SVHCD QUALITY COMMITTEE

AGENDA

WEDNESDAY, DECEMBER 15, 2021

5:00 p.m. Regular Session

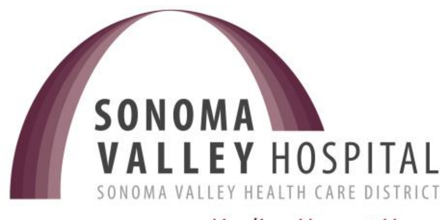
TO BE HELD VIA ZOOM VIDEOCONFERENCE

To Participate Via Zoom Videoconferencing
use the link below:
https://sonomavalleyhospital-org.zoom.us/j/97694045982?pwd=L1JMd1FaWm9pUjhyV0RQcko5NWVwQT09

and Enter the **Meeting ID: 976 9404 5982**
Passcode: 825957

To Participate via Telephone only, dial:
1-669-900-9128 or 1-669-219-2599
and Enter the **Meeting ID: 976 9404 5982**
Passcode: 825957

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, Jenny Fontes, at jfontes@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 10.27.21	*Mainardi*	Action
4. IMAGING QAPI	*Young*	Inform
5. HOSPITAL QAPI SCORECARD FOR OCTOBER/NOVEMBER	*Cooper*	Inform
6. DRAFT BOARD QUALITY WORK PLAN 2022	*Mainardi/Kidd*	Inform
7. POLICIES AND PROCEDURES	*Cooper*	Review/ Comment
8. CLOSED SESSION: a. Calif. Health & Safety Code §32155: Medical Staff Credentialing & Peer Review Report		
9. ADJOURN	*Mainardi*	



SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
October 27, 2021 5:00 PM
MINUTES
Via Zoom Teleconference

Members Present – Via Zoom	Members Present cont.	Excused	Public/Staff – Via Zoom
Michael Mainardi, MD Susan Kornblatt Idell Carol Snyder Ingrid Sheets Ako Walther, MD Howard Eisenstark Cathy Webber		John Hennelly, CEO	Sabrina Kidd, MD, CMO Jessica Winkler, Patient Care Services Director Kylie Cooper, Quality and Risk Mgmt Mark Kobe, CNO Judy Bjorndal, Board Member Jenny Fontes, Board Clerk

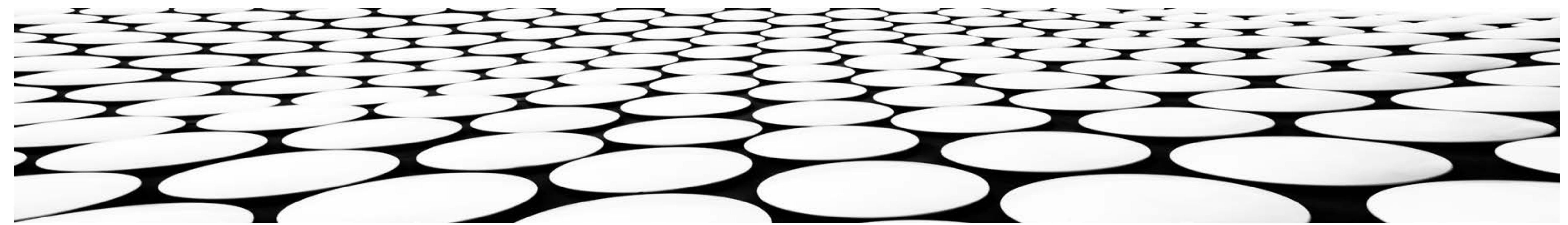
AGENDA ITEM	DISCUSSION	ACTION
1. CALL TO ORDER/ANNOUNCEMENTS	*Mainardi*	
	Meeting called to order at 5:00 pm. Dr. Mainardi welcomed Kylie Cooper the new Director of Quality.	
2. PUBLIC COMMENT	*Mainardi*	
	None	
3. CONSENT CALENDAR	*Mainardi*	
• QC Minutes 09.22.21	Dr. Eisenstark suggested changes to item 7 of the September 22, 2021 minutes.	**MOTION:** by Eisenstark to approve with changes, 2nd by Kornblatt Idell. All in favor.
4. MED-SURG/ICU QAPI PLAN FOR INPATIENT SERVICES	*Winkler*	
	Ms. Jessica Winkler, Director of Patient Care Services reviewed the Quality Assurance Improvement Plan for inpatient services. The plan covers Respiratory Therapy, Critical Care and Medical/Surgical Departments. She indicated the Palliative Care project has been active since the begininning of 2021. The project has included private care education for the staff and Hospitalist. Ms. Winkler	

AGENDA ITEM	DISCUSSION	ACTION
	created a nursing assessment for palliative care needs, and the automated referral process went live on August 17. The old process involved printing, faxing and phone calls. With the new nursing assessment, there is one click, and the referral is automatically sent. Data analysis and reporting will be finished in November. After analysis, they can determine how the interventions made a difference with the number of private care referrals. Ms. Winkler said she is aligning inpatient care of stroke victims with the American Heart Association Guidelines and UCSF. The physician order sets were amended and a stroke specific assessment tab was created to align with the American Heart Association and UCSF.	
5. QUALITY INDICATOR PERFORMANCE INDICATORS/SCORECARD AUGUST 2021	*Kidd*	
	Dr. Kidd presented the Qualiity Performance Indicators for August 2021. This included reviews of mortality, AHRQ patient safety indicators, patient falls (preventable harm), readmissions, blood culture contamination, CIHQ stroke certification measures, utilization management, core measures, core measures sepsis, infection prevention, inpatient patient satisfaction, and ambulatory surgery patient satisfaction.	
6. PATIENT CARE SERVICES DASHBOARD Q3	*Kobe*	
	Mr. Kobe reviewed the revised Patient Care Services Dashboard Q3. He mentioned that he removed information that Dr. Kidd had already reported. Mr. Kobe is now focusing on outpatient experience. Quality indicators (QAPI) include antibiotics administered within 30 minutes, continuous observation of psychiatric patients, and drug administration errors in the Pharmacy. Mr. Kobe reviewed case management data, nursing turnover, nurse staffing effectiveness, and outpatient experience. He said patients are texted a link to a 10 question survey 2 hours after they are discharged. The patients answer the survey and rate their experience at the hospital from 1 to 5 stars. The goal is 4.9 stars. There are positive results from the texting survey.	
7. QUALITY COMMITTEE ROLE IN POLICIES AND PROCEDURES MEMO - REVISED	*Mainardi*	

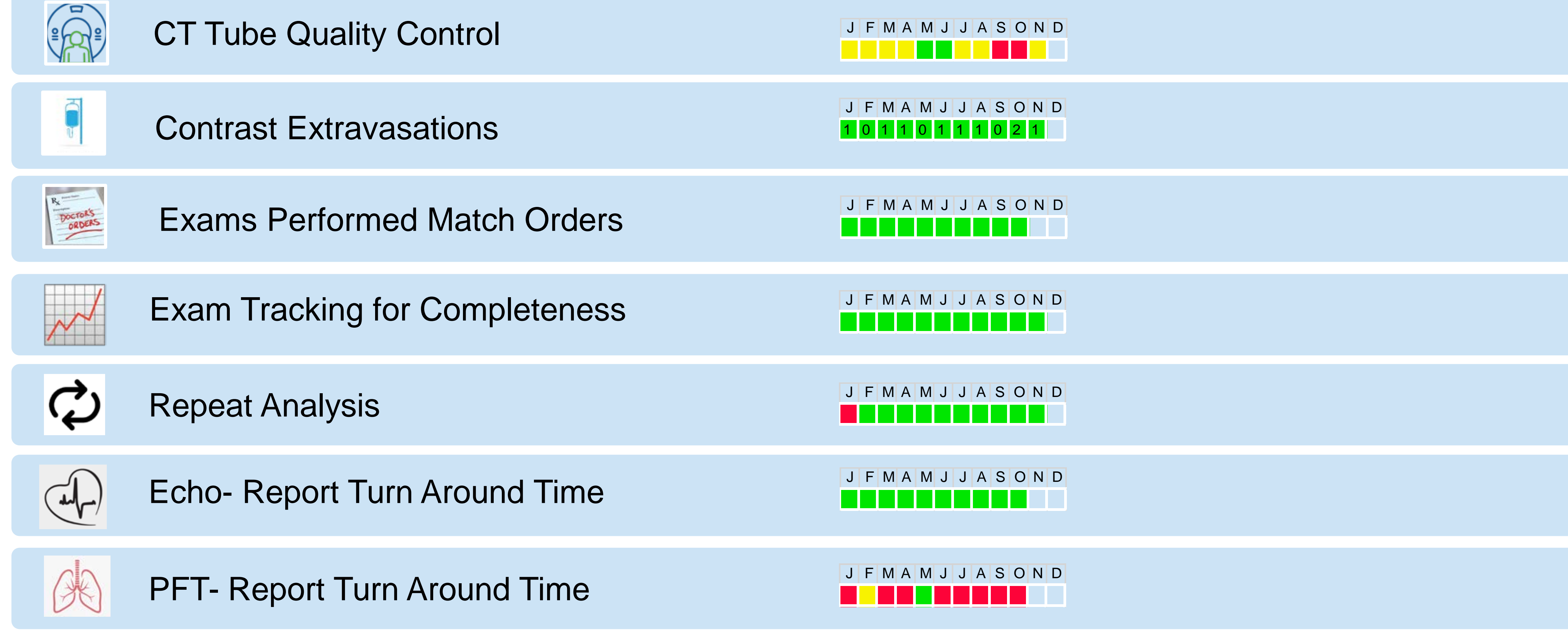
AGENDA ITEM	DISCUSSION	ACTION
	Dr. Mainardi reviewed the Committee's Role in Policies and Procedures Memorandum. The committee will review and comment. Any comments or requests for further information needs approval from the committee and if obtained will be forwarded to the policy maker. The policy maker chooses to respond or not respond to the committee's comments or requests. If the policy maker chooses not to respond, the denial is forwarded to the Board with a policy. The Board will then make a decision. The Board would like comments and procedures on the agenda to be forwarded to Dr. Kidd and the new Quality Director before the meeting.	
8. POLICIES AND PROCEDURES	*Kidd*	
	Dr. Kidd reviewed the following policies: **Policies with changes made:** Norovirus Outbreak Management **Policies with no changes made:** DVT-PE Prophylaxis and Treatment Protocol Managing Patients in Isolation Requiring Rehab Services	
9. CLOSED SESSION: a. Calif. Health & Safety Code §32155: Medical Staff Credentialing & Peer Review Report		
10. REPORT ON CLOSED SESSION	*Mainardi*	
	The Medical Staff credentialing report was approved.	**MOTION:** by Eisenstark, 2nd by Sheets. All in favor.
11. ADJOURN	*Mainardi*	
	6:05 pm	

DIAGNOSTIC SERVICES – QUALITY ASSURANCE

DECEMBER 2021



2021 QUALITY MEASURES



2022 QUALITY MEASURES

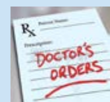
CT Tube Quality Control

Contrast Extravasations

PFT- Report Turn Around Time

Repeat Analysis

MRI Near Misses New



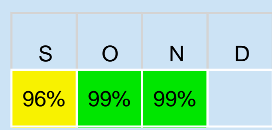
Echo Inpatient Order to Exam Performed New

CT Dose Tracking New

Wrong Site/Side New

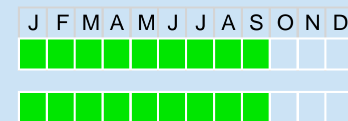
2021 PERFORMANCE IMPROVEMENT

Missing PCP at Registration



S	O	N	D
96%	99%	99%	

Stroke- Door to CT
Stroke- Door to Radiologist Report



Quality Indicator Performance & Plan

December Board Quality

Data for October/November 2021

Mortality

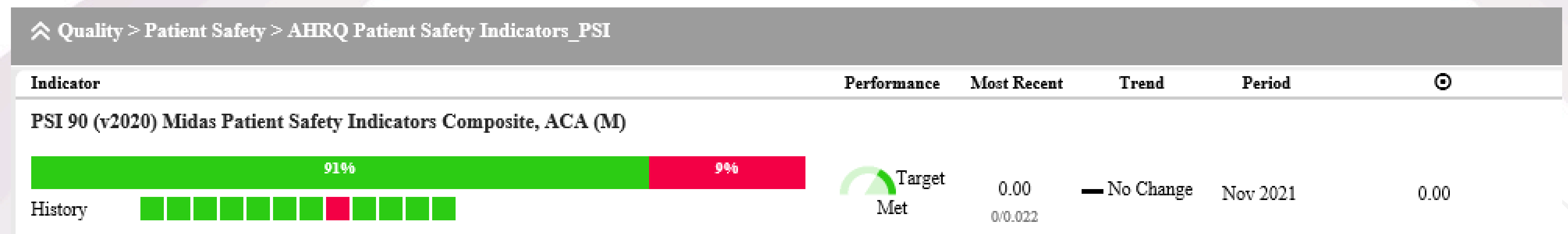
Quality > Autopsies Mortalities

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔	Ilill	⊼
Acute Care Mortality Rate (M) — 100%	Target Met	3.1% 2/64	Improved	Nov 2021	15.3%	n/a	n/a	3.7%
COPD Mortality Rate |M| — 75% / 9% / 16%	Breaches Alarm	33.3% 1/3		Sep 2021	8.5%	n/a	n/a	4.3%
Congestive Heart Failure Mortality Rate |M| — 83% / 17%	Breaches Alarm	25.0% 1/4	Deteriorated	Nov 2021	11.5%	n/a	n/a	5.0%
Ischemic Stroke Mortality Rate |M| — 100%	Target Met	0.0% 0/4	No Change	Nov 2021	13.8%	n/a	n/a	0.0%
Pneumonia Mortality Rate |M| — 83% / 17%	Target Met	0.0% 0/3	Improved	Nov 2021	15.6%	n/a	n/a	5.6%

Quality > Process of Care > Sepsis Care

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔	Ilill	⊼
Sepsis, Severe - Mortality Rate (M) — 95% / 5%	Target Met	0.0% 0/2	Improved	Nov 2021	25.0%	n/a	n/a	7.5%
Septic Shock - Mortality Rate (Q) — 100%	Target Undefined	0.0% 0/5	Improved	Q3-2021	n/a	n/a	n/a	15.5%

AHRQ Patient Safety Indicators



Quality > Patient Safety > AHRQ Patient Safety Indicators_PSI

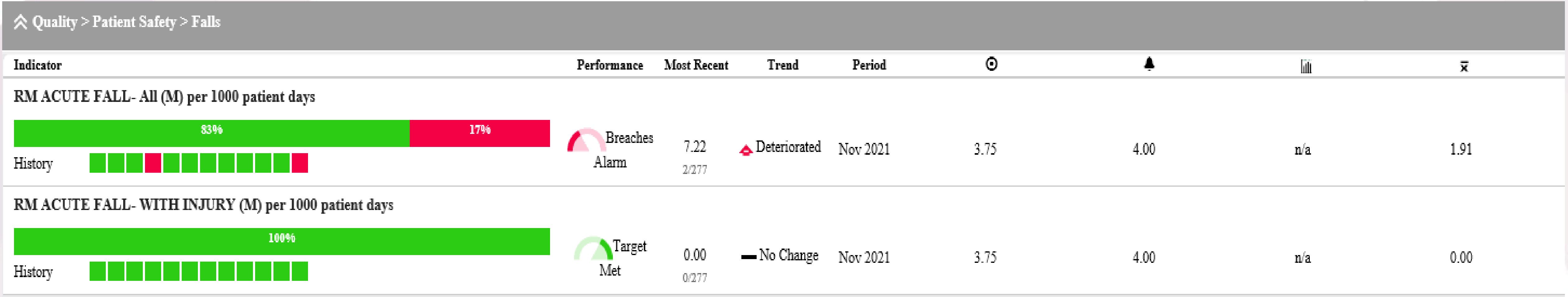
Indicator	Performance	Most Recent	Trend	Period	
PSI 90 (v2020) Midas Patient Safety Indicators Composite, ACA (M) 91% / 9% History	Target Met	0.00 0/0.022	No Change	Nov 2021	0.00

The Patient Safety Indicators 90 (PSIs)

- PSI 03 Pressure Ulcer
- PSI 06 Iatrogenic Pneumothorax Rate
- PSI 08 In Hospital Fall with Hip Fracture
- PSI 09 Perioperative Hemorrhage or Hematoma
- PSI 10 Postoperative Acute Kidney Injury Requiring Dialysis
- PSI 11 Postoperative Respiratory Failure
- PSI 12 Perioperative Pulmonary Embolism or DVT
- PSI 13 Postoperative Sepsis
- PSI 14a Postoperative Wound Dehiscence, Open
- PSI 14b Postoperative Wound Dehiscence, Non-Open
- PSI 15 Accidental Puncture or Laceration

Patient Falls

Preventable Harm



Quality > Patient Safety > Falls

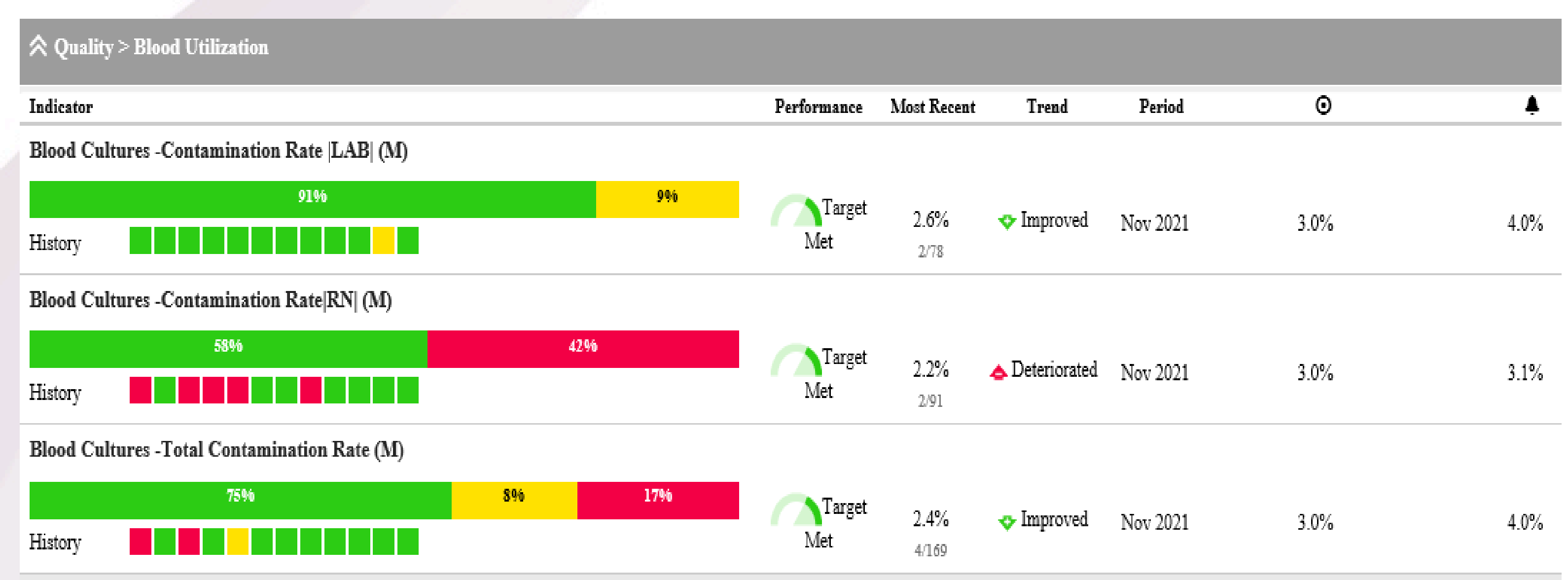
Indicator	Performance	Most Recent	Trend	Period				
RM ACUTE FALL- All (M) per 1000 patient days 83% / 17% History	Breaches Alarm	7.22 2/277	Deteriorated	Nov 2021	3.75	4.00	n/a	1.91
RM ACUTE FALL- WITH INJURY (M) per 1000 patient days 100% History	Target Met	0.00 0/277	No Change	Nov 2021	3.75	4.00	n/a	0.00

Readmissions

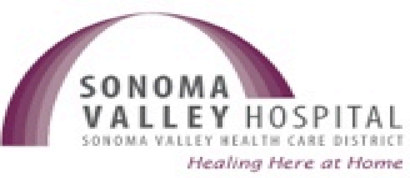
Indicator	Performance	Most Recent	Trend	Period	⦿	🔔	ılıl	⌅
30-DV Inpatients - % Readmit to Acute Care within 30 Days (M) 100% History	Target Met	5.56% 3/54	Deteriorated	Nov 2021	15.30%	15.50%	n/a	5.45%
COPD, CMS Readm - % Readmit within 30 Days, ACA (M) 83% 17% History	Target Met	0.0% 0/2		Sep 2021	19.5%	20.0%	n/a	0.0%
HF, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M) 83% 17% History	Target Met	0.0% 0/2	No Change	Nov 2021	21.6%	22.0%	n/a	8.8%
Hip/Knee, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M) 83% 9% 8% History	Target Met	0.0% 0/1	No Change	Nov 2021	4.0%	5.0%	n/a	4.8%
PNA, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M) 75% 8% 17% History	Target Met	0.0% 0/2	No Change	Nov 2021	16.6%	17.0%	n/a	9.4%
Sepsis, Severe - % Readmit within 30 Days (M) 100% History	Target Met	0.0% 0/2	Improved	Nov 2021	12.0%	13.0%	n/a	0.2%
Septic Shock - % Readmit within 30 Days (M) 100% History	Target Met	0.0% 0/1	No Change	Oct 2021	13.3%	14.0%	n/a	0.1%

Blood Culture Contamination

	Comment	Action Plan
Sep 2021	Action plan from ED Director	1:1 conversation and return demonstration



Month	RN-Contaminated Culture Reports (num)	Blood Cultures Drawn by RN (den)	Percent
Nov 2021	2	91	2.2%
Oct 2021	2	92	2.2%
Sep 2021	1	71	1.4%
Aug 2021	1	96	1.0%
Jul 2021	3	74	4.1%
Jun 2021	0	65	0.0%
May 2021	1	72	1.4%
Apr 2021	4	60	6.7%
Mar 2021	4	85	4.7%
Feb 2021	4	43	9.3%
Jan 2021	2	89	2.2%
Dec 2020	8	130	6.2%



CIHQ Stroke Certification Measures

Indicator	Performance	Most Recent	Trend	Period				
CDSTK-03|Median- Code Stroke Called |M| elapsed time (mins) 100% History	Target Met	-4.50	Improved	Nov 2021	10.00	11.00	n/a	3.00
CDSTK-04|Median- Door to Phys Eval |M| minutes 100% History	Target Met	-0.50	Improved	Nov 2021	10.00	11.00	n/a	1.00
CDSTK-05|Median- Door to CT Scanner |M|elapsed time (minutes) 100% History	Target Met	1.50	Improved	Nov 2021	25.00	26.00	n/a	8.00
CDSTK-06|Median- Neuro Consult Contacted |M| minutes 100% History	Target Met	26.00	Deteriorated	Nov 2021	30.00	31.00	n/a	16.00
CDSTK-07|Median- CT Read by Radiology |M| minutes 100% History	Target Met	21.00	Deteriorated	Nov 2021	45.00	46.00	n/a	27.00
CDSTK-08|Median- Lab Results Posted |M| minutes 100% History	Target Met	35.50	Improved	Nov 2021	45.00	46.00	n/a	31.50
CDSTK-10|Median- Door to EKG Complete |M| minutes 100% History	Target Met	40.00	Deteriorated	Nov 2021	60.00	61.00	n/a	38.00
CDSTK-12|Median-Door to tPA |M| minutes 33% 8% 59% History	Breaches Alarm	77.00	Deteriorated	Oct 2021	60.00	61.00	n/a	69.25
CDSTK-11|Median-Door to tPA Decision |M| minutes 100%	Target	4.00	Improved	Nov 2021	60.00	61.00	n/a	23.50

Utilization Management

Indicator	Performance	Most Recent	Trend	Period	Target	Alarm		
1 Day Stay Rate Medi-Cal [M] — 50% / 50%	Target Met	0.00% 0/6	No Change	Nov 2021	2.61%	5.00%	n/a	4.93%
1 Day Stay Rate-Medicare [M] — 50% / 8% / 42%	Bet. Target & Alarm	9.09% 4/44	Improved	Nov 2021	8.10%	10.00%	n/a	9.47%
Acute Care - Geometric Mean Length of Stay [M] — 41% / 9% / 50%	Breaches Alarm	4.08 44.9026/11	Deteriorated	Nov 2021	2.75	3.23	n/a	3.26
Acute Care Age over 64 - MS-DRG Case Mix Index [M] — 62% / 17% / 21%	Target Met	1.30 58.3044/45	Improved	Nov 2021	1.56	1.65	n/a	1.52
Acute Care- MS-DRG Case Mix Index [M] — 50% / 41% / 9%	Target Met	1.31 81.2904/62	Improved	Nov 2021	1.55	1.65	n/a	1.52

Geometric mean is a statistical/mathematical term that is applied in many other areas outside of health care. This is calculated by multiplying all of the lengths of stay and then taking the nth root of that number (where n=number of patients). (Minimizes the impact of outliers)

The Case Mix Index (CMI) is the average relative DRG weight of a hospital's inpatient discharges, calculated by summing the Medicare Severity-Diagnosis Related Group (MS-DRG) weight for each discharge and dividing the total by the number of discharges.

Core Measures

Quality > Core Measures > HOP Measures > HOP Colonoscpy

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		
Core OP29/ASC9 - Colonoscopy:F/U for Avg Risk Pts (M) 91% / 9% History	Target Met	100.0% 8/8	No Change	Nov 2021	89.0%	50.0%	n/a	100.0%

Quality > Core Measures > HOP Measures > HOP ED Throughput

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		
Core OP 18b Median Time ED Arrival to ED Departure - Reporting Measure (M) 58% / 17% / 25% History	Target Met	124.50	Improved	Nov 2021	132.00	140.00	n/a	129.50
Core OP 22 ED LWBS Emergency Dept Left Without Being Seen (M) 100% History	Target Met	1.7% 11/655	Deteriorated	Nov 2021	2.0%	2.5%	n/a	1.2%

Quality > Core Measures > HOP Measures > HOP Stroke

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		
Core OP-23 - Head CT/MRI Results for STK Pts w/in 45 Min of Arrival (M) 100% History	Target Met	100.0% 3/3	No Change	Nov 2021	72.0%	70.0%	n/a	100.0%

Core Measures Sepsis

Quality > Core Measures > Sepsis

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔	Iılı	⌅
SEP-1 Early Management Bundle, Severe Sepsis/Septic Shock (M) 41% / 9% / 50% History	Breaches Alarm	62.5% 5/8	Deteriorated	Nov 2021	81.0%	80.0%	n/a	71.1%
SEPa - Severe Sepsis 3 Hour Bundle (M) 50% / 50% History	Breaches Alarm	77.8% 7/9	Improved	Nov 2021	94.0%	90.0%	n/a	82.7%
SEPb - Severe Sepsis 6 Hour Bundle (M) 83% / 17% History	Target Met	100.0% 6/6	No Change	Nov 2021	100.0%	90.0%	n/a	96.0%

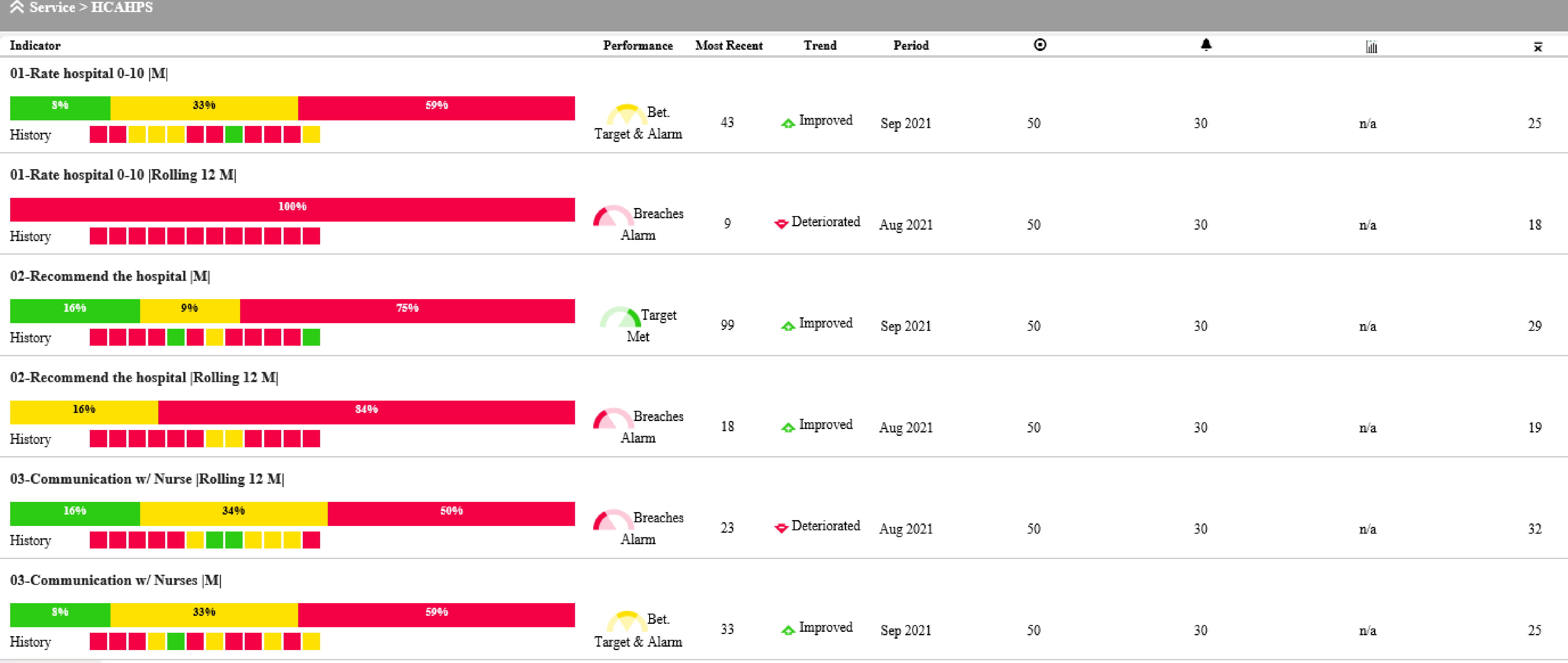
September data in Progress.

Infection Prevention

Quality > Infection Surveillance and Prevention

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔	|||	✕
IC-Surveillance| HAI-C.DIFF Inpatient infections per 10k pt days |M| 80% 20% History	Target Met	0	Improved	Nov 2021	1	1	n/a	0
IC-Surveillance| HAI-CAUTI Inpatient infections per 10k patient days |M| 100% History	Target Met	0	No Change	Nov 2021	1	1	n/a	0
IC-Surveillance| HAI-CLABSI Inpatient infections per 10k patient days |M| 100% History	Target Met	0	No Change	Nov 2021	1	1	n/a	0
IC-Surveillance| HAI-MRSA Inpatient infections per 10k patient days |M| 100% History	Target Met	0	No Change	Nov 2021	1	1	n/a	0
IC-Surveillance| All Inpatient infections |M| 100% History	Target Undefined	n/a		Nov 2021	n/a	n/a	n/a	25
IC-Surveillance| Inpatient Infections Reviewed |M| 100% History	Target Undefined	n/a		Nov 2021	n/a	n/a	n/a	15

Inpatient Patient Satisfaction



Service > HCAHPS

Indicator	Performance	Most Recent	Trend	Period				
01-Rate hospital 0-10 |M| (8% / 33% / 59%; History)	Bet. Target & Alarm	43	Improved	Sep 2021	50	30	n/a	25
01-Rate hospital 0-10 |Rolling 12 M| (100%; History)	Breaches Alarm	9	Deteriorated	Aug 2021	50	30	n/a	18
02-Recommend the hospital |M| (16% / 9% / 75%; History)	Target Met	99	Improved	Sep 2021	50	30	n/a	29
02-Recommend the hospital |Rolling 12 M| (16% / 84%; History)	Breaches Alarm	18	Improved	Aug 2021	50	30	n/a	19
03-Communication w/ Nurse |Rolling 12 M| (16% / 34% / 50%; History)	Breaches Alarm	23	Deteriorated	Aug 2021	50	30	n/a	32
03-Communication w/ Nurses |M| (8% / 33% / 59%; History)	Bet. Target & Alarm	33	Improved	Sep 2021	50	30	n/a	25

HCAHPS

Inpatient Patient Satisfaction

Measure	Bar	History	Status	Value	Trend	Period				
04-Response of Hosp Staf |Rolling 12 M|	58% / 17% / 25%	History	Target Met	62	Improved	Aug 2021	50	30	n/a	49
04-Response of Hosp Staff |M|	58% / 8% / 34%	History	Breaches Alarm	23	Improved	Sep 2021	50	30	n/a	48
05-Communication w/ Doctors |M|	25% / 75%	History	Target Met	56	Improved	Sep 2021	50	30	n/a	23
05-Communication w/ Doctors |Rolling 12 M|	100%	History	Breaches Alarm	5	No Change	Aug 2021	50	30	n/a	12
06-Cleanliness of hospital environment |Rolling 12 M|	100%	History	Breaches Alarm	24	Improved	Aug 2021	50	30	n/a	21
06-Cleanliness of hospital environment|M|	25% / 8% / 67%	History	Breaches Alarm	1	Deteriorated	Sep 2021	50	30	n/a	29

HCAHPS

Inpatient Patient Satisfaction

07-Quietness of hospital environment |M|

33% | 33% | 34%

History

Target Met | 60 | Improved | Sep 2021 | 50 | 30 | n/a | 44

07-Quietness of hospital environment |Rolling 12 M|

8% | 67% | 25%

History

Bet. Target & Alarm | 44 | Improved | Aug 2021 | 50 | 30 | n/a | 35

08-Communication About Medicines |M|

33% | 67%

History

Breaches Alarm | 5 | Improved | Sep 2021 | 60 | 30 | n/a | 32

08-Communication About Medicines |Rolling 12 M|

33% | 67%

History

Bet. Target & Alarm | 34 | Improved | Aug 2021 | 60 | 30 | n/a | 16

09-Discharge Information |M|

33% | 67%

History

Breaches Alarm | 5 | Improved | Sep 2021 | 50 | 30 | n/a | 32

09-Discharge Information |Rolling 12 M|

100%

History

Breaches Alarm | 4 | No Change | Aug 2021 | 60 | 30 | n/a | 7

10-Care Transitions |M|

8% | 33% | 59%

History

Breaches Alarm | 1 | No Change | Sep 2021 | 50 | 30 | n/a | 24

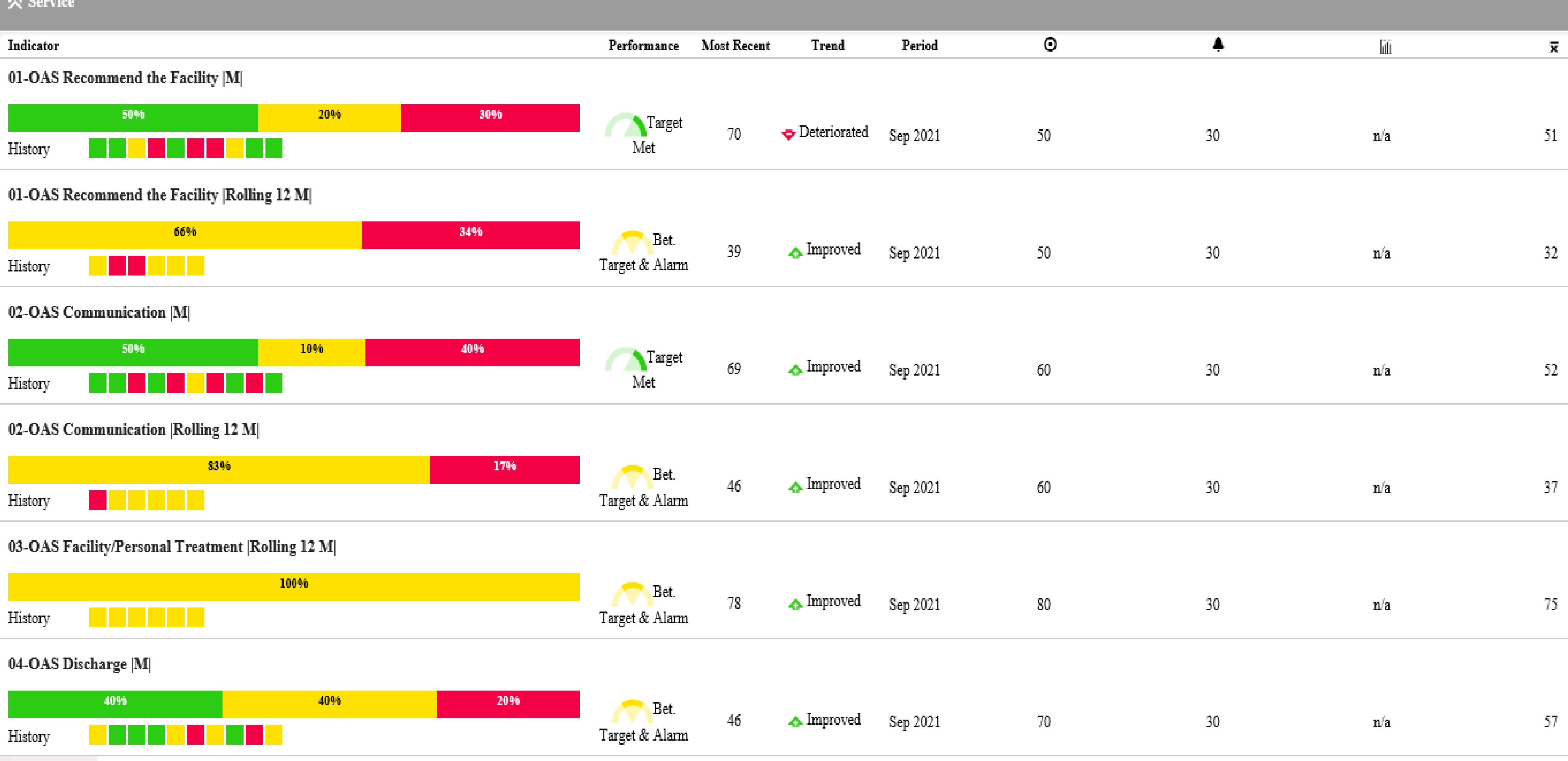
10-Care Transitions |Rolling 12 M|

16% | 84%

History

Breaches Alarm | 8 | Deteriorated | Aug 2021 | 60 | 30 | n/a | 23

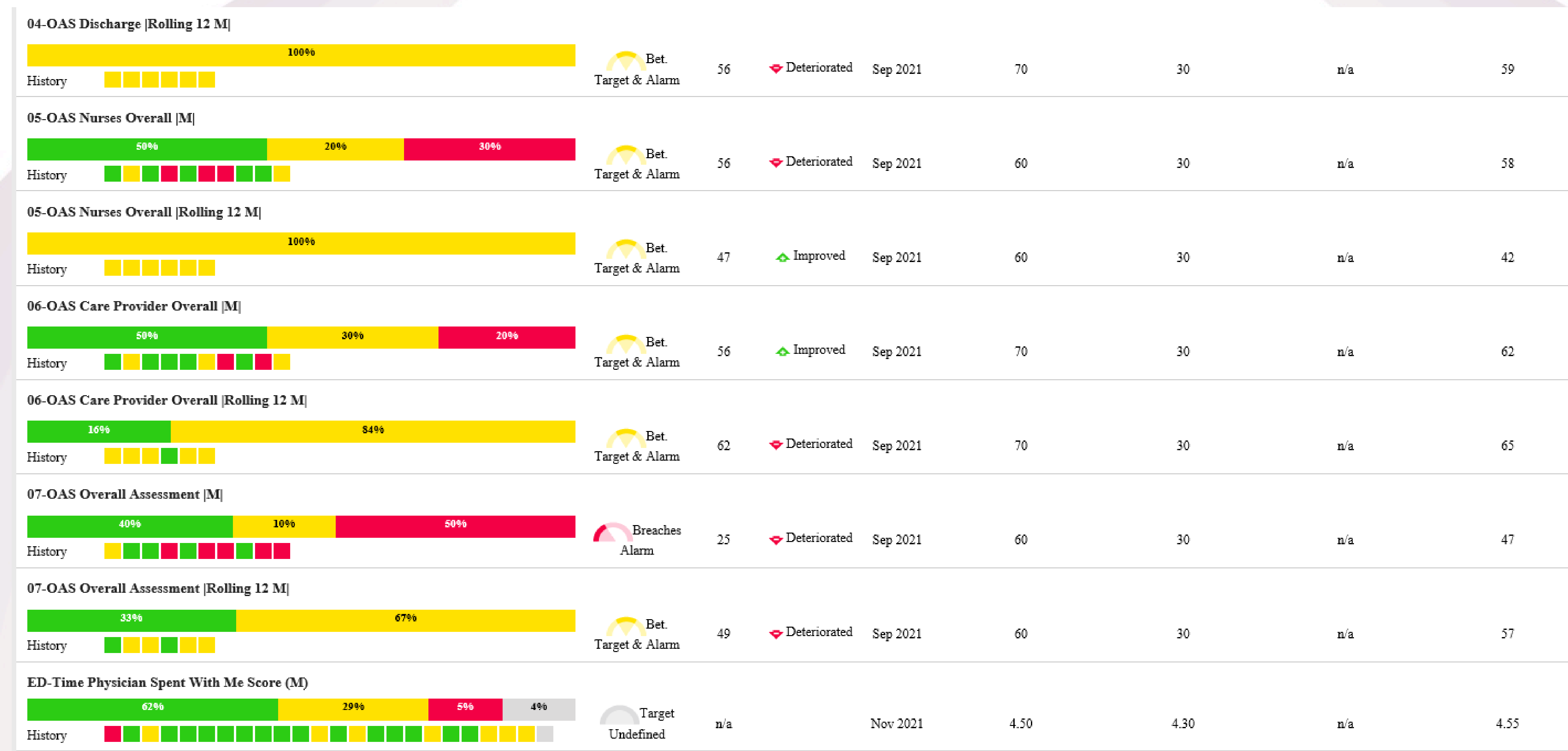
Ambulatory Surgery Patient Satisfaction



Service

Indicator	Performance	Most Recent	Trend	Period				
01-OAS Recommend the Facility |M| (50% / 20% / 30%; History)	Target Met	70	Deteriorated	Sep 2021	50	30	n/a	51
01-OAS Recommend the Facility |Rolling 12 M| (66% / 34%; History)	Bet. Target & Alarm	39	Improved	Sep 2021	50	30	n/a	32
02-OAS Communication |M| (50% / 10% / 40%; History)	Target Met	69	Improved	Sep 2021	60	30	n/a	52
02-OAS Communication |Rolling 12 M| (83% / 17%; History)	Bet. Target & Alarm	46	Improved	Sep 2021	60	30	n/a	37
03-OAS Facility/Personal Treatment |Rolling 12 M| (100%; History)	Bet. Target & Alarm	78	Improved	Sep 2021	80	30	n/a	75
04-OAS Discharge |M| (40% / 40% / 20%; History)	Bet. Target & Alarm	46	Improved	Sep 2021	70	30	n/a	57

Ambulatory Surgery Patient Satisfaction



04-OAS Discharge |Rolling 12 M| (History)	100%	Bet. Target & Alarm	56	Deteriorated	Sep 2021	70	30	n/a	59
05-OAS Nurses Overall |M| (History)	50% / 20% / 30%	Bet. Target & Alarm	56	Deteriorated	Sep 2021	60	30	n/a	58
05-OAS Nurses Overall |Rolling 12 M| (History)	100%	Bet. Target & Alarm	47	Improved	Sep 2021	60	30	n/a	42
06-OAS Care Provider Overall |M| (History)	50% / 30% / 20%	Bet. Target & Alarm	56	Improved	Sep 2021	70	30	n/a	62
06-OAS Care Provider Overall |Rolling 12 M| (History)	16% / 84%	Bet. Target & Alarm	62	Deteriorated	Sep 2021	70	30	n/a	65
07-OAS Overall Assessment |M| (History)	40% / 10% / 50%	Breaches Alarm	25	Deteriorated	Sep 2021	60	30	n/a	47
07-OAS Overall Assessment |Rolling 12 M| (History)	33% / 67%	Bet. Target & Alarm	49	Deteriorated	Sep 2021	60	30	n/a	57
ED-Time Physician Spent With Me Score (M) (History)	62% / 29% / 5% / 4%	Target Undefined	n/a		Nov 2021	4.50	4.30	n/a	4.55

2022 Quality Committee Work Plan

January 1/26	February 2/23	March 3/23	April 4/27
▪ ED QA/PI ▪ Quality Indicator Performance and Plan ▪ Patient Care Services Dashboard 4th Qtr ▪ Policies and Procedures ▪ Credentialing	▪ Pharmacy QA/PI ▪ Quality Indicator Performance and Plan ▪ Policies and Procedures ▪ Credentialing	▪ Annual Quality Department Review ▪ Quality Indicator Performance and Plan ▪ Policies and Procedures ▪ Credentialing	▪ Infection Prevention Annual Risk Assessment / Plan ▪ Quality Indicator Performance and Plan ▪ Patient Care Services Dashboard 1st Qtr ▪ Policies and Procedures ▪ Credentialing
May 5/25	**June 6/22**	**July 7/27**	**August 8/24**
▪ Imaging QA/PI ▪ Quality Indicator Performance and Plan ▪ Policies and Procedures ▪ Credentialing	▪ PT/OT QA/PI ▪ Quality Indicator Performance and Plan ▪ Policies and Procedures Credentialing	▪ ED QA/PI ▪ Quality Indicator Performance and Plan ▪ Patient Care Services Dashboard 2nd Qtr ▪ Policies and Procedures ▪ Credentialing	▪ Lab QA/PI ▪ Quality Indicator Performance and Plan ▪ Policies and Procedures ▪ Credentialing
September 9/28	**October 10/26**	**November No Meeting**	**December 12/14**
▪ Pharmacy QA/PI ▪ Quality Indicator Performance and Plan ▪ Policies and Procedures ▪ Credentialing	▪ Inpatient Services QA/PI ▪ Quality Indicator Performance and Plan ▪ Patient Care Services Dashboard 3rd Qtr ▪ Policies and Procedures ▪ Credentialing		▪ Imaging QA/PI ▪ Quality Indicator Performance and Plan ▪ Policies and Procedures ▪ Credentialing

Updated 08.30.21

Document Tasks by Committee

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

Sonoma Valley Hospital

Run by: Newman, Cindi (cnewman)
Run date: 12/09/2021 4:29 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: 14

Committee: 07 BOD-Quality Committee of the Board

Committee Members: **Fontes, Jenny (jfontes)**

Current Approval Tasks (due now)

Document	Task/Status	Pending Since	Days Pending
Administration of Anesthesia *Anesthesia Dept Policies*	**Pending Approval**	11/22/2021	17

Summary Of Changes: **Policy reviewed and reference details added.**

Moderators: **Newman, Cindi (cnewman)**
Lead Authors: **Kidd, Sabrina (skidd)**
ExpertReviewers: **Medical Director-Anesthesia**
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
Admission of Pediatric Patients to the Nursing Unit *Patient Care Policy*	**Pending Approval**	11/22/2021	17

Summary Of Changes: **; Recommend retiring--this policy is no longer active as we do not routinely admit pediatric patients;**

Moderators: **Newman, Cindi (cnewman)**
Lead Authors: **Winkler, Jessica (jwinkler)**
ExpertReviewers: **Medical Director-Patient Care Services**
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
Anesthesia Coverage and Availability *Anesthesia Dept Policies*	**Pending Approval**	11/26/2021	13

Summary Of Changes: **Reviewed and revised:**
,..."the anesthesiologist must respond via phone with 30 minutes and in person within 60 minutes from the time of the initial call to the anesthesiologist. " In person requirement increased due to traffic patterns.
Deleted specificity of communication device required while on call.

Moderators: **Newman, Cindi (cnewman)**
Lead Authors: **Kidd, Sabrina (skidd)**

ExpertReviewers: **Medical Director-Anesthesia**
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)**

Compounding Drug Products	**Pending Approval**	11/26/2021	13

Medication Management Policies (MM)

Summary Of Changes: **Added word "annual" to the first bullet point on page 7 per request of pharmacy board inspector.**
Moderators: **Newman, Cindi (cnewman)**
Lead Authors: **Kutza, Chris (ckutza)**
Approvers: **01 P&P Committee -> 04 MS-Performance Improvement/Pharmacy & Therapeutics Committee - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

COVID-19 Surge Planning-Pharmacy	**Pending Approval**	11/26/2021	13

Emergency Preparedness Policies (EP)

Summary Of Changes: **Added Specific titles to acronyms.**
Removed specific therapeutic name (Remdesivir) to "approved therapeutics" for more flexibility.
Moderators: **Newman, Cindi (cnewman)**
Lead Authors: **Kutza, Chris (ckutza)**
Approvers: **01 P&P Committee -> 04 MS-Performance Improvement/Pharmacy & Therapeutics Committee - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Discharge Criteria	**Pending Approval**	11/26/2021	13

Rehabilitation Services Dept

Summary Of Changes: **Changed Appendix A---**
CIHQ requires a patient letter to be sent as a form of notification if we cannot make contact otherwise.
The letter was modified to make it patient centric and have a more friendly tone.
Moderators: **Newman, Cindi (cnewman)**
Lead Authors: **Gallo, Christopher (cgallo)**
Approvers: **Kuwahara, Dawn (dkuwahara) -> 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)**

Duties and Responsibilities of Chief Anesthesiologist	**Pending Approval**	11/26/2021	13

Anesthesia Dept Policies

Summary Of Changes: **Reviewed**
Name change for policy - (Medical Director in place of Chief).
Removed references to TJC and NIAHO
Moderators: **Newman, Cindi (cnewman)**
Lead Authors: **Kidd, Sabrina (skidd)**
ExpertReviewers: **Medical Director-Anesthesia**
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)**

Flexible Endoscopes-Reprocessing	**Pending Approval**	11/26/2021	13

Central Sterile Dept

Summary Of Changes: **Added two lines at the bottom of the Policy section referring to daily temperature and humidity monitoring, and terminal cleaning.**

Changes to number 2 under Procedure to include hard-sided and covered container labeled biohazard. On number 9 added the word hard-sided to covered container.

Moderators: **Newman, Cindi (cnewman)**
Lead Authors: **Fry, Dana (dfry)**
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)**

Metformin and Intravenous Contrast Media | **Pending Approval** | 11/26/2021 | 13
Diagnostic Services Dept Policies

Summary Of Changes: **Updated guidelines to match American College of Radiology recommendations.**
Moderators: **Newman, Cindi (cnewman)**
Lead Authors: **Todeschini, Laurel (ltodeschini), Young, Dave (dyoung)**
ExpertReviewers: **Medical Director-Diagnostic Radiology**
Approvers: **Kuwahara, Dawn (dkuwahara) -> 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)**

Patient Personal Belongings Policy | **Pending Approval** | 12/7/2021 | 2
Patient Rights Policies (PR)

Summary Of Changes: **Fixed Acronyms. Changed 2N to read Medical Surgical Unit. Deleted reference to Birthplace and SNF**
Moderators: **Newman, Cindi (cnewman)**
Lead Authors: **Kobe, Mark (mkobe), Cooper, Kylie (kcooper)**
Approvers: **Kobe, Mark (mkobe) -> 01 P&P Committee - (Committee) -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Performance improvement completion for the Department of Anesthesia | **Pending Approval** | 11/26/2021 | 13
Anesthesia Dept Policies

Summary Of Changes: **Removed the reference to The Joint Commission, some other grammatical edits.**
Moderators: **Newman, Cindi (cnewman)**
Lead Authors: **Kidd, Sabrina (skidd)**
ExpertReviewers: **Medical Director-Anesthesia**
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)**

Respiratory Assistance During In House Transport | **Pending Approval** | 11/26/2021 | 13
Respiratory Therapy Dept

Summary Of Changes: **Reviewed. Recommend retiring. Same information available in EBSCO Dynamic Health ("Transporting Mechanically Ventilated Patients")**
Moderators: **Newman, Cindi (cnewman)**
Lead Authors: **Winkler, Jessica (jwinkler)**
Approvers: **Medical Director-Respiratory Therapy -> 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)**

RETIRE-Physical Assessment of Adult and_or Pediatric Patients | **Pending Approval** | 11/26/2021 | 13
ICU Dept

Summary Of Changes: **Recommendation: RETIRE**
Redundant --documented in the Documentation in the Intensive Care Unit policy

Moderators: **Newman, Cindi (cnewman)**

Lead Authors: **Winkler, Jessica (jwinkler)**

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)**

Sterile Compounding MM8610-117	**Pending Approval**	11/22/2021	17
Medication Management Policies (MM)			

Summary Of Changes: **Updates section on immediate use compounding to more closely match the language of the regulation it complies with; "3. The preparation involves the simple transfer of not more than 3 commercially manufacture packages of sterile non-hazardous preparations and not more than 2 entries into any one container or package."**

Moderators: **Newman, Cindi (cnewman)**

Lead Authors: **Kutza, Chris (ckutza)**

Approvers: **01 P&P Committee -> 04 MS-Performance Improvement/Pharmacy & Therapeutics Committee - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**