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**SVHCD QUALITY COMMITTEE**

# AGENDA

**WEDNESDAY, APRIL 22, 2020**
**5:00 p.m. Regular Session**
(Closed Session will be held upon adjournment of the Regular Session)

**TO BE HELD VIA ZOOM VIDEOCONFERENCE**

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**and enter the Meeting ID: 964 1649 5828**
**Password: 008463**

To Participate via Telephone only (no video), dial:
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**Password: 008463**

| 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**<br>*The mission of the SVHCD is to maintain, improve, and restore the health of everyone in our community.* | | |
| **1. CALL TO ORDER/ANNOUNCEMENTS** | *Hirsch* | |
| **2. PUBLIC COMMENT SECTION**<br>*At this time, members of the public may comment on any item not appearing on the agenda. It is recommended that you keep your comments to three minutes or less, Under State Law, matters presented under this item cannot be discussed or acted upon by the Committee at this time For items appearing on the agenda, the public will be invited to make comments at the time the item comes up for Committee consideration.* | *Hirsch* | |
| **3. CONSENT CALENDAR**<br>• Minutes 02.26.20 | *Hirsch* | Action |
| **4. SVH QUALITY INDICATOR PERFORMANCE AND PLAN** | *Jones* | Inform |
| **5. CENTER FOR IMPROVEMENT IN HEALTHCARE QUALITY CORRECTIVE ACTION PLAN** | *Jones* | Inform |
| **6. PROPOSED QUALITY COMMITTEE CHARTER** | *Jones* | Action |
| **7. PATIENT CARE SERVICES DASHBOARD** | *Kobe* | Inform |
| **7. POLICIES AND PROCEDURES** | *Jones* | Action |
| **8. COVID-19 UPDATE** | *Kidd* | Inform |

| | | |
|---|---|---|
| **9. CLOSED SESSION:**<br>a. Calif. Health & Safety Code §32155: Medical Staff Credentialing & Peer Review Report<br>b. Government Code §54956.9(d)(2): Discussion Regarding Significant Exposure to Litigation | *Hirsch*<br><br>*Hirsch* | Action<br><br>Inform |
| **10. REPORT OF CLOSED SESSION** | *Hirsch* | Inform/Action |
| **11. ADJOURN** | *Hirsch* | |

# SONOMA VALLEY HEALTH CARE DISTRICT
# QUALITY COMMITTEE
## February 26, 2020 5:00 PM
## MINUTES
### Schantz Conference Room

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

| AGENDA ITEM | DISCUSSION | ACTION |
|---|---|---|
| **1. CALL TO ORDER/ANNOUNCEMENTS** | *Hirsch* | |
| | 5:03 pm | |
| **2. PUBLIC COMMENT** | *Hirsch* | |
| | None | |
| **3. CONSENT CALENDAR** | | Action |
| • QC Minutes, 01.22.20 | | **MOTION:** by Mainardi to approve, 2nd by Eisenstark. All in favor. |
| **7. SVH QUALITY INDICATOR PERFORMANCE AND PLAN** | *Jones* | Inform |
| | Ms. Jones presented the quality indicator performance for January 2020. The Committee requested 1) national benchmarks be added; 2) report only cardiac deaths not present on admission that were strictly cardiac related, not due to some other primary cause; 3) include a definition of "total error reports" on good catches. | |
| **8. PROPOSED QUALITY COMMITTEE CHARTER** | *Jones* | Inform |
| | The sample charter was reviewed and changes suggested. Ms. Jones will send out a revised copy to the Committee. | |
| **9. POLICIES AND PROCEDURES** | *Jones* | Action |

| AGENDA ITEM | DISCUSSION | ACTION |
|---|---|---|
| | | **MOTION:** by Idell to approve, 2nd by Eisenstark. All in favor. |
| **10. CLOSED SESSION** | *Hirsch* | |
| **a.** Calif. Health & Safety Code § 32155 Medical Staff Credentialing & Peer Review Report | Called to order at 6:40 pm | |
| **11. REPORT OF CLOSED SESSION** | *Hirsch* | Inform/Action |
| | Medical Staff credentialing was reviewed. | **MOTION:** by Eisenstark to approve credentialing with correction, 2nd by Snyder. All in favor. |
| **12. ADJOURN** | *Hirsch* | |
| | 6:42 pm | |

# Quality Indicator Performance & Plan

## April 2020

Data for March 2020

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# MORTALITY

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# Scorecard Summary
# Mortality

| Status | Indicator | Current Value | Target | SPC Alert | Updated |
|---|---|---|---|---|---|
| **Quality > Autopsies Mortalities** | | | | | |
| ▲ | Acute Care Mortality Rate (M) | 1.6% | n/a | | Mar 2020 |
| ▲ | DV Inpatients - Percent Transferred to Hospice (M) | 3.1% | n/a | | Mar 2020 |
| **Quality > Process of Care > Sepsis Care** | | | | | |
| ▲ | Sepsis, Any Diagnosis - Mortality Rate (M) | 5.9% | 0.0% | | Mar 2020 |
| — | Sepsis, Principal Diagnosis - Mortality Rate (M) | 0.0% | 0.0% | | Mar 2020 |
| ▲ | Sepsis, Secondary Diagnosis - Mortality Rate (M) | 100.0% | 0.0% | | Mar 2020 |
| — | Sepsis, Severe - Mortality Rate (M) | 0.0% | 0.0% | | Mar 2020 |
| — | Sepsis, Simple - Mortality Rate (M) | 0.0% | 0.0% | | Mar 2020 |
| ▲ | Septic Shock - Mortality Rate (M) | 33.3% | 0.0% | | Mar 2020 |
| ▲ | Severe Sepsis or Septic Shock - Mortality Rate (M) | 11.1% | 0.0% | | Mar 2020 |

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# PREVENTABLE HARM EVENTS

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# Scorecard Summary

# AHRQ Patient Safety Indicators

## Preventable Harm

| 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\| | 3.2% | 0.0% | | Mar 2020 |
| — | AHRQ v6.0 PSI 04 Death in Surgical IP with Serious Complications overall\|M\| per 1,000 py days | 0.00 | 163.10 | | Mar 2020 |
| — | AHRQ v6.0 PSI 06 Iatrogenic Pneumothorax Rate \|M\| | 0.0% | 0.0% | | Mar 2020 |
| — | AHRQ v6.0 PSI 08 In-Hospital Fall with Hip Fracture Rate \|M\| | 0.0% | 0.0% | | Mar 2020 |
| — | AHRQ v6.0 PSI 09 Perioperative Hemorrhage or Hematoma Rate \|M\| | 0.0% | 0.0% | | Mar 2020 |
| — | AHRQ v6.0 PSI 10 Post-Operative Acute Kidney Injury Requiring Dialysis Rate \|M\| | 0.0% | 0.0% | | Mar 2020 |
| — | AHRQ v6.0 PSI 11 Postoperative Respiratory Failure Rate \|M\| | 0.0% | 0.0% | | Mar 2020 |
| — | AHRQ v6.0 PSI 12 Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate \|M\| | 0.0% | 0.0% | | Mar 2020 |
| — | AHRQ v6.0 PSI 13 Postoperative Sepsis Rate \|M\| | 0.0% | 0.0% | | Mar 2020 |
| — | AHRQ v6.0 PSI 14 Postoperative Wound Dehiscence Rate\|M\| | 0.0% | 0.0% | | Mar 2020 |
| — | AHRQ v6.0 PSI 15 Accidental Puncture or Laceration Rate \|M\| | 0.0% | 0.0% | | Mar 2020 |

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# Scorecard Summary

## Patient Falls

### Preventable Harm

| Status | Indicator | Current Value | Target | SPC Alert | Updated |
|---|---|---|---|---|---|
| Quality > Patient Safety > Falls | | | | | |
| ▲ | RM ACUTE FALL- NO INJURY (M) per 1000 patient days | 4.59 | 0.00 | | Mar 2020 |
| – | RM ACUTE FALL- WITH INJURY (M) per 1000 patient days | 0.00 | 0.00 |  | Mar 2020 |
| – | RM ED FALL- NO INJURY (M) per 1000 patient days | 0.00 | 0.00 | | Mar 2020 |
| – | RM ED FALL- WITH INJURY (M) per 1000 patient days | 0.00 | 0.00 | | Mar 2020 |

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# Scorecard Summary

## Coded Complications of Care

### Preventable Harm

| Status | Indicator | Current Value | Target | SPC Alert | Updated |
|---|---|---|---|---|---|
| — | Air Embolism NPOA - Per 1000 ACA (M) | 0.00 | 0.00 | | Mar 2020 |
| — | Cardiac Arrest- per 1000 ACA (M) | 0.00 | n/a | | Mar 2020 |
| — | Cardiac Arrest-NPOA per 1000 ACA (M) | 0.00 | 0.00 | | Mar 2020 |
| — | Cardiac Complications NPOA per 1000 ACA (M) | 0.00 | 0.00 | | Mar 2020 |
| — | Cardiogenic Shock NPOA per 1000 ACA (M) | 0.00 | 0.00 | | Mar 2020 |
| — | Deaths per 1000 ACA Elective Admission (M) | 0.00 | 0.00 | | Mar 2020 |
| — | Device/Implant Complications, Cardiac Incl. Valve, NPOA - Per 1000 ACA (M) | 0.00 | 0.00 | | Mar 2020 |
| — | Device/Implant Complications, Genitourinary/Urologic NPOA - Per 1000 ACA (M) | 0.00 | 0.00 | | Mar 2020 |
| — | Device/Implant Complications, Nervous System NPOA - Per 1000 ACA (M) | 0.00 | 0.00 | | Mar 2020 |
| — | Device/Implant Complications, Orthopedic Device NPOA - Per 1000 ACA (M) | 0.00 | 0.00 | | Mar 2020 |
| — | Device/Implant Complications, Other/NEC Device NPOA - Per 1000 ACA (M) | 0.00 | 0.00 | | Mar 2020 |
| — | Device/Implant Complications, Vascular Device NPOA - Per 1000 ACA (M) | 0.00 | 0.00 | | Mar 2020 |
| — | Device/Implant Complications, Vascular NPOA - Per 1000 ACA (M) | 0.00 | 0.00 | | Mar 2020 |
| — | Device/Implant Functional Complications NPOA - Per 1000 ACA (M) | 0.00 | 0.00 | | Mar 2020 |
| — | Device/Implant Other Complications NPOA - Per 1000 ACA (M) | 0.00 | 0.00 | | Mar 2020 |
| — | Device/Implant, Inflammatory Reaction NPOA - Per 1000 ACA (M) | 0.00 | 0.00 | | Mar 2020 |

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# Scorecard Summary
## Coded Complications of Care
### Preventable Harm

| | | | | | |
|---|---|---|---|---|---|
| Disruptions of Operative Wound, NPOA - Per 1000 ACA (M) | 0.00 | 0.00 | | Mar 2020 |
| DVT/PE, Orthopedic, NPOA - Per 1000 Inpatients w/ Total Knee/Hip Replacement (M) | 0.00 | 0.00 | | Mar 2020 |
| Iatrogenic Pneumothorax NPOA - Per 1000 ACA (M) | 0.00 | 0.00 | | Mar 2020 |
| Iatrogenic Pulmonary Embolus NPOA - Per 1000 ACA (M) | 0.00 | 0.00 | | Mar 2020 |
| Infection from Central Venous Cath, NPOA - Per 1000 Inpatients w/ CV Cath (M) | 0.00 | 0.00 | | Mar 2020 |
| Intraoperative Injuries NPOA- Per 1000 ACA with a Surgical Procedure (M) | 0.00 | 0.00 | | Mar 2020 |
| Nervous System Complications NPOA- Per 1000 ACA (M) | 0.00 | 0.00 | | Mar 2020 |
| Other Complications NPOA- Per 1000 ACA (M) | 0.00 | 0.00 | | Mar 2020 |
| Peripheral Vascular Complications NPOA - Per 1000 ACA (M) | 0.00 | 0.00 | | Mar 2020 |
| Postoperative Hemorrhage_Hematoma NPOA - Per 1000 ACA with surgical procedure (M) | 0.00 | 0.00 |  | Mar 2020 |
| Postoperative Infection - Per 1000 ACA (M) | 0.00 | 0.00 | | Mar 2020 |
| Postoperative Pulmonary Edema - Per 1000 ACA (M) | 0.00 | 0.00 |  | Mar 2020 |
| Postoperative Pulmonary Edema NPOA with Surgical Procedure- Per 1000 ACA (M) | 0.00 | 0.00 |  | Mar 2020 |
| Postoperative Shock NPOA with Surgical Procedure- Per 1000 ACA (M) | 0.00 | 0.00 | | Mar 2020 |
| Respiratory Complications NPOA- Per 1000 ACA (M) | 0.00 | 0.00 | | Mar 2020 |
| Retained Foreign Body NPOA- Per 1000 ACA (M) | 0.00 | 0.00 | | Mar 2020 |
| Transfusion Reaction, all types NPOA- Per 1000 ACA (M) | 0.00 | 0.00 | | Mar 2020 |
| Urinary Complication NPOA- Per 1000 ACA (M) | 0.00 | 0.00 | | Mar 2020 |

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# Scorecard Summary
## Blood Utilization

| | | | | | |
|---|---|---|---|---|---|
| ▲ | Blood Cultures -Contamination Rate \|LAB\| (M) | 2% | 3% | | Mar 2020 |
| ▼ | Blood Cultures -Contamination Rate\|RN\| (M) | 4% | 3% | | Mar 2020 |
| ▲ | Blood Cultures -Total Contamination Rate (M) | 3% | 3% | | Mar 2020 |

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# HEALTHCARE ACQUIRED INFECTION

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## Infection Prevention Report: 4th 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. NHSN provides the predicted number of HAIs based on standardized infection rations (SIRS). ** indicates public reporting on CDPH website. Green indicates no action indicated, yellow indicates | | | | | |
| ***CLABSI (NHSN) (CMS Never Event)**<br>*# Central Line Associated Bloodstream infections (CLABSI)/1000 central line days* | **0 since 2011** | **0**<br>0/108 | **0**<br>0/89 | **0**<br>0/51 | **0**<br>0/77 |
| ***CDI (NHSN)**<br>*#Inpatient Hospital Acquired infections due to C. difficile per 10,000 patient days* | **2.1 /7.2 /12 15/21.7/7.5** | **0**<br>0/872 | **0**<br>0/901 | 0<br>**0/821** | **9.9**<br>1/1006 |
| ***MRSA Bloodstream Infections (NHSN)**<br>*#bloodstream infections due to MRSA per 1000 pt. days* | **1.3 /0 /0 0/ 0/0** | **0**<br>0/872 | **0**<br>0/901 | **0**<br>0/821 | **0**<br>0/1006 |
| ***VRE Bloodstream Infections (NHSN)**<br>*#Hospital Acquired bloodstream infections due to VRE per 1000 pt. days* | **0 x 6 yrs** | **0**<br>0/872 | **0**<br>0/901 | **0**<br>0/821 | **0**<br>0/1006 |
| ***Hip: Deep or Organ Space Surgical Site Infections (NHSN)**<br>*# infections/ # Total Hip Cases x 100* | **0 / 1.8% / 0 1.6% / 0** | **0**<br>0/11 | **0** | **0**<br>0/12 | **0**<br>0/15 |
| ***Knee: Deep or Organ/Space Surgical Site Infections (NHSN)**<br>*# infections/ # Total Knee Cases x 100* | **0 / 1.7% / 2 1.4% / 1.3%/3.5** | **0**<br>0/17 | **0** | **0**<br>0/14 | **0**<br>0/19 |
| ***Overall Surgical Site Infections (SSI)**<br>*Total # SSI/Total # surgeries x 100* | **0.2%/0.7% (12)/ 0.4% (6)/ 0.5% (8)/ 0.4% (8)** | 0.4%<br>2/473 | **0.8%**<br>**5/586** | **0**<br>0/462 | **0.4%**<br>2/532 |
| **Class I SSI rate** | **<1% x 5 yrs** | 0.2%<br>1/409 | **0.9%**<br>**4/420** | 0<br>0/373 | 0.2%<br>1/470 |
| **Class II SSI rate** | **< 1.3% x 5 yrs** | 0<br>0/56 | **0 0/54** | 0<br>0/61 | 0<br>0/44 |
| **Total Joint SSI rate** | **0 / 0.8%/1.9%/1.4%/1.4%** | **0** | **0** | 0<br>0/23 | 0<br>0/39 |
| **Post discharge surveillance surgeon compliance** | **57%, 64%, 84%, 96.5%, 95.3%** | 92% Jan sample | **90.5% Apr/May** | 90% Jul/Aug | 90% Oct/Nov |
| **Hand Hygiene Compliance**<br>*hand hygiene observations: # opportunities/# hand hygiene procedure observed* | **2017 98.7%**<br>**2018 92.7%** | **95%**<br>**19/20** | **100&**<br>**19/19** | **100%**<br>23/23 | |

| | | | | | |
|---|---|---|---|---|---|
| ****Ventilator Associated Event (VAE)**<br>*# Ventilator Associated Pneumonias or events/ # vent days x 1000* | **0 x 4 yrs.** | **0**<br>0/7 | **0 0/23** | **0/0** | **41.6 1/24** |
| ****Hospital Acquired Pneumonia (HAP)**<br>*# hospital acquired pneumonia/# pt days x 1000 pt days* | **0.2/0.5/0.9/1.6/ 0.7** | acute 0/872<br>SNF 0/988 | 1.1<br>1/901 | 0<br>0/821 | 0.1<br>1/1006 |
| ****Inpatient Hospital Acquired Catheter Associated Urinary Tract Infections (CA-UTI) (CMS Never Event)**<br>*# inpatient CAUTI/# catheter days x 1000* | **0.7 /0 / 1.7 1.4/1.6/0.85** | **0**<br>0/197 | **4.6**<br>1/217 | **0**<br>**0/221** | **0**<br>**0/274** |
| **Communicable Disease Exposures** | | 1 | 1 | **0** | **0** |
| **MRSA Active Surveillance Cultures (nares cultures only)**<br>*# positives/total screened x 100* | **14%, 20%, 26%**<br>**9.2%/5.8%** | **9.5%**<br>10/105 | **11%**<br>11/100 | **6.3%%**<br>5/80 | **9.7%**<br>9/93 |
| ***% ESBL (E. coli;K. pneumoniae, K. oxytoca, P. mirabilis)*** | **2% /3%/4.2%/4.1%** | 7% | 15.5% | 7.7% | 7.6% |
| ***# CRE cases*** | **0/0/0/1** | 1 (0.34%) | 0 | 0 | 1(.34%) |
| **Legionella Monitoring**: water samples and patients with HA pneumonia | | 0 | 0 | 0 | 0 |
| **Environmental Cleanliness Monitoring** | 95% | 97% | 96% | 100% | 100% |
| **Total Influenza Vaccination All HCP** | 80%, (2018) | | | | |
| Physicians, LIP, PAs | | 81% | | | pending |
| Employees | | 87% | | | 89% |
| Volunteers | 100% | pending | | | |
| Students | | 100% | | | 100% |
| Patients | | 64 flu shots | | | 50 flu |

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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 | 0.65 | 1.00 | | Mar 2020 |
| ▲ | Rx-ADEs-High Risk Med Errors Per 10,000 Doses | 0.32 | 1.13 | | Mar 2020 |
| – | Rx-Adverse Drug Reactions | 4 | n/a | | Q1-2020 |
| – | Rx-Adverse Drug Reactions-Antibiotics | 25% | n/a | | Q1-2020 |
| ▲ | Rx-Adverse Drug Reactions-Anticoagulants | 25% | n/a | | Q1-2020 |
| – | Rx-Adverse Drug Reactions-Cardiovascular | 25% | n/a | | Jan 2020 |
| – | Rx-Warfarin-Inpatient | 0.0% | 5.0% | | Dec 2019 |

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# ADVERSE EVENTS

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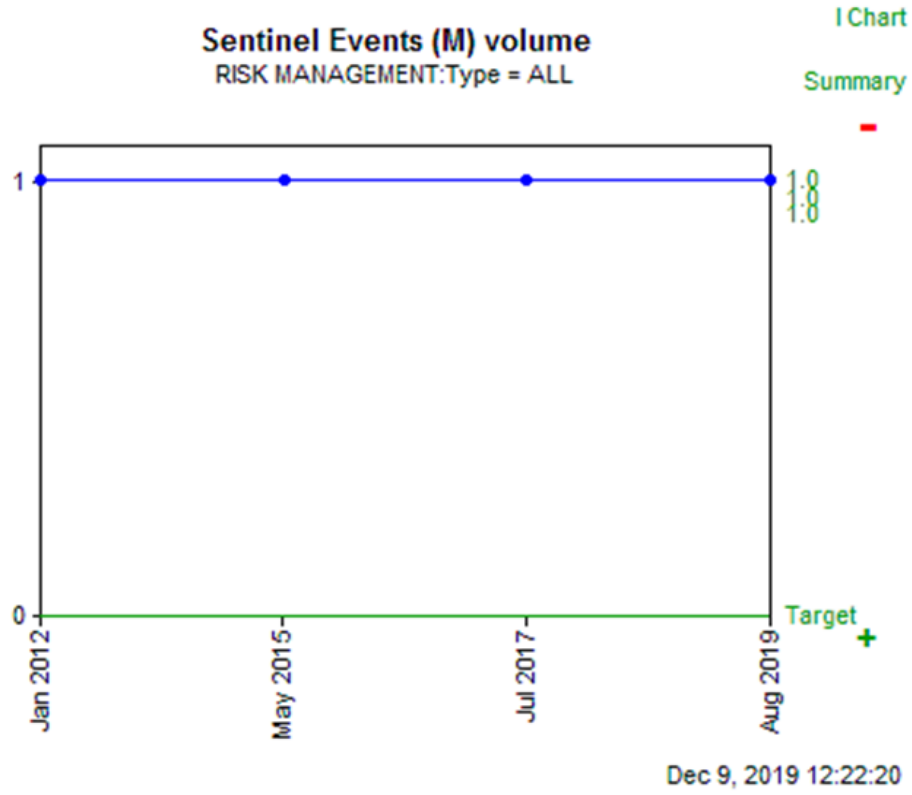
# Adverse Events




- 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

| Quality > Core Measures | | | | | |
|---|---|---|---|---|---|
| ▲ | Core OP-18b - Median Time ED Arrival to ED Departure - Reporting Measure (M) | 149.00 | 140.00 | | Mar 2020 |
| – | Core OP-23 - Head CT/MRI Results for STK Pts w/in 45 Min of Arrival (M) | 100.0% | 72.0% | | Mar 2020 |
| **Quality > Core Measures > HOP Measures > HOP Colonoscpy** | | | | | |
| ▼ | Core OP29/ASC9 - Colonoscopy:F/U for Avg Risk Pts (M) | 50.0% | 89.0% | | Mar 2020 |

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# Scorecard Summary
# Electronic Clinical Quality Measures (eCQM)

| Quarter | Category | Measure Title | Performance Denominator | Numerator | Performance Rate |
|---|---|---|---|---|---|
| Q4 2019 | STK-02 | Discharged on Antithrombotic Therapy | 6 | 6 | 100.00% |
| Q4 2019 | STK-03 | Anticoagulation Therapy for Atrial Fibrillation/Flutter | 3 | 2 | 66.67% |
| Q4 2019 | STK-05 | Antithrombotic Therapy By End of Hospital Day 2 | 7 | 6 | 85.71% |
| Q4 2019 | STK-06 | Discharged on Statin Medication | 6 | 5 | 83.33% |
| Q4 2019 | STK-08 | Stroke Education | 1 | 1 | 100.00% |
| Q4 2019 | STK-10 | Assessed for Rehabilitation | 6 | 6 | 100.00% |
| Q4 2019 | VTE-1 | Venous Thromboembolism Prophylaxis | 140 | 126 | 90.00% |
| Q4 2019 | VTE-2 | Intensive Care Unit Venous Thromboembolism Prophylaxis | 76 | 71 | 93.42% |

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# READMISSION

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# Scorecard Summary
## Readmissions
### Sepsis

| Quality > Process of Care > Sepsis Care | | | | | |
|---|---|---|---|---|---|
| Sepsis, Severe - % Readmit within 30 Days (M) | 0.00% | 0.00% | | Mar 2020 |
| Sepsis, Simple - % Readmit within 30 Days (M) | 0.00% | 0.00% | | Mar 2020 |
| Septic Shock - % Readmit within 30 Days (M) | 0.00% | 0.00% | | Mar 2020 |

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# Scorecard Summary
# Readmissions

| Quality > Readmissions | | | | | |
|---|---|---|---|---|---|
| ▼ | 07-DV Inpatients - % Readmit to Acute Care within 07 Days (M) | 1.7% | 8.0% | | Mar 2020 |
| ▼ | 14-DV Inpatients - % Readmit to Acute Care within 14 Days (M) | 1.7% | 8.0% | | Mar 2020 |
| ▼ | 30-DV Inpatients - % Readmit to Acute Care within 30 Days (M) | 1.7% | 8.0% | | Mar 2020 |
| – | COPD, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M) | 0% | 20% |  | Mar 2020 |
| ▼ | DV Inpatients - % Readmit to ED within 30 Days (M) | 1.7% | 8.0% |  | Mar 2020 |
| – | DV Inpatients - % Readmit to Observation/Short Stay within 30 Days (M) | 0.0% | 8.0% | | Mar 2020 |
| ▼ | HF, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M) | 0% | 22% | | Mar 2020 |
| – | Hip/Knee, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M) | 0.00% | 4.00% | | Mar 2020 |
| ▼ | Medicine, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M) | 0% | 0% | | Mar 2020 |
| – | PNA, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M) | 0% | 17% | | Mar 2020 |
| – | Sepsis, Any Diagnosis - % Readmit within 30 Days (M) | 0% | 0% | | Mar 2020 |
| ▼ | Surgery, CMS Readm Rdctn -% Readmit within 30 Days_ ACA \|M\| | 0.00% | 8.00% | | Mar 2020 |

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**Corrective Action Plan**

Print Corrective Action

**Corporate Information**
Sonoma Valley Health Care District
347 Andrieux Street
Sonoma, CA 95476-6811
Phone: 707-935-5000
CCN: 050090
CIHQ Hospital Id: 1004

**Survey**
Type: Reaccreditation
Survey Date: 3/10/2020 to 3/12/2020
Action Due: 4/7/2020

Deficiency #01
Level: Standard–Level
GL-04: Leadership Responsibilities
Requirement: B

**The standard was not met as evidenced by the following**
Observed during Document Review
3/10/20 @ approximately 1030 by A. McLain
Based on a review of documents, it was noted that multiple policies were past their triennial review date. Staff present (#2) confirmed the finding.

**Action Plan**
Action #1

Sonoma Valley Hospital is in the process of contracting HospitalPORTAL, a policy management solution that automates and addresses all aspects of policies and procedures, forms and contract publishing, access, review and approvals. The HospitalPORTAL solution supports comprehensive document management, document review and approval workflows, tracking, versioning, auditing, and certification of policies and procedures. Automating the policy and procedure process will ensure compliance with triennial review dates.
SVH Quality Department and IT met with HospitalPORTAL representatives 3/31/2020
The plan and contract will be presented to the Administrative team on 4/9/2020 for approval. IT will work with HospitalPORTAI to install and train staff after approval.

Title of Person Responsible for Implementing the Action: **Chief Quality Officer**
Date Action Plan was or will be Implemented: **3/31/2020**
Is a Monitoring Plan Required?: yes
Monitoring Plan
What will be monitored: Policy triennial reveiw date
What is the sample size: 100%
What is the threshold of compliance: 100%
How frequently will monitoring occur: Monthly
How long will the monitoring last: Ongoing
Who will oversee the monitoring: Chief Quality Officer
What committee in the QAPI program will receive reports on the results: Board Quality

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Deficiency #02
Level: Condition–Level
GL-04: Leadership Responsibilities
Requirement: C

**The standard was not met as evidenced by the following**
Observed as a Result of Survey Activities
Based on the following condition level findings, the governing body failed to assure that the organization was in substantial compliance to CIHQ accreditation standards, and failed to establish a QAPI program sufficient in scope and depth to prevent the deficiencies contained herein:
• CE-11
• CE-19
• QS-10
Please refer to the specific findings under each of the above standards for a description of non-compliance. The governing body must establish and implement processes to assure that it provides active oversight and resources to support quality and patient safety. Note that a condition-level deficiency is assigned to the governing body whenever such deficiencies are noted in other standards.
THIS IS A CONDITION LEVEL DEFICIENCY

**Action Plan**
Action #1

See corrective action plans for CE-11, CE-19 and QS-10
The Board Quality will be informed of this condition level finding at next Board Quality meeting on 4/22/2020. Board Quality will also be provided with reports on progress and status of the corrective action plans. This will be added to the monthly agenda until all items have been resolved.

Title of Person Responsible for Implementing the Action: **Cheif Quality Officer**
Date Action Plan was or will be Implemented: **4/22/2020**
Is a Monitoring Plan Required?: yes
Monitoring Plan
What will be monitored: corrective action plans
What is the sample size: 100%
What is the threshold of compliance: 100%
How frequently will monitoring occur: Monthly
How long will the monitoring last: Until resolution
Who will oversee the monitoring: Chief Quality Officer
What committee in the QAPI program will receive reports on the results: Board Quality

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Deficiency #03
Level: Standard–Level
GL-08: Contract Services
Requirement: E

**The standard was not met as evidenced by the following**
Observed during Document Review
3/11/20 @ approximately 1530 by A. McLain
Based on information available at the time of survey, the organization could not substantiate that results of the analysis, including issues identified and corrective actions taken are presented at least annually to the governing body for the following contract services:
• CPS Telepharmacy Inc.
• V-Rad
• Blood Systems
Staff present (#2) confirmed the finding.

**Action Plan**
Action #1

A review of contract services inculding evaluation of expectations and performance meterics will be added to the annual Board Quality work plan. An overview of this new process will be added to the April 2020 agenda.

Title of Person Responsible for Implementing the Action: **Chief Quality Officer**
Date Action Plan was or will be Implemented: **4/1/2020**
Is a Monitoring Plan Required?: yes
Monitoring Plan
What will be monitored: Review of contract services
What is the sample size: 100%
What is the threshold of compliance: 100%
How frequently will monitoring occur: Annually
How long will the monitoring last: Ongoing
Who will oversee the monitoring: Chief Quality Officer
What committee in the QAPI program will receive reports on the results: Board Quality

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Deficiency #04
Level: Standard–Level
MS-05: Granting of Clinical Privileges
Requirement: A

**The standard was not met as evidenced by the following**
In 2 of 10 files reviewed, the following was noted:
Observed during the Medical Staff Credential Review
3/12/20 @ approximately 0945 by G. Miller
The credential file of an internal medicine physician last appointed on 3/3/19 was reviewed. It was noted that one of the criteria for granting privileges for ventilator management was to be involved in the care of at least 5 patients during the prior appointment period. There was no documentation in the file that the practitioner met this criterion. Staff present (#13) confirmed the finding.
Observed during the Medical Staff Credential Review
3/12/20 @ approximately 1000 by G. Miller
The credential file of a pediatrician last appointed on 1/1/19 was reviewed. It was noted that one of the criteria for granting privileges was NRP and PALS certification. There was no evidence that the physician had the required certifications. Staff present (#13) confirmed the finding.

**Action Plan**
Action #1

The Medical Executive Committee voted to removed the unsupported vent privilege from the identified physicians privilege set.

Title of Person Responsible for Implementing the Action: **Medical Staff Coordinator**
Date Action Plan was or will be Implemented: **3/19/2020**
Is a Monitoring Plan Required?: no
Action #2
The Medical Executive Committee voted to adjust all Pediatricians staff status to Refer and Follow, which in turn removes the requirement of NRP and PALS.

Title of Person Responsible for Implementing the Action: **Stacey Finn**
Date Action Plan was or will be Implemented: **3/19/2020**
Is a Monitoring Plan Required?: no

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Deficiency #05
Level: Standard–Level
MS-07: Resources to Support Privileges
Requirement: A

**The standard was not met as evidenced by the following**
In 1 of 10 files reviewed, the following was noted:
Observed during Medical Staff Credential Review – 3/12/20 @ approximately 1015 by G. Miller
The credential file of a pain management physician appointed on 2/2/19 was reviewed. It was noted that the practitioner was granted privileges to perform transesophageal echocardiogram (TEE). The facility does not have the equipment, supplies, policies and personnel necessary to allow the practitioner to safely and effectively exercise this privilege. Staff present (#13) confirmed the finding.

**Action Plan**
Action #1

The Medical Executive Committee removed the privleges from the identified physicians file because the hospital does not perform the procedure.

Title of Person Responsible for Implementing the Action: **Medical Staff Coordinator**
Date Action Plan was or will be Implemented: **3/19/2020**
Is a Monitoring Plan Required?: no

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Deficiency #06
Level: Standard–Level
MS-09: Provision of Telemedicine Services by a Distant Site
Requirement: A

**The standard was not met as evidenced by the following**
Observed during Document Review - 3/10/20 @ approximately 1000 by G. Miller
Based on review of documents provided at the time of the survey, it was noted that the telemedicine contracts for Neurology and Infectious Disease did not contain the verbiage required by CMS §482.12(a)(8). Specifically, the contracts need to specify that the governing body of the distant-site hospital will satisfy the requirements of §482.12(a)(1) through (a)(7) for practitioners providing telemedicine services.

**Action Plan**
Action #1

Revisions to the contract are in process with the distant site. The correct CMS conditions of particiaption verbiage will be added to the stated contract as well as all others in similar nature.

Title of Person Responsible for Implementing the Action: **Medical Staff Coordinator**
Date Action Plan was or will be Implemented: **3/19/2020**
Is a Monitoring Plan Required?: no

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Deficiency #07
Level: Standard–Level
HR-03: Competency of Staff
Requirement: A

**The standard was not met as evidenced by the following**
In 1 of 12 files, the following was noted
Observed during the Human Resources Review – 3/12/20 @ approximately 1100 by A. McLain

The personnel file of a medical social worker hire on 7/16/18 was reviewed. There was no evidence that the education requirement of a bachelor's degree had been verified as required by the job position. Staff present (#12) confirmed the finding.

**Action Plan**
Action #1

Add education verification requirement to our existing New Hire Packet check list.

Title of Person Responsible for Implementing the Action: **Chief Human Resources Officer**
Date Action Plan was or will be Implemented: **4/1/2020**
Is a Monitoring Plan Required?: yes
Monitoring Plan
What will be monitored: education verification requirement to our existing New H
What is the sample size: 100
What is the threshold of compliance: 100
How frequently will monitoring occur: Monthly
How long will the monitoring last: Ongoing
Who will oversee the monitoring: Human Resources
What committee in the QAPI program will receive reports on the results: Board Quality

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Deficiency #08
Level: Standard–Level
HR-03: Competency of Staff
Requirement: B

**The standard was not met as evidenced by the following**
In 1 of 12 files, the following was noted
Observed during the Human Resource Review Session – 3/12/20 @ approximately 1100 by A. McLain
The personnel file of a MRI technician was reviewed. It was noted that there was no documented initial assessment of competency related to the duties of a MRI technician. Staff present (#12) confirmed the finding.

**Action Plan**
Action #1

Existing process in place for this requirment and included in our quarterly QAPI reporting. Greater attention and sense of urgency will be communicated to responsible managers.

Title of Person Responsible for Implementing the Action: **Chief HR Officer**
Date Action Plan was or will be Implemented: **4/1/2020**
Is a Monitoring Plan Required?: yes
Monitoring Plan
What will be monitored: Competency compliance
What is the sample size: 100
What is the threshold of compliance: 100
How frequently will monitoring occur: Monthly
How long will the monitoring last: Ongoing
Who will oversee the monitoring: Human Resources
What committee in the QAPI program will receive reports on the results: Board Quality

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Deficiency #09
Level: Standard–Level
HR-04: Management of Contract / Volunteer Staff
Requirement: B

**The standard was not met as evidenced by the following**
In 1 of 12 files, the following was noted
Observed during the Human Resource Competency Review
The personnel file of a contract pharmacist who last worked March of 2020 was reviewed. It was noted that primary source verification of the individual's license was not performed. The pharmacy board was queried at the time of survey and current licensure was verified. Staff present (#12) confirmed the finding.

**Action Plan**
Action #1

Before HR will issue an ID Badge to a contracted staff member, source verification of required license will be performed and maintained in contract file. This will be added to the HR department QAPI.

Title of Person Responsible for Implementing the Action: **Chief HR Officer**
Date Action Plan was or will be Implemented: **4/1/2020**
Is a Monitoring Plan Required?: yes

Monitoring Plan
What will be monitored: source verification of contract workers
What is the sample size: 100
What is the threshold of compliance: 100
How frequently will monitoring occur: Monthly
How long will the monitoring last: Ongoing
Who will oversee the monitoring: Human Resources
What committee in the QAPI program will receive reports on the results: Board Quality

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Deficiency #10
Level: Standard–Level
CE-01: Provision of Facilities
Requirement: A

**The standard was not met as evidenced by the following**
Observed during Document Review – 3/10/20 @ approximately 0910 by D. Roush
During a review of documents, it was noted that preventive maintenance related to the water and steam system(s) was not being performed as outlined in the Water Management Program. This is a violation of ANSI/ASHRAE Standard 188-2015. Staff present (#5) confirmed the finding.

Observed during Document Review – 3/10/20 @ approximately 0930 by D. Roush
During a review of documents, it was noted that the 2018 tests results related to the Water Management Program identified deficiencies but corrective action to these deficiencies was not available at the time of the survey for review. This is a violation of ANSI/ASHRAE Standard 188-2015. Staff present (#5) confirmed the finding.

**Action Plan**
Action #1

Vendor - Forensic Analytical Consulting Services "FACS" was engaged to develop a water managent plan. The plan was received by the Hospital and it is in draft form. Plant Operations Manager will set up a quarterly meeting of the Water Management Team "WMT". The WMT will review and adopt a final plan. Final plan will implement necessary mitigations per Facility Assessment.

Title of Person Responsible for Implementing the Action: **Plant Operations Manager**
Date Action Plan was or will be Implemented: **4/30/2020**
Is a Monitoring Plan Required?: yes

Monitoring Plan
What will be monitored: preventive maintenance related to the water and steam sy
What is the sample size: 100
What is the threshold of compliance: 100
How frequently will monitoring occur: Quarterly
How long will the monitoring last: Ongoing
Who will oversee the monitoring: Plant Operations Manager
What committee in the QAPI program will receive reports on the results: Safety Committee

Action #2
2018 test results from Garret Callahan were reviewed by Plant Operations Manager. Plant Operations Manager will engage vendor FACS to retest areas that were identified as deficiencies from 2018 test results. Any further deficiencies will be corrected per recommendations from FACS.

Title of Person Responsible for Implementing the Action: **Plant Operations Manager**
Date Action Plan was or will be Implemented: **4/30/2020**
Is a Monitoring Plan Required?: no

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Deficiency #11
Level: Standard–Level
CE-03: Provision of a Safe Environment
Requirement: A

**The standard was not met as evidenced by the following**
Observed during the Building Tour – 3/11/20 @ approximately 1051 by D. Roush
During a tour of the environment, it was noted that the fire extinguisher(s) was not properly supported or mounted in the following locations:
• Reception area construction site, two (2) extinguishers were standing on the floor
• Computed tomography room construction site, one (1) extinguisher was standing on the floor
• On site storage room, five (5) extinguishers were standing on floor
This is a violation of NFPA 10-2013, 6.1.3.4. Staff present (#5) confirmed the findings.

Observed during the Building Tour – 3/11/20 @ approximately 1136 by D. Roush
During a tour of the environment, it was noted that two (2) electrical boxes (4"x4" and 8"x8") did not have a cover plate and energized wires were exposed in the ceiling of the administrative corridor next to the cross-corridor doors. This is a violation of NFPA 70E-2012, 245.1. Staff present (#5) confirmed the finding.

Observed during the Building Tour – 3/11/20 @ approximately 1321 by D. Roush
During a tour of the environment, it was noted that an evacuation chair was being stored in the north and south stairwell enclosures. This is a violation of NFPA 101-2012, 7.2.3.5.2. Staff present (#5) confirmed the finding.

Observed during the Building Tour – 3/11/20 @ approximately 1331 by D. Roush
During a tour of the environment, it was noted that the manual pull station was blocked by papers hanging down from the communication board by room E-1152 located in the dietary department. This is a violation of NFPA 101-2012, 9.6.2.7. Staff present (#5) confirmed the finding.

Observed during the Building Tour – 3/11/20 @ approximately 1314 by D. Roush
During a tour of the environment, it was noted that a label identifying the contents and hazard warnings of hazardous waste being stored in the biohazard room (C1185) was not posted on the door located in the wound care department. This is a violation of OSHA 29 CFR §1910.145(a)(1); ANSI Z535-2011. Staff present (#5) confirmed the finding.

**Action Plan**
Action #1

CE3 - A-1
General Contractor supported extinguishers on job site. Engineers purchased a rack to properly secure unused fire extinguishers and completed per work order 203748.

Title of Person Responsible for Implementing the Action: **Plant Operations Manager**
Date Action Plan was or will be Implemented: **3/17/2020**
Is a Monitoring Plan Required?: no
Action #2
CE3 - A-2
Engineer covered the two electrical boxes - 4" x 4" and 8" x 8" per work order 203393 on 3/25/20.

Title of Person Responsible for Implementing the Action: **Plant Operations Manager**
Date Action Plan was or will be Implemented: **3/25/2020**
Is a Monitoring Plan Required?: no
Action #3
CE3 - A-3
All evacuation chairs located in the North and South stairwell enclosures will be relocated as per work order 203871

Title of Person Responsible for Implementing the Action: **Plant Operations Manager**
Date Action Plan was or will be Implemented: **4/30/2020**
Is a Monitoring Plan Required?: no
Action #4
CE3 - A-4
The Food & Nutrition Manager removed the paperwork and Engineering removed the bulletin board from the wall as per work order 203365.

Title of Person Responsible for Implementing the Action: **Plant Operations Manager**
Date Action Plan was or will be Implemented: **3/12/2020**
Is a Monitoring Plan Required?: no
Action #5
CE3 - A-5
Engineer will post a sign on the door with the appropriate biohazard label as per work order 204466.

Title of Person Responsible for Implementing the Action: **Plant Operations Manager**
Date Action Plan was or will be Implemented: **4/30/2020**
Is a Monitoring Plan Required?: no

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Deficiency #12
Level: Standard–Level
CE-06: Management of General and Medical Waste
Requirement: A

**The standard was not met as evidenced by the following**
Observed in the Wound Care Clinic – 3/11/20 @ approximately 1200 by G. Miller
During a tour of the environment, it was noted that a room containing used medical instruments awaiting decontamination did not have a biohazard symbol or other placard alerting personnel that said waste is stored in the room. Staff present (#3) confirmed the finding.

**Action Plan**
Action #1

Engineer will post a sign on the door with the appropriate biohazard label as per work order 204466. This is the same door/room as reflected in CE-3: Provision of a safe environment CFR Reference 482.41 (a).

Title of Person Responsible for Implementing the Action: **Plant Operations Manager**
Date Action Plan was or will be Implemented: **4/30/2020**
Is a Monitoring Plan Required?: no

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Deficiency #13
Level: Standard–Level
CE-07: Management of Hazardous Materials & Waste
Requirement: A

**The standard was not met as evidenced by the following**
Observed in the Surgical Services Department – 3/11/20 @ approximately 1000 by A. McLain
During a tour of the environment, it was noted that an unlabeled plastic container with clear liquid assumed to be formalin was found stored on the top of the specimen / formalin cart. Chemicals must be labeled when removed from the original container. Staff present (#11) confirmed the finding.

Observed in the Outpatient Rehabilitation Clinic – 3/12/20 @ approximately 1130 by G. Miller
During a tour of the environment, a bottle of clear solution was noted in the hand therapy area. The bottle was labeled with an expiration date however the contents of the bottle were not identified. Staff present (#14) confirmed the bottle contained rubbing alcohol which should have been identified on the label.

**Action Plan**
Action #1

No written policy had been developed for the safe maintenance and handling of all hazardous materials in use at the Outpatient Rehabilitation Clinic. The Rehab Services Manager will create a written policy, 7770- by 4/3/2020, whose purpose will be to assure that in regards to hazardous materials, staff will maintain and handle such materials in a safe and appropriate manner. This policy will be submitted for approval as follows:
Policy and Procedures Team: 5/6/2020
Medicine Committee: 5/14/2020
Medical Executive Board: 5/21/2020
Board Quality Committee: 5/27/2020
The Board of Directors: 7/2/2020
The policy will be introduced to staff on /4/3/2020. Staff will be educated about new policy and sign an attestation. The new policy will be posted in the staff room and available by hardcopy in office P+P book and on the Intranet under our departmental policies.

Title of Person Responsible for Implementing the Action: **Rehab Services Manager**
Date Action Plan was or will be Implemented: **5/1/2020**
Is a Monitoring Plan Required?: yes
Monitoring Plan
What will be monitored: safe maintenance and handling of hazardous material
What is the sample size: 100
What is the threshold of compliance: Monitoring will be done on a monthly basis by Rehab Serv
How frequently will monitoring occur: Monthly
How long will the monitoring last: Monitoring will be done on a monthly basis by Rehab Serv
Who will oversee the monitoring: Rehab Services Manager
What committee in the QAPI program will receive reports on the results: Board Quality

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Deficiency #14
Level: Standard–Level
CE-09: Management of Supplies
Requirement: B

**The standard was not met as evidenced by the following**
Observed in the Pre / Post-Operative Unit – 3/11/20 @ approximately 0945 by A. McLain
During a tour of the environment, the following items were noted to be past the expiration date and were still available for use.
• IV catheters expired 1/20
• IV start kits expired 12/19
Staff present (#11) confirmed the finding.

Observed in the Emergency Department – 3/10/20 @ approximately 1045 by G. Miller
During a tour of the environment, the following items were noted to be past the expiration date and were still available for use.
• Blood collection tubes expired 1/31/20

• Culture swabs expired 2/20/19
• Urine specimen tubes expired 1/31/19
• Mucus traps expired 9/19/19
Staff present (#4) confirmed the finding.

**Action Plan**
Action #1

1. **Pre-OP/Post-OP unit will no longer keep product on Mobile Nurse Cart. All supplies will be returned to main supply area where the Distribution Technician currently monitors outdates.**
2. **Emergency Department: Lab staff deliver product to ED and will review lab supplies for outdates that are stocked in ED. They will sign off weekly that they did their check.**
3. **Pre-op/Post-Op – Yes. Distribution Tech will continue to monitor main supply area for out dates and log this on a weekly basis. Pre-OP/Post-OP staff will double check Mobile Nurse Cart to ensure supplies are return to stock room.**
4. **Emergency Department – Lab staff who deliver supplies to ED will check current supplies for outdates. A sign off sheet will be placed for them to initial this task has been done once a week. Materials will add this to the spreadsheet on a monthly basis to ensure checks are being done.**

Title of Person Responsible for Implementing the Action: **- Assistant Director of Materials Management**
Date Action Plan was or will be Implemented: **4/1/2020**
Is a Monitoring Plan Required?: yes
Monitoring Plan
What will be monitored: Outdate checks to ensure they are being done weekly
What is the sample size: 100
What is the threshold of compliance: 100
How frequently will monitoring occur: Weekly
How long will the monitoring last: 24 weeks (6 months), or 4 weeks per month for weekly out
Who will oversee the monitoring: Assistant Director of Materials Management
What committee in the QAPI program will receive reports on the results: Board Quality

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Deficiency #15
Level: Standard–Level
CE-11: Ventilation, Lighting & Temperature Control
Requirement: C

**The standard was not met as evidenced by the following**
Observed during the Building Tour – 3/10/20 @ approximately 1540 by D. Roush
During a tour of the environment, it was noted that the main linen storage room was required to be positive pressure and tested as negative pressure. This is a violation of ANSI/ASHRAE/ASHE Standard 170-2008: Ventilation of Health Care Facilities. Staff present (#5) confirmed the finding.

**Action Plan**
Action #1

Engineering adjusted supply air damper and verified positive room pressure with testing guage per work order 203877 completed on 3/26/20. This room was added to quarterly PM to monitor room pressure.

Title of Person Responsible for Implementing the Action: **Plant Operations Manager**
Date Action Plan was or will be Implemented: **3/26/2020**
Is a Monitoring Plan Required?: yes
Monitoring Plan
What will be monitored: positive linen room pressure
What is the sample size: 100
What is the threshold of compliance: 100
How frequently will monitoring occur: Quarterly
How long will the monitoring last: Ongoing
Who will oversee the monitoring: Plant Operations Manager
What committee in the QAPI program will receive reports on the results: Safety committee

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Deficiency #17
Level: Standard–Level
CE-11: Ventilation, Lighting & Temperature Control
Requirement: C

**The standard was not met as evidenced by the following**
Observed during the Building Tour – 3/11/20 @ approximately 1312 by D. Roush
During a tour of the environment, it was noted that the biohazard room (C1185) was required to be negative pressure and tested as

positive pressure that was located in wound care department. This is a violation of ANSI/ASHRAE/ASHE Standard 170-2008: Ventilation of Health Care Facilities. Staff present (#5) confirmed the finding.

**Action Plan**
Action #1

Engineering to engage Mechanical Engineer to create building plans to extend adjacent exhaust into the room. Plans will be submitted to OSHPD for approval. Due to shelter in place, the process cannot be expedited through field review or over the counter methods. Typical OSHPD appoval turnaround is 30 days from submission. Mechanical Contractor to extend exhaust and create negative pressure room. Once this room has been modified, it will be added to the PM for quarterly testing/monitoring. Meanwhile the biohazard waste is relocated to room 1190A with negative pressure.

Title of Person Responsible for Implementing the Action: **Plant Operations Manager**
Date Action Plan was or will be Implemented: **5/16/2020**
Is a Monitoring Plan Required?: yes

Monitoring Plan
What will be monitored: negative pressure wound care room
What is the sample size: 100
What is the threshold of compliance: 100
How frequently will monitoring occur: Quarterly
How long will the monitoring last: Ongoing
Who will oversee the monitoring: Plant Operations Manager
What committee in the QAPI program will receive reports on the results: Safety Committee

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Deficiency #18
Level: Standard–Level
CE-13: Testing of Emergency Power Generators
Requirement: B

**The standard was not met as evidenced by the following**
Observed during Document Review – 3/10/20 @ approximately 0940 by D. Roush
During a review of documents, it was noted that the 2019 monthly testing of the automatic transfer switch related to the 250 KW generator was not available at the time of the survey for review. This is a violation of NFPA 110-2010, 8.4.6; 8.4.6.1. Staff present (#5) confirmed the finding.

**Action Plan**
Action #1

Transfer switches have been labeled as #1, #2, and #3. The testing log has been modified to show the 3 transfer switches.
The Engineer will track which transfer switch was used to initiate the monthly test and document on the testing log that a different switch was used each time testing was conducted.

Title of Person Responsible for Implementing the Action: **Plant Operations Manager**
Date Action Plan was or will be Implemented: **3/11/2020**
Is a Monitoring Plan Required?: no

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Deficiency #19
Level: Standard–Level
CE-15: Compliance to the NFPA Life Safety Code
Requirement: A

**The standard was not met as evidenced by the following**
Observed during Document Review – 3/10/20 @ approximately 1137 by D. Roush
During a review of the documents, it was noted that when a fire watch was initiated it was not performed continuously. A fire watch has to be continuous. This is a violation of NFPA 25-2011, A.15.5.2(4)(b). Staff present (#5) confirmed the finding.

Observed during the Building Tour – 3/10/20 @ approximately 1211 by D. Roush
During a tour of the environment, it was noted that the piping for approved automatic sprinkler systems was being used to support other items in the following areas:
• Computed tomography room construction site, condensate line was tied to sprinkler line
• Material management department, sprinkler line was supporting wires
• Maintenance shop, sprinkler line was supporting HVAC ductwork
• Surgery west wing, sprinkler line was supporting wires
This is a violation of NFPA 25-2011, 5.2.2.2. Staff present (#5) confirmed the findings.

Observed during the Building Tour – 3/10/20 @ approximately 1320 by D. Roush
During a tour of the environment, it was noted that the fire/smoke rated wall or ceiling had penetration(s) that were not properly sealed with fire stopping material in the following areas:

• Engineering corridor by cross corridor door leading to west wing, in ceiling ½" conduit and a 6" pipe going through the wall
• Environmental service storeroom in the basement, in ceiling 8" air duct going through the wall
• Main linen storage room (WB-121), 16"x7" section of drywall cut out of the rated wall
This is a violation of NFPA 101-2012, 8.3.5. Staff present (#5) confirmed the findings.

Observed During the Building Tour – 3/10/20 @ approximately 1420 by D. Roush
During a tour of the environment, it was noted that the smoke detector was closer than 36 inches from an air supply or return diffuser in the following locations:
• Basement elevators
• Old ER by room C-1265
• Medical records corridor by bathroom
• Cafeteria entrance
This is a violation of NFPA 72-2010, A.17.7.4.1. Staff present (#5) confirmed the findings.

Observed during the Building Tour – 3/10/20 @ approximately 1455 by D. Roush
During a tour of the environment, it was noted that the doors did not have a fire rating label to the following hazardous rooms:
• Environmental storeroom in basement (WB-118)
• Housekeeping main linen storage room (WB-121)
Rated doors must have a visible rating plate. This is a violation of NFPA 101-2012, 8.3.4. Staff present (#5) confirmed the findings.

Observed during the Building Tour – 3/10/20 @ approximately 1620 by D. Roush
During a tour of the environment, it was noted that the fire rated north side stairwell door did not latch when closed that was located in the basement. This is a violation of NFPA 101-2012, 8.1/8.3.3.1. Staff present (#5) confirmed the finding.

Observed during the Building Tour – 3/11/20 @ approximately 1302 by D. Roush
During a tour of the environment, it was noted that two (2) relocatable power strips were not affix to the equipment or wall in the magnetic resonance imaging trailer control room. This is a violation of NFPA 99-2012 10.2.3.6, NFPA 70-2011, 240.5 (3), CMS CoP, A-0701. Staff present (#5) confirmed the finding.

Observed During the Building Tour – 3/11/20 @ approximately 1336 by D. Roush
During a tour of the environment, it was noted that non-fire-retardant wood shelving was installed in chemical storage room E-1157 of the dietary department. Non-fire-retardant wood shelving cannot be used in this area. This is a violation of NFPA 101-2012 19.1.6.6. Staff present (#5) confirmed the finding.

Observed during the Building Tour – 3/11/20 @ approximately 1352 by D. Roush
During a tour of the environment, it was noted that the electrical receptacle next to the sink had no ground fault circuit interrupt protection that was located next to the lab sink. This is a violation of NFPA 70-2014, 550.13. Staff present (#5) confirmed the finding.

**Action Plan**
Action #1

CE15 A-1
The document reviewed during survey was the Fire Watch policy. Surveyor noted that the policy did not state that fire watch duties were to be conducted on a continuous basis. The Plant Operations Manager modified the Fire Watch policy to add the clarification that fire watch duties are continuous. The policy reflects OSHPD Pin 14 language. This policy will complete its approval process through all committees by 7/2/20. Engineering adherence to continuous fire watch is effective immediately.

Title of Person Responsible for Implementing the Action: **Plant Operations Manager**
Date Action Plan was or will be Implemented: **3/11/2020**
Is a Monitoring Plan Required?: no
Action #2

CE15 A-2
All corrective actions have been completed. CT Construction site - completed by General Contractor - Dome Construction; Materials Mgt. department - completed by Engineer per work order 203858 on 3/23/20; Maintenance shop - completed by Engineer per work order 203859 on 3/24/20; Surgery west wing - completed by Engineer per work order 203860 3/23/20.

Title of Person Responsible for Implementing the Action: **Plant Operations Manager**
Date Action Plan was or will be Implemented: **3/23/2020**
Is a Monitoring Plan Required?: no
Action #3

CE15 - A-3
All corrective actions have been completed. Engineering corridor - Engineer completed per work order 203334 on 3/11/20; Environmental service storeroom - Engineer completed per work order 203861 on 3/23/20; Main linen storage room - Engineer completed per work order 203335 on 3/13/20.

Title of Person Responsible for Implementing the Action: **Plant Operations Manager**
Date Action Plan was or will be Implemented: **3/11/2020**
Is a Monitoring Plan Required?: no

Action #4
CE15 A-4
Basement elevators - Engineer completed per work order 203837 on 3/11/20;  Old ER by room C-1265 - Engineer completed per work order 203862 on 3/25/20; Medical Records corridor - Engineer completed per work order 203836 on 3/18/20; Cafeteria entrance - Engineer will complete per work order 203863 by 4/30/20.

Title of Person Responsible for Implementing the Action: **Plant Operations Manager**
Date Action Plan was or will be Implemented: **3/11/2020**
Is a Monitoring Plan Required?: no
Action #5
CE15 - A-5
Engineering engaged licensed vendor Intertek to certify and label doors.  Work was completed by the vendor on 3/30/20.

Title of Person Responsible for Implementing the Action: **Plant Operations Manager**
Date Action Plan was or will be Implemented: **3/30/2020**
Is a Monitoring Plan Required?: yes
Monitoring Plan
What will be monitored: door fire rating
What is the sample size: 100
What is the threshold of compliance: 100
How frequently will monitoring occur: Quarterly
How long will the monitoring last: Ongoing
Who will oversee the monitoring: Plant Operations Manager
What committee in the QAPI program will receive reports on the results: Safety Committee
Action #6
CE15 - A-6
Engineer adjusted door and confirmed it was latching per work order 203867 on 3/10/20

Title of Person Responsible for Implementing the Action: **Plant Operations Manager**
Date Action Plan was or will be Implemented: **3/10/2020**
Is a Monitoring Plan Required?: no
Action #7
CE15 - A-7
Engineer affixed power strips per work order 203394 on 3/16/20.

CE15 - A-8
Engineer will paint the shelf with fire-retardant paint per work order 203366 by 4/30/20.

CE15 - A-9
Engineer added a ground fault interrupter receptacle next to the sink per work order 203332 on 3/11/20.

Title of Person Responsible for Implementing the Action: **Plant Operations Manager**
Date Action Plan was or will be Implemented: **3/11/2020**
Is a Monitoring Plan Required?: no

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Deficiency #20
Level: Standard–Level
CE-18: Fire Drills
Requirement: A

**The standard was not met as evidenced by the following**
Observed during Document Review – 3/10/20 @ approximately 1051 by D. Roush
During a review of the documents, it was noted that the fire drills conducted in 2019 were not held at unexpected times. 3 of 4, 3rd shift drills were conducted at approximately 0500. This is a violation of NFPA 101-2012, A.19.7.1.4. Staff present (#5) confirmed the finding.

Observed during Document Review – 3/10/20 @ approximately 1053 by D. Roush
During a review of the documents, it was noted that the 2019 fire drills did not include documentation of the transmission of the fire alarm signal during fire drills. This is a violation of NFPA 101-2012, 19.7.1.4. Staff present (#5) confirmed the finding.

Observed during Document Review – 3/10/20 @ approximately 1057 by D. Roush
During a review of the documents, it was noted that the annual surgery department fire drill for 2019 was not available at the time of the survey for review. This is a violation of NFPA 99-2012, 15.13.3.10.3. Staff present (#5) confirmed the finding.

**Action Plan**
Action #1

CE18 - A-1
Plant Operations Manager has reviewed fire drill timings. Unannounced fire drills will be scheduled at different times at least 1.5 hours apart from previous drills. Fire drills times will be on the annual schedule and pre-scheduled to meet the unexpected time parameters.

Title of Person Responsible for Implementing the Action: **Plant Operations Manager**
Date Action Plan was or will be Implemented: **4/30/2020**
Is a Monitoring Plan Required?: no
Action #2
CE18 - A-2
Plant Operations Manager modified fire drill documentation form to include a line verifying signal transmission to the monitoring company.

Title of Person Responsible for Implementing the Action: **Plant Operations Manager**
Date Action Plan was or will be Implemented: **3/17/2020**
Is a Monitoring Plan Required?: no
Action #3
CE18 - A-3
Plant Operations Manager will create an annual calendar of fire drills and assign and Engineer to complete the task.

Title of Person Responsible for Implementing the Action: **Plant Operations Manager**
Date Action Plan was or will be Implemented: **4/30/2020**
Is a Monitoring Plan Required?: no

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Deficiency #21
Level: Condition–Level
CE-19: Inspection & Testing of Life Safety Systems
Requirement: A

**The standard was not met as evidenced by the following**
Observed during Document Review – 3/10/20 @ approximately 1100 by D. Roush
During a review of documents, it was noted that the 2019 testing of the smoke detectors indicated that nine (9) smoke detectors were not tested and no additional testing related to the smoke detectors was available at the time of the survey for review. This is a violation of NFPA 72-2010, Table 14.4.5. Staff present (#5) confirmed this finding.

Observed during Document Review – 3/10/20 @ approximately 1118 by D. Roush
During a review of documents, it was noted that the 2019 quarterly testing of the supervisory signal devices was conducted more than three (3) months and ten (10) after the date of the last event. This is a violation of NFPA 72-2010, Table 14.4.5; NFPA 25-2011, 13.7.1. Staff present (#5) confirmed the finding.

**Action Plan**
Action #1

CE19 - A-1
Vendor - Western States Fire Protection has been scheduled to test the missed detectors. Plant Operations Manager has instructed vendor that they must review any missed device testing with Plant Operations Manager or delegate prior to leaving the facility on the day of testing. Missed devices will be rescheduled for testing within 10 days.

Title of Person Responsible for Implementing the Action: **Plant Operations Manager**
Date Action Plan was or will be Implemented: **4/3/2020**
Is a Monitoring Plan Required?: yes
Monitoring Plan
What will be monitored: testing of the smoke detectors
What is the sample size: 100
What is the threshold of compliance: 100
How frequently will monitoring occur: Quarterly
How long will the monitoring last: Ongoing
Who will oversee the monitoring: Plant Operations Manager
What committee in the QAPI program will receive reports on the results: Safety Committee
Action #2
CE19 - A-2
Plant Operations Manager has requested an annual testing schedule. Vendor has committed that all quarterly inspections will not exceed 100 days. Vendor contract is being updated to add performance metrics.

Title of Person Responsible for Implementing the Action: **Plant Operations Manager**
Date Action Plan was or will be Implemented: **4/30/2020**
Is a Monitoring Plan Required?: yes
Monitoring Plan
What will be monitored: quarterly testing of the supervisory signal devices

What is the sample size: 100
What is the threshold of compliance: 100
How frequently will monitoring occur: Quarterly
How long will the monitoring last: Ongoing
Who will oversee the monitoring: Plant Operations Manager
What committee in the QAPI program will receive reports on the results: Safety Committee

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Deficiency #22
Level: Condition–Level
CE-19: Inspection & Testing of Life Safety Systems
Requirement: B

**The standard was not met as evidenced by the following**
Observed during Document Review – 3/10/20 @ approximately 1103 by D. Roush
During a review of documents, the five (5) year internal inspection of the sprinkler line was not available at the time of the survey for review. This is a violation NFPA 25-2011, 14.2.1. Staff present (#5) confirmed the finding.

Observed during Document Review – 3/10/20 @ approximately 1112 by D. Roush
During a review of the documents, it was noted that the 2019 annual testing of main drains did not include the return to normal time. This is a violation of NFPA 25-2011, 13.2.5, A.13.2.5(6). Staff present (#5) confirmed the finding.

Observed during Document Review – 3/10/20 @ approximately 1118 by D. Roush
During a review of the documents, it was noted that the 2019 quarterly testing of the fire department connections was conducted more than three (3) months and ten (10) after the date of the last event. This is a violation of NFPA 72-2010, Table 14.4.5; NFPA 25-2011, 13.7.1. Staff present (#5) confirmed the finding.

**Action Plan**
Action #1

CE19 - B-1
Plant Operations Manager is scheduling inspection of sprinkler lines to be completed by 4/30/20.

Title of Person Responsible for Implementing the Action: **Plant Operations Manager**
Date Action Plan was or will be Implemented: **4/30/2020**
Is a Monitoring Plan Required?: no
Action #2
CE19 - B-2
Vendor - Western States Fire Protection has committed to add the line "return to pressure" and record the time that main drains are returned to Normal pressure. Plant Operations Manager will validate that this change has occurred.

Title of Person Responsible for Implementing the Action: **Plant Operations Manager**
Date Action Plan was or will be Implemented: **4/30/2020**
Is a Monitoring Plan Required?: no
Action #3
CE19 - B-3
Plant Operations Manager has requested an annual testing schedule. Vendor has committed that all quarterly inspections will not exceed 100 days. Vendor contract is being updated to add performance metrics.

Title of Person Responsible for Implementing the Action: **Plant Operations Manager**
Date Action Plan was or will be Implemented: **4/30/2020**
Is a Monitoring Plan Required?: yes
Monitoring Plan
What will be monitored: quarterly testing of the fire department connections
What is the sample size: 100
What is the threshold of compliance: 100
How frequently will monitoring occur: Quarterly
How long will the monitoring last: Ongoing
Who will oversee the monitoring: Plant Operations Manager
What committee in the QAPI program will receive reports on the results: Safety Committee

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Deficiency #24
Level: Condition–Level
CE-19: Inspection & Testing of Life Safety Systems
Requirement: F

**The standard was not met as evidenced by the following**
Observed during Document Review – 3/10/20 @ approximately 1109 by D. Roush
During a review of the documents, it was noted that the 2019 testing of the air handling unit shutdown devices for the air handling

equipment was not available at the time of the survey for review. This is a violation of NFPA 90A-2010, 6.4.1. Staff present (#5) confirmed the finding.

**Action Plan**
Action #1

CE19 - F-1
Vendor - Western States Fire Protection "WSFP" process was to test that signal was sent to Air Handler Units "AHU" from the duct detector to shutdown the unit. Vendor will change the testing procedure to leave AHU's active during duct detector testing and validate actual shutdown and restart of the AHU. WSFP will add a line item on the testing form to document this activity.

Title of Person Responsible for Implementing the Action: **Plant Operations Manager**
Date Action Plan was or will be Implemented: **4/30/2020**
Is a Monitoring Plan Required?: yes

Monitoring Plan
What will be monitored: testing of the air handling unit shutdown devices
What is the sample size: 100
What is the threshold of compliance: 100
How frequently will monitoring occur: Annually
How long will the monitoring last: Ongoing
Who will oversee the monitoring: Plant Operations Manager
What committee in the QAPI program will receive reports on the results: Safety Committee

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Deficiency #26
Level: Standard–Level
CE-21: Compliance to the NFPA Health Care Facilities Code
Requirement: A

**The standard was not met as evidenced by the following**
Observed during the Building Tour – 3/10/20 @ approximately 1141 by D. Roush
During a tour of the environment, it was noted that the gas cylinders were not protected from the elements with any protective covering in the bulk oxygen tank area. This is a violation of NFPA 99-2012, 11.6.5.4 (3). Staff present (#5) confirmed the finding.

**Action Plan**
Action #1

CE21 - A-1
Engineering will add a cover to protect the O2 cylinders per work order 203879.

Title of Person Responsible for Implementing the Action: **Plant Operations Manager**
Date Action Plan was or will be Implemented: **4/24/2020**
Is a Monitoring Plan Required?: no

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Deficiency #27
Level: Standard–Level
CE-21: Compliance to the NFPA Health Care Facilities Code
Requirement: B

**The standard was not met as evidenced by the following**
Observed during the Building Tour – 3/10/20 @ approximately 1150 by D. Roush
During a tour of the environment, it was noted that the emergency oxygen supply connection did not have physical protection to prevent unauthorized tampering. This is a violation of NFPA 99-2012, 5.1.3.5.13.2(1). Staff present (#5) confirmed the finding.

**Action Plan**
Action #1

CE21 - B-1
Engineer added padlock to prevent tampering per work work 203868 on 3/24/20.

Title of Person Responsible for Implementing the Action: **Engineer added padlock to prevent tampering per**
Date Action Plan was or will be Implemented: **3/24/2020**
Is a Monitoring Plan Required?: no

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Deficiency #28
Level: Standard–Level
CE-21: Compliance to the NFPA Health Care Facilities Code
Requirement: C

**The standard was not met as evidenced by the following**
Observed during Document Review – 3/10/20 @ approximately 1115 by D. Roush
During a review of documents, it was noted that the organization did not have documentation of monthly inspection of the ground fault circuit interrupters as required by the manufacturer available at the time of the survey for review. This is a violation of NFPA 99-2012, 6.3.4.1.2. Staff present (#5) confirmed the finding.

Observed during the Building Tour – 3/11/20 @ approximately 1418 by D. Roush
During a tour of the environment, it was noted that the operating rooms did not have line isolation monitors and no record of a risk assessment to determine if the operating rooms were wet locations or protected with ground-fault circuit interrupters was available at the time of the survey for review. This is a violation of NFPA 99-2012, 6.3.2.2.8.4; 6.3.2.2.8.7; 6.4.4.2. Staff present (#5) confirmed the finding.

Observed during the Building Tour – 3/11/20 @ approximately 1445 by D. Roush
During a tour of the environment, it was noted that the electrical extension cords used in the operating rooms had not been evaluated for compliance with meeting the total connective load of 75% of devices being plugged into them at any one time. This is violation of NFPA 70-2011, 110.3(a)(7) Staff present (#5) confirmed the finding.

**Action Plan**
Action #1

CE21 - C-1

Engineering to engage Electrical Engineer to create building plans to replace receptacles with ground fault interrupter "GFI" receptacles in each OR. Plans will be submitted to OSHPD for approval. Due to shelter in place, the process cannot be expedited through field review or over the counter methods. Typical OSHPD appoval turnaround is 30 days from submission. Electrical Contractor to install GFI. Once this room has been modified, it will be added to the PM for monthly testing.

Title of Person Responsible for Implementing the Action: **Plant Operations Manager**
Date Action Plan was or will be Implemented: **5/16/2020**
Is a Monitoring Plan Required?: yes
Monitoring Plan
What will be monitored: monthly inspection of the ground fault circuit interrupt
What is the sample size: 100
What is the threshold of compliance: 100
How frequently will monitoring occur: Monthly
How long will the monitoring last: Ongoing
Who will oversee the monitoring: Plant Operations Manager
What committee in the QAPI program will receive reports on the results: Safety Committee
Action #2
CE21 - C-2
Engineering to engage Electrical Engineer to create building plans to replace receptacles with ground fault interrupter "GFI" receptacles in each OR. Plans will be submitted to OSHPD for approval. Due to shelter in place, the process cannot be expedited through field review or over the counter methods. Typical OSHPD appoval turnaround is 30 days from submission. Electrical Contractor to install GFI. Once this room has been modified, it will be added to the PM for monthly testing.

Title of Person Responsible for Implementing the Action: **Plant Operations Manager**
Date Action Plan was or will be Implemented: **7/31/2020**
Is a Monitoring Plan Required?: yes
Monitoring Plan
What will be monitored: ground fault interrupter receptacles in each OR
What is the sample size: 100
What is the threshold of compliance: 100
How frequently will monitoring occur: Monthly
How long will the monitoring last: Ongoing
Who will oversee the monitoring: Plant Operations Manager
What committee in the QAPI program will receive reports on the results: Safety Committee
Action #3
CE21 - C-3
Biomedical Engineer will evaluate all power strips used in ORs for 75% total connected load. Each power strip will be labeled with maximum allowed load. Engineer per work order 203874 will test loads and label equipment with actual load of the equipment on the cord near the plug and equipment.

Title of Person Responsible for Implementing the Action: **Plant Operations Manager**
Date Action Plan was or will be Implemented: **4/30/2020**
Is a Monitoring Plan Required?: yes
Monitoring Plan
What will be monitored: extension cords used in the operating rooms
What is the sample size: 100

What is the threshold of compliance: 100
How frequently will monitoring occur: Annually
How long will the monitoring last: Ongoing
Who will oversee the monitoring: Plant Operations Manager
What committee in the QAPI program will receive reports on the results: Safety Committee

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Deficiency #29
Level: Standard–Level
IC-03: Infection Prevention & Control Policies
Requirement: A

**The standard was not met as evidenced by the following**
Observed in the Emergency Department – 3/10/20 @ approximately 1050 by G. Miller
During a tour of the environment, it was noted that the medication room contains a sink. Permeable supplies were found stored on the counter next to the sink. Sinks are considered a contaminated environment and clean supplies should not be stored within three feet of the sink due to potential contamination if the water is activated. A functional separation needs to occur between the sink and the counter. Staff present (#4) confirmed the finding.

Observed on the Post Anesthesia Care Unit – 3/11/20 @ approximately 1356 by D. Roush
During a tour of the environment, it was noted that hand sanitizer by the nurse station expired in June 2019 and was available for use. Staff present (#5) confirmed the finding.

**Action Plan**
Action #1

IC3 - A-1
Engineer will add a splash guard to the medication sink per work order 204002.

Title of Person Responsible for Implementing the Action: **Plant Operations Manager**
Date Action Plan was or will be Implemented: **4/30/2020**
Is a Monitoring Plan Required?: no
Action #2
we no longer use that type of hand sanitizer and dispenser as they have all been replaced with the pump, wall dispensers. Work order to engineering for brackets to be removed from walls.

Title of Person Responsible for Implementing the Action: **Surgical Services Manager**
Date Action Plan was or will be Implemented: **4/1/2020**
Is a Monitoring Plan Required?: no

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Deficiency #30
Level: Standard–Level
IC-03: Infection Prevention & Control Policies
Requirement: B

**The standard was not met as evidenced by the following**
Observed in the Pre / Post-Operative Unit – 3/11/20 @ approximately 0945 by A. McLain
During a tour of the environment, it was noted that an excessive amount of calcification had accumulated on the down spout of an ice/water machine. Microorganisms can harbor in the calcification and then may be transmitted through the passing water to patients and staff. The down spout needs to be free of calcification. Staff present (#11) confirmed the finding.

Observed in the Imaging Department – 3/11/20 @ approximately 1040 by G. Miller
During a tour of the environment, it was noted that the pull cord in the patient bathroom was made of synthetic rope. The rope cannot be effectively cleaned between patients and can pose as a portal for the transmission of infection. Staff present (#10) confirmed the finding.

Observed in the Wound Care Clinic – 3/11/20 @ approximately 1150 by G. Miller
During a tour of the environment, it was noted that three (3) bottles of Iodoform and plain packing gauze were not sealed. Based on discussion with staff (#8), the gauze is used on multiple patients. These items are packaged as single patient use and may not be shared among patients.

Observed in the Dietary Kitchen – 3/10/20 @ approximately 1400 by G. Miller
During a tour of the environment, it was noted that a ceiling tile had staining due to water damage over the dry food storage shelving. The source of the staining should be identified, and the tile replaced. This is an infection control concern. Staff present (#6) confirmed the finding.

**Action Plan**
Action #1

IC3 - B-1
Environmental Services "EVS" Coordinator to train all staff to clean down spout daily. EVS coordinator will inspect ice machines weekly for signs of calcification.

Title of Person Responsible for Implementing the Action: **Director of Facilities**
Date Action Plan was or will be Implemented: **4/30/2020**
Is a Monitoring Plan Required?: yes

Monitoring Plan
What will be monitored: inspect ice machines weekly for signs of calcification
What is the sample size: 100
What is the threshold of compliance: 100
How frequently will monitoring occur: Weekly
How long will the monitoring last: Ongoing
Who will oversee the monitoring: Director of Facilities
What committee in the QAPI program will receive reports on the results: Safety Committee

Action #2
IC3 - B-2
Engineer replaced pull cord with plastic string per work order 203878 on 3/20/20

Title of Person Responsible for Implementing the Action: **Plant Operations Manager**
Date Action Plan was or will be Implemented: **3/20/2020**
Is a Monitoring Plan Required?: no

Action #3
IC3 - B-4
Engineer verified that there was no active leaking above ceiling tile and then replaced stained tile per work order 203362.

Title of Person Responsible for Implementing the Action: **Plant Operations Manager**
Date Action Plan was or will be Implemented: **3/12/2020**
Is a Monitoring Plan Required?: no

Action #4
Wound Care Staff to review Infection Control Policy 7471-116 and Instrument Cleaning and Processing Policy 7471-118. Wound Care staff to sign an attestation regarding the understanding of stated policies. Monitoring of storage and proper positioning of instruments will be done by Wound Care nurse. This will be recorded in the department QA/PI program on a monthly basis.

Title of Person Responsible for Implementing the Action: **Chief Ancillary Svcs. Officer**
Date Action Plan was or will be Implemented: **4/15/2020**
Is a Monitoring Plan Required?: yes

Monitoring Plan
What will be monitored: Monitoring of storage and proper positioning of instrume
What is the sample size: 100
What is the threshold of compliance: 100
How frequently will monitoring occur: Monthly
How long will the monitoring last: Ongoing
Who will oversee the monitoring: Wound Care nurse
What committee in the QAPI program will receive reports on the results: Board Quality

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Deficiency #31
Level: Standard–Level
IC-06: Hand Hygiene
Requirement: A

**The standard was not met as evidenced by the following**
Observed in the Main Lobby – 3/11/20 @ approximately 0815 by A. McLain
During a tour of the environment, it was noted that a staff member touched her face mask; pulled her mask down to call for a patient; and replaced the face mask without performing hand hygiene before or after touching the face mask. Staff present (#2) confirmed the finding.

**Action Plan**
Action #1

1.) Immediate education via Elmeno on proper use of PPE and hand hygiene during the COVID pandemic 2.) Annual Healthstream training on proper use of PPE including masks and hand hygiene. 3.) Rounds to provide 1:1 instruction to staff on proper use of masks and hand hygiene during COVID

Title of Person Responsible for Implementing the Action: **Laboratory Manager**
Date Action Plan was or will be Implemented: **4/15/2020**
Is a Monitoring Plan Required?: no

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Deficiency #32
Level: Standard–Level
IC-06: Hand Hygiene
Requirement: B

**The standard was not met as evidenced by the following**
Observed in Sterile Process Department – 3/11/20 @ approximately 1005 by A. McLain
During a tour of the environment, it was noted that the alcohol-based hand sanitizer dispenser rack was empty therefore, alcohol-based hand sanitizer not available for staff in the department. Staff present (#11) confirmed the finding.

**Action Plan**
Action #1

we no longer use that type of hand sanitizer and dispenser as they have all been replaced with the pump, wall dispensers. Work order to engineering for brackets to be removed from walls.

Title of Person Responsible for Implementing the Action: **Surgical Services Manager**
Date Action Plan was or will be Implemented: **4/1/2020**
Is a Monitoring Plan Required?: no

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Deficiency #33
Level: Standard–Level
IC-07: Disinfection & Sterilization Practices
Requirement: B

**The standard was not met as evidenced by the following**
Observed in the Wound Care Clinic – 3/11/20 @ approximately 1115 by G. Miller
During a tour of the environment, it was noted that several scissors were not sterilized in a fully open position so as to allow for maximum steam penetration. This is inconsistent with accepted standards of care. Staff present (#8) confirmed the finding.

Observed in the Imaging Department – 3/11/20 @ approximately 1030 by G. Miller
During a tour of the environment, it was noted that the organization uses a Trophon device to disinfect intracavity probes. A review of the disinfection log failed to substantiate that there was a mechanism in place to track the specific probe used on a patient. Additionally, there were multiple times where the results of the quality control check were not documented as pass/fail. Staff present (#10) confirmed the finding.

Observed in the Emergency Department – 3/10/20 @ approximately 1115 by G. Miller
During a tour of the environment, it was noted that sterile instruments are used during beside procedures. After use, the instruments are placed into a plastic tray in the soiled utility room to be picked up by the central sterile processing department. There was no mechanism in place to assure that the instruments are kept wet to prevent the drying of bioburden while awaiting gross decontamination, nor was there a biohazard label on the container where the instruments are held. Staff present (#4) confirmed the finding.

Observed in the Wound Care Clinic – 3/11/20 @ approximately 1200 by G. Miller
During a tour of the environment, it was noted that sterile instruments are used during beside procedures. After use, the instruments are transported through a public corridor and placed into a plastic tray in a holding area to be picked up by the central sterile processing department. Instruments should be transported in an impervious container marked with biohazard labeling when transported. Additionally, there was no mechanism in place to assure that the instruments are kept wet to prevent the drying of bioburden while awaiting gross decontamination. Staff present (#8) confirmed the finding.

Observed in the ICU – 3/10/20 @ approximately 1030 by A. McLain
During a tour of the environment, it was noted that sterile instruments are used during beside procedures. After use, the instruments are placed in the soiled utility room to be picked up by the central sterile processing department. There was no mechanism in place to assure that the instruments are kept wet to prevent the drying of bioburden while awaiting gross decontamination, nor was there a properly labeled container available to hold the instruments. Staff present (#1) confirmed the finding.

**Action Plan**
Action #1

Create a chart to post in ED and ICU dirty utility rooms with the following instructions:
a. gross decontamination process for used reprocessable instruments;
b. an Impervious container with lid and biohazard label will be provided by surgery department for placing dirty instruments after gross decontamination;
c. Enzymatic solution with instructions for use will be provided to these units by surgery department. Instructions for reorder will be given. Instructions for instruments to be soaked in water plus measured quantity according to IFU for enzymatic will be given by surgery department.
d. Instruments will be left in closed biohazard labelled impervious container until either delivery to surgery department or weekly collection by surgery department personnel.

Title of Person Responsible for Implementing the Action: **Surgical Services Manager**
Date Action Plan was or will be Implemented: **4/15/2020**
Is a Monitoring Plan Required?: no
Action #2
The Ultra Sound Tech visually verify that the indicator indicator strip has changed color from Red to Yellow. Yellow is a pass. A label prints out when a cycle is ran and the label is entered in the log book and will be marked pass/fail. If indicator remains red, the test is rerun with new supplies. Going forward a patient label will be entered into the log with the testing confirmation.

Title of Person Responsible for Implementing the Action: **Director of Meidal Imaging**
Date Action Plan was or will be Implemented: **3/13/2020**
Is a Monitoring Plan Required?: yes
Monitoring Plan
What will be monitored: Trophan quality control
What is the sample size: 100
What is the threshold of compliance: 100
How frequently will monitoring occur: Monthly
How long will the monitoring last: Ongoing
Who will oversee the monitoring: Director of Medical Imaging
What committee in the QAPI program will receive reports on the results: Board Quality
Action #3
Wound Care Staff to review Infection Control Policy 7471-116 and Instrument Cleaning and Processing Policy 7471-118. Wound Care staff to sign an attestation regarding the understanding of stated policies. Wound care staff will monitor scissors returned from Central Sterile ensuring that they are packaged and positioned in a fully open position. If they are not, the scissors will be returned for resterilization. This will be recorded in the department QA/PI program on a monthly basis.

Title of Person Responsible for Implementing the Action: **Chief Ancillary Svcs. Officer**
Date Action Plan was or will be Implemented: **4/15/2020**
Is a Monitoring Plan Required?: yes
Monitoring Plan
What will be monitored: Wound Care scissors
What is the sample size: 100%
What is the threshold of compliance: 100%
How frequently will monitoring occur: Monthly
How long will the monitoring last: Ongoing
Who will oversee the monitoring: Chief Ancillary Svcs. Officer
What committee in the QAPI program will receive reports on the results: Board Quality

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Deficiency #34
Level: Standard–Level
EP-06: Testing of the Emergency Preparedness Plan
Requirement: E

**The standard was not met as evidenced by the following**
Observed during Document Review – 3/11/20 @ approximately 1005 by D. Roush
During a review of documents, it was noted that deficiencies and opportunities for improvement were identified during emergency response exercises. However, documentation related to corrective action to resolve these deficiencies and opportunities for all items identified was not available at the time of the survey for review. This is a violation of NFPA 99-2012, 12.5.3.3.9.7. Staff present (#5) confirmed the finding.

**Action Plan**
Action #1

EP6
Emergency Preparedness Committee will review AAR Reporting forms for improvement opportunities. They will be reviewed at the Emergency Preparedness Committee meetings and corrective actions documented. Improvement opportunities identified after Incident Command activations will be part of Emergency Prepardness Committee to resolve and document in meeting minutes.

Title of Person Responsible for Implementing the Action: **Plant Operations Manager**
Date Action Plan was or will be Implemented: **4/30/2020**
Is a Monitoring Plan Required?: yes
Monitoring Plan
What will be monitored: AAR Reporting forms
What is the sample size: 100
What is the threshold of compliance: 100
How frequently will monitoring occur: Quarterly
How long will the monitoring last: Ongoing
Who will oversee the monitoring: Plant Operations Manager
What committee in the QAPI program will receive reports on the results: Emergency Preparedness Committee

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Deficiency #35
Level: Standard–Level
EP-07: Emergency & Standby Power Systems
Requirement: A

**The standard was not met as evidenced by the following**
Observed during Document Review – 3/10/20 @ approximately 0947 by D. Roush
During a review of the documents, testing of fuel quality to American Society for Testing and Materials (ASTM) standards was not available at the time of survey for review. This is a violation of NFPA 110-2010, 8.3.8. Staff present (#5) confirmed the finding.

**Action Plan**
Action #1

Vendor - Peterson Power added the ASTM standards to the fuel tesing reports.

Title of Person Responsible for Implementing the Action: **Plant Operations Manager**
Date Action Plan was or will be Implemented: **3/23/2020**
Is a Monitoring Plan Required?: no

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Deficiency #36
Level: Standard–Level
UR-02: Utilization Review Committee
Requirement: A

**The standard was not met as evidenced by the following**
Observed during Document Review - 3/10/20 @ approximately 1030 by G. Miller
The governing body delegated the utilization function to the medical executive committee. The minutes provided from 2019 had no evidence that utilization functions including the appropriateness of admission, utilization of professional services, and continued medical necessity for inpatient stays were being monitored or reviewed. Evidence was requested but not received prior to the end of the survey. Staff present (#2) confirmed the finding.

**Action Plan**
Action #1

A Utilzation Reveiw dashboard has been created to include case mix indes, reasmission, return to ED, One Day stays, Length of Stay and PA referrals. The UR dashboard will be presented monthly to Board Quality and everyother month to Performance Improvement committee.

Title of Person Responsible for Implementing the Action: **Chief Quality Officer**
Date Action Plan was or will be Implemented: **4/1/2020**
Is a Monitoring Plan Required?: yes
Monitoring Plan
What will be monitored: Utilization Review dashboard
What is the sample size: 100
What is the threshold of compliance: 100
How frequently will monitoring occur: Monthly
How long will the monitoring last: Ongoing
Who will oversee the monitoring: Chief Quality Officer
What committee in the QAPI program will receive reports on the results: Board Quality & Performance Improvement.

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Deficiency #37
Level: Standard–Level
PR-02: Informing Patients of Their Rights
Requirement: B

**The standard was not met as evidenced by the following**
In 1 of 23 records, the following was noted
Observed on the 3rd Floor Medical Surgical Unit – 3/10/20 @ approximately 1445 by A. McLain
The medical record of Patient #4 was reviewed. It was noted that the medical record lacked documentation to provide evidence that the patient had received the MOON (Medication Outpatient Observation Notice) from Medicare. The patient had been in observation status for approximately 42 hours at the time of survey. CMS requires that Medicare beneficiaries receive this notice when they receive outpatient care for longer than 24 hours and it must be provided to them no later than 36 hours after the outpatient care begins. Staff present (#1) confirmed the finding.

**Action Plan**
Action #1

When an order is received for a patient in the ER to be admitted under Observation status the Patient Access Representative will go bedside to obtain a signature of the MOON form explaining that the stay will be covered under the Medicare Part B benefits. If the patient becomes Observation after already being admitted to the floor the Case Manager will be responsible for obtaining this signature. This form will be scanned into the patient medical record under MOON form. This will be added to the Department QAPI.

Title of Person Responsible for Implementing the Action: **Patient Access Manager**
Date Action Plan was or will be Implemented: **4/1/2020**
Is a Monitoring Plan Required?: yes
Monitoring Plan
What will be monitored: MOON form
What is the sample size: 100
What is the threshold of compliance: 100
How frequently will monitoring occur: Monthly
How long will the monitoring last: 100% of Observation accounts will be monitored until 100
Who will oversee the monitoring: Patient Access Manager
What committee in the QAPI program will receive reports on the results: Board Quality

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Deficiency #38
Level: Standard–Level
PR-06: Advance Directives
Requirement: B

**The standard was not met as evidenced by the following**
In 1 of 23 records, the following was noted
Observed in ICU – 3/10/20 @ approximately 1110 by A. McLain
The medical record of Patient #1 was reviewed. It was noted that the patient was assessed as having an advance directive on file. There was no directive in the patient's record. Staff present (#1) confirmed the finding.

**Action Plan**
Action #1

Staff to sign attestation on proper procedure for Advanced Directives. Staff to ask patients if Advanced Directive is on file here at SVH then check medical record to ensure information is correct. If medical record is incorrect it will be fixed at the time the patient is present. This will be added to Department QAPI.

Title of Person Responsible for Implementing the Action: **Patient Access Manager**
Date Action Plan was or will be Implemented: **4/1/2020**
Is a Monitoring Plan Required?: yes
Monitoring Plan
What will be monitored: Advanced Directives
What is the sample size: 30
What is the threshold of compliance: 100
How frequently will monitoring occur: Monthly
How long will the monitoring last: 3 consecutive months at 100%
Who will oversee the monitoring: Patient Access Manager
What committee in the QAPI program will receive reports on the results: Board Quality

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Deficiency #39
Level: Standard–Level
MM-05: Storage of Medications
Requirement: A

**The standard was not met as evidenced by the following**
Observed in the Emergency Department – 3/10/20 @ approximately 1040 by G. Miller
During a tour of the environment, it was noted that a 1000 mL Normal Saline IV solution found in the fluid warmer was not labeled with the date it was placed in the warmer or a beyond use date of 14 days. Staff present (#4) confirmed the finding.

**Action Plan**
Action #1

Signed attestation by all saff asserting accountabilit to policy regarding fluids in warmer.

Title of Person Responsible for Implementing the Action: **Chief Nursing Officer**
Date Action Plan was or will be Implemented: **5/1/2020**
Is a Monitoring Plan Required?: no

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Deficiency #40
Level: Standard–Level

MM-08: Security of Medications
Requirement: B

**The standard was not met as evidenced by the following**
Observed in the Cardiopulmonary Lab – 3/11/20 @ approximately 0945 by G. Miller
During a tour of the environment, it was noted that Nitroglycerin was stored in a plastic bin on the counter of the cardiac stress lab, and Aminophylline / Regadenson in a plastic box with a breakaway lock in an unlockable cabinet. There was a biomedical technician and a vendor in the area at the time of the survey. Neither of these individuals were authorized to be in an area where medications are stored without supervision. These medications would not be considered secured. Staff present (#3) confirmed the finding.

**Action Plan**
Action #1

The RT in charge of the cardiac testing had a lock placed on the cabinet where the medications are stored. The only person with a key is the RT that performs the cardiac stress testing. The key is kept with thr RT that performs the cardiac testing during business hours. After hours, the key will be stored in locked RT office.

Title of Person Responsible for Implementing the Action: **Director of Medical Imaging**
Date Action Plan was or will be Implemented: **3/11/2020**
Is a Monitoring Plan Required?: no

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Deficiency #41
Level: Standard–Level
MM-19: Availability of Patient-Specific Information
Requirement: C

**The standard was not met as evidenced by the following**
In 1 of 23 records, the following was noted
Observed during Closed Record Review – on 3/11/20 @ approximately 1510 by G. Miller
The medical record of Patient #14 was reviewed. It was noted that last review date on the medication list was 12/29/19 rather than the day of the procedure which was 1/21/20. Staff present (#3) confirmed the finding.

**Action Plan**
Action #1

a. Review with all RN staff of Surgery Department need to review patient medications and update record for any medications that are pertinent and relevant to the safe rendering of care to the patient for patients as defined by hospital policy MM8610-144, at next staff meeting 5/12/2020
b. Have attestation for all RN staff regarding medication review as noted above.

Monday through Friday, except days of no surgeries and holidays, for 3 months period. If 95% or greater are found in compliance, will then do random audits as needed. If <95%, will continue audits for additional 3 months with additional inservice discussion with nursing staff. Add to department QAPI plan.

Title of Person Responsible for Implementing the Action: **Surgical Services Manager**
Date Action Plan was or will be Implemented: **4/15/2020**
Is a Monitoring Plan Required?: yes
Monitoring Plan
What will be monitored: Moderate sedation by SCU RN outside of surgery
What is the sample size: 100
What is the threshold of compliance: 95
How frequently will monitoring occur: Monthly
How long will the monitoring last: If 95% or greater are found in compliance, will then do
Who will oversee the monitoring: Surgical Services Manager
What committee in the QAPI program will receive reports on the results: Board Quality

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Deficiency #42
Level: Standard–Level
MM-22: Medication Orders
Requirement: H

**The standard was not met as evidenced by the following**
In 1 of 23 records, the following was noted
Observed on the 3rd Floor Medical Surgical Unit – 3/10/20 @ approximately 1400 by A. McLain
The medical record of Patient #3 was reviewed. It was noted that Dilaudid 0.5mg IV was ordered PRN for pain levels between 4 and 6. In addition, Percocet was ordered PRN for pain levels between 4 and 6. The overlapping pain levels would be considered duplicate therapy. The orders did not provide sufficient direction to personnel to determine which PRN medication to administer. Staff present (#1) confirmed the finding.

**Action Plan**
Action #1

**Update Policy Ordering and Prescribing of Medications MM8610-133 to include the following changes indicated in BOLD:**

**Medication Order Types**

PRN or As Needed Orders

· The diagnosis, condition or indication for use of a PRN medication is documented in the medical record

· The order contains all of the elements of a complete medication order. (i.e., dose, route, frequency, etc)

· PRN orders written for multiple medications or doses to treat the same indication or symptoms include, as part of the order, specific parameters or criteria for the use of each medication/dose that clearly communicates and delineates when each medication or dose may be administered.

· Medication orders written with more than one route of administration (i.e. IV/PO) clearly define, as part of the order, the parameters for selecting the route of administration. ~~(i.e. may give IV if unable to take PO)~~

o **For IV and PO routes only, if two different medications are ordered with identical PRN parameters, by policy the oral route will be used by default unless clinically unavailable or not feasible, at which time the IV route will be used.**

**Verify that policy has been updated and an attestation of understanding is obtained for inpatient nurses and pharmacists.**

If in the judgment of the pharmacist or registered nurse an order concerning a drug, dose, regimen, route of administration **is unclear or** may compromise patient safety, steps will be taken to resolve the situation prior to processing the order

Title of Person Responsible for Implementing the Action: **Director of Pharmacy**
Date Action Plan was or will be Implemented: **4/30/2020**
Is a Monitoring Plan Required?: no

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Deficiency #43
Level: Standard–Level
MM-23: Pharmacy Review of Medication Orders
Requirement: A

**The standard was not met as evidenced by the following**
Observed in the Pharmacy – 3/11/20 @ approximately 1400 by G. Miller
Based on a discussion with staff/leadership present (#15), it was noted that there was no current mechanism for a pharmacist to review the dose of medication used in a screen or complete pulmonary function test prior to or after administration. Staff present (#2) confirmed the finding.

**Action Plan**
Action #1

Implement process in which Respiratory Therapist (RT) administering pulmonary function tests (PFTs) completes a log sheet that records:

· Patient Name

· Patient allergies

· Medication(s) ordered

· Dose used

· Lot/Expiration of medication

· Comments/Adverse reactions if applicable

· RT initials

The log will be faxed to pharmacist on a daily basis whenever PFTs are performed. The log will be reviewed by a pharmacist and stored in the pharmacy

Title of Person Responsible for Implementing the Action: **Director of Pharmacy**
Date Action Plan was or will be Implemented: **4/30/2020**
Is a Monitoring Plan Required?: yes

Monitoring Plan
What will be monitored: presence of completed log for all PFT patients
What is the sample size: 100
What is the threshold of compliance: 100
How frequently will monitoring occur: Monthly
How long will the monitoring last: Ongoing
Who will oversee the monitoring: Director of Pharmacy
What committee in the QAPI program will receive reports on the results: Board Quality

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Deficiency #44
Level: Standard–Level
MM-24: Preparation of Medications
Requirement: C

**The standard was not met as evidenced by the following**
Observed in the ICU - 3/10/20 @ approximately 1045 by A. McLain
During a tour of the environment, it was noted that a single pill splitter is used for multiple patients. The splitter cannot be effectively cleaned between patients. Thus, residue of medication from one patient is introduced into the medication for another patient. Each patient should have their own splitter. Staff present (#1) confirmed the finding.

**Action Plan**
Action #1

a. Implement process in which a new pill splitter is used for each patient.
b. Staff will be notified and in-serviced on new process
c. The splitter will have a pt label affixed to it and be kept in the patient's own med bin

Title of Person Responsible for Implementing the Action: **Director of Patient Care Serv.**
Date Action Plan was or will be Implemented: **4/13/2020**
Is a Monitoring Plan Required?: no

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Deficiency #45
Level: Standard–Level
MM-26: Labeling of Medications
Requirement: A

**The standard was not met as evidenced by the following**
Observed in the Outpatient Rehabilitation Clinic – 3/12/20 @ approximately 1100 by G. Miller
During a tour of the environment, it was noted that a multi-use vial of Dexamethasone was not labeled when opened with a beyond use date of 28 days. Staff present (#14) confirmed the finding.

Observed in the Wound Care Clinic – 3/11/20 @ approximately 1140 by G. Miller
During a tour of the environment, it was noted that topical medications are used during wound care. When used, the tubes are dispensed to the patient per order of the attending physician. There was no process in place for labeling the medication as required by regulation. Staff present (#8) confirmed the finding.

**Action Plan**
Action #1

Revised policy 7770-127 regarding Iontophoresis to include folowing changes in RED: 5. Single use vials of Dexamethasone are to be used and any residual will be discarded by returning to pharmacy. Staff will be educated about new policy and sign attestation. The revised policy will be posted in the staff room and available by hardcopy in office P+P book and on the Intranet under our departmentalal policies. Policy 7770-127 was revised to change the current use of multi-use vials of dexamethasone to a single use vial now available. Previously, Outpatient Rehabilitation used multi use 120 mg/30 ml vials which was found to be lacking in a label with a by use date (BUD) as required by this standard. Due to infrequency of use, per every 28 days, much product would have been wasted. In consultation c Director of Pharmacy, the suggestion was to implement concentration equivalent single use vials of 4mg/1 ml of dexamethasone and discard any remainder back to the pharmacy. This plan ensures medication is used in the appropriate time frame and will reduce waste to less than 5 ml or less per use.
This plan was instituted 4/3/20. The policy 7770-127 has been revised as of 4/3/20 and will be submitted for approval as follows:

Policy and Procedures Team: 5/6/2020
Medicine Committee: 5/14/2020
Medical Executive Board: 5/21/2020
Board Quality Committee: 5/27/2020
The Board of Directors: 7/02/20
The policy will be introduced to staff on /4/3/2020. Staff will be educated about new policy and sign attestation. The revised policy will be posted in the staff room and available by hardcopy in office P+P book and on the Intranet under our departmental policies. Monitoring will not be needed.

Title of Person Responsible for Implementing the Action: **Rehab Services Manager**
Date Action Plan was or will be Implemented: **5/1/2020**
Is a Monitoring Plan Required?: no
Action #2

As recommended by the Director of Pharmacy, Wound Care will no longer dispense topical medications. Wound Care Staff Will sign an attestation of understanding and agreement of this recommendation.

Title of Person Responsible for Implementing the Action: **Chief Ancillary Svcs. Officer**
Date Action Plan was or will be Implemented: **4/1/2020**
Is a Monitoring Plan Required?: no

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Deficiency #46
Level: Standard–Level
MM-28: Administration of Medication
Requirement: F

**The standard was not met as evidenced by the following**
In 1 of 23 records, the following was noted
Observed on the 3rd Floor Medical Surgical Unit – 3/10/20 @ approximately 1500 by A. McLain
The medical record of Patient #6 was reviewed. It was noted that Vancomycin was ordered every 12 hours. This is an antibiotic that the organization has classified as a critically timed medication. Documentation in the MAR indicated that the medication was administered outside of the 30 minute allowable window as follows:
• On 3/7/20 the medication was scheduled to be given at 0800. It was administered at 0905.
• On 3/7/20 the medication was scheduled to be given at 2000. It was administered at 2151.
• On 3/9/20 the medication was scheduled to be given at 0800. It was administered at 0912.
Staff present (#1) confirmed the finding.

**Action Plan**
Action #1

All RN staff to review medication administration policy, and sign attestation. Administration of timed IV antibiotics will be reviewed for administration within thirty minutes prior to scheduled time or thirty minutes after scheduled time, per policy. Administrations with documented appropriate delays will be excluded. This is added to QAPI plan

Title of Person Responsible for Implementing the Action: **Director of Patient Care Serv.**
Date Action Plan was or will be Implemented: **4/14/2020**
Is a Monitoring Plan Required?: yes
Monitoring Plan
What will be monitored: Administration of timed IV antibiotics
What is the sample size: 20
What is the threshold of compliance: 100
How frequently will monitoring occur: Monthly
How long will the monitoring last: Ongoing
Who will oversee the monitoring: Director of Patient Care Serv.

What committee in the QAPI program will receive reports on the results: Board Quality

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Deficiency #47
Level: Standard–Level
MR-04: Entries into the Medical Record
Requirement: D

**The standard was not met as evidenced by the following**
In 1 of 23 records, the following was noted
Observed in the PACU – 3/11/20 @ approximately 1115 by A. McLain
The medical record of Patient #18 was reviewed. It was noted that multiple vital sign values were not documented during the post-operative recovery period. A check mark was entered in lieu of a values which is not in accordance with hospital policy. Staff present (#11) confirmed the finding.

**Action Plan**
Action #1

a) Review all forms in perioperative charts for completeness for all data elements including but not limited to signatures, date, time, etc.
b) Review with all RN staff of Surgery Department need for accurate and complete documentation by all participants at next staff meeting, 5/12/2020. Will have RN's sign attestation to such.
c) Review with anesthesia group chief physician for discussion amongst group.
d) Present at Surgery Committee Meeting and review documentation requirements with all attendees on 5/14/2020.
e) Add to QAPI plan for department.

Title of Person Responsible for Implementing the Action: **Surgical Services Manager**
Date Action Plan was or will be Implemented: **4/15/2020**
Is a Monitoring Plan Required?: yes
Monitoring Plan
What will be monitored: vital sign documentation
What is the sample size: 5/day
What is the threshold of compliance: 95
How frequently will monitoring occur:
How long will the monitoring last: f 95% or greater are found in compliance, will then do r
Who will oversee the monitoring: Surgical Services Manager
What committee in the QAPI program will receive reports on the results: Board Quality

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Deficiency #48
Level: Standard–Level
MR-04: Entries into the Medical Record
Requirement: E

**The standard was not met as evidenced by the following**
In 1 of 23 records, the following was noted
Observed during Closed Record Review – 3/11/20 @ approximately 1500 by G. Miller
The medical record of Patient #14 was reviewed. A progress note entered on 1/21/20 at 1300 was not signed, therefore it was unable to be determined who was the author of the note. Staff present (#3) confirmed the finding.

**Action Plan**
Action #1

a) Review all forms in perioperative charts for completeness for all data elements including but not limited to signatures, date, time, etc.
b) Review with all RN staff of Surgery Department need for accurate and complete documentation by all participants at next staff meeting, 5/12/2020. Will have RN's sign attestation to such.
c) Review with anesthesia group chief physician for discussion amongst group.
d) Present at Surgery Committee Meeting and review documentation requirements with all attendees on 5/14/2020.
e) Add to QAPI plan for department.

Title of Person Responsible for Implementing the Action: **Surgical Services Manager**
Date Action Plan was or will be Implemented: **4/15/2020**
Is a Monitoring Plan Required?: yes
Monitoring Plan
What will be monitored: Progress note signature
What is the sample size: 5/day
What is the threshold of compliance: 95
How frequently will monitoring occur: Monthly
How long will the monitoring last: If 95% or greater are found in compliance, will then do
Who will oversee the monitoring: Surgical Services Manager
What committee in the QAPI program will receive reports on the results: Board Quality

Deficiency #49
Level: Standard–Level
MR-04: Entries into the Medical Record
Requirement: F

**The standard was not met as evidenced by the following**
In 5 of 23 records, the following was noted
Observed during Closed Record Review – 3/10/20 @ approximately 1505 by G. Miller
The medical record of Patient #11 was reviewed. It was noted that the post-sedation evaluation form was not timed by the physician, therefore it was unable to be determined if it had been performed after the procedure. Staff present (#3) confirmed the finding.

Observed during Closed Record Review – 3/11/20 @ approximately 1500 by G. Miller
The medical record of Patient #14 was reviewed. It was noted that the pre-sedation evaluation was not timed by the physician, therefore it was unable to be determined if it had been performed prior to administration of the sedation. Additionally, the admission order form and the discharge order form did not include documentation of the date and time the orders were signed by the physician. Staff present (#3) confirmed the finding.

Observed in the PACU – 3/11/20 @ approximately 1050 by A. McLain
The medical record of Patient #17 was reviewed. It was noted that the handwritten post-operative orders were not timed. Staff present (#11) confirmed the finding.

Observed in the PACU – 3/11/20 @ approximately 1130 by A. McLain
The medical record of Patient #19 was reviewed. It was noted that the pre-operative nursing assessment was not dated or timed. Staff present (#11) confirmed the finding.

Observed in the PACU – 3/11/20 @ approximately 1130 by A. McLain
The medical record of Patient #19 was reviewed. It was noted that the pre-anesthesia assessment was not timed. Staff present (#11) confirmed the finding.

**Action Plan**
Action #1

a) Review all forms in perioperative charts for completeness for all data elements including but not limited to signatures, date, time, etc.
f) Review with all RN staff of Surgery Department need for accurate and complete documentation by all participants at next staff meeting, 5/12/2020 and have attestation signed to such. (see Attestation #1)
b) Review with anesthesia group chief physician for discussion amongst group.
c) Present at Surgery Committee Meeting and review documentation requirements with all attendees, 5/14/2020.
d) Add to department QAPI.

Title of Person Responsible for Implementing the Action: **Surgical Services Manager**
Date Action Plan was or will be Implemented: **4/15/2020**
Is a Monitoring Plan Required?: yes
Monitoring Plan
What will be monitored: preanesthesia assessment
What is the sample size: 5/day
What is the threshold of compliance: If 95% or greater are found in compliance, will then do
How frequently will monitoring occur:
How long will the monitoring last: If 95% or greater are found in compliance, will then do
Who will oversee the monitoring: Surgical Services Manager
What committee in the QAPI program will receive reports on the results: Board Quality
Action #2
a) Review all forms in perioperative charts for completeness for all data elements including but not limited to signatures, date, time, etc.
b) Review with all RN staff of Surgery Department need for accurate and complete documentation by all participants at next staff meeting, 5/12/2020 Will have RN's sign attestation to such.

Title of Person Responsible for Implementing the Action: **Surgical Services Manager**
Date Action Plan was or will be Implemented: **4/15/2020**
Is a Monitoring Plan Required?: yes
Monitoring Plan
What will be monitored: Perioperative forms
What is the sample size: 5/day
What is the threshold of compliance: 95
How frequently will monitoring occur: Monthly
How long will the monitoring last: f 95% or greater are found in compliance, will then do r
Who will oversee the monitoring: Surgical Services Manager
What committee in the QAPI program will receive reports on the results: Board Quality
Action #3

a) Review all forms in perioperative charts for completeness for all data elements including but not limited to signatures, date, time, etc.
b) Review with all RN staff of Surgery Department need for accurate and complete documentation by all participants at next staff meeting, 5/12/2020 Will have RN's sign attestation to such. (see Attestation #1)
c) Review with anesthesia group chief physician for discussion amongst group.
d) Present at Surgery Committee Meeting and review documentation requirements with all attendees on 5/14/2020.
e) Add to QAPI plan for department.

Title of Person Responsible for Implementing the Action: **Surgical Services Manager**
Date Action Plan was or will be Implemented: **4/15/2020**
Is a Monitoring Plan Required?: yes

Monitoring Plan
What will be monitored: perioperative charts for completeness
What is the sample size: 5/day
What is the threshold of compliance: 95
How frequently will monitoring occur: Monthly
How long will the monitoring last: If 95% or greater are found in compliance, will then do
Who will oversee the monitoring: Surgical Services Manager
What committee in the QAPI program will receive reports on the results: Board Quality

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Deficiency #50
Level: Standard–Level
MR-05: Minimum Content of the Medical Record
Requirement: B

**The standard was not met as evidenced by the following**
In 3 of 23 records, the following was noted
Observed in the PACU – 3/11/20 @ approximately 1130 by A. McLain
The medical record of Patient #19 was reviewed. It was noted that the history and physical examination had been performed prior to admission/registration. There was an update in the record, but it did not include that an examination of the patient, including any changes in the patient's condition had been performed. The only documentation was the physician's signature, date and time. Staff present (#11) confirmed the finding.

Observed in the PACU – 3/11/20 @ approximately 1145 by A. McLain
The medical record of Patient #20 was reviewed. It was noted that the record lacked documentation of an updated examination of the patient, including any changes in the patient's condition on the day of registration. The H&P had been performed the day prior to admission. Staff present (#11) confirmed the finding.

Observed on the 3rd Floor Medical Surgical Unit – 3/10/20 @ approximately 1400 by A. McLain
The medical record of Patient #3 was reviewed. It was noted that the record failed to substantiate that an update to an H&P was performed within required timeframes. There was an update in the record, but the entry was not timed; so, there was no way to determine when it had been made. Staff present (#1) confirmed the finding.

**Action Plan**
Action #1

a) Will now place updated H&P stamp on every patient pre-surgery History and Physical that includes "patient examined". Review forms "Consent to Surgery" for proceduralists name, date and time to be documented.
b) Review with all RN staff of Surgery Department need to review H&P for accurate and complete documentation regarding H&P update definition that H&P must be within 24 hours from time of patient admission and prior to procedure/surgery, at staff meeting, 5/12/2020 and have attestation signed to such.
c) Present at Surgery Committee Meeting and review documentation requirements with all attendees 5/14/2020.
d) Add to department QAPI.

Title of Person Responsible for Implementing the Action: **Surgical Services Manager**
Date Action Plan was or will be Implemented: **4/15/2020**
Is a Monitoring Plan Required?: yes

Monitoring Plan
What will be monitored: H&P
What is the sample size: 5/day
What is the threshold of compliance: 95
How frequently will monitoring occur: Monthly
How long will the monitoring last: If 95% or greater are found in compliance, will then do
Who will oversee the monitoring: Surgical Services Manager
What committee in the QAPI program will receive reports on the results: Board Quality

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Deficiency #51
Level: Standard–Level
MR-05: Minimum Content of the Medical Record
Requirement: G

**The standard was not met as evidenced by the following**
In 3 of 23 records, the following was noted
Observed during Closed Record Review – 3/11/20 @ approximately 1520 by G. Miller
The medical record of Patient #14 was reviewed. It was noted that the record contained documentation of administration of Lidocaine for a lung biopsy. The dose of Lidocaine administered was not documented by the physician or by the nursing staff. Staff present (#3) confirmed the finding.

Observed during Closed Record Review – 3/11/20 @ approximately 1545 by G. Miller
The medical record of Patient #16 was reviewed. It was noted that the record contained documentation of administration of Lidocaine with and without Epinephrine for a breast biopsy. The dose of Lidocaine administered was not documented by the physician or by the nursing staff. Staff present (#3) confirmed the finding.

Observed during Closed Record Review – 3/11/20 @ approximately 1520 by G. Miller
The medical record of Patient #14 was reviewed. The record contained documentation of administration of Fentanyl (200mcg) and Versed (4mg) for sedation during a lung biopsy. It was noted that there was no physician order in the record for the sedation medications. Staff present (#3) confirmed the finding.

**Action Plan**
Action #1

a) Implement use of paper form 2900771 “Moderate Sedation Medication Order Set” for each moderate sedation case for physician ordering and signature. Form 2900771 will become part of moderate sedation packet for RNs going outside of Surgery Department for moderate sedation cases.
b) Inservice all Surgery Department RN’s regarding form and its use at next staff meeting, 5/12/2020 and have signed attestation to such. (See Attestation #2)
c) Add to department QAPI.

Title of Person Responsible for Implementing the Action: **Surgical Services Manager**
Date Action Plan was or will be Implemented: **4/15/2020**
Is a Monitoring Plan Required?: yes
Monitoring Plan
What will be monitored: Moderate Sedation Medication Order Set
What is the sample size: 5/day
What is the threshold of compliance: 95
How frequently will monitoring occur: Monthly
How long will the monitoring last: If 95% or greater are found in compliance, will then do
Who will oversee the monitoring: Surgical Services Manager
What committee in the QAPI program will receive reports on the results: Board Quality

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Deficiency #52
Level: Standard–Level
QS-01: Fall Management Program
Requirement: B

**The standard was not met as evidenced by the following**
In 1 of 23 records, the following was noted
Observed in the Emergency Department – 3/10/20 @ approximately 1140 by G. Miller
The medical record of Patient #7 was reviewed. It was noted that emergency department patients are not individually assessed for risk of a fall. There was no evidence provided that an environmental risk assessment had been completed as required by the standard. Staff present (#4) confirmed the finding.

**Action Plan**
Action #1

Conduct environmental risk assessment. Amend policy to state all Emergency Department patients are considered a fall risk.

Title of Person Responsible for Implementing the Action: **Chief Nursing Officer**
Date Action Plan was or will be Implemented: **5/1/2020**
Is a Monitoring Plan Required?: no

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Deficiency #53
Level: Condition–Level
QS-10: Protecting Patients from Self-Harm
Requirement: B

**The standard was not met as evidenced by the following**
In 2 of 23 records, the following was noted

Observed during Closed Record Review – on 3/10/20 @ approximately 1430 by G. Miller
The medical record of Patient #9 was reviewed. It was noted that an assessment performed in triage at 1830 determined the patient to be at risk for self-harm. The record lacked documentation that the patient was placed on continuous observation or 1:1 observation for the duration of the stay or that steps were taken to provide a safe environment for the patient. Staff present (#3) confirmed the finding.

Observed during Closed Record Review – on 3/10/20 @ approximately 1500 by G. Miller
The medical record of Patient #10 was reviewed. It was noted that the patient had cut his arms in an apparent suicide attempt and was documented at risk for suicide by the physician and later placed on a 5150 hold. The assessment performed by the RN at 0054 determined the patient was not at risk for self-harm. There was no documentation that the patient was placed on continuous observation or 1:1 observation for during the time period that the patient was assessed as being at self-harm. Staff present (#3) confirmed the finding.

THESE FINDINGS AGGREGATE TO A CONDITION LEVEL DEFICIENCY

**Action Plan**
Action #1

1. Conduct ligature assessment of Emergency Department by 5/1/2020: Assessment findings will be addressed and communicated to staff, physicians and medical staff committee
2. Electronic Medical Record has been revised to include assessment and documentation of continuous observation for patients at risk for harm All staff are inserviced and attestation of understanding and compliance evidenced by signed attestation. See attestation for changes to medical record

Title of Person Responsible for Implementing the Action: **Chief Nursing Officer**
Date Action Plan was or will be Implemented: **4/1/2020**
Is a Monitoring Plan Required?: yes
Monitoring Plan
What will be monitored: Documentation of risk for harm documentation
What is the sample size: 100%
What is the threshold of compliance: 90%
How frequently will monitoring occur: Monthly
How long will the monitoring last: For 3 months if 90% compliance is met
Who will oversee the monitoring: Chief Nursing Officer
What committee in the QAPI program will receive reports on the results: Board Quality

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Deficiency #54
Level: Standard–Level
QS-10: Protecting Patients from Self-Harm
Requirement: C

**The standard was not met as evidenced by the following**
Observed in the Emergency Department – on 3/10/20 @ approximately 1100 by G. Miller
During a tour of the environment, an assessment of the environment for ligature and other risks was requested. The assessment was not received prior to the end of the survey. Staff present (#2) confirmed the finding.

**Action Plan**
Action #1

Conduct a ligature risk assessment for the Emergency Department.

Title of Person Responsible for Implementing the Action: **Chief Nursing Officer**
Date Action Plan was or will be Implemented: **5/1/2020**
Is a Monitoring Plan Required?: no

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Deficiency #55
Level: Standard–Level
AN-02: Provision of Anesthesia
Requirement: D

**The standard was not met as evidenced by the following**
In 1 of 23 records, the following was noted
Observed during Closed Record Review – 3/10/20 @ approximately 1510 by G. Miller
The medical record of Patient #11 was reviewed. It was noted that the pre-anesthesia evaluation did not address all data elements contained in the above requirement. Specifically, notation of the anesthesia risk (e.g. ASA classification) was not addressed. Staff present (#3) confirmed the finding.

**Action Plan**
Action #1

a) Review all forms in perioperative charts for completeness for all data elements including but not limited to signatures, date, time, etc.
f) Review with all RN staff of Surgery Department need for accurate and complete documentation by all participants at next staff meeting, 5/12/2020 and have attestation signed to such.
b) Review with anesthesia group chief physician for discussion amongst group.
c) Present at Surgery Committee Meeting and review documentation requirements with all attendees, 5/14/2020.
d) Add to department QAPI.

Title of Person Responsible for Implementing the Action: **Surgical Services Manager**
Date Action Plan was or will be Implemented: **4/15/2020**
Is a Monitoring Plan Required?: yes
Monitoring Plan
What will be monitored: ASA classification
What is the sample size: 5/day
What is the threshold of compliance: 100
How frequently will monitoring occur: Monthly
How long will the monitoring last: If 95% or greater are found in compliance, will then do
Who will oversee the monitoring: Surgical Services Manager
What committee in the QAPI program will receive reports on the results: Board Qualty

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Deficiency #56
Level: Standard–Level
AN-02: Provision of Anesthesia
Requirement: G

**The standard was not met as evidenced by the following**
In 1 of 23 records, the following was noted
Observed in the PACU – 3/11/20 @ approximately 1130 by A. McLain
The medical record of Patient #19 was reviewed. It was noted that the post-anesthesia evaluation did not address all data elements contained in the above requirement. Specifically, respiratory rate, temperature, pain, nausea and vomiting, and postoperative hydration were not addressed. Staff present (#11) confirmed the finding.

**Action Plan**
Action #1

a) Review all forms in perioperative charts for completeness for all data elements including but not limited to signatures, date, time, etc.
f) Review with all RN staff of Surgery Department need for accurate and complete documentation by all participants at next staff meeting, 5/12/2020 and have attestation signed to such.
b) Review with anesthesia group chief physician for discussion amongst group.
c) Present at Surgery Committee Meeting and review documentation requirements with all attendees, 5/14/2020.
d) Add to department QAPI.

Title of Person Responsible for Implementing the Action: **Surgical Services Manager**
Date Action Plan was or will be Implemented: **4/15/2020**
Is a Monitoring Plan Required?: yes
Monitoring Plan
What will be monitored: VS and data elements
What is the sample size: 5/day
What is the threshold of compliance: 100
How frequently will monitoring occur: Monthly
How long will the monitoring last: If 95% or greater are found in compliance, will then do
Who will oversee the monitoring: Surgical Services Manager
What committee in the QAPI program will receive reports on the results: Board Quality

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Deficiency #57
Level: Standard–Level
AN-03: Provision of Moderate Sedation/Analgesia
Requirement: A

**The standard was not met as evidenced by the following**
Observed during Document Review – 3/10/20 @ approximately 0945 by G. Miller
The organization's policy on moderate sedation (AN8610-102) was last reviewed in April of 2017. The policy lists the Center for Medicare and Medicaid Services and the Center for Improvement for Hospital Quality as the nationally recognized guideline used in its development. These are not curators of nationally recognized guidelines for anesthesia. Accreditation standards can be referenced, but the clinical content of the policy must also be referenced. The content of the policy appears to be based on guidelines published by the

American Society of Anesthesiology – which are nationally recognized. The policy reference needs to be amended. Staff present (#2) confirmed the finding.

**Action Plan**
Action #1

Amended policy #AN8610-102 to reference correct nationally recognized anesthesia guidelines. Sent to Quality to begin Committee approval process . The following is a list of the committees that the policy will pass through for approval and dates of such: Policy and Procedure Committee: 5/6/2020; Surgery Committee: 5/14/2020; Medicine Committee: 5/21/2020; Board Quality: 5/27/2020; Board of Directors: 7/2/2020

Title of Person Responsible for Implementing the Action: **Surgical Services Manager**
Date Action Plan was or will be Implemented: **4/1/2020**
Is a Monitoring Plan Required?: no

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Deficiency #58
Level: Standard–Level
ED-02: Provision of Emergency Services at Non-Emergency Department Locations
Requirement: B

**The standard was not met as evidenced by the following**
Observed during Document Review – 3/12/20 @ approximately 1240 by G. Miller
Based on a review of documents, the organization could not substantiate that a written policy has been developed for appraisal of emergencies and referral at the off-campus rehabilitation clinic. Of note, staff verbalized a process to provide care in an emergent situation. Staff present (#14) confirmed the finding.

**Action Plan**
Action #1

Policy 7770-141 was created. Policy and Procedures Team: 5/6/2020
Medicine Committee: 5/14/2020
Medical Executive Board: 5/21/2020
Board Quality Committee: 5/27/2020
The Board of Directors: 7/2/2020
The policy will be introduced to staff on 4/3/2020. At that time staff will sign an attestation that they have read and understand the new policy. Staff will be assessed by a written test to demonstrate their understanding and knowledge. They will be expected to score at least 90% on the test. Staff will include reception personnel and all onsite clinicians- Physical Therapist and Occupational therapists. The policy will be posted in the staff room and placed in a hard copy P+P binder and will be on the SVH Intranet under our departmental policies.

Title of Person Responsible for Implementing the Action: **Rehab Services Manager**
Date Action Plan was or will be Implemented: **5/1/2020**
Is a Monitoring Plan Required?: no

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Deficiency #59
Level: Standard–Level
LB-03: Management of Tissue Specimens
Requirement: B

**The standard was not met as evidenced by the following**
Observed during Document Review – 3/12/20 @ approximately 0900 by A. McLain
The organization's policy on pathology specimens does not address which tissue specimens require a macroscopic examination and which tissue specimens require both macroscopic and microscopic examination. The policy provided was dated 1997 and signed by the pathologist on 2/16/20. There was no evidence that the medical staff had approved the policy. Staff present (#2) confirmed the finding.

**Action Plan**
Action #1

Sonoma Valley Hospital contracts with Marin Pathology for Pathology services. An updated policy dated 2019 was provided, see policy #36115-825 Section VI Tissue Specimens for clarification of specimens requiring both macroscopic and microscopic examination. Policy will be sent to medicine committees for approval and once approved, will be adopted by Sonoma Valley Hospital.

Title of Person Responsible for Implementing the Action: **Laboratory Manager**
Date Action Plan was or will be Implemented: **4/15/2020**
Is a Monitoring Plan Required?: no

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Deficiency #60
Level: Standard–Level
LB-04: Management of Potentially Infectious Blood & Blood Components
Requirement: A

**The standard was not met as evidenced by the following**
Observed during Document Review – 3/12/20 @ approximately 0900 by A. McLain
Based on information provided at the time of survey, it was noted the organization's policy addressing the management of contaminated blood products, entitled Look Back last reviewed 9/14, did not contain all the elements required by CMS. Specifically, the policy did not address the time frame for patient notification; the content of the notification; and the documentation requirements. Staff present (#2) confirmed the finding.

**Action Plan**
Action #1

The lab developed a new policy Transfusion Transmitted Infectious Disease Notification that addresses the management of contaminated blood products, it is being submitted to medicine committees for approval. Included in this policy is the following components: timeframe of notifying recipient, content of notification and documentation requirements. All lab personnel will be required to read the above policy and sign an attestation that they have read and understood the content of this policy.

Title of Person Responsible for Implementing the Action: **Laboratory Manager**
Date Action Plan was or will be Implemented: **4/15/2020**
Is a Monitoring Plan Required?: no

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Deficiency #61
Level: Standard–Level
LB-06: Tissue Management
Requirement: B

**The standard was not met as evidenced by the following**
Observed in the Surgical Services Department – 3/11/20 @ approximately 1000 by A. McLain
During a tour of the environment, it was noted that the current log used to track tissue does not include the date and time that tissue is received into the organization, nor does the log include any documentation that temperature requirements were maintained when the tissue was received. Further, entries into the log including using ditto marks instead of completing each entry into the log. Staff present (#11) confirmed the finding.

**Action Plan**
Action #1

a) New log in sheet was created for the Tissue Log with required entry areas for date and time tissue is received into the organization as well as any temperature requirements for maintaining the tissue also to be noted.
b) Review with staff new log in sheet and instruct on use. Will also instruct regarding filling out form completely and no use of ditto marks permitted. Will present at staff meeting, 5/12/2020 and have attestation to sign for such.
c) Will add to department QAPI

Title of Person Responsible for Implementing the Action: **Surgical Services Manager**
Date Action Plan was or will be Implemented: **4/15/2020**
Is a Monitoring Plan Required?: yes
Monitoring Plan
What will be monitored: Tissue log
What is the sample size: 100%
What is the threshold of compliance: 100%
How frequently will monitoring occur: Monthly
How long will the monitoring last: One year
Who will oversee the monitoring: Surgical Services Manager
What committee in the QAPI program will receive reports on the results: Board Quality

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Deficiency #62
Level: Standard–Level
NM-01: Organization of Nuclear Medicine Services
Requirement: A

**The standard was not met as evidenced by the following**
Observed during Document Review – 3/11/20 @ approximately 1530 by G. Miller
The organization uses radiopharmaceuticals for sentinel node biopsies. Based on a review of documents, it was noted that the organization was unable to provide evidence that the scope of nuclear medicine services had been defined and approved by the medical staff. Staff present (#2) confirmed the finding.

**Action Plan**
Action #1

A. The existing Policy of Nuclear Medicine services will be revised and brought up to date to provide the defined scope of nuclear medicine services and will be approved by the medical staff. C. This will be added to the revised policy and will specify the qualifications, training, functions and experience of personnel responsible for performing Sentinel Node Biopsys and will be approved by the nuclear medicine service director and medical staff.

Title of Person Responsible for Implementing the Action: **Director of Medical Imaging**
Date Action Plan was or will be Implemented: **4/19/2020**
Is a Monitoring Plan Required?: no

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Deficiency #63
Level: Standard–Level
NM-01: Organization of Nuclear Medicine Services
Requirement: C

**The standard was not met as evidenced by the following**
Observed during Document Review – 3/11/20 @ approximately 1530 by G. Miller
Based on a review of documents, it was noted that the organization was unable to provide evidence that a policy had been developed and approved by the nuclear medicine service director and medical staff that specifies the qualifications, training, functions and experience of personnel responsible for performing each type of nuclear medicine procedure. Staff present (#2) confirmed the finding.

**Action Plan**
Action #1

A. The existing Policy of Nuclear Medicine services will be revised and brought up to date to provide the defined scope of nuclear medicine services and will be approved by the medical staff. C. This will be added to the revised policy and will specify the qualifications, training, functions and experience of personnel responsible for performing Sentinel Node Biopsys and will be approved by the nuclear medicine service director and medical staff.

Title of Person Responsible for Implementing the Action: **Director of Medical Imaging**
Date Action Plan was or will be Implemented: **4/19/2020**
Is a Monitoring Plan Required?: no

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Deficiency #64
Level: Standard–Level
NM-02: Provision of Nuclear Medicine Services
Requirement: G

**The standard was not met as evidenced by the following**
Observed during Document Review – 3/11/20 @ approximately 1530 by G. Miller
Based on a review of documents, it was noted that the organization was not able to provide evidence that policies had been developed for reviewing records of the receipt and distribution of radiopharmaceuticals. Staff present (#2) confirmed the finding.

**Action Plan**
Action #1

Revise current Policies to reflect our current paractices. Policy will reviewed by Policy and Procedure Team, Surgery Committee, Medical Executive Committee, Board Quality Committee, The Board of Directors.

Title of Person Responsible for Implementing the Action: **Director of Medical Imaging**
Date Action Plan was or will be Implemented: **4/19/2020**
Is a Monitoring Plan Required?: no

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Deficiency #65
Level: Standard–Level
NS-03: Delivery of Nursing Care
Requirement: C

**The standard was not met as evidenced by the following**
In 1 of 23 records, the following was noted
Observed in ICU – 3/10/20 @ approximately 1110 by A. McLain
The medical record of Patient #1 was reviewed. It was noted that the patient was placed on contact and droplet precautions for respiratory symptoms. The nursing care plan did not recognize the need for isolation. Staff present (#1) confirmed the finding.

**Action Plan**
Action #1

a. Create Isolation care plan problem (completed 4/2) b. All nursing staff to review policy for creating plan of care and sign attestation c. All nursing staff in-serviced on new Isolation Care Plan problem. Care plans of isolation patients will be audited for inclusion of isolation problem, add to QAPI

Title of Person Responsible for Implementing the Action: **Director of Patient Care Serv.**
Date Action Plan was or will be Implemented: **4/13/2020**
Is a Monitoring Plan Required?: yes
Monitoring Plan
What will be monitored: Care plans of isolation patients
What is the sample size: 100
What is the threshold of compliance: 100
How frequently will monitoring occur: Monthly
How long will the monitoring last: Ongoing
Who will oversee the monitoring: Director of Patient Care Serv.
What committee in the QAPI program will receive reports on the results: Board Quaity

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Deficiency #66
Level: Standard–Level
OI-05: Informed Consent
Requirement: A

**The standard was not met as evidenced by the following**
In 1 of 23 records, the following was noted
Observed during Closed Record Review – 3/11/20 @ approximately 1500 by G. Miller
The medical record of Patient #14 was reviewed. It was noted that the consent form signed on 3/11/20 did not list the name of the physician who would be performing the procedure. Staff present (#3) confirmed the finding.

**Action Plan**
Action #1

a) Review all forms in perioperative charts for completeness for all data elements including but not limited to signatures, date, time, etc.
f) Review with all RN staff of Surgery Department need for accurate and complete documentation by all participants at next staff meeting, 5/12/2020 and have attestation signed to such.
b) Review with anesthesia group chief physician for discussion amongst group.
c) Present at Surgery Committee Meeting and review documentation requirements with all attendees, 5/14/2020.
d) Add to department QAPI.

Title of Person Responsible for Implementing the Action: **Surgical Services Manager**
Date Action Plan was or will be Implemented: **4/15/2020**
Is a Monitoring Plan Required?: yes
Monitoring Plan
What will be monitored: Consent
What is the sample size: 5/day
What is the threshold of compliance: 100
How frequently will monitoring occur: Monthly
How long will the monitoring last: If 95% or greater are found in compliance, will then do
Who will oversee the monitoring: Surgical Services Manager
What committee in the QAPI program will receive reports on the results: Board Quality

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Deficiency #67
Level: Standard–Level
RD-01: Provision of Radiology Services
Requirement: D

**The standard was not met as evidenced by the following**
Observed in the Imaging Department – 3/11/20 @ approximately 1100 by G. Miller
During a tour of the environment, the surveyor and escorts were allowed to enter Zone III without being screened for MRI safety risks. The American College of Radiology guidelines for MRI safety call for screening to occur in Zone II prior to entering into Zone III. Staff present (#10) confirmed the finding.

**Action Plan**
Action #1

New Practice was implemented to screen all persons entering the MRI Zone III for MRI Safety Risks. Hospital employees and Maintainance/Repair personnel will view new MRI Safety Video and complete screening forms that will be kept on file and reviewed annually.

Title of Person Responsible for Implementing the Action: **Director of Medical Imaging**
Date Action Plan was or will be Implemented: **4/19/2020**
Is a Monitoring Plan Required?: yes

Monitoring Plan
What will be monitored: MRI Safety competency
What is the sample size: 100
What is the threshold of compliance: 100
How frequently will monitoring occur: Annually
How long will the monitoring last: Onging
Who will oversee the monitoring: Director of Medical Imaging
What committee in the QAPI program will receive reports on the results: board Quality

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Deficiency #68
Level: Standard–Level
RD-04: Safety of Radiology Services
Requirement: A

**The standard was not met as evidenced by the following**
In 1 of 12 files, the following was noted
Observed during the Human Resources Review – 3/12/20 @ approximately 1100 by A. McLain
The file of a radiology technician hired 9/29/17 was reviewed. The file lacked evidence of education/training about the appropriate storage of the meters and/or badges as well as the procedures to follow if the exposure device exceeds cumulative dosage parameters specified by policy. Staff present (#12) confirmed the finding.

**Action Plan**
Action #1

Create a new Healthstream policy review course with employee signature page done with other new employee requirements. New Hire Procedure changed to include policy review and proof of training.

Title of Person Responsible for Implementing the Action: **Director of Medical Imaging**
Date Action Plan was or will be Implemented: **4/19/2020**
Is a Monitoring Plan Required?: no

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Deficiency #69
Level: Standard–Level
RB-01: Rehabilitation Services
Requirement: A

**The standard was not met as evidenced by the following**
Observed in the Outpatient Rehab Clinic – 3/12/20 @ approximately 1230 by G. Miller
Based on discussion with staff, it was determined that there was no current process to notify the patient in writing of the risks and/or consequences of discontinuing treatment when the recommended therapy is not completed. Staff present (#14) confirmed the finding.

**Action Plan**
Action #1

Revised policy 7770-111 to incude the following changes indicated in RED:
Outpatient Rehab Services- Prior to discharge, the primary therapist, or their substitute, will send a letter via mail, using the attached discharge notification letter. This letter will act as a notification to any patient who has failed to comply with the plan of care as developed by the primary therapist. This letter will notify the patient in writing of the risks and/or consequences of discontinuing treatment when the recommended therapy is not completed. A copy of this letter will be sent to the referring physician and a copy will be placed in the patient's chart. If there is no response after 10 days, a discharge summary will be sent to the referring physician. Staff will be educated about new policy, sign attestation. Notices of the revised policy will be posted in the staff room and available by hardcopy in office P+P book and on the Intranet under our departmental policies.

Title of Person Responsible for Implementing the Action: **Rehab Services Manager**
Date Action Plan was or will be Implemented: **5/1/2020**
Is a Monitoring Plan Required?: no

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Deficiency #70
Level: Standard–Level
RT-01: Respiratory Services
Requirement: D

**The standard was not met as evidenced by the following**
In 1 of 23 records, the following was noted
Observed during Closed Record Review – 3/11/20 @ approximately 1530 by G. Miller
The medical record of Patient # 15 was reviewed. The record contained an order for a pulmonary function screen with bronchodilator. It was noted that the amount and type of bronchodilator to use was not specified in the order, nor did the organization have a policy or protocol that addressed the amount of bronchodilator to use during a screening test. Staff (#2 and #9) confirmed the finding.

**Action Plan**
Action #1

Pulmonary Function Screening Brochospasm Policy has been amended to identify the amount and type of bronchodilator used during screening test. Communication to staff will be made during the April 2020 monthly staff meeting. The updated policy will be available on the Intranet. The RT staff who preform PTFs will be trained to the new policy and training will be completed 4/30/2020. PFT staff to sign an attestation regarding the understanding of stated policies.

Title of Person Responsible for Implementing the Action: **Medical Imaging Director**
Date Action Plan was or will be Implemented: **4/30/2020**
Is a Monitoring Plan Required?: no

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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~~ [LG1]~~(Committee)~~ Board Quality Committee is responsible for guiding and assisting the Executive Leaders, Medical ~~Board~~[LG2]Staff, 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.

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 patient care, 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~~ examines 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~~[LG3] Triple Healthcare Aim: Better Care for patients ~~and~~and positive staff engagement ~~providers~~[LG4], Better Population Health, Lower Per Capita 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. The Committee has the delegated authority to establish accountability in medical

| SUBJECT: Charter | POLICY: QA8610-108 |
|---|---|
| | PAGE 2 |
| DEPARTMENT: ORGANIZATIONAL | EFFECTIVE: |
| REVISED: | |

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 [LG5]department policies for adherence to quality and safety priorities.
- Review all medical credentialing. ~~staff requiests 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.
- Perform such other activities as requested by the Executive Leadership of Sonoma Valley Hospital.
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- ~~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:
   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
      viii. Utilization Review
   b. Patient Experience
   c. Accreditation & Regulatory Standards
   d. Quality Assurance Performance Improvement
   e. Culture of Safety
   f. Risk Event Reports
   g. Policies & Procedures
   ~~1.~~h. Patient Care Contracts
   ~~*(List as relevant to the organization)*~~

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

~~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~~[LC6] ~~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~~ In compliance with the Charter and as directed by Executive Leadership and the District Board |

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

| | |
|---|---|
| ~~Composition~~ | ~~Medical and Clinical Staff Leadership appointments; Operations, Executive~~<br>~~Staff, and Board Members~~<br>~~Patient/ Families membership should be considered~~ |
| Meeting Schedule | At least ~~T~~ten meetings per year |
| 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~~Half plus one member present. |
| Chair | Two appointed Board Members ~~Board Chair or Chief Executive Officer (CEO)~~ |
| ~~Major Staff Support~~ | ~~Chief Quality Officer and Patient Safety Officer, Quality Staff~~ |
| ~~Notices Forwarded To~~Composition | Committee Members, Presenters, CEO, Chief Medical Officer (CMO) and Chief Nursing Officer (CNO), Chief Quality Officer (CQO) |
| ~~Non-member attendees~~ | ~~Staff resources as requested~~<br>~~Subject matter experts as requested~~ |

~~**Summary of Quality and Patient Safety Committee Roles and Responsibility**~~

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

| SUBJECT: Charter | POLICY: QA8610-108 |
|---|---|
| | PAGE 6 |
| DEPARTMENT: ORGANIZATIONAL | EFFECTIVE: |
| REVISED: | |

~~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. ~~C~~compliance.
11. ~~Leading celebration of gains made.~~
- ~~Improving its own methods.~~
- ~~Review all new and updated hospital organization and~~ [LG7]~~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.~~

~~12.~~1. ~~Review medical staff bylaws for completeness and adherence to legal~~ requirements.

**REFERENCES:**
www.hginstitute.org

# Patient Care Services Dashboard 2019

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT

| Medication Scanning Rate | 2019-2020 | | | | |
|---|---|---|---|---|---|
| | Q2 | Q3 | Q4 | Q1 | Goal |
| Acute | 90.3% | 94.0% | 91.4% | N/A | ≥90% |
| ED | 90.4% | 90.6% | 90.0% | N/A | ≥90% |
| Preventable med errors R/T Med Scanning | 0 (n=20) | 2 (n=12) | 2 (n=7) | 4 (n=22) | ≤2 |

| Falls (Per 1000 days) 2019-2020 | | | | | |
|---|---|---|---|---|---|
| | Q3-Q2 | Q4-Q3 | Q1-Q4 | Q2-Q1 | 50th %tile |
| Acute | 1.90 | 1.50 | 1.10 | 1.50 | 3.75 |
| ED | 0.0 | 0.4 | 0.1 | 0.0 | |

| Hospital Acquired Pressure Ulcer Incidents (Per 1000 admissions) | 2019-2020 | | | | |
|---|---|---|---|---|---|
| | Q2 | Q3 | Q4 | Q1 | National |
| Acute | 0.0 | 0.0 | 0.0 | 4.5* | 3.68 |
| * 1 pt out of 222 | | | | | |

| Nursing Turnover | 2019-2020 RNs/Quarter | | | | |
|---|---|---|---|---|---|
| # of RNs | Q2 | Q3 | Q4 | Q1 | Goal |
| Acute (n=65) | 1 | 3 | 0 | 0 | ≤6 |

| Patient Experience (CAHPS) | 2019-2020 | | | | |
|---|---|---|---|---|---|
| | Q1 | Q2 | Q3 | Q1 | Goal |
| HCAHPS (rolling 12 month) | | | | | |
| Would Recommend | 87.1 | 72 | 72 | N/A | 70.0 |
| Quietness of Hosp Environment | 68.3 | 61.3 | 38 | N/A | 51.0 |
| OASCAHPS (rolling 12 month) | | | | | |
| Care of Patients (MD/RN respect) | 98 | 97.5 | 97.9 | N/A | 97.1 |
| Would Recommend | 83.8 | 83.5 | 83.5 | N/A | 88.6 |
| RATE MY HOSPITAL - ED | Q2 | Q3 | Q4 | Q1 | |
| Overall score | 4.6 | 4.7 | 4.5 | 4.7 | ≥4.5 |
| RATE MY HOSPTIAL-INPATIENT | Q2 | Q3 | Q4 | Q1 | |
| How Do You Feel About Your Stay? | N/A | N/A | 4.3 | 4.6 | ≥4.5 |

| Nurse Staffing Effectiveness: Transfers r/t staffing/beds | | | | | |
|---|---|---|---|---|---|
| 2019 | Q2 | Q3 | Q4 | Q1 | Goal |
| | 0 | 0 | 1 | 0 | ≤0 |

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

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

1. Proparacaine ordered by tetracaine overrode from Pyxis and given 2. Seroquel XR overrode from Pyxis when order already active for Seroquel plain, dose given 3. Senna removed on override from Pyxis when order already active for Senna w/ docusate. Dose given 4. Xopenex neb removed on override from Pyxis by RT and given when albuterol neb ordered

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

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

## Review and Approval Requirements

The SVH departmental/organizational policies and/or procedures on the attached list have been reviewed and approved 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:**

Admits, transfers, readmissions PC8610-192
Policy required for Bariatric Accreditation

Management of Medical Emergencies in Off-side Locations PC8610-192
CMS and CIHQ require policies stating the organization's responsibility to respond to medical emergencies on their 'campus'. Campus is defined as well as the scope of responsibility

Pest Management Program CE8610-184
To prevent and control the entrance of pests and eradicate infestations in the facilities.

**REVISIONS:**

Hazardous Materials and Waste Management Plan CE8610-140
Review of policy by all authority stakeholders. Update policy to reflect current practices, hazardous materials handling and communication.

Medical Waste Management Plan CE8610-158
Add language from Disposal of Medical and Biohazardous waste into the Medical Waste Management Plan to consolidate into 1 policy. To combine 2 organizational policies that pertain to Medical and biohazard waste management.

Storage of Medications MM8610-123
removed reference to non-existent policy; removed reference to hazardous drugs which will be addressed in a new policy.

Department Specific Performance Improvement (PI) Plan QA8610 -104
Removed requirement for annual department reports to Board Quality to reflect updated Quality Charter and triannual review

Formalin Spill Cleanup LB8610-106
Update

Pathology Specimen Handling LB8610-122
Wording update

Reporting of Quality Monitoring and Performance QA8610-106
Changed Director of Quality and Resource Management to Chief Quality Officer

Sara lite PC8610-165
Updates establishes guidelines for use of Sara Lite Sit to Stand Lift and the applicable slings

**Reviewed/No Changes**
Use of Medication Not Procured by the Facility MM8610-116
AccuChek Inform II Glucose Monitoring System LB8610-102
Patient Safety Evaluation System QA8610-101

**DEPARTMENTAL**

**NEW:**

**Surgical Services**
Metabolic and Bariatric Anesthesia Protocol 7430-109
To have a hard stop for the purposes of cancelling patients who otherwise are at greater risks for complications during and after surgery and could potentially need a higher level of postop care than we can provide at SVH

**Wound Care**
Maggot Therapy 7740-109
This is a new Wound Care policy and procedure that addresses the clinical indications, policy, procedures and qualifications for personnel involved in maggot debridement therapy.

**Engineering**
Failure of HVAC Systems 8450-15
To explain how Sonoma Valley Hospital will maintain safe temperatures when the HVAC system is affected during a disaster

Failure of Sewer services 8450-14
To explain how Sonoma Valley Hospital will maintain safe environment when the sewer system is affected during a disaster.

**REVISIONS:**

**Emergency**
EMTALA COBRA Transfers 7010-07
Added EMTALA to title of policy and spelled out acronyms referred to in the policy

**Wound Care**
Cancellation No Show Wound Care 7740-102
Failure to attend 2 consecutive visits or 3 visits total without proper 24 hour notice will result in discharge from the Wound Care Program. To resume treatment, the patient will be required to obtain a new order from their primary care physician. Added Clarity regarding consequences of missed visits

**Engineering**
Battery Powered Exit Lights 8450-100
National Fire Protection Association (“NFPA”) reference update. new NFPA code acceptance by CMS

Bulk Liquid Oxygen 8450-77
Updated vendor information. Vendors have changed.

Electrical Failure 8450-63
corrected asset numbers for the generators because the new generators were installed

Emergency generator testing 8450-65
DEXA and Mammo added. new departments in Central wing.

Equipment Inventory 8450-48
Policy for Engineering Equipment preventative maintenance documentation. Removed reference to biomed equipment. Biomed equipment is reflected in an organizational policy called Clinical Engineering Equipment Safety/PM Program.

Fire Alarm Testing 8450-91
Changed code reference year to 2010 updated National Fire Protection Association "NFPA" edition

Medical Gases Procurement and Contingency Plan 8450-76
Updated vendor information. outdated information

Utilities Failure Phone List 8450-38
Updated Utility phone lists. Update outdated information

Vendor Contact List 8450-31
List of vendors used by Engineering to maintain Central Utility Plant Equipment. Updated vendors, contact info and remove warranty info.

**EVS**
Linen Management Services 8440-43
Change policy to reflect current linen handling procedures for clean and soiled linen. Also included linen ordering, delivery procedure and linen plant contingency plan. Old policy only stated that linen was sent out for processing

**Imaging**
Scope of Services 7630-233
Expanded Scope of Services to include Dexa and Interventional Radiology. Remove MRI contracted by outside company. Services absent in prior policy. Interventional Radiology needs to be noted for Bariatric Accreditation. MRI is not contracted out.

**Medical Staff**
Medical Staff QAPI 8710-105
Minor wording revisions, removal of Labor & Delivery reference and neonatal codes. Revision to reflect current practice and hospital status.

**Nutritional Services**
Diet Manual 8340-151
Removed reference to old diet manual. Removed reference to online diet manual from the Academy of Nutrition and Dietetics. Change review of diet manual every 3 years to annually with revision and approval at

least every 5 years per regulations. Diet manual not current. Online diet manual does not match official approved diet manual to be used.

**REVIEWED/NO CHANGES:**

**Laboratory**

AccuChek Certification and Recertification 7500-100
AccuChek Meter Replacement 7500-102
Individualized Quality Control Plan 7500-104

**RETIRE:**

**Engineering**

Emergency Battery Powered Lights 8450-90

| | |
|---|---|
| SUBJECT: VISITS, ADMISSIONS, READMISSIONS, TRANSFERS THROUGH THE EMERGENCY DEPARTMENT | POLICY # PC8610-192<br>PAGE 1 OF 2 |
| DEPARTMENT: ORGANIZATION | EFFECTIVE: |
| APPROVED BY: | REVISED: |

**POLICY:**

Per California Department of Public Health (CDPH) Title 22 regulations, acute care hospitals with a 24/7 Emergency Department (ED) shall maintain a log of all ED visits. The log must contain name, date of birth, chief complaint and disposition.

All admissions from the ED to the acute inpatient units will be ordered and managed by the Hospitalist Service (medical admission) or the Surgical Service (surgical admission). Any Bariatric admissions will be managed by the Bariatric surgeons.

The Sonoma Valley Hospital Quality Department monitor all readmissions in the ED and to the inpatient units. In the ED, readmissions within 24 hours, 7 day, 14 day and 30 day are monitored and assessed.

If transfer has been identified for higher level of care needs in an ED patient, they can expect a safe and expedient transfer under any of the following circumstances:

A. Patient requires a higher level of care not provided here i.e., metabolic and bariatrics, cardiac catheterization, neurosurgery, specialized burn care, intensive pediatric care, etc.
B. Situations when no beds are available or there is inadequate staffing.
C. Family/patient requests.
D. By request of a patient's HMO, as in Kaiser Plan members.

**REFERENCE:**
EMTALA STATUTE: 42 USC 1395 dd
42 USC 1395dd. Examination and treatment for emergency medical conditions and women in labor; also known as Section 1867 of the Social Security Act; also known as Section 9121 of the Consolidated Omnibus Budget Reconciliation Act of 1985. Common names: COBRA, EMTALA, Anti-dumping law.

**OWNER:**
Chief Nursing Officer

**AUTHORS/REVIEWERS:**
Mark Kobe, Chief Nursing Officer

**APPROVALS:**
Policy & Procedure Team: 2/5/20

| | |
|---|---|
| SUBJECT: VISITS, ADMISSIONS, READMISSIONS, TRANSFERS THROUGH THE EMERGENCY DEPARTMENT | POLICY # PC8610-192<br>PAGE 2 OF 2 |
| DEPARTMENT: ORGANIZATION | EFFECTIVE: |
| APPROVED BY: | REVISED: |

Medicine Committee: 3/12/20
Medical Executive Committee: 3/19/20
Board Quality Committee:
The Board of Directors:

| | |
|---|---|
| SUBJECT: Management of Medical Emergencies in off-site locations | POLICY #PC8610-192 |
| | PAGE 1 OF 2 |
| DEPARTMENT: Organizational | EFFECTIVE: |
| REVISED: | |

**PURPOSE:**

To define the responsibility of the hospital for medical emergencies in off-site locations. In 2000, CMS issued new amendments to the rules under 42 CFR 489.24, expanding the responsibility of the emergency room to respond to any "presentation" on the hospital campus or at any provider-based off-campus facility of the hospital. Campus means the physical area immediately adjacent to Sonoma Valley Hospital's main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual case basis, by the CMS regional office, to be part of the providers campus.

**POLICY:**

A person who presents anywhere on the hospital campus and requests emergency services, or who would appear to a reasonably prudent person to be in need of medical attention, must be handled under EMTALA. Other presentations outside the emergency room do not invoke EMTALA.

- The 250-yard zone will continue to apply when defining the "hospital campus. That does not include non-medical businesses (shops, residences and restaurants located close to the hospital), nor does it include physicians' offices or other medical entities that have a separate Medicare identity.

- EMTALA does not apply to any off-campus facility, regardless of its provider-based status, unless it independently qualifies as a dedicated emergency department

The following Sonoma Valley Hospital off campus entities do not apply in respect to the 250-yard rule. These entities would call 911 for medical emergencies:

- Hand and Physical Therapy Highway 12
- Specialty Clinic West Napa Street
- Specialty Clinic; Family Practice Perkins Street

**REFERENCES:**
Center for Medicare and Medicaid 42 CFR 489.24

**OWNER:**
Chief Nursing Officer

| | |
|---|---|
| SUBJECT: Management of Medical Emergencies in off-site locations | POLICY #PC8610-192<br>PAGE 2 OF 2 |
| DEPARTMENT: Organizational | EFFECTIVE: |
| REVISED: | |

**AUTHORS/REVIEWERS:**
Mark Kobe, Chief Nursing Officer

**APPROVALS:**
Policy & Procedure Team: 2/19/20
Medicine Committee: 3/12/20
Medical Executive Committee: 3/19/20
Board Quality Committee:
The Board of Directors:

| SUBJECT: Pest Management Program | POLICY: CE8610-184 |
|---|---|
| | PAGE 1 |
| DEPARTMENT: Engineering | EFFECTIVE: |
| REVISED: | |

**NEW POLICY**

**WHY:** To prevent and control the entrance of pests and eradicate infestations in the facilities.

**OWNER:**
Director of Facilities

**AUTHORS/REVIEWERS:**
Grigory Gatenian, Plant Operations Manager
Lynn McKissock, Director of Human Resources
Kimberly Drummond, Director of Facilities

**APPROVALS:**
Policy & Procedure Team: 3/4/20
Board Quality Committee:
The Board of Directors:

| | |
|---|---|
| SUBJECT: Pest Management Program | POLICY: CE8610-184 |
| | PAGE 1 |
| DEPARTMENT: Engineering | EFFECTIVE: |
| REVISED: | |

**POLICY:**

It is the policy of Sonoma Valley Hospital that unwanted pests will be managed by Engineering, utilizing an outside pest control company on a regular basis (by-weekly maintenance) as regular monitoring is essential to determine and mitigate pest presence.

Definition

Pest: A pest is any animal or plant which has a harmful effect on humans, their food or their living conditions. Pests include animals which:

- carry disease-causing micro-organisms and parasites, damage stored food;
- damage clothing, damage buildings;
- bite people

**PROCEDURE:**

Twice per month, the ~~Orkin~~ Pest Control technician will inspect the areas of the facility identified in Appendix A: Gold-Station List Report and perform scheduled services. Emergency response is provided within 24 hours 365 days per year.

It is the responsibility of each department to notify Engineering of a presence or evidence of presence of pests in their location.

Once such notification is made, Engineering will evaluate the request and notify pest controls vendor. Depending on the urgency of the situation the vendor may respond immediately or postpone it until the next scheduled visit.

Detailed documentation is maintained by the vendor in Log Binder which remains on site at all times.

Site visit reports are emailed to Engineering department after each visit.

**APPENDICES:**
Appendix A: Gold – Station List Report

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

| | |
|---|---|
| SUBJECT: Pest Management Program | POLICY: CE8610-184 |
| | PAGE 1 |
| DEPARTMENT: Engineering | EFFECTIVE: |
| REVISED: | |

## APPENDIX A

**Gold - Station List Report**

Account ID = 27684680
All Service Centers

12/15/2017 1:14 PM
savila@rollins.com - Santiago Avila
Page 1 Of 2

SONOMA VALLEY HOSPITAL
347 ANDRIEUX St
Sonoma, CA 95476

| ZONE | TRAP | STATION | LOCATION DESCRIPTION | COUNT |
|---|---|---|---|---|
| **01 LOGBOOK** | | | | |
| | **Area** | | | |
| | | 1 | CORRECTIVE ACTIONS | |
| | | | **Total for 01 LOGBOOK** | 1 |
| **02 DIETARY** | | | | |
| | **Area** | | | |
| | | 5 | 0005 KITCHEN DOOR JAM | |
| | **Internal Insect Light Trap** | | | |
| | | 6 | 0006 CAFETERIA | |
| | | 8 | 0008 HALLWAY | |
| | **Tin Cat Trap** | | | |
| | | 7.1 | 0007A ACROSS FROM STOVE | |
| | | 7.2 | 0007B LEFT OF WALK IN FREEZER | |
| | | 9 | 0009 DISHWASH | |
| | | 10 | 0010 DOOR TO HALL | |
| | | 12 | 0012 PREP WASH | |
| | | 13 | UNDER FRIDGE ACROSS COOKLINE | |
| | | | **Total for 02 DIETARY** | 9 |
| **03 DIETARY STORAGE** | | | | |
| | **Area** | | | |
| | | 6 | 0013 DOOR JAM TO STORAGE | |
| | | 15 | 0015 DRY STORAGE | |
| | **Tin Cat Trap** | | | |
| | | 14 | 0014 DRY STORAGE | |
| | | 16 | 0016 DOOR TO HALL | |
| | | 17 | 0017 DRY STORAGE CAGE | |
| | | 18 | under middle dry shelf | |
| | | | **Total for 03 DIETARY STORAGE** | 6 |
| **04 SHIPPING AND RECEIVING** | | | | |
| | **Area** | | | |
| | | 7 | 0018 DOUBLE DOOR BY HALL ILT | |
| | | | **Total for 04 SHIPPING AND RECEIVING** | 1 |
| **06 EXTERIOR** | | | | |
| | **Area** | | | |
| | | 17 | in box 16 | |
| | **EZ-Secured** | | | |
| | | 1 | south patio | |
| | | 2 | past south patio thru Machinary room and outside | |
| | | 3 | right of sw corner door | |
| | | 4 | left of sw corner door | |

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

| SUBJECT: Pest Management Program | POLICY: CE8610-184 |
|---|---|
| | PAGE 1 |
| DEPARTMENT: Engineering | EFFECTIVE: |
| REVISED: | |

**Gold - Station List Report**

Account ID = 27684680
All Service Centers

12/15/2017 1:14 PM
savila@rollins.com - Santiago Avila
Page 2 Of 2

SONOMA VALLEY HOSPITAL
347 ANDRIEUX St
Sonoma, CA 95476

| ZONE / TRAP | STATION | LOCATION DESCRIPTION | COUNT |
|---|---|---|---|
| **06 EXTERIOR** | | | |
| | 5 | left of south corner door | |
| | 6 | north side left of patio | |
| | 7 | right of emergency evacuation route | |
| | 8 | right of Coke machine | |
| | 9 | left of outpatient door | |
| | 10 | northeast corner | |
| | 11 | right of compacter | |
| | 12 | left of compactor in mop area | |
| | 13 | patio right of door | |
| | 14 | patio left of door | |
| | 15 | patio right of door | |
| | 16 | east side near bushes | |
| | 18 | south side left of last patio door | |
| | 19 | behind trailer by lobby | |
| | | **Total for 06 EXTERIOR** | **19** |
| **07 2ND FLOOR SURGERY CARE** | | | |
| **Internal Insect Light Trap** | | | |
| | 1 | 0001 2ND FLOOR | |
| | 2 | 0002 SURGERY 7420 | |
| | | **Total for 07 2ND FLOOR SURGERY CARE** | **2** |
| **08 LOGBOOK CHECK OUT** | | | |
| **Log book** | | | |
| | 37 | 0037 PESTICIDE USAGE | |
| | 38 | 0038 SERVICE TICKET | |
| | | **Total for 08 LOGBOOK CHECK OUT** | **2** |
| **SKILLED NURSING CENTER** | | | |
| **Area** | | | |
| | 1 | under sink in the activity room | |
| | 2 | break room door frame | |
| | 4 | back exterior door | |
| **Vector Discreet** | | | |
| | 3 | back hallway by door | |
| | | **Total for SKILLED NURSING CENTER** | **4** |
| | | **Total for 347 ANDRIEUX St** | **44** |

| | |
|---|---|
| E. Rodent Bait Station | **18** |
| Insect Light Traps | **5** |
| Inspection | **11** |
| Rodent Traps | **10** |
| **Total for Location 347 ANDRIEUX** | **44** |
| **Total for Customer SONOMA VALLEY HOSPITAL** | **44** |
| **Total for Route 661-05 Larry Oomens** | **44** |

| | |
|---|---|
| SUBJECT: Metabolic and Bariatric Anesthesia Protocol for selection criteria at SVH | POLICY # 7430-109 |
| | PAGE 1 OF 3 |
| DEPARTMENT: Surgical Care Unit | EFFECTIVE: |
| REVISED: | |

**NEW POLICY**

Briefly state the reasons for creating a new policy.

**WHY:** To have a hard stop for the purposes of cancelling patients who otherwise are at greater risks for complications during and after surgery and could potentially need a higher level of postop care than we can provide at SVH

**OWNER:**
Surgery Manager

**AUTHORS/REVIEWERS:**
Janine Clark, Surgery Manager

**APPROVALS:**
Policy & Procedure Team: 1/8/20
Surgery Committee: 3/12/20
Medical Executive Committee: 3/19/20
Board Quality Committee:
The Board of Directors:

| | |
|---|---|
| SUBJECT: Metabolic and Bariatric Anesthesia Protocol for selection criteria at SVH | POLICY # 7430-109<br>PAGE 2 OF 3 |
| DEPARTMENT: Surgical Care Unit | EFFECTIVE: |
| REVISED: | |

**PURPOSE:**

The purpose of this protocol is to provide a basic risk assessment tool specific to bariatric surgical patients. By providing criteria, anesthesia providers will have common guidelines to use as criteria for evaluating the morbidly obese patient who is considering surgery at Sonoma Valley Hospital.

**POLICY:**

Patient evaluation to determine risk and eligibility based on a low acuity center's resources should happen prior to the date of surgery. For the morbidly obese patient, combined risk factors can lead to even greater risks for surgery and their postop health management. By providing a protocol, the nurse navigators will have guidelines to use in reviewing patient health information, and then passing along critical findings to anesthesiologists for review, prior to the intended date of surgery, thus reducing rates for same day cancellations and reducing risks to the patient.

**PROCEDURE:**

1. The following general guidelines in combination or as stand-alone criteria will be used to determine eligibility for patients considering bariatric surgery at SVH, and to mitigate the risk of patients needing higher levels of care post-surgery due to increased risk factors. All bariatric surgical candidates should meet the following criteria. If one or more of these criteria is not met, the patient will be cancelled and is not eligible for bariatric surgery at SVH:
    a. Age >17 and $\leq$ 65 years.
    b. Male BMI <55
    c. Female BMI < 60
    d. Patients must be ambulatory
    e. No significant cardiac or pulmonary impairment. For example:
        i. Patients with moderate to severe pulmonary hypertension (PA pressures > 40)
        ii. Oxygen saturation <92% on room air with patient supine (flat lying)
        iii. Estimated heart ejection fraction < 40%
    f. No patients with ASA 4 or greater.
    g. No pre-transplant patients

2. The following considerations will also be taken in to account for patients considering bariatric surgery at SVH and should be referred to the anesthesia provider for further approval prior to proceeding with surgery:

**REFERENCES:**

American College of Surgeons. (2016). *www.asmbs.org/guidelines.* Retrieved from www.asmbs.org: https://www.facs.org/-/media/files/quality-programs/bariatric/mbsaqip-standardsmanual.ashx

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|---|---|
| SUBJECT: Maggot Debridement Therapy (MDT) | POLICY #7740-109 |
| | PAGE 1 OF 5 |
| DEPARTMENT: Wound Care | EFFECTIVE: |
| REVISED: | |

**PURPOSE:**

The purpose of this policy is to provide guidelines for the use of Maggot Debridement Therapy (MDT) in wound management.

**POLICY:**

Maggot debridement therapy shall be performed in accordance with approved clinical indications by a licensed practitioner, trained to perform MDT.

**PROCEDURE:**
*The following is a guideline for the MDT, the location of the wound affects the bandage configuration. Containing the larva, allowing the larva to breath and protecting the wound periarea from the larva's discharge is essential for a successful treatment.*

1. Assess wound for appropriateness (see Clinical Indications section).
2. Obtain MD order.
3. Obtain patient and/or family informed consent, and consent for photography, if applicable.
4. Obtain supplies.(See Equipment Supplies, below)
5. Ensure that maggot container is intact and larvae are active.
6. Measure and photograph the wound before treatment
7. Use bandage or Hydrocolloid dressing and cut opening to expose wound bed.
8. Apply larva to wound surface.
    a. Maggots may be transferred from the vial either by wiping them from the vial wall with a normal saline dampened 2x2" gauze pad or by transferring the maggot-laden gauze pad supplied within the container.
9. Secure flap of the dressing or cover hydrocoloid with Adaptic and secure with tape.
10. Cover the Hydrocoloid dressing with dry absorbent gauze and secure loosely with tape. Air should be able to enter the dressing and the liquefied necrotic tissue should be able to drain out of wound bed and into the gauze.
11. After 24 hours, remove outer dressing of gauze and replace with fresh gauze. If discharge is copious, add product such as Ca Alginate around dressing, ensuring air flow is still available.
12. After 48 hours, remove the Larva.
13. To remove the larva & dressings, place absorbent pad & plastic trash bag under the appendage or place plastic trash bag next to the wound and absorbent pad under wound.
14. Inspect the dressing and surrounding skin carefully, noting any problems or abnormalities.

15. Remove the outer gauze dressing
16. Peel back the Le-Flap or hydrocolloid dressing from the wound with one hand, while wiping the larvae in the same direction with a moist 4x4" gauze held in the other hand, "sandwiching" the maggots between the hydrocoloid pad and the fresh moist gauze pad. The "wiping" gauze pad can be moistened with normal saline if desired.
17. Discard the dressing and any unused larvae into the garbage bag.
    a. If the bag is mounted underneath the wounded limb, then the loose maggots will drop into the bag below as they attempt to escape.
18. It may be necessary to use gloved fingers, forceps, or cotton swabs to remove larvae.
    a. For areas of the wound where larvae are penetrating the skin, fill with normal saline. This encourages the larvae to exit the wound..
    b. Never kill the larvae within the wound if you are unable to extract them. It is better to leave live larvae in the wound, they will crawl out on their own and bury themselves in a dry gauze dressing..
19. Secure the waste bag in the following manner: tie a knot in the plastic bag, double-bag this plastic bag into a second contaminated waste (red) bag and seal it securely with a knot. " Be sure that the knots are tied completely, securely, and "AIR-TIGHT." A bow tie made from two opposing edges of the bag ("rabbit-ear bow-tie") is not adequate to prevent maggots from escaping from the bag.
20. Call janitor to remove the contaminated waste.Apply dressing over the wound per wound conditions and MD order.
21. Document

**Miscellaneous -**

1. The practitioner applying the MDT must be on call and available at all times to answer questions and address problems with MDT patients (both inpatient and outpatient).
2. Staff must notify the wound care specialist on call for MDT patients if:
    a. The maggots are escaping. (Notify Infection Preventionist)
    b. If the dressing comes loose.
    c. If the patient is not tolerating the therapy.
    d. If there are any other non-routine problems.

**Equipment/Supplies**

- Larvae- 5-10 maggots per cm2 of wound surface.
- Bandage or hydrocolloid
- 2"X 2", 4"x 4", gauze wrap; scissors, forceps, Normal Saline; skin prep, Skin Barrier cream, garbage bags
- Wound documentation supplies - Camera, wound ruler, marker, Skin Ulcer Flow Sheet, Nursing records
- Gloves

**Competencies**

Only licensed personnel who have been trained in the procedure will apply and remove MDT dressings. Outer dressings may be changed by any personnel allowed to change simple dry dressings by current hospital policy. Patients, family members and caregivers may remove MDT and/or change outer dressings ONLY under supervision and as a part of teaching prior to discharge.

**Warnings, Contraindications, and Relative Contraindications**

1. Persons allergic to fly larvae or materials used in their manufacture (brewer's yeast; soy) may manifest allergic reactions to maggots prepared in such media. Check manufacturer's labeling.
2. Rapidly advancing infection that needs frequent inspection and possibly surgical intervention.
3. As an alternative to surgical resection for osteomyelitis, when surgery itself is not contraindicated.
4. Necrosis extending to major blood vessels that may bleed uncontrollably if debrided.
5. Wounds with inadequate blood supply to support healing should not be treated with maggot therapy, unless wound healing is not the ultimate goal.
6. Patients with natural or pharmacologically induced coagulopathy are at increased risk of bleeding, if they are treated with MDT they must be observed closely and frequently.
7. Disinfected maggots should never be transferred from one patient to another.
8. Vials of medicinal maggots should never be used more than once, unless the vial has been approved for "multi-dosing".
9. Pseudomonas infections may not always respond to maggot therapy; they may need specific antimicrobial therapy before or during MDT.
10. Medicinal maggots should not be used if the sterile seal is broken, if the container is damaged, if the maggots have a strong offensive odor, or if they are known or suspected of being contaminated.

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| SUBJECT: Maggot Debridement Therapy (MDT) | POLICY #7740-109 |
| | PAGE 5 OF 5 |
| DEPARTMENT: Wound Care | EFFECTIVE: |
| REVISED: | |

**OWNER:**
Chief Nursing Officer

**AUTHORS/REVIEWERS:**
Kathy Mathews, RN, Infection Control
Joe Cornett, RN, Wound Care

**APPROVALS:**
Policy & Procedure Team: 1/8/20
Medicine Committee: 3/12/20
Medical Executive Committee: 3/19/20
Board Quality Committee:
The Board of Directors:

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|---|---|
| SUBJECT: Failure of Sewer Services | POLICY # 8450-14 |
| | PAGE 1 OF 2 |
| DEPARTMENT: Engineering | EFFECTIVE: |
| REVISED: | |

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

**WHY:** To explain how Sonoma Valley Hospital will maintain safe environment when the sewer system is affected during a disaster.

**OWNER:**
Director of Engineering

**AUTHORS/REVIEWERS:**
Grigory Gatenian, Plant Operations Manager

**APPROVALS:**
Policy & Procedure Team: 3/4/20
Board Quality Committee:
The Board of Directors:

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

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| SUBJECT: Failure of Sewer Services | POLICY # 8450-14 |
| | PAGE 2 OF 2 |
| DEPARTMENT: Engineering | EFFECTIVE: |
| REVISED: | |

**Purpose:**
To outline the actions of the hospital personnel in case of sewer system services interruption during a disaster.

**Policy:**
In an effort to maintain a safe environment in the hospital during the outage of the sewer services system the hospital personnel will implement the following actions:

**Procedure:** Assess the damage to the sewer system and develop a plan and a timeline for repair.

- Shut off water supply to the toilets;
- Lock public restrooms;
- Bag restroom waste in patient rooms as needed;
- Collect bagged waste at the biohazardous cage;
- Have portable toilets delivered if needed.

**Reference:** CIHQ Standard EP3A

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| SUBJECT: Failure of Heating, Ventilation and Air Conditioning (HVAC) systems. | POLICY # 8450-15<br>PAGE 1 OF 2 |
| DEPARTMENT: Engineering | EFFECTIVE: |
| REVISED: | |

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

**WHY:** To explain how Sonoma Valley Hospital will maintain safe temperatures when the HVAC system is affected during a disaster

**OWNER:**
Director of Engineering

**AUTHORS/REVIEWERS:**
Grigory Gatenian, Plant Operations Manager

**APPROVALS:**
Policy & Procedure Team: 3/4/20
Board Quality Committee:
The Board of Directors:

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|---|---|
| SUBJECT: Failure of Heating, Ventilation and Air Conditioning (HVAC) systems. | POLICY # 8450-15<br>PAGE 2 OF 2 |
| DEPARTMENT: Engineering | EFFECTIVE: |
| REVISED: | |

**PURPOSE:**

To outline the actions of the hospital personnel in case of partial or total loss of HVAC to the hospital during a disaster.

**POLICY:**

In an effort to maintain the safe temperatures in the patient care areas and safe sanitary storage of provisions during the outage of the HVAC systems the hospital personnel will implement the following actions:

**PROCEDURE:**

- In the event of cooling side failure for extended period of time:
  - Open windows (if possible), use fans in patient care areas, clean and sterile supplies rooms and IDF (computer) closets to keep the temperature down.
  - In most critical areas use portable A/C units.

- In the event of heating side failure for extended period of time:
  - Secure the facility and restrict visitation. Use blankets to keep patients warm.
  - In most critical areas use multiple area heaters.

- In the event of a total loss of the HVAC system for extended period of time:
  - Use above actions as appropriate.

- Assess the damage to the HVAC system and develop a plan and a timeline for repair;
- Contact other facilities to request loaner equipment if possible;
- Consider relocation of patient services within facility or partial or complete evacuation.

**REFERENCES:**
CIHQ Standard EP3A