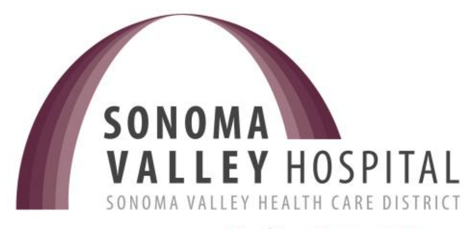


SVHCD QUALITY COMMITTEE

AGENDA

WEDNESDAY, MARCH 24, 2021

5:00 p.m. Regular Session

TO BE HELD VIA ZOOM VIDEOCONFERENCE

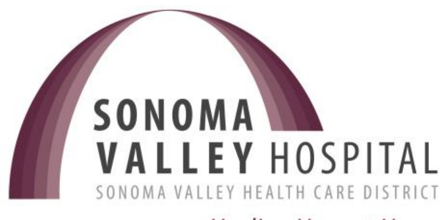
To Participate Via Zoom Videoconferencing
use the link below:

https://sonomavalleyhospital-org.zoom.us/j/92697642290?pwd=MXlERGJpTmt2VlluMk10K3lsL1FNdz09

and Enter the **Meeting ID: 926 9764 2290**
Passcode: 204848

To Participate via Telephone only, dial:
1-669-900-9128 or 1-669-219-2599
and Enter the **Meeting ID: 926 9764 2290**
Passcode: 204848

AGENDA ITEM	RECOMMENDATION	
In compliance with the Americans with Disabilities Act, if you require special accommodations to attend a District meeting, please contact the District Clerk, Vivian Woodall, at vwoodall@sonomavalleyhospital.org or 707.935.5005 at least 48 hours prior to the meeting.		
MISSION STATEMENT *The mission of the SVHCD is to maintain, improve, and restore the health of everyone in our community.*		
1. CALL TO ORDER/ANNOUNCEMENTS	*Mainardi*	
2. PUBLIC COMMENT SECTION *At this time, members of the public may comment on any item not appearing on the agenda. It is recommended that you keep your comments to three minutes or less. Under State Law, matters presented under this item cannot be discussed or acted upon by the Committee at this time. For items appearing on the agenda, the public will be invited to make comments at the time the item comes up for Committee consideration.*	*Mainardi*	
3. CONSENT CALENDAR • Minutes 02.24.21	*Mainardi*	Action
4. QUALITY INDICATOR PERFORMANCE AND PLAN FOR FEBRUARY 2021	*Jones*	Inform
5. 2020 ANNUAL QUALITY DEPARTMENT REVIEW	*Jones*	Inform
6. POLICIES AND PROCEDURES	*Jones*	Action
7. CLOSED SESSION: a. Government Code §54956.86: Complaint Involving Information Protected by Federal Law b. Calif. Health & Safety Code §32155: Medical Staff Credentialing & Peer Review Report		
8. REPORT OF CLOSED SESSION	*Mainardi*	Action
9. ADJOURN	*Mainardi*	



SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
February 24, 2021 5:00 PM
MINUTES
Via Zoom Teleconference

Members Present	**Members Present cont.**	**Excused**	**Public/Staff**
Michael Mainardi, MD, via Zoom Howard Eisenstark, MD, via Zoom Susan Kornblatt Idell via Zoom Ingrid Sheets via Zoom	Carol Snyder via Zoom Andrew Solomon, MD, via Zoom Cathy Webber via Zoom		Sabrina Kidd, MD, CMO and COO, via Zoom Danielle Jones, RN, Chief Quality Officer, via Zoom Mark Kobe, CNO, via Zoom Dr. Judith Bjorndal via Zoom

AGENDA ITEM	**DISCUSSION**	**ACTION**
1. CALL TO ORDER/ANNOUNCEMENTS	*Mainardi*	
	5:00 pm	
2. PUBLIC COMMENT	*Mainardi*	
	None	
3. CONSENT CALENDAR	*Mainardi*	Action
• QC Minutes, 01.27.21	Item 6 of the January 27, 2021, minutes should be changed to read "… post-discharge calls from pharmacists."	**MOTION:** by Eisenstark to approve with change, 2nd by Sheets. All in favor.
4. PATIENT CARE SERVICES QUALITY DASHBOARD	*Kobe*	Inform
	Mr. Kobe reviewed the fourth quarter patient services dashboard, indicating these are areas over which nursing has direct control. Low numbers for medication scanning in the third and fourth quarters were due to the cyberattack, and SVH did not have that capability back until late January. Patient satisfaction naturally slipped a bit during the cyberattack as well, but that is being addressed.	
5. QUALITY INDICATOR PERFORMANCE AND PLAN FOR JANUARY 2021	*Jones*	Inform

AGENDA ITEM	DISCUSSION	ACTION
	Ms. Jones reviewed the quality indicator performance for January. New metrics added include hospital acquired infections, risk events, and patient relations. CMS has made changes in their star rating system; SVH is now rated 3 stars, although performance has not gone down at all.	
6. POLICIES AND PROCEDURES	*Jones*	Inform
	Policies with Changes Made: Airborne Infection Isolation Precautions Authority Statement Communicable Disease Reporting to Public Health Contact Isolation Precautions Contact Plus Enteric Isolation Precautions Diet Orders and Diet Changes Discharge Medication Charity Program Droplet Precautions Enteral and Oral Supplementation, Role of Dietitian Humidity Temperature Surgical Areas Late Trays Lice, Management of Infestation Management of Multi-Drug Resistant Organisms Menu Distribution Paging Codes Overhead Personal Hygiene and Food Safety Purchase Order Returns Quality Improvement Plan Safety in Materials Management Sales Representative Policy System Downtime Procedures Utilization Review Plan Policies Reviewed – No Changes: Aerosol Transmissible disease Exposure Control Bloodborne Pathogen Exposure Control Discharge Planning Ebola Viral Disease Hand Hygiene Infection Control Committee Infection Control Mandatory Reporting Infection Control Water Management Infection Prevention and Control Training for Healthcare Workers	**MOTION:** by Eisenstark to approve policies, with minor changes to new policies, **EXCEPT** "PPE 90-day Supply," which was not approved; 2nd by Kornblatt Idell. All in favor.

AGENDA ITEM	DISCUSSION	ACTION
	Rehabilitation Services with Patients in Contact Isolation Statement of Service New Policies: Cleaning Schedules and Procedures Parenteral Nutrition, Role of the Dietitian PPE 90-day Supply Storage of Food for Patients Brought in from Non-Facility Source The new policy “PPE 90-day Supple” was not approved and was returned for rewrite. The Committee requested an addition to the summary of why the policy was changed, in addition to what was changed.	
7. CLOSED SESSION: a. Calif. Health & Safety Code §32155: Medical Staff Credentialing & Peer Review Report		
8. REPORT OF CLOSED SESSION	*Mainardi*	
	The Medical Staff credentialing report was approved.	**MOTION:** by Eisenstark, 2nd by Kornblatt Idell. All in favor.
9. ADJOURN	*Mainardi*	
	6:14 pm	

Quality Indicator Performance & Plan

March 2021

Data for February 2021

MORTALITY

Scorecard Summary
Mortality

All Indicators Scorecard: PI Committee Mortality EDIT

Status	Indicator	Current Value	Target	SPC Alert	Updated
Quality > Autopsies Mortalities					
	Acute Care Mortality Rate (M)	1.6%	15.3%		Feb 2021
—	Congestive Heart Failure Mortality Rate [M]	0.0%	11.5%		Feb 2021
—	COPD Mortality Rate [M]	0.0%	8.5%		Feb 2021
—	Ischemic Stroke Mortality Rate [M]	0.0%	13.8%		Feb 2021
—	Pneumonia Mortality Rate [M]	0.0%	15.6%		Feb 2021
Quality > Process of Care > Sepsis Care					
—	Sepsis, Severe - Mortality Rate (M)	0.0%	25.0%		Feb 2021
	Septic Shock - Mortality Rate (M)	0.0%	25.0%		Feb 2021

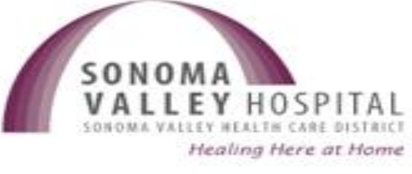
PREVENTABLE HARM EVENTS

Scorecard Summary
AHRQ Patient Safety Indicators

All Indicators Scorecard: PI Committee AHRQ PSI EDIT

Status	Indicator	Current Value	Target	SPC Alert	Updated
Quality > Patient Safety > AHRQ Patient Safety Indicators_PSI					
—	PSI 02 (v2019) Death in Low-mortality DRGs - Per 1000 ACA (M)	0.00	0.21		Feb 2021
—	PSI 03 (v2019) Pressure Ulcer - Per 1000 ACA (M)	0.00	0.51		Feb 2021
	PSI 04 (v2019) Death in Surgical IP w/Ser Comp, Overall - Per 1000 ACA (M)	0.00	146.36		Feb 2021
—	PSI 05 (v2019) Retained Surgical Item/Device Fragment - Per 1000 ACA (M)	0.00	0.00		Feb 2021
—	PSI 06 (v2019) Iatrogenic Pneumothorax - Per 1000 ACA (M)	0.00	0.21		Feb 2021
—	PSI 07 (v2019) Central Venous Catheter-related BSI - Per 1000 ACA (M)	0.00	0.12		Feb 2021
—	PSI 08 (v2019) In Hospital Fall with Hip Fracture - Per 1000 ACA (M)	0.00	0.08		Feb 2021
—	PSI 09 (v2019) Perioperative Hemorrhage or Hematoma - Per 1000 ACA (M)	0.00	2.29		Feb 2021
—	PSI 10 (v2019) Postop Acute Kidney Injury Requiring Dialysis - Per 1000 ACA (M)	0.00	0.73		Feb 2021
—	PSI 11 (v2019) Postoperative Respiratory Failure - Per 1000 ACA (M)	0.00	5.53		Feb 2021
—	PSI 12 (v2019) Perioperative Pulmonary Embolism or DVT - Per 1000 ACA (M)	0.00	3.45		Feb 2021
—	PSI 13 (v2019) Postoperative Sepsis - Per 1000 ACA (M)	0.00	4.05		Feb 2021
—	PSI 14 (v2019) Postoperative Wound Dehiscence - Per 1000 ACA (M)	0.00	0.69		Feb 2021
—	PSI 15 (v2019) Accidental Puncture or Laceration - Per 1000 ACA (M)	0.00	1.06		Feb 2021
—	PSI 90 (v2019) Midas Patient Safety Indicators Composite, ACA (M)	0.00	1.00		Feb 2021

The Patient Safety Indicators (PSIs) provide information on potentially avoidable safety events that represent opportunities for improvement in the delivery of care.



Scorecard Summary
Patient Falls
Preventable Harm

All Indicators Scorecard: PI Committee Falls EDIT

Status	Indicator	Current Value	Target	SPC Alert	Updated
Quality > Patient Safety > Falls					
—	RM ACUTE FALL- NO INJURY (M) per 1000 patient days	0.00	3.75		Feb 2021
—	RM ACUTE FALL- WITH INJURY (M) per 1000 patient days	0.00	3.75		Feb 2021
—	Falls with injury % of all Acute falls |M|	0.0%	0.0%		Feb 2021

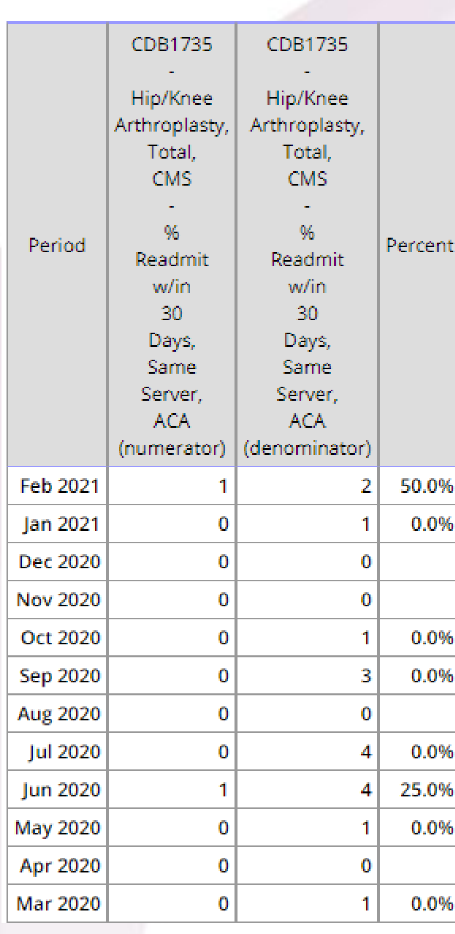
READMISSION

Scorecard Summary Readmissions

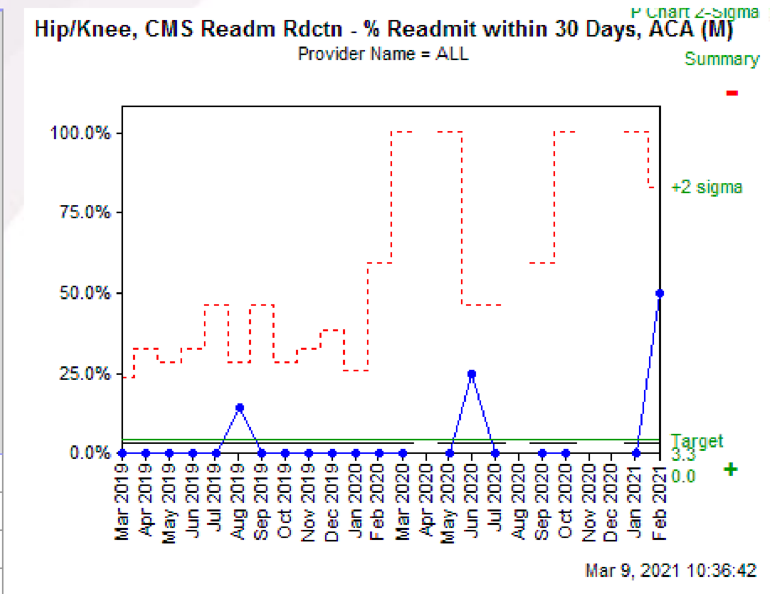
All Indicators Scorecard: PI Committee Readmissions EDIT

Status	Indicator	Current Value	Target	SPC Alert	Updated
Quality > Readmissions					
	30-DV Inpatients - % Readmit to Acute Care within 30 Days (M)	1.7%	15.3%		Feb 2021
	COPD, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)	0.0%	19.5%		Feb 2021
	HF, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)	0.0%	21.6%		Feb 2021
	Hip/Knee, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)	50.0%	4.0%		Feb 2021
	PNA, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)	0.0%	16.6%		Feb 2021
	Sepsis, Severe - % Readmit within 30 Days (M)	0.0%	12.0%		Feb 2021
	Septic Shock - % Readmit within 30 Days (M)	0.0%	13.3%		Feb 2021

Hip/Knee CMS Readmission



Period	CDB1735 - Hip/Knee Arthroplasty, Total, CMS - % Readmit w/in 30 Days, Same Server, ACA (numerator)	CDB1735 - Hip/Knee Arthroplasty, Total, CMS - % Readmit w/in 30 Days, Same Server, ACA (denominator)	Percent
Feb 2021	1	2	50.0%
Jan 2021	0	1	0.0%
Dec 2020	0	0	
Nov 2020	0	0	
Oct 2020	0	1	0.0%
Sep 2020	0	3	0.0%
Aug 2020	0	0	
Jul 2020	0	4	0.0%
Jun 2020	1	4	25.0%
May 2020	0	1	0.0%
Apr 2020	0	0	
Mar 2020	0	1	0.0%



- February 2021
  - Peripheral edema
  - Chronic lower extremity venous stasis
  - Congestive heart failure
  - Medication changes
  - Referral to high level of care
  - Weight gain during post op period

Percentage of encounters with an unplanned readmission to any facility within 30 days among adult acute care inpatient encounters with a principal discharge procedure of total hip arthroplasty or total knee arthroplasty

BLOOD CULTURE CONTAMINATION

Blood Culture Contamination

Blood Culture Report - Monthly for 2021	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Total Blood Cultures Processed	137	93										
True Postive Cultures	3	5										
True Postive Culture Rate (percent)	2.2	5.4										
Total Contamination Cultures	3	4										
Total Contamination Rate (percent)	***2.2***	***4.3***										
Acceptable Contamination Rate ≤3.0%	Yes	No										
Blood Cultures Drawn by RN Staff	89	43										
Contaminated Culture Reported	2	4										
RN Contamination Rate (percent)	2.2	9.3										
Acceptable Contamination Rate ≤3.0%	Yes	No										
Blood Culture Drawn by Lab Staff	48	50										
Contaminated Culture Reported	1	0										
Lab Contamination Rate (percent)	2.1	0.0										
Acceptable Contamination Rate ≤3.0%	Yes	Yes										

Percent (0.0–10.0)

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
RN	2.2	4.3										
Total	2.2	9.3										
Lab	2.1	0.0										

Month

Blood Culture Contamination

- Case Review
  - Emergency Department
  - February 2021
  - Four contaminations
    - 3 ED RNs identified
      - 1:1 conversation and return demonstration; next fallout will require extensive remediation session with staff educator
    - 1 unidentified RN draw

- Case Review
  - Lab
  - February 2021
  - Zero contamination

INFECTION PREVENTION

Hospital Acquired Infections: Days Since

- Clostridium difficile
  - 12 months
- Catheter Associated Urinary Track Infection
  - 1 year, ten months
- Central Line Associated Blood Stream Infection
  - 10 years
- Surgical Site Infection
  - 1 year, seven months
- Methicillin-resistant staphylococcus aureus
  - 10 years+
- Ventilator Associated Episode
  - 10 years +

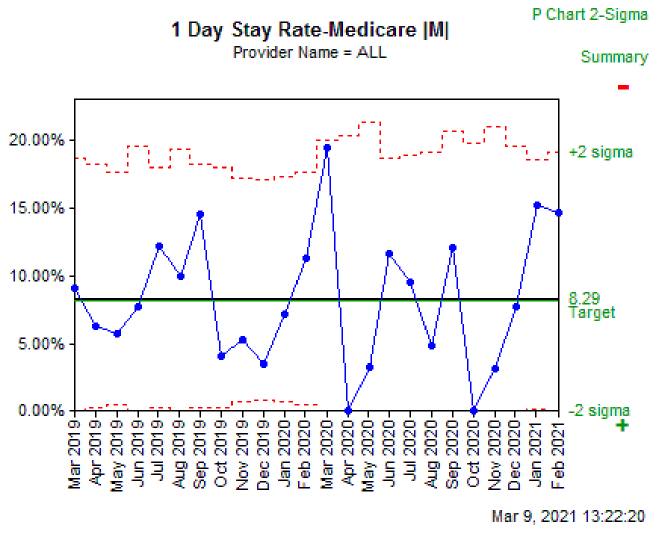
UTILIZATION MANAGEMENT

Utilization Management

Finance > Utillization Management					
	1 Day Stay Rate-Medicare |M|	14.63%	8.10%		Feb 2021
	1 Day Stay Rate Medi-Cal |M|	10.00%	2.61%		Feb 2021
	Acute Care Risk-adjusted Average Length of Stay O/E Ratio |M|	0.91	0.79		Feb 2021
	InterQual Criteria Status Not Met: Admission |M|vol	0	2		Feb 2021
	InterQual Criteria Status Not Met: Continued Stay |M| vol	0	0		Feb 2021

One day stay Medicare

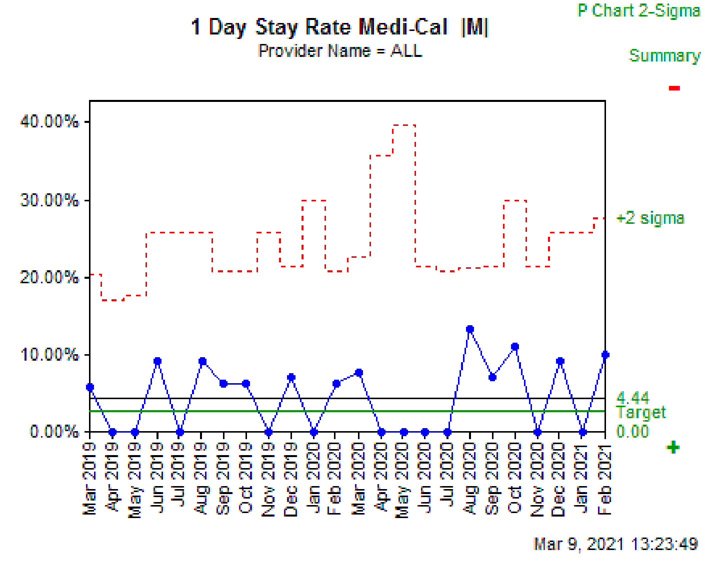
Period	R-ENC-1 Day Stay Medicare rate (numerator)	R-ENC-1 Day Stay Medicare rate (denominator)	Percent
Feb 2021	6	41	14.63%
Jan 2021	7	46	15.22%
Dec 2020	3	39	7.69%
Nov 2020	1	32	3.12%
Oct 2020	0	38	0.00%
Sep 2020	4	33	12.12%
Aug 2020	2	41	4.88%
Jul 2020	4	42	9.52%
Jun 2020	5	43	11.63%
May 2020	1	31	3.23%
Apr 2020	0	34	0.00%
Mar 2020	7	36	19.44%



- Case Review
  - February 2021
  - 6 encounters

One day stay Medi-Cal

Period	R-ENC-1 Day Stay Medi-Cal rate (numerator)	R-ENC-1 Day Stay Medi-Cal rate (denominator)	Percent
Feb 2021	1	10	10.00%
Jan 2021	0	11	0.00%
Dec 2020	1	11	9.09%
Nov 2020	0	14	0.00%
Oct 2020	1	9	11.11%
Sep 2020	1	14	7.14%
Aug 2020	2	15	13.33%
Jul 2020	0	16	0.00%
Jun 2020	0	14	0.00%
May 2020	0	5	0.00%
Apr 2020	0	6	0.00%
Mar 2020	1	13	7.69%



- Case Review
  - February 2021
  - 1 encounter

RISK EVENT REPORTS

Risk Event Reports

Event Class/Parameters	Count of Event No.
BEHAVIOR ISSUES	**1**
Workplace Violence- Patient	1
COMPLICATION	**1**
Complication-Surgical	1
CRITICAL RESPONSE	**3**
CODE ARREST,<24 HOURS OF ADM.	2
RAPID RESPONSE	1
DOCUMENTATION ISSUES	**6**
Documentation, Incomplete Surgical Safety Checklist	1
Documentation, Missing from Medical Record	2
Documentation, Other	2
Lab, Reference Ranges/results	1
DX,DIAGNOSTIC TEST	**2**
DX,DELAYED	1
Lab, collection/reporting timing error	1
EQUIPMENT ISSUES	**1**
EQUIP/MED DEVICE	1
INJURY	**1**
INJURY,HOSP GROUNDS	1
MEDICATION	**5**
MED,ALLERGIC/ADVERSE REACTION	1
MERP-Administration	1
MERP-Dispensing	1
MERP-Prescribing	1
MERP-Prescription order communication	1
OR RELATED	**1**
OR,DELAY	1
TREATMENT/PROCEDURE ISSUE	**5**
SKIN INTEGRITY-HAC (hospital acquired condition)	1
TREAT/PROCED, CANCELED	2
TREAT/PROCED, DELAYED	1
TREAT/PROCED,CENTRAL LINE	1
Grand Total	**26**

HUMAN EXPERIENCE

Patient Relations

#	Location	Significance	Type(s)
20-102	Emergency Dept.	Complaint, process not completed by patient	Complaint-Other
17-137	Emergency Dept.	Grievance-No Findings	Grievance-Billing Grievance-Physician Care
21-25	Med Surg- 3rd floor	Grievance-No Findings	Grievance-Communication Grievance-Patient Care
21-11	Emergency Dept.	Grievance-Sorry Works!	Grievance-Communication Grievance-Physician Care

Grievance elapsed time

Avg days to Acknowledgement:	4.7
Avg days to Resolution:	8.3
Avg days to Close:	9.7

Inpatient Patient Satisfaction

Service Line Performance

CAHPS Rate 0-10

n	17
Top Box Score	64.71%
Score Goal	50.00%
Percentile Rank	22

Time Period	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021
n	32	46	29	28	31	17
Top Box Score	65.63%	60.87%	62.07%	75.00%	67.74%	64.71%
Percentile Rank	21	11	14	65	32	22

Dashboard Name: Performance Overview| System Name: Sonoma Valley Hospital - System| System ID: 15704| Service Line: Inpatient| Measure: CAHPS Rate 0-10| Metric: Top Box Score| Date Type: Received Date| Time Frame: Quarter To Date| Peer Group: All PG Database| Priority Index - Survey Type: CAHPS| Priority Index View: External| Phone Calibration: Applied| CMS Reportable Responses: Applied| Skip Logic: Applied| Current Benchmarking Period: 12/01/2020 - 02/28/2021| Fiscal Start Month: 01| Download Date & Time: Mar 15, 2021 12:09 am EDT

Surgery Patient Satisfaction

Service Line Performance

CAHPS Rate 0-10

● Top Box Score | < 50th Percentile | 75th - 89th Percentile
Score Goal | 50th - 74th Percentile | >= 90th Percentile

AS 98.33%

0% 20% 40% 60% 80% 100%

● High Point ● Low Point

99.33%
88.62%
77.91%

Q4 2019 Q1 2020 Q2 2020 Q3 2020 Q4 2020 Q1 2021

n	60
Top Box Score	98.33%
Score Goal	50.00%
Percentile Rank	99

Time Period	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021
n	112	128	54	52	64	60
Top Box Score	79.46%	78.91%	83.33%	80.77%	79.69%	98.33%
Percentile Rank	14	11	25	15	12	99

Dashboard Name: Performance Overview | System Name: Sonoma Valley Hospital - System | System ID: 15704 | Service Line: Ambulatory Surgery | Measure: CAHPS Rate 0-10 | Metric: Top Box Score | Date Type: Received Date | Time Frame: Quarter To Date | Peer Group: All PG Database | Priority Index - Survey Type: CAHPS | Priority Index View: External | Phone Calibration: Applied | CMS Reportable Responses: Not Applied | Skip Logic: Not Applied | Current Benchmarking Period: 12/01/2020 - 02/28/2021 | Fiscal Start Month: 01 | Download Date & Time: Mar 14, 2021 11:37 pm EDT

QUALITY ASSURANCE/PERFORMANCE IMPROVEMENT PROGRAM REVIEW 2020

Purpose

The Quality Department, in cooperation with the Medical Staff Performance Improvement Committee and Administrative Leadership, has completed an appraisal of the Performance Improvement Program.

The purpose of this appraisal is to:

- Evaluate the comprehensiveness and scope of the program.
- Assess the effectiveness of the FOCUS / PDSA model.
- Measure the extent of interdisciplinary collaboration.
- Assure that all key functions and dimensions of performance have been addressed.
- Provide the Governance, Administration and Medical Staff leaders with the results of prior year activities to assist in development of priorities for improvement.
- Determine the extent to which the Performance Improvement Program supported the mission and vision.

Scope and Applicability

This is an organization-wide program. It applies to all settings of care and services provided by Sonoma Valley Hospital.

Quality Assurance Performance Improvement (QAPI) Purpose Statement
The purpose of QAPI at Sonoma Valley Hospital is to take a proactive approach to continually improve the way we care for and engage with our patients, physicians and employees and other partners so that we may realize our vision to be a trusted resource for compassionate, exceptional care. To do this, all employees will participate in ongoing QAPI efforts which support our mission by continually working to restore, maintain and improve the health of everyone in our community.

QAPI Guiding Principles

1. Sonoma Valley Hospital uses quality assurance and performance improvement to make decisions and guide our day-to-day operations.
2. In Sonoma Valley Hospital, QAPI includes all employees, all departments and all services provided.
3. QAPI focuses on systems and processes. The emphasis is on identifying system gaps rather than on blaming individuals.

Findings

The Leaders attention was directed towards the COVID-19 global pandemic in 2020. While each department maintained their Quality Assurance Performance Improvement (QAPI) plans, no formalized projects were presented as posters.

The leaders maintained alignment in their QAPI plans with Sonoma Valley Hospital Strategic Priorities 2020-2025 which outlined four priorities:

1. Create UCSF Health Outpatient Center
2. Exceed community expectations, especially in Emergency Services
3. Become a 5 Star Hospital
4. Provide access to excellent physicians

2020 Quality Department Initiatives

Department Restructure
The Quality Department (Quality, Risk, Infection Prevention, Human Experience, Medical Staff Peer Review, Case Management and Health Information Management) reorganization has strengthened the department's ability to serve as a resource for the organization assisting and coordinating with all internal departments and external customers. The Quality Department welcomed an Infection Preventionist, Quality/Case Management assistant, and Patient Experience Manager & Clinical Quality Analyst.

The Infection Preventionist oversees the development and day-to-day implementation of the annual infection prevention plan and goals, as approved by the Performance Improvement Committee. This position is responsible for the hospital-wide Infection Prevention and Control Program and ensures activities are directed toward preventing and decreasing healthcare associated infections and improving patient safety across the continuum of care. This position also provides employee health services support, coordinates annual health screenings including facility-wide inoculations, and coordinates the return-to-work program associated with Workers' Compensation.

The Quality /Case Management assistant performs specialized, analytical and administrative duties in support of various quality, case management, infection control, and initiatives. The role entails database entry and maintenance, report generation, administrative assistance, coordination of priorities between multiple departments, assistance with accreditation, survey coordination and action plan follow up, policy and procedure maintenance.

The Patient Experience Manager & Clinical Quality Analyst is responsible for managing the implementation of programs and processes designed to build and improve patient experience, and activities in alignment with the hospital's strategic plan. Additionally, this role is responsible for

concurrent clinical chart review to identify specific data measures for reporting to regulatory agencies and data repositories.

Human Experience

The Quality Department partnered with a consultant to help us assess identify our opportunities for improvement and design strategies to improve the experience for our teams, patients, and families. Front line staff and physicians were given the opportunity to provide insights through the pulse survey, interviews, and focus groups. As part of this, we conducted a series of focus groups with members of our team along with patients and families. We gathered insight and input, and brought together a multidisciplinary team that helped us define a shared vision of the Sonoma Valley Hospital Human Experience and core strategies to help achieve it.

The Quality Department established key process indicators for 2020 and developed three committee charters-Communication with Nurses, Communication with Physicians, and Communication about Medications. These projects will begin in 2021. The Quality Department worked to establish rapport with frontline clinicians and launched real-time daily Patient Rounding by Patient Experience Manager and reporting to leadership. We found pleasure in writing personalized Thank You notes to staff, physicians and patients when they share their SVH experience.

The Quality Department established monthly Press Ganey platform training with Press Ganey advisor. Additionally, we created a monthly Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) and patient comments report that is shared with leadership and Medical Directors. Also, the Chief Quality Officer and Patient Experience Manager attended three day National Press Ganey Virtual Conference where we were able to bring back best practice to leverage Human Experience at SVH.

COVID-19

The Quality Department provided COVID-19 infection control surveillance. Additional COVID responsibilities included and which included: chart review; collaborating with COVID-19 hotline and drive thru; specimen monitoring and tracking; communicating with Department of Public Health, physician offices and reference labs; notifying and educating patients (including staff) and/or receiving their phone calls regarding results

The Quality Department partnered with Information Systems to implement COVID Access database for real time data collection and reporting. The Quality Department maintained the database. The Infection Preventionist is responsible for rounding on staff to ensure compliance and provide real time coaching related to monitoring for masking, hand hygiene, isolation precautions, and Personal Protective Equipment (PPE) don/doff procedures.

The Infection Preventionist is also responsible for screening employees with COVID-19 symptoms or positive tests for adherence to quarantine and return-to-work guidelines
The Infection Preventionist supported the Education RN in providing training for SVH's new Powered Air Purifying Respirators (PAPR). In 2020, the Infection Preventionist also provided community education related to COVID-19 with a radio spot and community presentations in partnership with the Marketing Department.

Accreditation
The Quality Department supported and managed the triennial Center for Improvement in Healthcare Quality (CIHQ) survey. Sonoma Valley Hospital has successfully met the requirements for reaccreditation under the acute care hospital program.

Additionally, The Quality Department supported and managed the CIHQ Stroke Ready Certification. CIHQ awarded this disease specific certification to Sonoma Valley Hospital as an Acute Stroke Ready Hospital effective from April 2020. Certification as an Acute Stroke Ready Hospital means that SVH has successfully met the requirements outlined in CIHQ's standards.

Furthermore, the Quality Department supported and managed the California Department of Public Health (CDPH) Covid-19 Survey. In 2020, CDPH conducted a COVID-19 infection control survey that focused on transmission precautions, personal protective equipment, environmental cleaning protocols, infection surveillance, visitor, staff and patient screening and emergency preparedness plan. SVH successfully met the new COVID requirements without any deficiencies.

Clinical Quality Review
The Quality Department created focus studies to capture opportunities for improvement for nurses and clinical care providers such as phlebotomists, medical imaging techs, etc. We will be able to track and trend the data and provide solutions for any identified systems or process errors.

The Quality Department developed new guidelines for real-time review of mortality and readmission encounters. We were able to identify opportunities related to palliative care, LACE scores and MD documentation requirements for hospice patients. The Quality Department also established mechanisms to review and report clinical quality issues in Midas and refer to manager for review if appropriate.

We worked to establish processes to enter core measure sepsis/stroke physician opportunities for improvement in Midas and refer to Quality Management for Peer Review by appropriate Medical Director.

Lastly, we collaborated with Information Systems to create enhanced Flow Sheets and orders in Paragon for Sepsis to improve documentation and adherence to new CMS guidelines including COVID-19.

Cyberattack Breach Notification

The Quality Department was instrumental during the cyberattack for Health Insurance Portability and Accountability Act (HIPAA) breach notification to State's Attorneys General and the Office of Civil Rights. The Quality Department was tasked with the implementation of the patient call center and escalation through our internal patient grievance program for personalized patient follow up. We also supported Information Systems with regulatory notifications, audit readiness, report management, and partnered with legal representative during the breach notification process.

American Heart Association Get with the Guidelines-Stroke (GWTG-S)

The Quality Department initiated GWTG-S, an industry standard for in-hospital data collection that improves stroke care by promoting consistent adherence to the latest standard of practice treatment guidelines. The Quality Department is responsible for management, abstracting and submitting data to GWTG-S reporting data back to Stroke Committee and making recommendations for improvement.

Hospital Quality Institute (HQI) Hospital Improvement Platform

The Quality Department implemented the comparative data analytics tool that will allow us to identify challenges and success in our quality performance. The Quality Department is able to use reports that are already sent to Office of Statewide Health Planning and Development (OSHPD) and National Healthcare Safety Network (NHSN). The data is as new as the latest OSHPD uploads. This means that we can identify trends prior to regulatory reporting deadlines and make clinical changes for improvement rather than relying on two year old CMS data.

STATIT

The Quality Department focused on specialized areas to increase data accessibility and standardization through the use of control charts for various indicators throughout the organization. STATIT has supported actionable performance improvement projects based on relevant benchmarks and standards. In 2020, the Quality Department created dashboards for utilization management, medical staff, surgery department and the emergency department. The goal is to increase data accessibility and standardization. These new dashboards support actionable performance improvement projects based on relevant benchmarks and standards. STATIT has provided insights to help SVH make objective, sustainable, and defensible decisions while improving clinical quality, patient experience, and satisfaction.

MedMined

The Quality Department employed the automation resources of MedMined to eliminate time and labor intensive and processes once used to report CMS required data with regard to infection control and surveillance. The Infection Preventionist is also able to perform real time clinical surveillance of healthcare associated infections (HAIs) instead of relying on data push from manual lab reports. This empowers the Infection Preventionist to spend less time on administrative tasks and more time on patient care.

The Quality Department continued to support the Midas Risk/Pt Relations Committee. The Patient Relations Committee restructure included standardized acknowledgment and final letters, policy review, agenda and meeting minute update. This led to a decrease in the average length of first response to six days and the reduction in the average length to resolution is 12 days!

An annual review of the budget for Quality, Risk Management, Infection Prevention, Medical Staff Peer Review, Health Information Management and Patient Satisfaction indicates adequate staffing and resources have been allocated to these functions.

The Quality Department provided Anthem Blue Cross with hospital data this year for their Q-HIP program. We also provided healthcare associated infection data to the National Healthcare Safety Network and the Centers for Disease Control for surveillance and benchmarking purposes. We successfully reported quarterly data to our Patient Safety Organization. Lastly, in a combined effort, Information systems and Quality were able to again successfully send Electronic Quality Measures to CMS.

Interdisciplinary collaboration was demonstrated through the following:

Sorry Works	**Culture of Safety Program**	**Good Catch Program**
Stroke Committee	Patient Safety Committee	Clinical Informatics Team
Pharmacy and Therapeutics Committee	Departmental and cross departmental performance improvement projects and organization wide performance improvement	Medical Staff Performance Improvement Committee
Grievance Committee	Incident Command Center COVID Committee	Policy & Procedure Committee
Antimicrobial Stewardship	Compliance Committee	Medical Staff Committees
Administrative and Leadership Meetings	Daily Multidisciplinary Patient Care Huddle	Utilization Review Program

Assessment of Performance

The Performance Improvement Program supports the hospital's mission and is well on the way to supporting an organizational Culture of Quality and Safety. The effectiveness of the PI program is measured by its accomplishments. Data was collected and aggregated on performance measures and thoroughly analyzed. Intensive assessments were completed when SVH detected or suspected a significant undesirable performance or variation. Progress was made on the following program goals:

I***. Quality Department Infrastructure Goals for 2020***

Performance Goal	Outcome
• Policy and Procedure renovation from manual to automated	Completed
• Get With the Guidelines Stroke membership	Completed
• Case Management department restructure	In Process
• Create additional STATIT indicators including Risk, Patient Relations, Medical Records QA/PI, Code Stroke Protocol	Completed
• Continue to work with department leaders and their staff to revise, refine and improve their department specific QAPI plans including development and reporting of meaningful quality and patient safety indicators	Completed

II. ***Performance Improvement, Reportable Outcome Measures***
See Attached Dashboards

Assessment of Effectiveness

The Performance Improvement Program, in 2020, met the needs of the Performance Improvement Committee, Medical Executive Committee and Sonoma Valley Hospital.

Objectives for Next Evaluation Period

With input from the medical staff and leadership, the Administrative Team performed an assessment of potential organizational performance improvement activities for 2020 that align with the strategic plan and core strategic initiatives and reflects the scope and complexity of patient care services. In addition to departmental and interdepartmental continuous performance improvement activities, the organization will focus on the following priorities.

A. Prioritized Organizational Performance Improvement Projects for 2021 include the following:
   - Palliative Care-to improve the quality of life and wellbeing of our patients by increasing palliative care consults and strengthening the partnership between SVH and community palliative care providers. Director of Patient Care Services, Hospitalists, Chief Quality Officer

B. Quality Department Infrastructure Goals 2020:

   - Continue Case Management department restructure in partnership with Banyan
   - Increase the CMS HCAHPs ranking of Communication about Medications Domain
   - Improve the standard of care for sepsis through best-practice bundles
   - Create a national database with AHA-Get With The Guidelines-Stroke
   - Create Risk Management Trending Reports
   - Opioid Reduction PI Monitoring
   - Complete Surgery Department Central Processing Risk Assessment

Mortality

ALL Scorecard: PI Committee Mortality

Acute Care Mortality Rate (M)

15.0%
10.0%
5.0%
0.0%
Feb 2021

Congestive Heart Failure Mortality Rate |M|

100.0%
75.0%
50.0%
25.0%
0.0%
Feb 2021

COPD Mortality Rate |M|

100.0%
75.0%
50.0%
25.0%
0.0%
Feb 2021

Ischemic Stroke Mortality Rate |M|

100.0%
75.0%
50.0%
25.0%
0.0%
Feb 2021

Pneumonia Mortality Rate |M|

100.0%
75.0%
50.0%
25.0%
0.0%
Feb 2021

Sepsis, Severe - Mortality Rate (M)

100.0%
75.0%
50.0%
25.0%
0.0%
Feb 2021

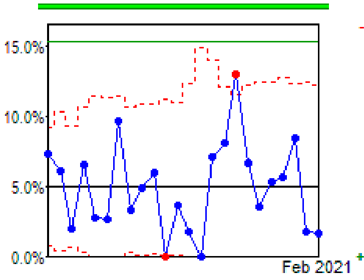
Septic Shock - Mortality Rate (M)

100.0%
75.0%
50.0%
25.0%
0.0%
Feb 2021

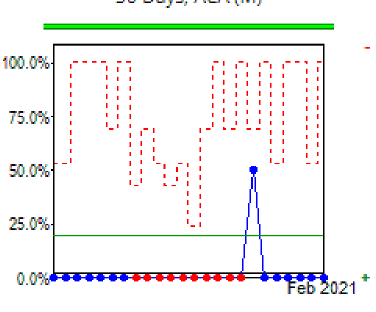
Readmissions

ALL Scorecard: PI Committee Readmissions

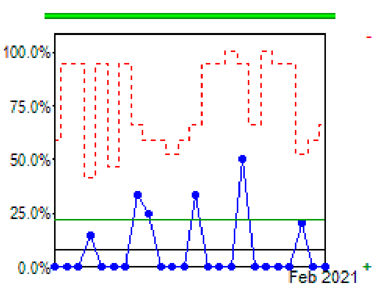
30-DV Inpatients - % Readmit to Acute Care within 30 Days (M)



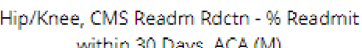
COPD, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)

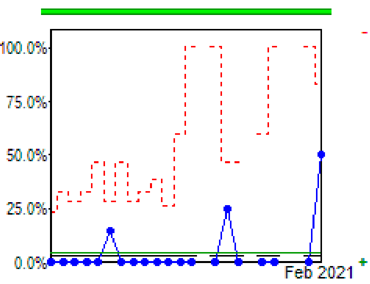


HF, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)

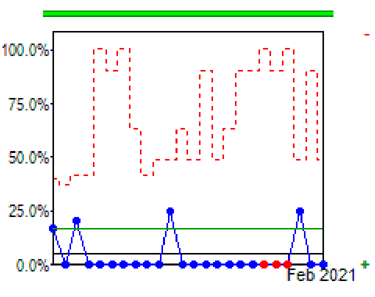


Hip/Knee, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)

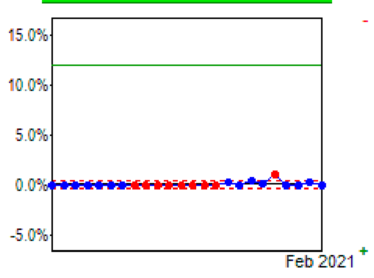




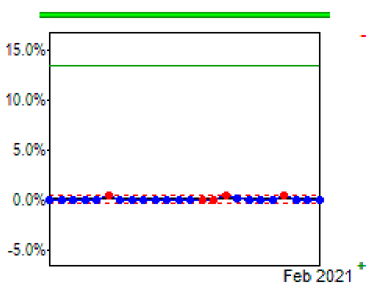
PNA, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)



Sepsis, Severe - % Readmit within 30 Days (M)



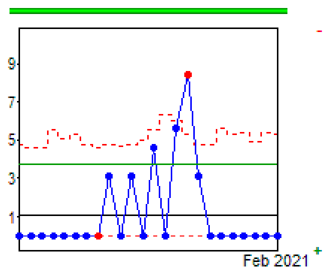
Septic Shock - % Readmit within 30 Days (M)



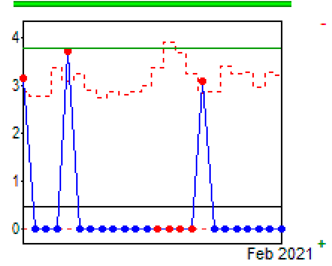
Falls

ALL Scorecard: PI Committee Falls

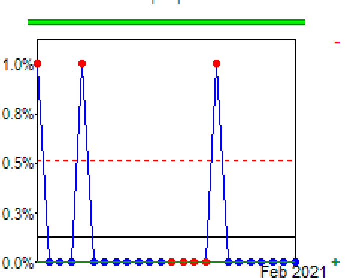
RM ACUTE FALL- NO INJURY (M) per 1000 patient days



RM ACUTE FALL- WITH INJURY (M) per 1000 patient days



Falls with injury % of all Acute falls |M|



Patient Safety Indicators

ALL Scorecard: PI Committee AHRQ PSI

PSI 02 (v2019) Death in Low-mortality DRGs - Per 1000 ACA (M)

0.3 0.2 0.1 0 Feb 2021

PSI 03 (v2019) Pressure Ulcer - Per 1000 ACA (M)

30 25 20 15 10 5 0 Feb 2021

PSI 04 (v2019) Death in Surgical IP w/Ser Comp, Overall - Per 1000 ACA (M)

1250 1000 750 500 250 0 Feb 2021

PSI 05 (v2019) Retained Surgical tem/Device Fragment - Per 1000 ACA (M)

1 0 -1 Feb 2021

PSI 06 (v2019) Iatrogenic Pneumothorax - Per 1000 ACA (M)

0.3 0.2 0.1 0 Feb 2021

PSI 07 (v2019) Central Venous Catheter-related BSI - Per 1000 ACA (M)

0.15 0.1 0.05 0 Feb 2021

PSI 08 (v2019) In Hospital Fall with Hip Fracture - Per 1000 ACA (M)

0.08 0.06 0.04 0.02 0 Feb 2021

PSI 09 (v2019) Perioperative Hemorrhage or Hematoma - Per 1000 ACA (M)

2.5 2 1.5 1 0.5 0 Feb 2021

PSI 10 (v2019) Postop Acute Kidney Injury Requiring Dialysis - Per 1000 ACA (M)

0.8 0.6 0.4 0.2 0 Feb 2021

PSI 11 (v2019) Postoperative Respiratory Failure - Per 1000 ACA (M)

6 5 4 3 2 1 0 Feb 2021

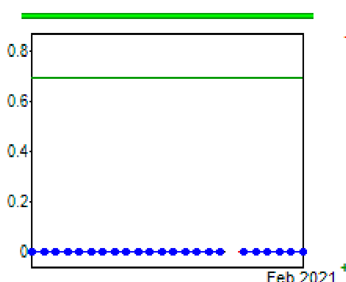
PSI 12 (v2019) Perioperative Pulmonary Embolism or DVT - Per 1000 ACA (M)

4 3 2 1 0 Feb 2021

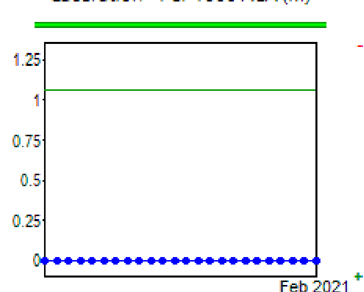
PSI 13 (v2019) Postoperative Sepsis - Per 1000 ACA (M)

200 150 100 50 0 Feb 2021

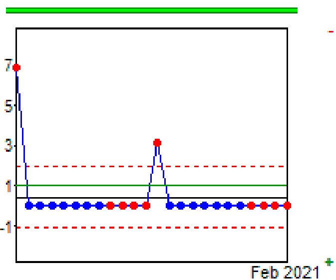
PSI 14 (v2019) Postoperative Wound Dehiscence - Per 1000 ACA (M)



PSI 15 (v2019) Accidental Puncture or Laceration - Per 1000 ACA (M)



PSI 90 (v2019) Midas Patient Safety Indicators Composite, ACA (M)



Document Tasks by Committee

Listing of currently pending and/or upcoming document tasks grouped by committee.

Sonoma Valley Hospital

Run by: Woodall, Vivian (vwoodall)
Run date: 03/19/2021 12:35 PM

Report Parameters

Filtered by: Document Set: all applicable
Committee: 07 BOD-Quality Committee of the Board
Include Current Tasks: Yes
Include Upcoming Tasks: No

Grouped by: Committee

Sorted by: Document Name, Document Location

Report Statistics

Total Documents: 55

Committee: 07 BOD-Quality Committee of the Board

Committee Members: **Woodall, Vivian (vwoodall)**

Current Approval Tasks (due now)

Document	Task/Status	Pending Since	Days Pending
Adverse Tissue Reactions *Patient Care Policy*	**Pending Approval**	3/18/2021	1

Summary Of Changes: **Reviewed, no changes.**

Moderators: **Newman, Cindi (cnewman), Tierney, Pat (ptierney)**

Lead Authors: **Clark, Janine (jclark), Kobe, Mark (mkobe)**

Approvers: **Kobe, Mark (mkobe) -> 01 P&P Committee - (Committee) -> 02 MS-Medicine Department - (Committee) -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Document	Task/Status	Pending Since	Days Pending
Adverse Tissue Reactions *Surgical Services/OR Dept*	**Pending Approval**	3/18/2021	1

Summary Of Changes: **Corrected spelling errors.**

Moderators: **Newman, Cindi (cnewman), Tierney, Pat (ptierney)**

Lead Authors: **Clark, Janine (jclark)**

Approvers: **01 P&P Committee -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Document	Task/Status	Pending Since	Days Pending
Allografts and Tissue; Procurement for Surgical Procedures Requiring Grafting *Surgical Services/OR Dept*	**Pending Approval**	3/18/2021	1

Summary Of Changes: **Reviewed, no changes**

Moderators: **Newman, Cindi (cnewman), Tierney, Pat (ptierney)**

Lead Authors: **Clark, Janine (jclark)**

Approvers: **01 P&P Committee -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Document	Task/Status	Pending Since	Days Pending
Anesthesia Rules and Regulations *Anesthesia Dept Policies*	**Pending Approval**	3/18/2021	1

Summary Of Changes: **Changed the inspection schedule of anesthesia machines from quarterly to semiannual-current and recommended this new practice through BIOMED.**
Removed references to The Joint Commission.

Moderators: **Newman, Cindi (cnewman), Tierney, Pat (ptierney)**
Lead Authors: **Clark, Janine (jclark)**
Approvers: **01 P&P Committee -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Anesthesia Scope of Service	**Pending Approval**	3/18/2021	1
Anesthesia Dept Policies			

Summary Of Changes: **Removed all references to The Joint Commission.**
Deleted "pain management" to avoid confusion that the anesthesiologist provides that service line (per anesthesia request to delete); Changed conscious sedation to moderate sedation.

Moderators: **Newman, Cindi (cnewman), Tierney, Pat (ptierney)**
Lead Authors: **Clark, Janine (jclark)**
Approvers: **01 P&P Committee -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

ASA Classification	**Pending Approval**	3/18/2021	1
Anesthesia Dept Policies			

Summary Of Changes: **Removed references to the Joint Commission and new reference information provided.**

Moderators: **Newman, Cindi (cnewman), Tierney, Pat (ptierney)**
Lead Authors: **Clark, Janine (jclark)**
Approvers: **01 P&P Committee -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Aseptic Technique	**Pending Approval**	3/18/2021	1
Surgical Services/OR Dept			

Summary Of Changes: **Reviewed, no changes.**

Moderators: **Newman, Cindi (cnewman), Tierney, Pat (ptierney)**
Lead Authors: **Clark, Janine (jclark)**
Approvers: **01 P&P Committee -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Assessing and Managing Patients at Risk for Suicide	**Pending Approval**	3/18/2021	1
Patient Care Policy			

Summary Of Changes: **Removed references to Attachment A, since no Attachment A exists.**

Moderators: **Newman, Cindi (cnewman), Tierney, Pat (ptierney)**
Lead Authors: **Winkler, Jessica (jwinkler), Kobe, Mark (mkobe)**
Approvers: **Kobe, Mark (mkobe) -> 01 P&P Committee - (Committee) -> 02 MS-Medicine Department - (Committee) -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Assessment and Admission of OR Patients	**Pending Approval**	3/18/2021	1
Surgical Services/OR Dept			

Summary Of Changes: **Distinguished procedures of Surgical Care Unit nurse from Circulating nurse.**

Moderators: **Newman, Cindi (cnewman), Tierney, Pat (ptierney)**
Lead Authors: **Clark, Janine (jclark)**
Approvers: **01 P&P Committee -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Attire Surgical in the Operating Room | **Pending Approval** | 3/18/2021 | 1
Surgical Services/OR Dept

Summary Of Changes: **Deleted a phrase stating that long sleeves are required by non scrubbed personnel.**
Added a phrase indicating that facial piercings should be contained by band-aid, hat or mask.
Changed phrase regarding cover apparel upon leaving surgery area to read that a cover gown or jacket IS required upon leaving the surgery area/dept.
Rewrote shoe attire verbiage to make better sense.
Moderators: **Newman, Cindi (cnewman), Tierney, Pat (ptierney)**
Lead Authors: **Clark, Janine (jclark)**
Approvers: **01 P&P Committee -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Autoclave Failure 7471-101 | **Pending Approval** | 3/18/2021 | 1
Central Sterile Dept

Summary Of Changes: **Removed vague verbiage regarding actions to take in the event of a load failure.**
Simplified comments to clarify that a load failure results in the load remaining unsterile and needs to reprocessed.
Moderators: **Newman, Cindi (cnewman), Tierney, Pat (ptierney)**
Lead Authors: **Clark, Janine (jclark)**
Approvers: **01 P&P Committee -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Bullets-Evidence for Police Matters | **Pending Approval** | 3/18/2021 | 1
Surgical Services/OR Dept

Summary Of Changes: **Reviewed, no changes.**
Moderators: **Newman, Cindi (cnewman), Tierney, Pat (ptierney)**
Lead Authors: **Clark, Janine (jclark)**
Approvers: **01 P&P Committee -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Cardiac Rhythm Monitoring | **Pending Approval** | 3/18/2021 | 1
Patient Care Policy

Summary Of Changes: **Updated reference to EBSCO (Evidence Based Skills Content and Corresponding Skills checklist) Dynamic Health Cardiac Rhythm Monitoring standard, that was revised in 2017.**
Moderators: **Newman, Cindi (cnewman), Tierney, Pat (ptierney)**
Lead Authors: **Winkler, Jessica (jwinkler), Kobe, Mark (mkobe)**
Approvers: **Kobe, Mark (mkobe) -> 01 P&P Committee - (Committee) -> 02 MS-Medicine Department - (Committee) -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Care of Patients Under Legal Restriction | **Pending Approval** | 3/18/2021 | 1
Patient Care Policy

Summary Of Changes: **Reviewed, no changes.**

Moderators: **Newman, Cindi (cnewman), Tierney, Pat (ptierney)**
Lead Authors: **Winkler, Jessica (jwinkler), Kobe, Mark (mkobe)**
Approvers: **Kobe, Mark (mkobe) -> 01 P&P Committee - (Committee) -> 02 MS-Medicine Department - (Committee) -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Care of the Pediatric Patient in 7430-103 | **Pending Approval** | 3/18/2021 | 1
SCU (Surgical Care Unit Dept

Summary Of Changes: **Corrected spelling errors**
Moderators: **Newman, Cindi (cnewman), Tierney, Pat (ptierney)**
Lead Authors: **Clark, Janine (jclark)**
Approvers: **01 P&P Committee -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Cartilage Biopsy and Transplant | **Pending Approval** | 3/18/2021 | 1
Surgical Services/OR Dept

Summary Of Changes: **We have changed vendors and use a different kit for these procedures. As kits are changed and modified, specific directions and guidelines should follow manufacturer's recommendations and instructions for use. Added verbiage to reference policy on aseptic technique relating to standards for sterile procedures.**
Moderators: **Newman, Cindi (cnewman), Tierney, Pat (ptierney)**
Lead Authors: **Clark, Janine (jclark)**
Approvers: **01 P&P Committee -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Code Red-OR | **Pending Approval** | 3/18/2021 | 1
Surgical Services/OR Dept

Summary Of Changes: **The policy was reviewed. Minor punctuation changes were made to the document.**
Moderators: **Newman, Cindi (cnewman), Tierney, Pat (ptierney)**
Lead Authors: **Clark, Janine (jclark)**
Approvers: **01 P&P Committee -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Counts Sponges, Sharps and Instruments | **Pending Approval** | 3/18/2021 | 1
Surgical Services/OR Dept

Summary Of Changes: **Removed the reference to The Joint Commission from the document.**
Added verbiage, that in the event of an incorrect count, this information must be documented in the Midas system.
Moderators: **Newman, Cindi (cnewman), Tierney, Pat (ptierney)**
Lead Authors: **Clark, Janine (jclark)**
Approvers: **01 P&P Committee -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Direct Admissions to ICU from Surgery | **Pending Approval** | 3/18/2021 | 1
Surgical Services/OR Dept

Summary Of Changes: **Corrected spelling errors.**
Moderators: **Newman, Cindi (cnewman), Tierney, Pat (ptierney)**
Lead Authors: **Clark, Janine (jclark)**
Approvers: **01 P&P Committee -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Documentation | **Pending Approval** | 3/18/2021 | 1

SCU (Surgical Care Unit Dept

Summary Of Changes: **Removed references to documentation in electronic medical record: documentation in the surgical care unit can be either paper and/or electronic.**

Moderators: **Newman, Cindi (cnewman), Tierney, Pat (ptierney)**

Lead Authors: **Clark, Janine (jclark)**

Approvers: **01 P&P Committee -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Documentation in Surgery | **Pending Approval** | 3/18/2021 | 1

Surgical Services/OR Dept

Summary Of Changes: **Reviewed, no changes.**

Moderators: **Newman, Cindi (cnewman), Tierney, Pat (ptierney)**

Lead Authors: **Clark, Janine (jclark)**

Approvers: **01 P&P Committee -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Draping of the Patient in Surgery | **Pending Approval** | 3/18/2021 | 1

Surgical Services/OR Dept

Summary Of Changes: **Reviewed, no changes.**

Moderators: **Newman, Cindi (cnewman), Tierney, Pat (ptierney)**

Lead Authors: **Clark, Janine (jclark)**

Approvers: **01 P&P Committee -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Electrical Equipment Safety | **Pending Approval** | 3/18/2021 | 1

Surgical Services/OR Dept

Summary Of Changes: **Reviewed, no changes.**
Per P&P Committee, redundant and needs to be retired

Moderators: **Newman, Cindi (cnewman), Tierney, Pat (ptierney)**

Lead Authors: **Clark, Janine (jclark)**

Approvers: **01 P&P Committee -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Emergency Operations Plan 2020 EP8610-100 | **Pending Approval** | 3/18/2021 | 1

Emergency Preparedness Policies (EP)

Summary Of Changes: **Annual review requirement completed.**
Removed "2020" on the cover page - Cover page does not need to reference a specific year
Corrected pagination - wrong page numbers listed for some sections in Table of Contents
Section 10 missing from Table of Contents page. this section was added this section to the Table of Contents page

Moderators: **Newman, Cindi (cnewman), Tierney, Pat (ptierney)**

Lead Authors: **Kobe, Mark (mkobe)**

Approvers: **Kobe, Mark (mkobe) -> 01 P&P Committee - (Committee) -> 02 MS-Medicine Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Event Related Shelf Life Policy | **Pending Approval** | 3/18/2021 | 1

Surgical Services/OR Dept

Summary Of Changes: **Removed verbiage regarding items packaged by Central Sterile "will be marked sterile unless package open or damaged". Removed system for "freshly sterilized rotation"-left verbiage using system "first in, first out" as rotation plan. Removed "checked two times a year by Safety committee Inspection Team"-non existent. Removed "Central Sterile Coordinator will confer with managers" to "Central Sterile may confer with managers."**

Moderators: **Newman, Cindi (cnewman), Tierney, Pat (ptierney)**

Lead Authors: **Clark, Janine (jclark)**

Approvers: **01 P&P Committee -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Handling of Anesthetic Drugs in Secure Anesthetizing Locations | **Pending Approval** | 3/18/2021 | 1

Anesthesia Dept Policies

Summary Of Changes: **Removed the reference to the Joint Commission in reference section and added updated reference information. Deleted "will" and replaced with the word "may" related to the following sentence -If controlled substances needed during surgery case, the circulator MAY withdraw from pyxis and give to anesthesiologist.**

Moderators: **Newman, Cindi (cnewman), Tierney, Pat (ptierney)**

Lead Authors: **Clark, Janine (jclark)**

Approvers: **01 P&P Committee -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

HIPAA Data Backup Recovery and Contingency Plan | **Pending Approval** | 3/4/2021 | 15

Information Systems Dept

Summary Of Changes: **NEW POLICY**
The Health Insurance Portability and Accountability Act (HIPAA) Data Backup, Recovery & Contingency Plan policy is required to document the existing practice of backup, recovery and contingency planning as required by the Office of Civil Rights (OCR) Audit post cybersecurity breach in October.

Moderators: **Newman, Cindi (cnewman), Tierney, Pat (ptierney)**

Lead Authors: **Sendaydiego, Fe (fsendaydiego)**

Approvers: **01 P&P Committee -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

HIPAA Privacy Risk Assessment and Reporting | **Pending Approval** | 3/3/2021 | 16

Governance and Leadership Policies

Summary Of Changes: **The only change is the title of the policy to appropriately be named as "HIPAA Privacy Risk Assessment and Reporting" instead of "HIPAA Committee Reporting, Monitoring and Enforcing."**

Moderators: **Newman, Cindi (cnewman), Tierney, Pat (ptierney)**

Lead Authors: **Pryszmant, Rosemary (rpryszmant)**

Approvers: **01 P&P Committee -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

HIPAA Security – Security Incident Procedures Policy | **Pending Approval** | 3/3/2021 | 16

Patient Rights Policies (PR)

Summary Of Changes: **Replaced the old 8610-164 with contents from the HIPAA Manual Template provided by BBKLaw legal counsel as part of the Office of Civil Rights Audit response.**

Former name:HIPAA Security Incident and Breach Response & Reporting

Moderators: **Newman, Cindi (cnewman), Tierney, Pat (ptierney)**
Lead Authors: **Sendaydiego, Fe (fsendaydiego)**
Approvers: **Sendaydiego, Fe (fsendaydiego) -> 01 P&P Committee - (Committee) -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

HIPAA Security Audit Control | **Pending Approval** | 3/3/2021 | 16
Information Systems Dept

Summary Of Changes: **NEW POLICY**

The purpose of this Policy is to ensure that hardware, software and/or procedural mechanisms have been implemented by Sonoma Valley Hospital to record and examine activity in information systems that contain or use electronic Protected Health Information.

This is a requirement from the Office of Civil Rights as it relates to the cyberattack mitigations.

Moderators: **Newman, Cindi (cnewman), Tierney, Pat (ptierney)**
Lead Authors: **Sendaydiego, Fe (fsendaydiego)**
Approvers: **01 P&P Committee -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

HIPAA Transmission Security | **Pending Approval** | 3/3/2021 | 16
Information Systems Dept

Summary Of Changes: **NEW POLICY**

This new policy was instituted as a result of findings from the cyber-attack response.

The purpose of this Policy is to ensure that electronic Protected Health Information (“ePHI”) and Personal Information is maintained by Sonoma Valley Hospital (SVH) and is transmitted in a secure manner.
HIPAA Technical Standard 45 C.F.R. §§ 164.310(a)(2)(iv), 164.312(e)(1).

Moderators: **Newman, Cindi (cnewman), Tierney, Pat (ptierney)**
Lead Authors: **Sendaydiego, Fe (fsendaydiego)**
Approvers: **01 P&P Committee -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

HIPAA Workforce Regulations | **Pending Approval** | 3/3/2021 | 16
Patient Rights Policies (PR)

Summary Of Changes: **This policy was updated with new Health Insurance Portability and Accountability Act references.**

Moderators: **Newman, Cindi (cnewman), Tierney, Pat (ptierney)**
Lead Authors: **Sendaydiego, Fe (fsendaydiego)**
Approvers: **Sendaydiego, Fe (fsendaydiego) -> 01 P&P Committee - (Committee) -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

HIPAA Workforce Security- Access Control and Management | **Pending Approval** | 3/3/2021 | 16
Patient Rights Policies (PR)

Summary Of Changes: **The context of the updated policy has been adopted from BBKLaw HIPAA Manual template as part of the OCR Audit response.**

Policy name has been changed from HIPAA Security - Person or Entity Authentication to new title, HIPAA Workforce Security: Access Control and Management

Moderators: **Newman, Cindi (cnewman), Tierney, Pat (ptierney)**
Lead Authors: **Sendaydiego, Fe (fsendaydiego)**
Approvers: **Sendaydiego, Fe (fsendaydiego) -> 01 P&P Committee - (Committee) -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Infection Control in Surgical Services | **Pending Approval** | 3/18/2021 | 1

Surgical Services/OR Dept

Summary Of Changes: **Updated the location of the Power Air Purifying Respirator and made minor grammatical changes.**

Moderators: **Newman, Cindi (cnewman), Tierney, Pat (ptierney)**

Lead Authors: **Clark, Janine (jclark)**

Approvers: **01 P&P Committee -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Information Management, System Security and Password Control | **Pending Approval** | 3/4/2021 | 15

Patient Rights Policies (PR)

Summary Of Changes: **Updated reference section. -- A Security form that is referenced in the body of the document is linked in system to this document.**

Moderators: **Newman, Cindi (cnewman), Tierney, Pat (ptierney)**

Lead Authors: **Sendaydiego, Fe (fsendaydiego)**

Approvers: **01 P&P Committee -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Nurse to Patient Ratio | **Pending Approval** | 3/18/2021 | 1

SCU (Surgical Care Unit Dept

Summary Of Changes: **Reviewed, no changes.**

Moderators: **Newman, Cindi (cnewman), Tierney, Pat (ptierney)**

Lead Authors: **Clark, Janine (jclark)**

Approvers: **01 P&P Committee -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Organ & Tissue Donation-Anatomical Donation After Brain Death | **Pending Approval** | 3/18/2021 | 1

Organ & Tissue Procurement Policies (OP)

Summary Of Changes: **Updated document to indicate that Organ Procurement Organizations are exempt from Health Insurance Portability and Accountability Act regulations.**

Moderators: **Newman, Cindi (cnewman), Tierney, Pat (ptierney)**

Lead Authors: **Kobe, Mark (mkobe)**

Approvers: **01 P&P Committee -> 02 MS-Medicine Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Organ and Tissue Donation | **Pending Approval** | 3/18/2021 | 1

Organ & Tissue Procurement Policies (OP)

Summary Of Changes:
Page 3 C 1 signed death certificate AFTER body.... Legal next of kin NOT REQUIRED
Page 4 A 1 Concurrence from family sought BUT NOT REQUIRED
Page 6 B 4 Death will likely occur within 90 minutes
Page 7 B Tissue Donation Form or provides Notification of Gift in case of patients in registry

Moderators: **Newman, Cindi (cnewman), Tierney, Pat (ptierney)**

Lead Authors: **Kobe, Mark (mkobe)**

Approvers: **01 P&P Committee -> 02 MS-Medicine Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Organ Donation After Circulatory Death | **Pending Approval** | 3/18/2021 | 1

Organ & Tissue Procurement Policies (OP)

Summary Of Changes: **Page 2, G death will likely occur within 90 minutes… (DNW-expanded time period from 1 hour)**
Page 5 …coroner/medical examiner staff to notify them of the organ and tissue recovery. (DNW-coroner does not authorize)
Withdrawal of ventilator support and extubation will ordinarily occur in the operating room or predesignated area. (DNW suggestion
Page 6… cessation of circulatory function: These criteria are concurrent (DNW-criteria are concurrent and not 5 separate minutes of each observed)
If the patient does not die within the designated time of 90 minutes… (DNW-expanded time period from 1 hour)
Page 7…encouraged to attend.

Moderators: **Newman, Cindi (cnewman), Tierney, Pat (ptierney)**
Lead Authors: **Kobe, Mark (mkobe)**
Approvers: **01 P&P Committee -> 02 MS-Medicine Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Packaging Guidelines | **Pending Approval** | 3/18/2021 | 1
Central Sterile Dept

Summary Of Changes: **One grammatical error corrected.**
Moderators: **Newman, Cindi (cnewman), Tierney, Pat (ptierney)**
Lead Authors: **Clark, Janine (jclark)**
Approvers: **01 P&P Committee -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Patient Elopement | **Pending Approval** | 3/18/2021 | 1
Patient Care Policy

Summary Of Changes: **One grammatical error corrected.**
Moderators: **Newman, Cindi (cnewman), Tierney, Pat (ptierney)**
Lead Authors: **Winkler, Jessica (jwinkler), Kobe, Mark (mkobe)**
Approvers: **Kobe, Mark (mkobe) -> 01 P&P Committee - (Committee) -> 02 MS-Medicine Department - (Committee) -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Plan for the Assessment and Provision of Individual patient Family Needs | **Pending Approval** | 3/18/2021 | 1
Patient Care Policy

Summary Of Changes: **No substantive changes. Removed reference to non-existant Attachment A.**
Moderators: **Newman, Cindi (cnewman), Tierney, Pat (ptierney)**
Lead Authors: **Winkler, Jessica (jwinkler), Kobe, Mark (mkobe)**
Approvers: **Kobe, Mark (mkobe) -> 01 P&P Committee - (Committee) -> 02 MS-Medicine Department - (Committee) -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Post-Mortem Procedures PC8610-160 | **Pending Approval** | 3/18/2021 | 1
Patient Care Policy

Summary Of Changes: **Updated reference information.**
Moderators: **Newman, Cindi (cnewman), Tierney, Pat (ptierney)**
Lead Authors: **Winkler, Jessica (jwinkler), Kobe, Mark (mkobe)**
Approvers: **Kobe, Mark (mkobe) -> 01 P&P Committee - (Committee) -> 02 MS-Medicine Department - (Committee) -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Rapid Response Team-Unexpected Clinical Deterioration | **Pending Approval** | 3/18/2021 | 1

Targeted Quality & Safety Initiatives Policies (QS)

Summary Of Changes: **Clarified the role of the ICU RN when the Emergency Department RN is encumbered.**

Moderators: **Newman, Cindi (cnewman), Tierney, Pat (ptierney)**

Lead Authors: **Kobe, Mark (mkobe)**

Approvers: **Kobe, Mark (mkobe) -> 01 P&P Committee - (Committee) -> 02 MS-Medicine Department - (Committee) -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Scope of Service | **Pending Approval** | 3/18/2021 | 1

SCU (Surgical Care Unit Dept

Summary Of Changes: **Regarding extended observation of a patient, the word "will" was changed to "may" be done in an in-patient unit for continuation of care. Item #4 - under Hours of Operation.**

Moderators: **Newman, Cindi (cnewman), Tierney, Pat (ptierney)**

Lead Authors: **Clark, Janine (jclark)**

Approvers: **01 P&P Committee -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Standardized Procedure for Patient Discharge | **Pending Approval** | 3/18/2021 | 1

SCU (Surgical Care Unit Dept

Summary Of Changes: **Reviewed, no changes.**

Moderators: **Newman, Cindi (cnewman), Tierney, Pat (ptierney)**

Lead Authors: **Clark, Janine (jclark)**

Approvers: **01 P&P Committee -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Sterile Supplies, Storage of | **Pending Approval** | 3/18/2021 | 1

Central Sterile Dept

Summary Of Changes: **Changed the maximum allowed humidity for the storage area from 70% to 60%.**

Moderators: **Newman, Cindi (cnewman), Tierney, Pat (ptierney)**

Lead Authors: **Clark, Janine (jclark)**

Approvers: **01 P&P Committee -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Sterilization | **Pending Approval** | 3/18/2021 | 1

Central Sterile Dept

Summary Of Changes: **Removed the word "flash" and replaced with immediate use.**
Removed the phrase "porous items only"

Moderators: **Newman, Cindi (cnewman), Tierney, Pat (ptierney)**

Lead Authors: **Clark, Janine (jclark)**

Approvers: **01 P&P Committee -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Sterilzation Processes,Monitoring of | **Pending Approval** | 3/18/2021 | 1

Central Sterile Dept

Summary Of Changes: **Reviewed, no changes.**

Moderators: **Newman, Cindi (cnewman), Tierney, Pat (ptierney)**
Lead Authors: **Clark, Janine (jclark)**
Approvers: **01 P&P Committee -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Surgical Invasive Procedure and Site Confirmation Verification OI8610-104 | **Pending Approval** | 3/18/2021 | 1
Operative & Invasive Services Policies (OI)

Summary Of Changes: **Updated the verbiage to reflect and include all procedural timeouts, i.e., that timeouts should be standardized and performed prior to any invasive procedure, not just surgical procedures.**
Moderators: **Newman, Cindi (cnewman), Tierney, Pat (ptierney)**
Lead Authors: **Clark, Janine (jclark)**
Approvers: **Kobe, Mark (mkobe) -> 01 P&P Committee - (Committee) -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Tourniquet Use of the Pneumatic Tourniquet in the Operating Room | **Pending Approval** | 3/18/2021 | 1
Surgical Services/OR Dept

Summary Of Changes: **Reference was added about the cleaning of tourniquets: only necessary if using reusable tourniquet.**
Removed specific references regarding to previously used tourniquet machine and left in the verbiage that would apply to any tourniquet equipment used.

Eliminated the phrase "to exsanguinate for minimum of two minutes prior to inflating tounriquet.'"This is not generally done.
Moderators: **Newman, Cindi (cnewman), Tierney, Pat (ptierney)**
Lead Authors: **Clark, Janine (jclark)**
Approvers: **01 P&P Committee -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Traffic Patterns | **Pending Approval** | 3/18/2021 | 1
Central Sterile Dept

Summary Of Changes: **Reviewed, no changes.**
Moderators: **Newman, Cindi (cnewman), Tierney, Pat (ptierney)**
Lead Authors: **Clark, Janine (jclark)**
Approvers: **01 P&P Committee -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Ultrasonic Cleaner | **Pending Approval** | 3/18/2021 | 1
Central Sterile Dept

Summary Of Changes: **Reviewed, no changes.**
Moderators: **Newman, Cindi (cnewman), Tierney, Pat (ptierney)**
Lead Authors: **Clark, Janine (jclark)**
Approvers: **01 P&P Committee -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Unintended Intra-Operative Awareness During General Anesthesia | **Pending Approval** | 3/18/2021 | 1
Anesthesia Dept Policies

Summary Of Changes: **Updated reference information.**

Moderators: **Newman, Cindi (cnewman), Tierney, Pat (ptierney)**
Lead Authors: **Clark, Janine (jclark)**
Approvers: **01 P&P Committee -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Vacuum Assisted Wound Closure	**Pending Approval**	3/18/2021	1
Surgical Services/OR Dept			

Summary Of Changes: **Corrected spelling errors.**
This policy was given to J. Cornett in wound care to review according to protocols. He updated a few points of this policy to ensure that it conforms with wound care policy and procedure.

Moderators: **Newman, Cindi (cnewman), Tierney, Pat (ptierney)**
Lead Authors: **Clark, Janine (jclark)**
Approvers: **01 P&P Committee -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

SUBJECT: HIPAA Data Backup, Recovery & Contingency Plan	POLICY: IM8480-401
	PAGE **1** of **6**
DEPARTMENT: Organizational	EFFECTIVE:
REVISED:	

PURPOSE:
The purpose of this policy is to ensure that Sonoma Valley Hospital (SVH) is able to restore data and continue business operations in the event of emergencies or other occurrences.

POLICY:

I. SVH has a contingency plan to respond to emergencies or other occurrences that may damage systems that contain electronic Protected Health Information (PHI).

Commented [DJ1]: Acronym

II. The contingency plan consists of a data backup plan to create and maintain retrievable, exact copies of ePHI; a disaster recovery plan to restore any loss of data; and an emergency mode operations plan to enable continuation of critical business processes for protection of the security of ePHI while operating in emergency mode.

PROCEDURE:

I. **Data Backup Plan** – SVH creates and maintains retrievable, exact copies of ePHI through the development of a data backup plan based on a regularly scheduled data backup routine. The data backup plan applies to all medium and high risk files, records, images, voice, or video files that may contain ePHI.

A. The HIPAA Security Officer identifies all ePHI media and sources within the organization on an ongoing basis.

B. The data backup plan requires that all media used for backing up ePHI be stored in a physically secure environment, including a secure, off-site storage facility or, if backup media remains on site, in a physically secure location, different from the location of the computer systems it backed up.

C. The data backup plan factors in the cost of the backup and the likelihood of inability to function in the event that the data was lost.

D. The HIPAA Security Officer determines which systems and/or information must be retrievable for SVH to continue to function as usual in the event of damage or destruction of the data, hardware, or software.

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E. The HIPAA Security Officer identifies the frequency that the ePHI files can feasibly be backed up without causing disruption to SVH's network or operations.

   i. SVH's Tier 1 Applications (defined as those applications housing e-PHI) have a 15 minute recovery SLA. SVH backs up its Tier 1 applications on a daily, monthly and yearly basis.

F. SVH stores the backup files at an off-site storage facility

   i. Backups are maintained by iLand Veeam data center location in Denver, Colorado.

   ii. The backup server may only be accessed by individuals who are authorized to access SVH's ePHI and have been trained on how to properly restore to onsite data center.

   iii. The storage facility has a security system in place which limits physical and electronic access to the facility.

G. The HIPAA Security Officer or designee establishes a process to review a sampling of the backup files on a periodic basis to assess the reliability and data integrity of the backup files.

H. The HIPAA Security Officer or designee documents SVH's data backup plan and the periodic assessments thereof.

II. **Disaster Recovery Plan** – SVH maintains the Software & Business Continuity Plan which includes a complete systems inventory with operational impact during a disruption of each service, contingency plan for scheduled and unscheduled disruptions and the process for data or system retrieval mechanism as a result of a disaster or system failure.

A. SVH restores lost data containing ePHI through the disaster recovery plan. For the purposes of this policy, a disaster may include a fire, vandalism, system failure, or a natural disaster which jeopardizes the integrity of SVH's ePHI.

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B. The disaster recovery plan includes procedures to restore ePHI from data backups based on system criticality to hospital operations in the case of a disaster causing data loss or interruption of services.

C. The disaster recovery plan includes procedures to log system outages, failures, and data loss to critical systems, and procedures to train the appropriate personnel to implement the disaster recovery plan.

D. The disaster recovery plan, at a minimum, contains the following requirements for systems containing ePHI:

   i. SVH conducts a daily backup.

   ii. The daily backup only backs up changes from the previous day.

   iii. Each month, a full system backup is conducted.

E. The disaster recovery plan is documented and easily available to the Information Systems staff, who are trained to restore and recover implement the disaster recovery plan.

F. The disaster recovery procedures outlined in the disaster recovery plan are tested on a periodic basis to ensure that ePHI and the systems needed to make ePHI available can be restored or recovered.

G. After a disaster, SVH will assess the damage to its ePHI and will identify applicable files which need to be recreated.

H. SVH will access ePHI that is maintained at the off-site or remotely hosted storage facility and will use this data to recreate damaged ePHI files.

III. **Emergency Mode Operation Plan** – As a result of a disaster or system failure, SVH establishes and implements procedures to enable continuation of critical business processes for protection of the security of ePHI while operating in

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emergency mode. The emergency operation plan will allow Workforce members to obtain necessary ePHI during an emergency.

A. The HIPAA Security Officer engages the hospital Administrator on-call who executes the Incident Command Center (ICC), as needed. The ICC team designates the Workforce members who are responsible for activating, implementing, and monitoring an emergency mode operation plan.

B. The ICC team will identify critical business processes which must be maintained during an emergency.

C. The ICC team determines whether SVH will need to have access to ePHI in order to carry out critical business processes during the emergency.

D. The ICC team ensures that safeguards are implemented to protect the security of ePHI when SVH is operating in emergency mode.

E. The ICC team documents the emergency procedures.

F. Emergency mode operation procedures outlined in the Continuity of Operations Plan (COOP) EP8610-107 are tested on a periodic basis to ensure that critical business processes can continue in a satisfactory manner while operating in emergency mode.

IV. **Applications and Data Criticality Analysis** – SVH assesses the relative criticality of specific applications and data in support of other contingency plan components.

A. The HIPAA Security Officer or designee identifies the IT systems at various locations.

B. SVH maintains a list of employees and other individuals who monitor and maintain each IT system.

C. SVH identifies applications, data files, and other IT resources that are necessary for maintaining critical business processes during emergency mode operation.

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D. The HIPAA Security Officer or designee assesses the relative criticality of specific software applications and data in support of other contingency plan components to ensure that critical software is accessible. Such a plan will consider:

   i. The physical and technical security of data and ePHI;

   ii. Access to data and critical networks, software, and hardware in the event of emergency; and

   iii. Critical business functions.

E. SVH implements procedures to ensure that critical IT systems are accessible during emergency mode operation and documents such procedures.

V. **Testing and Revising the Contingency Plan** – SVH may periodically test and revise SVH's contingency plan.

A. The HIPAA Security Officer or designee develops a list of elements in the contingency plan which will be tested and a team of Workforce members who will participate in the contingency plan test.

B. The HIPAA Security Officer or designee may create artificial disaster scenarios to test the effectiveness of the contingency plan and assess whether the contingency plan was effective in protecting the security of ePHI during the artificial disaster scenarios.

C. The HIPAA Security Officer may revise the contingency plan to ensure that the plan will effectively respond to an emergency or disaster, as appropriate.

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REFERENCES:
DHHS 45 C.F.R. §§ 164.308(a)(7), 164.310(a)(2)(i), 164.312(a)(2)(ii).
SVH Software & Business Continuity Plan
SVH Continuity of Operations Plan (COOP) EP8610-107

Approver
HIPAA Security Officer

AUTHORS/REVIEWERS:
Fe Sendaydiego, Chief Information Officer/HIPAA Security Officer
Compliance Committee Members

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

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SUBJECT: HIPAA Security Audit Control	POLICY: IM8480-402
	PAGE **1** of **2**
DEPARTMENT: ORGANIZATIONAL	EFFECTIVE:
REVISED:	

PURPOSE:

The purpose of this Policy is to assure that hardware, software and/or procedural mechanisms have been implemented by SVH to record and examine activity in information systems that contain or use electronic Protected Health Information (ePHI).

POLICY:

SVH employs internal audit controls and audit trail capabilities to record and examine activity in the system.

PROCEDURE:

I. Audit Control Mechanisms

A. SVH systems containing medium and high risk ePHI utilize a mechanism to log and store system activity. SVH utilizes system scanning and reporting systems, including Windows user account audit, Security Information and Event Management (SIEM) tracking, firewall, network switches and network logs, which scans SVH's systems and report based on defined security triggers. Reports are distributed via email in real time based on alert triggers, as well as on a daily, weekly and monthly basis. Reports in the above-referenced systems are maintained by those systems in perpetuity.

B. Each system's audit log includes, but is not limited to, User ID, Login Date/Time, and Activity Time. Audit logs may include system and application log-in reports, activity reports, exception reports or other mechanisms to document and manage system and application activity.

C. System audit logs are reviewed on a regular basis.

II. Audit Control and Review Plan

A. An Audit Control and Review Plan is developed by SVH and approved by the HIPAA Security Officer or designee. If the ePHI inventory changes, its Audit Control and Review Plan is reevaluated and resubmitted to the HIPAA Security Officer or designee. The plan includes:

i. Systems and applications to be logged.

Commented [DJ1]: Acronym

Commented [FS2]: Updated this section as recommended by the P&P committee to make the verbiage generic.

Once I have the procedure document with the current mechanism being used, I will send for an attachment to this policy.

Commented [FS3]: Once the procedure has been established for auditing the system logs in a specified regular basis, an additional document would be attached to this policy.

Commented [DJ4]: Where does this plan live? Do we have a current plan?

Commented [FS5]: The plan will be submitted as an attachment to this policy once it has been documented.

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ii. Who has access to the logs.

iii. Information to be logged for each system.

iv. Log-in reports for each system.

v. Retention time of logs.

vi. Procedures to review all audit logs and activity reports.

REFERENCES:

45 C.F.R. § 164.312(b).

APPROVER:
HIPAA Security Officer

AUTHORS/REVIEWERS:
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APPROVALS:
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SUBJECT: HIPAA Transmission Security	POLICY: IM8610-xxxx
	PAGE **1** of **2**
DEPARTMENT: ORGANIZATIONAL	EFFECTIVE:
REVISED:	

PURPOSE:

The purpose of this Policy is to assure that electronic Protected Health Information ("ePHI") and Personal Information is maintained by SVH is transmitted in a secure manner.

POLICY:

SVH enacts reasonable safeguards to ensure ePHI and Personal Information is transmitted to outside entities in a secure manner and is protected against loss, alteration, duplication, substitution, or destruction.

PROCEDURE:

I. ePHI Transmissions

A. All transmissions of ePHI or Personal Information from SVH domains to a network outside of the aforementioned networks utilize an encryption mechanism between the sending and receiving entities or the file, document, or folder containing said ePHI is encrypted before transmission.

B. Prior to transmitting ePHI or Personal Information from SVH domains to a network outside of the aforementioned networks, the receiving person or entity is authenticated.

C. All transmissions of ePHI from SVH domains to a network outside of the aforementioned networks should include only the minimum necessary amount of PHI.

II. SVH may email ePHI through a secure email system.

A. For transmissions of ePHI or Personal Information via email, SVH automatically encrypts email that may contain ePHI or Personal Information by scanning for such ePHI using preconfigured rules established by the SVH IT department.

B. Employees may manually encrypt emails by adding "secure" to the subject line of the email message.

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III. PHI Transmissions Using Electronic Removable Media

A. When transmitting ePHI or Personal Information via removable media, including but not limited to floppy disks, CD ROM, memory cards, magnetic tape and removable hard drives, the sending party must:

i. Use an encryption mechanism to protect against unauthorized access or modification

ii. Authenticate the person or entity requesting said ePHI in accordance with the Person or Entity Authentication Policy.

iii. Send the minimum necessary amount of said ePHI required by the receiving person or entity.

IV. Cell Phone

i. Workforce members may send text messages containing ePHI or Personal Information to each other using a HIPAA compliant application that provides for encryption of text messages.

REFERENCES:

HIPAA Technical Standard 45 C.F.R. §§ 164.310(a)(2)(iv), 164.312(e)(1).

APPROVER:
HIPAA Security Officer

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