SVHCD QUALITY COMMITTEE
AGENDA
WEDNESDAY, JUNE 29, 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
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	*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 05.25.22	*Kornblatt Idell*	Action
4. ED QA/PI	*Brown*	Inform
5. QUALITY INDICATOR PERFORMANCE AND PLAN	*Cooper*	Inform
6. POLICIES AND PROCEDURES	*Cooper*	Review/ Recommend
7. CLOSED SESSION: a. Calif. Health & Safety Code §32155: Medical Staff Credentialing & Peer Review Report		Action
8. ADJOURN	*Kornblatt Idell*	

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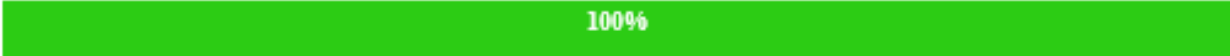
Members Present – Via Zoom	Members Present cont.	Excused	Public/Staff – Via Zoom
Susan Kornblatt Idell Ingrid Sheets Cathy Webber Carol Snyder Howard Eisenstark Michael Mainardi, MD			John Hennelly, CEO Ako Walther, MD Kylie Cooper, Quality and Risk Mgmt Mark Kobe, CNO Judy Bjorndal, Board Member Jenny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

AGENDA ITEM	DISCUSSION	ACTION
1. CALL TO ORDER/ANNOUNCEMENTS	*Kornblatt Idell*	
	Meeting called to order at 5:00 p.m.	
2. PUBLIC COMMENT	*Kornblatt Idell*	
	None	
3. CONSENT CALENDAR	*Kornblatt Idell*	**ACTION**
• QC Minutes 04.27.22		**MOTION:** by Snyder to approve, 2nd by Webber. All in favor.
4. IMAGING QA/PI	*Young*	**INFORM**
	Mr. Young reviewed the 2022 Quality Measures including CT tube quality control, contrast extravasations, wrong site/side, repeat analysis, MRI near misses, echo inpatient order to Exam performed and CTDi dose tracking. Mr. Young reviewed performance improvement. He said they provided more training to staff and tightened up analysis and reporting of "missing PCP at registration." The efforts increased measures to 98%. The stroke-door to CT	

	scan is 25 minutes and stroke-door to radiologist report is 45 minutes.	
5. QUALITY INDICATOR PERFORMANCE AND PLAN	*Cooper*	**INFORM**
	Ms. Cooper reviewed the Quality Indicator Performance and Plan for April 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, inpatient patient satisfaction and ambulatory surgery patient satisfaction. Mr. Kobe reviewed the rate your hospital scores.	
6. POLICIES AND PROCEDURES	*Cooper*	**REVIEW/ RECOMMEND**
	Ms. Cooper reviewed the following policies: **Policies with changes made:** Assessment and Reassessment (CM) Blood or Body Fluids Exposure Follow-Up (Patient /Visitor) Case Finding Criteria for Assessment Case Management in the Emergency Department Central Venous Catheter/Implanted Port: Access and Management Classification of Employees Equipment Cleaning Policy Expedited Review of Continued Hospital Stay Flowmeters for Oxygen Procedure Fluoroscan Foodborne Illness Outbreak Investigation Infection Prevention Program (2022) Infection Prevention Risk Assessment (2022) MRSA Active Surveillance Culture (ASC) NEW::Medicinal Cannabis Use in the Terminally Ill Outbreak Management Outpatient Infusion Service Oxygen Protocol Patient Positioning Patient Transportation Pet TherapyVisitation Plan for Patient and Family Education Pre-admission Evaluation	

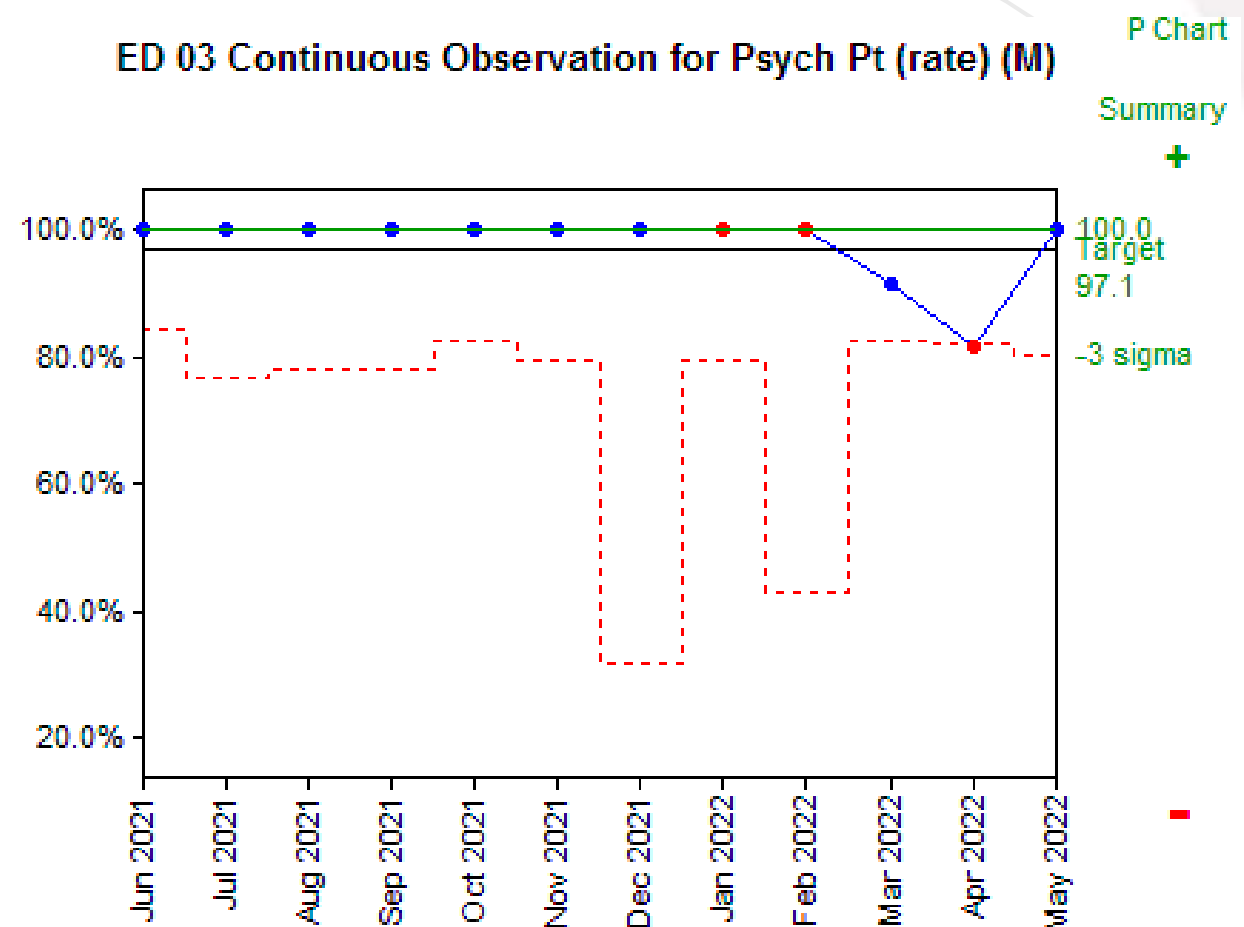|		
	Prevention of Catheter Associated Urinary Tract Infections Prevention of Central Line Associated Blood Stream Infections Reporting Infections and Communicable Diseases to Infection Control Restraint Use RETIRE::Cardioversion RETIRE:Hand off protocol Scope of Service Skilled Level of Care Criteria Transfer Process, Case Management Role Visitor Policy in the Intensive Care Unit **Recommendations by the Board to make revisions:** Medicinal Cannabis Use in the Terminally Ill Outpatient Infusion Service	
8. CLOSED SESSION/REPORT ON CLOSED SESSION	*Kornblatt Idell*	**ACTION**
a. Calif. Health & Safety Code §32155: Medical Staff Credentialing & Peer Review Report	Medical Staff Credentialing was reviewed and approved.	**MOTION:** by Eisenstark to approve, 2nd by Mainardi. All in favor.
9. ADJOURN	*Kornblatt Idell*	
	6:25 pm	

Emergency Services

Indicator	Performance	Most Recent
ED 03 Continuous Observation for Psych Pt (rate) (M)		
83% / 8% / 9% — History	Target Met	100.0% 9/9
ED 04 NIHSS Dated and Timed (rate) (M)		
66% / 17% / 17% — History	Target Met	100.0% 4/4
ED 05 NIHSS Disposition Accurate (rate) (M)		
100% — History	Target Met	100.0% 12/12
Blood Cultures -Contamination Rate |RN| (M)		
58% / 42% — History	Breaches Alarm	4.7% 5/107

Emergency Services

Continuous Observation for Psych Pt

Audit Month	Numerator	Denominator	Percent
May 2022	9	9	100.0%
Apr 2022	9	11	81.8%
Mar 2022	11	12	91.7%
Feb 2022	5	5	100.0%
Jan 2022	8	8	100.0%
Dec 2021	4	4	100.0%
Nov 2021	8	8	100.0%
Oct 2021	12	12	100.0%
Sep 2021	7	7	100.0%
Aug 2021	7	7	100.0%
Jul 2021	6	6	100.0%
Jun 2021	15	15	100.0%

ED 03 Continuous Observation for Psych Pt (rate) (M)

P Chart

Summary

+

100.0
Target
97.1

-3 sigma

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Emergency Services

NIHSS Scoring Sheet Dated & Timed

Audit Month	Numerator	Denominator	Percent
May 2022	4	4	100.0%
Apr 2022	13	13	100.0%
Mar 2022	7	7	100.0%
Feb 2022	4	4	100.0%
Jan 2022	10	11	90.9%
Dec 2021	6	7	85.7%
Nov 2021	7	7	100.0%
Oct 2021	7	7	100.0%
Sep 2021	12	12	100.0%
Aug 2021	7	8	87.5%
Jul 2021	11	12	91.7%
Jun 2021	15	15	100.0%

ED 04 NIHSS Dated and Timed (rate) (M)

P Chart

Summary

+

100.0
Target
96.3

-3 sigma

−

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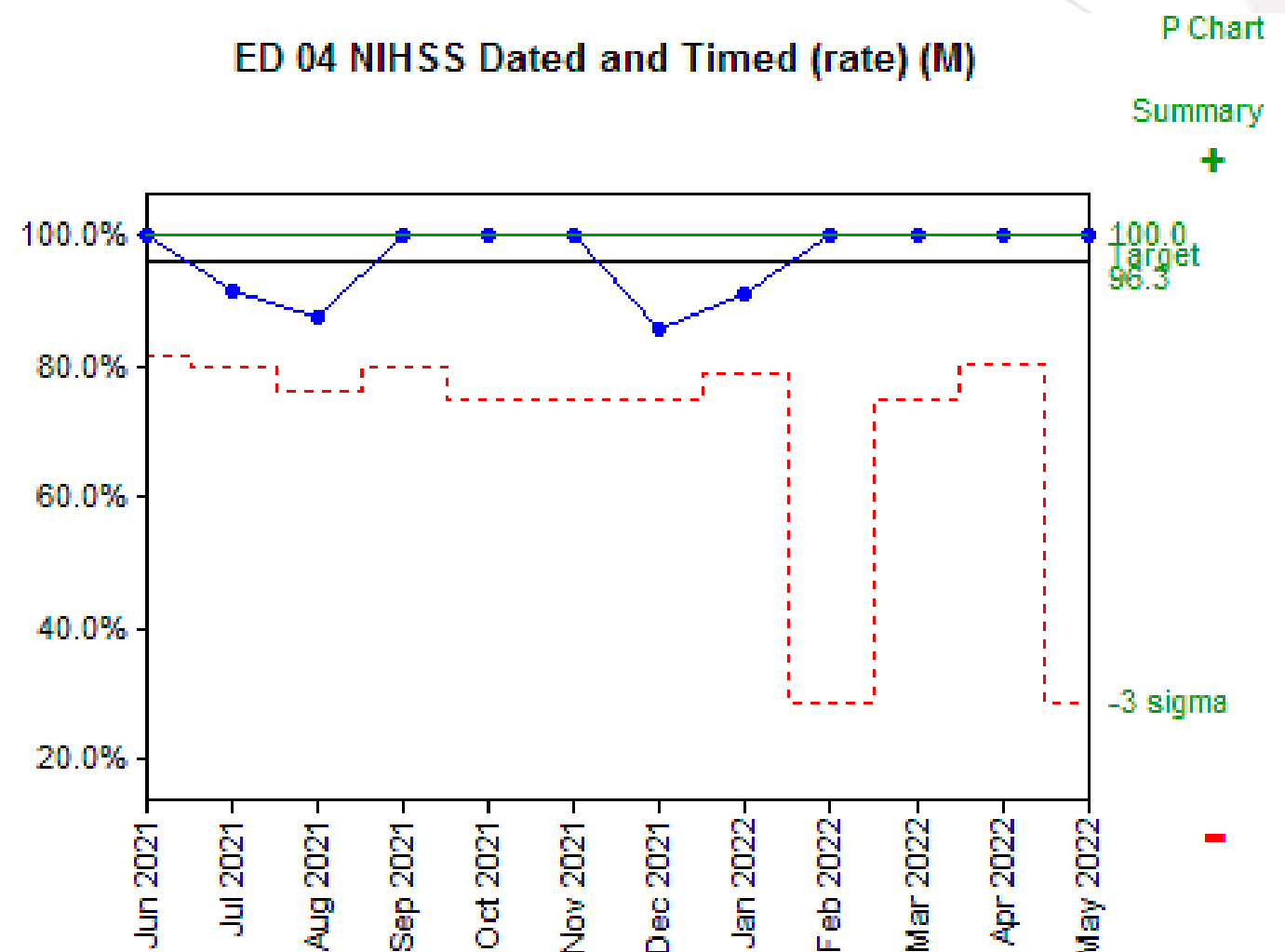
Emergency Services

NIHSS Disposition Accuracy

Audit Month	Numerator	Denominator	Percent
May 2022	12	12	100.0%
Apr 2022	13	13	100.0%
Mar 2022	7	7	100.0%
Feb 2022	4	4	100.0%
Jan 2022	11	11	100.0%
Dec 2021	7	7	100.0%
Nov 2021	7	7	100.0%
Oct 2021	7	7	100.0%
Sep 2021	12	12	100.0%
Aug 2021	8	8	100.0%
Jul 2021	12	12	100.0%
Jun 2021	15	15	100.0%

ED 05 NIHSS Disposition Accurate (rate) (M)

P Chart

Summary

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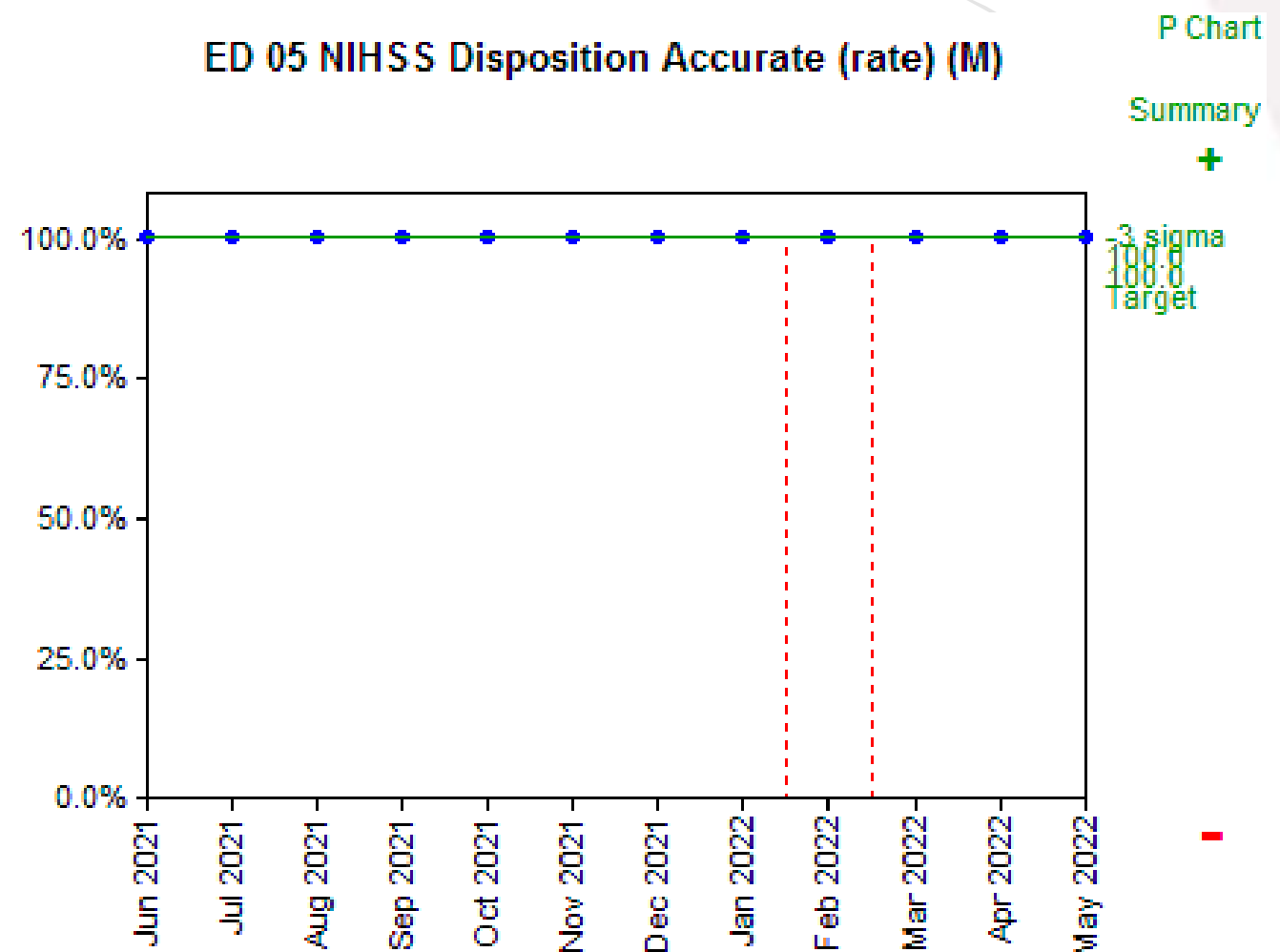
Emergency Services

Blood Culture Contamination

Month	RN-Contaminated Culture Reports (num)	Blood Cultures Drawn by RN (den)	Percent
May 2022	5	107	4.7%
Apr 2022	5	81	6.2%
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%

Blood Cultures -Contamination Rate |RN| (M)

P Chart 2-Sigma

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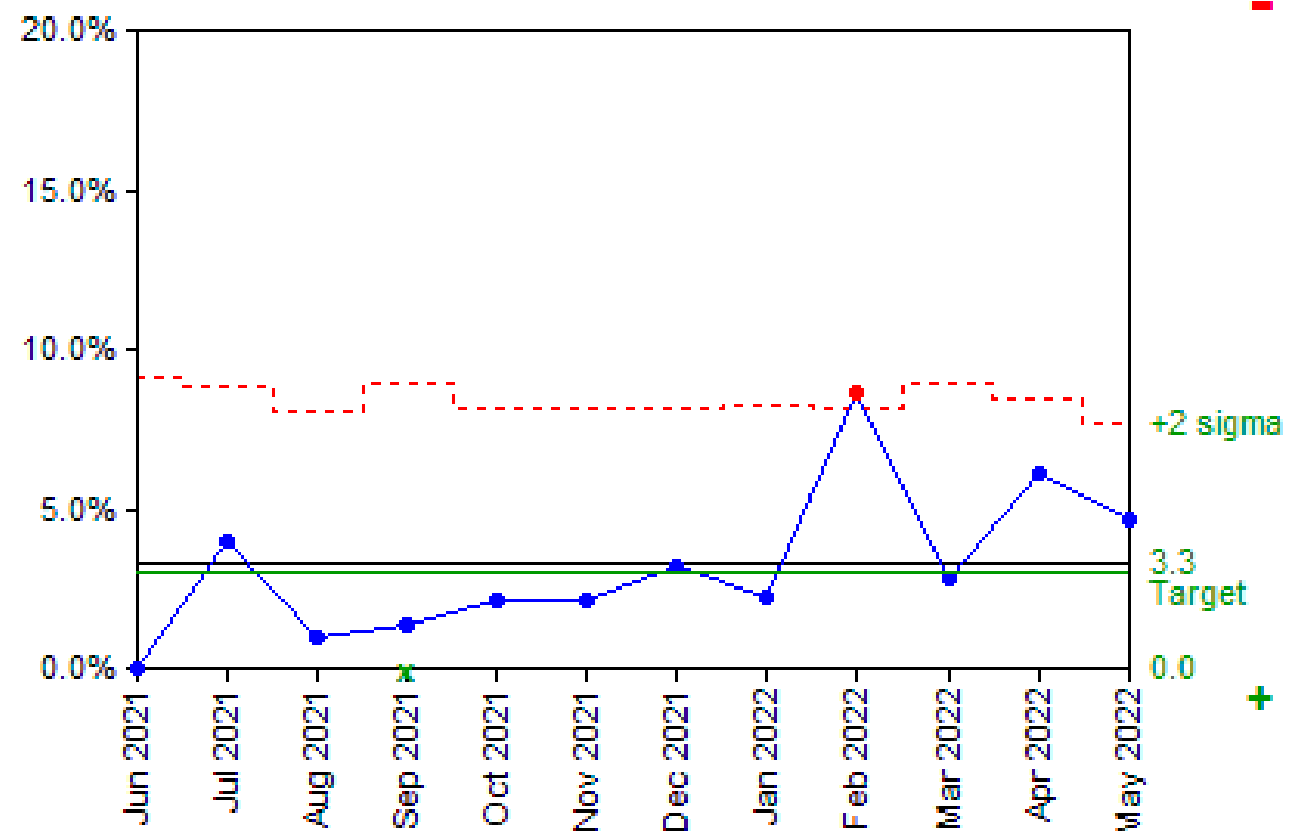
Emergency Services

- Near real time review of sepsis cases & objective auditing
- Stroke Silver Plus Award

American Heart Association.

2022 GET WITH THE GUIDELINES.

SILVER PLUS

STROKE

Silver Plus Recognition

"Hospitals receiving Get With The Guidelines® Silver Plus Achievement Award have reached an aggressive goal of treating patients to core standard levels of care as outlined by the American Heart Association/American Stroke Association® for one calendar year. In addition, those hospitals have demonstrated compliance to an addition level of heart failure quality during the 12-month period."

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Mortality

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔	📊	⊼
Acute Care Mortality Rate (M)								
History — 100%	Target Met	2.9% 2/69	▲ Deteriorated	May 2022	15.3%	n/a	n/a	3.4%
COPD Mortality Rate |M|								
History — 50% / 9% / 41%	Target Undefined	n/a		May 2022	8.5%	n/a	n/a	6.2%
Congestive Heart Failure Mortality Rate |M|								
History — 58% / 42%	Breaches Alarm	25.0% 1/4	▲ Deteriorated	May 2022	11.5%	n/a	n/a	16.1%
Pneumonia Mortality Rate |M|								
History — 75% / 25%	Target Met	0.0% 0/2	— No Change	May 2022	15.6%	n/a	n/a	10.0%
Ischemic Stroke Mortality Rate |M|								
History — 100%	Target Met	0.0% 0/5	— No Change	May 2022	13.8%	n/a	n/a	0.0%
Hemorrhagic Stroke - Mortality Rate (M)								
History — 77% / 23%	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)								
History — 91% / 9%	Target Met	0.0% 0/5	◆ Improved	May 2022	25.0%	n/a	n/a	5.9%
Septic Shock - Mortality Rate (Q)								
History — 33% / 67%	Target Met	0.0% 0/7	◆ Improved	Q1-2022	0.0%	n/a	n/a	14.0%

AHRQ Patient Safety Indicators

Indicator			Performance	Most Recent	Trend	Period	⊙	🔔	📊	x̄
PSI 90 (v2020) Midas Patient Safety Indicators Composite, ACA (M)										
91%	9%		Target Met	0.00 0/0.023	— No Change	May 2022	0.00	n/a	n/a	0.56
History										
PSI 90 (v2020) Patient Safety Indicators Composite, ACA - Volume (M)										
91%	9%		Target Met	0	— No Change	May 2022	0	n/a	n/a	0
History										

The Patient Safety Indicators 90 (PSIs)
- o PSI 03 Pressure Ulcer
- o PSI 06 Iatrogenic Pneumothorax Rate
- o PSI 08 In Hospital Fall with Hip Fracture
- o PSI 09 Perioperative Hemorrhage or Hematoma
- o PSI 10 Postoperative Acute Kidney Injury Requiring Dialysis
- o PSI 11 Postoperative Respiratory Failure
- o PSI 12 Perioperative Pulmonary Embolism or DVT
- o PSI 13 Postoperative Sepsis
- o PSI 14a Postoperative Wound Dehiscence, Open
- o PSI 14b Postoperative Wound Dehiscence, Non-Open
- o PSI 15 Accidental Puncture or Laceration

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Patient Falls
Preventable Harm

Indicator			Performance	Most Recent	Trend	Period	⊙	🔔	📊	⊼
RM ACUTE FALL- All (M) per 1000 patient days										
83%		17%	Target Met	0.00	— No Change	May 2022	3.75	4.00	n/a	1.25
History	▮▮▮▮▮▮▮▮▮▮▮			0/313						
RM ACUTE FALL- WITH INJURY (M) per 1000 patient days										
100%			Target Met	0.00	— No Change	May 2022	3.75	4.00	n/a	0.31
History	▮▮▮▮▮▮▮▮▮▮▮			0/313						

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Readmissions

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔	📊	x̄
30-DV Inpatients - % Readmit to Acute Care within 30 Days (M)								
History — 100%	Target Met	7.81% 5/64	▲ Deteriorated	May 2022	15.30%	15.50%	n/a	7.76%
COPD, CMS Readm - % Readmit within 30 Days, ACA (M)								
History — 50% / 9% / 41%	Target Undefined	n/a		May 2022	19.5%	20.0%	n/a	7.1%
HF, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)								
History — 75% / 25%	Target Met	0.0% 0/3	— No Change	May 2022	21.6%	22.0%	n/a	13.6%
Hip/Knee, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)								
History — 83% / 17%	Target Met	0.0% 0/1	⬦ Improved	May 2022	4.0%	5.0%	n/a	10.7%
PNA, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)								
History — 75% / 25%	Target Met	0.0% 0/2	— No Change	May 2022	16.6%	17.0%	n/a	13.0%
Sepsis, Severe - % Readmit within 30 Days (M)								
History — 100%	Target Met	0.0% 0/4	— No Change	May 2022	12.0%	13.0%	n/a	0.1%
Septic Shock - % Readmit within 30 Days (M)								
History — 100%	Target Met	0.0% 0/1	— No Change	May 2022	13.3%	14.0%	n/a	0.1%

Blood Culture Contamination

Blood Cultures -Contamination Rate |RN| (M)

58%	42%	Breaches Alarm	4.7% 5/107	Improved	May 2022	3.0%	3.1%

History

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔

Blood Cultures -Contamination Rate |LAB| (M)

| 91% | 9% | Target Met | 1.9% 2/106 | Deteriorated | May 2022 | 3.0% | 4.0% |

History

Blood Cultures -Total Contamination Rate (M)

| 75% | 16% | 9% | Bet. Target & Alarm | 3.3% 7/213 | Improved | May 2022 | 3.0% | 4.0% |

History
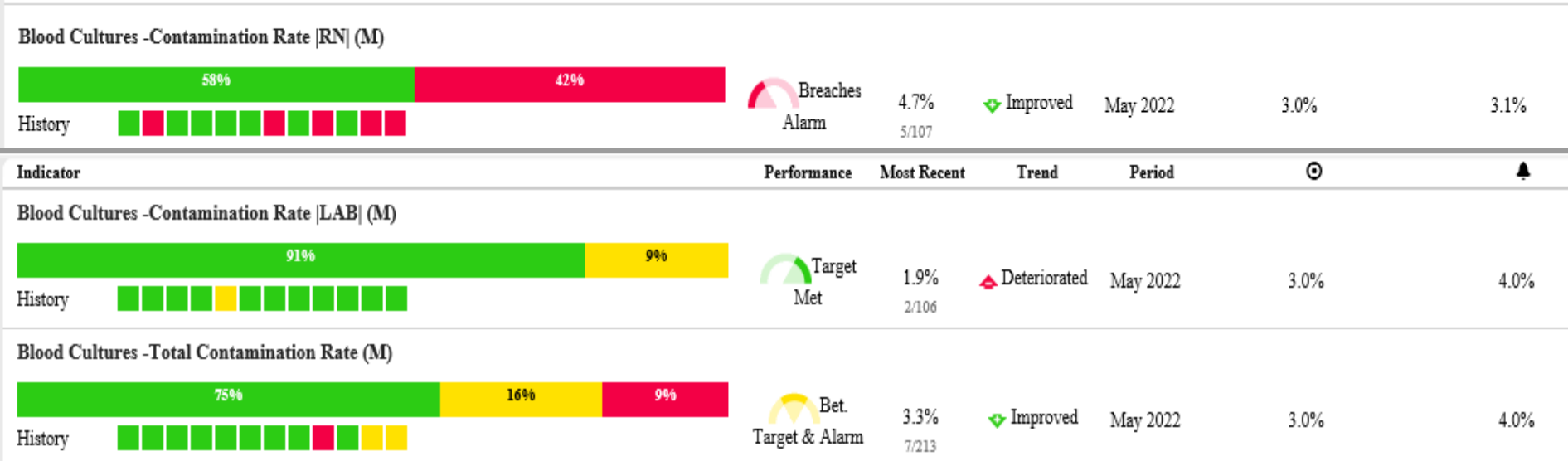
Month	RN-Contaminated Culture Reports (num)	Blood Cultures Drawn by RN (den)	Percent
Apr 2022	5	81	6.2%
Mar 2022	2	71	2.8%
Feb 2022	8	92	8.7%
Jan 2022	2	88	2.3%
Dec 2021	3	92	3.3%
Nov 2021	2	91	2.2%
Oct 2021	2	92	2.2%
Sep 2021	1	71	1.4%
Aug 2021	1	96	1.0%
Jul 2021	3	74	4.1%
Jun 2021	0	65	0.0%
May 2021	1	72	1.4%

CIHQ Stroke Certification Measures

Indicator		Performance	Most Recent	Trend	Period	⊙	🔔	ⅲ	x̄
CDSTK-03|Median- Code Stroke Called |M| elapsed time (mins)									
91% / 9%	History	Target Met	4	◇ Improved	May 2022	10	11	n/a	4
CDSTK-04|Median- Door to Phys Eval |M| minutes									
100%	History	Target Met	2.50	▲ Deteriorated	May 2022	10.00	11.00	n/a	1.25
CDSTK-05|Median- Door to CT Scanner |M|elapsed time (minutes)									
100%	History	Target Met	5.00	◇ Improved	May 2022	25.00	26.00	n/a	6.00
CDSTK-06|Median- Neuro Consult Contacted |M| minutes									
75% / 25%	History	Target Met	27.50	▲ Deteriorated	May 2022	30.00	31.00	n/a	18.50
CDSTK-07|Median- CT Read by Radiology |M| minutes									
100%	History	Target Met	33.00	▲ Deteriorated	May 2022	45.00	46.00	n/a	25.50
CDSTK-08|Median- Lab Results Posted |M| minutes									
91% / 9%	History	Target Met	39.50	▲ Deteriorated	May 2022	45.00	46.00	n/a	30.25
CDSTK-10|Median- Door to EKG Complete |M| minutes									
100%	History	Target Met	40.50	◇ Improved	May 2022	60.00	61.00	n/a	40.25
CDSTK-11|Median-Door to tPA Decision |M| minutes									
100%	History	Target Met	24.00	◇ Improved	May 2022	60.00	61.00	n/a	27.75
CDSTK-12|Median-Door to tPA |M| minutes									
8% / 42% / 50%	History	Target Undefined	n/a		Apr 2022	60.00	61.00	n/a	69.75

Utilization Management

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔	📊	x̄
1 Day Stay Rate Medi-Cal |M| 58% / 42% — History	Target Met	0.00% 0/14	Improved	May 2022	2.61%	5.00%	n/a	3.68%
1 Day Stay Rate-Medicare |M| 58% / 8% / 34% — History	Bet. Target & Alarm	10.00% 5/50	Improved	May 2022	8.10%	10.00%	n/a	9.55%
Acute Care - Geometric Mean Length of Stay |M| 25% / 33% / 42% — History	Target Met	2.49 22.4138/9	Improved	May 2022	2.75	3.23	n/a	3.18
Acute Care Age over 64 - MS-DRG Case Mix Index |M| 33% / 54% / 13% — History	Bet. Target & Alarm	1.48 65.0933/44	Improved	May 2022	1.56	1.40	n/a	1.51
Acute Care- MS-DRG Case Mix Index |M| 41% / 42% / 17% — History	Bet. Target & Alarm	1.51 102.4727/68	Improved	May 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.

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Core Measures

Indicator		Performance	Most Recent	Trend	Period	⊙	🔔	📊	x̄
Core OP29/ASC9 - Colonoscopy:F/U for Avg Risk Pts (M)									
83% / 17%	History	Target Met	100.0% 5/5	△ Improved	May 2022	88.0%	50.0%	n/a	98.0%

Indicator		Performance	Most Recent	Trend	Period	⊙	🔔	📊	x̄
Core OP 22 ED LWBS Emergency Dept Left Without Being Seen (M)									
83% / 17%	History	Breaches Alarm	3.8% 33/879	◿ Deteriorated	May 2022	2.0%	2.5%	n/a	1.5%

Indicator		Performance	Most Recent	Trend	Period	⊙	🔔	📊	x̄
Core OP 18b Median Time ED Arrival to ED Departure - Reporting Measure (M)									
33% / 25% / 42%	History	Breaches Alarm	197.00	◿ Deteriorated	May 2022	132.00	140.00	n/a	137.00

Indicator		Performance	Most Recent	Trend	Period	⊙	🔔	📊	x̄
Core OP-23 - Head CT/MRI Results for STK Pts w/in 45 Min of Arrival (M)									
83% / 17%	History	Target Met	100.0% 3/3	— No Change	May 2022	72.0%	70.0%	n/a	100.0%

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Core Measures Sepsis

Infection Prevention

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔	📊	x̄
IC-Surveillance| HAI-C.DIFF Inpatient infections per 10k pt days |M|								
90%　　10%	Target Met	0	— No Change	May 2022	1	1	n/a	0
History ▮▮▮▮▮▮▮▮▮▮▮								
IC-Surveillance| HAI-CAUTI Inpatient infections per 10k patient days |M|								
90%　　10%	Target Met	0	✧ Improved	May 2022	1	1	n/a	0
History ▮▮▮▮▮▮▮▮▮▮▮								
IC-Surveillance| HAI-CLABSI Inpatient infections per 10k patient days |M|								
90%　　10%	Target Met	0	✧ Improved	May 2022	1	1	n/a	0
History ▮▮▮▮▮▮▮▮▮▮▮								
IC-Surveillance| HAI-MRSA Inpatient infections per 10k patient days |M|								
100%	Target Met	0	— No Change	May 2022	1	1	n/a	0
History ▮▮▮▮▮▮▮▮▮▮▮								

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Inpatient Patient Satisfaction N= 15

Indicator		Performance	Most Recent	Trend	Period	⊙	🔔	📊	x̄
01-Rate hospital 0-10 |M| Rank									
62% 25% 13%		Bet. Target & Alarm	49	⬆ Improved	Apr 2022	50	30	n/a	64
History									
02-Recommend the hospital |M| Rank									
87% 13%		Target Met	67	⬆ Improved	Apr 2022	50	30	n/a	75
History									
03-Communication w/ Nurses |M| Rank									
37% 13% 50%		Target Met	89	⬆ Improved	Apr 2022	50	30	n/a	43
History									
04-Response of Hosp Staff |M| Rank									
75% 12% 13%		Target Met	76	⬇ Deteriorated	Apr 2022	50	30	n/a	75
History									
05-Communication w/ Doctors |M| Rank									
50% 50%		Target Met	58	⬆ Improved	Apr 2022	50	30	n/a	43
History									
06-Cleanliness of hospital environment|M| Rank									
37% 25% 38%		Bet. Target & Alarm	35.00	⬆ Improved	Apr 2022	50.00	30.00	n/a	39.88
History									

Inpatient Patient Satisfaction

08-Communication About Medicines |M| Rank

12%	25%	63%

History

Breaches Alarm 15 Deteriorated Apr 2022 60 30 n/a 29

09-Discharge Information |M| Rank

25%	12%	63%

History

Breaches Alarm 15 Deteriorated Apr 2022 50 30 n/a 29

10-Care Transitions |M| Rank

25%	12%	63%

History

Breaches Alarm 5 Deteriorated Apr 2022 50 30 n/a 32

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Ambulatory Surgery Patient Satisfaction
N= 24

⌃⌃ **Patients' Perspectives of Care Surveys**

Indicator		Performance	Most Recent	Trend	Period	⦿	🔔	▥	x̄
01-OAS Recommend the Facility |M| Rank									
75% 25%	Target Met		88	⬦ Improved	Apr 2022	50	30	n/a	63
History	🟩🟩🟩🟩🟥🟩🟥🟩								
02-OAS Communication |M| Rank									
37% 25% 38%	Breaches Alarm		16	🔻 Deteriorated	Apr 2022	60	30	n/a	48
History	🟨🟨🟥🟩🟥🟩🟩🟥								
03-OAS Facility/Personal Treatment |M| Rank									
62% 25% 13%	Target Met		99	⬦ Improved	Apr 2022	80	30	n/a	76
History	🟨🟩🟥🟩🟩🟨🟩🟩								
04-OAS Discharge |M| Rank									
50% 25% 25%	Bet. Target & Alarm		38	⬦ Improved	Apr 2022	70	30	n/a	55
History	🟨🟩🟥🟩🟩🟩🟥🟨								
05-OAS Staff treat w/courtesy and respect |M| Rank									
75% 25%	Target Met		99	— No Change	Apr 2022	60	30	n/a	79
History	🟥🟩🟩🟥🟩🟩🟩🟩								
07-OAS Facility Clean |M| Rank									
100%	Target Met		99	— No Change	Apr 2022	60	30	n/a	99
History	🟩🟩🟩🟩🟩🟩🟩🟩								
ED-Time Physician Spent With Me Score (M)									
58% 37% 5%	Bet. Target & Alarm		4.44	🔻 Deteriorated	May 2022	4.50	4.30	n/a	4.54
History	🟩🟩🟩🟩🟨🟩🟨🟩🟩🟨🟩🟨🟩🟩🟥🟩🟩🟨								

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: 06/22/2022 8:00 AM

Report Parameters	
Filtered by:	Document Set: all applicable
	Committee: 07 BOD-Quality (P&P Review)
	Include Current Tasks: Yes
	Include Upcoming Tasks: No
Grouped by:	Committee
Sorted by:	Document Name, Document Location

Report Statistics	
Total Documents:	10

Committee: 07 BOD-Quality (P&P Review)

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

Current Approval Tasks (due now)

Document	Task/Status	Pending Since	Days Pending
Community Resources, Relationship of Case Management *Case Management/UM Dept*	**Pending Approval**	6/9/2022	13

Summary Of Changes:	**No major changes, updated to current process**
Moderators:	**Newman, Cindi (cnewman)**
Lead Authors:	**Kobe, Mark (mkobe)**
Approvers:	**00 Clinical P&P multidisciplinary review -> 01 P&P Committee - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Document	Task/Status	Pending Since	Days Pending
Neutropenic Precautions, Guidelines for Care of the Immunocompromised Patient *Infection Prevention & Control Policies (IC)*	**Pending Approval**	6/16/2022	6

Summary Of Changes:	**Added EBSCO as reference for Central line access care** **Updated Infection Preventionist's phone number.** **Updated Visitation section to state "Anyone who is ill or has been recently exposed to a contagious disease may not visit and nursing staff shall have final decision on who can visit:.**
Moderators:	**Newman, Cindi (cnewman)**
Lead Authors:	**Montecino, Stephanie (smontecino)**
ExpertReviewers:	**06 CMO/Designee for signature**
Approvers:	**Cooper, Kylie (kcooper) -> 01 P&P Committee - (Committee) -> 04 MS-Performance Improvement/Pharmacy & Therapeutics Committee - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Document	Task/Status	Pending Since	Days Pending
Physician Suspension: Medical Records *Medical Staff Policies (MS)*	**Pending Approval**	6/16/2022	6

Summary Of Changes:	**No changes**
Moderators:	**Newman, Cindi (cnewman)**
Lead Authors:	**Kobe, Mark (mkobe), Finn, Stacey (sfinn), Kidd, Sabrina (skidd), Cooper, Kylie (kcooper)**
ExpertReviewers:	**Pryszmant, Rosemary (rpryszmant)**
Approvers:	**Cooper, Kylie (kcooper), 06 CMO/Designee for signature - (Committee) -> 01 P&P Committee - (Committee) -> 04 MS-Performance Improvement/Pharmacy & Therapeutics Committee - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

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: 06/22/2022 8:00 AM

RETIRE::Care Transitions Program	**Pending Approval**	6/9/2022	13
Case Management/UM Dept			

Summary Of Changes:	**Retire.** **This was written for the grant and no decision has been made to continue this program in this manner**
Moderators:	**Newman, Cindi (cnewman)**
Lead Authors:	**Kobe, Mark (mkobe)**
Approvers:	**00 Clinical P&P multidisciplinary review -> 01 P&P Committee - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

RETIRE::Case Management in Skilled Nursing Unit	**Pending Approval**	6/9/2022	13
Case Management/UM Dept			

Summary Of Changes:	**Retire policy; no longer relevant**
Moderators:	**Newman, Cindi (cnewman)**
Lead Authors:	**Kobe, Mark (mkobe)**
Approvers:	**00 Clinical P&P multidisciplinary review -> 01 P&P Committee - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

S aureus Decolonization Protocol for Patients Undergoing Total Joint Replacement Surgery	**Pending Approval**	6/16/2022	6
Infection Prevention & Control Policies (IC)			

Summary Of Changes:	**Reviewed. Made some minor changes and defined some acronyms.** **Minor change completion of word (CHG)**
Moderators:	**Newman, Cindi (cnewman)**
Lead Authors:	**Montecino, Stephanie (smontecino)**
ExpertReviewers:	**Fry, Dana (dfry)**
Approvers:	**Cooper, Kylie (kcooper) -> 01 P&P Committee - (Committee) -> 04 MS-Performance Improvement/Pharmacy & Therapeutics Committee - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Scabies Infestation and Outbreak Management	**Pending Approval**	6/16/2022	6
Infection Prevention & Control Policies (IC)			

Summary Of Changes:	**Fixed acronyms, no content changes. Updated Owner/Author/Reviewers/approvals.**
Moderators:	**Newman, Cindi (cnewman)**
Lead Authors:	**Montecino, Stephanie (smontecino)**
ExpertReviewers:	**06 CMO/Designee for signature**
Approvers:	**Cooper, Kylie (kcooper) -> 01 P&P Committee - (Committee) -> 04 MS-Performance Improvement/Pharmacy & Therapeutics Committee - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Sterile Compounding	**Pending Approval**	6/16/2022	6
Medication Management Policies (MM)			

Summary Of Changes:	**Updated to include beyond use dates and compounding instructions that include use of glovebox isolator.**
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 (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

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: 06/22/2022 8:00 AM

| **Sterile Compounding Procedures 8390-03** | **Pending Approval** | 6/16/2022 | 6 |
| *Pharmacy Dept* | | | |

Summary Of Changes: **Added instructions for use and maintenance of glovebox isolator**

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 (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

| **Toy Cleaning Policy** | **Pending Approval** | 6/16/2022 | 6 |
| *Infection Prevention & Control Policies (IC)* | | | |

Summary Of Changes: **Literature search for toy cleaning policy, all organizations are referencing the 2007 policies. Nothing more current available yet.**

**Changes made to policy include adding the
OWNER Director of Quality**

**AUTHORS/REVIEWERS:
Infection Preventionist
Board Quality Committee**

**APPROVALS:
Policy & Procedure Team:
Performance Improvement /
Pharmacy & Therapeutics Committee:
Medical Executive Committee:
The Board of Directors:**

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

Lead Authors: **Montecino, Stephanie (smontecino)**

ExpertReviewers: **06 CMO/Designee for signature**

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