SVHCD QUALITY COMMITTEE

AGENDA

WEDNESDAY, APRIL 27, 2022

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
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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	*Kornblatt Idell*	
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.*	*Kornblatt Idell*	
3. CONSENT CALENDAR • Minutes 03.23.22	*Kornblatt Idell*	Action
4. INFECTION PREVENTION ANNUAL RISK ASSESSMENT/PLAN	*Montecino*	Inform
5. QUALITY INDICATOR PERFORMANCE AND PLAN	*Cooper*	Inform
6. PATIENT CARE SERVICES DASHBOARD 1ST QTR.	*Kobe*	Inform
7. POLICIES AND PROCEDURES	*Cooper*	Review/ Recommend
8. CLOSED SESSION: a. Calif. Health & Safety Code §32155: Medical Staff Credentialing & Peer Review Report		Action
9. ADJOURN	*Kornblatt Idell*	

SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
March 23, 2022 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		Howard Eisenstark	John Hennelly, CEO Ako Walther, MD Kylie Cooper, Quality and Risk Mgmt Mark Kobe, CNO Judy Bjorndal, Board Member Jenny Fontes, Board Clerk and EA

AGENDA ITEM	DISCUSSION	ACTION
1. CALL TO ORDER/ANNOUNCEMENTS	*Kornblatt Idell*	
	Meeting called to order at 5:01 p.m.	
2. PUBLIC COMMENT	*Kornblatt Idell*	
	None	
3. CONSENT CALENDAR	*Kornblatt Idell*	**ACTION**
• QC Minutes 02.23.22		**MOTION:** by Mainardi to approve, 2nd by Snyder. All in favor.
4. RECRUITMENT OF QC BOARD MEMBER	*Kornblatt Idell*	
	Currently, there are seven members in Quality Committee, four which are public members. Dr. Mainardi suggests leaving one slot available for Board members to transition back to their committee when they leave the Board. He said we currently have room for another member and if the person is qualified the Quality Committee should consider it. Ms. Snyder suggested advertising the committee positions in the newspaper, and Ms. Sheets suggested reaching out to the high school to talk about community service at the hospital.	

5. ANNUAL QUALITY DEPARTMENT REVIEW	*Cooper*	
	Ms. Cooper presented the Annual Quality Department review for year-end 2021. Quality success in 2021 included low benchmark rates in mortality, falls with injury and percent of readmissions, and the hospital exceeded measures for stroke care each month. Ms. Cooper reviewed Opportunity for improvements in 2022, including an opportunity to decrease LOS, improve sepsis measures, and 2022 patient satisfaction. She gave an overview of Quality department re-alignment, data abstraction, clinical quality review, Covid-19 support, peer review support, grievance/risk management support, clinical quality support, QIP partnership reward (for Medi-cal recipients of care/2020 data), and upgraded statit and administrative dashboards.	
6. QUALITY INDICATOR PERFORMANCE AND PLAN	*Cooper/Kobe*	
	Ms. Cooper reviewed the Quality Indicator Performance and Plan for February 2022, which included mortality, AHRQ patient safety indicators, patient falls, readmissions, blood culture contamination, CIHQ stroke certification measures, utilization management, core measures, core measures sepsis, and infection prevention. Mr. Kobe reviewed the inpatient patient satisfaction and ambulatory surgery patient satisfaction.	
7. POLICIES AND PROCEDURES	*Cooper*	Review/ Recommend
	Ms. Cooper reviewed the following policies: **<u>Policies with changes made:</u>** Code of Ethics Hepatitis B Vaccination Program MRI Code Blue Procedure NEW: COVID-19 Mandatory Vaccination NEW: COVID 19 State and Federal Reporting RETIRE -Notifiction Form_DOWNTIME event reporting Radiologist Availability 7630-223 RETIRE-Aerosol Therapy Procedure RETIRE: Radiation Safety Post Injection of Radioisotopes 7630-217 RETIRE - Suicide Risk Lethality Assessment Tool Virtual Radiology Services	

	<u>Policies with no content changes made:</u> Bio-Ethical Issues Certification of Technologists 7630-238 Contrast Extravasation 7630-121 Contrast Media Procurement and Storage 7630-123 Disclosure of Adverse Events or Unanticipated Outcomes Filming and Recording of Patients Handoff Communications with HealthCare Providers-SBAR Peer Review and Focused Professional Practice Evaluation Portable Fluoroscopy Usage Policy and Procedure 7630-210 Radiation Protection for Patients Radiography in the Surgical Suite	
8. CLOSED SESSION/REPORT ON CLOSED SESSION	*Kornblatt Idell*	
a. Calif. Health & Safety Code §32155: Medical Staff Credentialing & Peer Review Report	Medical Staff Credentialing was reviewed and approved.	**MOTION:** by Mainardi to approve, 2nd by Snyder. All in favor.
9. ADJOURN	*Kornblatt Idell*	
	5:51 pm	

Infection Prevention

Risk Assessment for 2022

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SCOPE OF ASSESSMENT

This risk assessment is organization-wide in scope. It covers inpatient acute medical/surgical, emergency, intensive care, ancillary services, as well as outpatient care settings.

PROCESS

The risk analysis is conducted at least annually and whenever there is a significant change in the scope or services. The assessment is facilitated by the Infection Preventionist and presented to the Performance Improvement Committee for review and approval.

Once risks are identified, the organization prioritizes those risks that are of epidemiological significance. Certain risks are automatically prioritized based on their nature, scope, and impact on the care, treatment, and services provided. These risks are outlined in this document as well.

Specific strategies are developed and implemented to address the prioritized risks. These strategies may take the form of policy and procedure establishment, surveillance and monitoring activities, education and training programs, environmental and engineering controls, or

combinations thereof. Strategies may differ in approach, form, scope, application, and/or duration depending on the specific risk issue, the care setting(s), and environment involved.

ASSESSMENT FINDINGS / MITIGATION STRATEGIES

The table below outlines the prioritized risks identified as the result of the assessment; provides a brief description of those risks, assigns a risk level (L=low, 1 point., M=medium, 5 points., or H=high, 10 points) based on the care setting, summarizes actions that have been or will be taken by the organization to address the risks, and how the organization will evaluate the effectiveness of actions taken:

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Legend for Care Settings Risk Designation

I = Inpatient services including medical surgical, critical care, and surgery

A = Ambulatory care services such as outpatient surgery, procedural and diagnostic services, and the Emergency Department

O = Outpatient services such as primary and specialty care clinics , rehabilitation clinics, and other services

Note: For each setting, the risk assessment also takes into account - as applicable - support services such as facilities, environmental services, materials management, sterile supply and processing, dietary, clinical laboratory, and all other departments and services of the organization.

Risk Designation – Enter the Level of Assessed Risk for Each Care Setting:

L = Low risk (1 point)

M = Medium Risk (5 points)

H = High Risk (10 points)

Prioritized Risk Description	Risk Assessment			Mitigation Strategies	Goals/How the Effectiveness of the Strategies is Evaluated
	I	A	O		
Transmission of infection associated with non-compliance with CDC guidelines and CIHQ	H	H	H	Information given to patients on admission on the importance of HH.	Goal is >90% compliance

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recommendations for hand hygiene (HH). **30 Points**				HH education included in hospital and nursing orientation and annual education. HH compliance rounds conducted by the Infection Preventionist plus "stealth audits" to obtain hospital-wide compliance data.	Assess compliance through audits. Report compliance rates to PI, Medicine and Surgery Committees, CEO, CNO, Director of Quality, Quality Board.
Unprotected exposure to pathogens throughout the organization through potential non-compliance with standard precautions, novel respiratory isolation, transmission-based precautions or other infection prevention measures. **30 points**	H	H	H	HR confirms immunity status at time of hire (MMR, varicella, TDaP, hepatitis B). TB testing upon hire and annually. Round on outpatient clinics to assess their practices. Infection Prevention training provided during orientation and annually. In services or other education to physician and nursing staff. Post appropriate visitor posters e.g., COVID-19 screening. Promote respiratory hygiene and cough etiquette in waiting areas and lobby. Patient education given	Goal: 100% Influenza immunization compliance by staff and physicians in 2021. The goal will be calculated based on the combined documentation of approved declination or vaccination to equal 100%. Zero cases of HAI influenza and COVID-19 Influenza immunization compliance is reported to CDPH and the aforementioned committees. Hospital-acquired infections are

				on admission on 'covering your cough'. Monitor isolation practices for appropriate placement, precautions and adherence to policies. Masks are worn by Anesthesia when performing epidurals. Investigate exposures and/or clusters of infections.	reported to Medicine, Surgery, Quality Board, and PI Committees. Communicable disease exposures and clusters of infection are investigated, tracked and actions are reported to PI Committee and other committees as appropriate.
Potential for transmission of infection related to procedures, medical equipment, and medical devices related to appropriate storage, cleaning, disinfection, sterilization, reuse and/or disposal of supplies and equipment, as well as use of personal protective equipment or reuse of Personal Protective Equipment (PPE) during supply chain delays. 30 points	H	H	H	Central Sterile Processing monitors QA logs daily on the following: sterilizers, immediate use sterilization, temperature logs, and endoscope processing equipment Round on outpatient clinics to assess their disinfection/sterilization practices. Medical Imaging utilizes and monitors the Trophon disinfection system. Endoscopy equipment is reprocessed in accordance with manufacturer's recommendation. EVS receives training on infection prevention for proper daily, OR, isolation and terminal	Goal: Monitor compliance with Endoscope reprocessing and enlist a validation method. Manager and Infection Preventionist monitor ongoing compliance with QA logs, appropriate cleaning, storage, disinfection, sterilization, reuse, and/or disposal of waste, supplies and equipment.

				room cleaning. UV light via Xenex robot performed all terminal cleans post discharge isolation patients. Florescent marker system to evaluate cleaning technique.	
Multi use vials (MUV) have the potential risk of contamination without proper handling 30 points	H	H	H	MUVs must be kept in the medication prep area rather than the pts room. MUVs are dated when opened and discarded by day 28.	Goal: IP, safety and department manager rounds to confirm that there is compliance with strategies by Nursing, Anesthesia, OR. Report breaches to PI Committee.
Potential for infection in ambulatory care, Emergency and outpatient settings due to potential prolonged wait times in common areas and potential exposure to infectious individuals. **20 points**	N A	H	H	COVID-19 precautions in place. Respiratory hygiene and cough etiquette signage posted in all inpatient, ambulatory care and outpatient waiting areas (including offsite radiology and outpatient rehab services). Measles information disseminated to all ED and Admitting staff. Train admitting staff on thorough patient screening, including COVID screening. Alcohol gel, face masks, and facial tissues available to patients in waiting areas and lobby.	Goal: 100% of patient waiting areas have signage and supplies to perform COVID screening and promote cough etiquette. IP monitors laboratory and other reports for evidence of exposures to infectious individuals and provides follow up as appropriate. Human Resources and Occupational Health assess all work related infectious disease exposures in staff and provides recommendations for follow up.

				Emergency Department patients and screened for obvious signs of contagious disease e.g., COVID-19. Appropriate control measures are taken for those who may present a risk of transmission of infectious agents. Airborne isolation utilized in room 3.	Outpatient departments are responsible for reporting any infection prevention noncompliance issues to Infection Preventionist for follow up as appropriate. Issues may be identified during Infection Prevention rounds as well.
Community-wide outbreaks of communicable diseases e.g., COVID 19, influenza, measles, pertussis, that carry the potential of adversely impacting operations and service capabilities 30 points	H	H	H	The Infection Preventionist is an active member of the SVH Incident Command Center for COVID 19. The Infection Preventionist also participates in the Infectious Disease Task Force facilitated by the Deputy Health Officer of Sonoma County on a quarterly basis as schedule permits. Health alerts are received from the Public Health Department and distributed to appropriate hospital staff and physicians. Infection Preventionist is on email lists for California Health Alert Network (CAHAN) for notification of any potential emergencies.	Goal: Infection Preventionist attends 90% of ID Task Force meetings and shares health alerts and other pertinent information with appropriate staff. Infection Preventionist evaluates all infectious clusters or outbreaks in a timely manner. Assess compliance with public health and CDC guidelines and recommendations. Prepare and implement an action plan to interrupt the cluster/outbreak. Report exposures, clusters and outbreaks to Performance Improvement Committee.

				Remain in close communication with the communicable disease control nurses at the Sonoma County Public Health Department. Policies/Guidelines in place for outbreak and disaster management. Recommendations and guidelines set forth by the DPH for various diseases e.g. COVID-19, Norovirus, Influenza, Pertussis, Ebola, are available and followed when infectious patients are admitted to the hospital.	TDaP, Hepatitis B, Influenza, MMR, and Varicella vaccination or evidence of immunity required for employees in accordance with Cal/OSHA regulations and CDC recommendations. Staff Influenza vaccination rates monitored and reported to NHSN as required by Ca law. TB testing performed annually and as needed post exposure.
Potential for a bioterrorism (BT) event that would require specific responses from the organization to successfully meet the threat. **15 points**	M	M	M	BT response plan and the plan to manage an influx of infectious patients are included in the Emergency Operations Plan for SVH. Maintain communication with CDPH for updates and alerts.	Goal: Infection Preventionst attends Emergency Management Committee meetings and actively participates in emergency preparedness Evaluate and update plans as necessary.
Acquisition and transmission of multi-drug resistant bacteria that carry the potential for healthcare associated MDRO infections among patients and staff. • MRSA	M	M	M	Contact precautions initiated for all patients currently infected or with a history of MRSA (not required for nares colonization). MDRO Patients are flagged in the system	Goal: Hospital Acquired MDRO cases are identified and reported quarterly to PI, Medicine and Surgery committees.

15 points				for identification and isolation on subsequent admissions. Hospital Acquired MRSA cases are tracked and reported. All MRSA BSI reported to NHSN Active surveillance cultures for MRSA obtained on designated "high risk" patients as required by SB 1058.	100% of HAI MRSA bacteremia cases are reported to CDPH including all cases identified in the ED. Pts colonized with MRSA (nares) are screened and informed in accordance with SB 1058. Antimicrobial Stewardship Program implements action plans to reduce the risk of MDRO.
• VRE **15 points**	M	M	M	Contact precautions initiated for all patient infected or colonized with VRE. Patients are flagged in the system for identification and isolation on subsequent admissions. Hospital Acquired VRE cases are tracked and reported. VRE bacteremia that is detected in the ED as well as after admission is required reporting to NHSN.	Goal: 100% of HAI VRE bacteremia cases are reported to CDPH including all cases identified in the ED. Hospital Acquired MDRO cases are identified and reported quarterly to PI, Medicine and Surgery committees.
• ESBL • Candida auris	M	M	L	Contact precautions initiated for all patients infected or colonized with ESBL or Candida auris.	Goal: ESBL rates are reported quarterly to PI, Medicine and Surgery committees. ASP reviews antibiogram annually

11 points				Patients are flagged in the system for identification and isolation on subsequent admissions. ESBL and C. auris cases are tracked and reported. Report C. auris to DPH if identified. Follow CDPH guidelines for management of C. auris.	and assesses antibiotic use in accordance with antibiotic guidelines. Antibiotic prescribing guidelines are posted on the intranet and reviewed/revised annually by ASP committee. Report and contain C. auris if identified.
• CDI **7 points**	H	L	L	Re-educate M/S and ICU nurses on nurse driven protocol for testing. Environmental disinfection of the isolation room utilizing bleach. Xenex robot UV disinfection is employed with terminal cleaning. Use of handwashing rather than alcohol-based hand sanitizer. Daily antibiotic rounds by Dietary, live culture yogurt/probiotics administered until 48 hours after antibiotics are discontinued and recommend DC or use alternate to PPI for patients on antibiotics. Encourage patient education for patients prescribed antibiotics in	Goal: <3 cases of HA-CDI per year. The ASP program includes weekly review of patients on antibiotics, annual antibiogram and preoperative antibiotic recommendations to promote antimicrobial stewardship and CDI prevention. Hospital Acquired CDI cases are identified and reported quarterly to PI Medicine and Surgery committees. CDI cases are reported to CDPH including cases identified in ED.

				the Emergency Department. Review of cases of concern in ASP weekly with MDs. Hospital Acquired CDI cases are tracked, trended, and reported to PI, Medicine and Surgery Committees.	
• Infection Prevention policies and procedures reflect current CIHQ standards. **6 points**	M	L	N/A	IP policies and procedures that were revised by March 31, 2017 prior to CIHQ survey need to be reviewed and revised.	Goal: Review and revise IP policies and procedures as required. Introduce new policies and procedures as indicated by IP literature, changes in the law or community standard.
• Central line associated bloodstream infections (CLABSI) **6 points**	M	L	N/A	Central Line Insertion Practice (CLIP) monitoring for ICU central line insertions and reported to NHSN. Daily review of line necessity and line removal as soon as possible. Conduct audits several times weekly and report outcomes to managers and staff. Provide just in time education at time of auditing. Report line days necessity data to CMO	Goal: Review 100% of CLIP forms and follow with clinician whenever CLIP is not performed correctly. CLABSI rates at or below NHSN benchmarks. CLABSI rates are reported quarterly to PI committee and appropriate medical staff committees.

				and Chair of Hospitalists.	
• Ventilator Associated Event (VAE) and Hospital-Associated Pneumonia **5 points**	H	N/A	N/A	VAP and HAP prevention project instituted in 2018. Monitor for improvement. Ventilators have been labeled with numbers. Ensure that the numbers of the ventilator uses with each patient is being recorded in ta standardized and consistent way in the EHR. Review and observe ventilator cleaning procedures.	.Goal: Zero VAP and 1.2 HAP per 1000 pt. days
• Catheter associated UTI (CAUTI) **11 points**	M	M	L	Daily review of catheter necessity to remove as soon as possible based on criteria. Include criteria in EHR. Conduct audits several times weekly and report outcomes to manager and staff. Provide just in time education at time of auditing. Report foley days necessity data to CMO and Chair of Hospitalists.	Goal: Reduce CAUTI rates to NHSN benchmarks. Reported quarterly to PI, Medicine and Surgery committees.
• Surgical Site Infections (SSI)	M	H	L	Elevated SSI rates (by procedure group) are	Goal: Overall SSI rate ≤1%, ≤ 2 colon

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16 points				investigated and action plans developed to reduce rates to baseline. CHG protocol in place for elective total joint patients. SSI outcomes (HAI report) shared with OR staff. Conduct full review of OR processes, including sterile processing.	or hysterectomy SSIs/ yr. 90% SSI post discharge reporting compliance by surgeons. SSI rates by procedure do not exceed benchmarks. Report SSI rates quarterly to Surgery, Medicine and PI Committees.
Potential for transmission of infection related to noncompliance with hospital sanitation measures. **15 points**	M	M	M	Regular meeting conducted with the EVS manager, Nutritional Services manager, and Engineering. Provide in-service on an as needed basis to ensure maintenance of a sanitary environment. Policy on cleaning of patient care equipment in place for a clear delineation of responsibility for cleaning specific areas of the hospital and equipment.	Track patient satisfaction survey feedback on cleanliness of the hospital. EVS provides cleanliness monitoring data to IP on a quarterly basis. Medication preparation is performed >3 feet from a sink or a splash guard is installed. (CIHQ) Isolation signs are left in place for EVS upon patient discharge.
Infection Prevention and Control involvement in construction activities **3 points**	L	L	L	Infection Prevention Risk Assessment complete for all construction activities.	Goal: 100% compliance with Infection Control Risk Assessment (ICRA) and compliance checklist completed

				Construction workers educated on Infection Prevention practices during safety orientation.	before initiating any construction projects. Documentation kept in Engineering.
A water management program that reduces the risk of microbial growth in building water systems and the accompanying risk of legionellosis and other waterborne infections **15 points**	M	M	M	Complete a risk analysis and implement a water management program.	Goal: zero healthcare associated legionellosis infections and compliance with the water management program policies and procedures

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Quality Indicator Performance & Plan

April Board Quality

Data for March 2022

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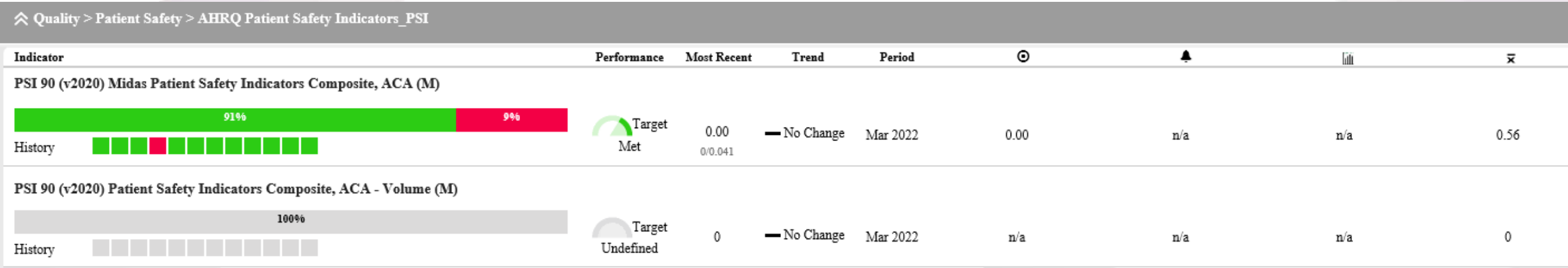
Mortality

Mortality

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
Acute Care Mortality Rate (M)	Target Met	3.2% 2/63	Deteriorated	Mar 2022	15.3%	n/a	n/a	3.8%
COPD Mortality Rate |M|	Target Met	0.0% 0/2		Mar 2022	8.5%	n/a	n/a	5.6%
Congestive Heart Failure Mortality Rate |M|	Breaches Alarm	50.0% 1/2	Deteriorated	Mar 2022	11.5%	n/a	n/a	13.3%
Pneumonia Mortality Rate |M|	Target Met	0.0% 0/4	Improved	Mar 2022	15.6%	n/a	n/a	11.4%
Ischemic Stroke Mortality Rate |M|	Target Met	0.0% 0/3	No Change	Mar 2022	13.8%	n/a	n/a	0.0%
Hemorrhagic Stroke - Mortality Rate (M)	Breaches Alarm	100.0% 1/1	Deteriorated	Jan 2022	0.0%	1.0%	n/a	22.2%

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
Sepsis, Severe - Mortality Rate (M)	Target Met	0.0% 0/4	No Change	Mar 2022	25.0%	n/a	n/a	5.6%
Septic Shock - Mortality Rate (Q)	Target Undefined	0.0% 0/7	Improved	Q1-2022	n/a	n/a	n/a	14.0%

AHRQ Patient Safety Indicators



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

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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%	Target Met	0.00 0/293	Improved	Mar 2022	3.75	4.00	n/a	1.60
History								
RM ACUTE FALL- WITH INJURY (M) per 1000 patient days								
100%	Target Met	0.00 0/293	No Change	Mar 2022	3.75	4.00	n/a	0.32
History								

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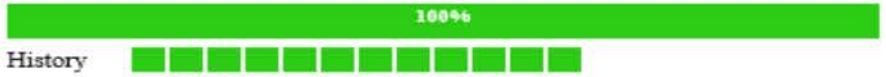
Readmissions

Readmissions

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
30-DV Inpatients - % Readmit to Acute Care within 30 Days (M)								
	Breaches Alarm	16.07% 9/56	Deteriorated	Mar 2022	15.30%	15.50%	n/a	8.36%
COPD, CMS Readm - % Readmit within 30 Days, ACA (M)								
	Breaches Alarm	50.0% 1/2		Mar 2022	19.5%	20.0%	n/a	5.9%
HF, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)								
	Target Met	0.0% 0/1	Improved	Mar 2022	21.6%	22.0%	n/a	18.2%
Hip/Knee, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)								
	Target Met	0.0% 0/2	No Change	Mar 2022	4.0%	5.0%	n/a	8.3%
PNA, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)								
	Breaches Alarm	33.3% 1/3	Deteriorated	Mar 2022	16.6%	17.0%	n/a	17.9%
Sepsis, Severe - % Readmit within 30 Days (M)								
	Target Met	0.0% 0/4	Improved	Mar 2022	12.0%	13.0%	n/a	0.2%
Septic Shock - % Readmit within 30 Days (M)								
	Target Met	1.0% 3/3	Deteriorated	Mar 2022	13.3%	14.0%	n/a	0.1%

Blood Culture Contamination

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔
Blood Cultures -Contamination Rate |RN| (M)						
66% / 34%	Target Met	2.8% (2/71)	Improved	Mar 2022	3.0%	3.1%
History						
Blood Cultures -Contamination Rate |LAB| (M)						
91% / 9%	Target Met	1.1% (1/91)	Improved	Mar 2022	3.0%	4.0%
History						
Blood Cultures -Total Contamination Rate (M)						
83% / 8% / 9%	Target Met	1.9% (3/162)	Improved	Mar 2022	3.0%	4.0%
History						

Month	RN-Contaminated Culture Reports (num)	Blood Cultures Drawn by RN (den)	Percent
Mar 2022	2	71	2.8%
Feb 2022	8	92	8.7%
Jan 2022	2	88	2.3%
Dec 2021	3	92	3.3%
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%

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CIHQ Stroke Certification Measures

Stroke > Code Stroke Elapsed Time

Indicator	Performance	Most Recent	Trend	Period				
CDSTK-03|Median- Code Stroke Called |M| elapsed time (mins)	Target Met	2	Improved	Mar 2022	10	11	n/a	4
CDSTK-04|Median- Door to Phys Eval |M| minutes	Target Met	0.00	Improved	Mar 2022	10.00	11.00	n/a	1.25
CDSTK-05|Median- Door to CT Scanner |M|elapsed time (minutes)	Target Met	4.00	Improved	Mar 2022	25.00	26.00	n/a	7.50
CDSTK-06|Median- Neuro Consult Contacted |M| minutes	Target Met	10.00	Improved	Mar 2022	30.00	31.00	n/a	18.50
CDSTK-07|Median- CT Read by Radiology |M| minutes	Target Met	22.00	Improved	Mar 2022	45.00	46.00	n/a	23.25
CDSTK-08|Median- Lab Results Posted |M| minutes	Target Met	25.00	Improved	Mar 2022	45.00	46.00	n/a	30.25
CDSTK-10|Median- Door to EKG Complete |M| minutes	Target Met	44.00	Deteriorated	Mar 2022	60.00	61.00	n/a	39.00
CDSTK-11|Median-Door to tPA Decision |M| minutes	Target Met	15.00	Improved	Mar 2022	60.00	61.00	n/a	23.50
CDSTK-12|Median-Door to tPA |M| minutes	Breaches	70.00		Mar 2022	60.00	61.00	n/a	69.75

Utilization Management

Utilization Management

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
1 Day Stay Rate Medi-Cal [M]								
	Breaches Alarm	12.50% 1/8	Deteriorated	Mar 2022	2.61%	5.00%	n/a	5.26%
1 Day Stay Rate-Medicare [M]								
	Target Met	4.65% 2/43	Deteriorated	Mar 2022	8.10%	10.00%	n/a	7.95%
Acute Care - Geometric Mean Length of Stay [M]								
	Bet. Target & Alarm	3.14 47.1318/15	Deteriorated	Mar 2022	2.75	3.23	n/a	3.26
Acute Care Age over 64 - MS-DRG Case Mix Index [M]								
	Target Met	1.63 74.8125/46	Improved	Mar 2022	1.56	1.40	n/a	1.51
Acute Care- MS-DRG Case Mix Index [M]								
	Target Met	1.64 93.3994/57	Improved	Mar 2022	1.55	1.40	n/a	1.50

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.

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

Core Measures

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
Core OP29/ASC9 - Colonoscopy:F/U for Avg Risk Pts (M)								
	Target Met	100.0% 4/4	— No Change	Mar 2022	88.0%	50.0%	n/a	99.1%

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
Core OP 22 ED LWBS Emergency Dept Left Without Being Seen (M)								
	Target Met	0.9% 6/672	Improved	Mar 2022	2.0%	2.5%	n/a	1.4%

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
Core OP 18b Median Time ED Arrival to ED Departure - Reporting Measure (M)								
	Target Met	125.00	Improved	Mar 2022	132.00	140.00	n/a	132.50

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
Core OP-23 - Head CT/MRI Results for STK Pts w/in 45 Min of Arrival (M)								
	Target Met	100.0% 2/2	— No Change	Feb 2022	72.0%	70.0%	n/a	100.0%

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Core Measures Sepsis

Core Measures > Sepsis -SEP-1-

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
SEP-1 Early Management Bundle, Severe Sepsis/Septic Shock (M)								
	Target Met	100.0% 7/7	Improved	Mar 2022	81.0%	80.0%	n/a	77.3%
SEPa - Severe Sepsis 3 Hour Bundle (M)								
	Target Met	100.0% 7/7	Improved	Mar 2022	94.0%	90.0%	n/a	85.5%
SEPb - Severe Sepsis 6 Hour Bundle (M)								
	Target Met	100.0% 7/7	Improved	Mar 2022	100.0%	90.0%	n/a	96.2%

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Infection Prevention

Infection Prevention

Indicator	Performance	Most Recent	Trend	Period				
IC-Surveillance| HAI-C.DIFF Inpatient infections per 10k pt days |M|								
88% / 12%	Target Met	0	No Change	Mar 2022	1	1	n/a	0
History								
IC-Surveillance| HAI-CAUTI Inpatient infections per 10k patient days |M|								
100%	Target Met	0	No Change	Mar 2022	1	1	n/a	0
History								
IC-Surveillance| HAI-CLABSI Inpatient infections per 10k patient days |M|								
100%	Target Met	0	No Change	Mar 2022	1	1	n/a	0
History								
IC-Surveillance| HAI-MRSA Inpatient infections per 10k patient days |M|								
100%	Target Met	0	No Change	Mar 2022	1	1	n/a	0
History								

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
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Inpatient Patient Satisfaction
N= 9

Patients' Perspectives of Care Surveys > Hospital -HCAHPS-

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
01-Rate hospital 0-10 |M| Rank								
83% / 17%	Target Met	82	Deteriorated	Feb 2022	50	30	n/a	71
History								
02-Recommend the hospital |M| Rank								
100%	Target Met	71	Deteriorated	Feb 2022	50	30	n/a	82
History								
03-Communication w/ Nurses |M| Rank								
33% / 67%	Breaches Alarm	12	Deteriorated	Feb 2022	50	30	n/a	37
History								
04-Response of Hosp Staff |M| Rank								
66% / 17% / 17%	Target Met	89	Deteriorated	Feb 2022	50	30	n/a	74
History								
05-Communication w/ Doctors |M| Rank								
50% / 50%	Breaches Alarm	12	Deteriorated	Feb 2022	50	30	n/a	47
History								
06-Cleanliness of hospital environment|M| Rank								
50% / 16% / 34%	Target Met	98.00	Improved	Feb 2022	50.00	30.00	n/a	45.67
History								

HCAHPS

Inpatient Patient Satisfaction

08-Communication About Medicines |M| Rank								
	Target Met	89	Improved	Feb 2022	60	30	n/a	26
09-Discharge Information |M| Rank								
	Target Met	89	Improved	Feb 2022	50	30	n/a	26
10-Care Transitions |M| Rank								
	Target Met	93	Improved	Feb 2022	50	30	n/a	38

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

Ambulatory Surgery Patient Satisfaction
N= 28

Patients' Perspectives of Care Surveys

Indicator	Performance	Most Recent	Trend	Period	◎	🔔		✕
01-OAS Recommend the Facility |M| Rank								
83% / 17%	Target Met	92	Improved	Feb 2022	50	30	n/a	67
History								
02-OAS Communication |M| Rank								
33% / 33% / 34%	Target Met	90	Improved	Feb 2022	60	30	n/a	50
History								
03-OAS Facility/Personal Treatment |M| Rank								
50% / 33% / 17%	Bet. Target & Alarm	67	Deteriorated	Feb 2022	80	30	n/a	69
History								
04-OAS Discharge |M| Rank								
66% / 17% / 17%	Target Met	76	Deteriorated	Feb 2022	70	30	n/a	65
History								
05-OAS Staff treat w/courtesy and respect |M| Rank								
66% / 34%	Target Met	99	No Change	Feb 2022	60	30	n/a	72
History								
07-OAS Facility Clean |M| Rank								
100%	Target Met	99	No Change	Feb 2022	60	30	n/a	99
History								
ED-Time Physician Spent With Me Score (M)								
66% / 29% / 5%	Target Met	4.57	Improved	Mar 2022	4.50	4.30	n/a	4.55
History								

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT

Medication Scanning Rate	2021-22				
	Q2	Q3	Q4	Q1	Goal
Acute	96.0%	95.7%	95.8%	96.9%	≥90%
ED	74.0%	78.0%	78.1%	81.2%	≥90%
Preventable med errors R/T Med Scanning	0 (n=3)	0 (n=7)	0 (n=24)	1 (n=11)	≤2

Quality Indicators (QAPI) 2021-22					
	Q2	Q3	Q4	Q1	Goal
Antibx admin within 30"- M/S and ICU	86.70	91.00	96.00	89.00	≥95%
Cont. OBS for Psych Pt-ED	77.8	100.0	100.0	90.0	100%
Drug Admin Errors- Pharmacy (per 10000 doses)	0.00	1.00	0.00	2.00	1.00

Case Management/Utilization Management 2021-22					
	Q2	Q3	Q4	Q1	Goal
Medical Necessity Denials	N/A	N/A	N/A	2.0	0
HCAHPS Care Transitions	36.3	37.3	47.0	N/A	53%

Nursing Turnover	2021-22 Staff/Quarter				
# of RNs	Q2	Q3	Q4	Q1	Goal
Acute (n=56)	1	2	17	5	≤6

Outpatient Experience 2020-21	2021-22				
	Q2	Q3	Q4	Q1	Goal
RATE MY HOSPITAL- PHYSICAL THERAPY					
Overall score	4.95	4.82	4.9	4.9	≥4.9
RATE MY HOSPITAL-OUTPATIENT SURGERY					
Overall Score	N/A	N/A	4.9	4.9	≥4.9
RATE MY HOSPITAL - ED					
Overall score	4.72	4.67	4.8	4.7	≥4.9
RATE MY HOSPITAL - MEDICAL IMAGING					
Overall score	4.86	4.78	4.8	4.8	≥4.9
RATE MY HOSPITAL-INPATIENT					
Overall score	4.81	4.43	4.8	4.9	≥4.9

Nurse Staffing Effectiveness: Transfers r/t staffing/beds					
2021-22	Q2	Q3	Q4	Q1	Goal
	1	1	1	3	≤0

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

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: 04/21/2022 12:05 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: 15

Committee: **07 BOD-Quality Committee of the Board**

Committee Members: **Fontes, Jenny (jfontes), Newman, Cindi (cnewman)**

Current Approval Tasks (due now)

Document	Task/Status	Pending Since	Days Pending
Conflict of Interest *Governance and Leadership Policies*	**Pending Approval**	4/21/2022	0

Summary Of Changes: **Reviewed. No Changes**

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

Lead Authors: **Cooper, Kylie (kcooper)**

ExpertReviewers: **Armfield, Ben (barmfield)**

Approvers: **Hennelly, John (jhennelly) -> 01 P&P Committee - (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)**

Document	Task/Status	Pending Since	Days Pending
Discharge Planning for the Homeless Patient *Discharge Planning (DP)*	**Pending Approval**	4/21/2022	0

Summary Of Changes: **No substantial changes. changed taxi voucher system to hospital transportation vendor or ride-sharing service.**

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

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

Approvers: **Cooper, Kylie (kcooper) -> 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)**

Document	Task/Status	Pending Since	Days Pending
NEW::Casirivimab-Imdevimab Monoclonal Antibody *Medication Management Policies (MM)*	**Pending Approval**	4/21/2022	0

Summary Of Changes: **New Policy**
Purpose: To outline the procedure for determining eligibility, ordering, obtaining, and administering Casirivimab-Imdevimab under United States FDA Emergency Use Authorization.

Accepted changes proposed in Board Quality Meeting and altered wording to make policy more generalized to COVID monoclonal antibody therapies and not to a specific one. Policy title has been changed to be more inclusive/generalized regarding therapies: NEW NAME: |||| COVID-19 Monoclonal Antibody Therapy||||

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

Lead Authors: **Kutza, Chris (ckutza), Kobe, Mark (mkobe), Kidd, Sabrina (skidd), Cooper, Kylie (kcooper)**

ExpertReviewers: **Kobe, Mark (mkobe)**
Approvers: **06 CMO/Designee for signature -> 01 P&P Committee - (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)**

Policies and Procedures | **Pending Approval** | 4/5/2022 | 16

Governance and Leadership Policies

Summary Of Changes: **Multiple changes due to new policy portal and work flows- will send through entire policy for apporval**
Removed references to SNF and Birthplace.
Moderators: **Newman, Cindi (cnewman)**
Lead Authors: **Newman, Cindi (cnewman), Cooper, Kylie (kcooper)**
ExpertReviewers: **06 CMO/Designee for signature**
Approvers: **06 CMO/Designee for signature -> 01 P&P Committee - (Committee) -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Release of Information-Patient Requests | **Pending Approval** | 4/5/2022 | 16

HIM/Medical Records

Summary Of Changes: **Updated to comply with regulatory requirements of 21st Century CURES Act regarding patient access to and delivery of electronic health information.**
Removed reference to charging for copies of records and invoicing, we no longer charge patients.
Updated processing time for requests from 14 days to 10 days to align with CURES Act notification timeline for exceptions.
Moderators: **Newman, Cindi (cnewman)**
Lead Authors: **Pryszmant, Rosemary (rpryszmant)**
Approvers: **Cooper, Kylie (kcooper) -> 01 P&P Committee - (Committee) -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

RETIRE::Committee Review Charts | **Pending Approval** | 4/5/2022 | 16

HIM/Medical Records

Summary Of Changes: **RETIRE::This policy is for paper records and no longer needed.**
Moderators: **Newman, Cindi (cnewman)**
Lead Authors: **Pryszmant, Rosemary (rpryszmant)**
Approvers: **Cooper, Kylie (kcooper) -> 01 P&P Committee - (Committee) -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

RETIRE::Creating a Duplicate Medical Record | **Pending Approval** | 4/5/2022 | 16

HIM/Medical Records

Summary Of Changes: **RETIRE::This process is no longer applicable, specifically relates to paper charting.**
Moderators: **Newman, Cindi (cnewman)**
Lead Authors: **Pryszmant, Rosemary (rpryszmant)**
Approvers: **Cooper, Kylie (kcooper) -> 01 P&P Committee - (Committee) -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

RETIRE::Emergency Room Record Processing | **Pending Approval** | 4/5/2022 | 16

HIM/Medical Records

Summary Of Changes: **Reviewed and retired. This process is for paper records and no longer needed.**
Moderators: **Newman, Cindi (cnewman)**
Lead Authors: **Pryszmant, Rosemary (rpryszmant)**

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

RETIRE::HIV Test Result Filing **Pending Approval** 4/5/2022 16

HIM/Medical Records

Summary Of Changes: **Reviewed and retired. This process is for paper records and no longer needed.**

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

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

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

RETIRE::Maintenance of Fetal Monitoring Tracings **Pending Approval** 4/5/2022 16

HIM/Medical Records

Summary Of Changes: **Reviewed and retired. OB unit closed and process is for paper records, no longer needed.**

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

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

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

RETIRE::Medical Record Availability **Pending Approval** 4/5/2022 16

HIM/Medical Records

Summary Of Changes: **Reviewed and retired. This process is for paper records and no longer needed.**

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

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

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

RETIRE::Medical Record Department Storage Area **Pending Approval** 4/5/2022 16

HIM/Medical Records

Summary Of Changes: **Reviewed and retired. This process is for paper records and no longer needed.**

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

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

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

RETIRE::Paragon HIS Chart Locator **Pending Approval** 4/5/2022 16

HIM/Medical Records

Summary Of Changes: **Recommend retirement, obsolete practice with use of EHR.**

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

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

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

RETIRE::Unit Medical Record **Pending Approval** 4/5/2022 16

HIM/Medical Records

Summary Of Changes: **Reviewed and retired. This process is for paper records and no longer needed.**

Moderators:	**Newman, Cindi (cnewman)**
Lead Authors:	**Pryszmant, Rosemary (rpryszmant)**
Approvers:	**Cooper, Kylie (kcooper) -> 01 P&P Committee - (Committee) -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

RETIRE::Unit Medical Record and Storage Locations	**Pending Approval**	4/5/2022	16
HIM/Medical Records			

Summary Of Changes:	**Reviewed and retired. This process is for paper records and no longer needed.**
Moderators:	**Newman, Cindi (cnewman)**
Lead Authors:	**Pryszmant, Rosemary (rpryszmant)**
Approvers:	**Cooper, Kylie (kcooper) -> 01 P&P Committee - (Committee) -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

SUBJECT: **COVID-19 Monoclonal Antibody Therapy**	POLICY: MM8610-165
	Page 1 of 3
DEPARTMENT: Organizational	EFFECTIVE:
REVISED:	

Purpose:
To outline the procedure for determining eligibility, ordering, obtaining, and administering COVID-19 monoclonal antibody therapies under United States FDA Emergency Use Authorization.

Policy:

Sonoma Valley Hospital will offer COVID-19 monoclonal antibody therapies to outpatients who qualify for receiving this treatment based on current FDA approval or EUA status. The organizational policy "Outpatient Infusion Service MM8610-163" will be followed for any processes not outlined in this policy.

Acronyms:

- ED—Emergency Department
- EUA—Emergency Use Authorization
- FDA—Food and Drug Administration
- MHOAC—Medical Health Operational Area Coordinator
- PCP—Primary Care Provider
- PPE—Personal Protective Equipment
- SVH—Sonoma Valley Hospital
- UA—Unit Assistant

Procedure:

1. Eligibility is determined by PCP or ED physician using FDA defined inclusion and exclusion criteria.
2. PCP or ED physician completes the applicable SVH order form for COVID-19 monoclonal antibody therapies documenting inclusion criteria. (See attached).
3. Order form and Outpatient Infusion Service Worksheet (see attached) is faxed to MedSurg UA.
4. Existing process for approving outpatient infusions is followed as per Outpatient Infusion Service MM8610-163.
5. Once approval process is completed:
    a. Pharmacy receives order per process defined in Outpatient Infusion Service MM8610-163.

NEW

b. Pharmacy follows process in force at time of ordering to obtain doses or contacts the Sonoma County MHOAC to obtain medication supply needed.
c. If no medication is available and it will NOT be available within the FDA defined window from onset of symptoms, pharmacy notifies clerk and ordering provider.

6. Clerk calls patient to schedule infusion appointment
    a. Appointment must be WITHIN 10 days of symptom onset..
    b. UA gives arrival instructions to patient.
        i. Patient must wear a well-fitting mask to hospital or preferably a N-95 if available to patient prior to arrival.
        ii. Patient is instructed to call the unit upon arrival and wait in their car for personnel to meet them.
7. Day of Infusion:
    a. Patient calls the unit as instructed.
    b. The UA notifies the receiving nurse and the nursing supervisor of the patient's arrival.
    c. The nursing supervisor will meet the patient outside at their car, provide the patient with an N-95 mask and escort the patient into the building.
        i. Patient will be ESCORTED directly upstairs following elevator COVID protocols (PROVIDER also wears N95) to private room or negative pressure room (if available) on 3rd floor.
        ii. Infusion given using COVID PPE (N95, gloves, gowns, eye protection).
        iii. Patient monitored for minimum of 1 hour.
        iv. Patient discharged and ESCORTED to car.
    d. If staff identifies an infusion reaction:
        i. Patient stable
            1. Contact ordering physician
        ii. Patient Unstable
            1. Call Rapid Response
            2. Transport patient to ED for further evaluation using full precautions

NEW

3. Contact ordering physician

References:

- Outpatient Infusion Service MM8610-163
- Fact Sheet for Health Care Providers Emergency Use Authorization (EUA) of Casirivimab-Imdevimab https://www.fda.gov/media/145612/download
- FDA EUA Letter to Eli Lilly: https://www.fda.gov/media/143602/download.

Attachments:

Attachment A: COVID-19 Sotrovimab Infusion Order Form
Attachment B: COVID-19 Monoclonal Antibody Infusion Order Form
Attachment C: Outpatient Infusion Service Worksheet

OWNER:
Director of Pharmacy

AUTHORS/REVIEWERS:
Director of Pharmacy
Chief Nursing Officer
Board Quality Committee

APPROVALS:
Policy & Procedure Team:
Pharmacy & Therapeutics Committee
Medical Executive Committee:
The Board of Directors:

NEW

SUBJECT: Policies and Procedures	POLICY # GL8610-162
	PAGE 1 OF 6
DEPARTMENT: Organizational	EFFECTIVE: 2/08
REVIEW/REVISED: 3/12, 3/15, 1/17, 2/18	

PURPOSE:

To insure that all new and/or revised Organizational policies or specific Department policies and procedures written for Sonoma Valley Hospital will be established, revised, reviewed and documented in a consistent format throughout the Hospital. All policies and procedures shall be expressed in writing and shall go through established channels for approval(s) and distribution.

POLICY:

All Sonoma Valley Hospital policies will conform to the procedures outlined in this policy.

1. All newly created and/or revised policies and procedures will be written in the prescribed format. The policies will be reviewed and approved by appropriate leader and/or committee(s). All affected departments will collaborate, as appropriate, in the initial policy development, and are responsible for agreement to stated content.

2. All old and revised policies must be saved for ten years, with the exception of Pediatrics policies which will be kept for 21 years.

3. Organizational policies and procedures are those which, as a general rule, affect patient care functions or organizational functions that involve more than a single department.

4. Departmental policies and procedures are those which affect only one department.

5. Departmental policies and procedures are always in the same format as Organizational policies and procedures. The prescribed format should be used for any new or revised documents. See Style Sheet and Template.

6. Policies will be reviewed and revised when warranted, and when needed to comply with changes in regulatory requirements. The period between reviews shall not exceed three years. If legally required, review and revision will be done on an annual basis.

RESPONSIBILITIES:

1. Each Director/Manager is responsible for writing/revising and maintaining policies and procedures covering their area of responsibility. If a policy or procedure requires technical, legal or other review/input (i.e. Bio-Med, legal), this information should be obtained or clarified at the time of the development or revision of the policy and procedure. The expert reviewer name and title will be added to the author review list.

NEW

2. Policies and procedures are reviewed with the Director and Medical Director, if applicable, of that area for approval/sponsorship.

3. All new, revised, retired, and reviewed policies will be presented to the Policy and Procedure Committee prior to submission to the appropriate Committees.

PROCEDURE:

1. Template: All policies will follow the standardized template that consists of the following sections.
    a. **Purpose:** a brief statement of the reason for the policy.
    b. **Policy Statement**: this section identifies the global intention of the policy and as such may be redundant to the Purpose section. If there aren't any procedural steps to the policy, then only A, B, & D. are required. ***"Responsibilities" may be included between "Policy" and "Procedure" paragraphs.***
    c. **Procedure:** a detailed outline of the steps in the policy.
    d. **References:** each policy must cite specific regulatory standards at a minimum, and professional standards of practice or best practice articles. For example: Association of peri Operative Registered Nurses (AORN), Association for Professionals in Infection Control and Epidemiology (APIC), EBSCO Dynamic Health Standards Of Practice for Nursing, etc.
    e. **Owner**
    f. **Author/Reviewers**
    g. **Committee Approvals**

2. Numbering of Policies and Procedures: all policies will adhere to the following policy numbering format.

    a. All policies will begin the with the CIHQ Standards Headings designation as below:

GL	Governance & Leadership
QA	Quality Assessment & Performance Improvement
MS	Medical Staff
HR	Human Resources
CE	Managing the Care Environment
IC	Infection Prevention & Control
EP	Emergency Preparedness
UR	Utilization Review
PR	Patient Rights
MM	Medication Management
MR	Management of Medical Record

NEW

RS	Use of Restraint & Seclusion
QS	Patient Quality & Safety Practices
AN	Anesthesia Services
NU	Dietary Nutrition Services
DC	Discharge Planning Services
ED	Emergency Services
LB	Laboratory Services
OP	Organ, Tissue & Eye Procurement
NM	Nuclear Medicine Services
NS	Nursing Services
OI	Operative & Invasive Services
OS	Outpatient Services
RD	Radiology Services
RB	Rehabilitation Services
RT	Respiratory Services
PC	Patient Care

After the functional heading, all departments will add the four digits of their department cost center. The last three numbers of departmental policies will be assigned by the Manager. Organizational policies will use the four digits of the Administration cost center (8610). Organizational policy: PR8610-101 (Organizational policy addressing Patients' Rights)

3. **Font:** The Policy and Procedure document will be prepared using Word, Arial, font size 11.

4. **Draft Process**:
   a. A system generated email is delivered to the lead author notifying them of the requirement to review the policy.
   b. The responsible Director/Manager/Author edits the DRAFT file utilizing tracked changes in collaboration with the Medical Director and additional leaders of effected departments and disciplines.
   c. The responsible Director/Manager/Author adds a summary of changes to the summary tab in the policy system. The summary statement will include the reason for the change, or explain the need for a new policy/procedure (Cheat Sheet Instruction Sheet provides short explanations to use when making changes and may be found in the policy system under the Organizational menu).

6. **Approval Routing:** All policies and procedures will follow an approval routing process dependent upon their impact on patient care. Sonoma Valley Hospital defines "direct patient care" as any process that directly, provided by a physician, nurse or ancillary department staff member, impacts the care a patient receives or the outcomes of care. All policies and procedures will be initially reviewed and approved by the Policy and Procedure Committee.

NEW

a. Direct patient care policies and procedures (See table below)

1. The Medical Director and Leader bring only new policies to committees for a full review and approval.

2. Policy content is reviewed and approved by the Medical Director with Director/Manager/Author. The Summary report becomes an item on the consent calendar of the committee agenda and approval is documented in the minutes.

Direct Patient Care Dept	**Medical Director/Committee Oversight**	**Committee Flow**
Patient Care Services (MS, ICU)	Medical Director Chair, Medicine	MEDICINE MEDICAL EXECUTIVE COMMITTEE (MEC), BOARD QUALITY, BOARD OF DIRECTORS (BOD)
Emergency Department	Medical Director Chair, Medicine	MEDICINE BOARD MEC, BOARD QUALITY, BOD
Surgical Services	Medical Director Chair, Surgery	SURGERY, MEC, BOARD QUALITY, BOD
Anesthesia Services	Medical Director Anesthesia/Surgery	SURGERY BOARD MEC, BOARD QUALITY, BOD
Pharmacy	Chair, Performance Improvement/Pharmacy and Therapeutics	PEROFRMANCE IMPROVEMENT AND PHARMACY AND THERAPEUTICS (PI/PT), MEC, BOARD QUALITY, BOD MEDICAL EXECUTIVE BD
Clinical Lab	Medical Director Chair, Medicine	MEDICINE, MEC, BOARD QUALITY, BOD
Medical Imaging	Medical Director Chair, Surgery	SURGERY, MEC, BOARD QUALITY, BOD
Inpatient Rehab	Chair, Medicine	MEDICINE, MEC, BOARD

NEW

		QUALITY, BOD MEDICAL
Outpatient Rehab	Chair, Medicine	MEDICINE. MEC, BOARD QUALITY, BOD
Cardiology & Respiratory	Medical Director Chair, Medicine	MEDICINE. MEC, BOARD QUALITY, BOD
Nutritional Services	Chair, PI Com	MEDICINE, MEC, BOARD QUALITY, BOD
Occupational Health	Medical Director Chair, Medicine	MEDICINE, MEC, BOARD QUALITY, BOD
Case Management	Chair, Medicine	MEDICINE, MEC, BOARD QUALITY, BOD
Infection Prevention	Chair, Medicine	MEDICINE, MEC, BOARD QUALITY, BOD
Medical Staff	Chief of Staff	MEDICAL EXECUTIVE, BOD
Wound Care	Medical Director Chair, Medicine	MEDICINE, MEC, BOARD QUALITY, BOD MEDICAL EXECUTIVE BD

b. Non-Direct patient care policies and procedures:

1. The following departments are designated as non-direct patient care departments:

HR, Information Systems, Facilities, EVS, Quality/Risk, HIM, Admin, Finance, Patient Access, Patient Financial Services, Education, Materials Management

2. All non-direct patient care policies and procedures by-pass the medical staff and follow this workflow:

Manager/Director – CEO/CMO (if applicable) –Board of Directors

REFERENCE:
Title 22, Licensing and Certification of Health Facilities and Referral Agencies, State of CA
CMS Conditions of Participation 482.12
CIHQ Standard GL-4: Leadership Responsibilities
Style Sheet, Template, Cheat Sheet

OWNER:
Director Quality & Risk Management

NEW

SUBJECT: Policies and Procedures	POLICY # GL8610-162
	PAGE 6 OF 6
DEPARTMENT: Organizational	EFFECTIVE: 2/08
REVIEW/REVISED: 3/12, 3/15, 1/17, 2/18	

AUTHORS/REVIEWERS:
Director of Quality and Risk Management,
Board Quality Committee:

APPROVALS:
Policy & Procedure Committee:
Board of Directors:

NEW