 (39.6%) 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%** **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%**	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.**	**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

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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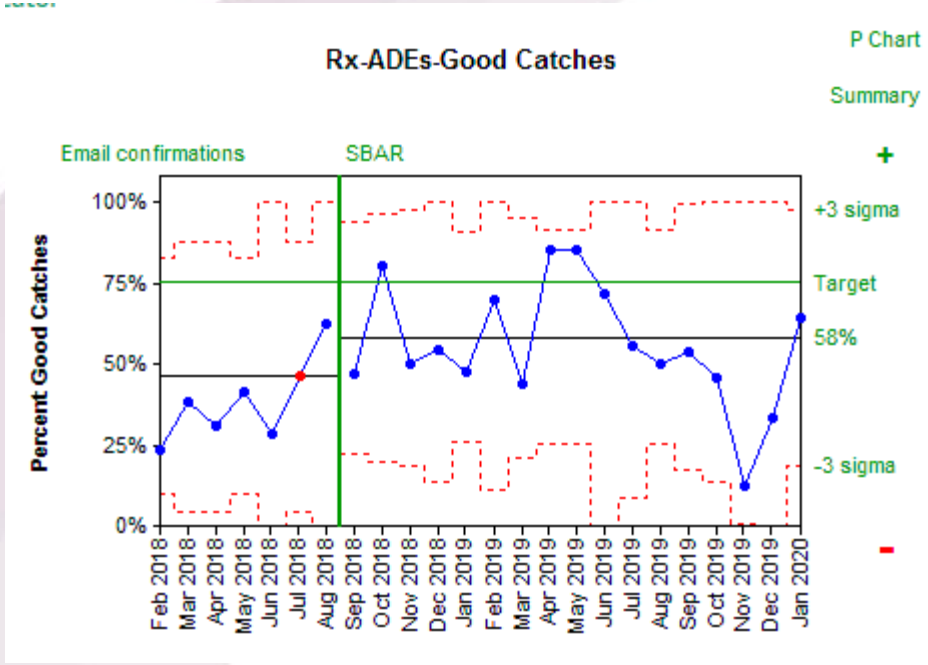
Good Catch

Champion: Leader: Danielle Jones



Date	Good Catch	Total Error Reports	Percent Good Catches
Jan 2020	9	14	64%
Dec 2019	2	6	33%
Nov 2019	1	8	12%
Oct 2019	5	11	45%
Sep 2019	7	13	54%
Aug 2019	10	20	50%
Jul 2019	5	9	56%
Jun 2019	5	7	71%
May 2019	17	20	85%
Apr 2019	17	20	85%
Mar 2019	7	16	44%
Feb 2019	7	10	70%
Jan 2019	10	21	48%
Dec 2018	6	11	55%
Nov 2018	7	14	50%
Oct 2018	12	15	80%
Sep 2018	8	17	47%
Aug 2018	5	8	62%
Jul 2018	6	13	46%
Jun 2018	2	7	29%
May 2018	7	17	41%
Apr 2018	4	13	31%
Mar 2018	5	13	38%
Feb 2018	4	17	24%

5494 for Safety
...make the call

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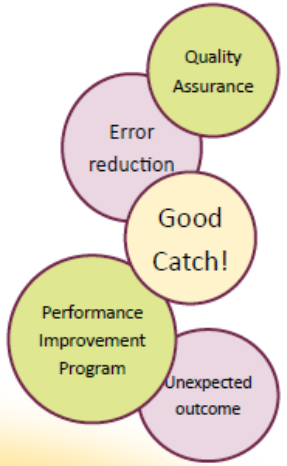
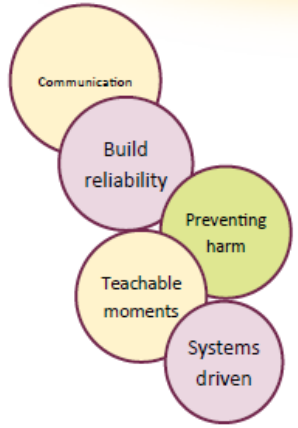
Patients
Staff
Family
Visitors

easy reporting of unexpected events or
Good Catches



Your Voice Matters



5494 for Safety
Anonymous or leave your contact info

S| Situation
B| Background
A| Assessment
R| Recommendation

easy reporting of unexpected events or
Good Catches

ADVERSE EVENTS

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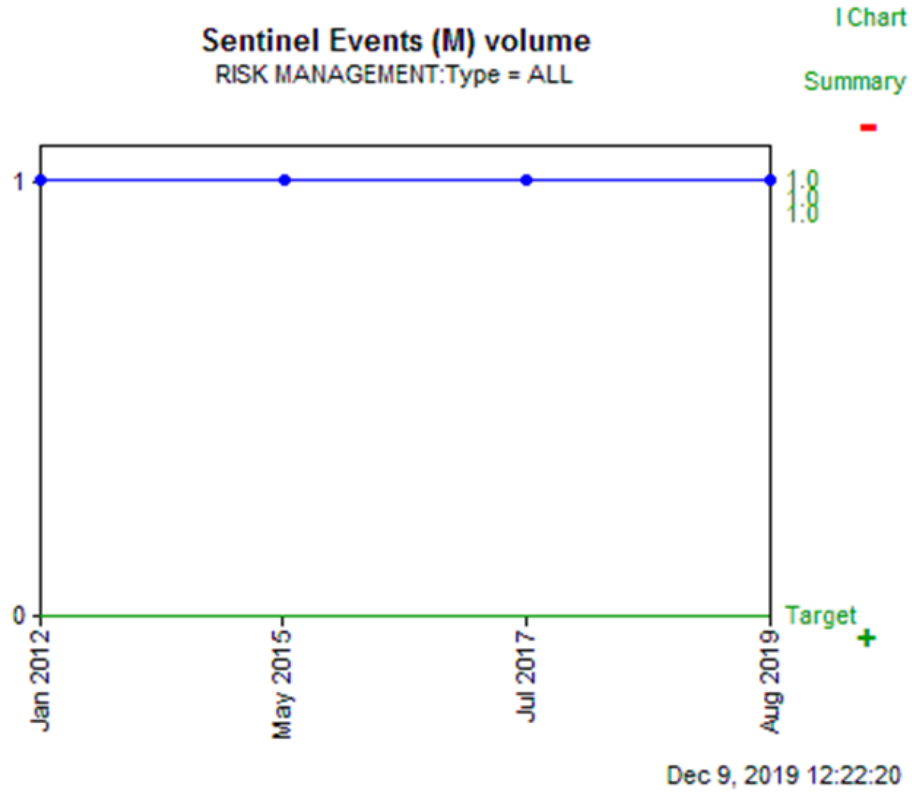
Adverse Events



- 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 OP-18b - Median Time ED Arrival to ED Departure - Reporting Measure (M)	165.00	140.00		Jan 2020
–	Core OP-23 - Head CT/MRI Results for STK Pts w/in 45 Min of Arrival (M)	100.0%	100.0%		Jan 2020
Quality > Core Measures > HOP Measures > HOP Colonoscpy					
▼	Core OP29/ASC9 - Colonoscopy:F/U for Avg Risk Pts (M)	62.5%	90.0%		Jan 2020
Quality > Core Measures > Sepsis					
▲	Core SEP1 - Early Management Bundle, Severe Sepsis/Septic Shock (M)	77.8%	100.0%		Dec 2019
▲	Core SEPa - Early Management , Severe Sepsis 3 Hour Bundle (M) before 1/20	88.9%	100.0%		Dec 2019
▼	Core SEPb - Severe Sepsis 6 Hour Bundle (M)	85.7%	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

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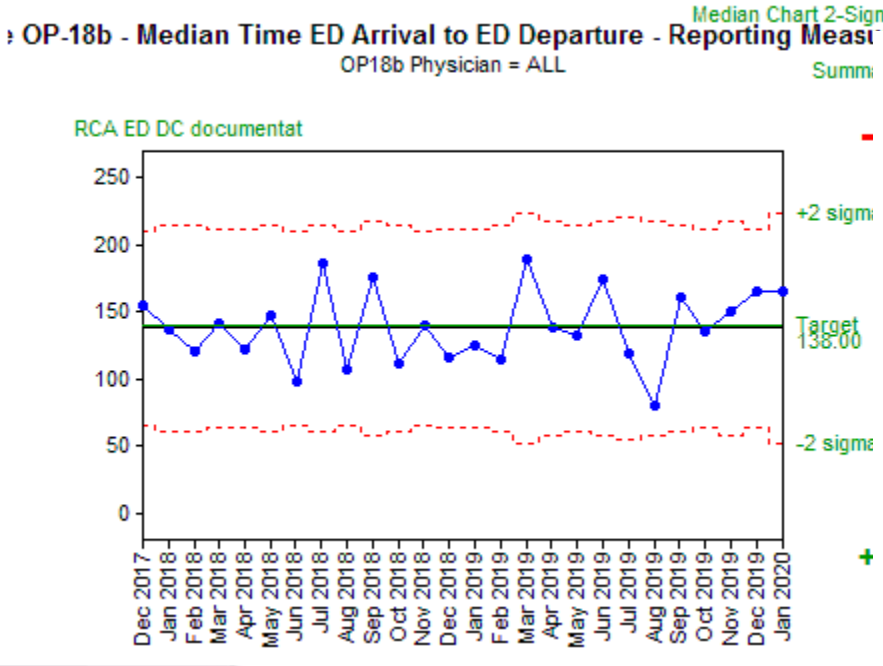
Median Time ED Arrival to ED Departure



Reference Date	OP-18bTimeArriveDepartRpt	N
Jan 2020	165.00	23
Dec 2019	165.50	30
Nov 2019	150.00	26
Oct 2019	136.00	31
Sep 2019	160.50	28
Aug 2019	81.00	27
Jul 2019	119.00	25
Jun 2019	175.00	26
May 2019	133.00	28
Apr 2019	139.00	27
Mar 2019	189.00	22
Feb 2019	115.00	29
Jan 2019	126.00	31
Dec 2018	116.50	30
Nov 2018	140.50	32
Oct 2018	112.00	29
Sep 2018	175.50	26
Aug 2018	108.00	32
Jul 2018	187.00	28
Jun 2018	98.00	32
May 2018	147.00	29
Apr 2018	122.00	31
Mar 2018	141.00	31
Feb 2018	121.00	29

Outpatient CMS Core Measure- OP-18b Emergency Department Throughput. Median Time from ED Arrival to ED Departure for Discharged ED Patients. Average time patients spent in the emergency department before being sent home

- **Case Review**
  - 23 encounters in January 2020
    - Pediatric patient transferred for surgery
    - One patient had 5 ED admission in January
    - Neurology consults
- **Action Plan**
  - Continue to monitor
  - Review with Emergency Department Medical Director

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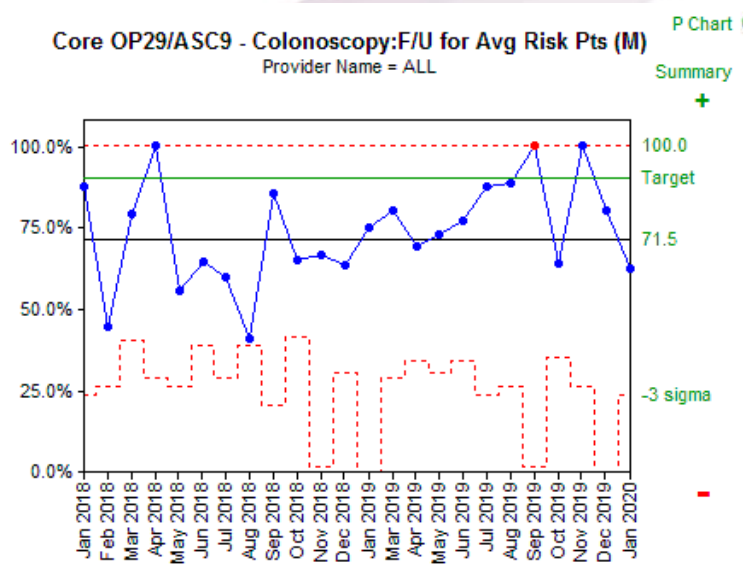
OP29 Colonoscopy



Period	Patients Received	Patients Eligible	Percent
Jan 2020	5	8	62.5%
Dec 2019	4	5	80.0%
Nov 2019	9	9	100.0%
Oct 2019	9	14	64.3%
Sep 2019	6	6	100.0%
Aug 2019	8	9	88.9%
Jul 2019	7	8	87.5%
Jun 2019	10	13	76.9%
May 2019	8	11	72.7%
Apr 2019	9	13	69.2%
Mar 2019	8	10	80.0%
Jan 2019	3	4	75.0%
Dec 2018	7	11	63.6%
Nov 2018	4	6	66.7%
Oct 2018	13	20	65.0%
Sep 2018	6	7	85.7%
Aug 2018	7	17	41.2%
Jul 2018	6	10	60.0%
Jun 2018	11	17	64.7%
May 2018	5	9	55.6%
Apr 2018	10	10	100.0%
Mar 2018	15	19	78.9%
Feb 2018	4	9	44.4%
Jan 2018	7	8	87.5%

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**
  - **January 2020**
  - 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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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

▼	Emergency Department, Treated/Released - % Readmit w/in 48 hours to ED (M)	3.4%	0.0%		Jan 2020
▲	Emergency Department, Treated/Released - % Readmit w/in 48 hours to IP (M)	0.5%	0.0%		Jan 2020
▲	Emergency Department, Treated/Released - % Readmit w/in 48 hours to OBS (M)	0.1%	0.0%		Jan 2020

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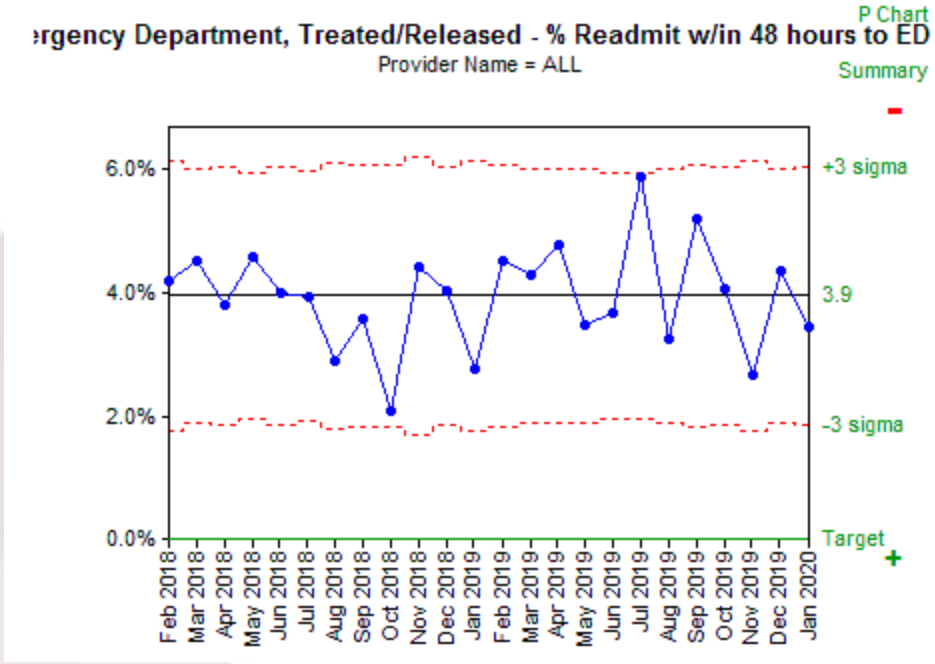
ED Treated/Released

% readmitted with in 48 hours to ED



Period	Numerator	Denominator	Percent
Jan 2020	27	785	3.4%
Dec 2019	35	805	4.3%
Nov 2019	19	711	2.7%
Oct 2019	32	787	4.1%
Sep 2019	39	753	5.2%
Aug 2019	26	800	3.2%
Jul 2019	50	855	5.8%
Jun 2019	32	870	3.7%
May 2019	28	809	3.5%
Apr 2019	39	819	4.8%
Mar 2019	34	797	4.3%
Feb 2019	34	756	4.5%
Jan 2019	20	722	2.8%
Dec 2018	31	773	4.0%
Nov 2018	30	681	4.4%
Oct 2018	16	764	2.1%
Sep 2018	27	757	3.6%
Aug 2018	21	727	2.9%
Jul 2018	33	844	3.9%
Jun 2018	31	780	4.0%
May 2018	39	854	4.6%
Apr 2018	30	790	3.8%
Mar 2018	36	799	4.5%
Feb 2018	30	717	4.2%

- **Plan of Action**
  - Review with Emergency Department Medical Director

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Scorecard Summary
Readmissions
Sepsis

All Indicators View: PI Committee Readmissions EDIT

Status	Indicator	Current Value	Target	SPC Alert	Updated
Quality > Process of Care > Sepsis Care					
—	Sepsis, Severe - % Readmit within 30 Days (M)	0.00%	0.00%		Jan 2020
▼	Sepsis, Simple - % Readmit within 30 Days (M)	0.00%	0.00%		Jan 2020
—	Septic Shock - % Readmit within 30 Days (M)	0.00%	0.00%		Jan 2020

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Scorecard Summary
Readmissions

All Indicators View: PI Committee Readmissions EDIT

Status	Indicator	Current Value	Target	SPC Alert	Updated
▼	07-DV Inpatients - % Readmit to Acute Care within 07 Days (M)	0.0%	8.0%		Jan 2020
▼	14-DV Inpatients - % Readmit to Acute Care within 14 Days (M)	0.0%	8.0%		Jan 2020
▼	30-DV Inpatients - % Readmit to Acute Care within 30 Days (M)	0.0%	8.0%		Jan 2020
–	COPD, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)	0%	0%		Jan 2020
▼	DV Inpatients - % Readmit to ED within 30 Days (M)	5.1%	8.0%		Jan 2020
▲	DV Inpatients - % Readmit to Observation/Short Stay within 30 Days (M)	1.3%	8.0%		Jan 2020
–	HF, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)	0%	0%		Jan 2020
▼	Medicine, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)	0%	0%		Jan 2020
▼	PNA, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)	0%	0%		Jan 2020
▼	Sepsis, Any Diagnosis - % Readmit within 30 Days (M)	0%	0%		Jan 2020
–	Surgery, CMS Readm Rdctn -% Readmit within 30 Days_ ACA |M|	0.00%	8.00%		Jan 2020
–	TJP, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)	0.00%	0.00%		Jan 2020

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PATIENT EXPERIENCE

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Human Experience

"Improving Human Experience is creating respectful, empathetic interactions that deliver joy and ease suffering for all people involved in healthcare, patients, families, and care team members."

- **Plan of Action**
  - Completed
    - Director/Manger/Front line staff focus groups
    - Physician Pulse Survey
    - 1:1 interviews
  - In process
    - Partnering with Marketing for community member focus group last week of February
    - Employee Engagement Survey

- **Next Steps**
  - Design Session
    - With insight and input, we are bringing together a multidisciplinary team that will help us to define a shared vision of the Sonoma Valley Hospital Human Experience and core strategies to help achieve it

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ACCREDITATION & REGULATORY

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Triennial Center for Improvement in Healthcare Quality (CIHQ)

- We are in the immediate window for the CIHQ triennial survey
- This is a unique circumstance as we will undergo both the CIHQ Reaccreditation & Acute Stroke Ready Survey at the same time

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QUALITY ASSURANCE PERFORMANCE IMPROVEMENT (QAPI)

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Q4 2019 QAPI Review

Quality & Risk Management Oversight 2019						
QAPI Monitoring Reporting:						
Due Dates		4/15/2019	7/15/2019	10/15/19	1/15/20	
Data Collection Period		Q1 2019	Q2 2019	Q3 2019	Q4 2019	QAPI 19/21
1	Acc/PtAcct	No	No	No	No	No
2	Admitting	Yes	Yes	No	No	Yes
3	Cardiopulm	No	No	No	No	Yes
4	Case Management	Yes	Yes	Yes	Yes	Yes
5	Emergency	Yes	Yes	Yes	Yes	Yes
6	EVS	Yes	Yes	Yes	Yes	Yes
7	Facilities	No	No	Yes	Yes	Yes
8	HIM	Yes	Yes	Yes	Yes	Yes
9	HR	Yes	Yes	No	Yes	Yes
10	ICU	Yes	Yes	Yes	Yes	Yes
11	Infection Prevention	Yes	Yes	Yes	Yes	Yes
12	IT	Yes	Yes	Yes	Yes	No
13	Lab	Yes	No	No	No	Yes
14	Materials Management	No	Yes	Yes	Yes	Yes
15	Med Staff	No	No	No	No	No
16	Med-Surg	Yes	Yes	Yes	Yes	Yes
17	Med Imaging	Yes	Yes	Yes	Yes	Yes
18	Nutritional Services	Yes	Yes	Yes	Yes	Yes
19	Occupational Health	Yes	Yes	No	Yes	Yes
20	Pharmacy	Yes	Yes	Yes	Yes	Yes
21	Quality	Yes	Yes	Yes	Yes	Yes
22	Rehab Ser IP	Yes	Yes	Yes	Yes	Yes
23	Rehab Ser OP	Yes	Yes	Yes	Yes	Yes
24	SNF	Yes	N/A	N/A	N/A	Yes
25	Surgery	Yes	Yes	Yes	Yes	Yes
26	Wound Care	Yes	Yes	Yes	Yes	Yes
27	Patient Financial Services	Yes	No	No	No	No
28	Respiratory Therapy	No	No	Yes	Yes	Yes
29	Risk	Yes	Yes	Yes	Yes	Yes
	Completion Rate	79%	75%	71%	79%	82%

- **Opportunities for Improvement**
  - Currently developing QAPI metrics for 2020 with Medical Staff and Cardiopulmonary
  - Working with Lab to update electronic indicator profile reporting for 2020
  - Focus on Accounting, Admitting, Patient Financial Services

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SUBJECT: Charter	POLICY: QA8610-108
	PAGE 0
DEPARTMENT: ORGANIZATIONAL	EFFECTIVE:
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:

SUBJECT: Charter	POLICY: QA8610-108
	PAGE 1
DEPARTMENT: ORGANIZATIONAL	EFFECTIVE:
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.

Commented [LG1]: Change in committee name?

Commented [LG2]: Name? of CA Medical Board

RESPONSIBILITIES:

The Committee has three broad sets of responsibilities.

1. ~~The first is~~ To directly oversee that quality assurance and improvement processes are in place and operating in the hospital ~~and clinics~~.
2. T~~The second is t~~o enhance quality across and throughout the technical, patient care, and operations of the Sonoma Valley Hospital. ~~The latter~~This encompasses all aspects of the interface and experience between patients, families, and the community. This also includes coordination and alignment within the organization.
3. T~~The third is t~~o 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 Population Health, Lower Per Capita Cost.

Commented [LG3]: Triple vs Quadruple?

Commented [LG4]: ??

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

achieved. To help meet this responsibility, the Board Quality Committee exists to:

- Develop the quality goals and blueprint (priorities and strategies) for Sonoma Valley Hospital, using an inclusive and data driven-process.
- Review and monitor patient safety, risk mitigation, quality assurance, and improvement plans and progress.
- Have the authority to initiate inquiries, studies, and investigations within the purview of duties assigned to the Committee.
- Perform, on behalf of the Governance Board and Medical Leadership, such other activities as are required by the ~~TJC~~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.
- Perform such other activities as requested by the Executive Leadership of Sonoma Valley Hospital.
- Review all new and updated hospital organizational and department policies for adherence to quality and safety priorities.
- Review all medical staff requests to start or change staff clinical privileges for regulatory completeness, and quality and safety priorities, prior to sending requests to the Governing Body.
- Review medical staff bylaws for completeness and adherence to legal requirements.
-
- ~~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

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SUBJECT: Charter	POLICY: QA8610-108
	PAGE 3
DEPARTMENT: ORGANIZATIONAL	EFFECTIVE:
REVISED:	

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:
   a. Quality Performance Indicator Set
      i. Mortality
      ii. Preventable Harm Events
      iii. Healthcare Acquired Infection
      iv. Medication Events
      v. Never Events
      vi. Core Measures
      vii. Readmissions
   b. Patient Experience
   c. Accreditation & Regulatory Standards
   d. Quality Assurance Performance Improvement
   e. Culture of Safety
   f. Risk Event Reports
   ~~1.~~g. Policies & Procedures
   ~~*(List as relevant to the organization)*~~

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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:

SUBJECT: Charter	POLICY: QA8610-108
	PAGE 4
DEPARTMENT: ORGANIZATIONAL	EFFECTIVE:
REVISED:	

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.~~1. Standard Agenda

The standard Agenda for the council will include:

- Quality Performance Indicator Set
- Clinical Priorities (clinical outcomes/process improvement), including:
  - Quality Assurance Performance Improvement
  - ~~(List relevant services)~~
  - 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
  - Medical Staff Credentialing

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

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SUBJECT: Charter	POLICY: QA8610-108
	PAGE 5
DEPARTMENT: ORGANIZATIONAL	EFFECTIVE:
REVISED:	

Recommend Size:	~~Based on organization~~The Board 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~~
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~~
10.9. Cc~~o~~mpliance.
11.10. Leading celebration of gains made.
11. Improving its own methods.
12. Review all new and updated hospital organization and department policies for adherence to quality and safety priorities.
13. Review all medical staff requests to start or change staff clinical privileges for regulatory completeness, and quality and safety priorities, prior to sending requests to the Governing Body.
12.14. Review medical staff bylaws for completeness and adherence to legal requirements.

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REFERENCES:
www.hginstitute.org

Policy and Procedures – Summary of Changes
Board Quality Committee, February 26th, 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:

Care of Unassigned Unaffiliated Metabolic Bariatric Surgery Patients PC8610-190
To outline the emergency care of patients in need of a metabolic and bariatric surgeon who may or may not have a prior affiliation with a credentialed Sonoma Valley Hospital surgeon.

REVISIONS:

Code Grey - Aggressive Behavior Management CE8610-102
Changed language to reflect the Workplace Violence Prevention Program protocols. Changed language to add standardized initial response for calling a code. Aligned policy with new Workplace Violence Prevention Program.

Code Pink - Infant Pediatric Security CE8610-148
Changed title from Code Pink/Purple to just Code Pink. Remove language specific to the Hospital Birthplace unit that was closed. Policy reflects general communication and response plan in an infant/pediatric security event. Simplified code so it is one code to encompass infant AND pediatric abduction.

Code Silver - Hostage-Active Shooter CE8610-147
Documented initial response as the communication steps of notification. Updated bullet points for Run, Hide, Fight to call out patient care area details. Describes that individuals will need to make decisions to maximize the protection of life and what tactics to employ based on a quickly evolving event. Updated in preparation of staff training classes in April 2020 and Interagency Active Shooter Drill.

Hospital Evacuation during Disaster EP8610-101
Updates to the Exiting to remove departments and simplify exit routing. Add Skilled Nursing as a distinct entity from Hospital. CDPH requested Skilled Nursing to be included separately. Exit routes added as bullet points in each building section. Changed language on specific routes to safest and closest route. Added exit routes for off-site location and removed Department and Locations that are no longer valid.

Patient's Rights to Visitation PR8610-166
Removed all references to official visiting hours. Removed all references to newborn and pediatric units. Added protocol on how to resolve disputes regarding visitation.

Scope and Integration of Services GL8610-180
Removed Obstetrics and Home Care Services. Added Hospice Services. Reviewed/Updated per triannual review.

DEPARTMENTAL

NEW:

Medical Records

Amendment of Protected Health Information 8700-185
Policy created to address patient requests for amendments to protected health information authored by physicians or nursing staff.

SUBJECT: Care of Unassigned / Unaffiliated Metabolic & Bariatric Surgery Patients	POLICY: PC8610-190
	PAGE 1
DEPARTMENT: Organizational	EFFECTIVE:
REVISED:	

PURPOSE:

To outline the emergency care of patients in need of a metabolic and bariatric surgeon who may or may not have a prior affiliation with a credentialed Sonoma Valley Hospital surgeon.

POLICY:

Regardless of affiliation with a credentialed Sonoma Valley Hospital surgeon, patients arriving in the emergency department in need of care by a Metabolic and Bariatric Surgeon will be evaluated by the Metabolic and Bariatric Surgeon on call who will assist in determining the care and disposition of the patient.

PROCEDURE:

Patients who arrive at Sonoma Valley Hospital in need of emergent care by a Metabolic and Bariatric Surgeon (MBS) shall be evaluated and cared for by the MBS on call that day regardless of their prior physician or surgeon affiliation. If the MBS on call determines that the patient needs a higher level of care than Sonoma Valley Hospital can provide then arrangements shall be made to transfer the patient in a timely manner to a facility, such as the University of California, San Francisco equipped with the necessary staff and resources for that patient. As needed, the MBS on call will be available to assist with the documentation and communication necessary to facilitate the timely transfer, as well as to assist in the care of the patient as needed until the time of transfer.

OWNER:
CMO
Medical Staff

AUTHORS/REVIEWERS:
Sabrina Kidd, MD CMO

APPROVALS:
Medicine Committee: 1/9/20
Medical Executive Committee: 1/16/20
Policy & Procedure Team: 2/5/20
Board Quality Committee:
The Board of Directors:

SUBJECT: Amendment of Protected Health Information	POLICY # 8700-185
	PAGE 1 OF 4
DEPARTMENT: Health Information Management	EFFECTIVE:
REVISED:	

PURPOSE:

To ensure that patients are provided with the rights to request that protected health information (PHI) they believe to be incorrect or incomplete be amended.

POLICY:

Patients will be provided the right to have Sonoma Valley Hospital (SVH) amend or append their PHI that is contained within a given record set for as long as the information is maintained by the hospital.

Under Health Insurance Portability and Accountability Act (HIPAA), the patient has the right to request an amendment of their record, however, Sonoma Valley Hospital does not have an absolute obligation to grant that request and may deny the request as outlined below.

Note: The policy and procedure for correcting/amending medical records should be followed in the event that a patient's request for amendment of their medical record is granted. In summary, the data to be amended should be lined out with a single line leaving the original writing legible. The reason for the change should be noted (i.e. patient request); the date of striking and signature. The amendment of a record should never involve erasure or obliteration of the material that is corrected. Correction of an electronic medical record should be done in a way that records the initial entry, the change, the date of the change and the person making the change.

PROCEDURE:

Receiving Request to Amend the Medical Record under HIPAA

1. HIPAA requires that patients make amendment requests in writing and to provide a reason to support the requested amendment/addendum of health information. A request for amendment will not be evaluated until the request form is completed and signed by the patient or personal representative.
2. Upon receipt of a request to amend, the request will be date stamped and logged.
3. The hospital must act on a request to amend, whether granting or denying, no later than 60 days after receipt.

Initial Processing of Request to Amend the Medical Record

1. The Privacy Officer will make a determination to accept or deny the amendment request after consultation with the appropriate staff, if needed.
2. The Privacy Officer will review the amendment request to determine whether the PHI referred to in the amendment request was authored by physician or nursing staff.
3. If the PHI was authored by a physician, the Privacy Officer will forward the amendment request to the physician for review with an expected response of no more than 14 days.
4. If the PHI was authored by nursing staff, the Privacy Officer will forward the amendment request to the Chief Nursing Officer with an expected response of no more than 14 days. Nursing staff will discuss the amendment request with patient and update the patient record. Examples of nursing amendment requests are nursing documentation related to medical information and/or nursing documentation related to patient's medication list.

Secondary Processing and Granting of Request to Amend the Medical Record

1. Once SVH decides to grant the request for an amendment, either in whole or in part, SVH will do the following:
   A) Inform the patient in writing the request for an amendment is accepted.
   B) SVH will notify the relevant persons of the amendment as determined by the patient on the amendment form.
   C) Insert the amendment in the proper location in permanent medical record.
2. Whenever a copy of the amended entry is released, a copy of the amendment form will accompany the released entry.
3. SVH will respond to an individual request for amendment, whether granting or denying, within sixty (60) days of receipt of the request.
4. If SVH is unable to process the request within sixty (60) days as specified above, SVH may extend the time by no more than thirty (30) days but only if:
   A) SVH provides the individual with a written statement outlining the reasons for the delay within the allowed time period and date when the amendment will be met.
   B) SVH has taken no other extensions of time with regards to this particular request.
   C) If it is foreseeable that the request cannot be met within ninety (90) days, the Privacy Officer will inform the Chief Quality Officer who must act to remediate the situation.

Denying Request for Amendment of Medical Record

1. SVH may deny the request to amend a record in these instances:
   A) SVH did not create the information the patient wants amended.
   B) The information the patient wants amended is not part of the designated record set.

C) The information the patient wants amended is accurate and complete.

2. If SVH denies a requested amendment, the Privacy Officer must provide the patient with a timely, written denial, in understandable language, that contains the following information:
   A) The reason for the denial.
   B) The patient's right to submit a written statement appealing the denial and with an explanation of how the individual may file such a statement.
   C) A statement that the patient may request SVH include the request and denial with any future disclosures of the information included in the request of the amendment.
   D) A description of how the patient may discuss the denial with the Privacy Officer and/or Chief Quality Officer or the Secretary of U.S. Department of Health and Human Services.

<u>Statement of Disagreement with Denial of Amendment</u>

1. SVH will allow patients to submit a written statement disagreeing with the denial of all or part of the requested amendment and the reason(s) for such disagreement.
2. SVH may prepare a written rebuttal to the patient's statement of disagreement. Whenever a rebuttal is prepared, SVH will provide a copy to the patient who submitted the statement of disagreement.
3. SVH must maintain the following documentation:
   A) The record that is the subject of the requested amendment including any amendment made to that specific record.
   B) The patient's request for amendment/correction and any addendum that the patient submitted.
   C) SVH's denial of the request.
   D) The patient's statement of disagreement, if any.
   E) SVH's written rebuttal, if any.

<u>Future Disclosures of Medical Record</u>

1. Any future disclosure of the medical record must include:
   A) The request for amendment and its denial, if any.
   B) The statement of disagreement.
2. If a release is made in a standard electronic transaction, the amendment may be separately transmitted via electronic transaction or via paper or fax.

SUBJECT: Amendment of Protected Health Information	POLICY # 8700-185
	PAGE 4 OF 4
DEPARTMENT: Health Information Management	EFFECTIVE:
REVISED:	

REFERENCES:
45 CFR Section 164.526 Amendment of Protected Health Information

OWNER:
Manager, Health Information Management

AUTHORS/REVIEWERS:
Rosemary Pryszmant, HIM Manager

APPROVALS:
Policy & Procedure Team: 2/5/20
Board Quality Committee:
The Board of Directors: