SVHCD QUALITY COMMITTEE

AGENDA

WEDNESDAY, DECEMBER 14, 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/92442472273?pwd=MkhYSmJMK09Xc0R1ODA4eS9hdlF0dz09

and Enter the **Meeting ID: 924 4247 2273**
Passcode: 073937

To Participate via Telephone only, dial:
1-669-900-9128 or 1-669-219-2599
and Enter the **Meeting ID: 924 4247 2273**
Passcode: 073937

AGENDA ITEM	RECOMMENDATION	
In compliance with the Americans with Disabilities Act, if you require special accommodations to attend a District meeting, please contact the Interim District Clerk, Stacey Finn, at sfinn@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 10.26.22	*Kornblatt Idell*	Action
4. IMAGING SERVICES QA/PI	*Young*	Inform
5. QUALITY INDICATOR PERFORMANCE PLAN	*Cooper*	Inform
6. POLICIES AND PROCEDURES	*Cooper*	Inform/Action
7. DRAFT QUALITY COMMITTEE WORK PLAN 2023	*Kornblatt Idell*	Action
8. EPIC UPDATE	*Cooper*	Inform
9. CLOSED SESSION: a. Calif. Health & Safety Code §32155: Medical Staff Credentialing & Peer Review Report		Action
10. ADJOURN	*Kornblatt Idell*	

SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
October 26, 2022, 5:00 PM
MINUTES
Via Zoom Teleconference

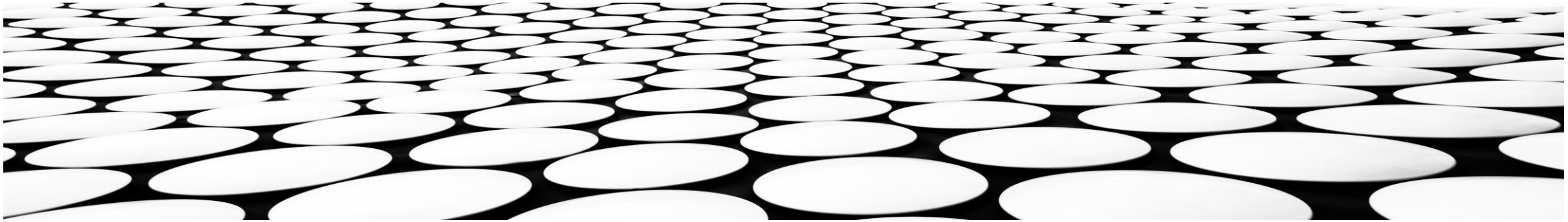
Members Present – Via Zoom	Members Present cont.	Excused	Public/Staff – Via Zoom
Susan Kornblatt Idell Carol Snyder Ingrid Sheets, EdD, MS, RN Carl Speizer, MD Kathy Beebe, RN PhD Michael Mainardi, MD Howard Eisenstark, MD			Jessica Winkler, DNP, RN, NEA-BC, CCRN-K, CNO Kylie Cooper, RN, BSN, CPHQ, MBA, Quality and Risk Mgmt. Ako Walther, MD, Vice Chief of Staff Celia Kruse De La Rosa Judith Bjorndal, MD

AGENDA ITEM	DISCUSSION	ACTION
1. CALL TO ORDER/ANNOUNCEMENTS	*Kornblatt Idell*	
	Meeting called to order at 5:01 p.m. Ms. Kornblatt Idell introduced Vivian Woodall as temporary Board Clerk. She also introduced new Committee members Dr. Carl Speizer and Dr. Kathy Beebe.	
2. PUBLIC COMMENT	*Kornblatt Idell*	
	None	
3. CONSENT CALENDAR	*Kornblatt Idell*	**ACTION**
• QC Minutes 09.28.22	Add the following language to item 4 of the September minutes: Mr. Gallo did note that utilization of rehab services has increased whilst there has been a decrease in staff in last 12 months. Staffing is now stabilizing. For future minutes, it was recommended that comments regarding policies be more accurately captured (e.g., review and return to sender, or review and recommend to Board).	**MOTION:** by Mainardi to approve with revisions, 2nd by Snyder. All in favor.

4. INPATIENT SERVICES QA/PI	*Winkler*	**INFORM**
	Ms. Winkler reviewed quality assurance for the third quarter of the year. Current process improvement projects include the following. 1) Palliative care referrals have increased and the social worker is becoming palliative care certified. Dr. Sheets suggested a certified nurse would be beneficial as well. 2) Postop placement of Foley catheter: nurses found great variation in practice. Standard practice is being developed across departments. 3) Epic implementation scheduled to go live in early December.	
5. QUALITY INDICATOR PERFORMANCE PLAN	*Cooper*	**INFORM**
	Ms. Cooper reviewed quality indicators for the month of September. The Committee would like to continue seeing Rate My Hospital scores.	
6. PATIENT CARE SERVICES DASHBOARD Q3	*Winkler*	**INFORM**
	Ms. Winkler review the third quarter patient care services dashboard.	
7. CONFIRM DECEMBER 14 MEETING DATE	*Cooper*	**ACTION**
	Ms. Kornblatt Idell confirmed that the November and December Committee meetings will be combined on December 14th.	No motion; meeting date confirmed.
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 Mainardi to approve, 2nd by Eisenstark. All in favor.
9. ADJOURN	*Kornblatt Idell*	
	Meeting adjourned at 6:05 pm	

DIAGNOSTIC SERVICES – QUALITY ASSURANCE

DECEMBER 2022



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2022 QUALITY MEASURES

CT Tube Quality Control

J	F	M	A	M	J	J	A	S	O	N	D

Contrast Extravasations

J	F	M	A	M	J	J	A	S	O	N	D
1	0	3	1	0	0	1	2	0	2		

Wrong Site/Side

J	F	M	A	M	J	J	A	S	O	N	D
0	2	1	0	1	0	0	0	0	0		

Repeat Analysis

J	F	M	A	M	J	J	A	S	O	N	D

MRI Near Misses

J	F	M	A	M	J	J	A	S	O	N	D

Echo Inpatient Order to Exam Performed

J	F	M	A	M	J	J	A	S	O	N	D

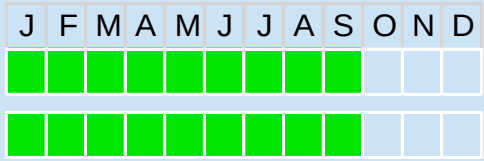
CT Dose Tracking

J	F	M	A	M	J	J	A	S	O	N	D

2022 PERFORMANCE IMPROVEMENT

Stroke- Door to CT (< 25 min)

Stroke- Door to Radiologist Report (< 45 min)



Quality Indicator Performance & Plan

December Board Quality

Data for October 2022

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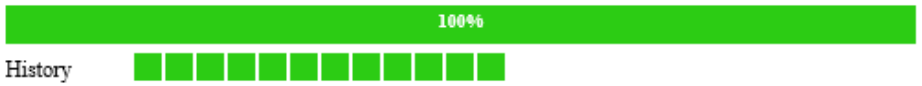
Mortality

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
Acute Care Mortality Rate (M)								
	Target Met	0.0% 0/53	Improved	Oct 2022	15.3%	n/a	n/a	2.4%
COPD Mortality Rate |M|								
	Target Met	0.0% 0/2	No Change	Oct 2022	8.5%	n/a	n/a	0.0%
Congestive Heart Failure Mortality Rate |M|								
	Target Met	0.0% 0/3	No Change	Oct 2022	11.5%	n/a	n/a	9.8%
Pneumonia Mortality Rate |M|								
	Target Met	0.0% 0/1	No Change	Oct 2022	15.6%	n/a	n/a	6.2%
Ischemic Stroke Mortality Rate |M|								
	Target Met	0.0% 0/2	No Change	Oct 2022	13.8%	n/a	n/a	0.0%
Hemorrhagic Stroke - Mortality Rate (M)								
	Target Met	0.0% 0/1	Improved	Aug 2022	0.0%	1.0%	n/a	20.0%

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
Sepsis, Severe - Mortality Rate (M)								
	Target Met	0.0% 0/2	No Change	Oct 2022	25.0%	n/a	n/a	1.9%
Septic Shock - Mortality Rate (Q)								
	Target Met	0.0% 0/6	No Change	Q3-2022	0.0%	n/a	n/a	11.6%

AHRQ Patient Safety Indicators

Indicator	Performance	Most Recent	Trend	Period				
PSI 90 (v2021) Midas Patient Safety Indicators Composite, ACA (M)								
100% History	Target Met	0.00 0/0.011	— No Change	Oct 2022	0.00	n/a	n/a	0.00
PSI 90 (v2021) Patient Safety Indicators Composite, ACA - Volume (M)								
100% History	Target Met	0	— No Change	Oct 2022	0	n/a	n/a	0

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

Indicator	Performance	Most Recent	Trend	Period				
RM ACUTE FALL- All (M) per 1000 patient days								
58% 8% 34%	Breaches Alarm	7.75 2/258	Deteriorated	Oct 2022	3.75	4.00	n/a	2.47
History								
RM ACUTE FALL- WITH INJURY (M) per 1000 patient days								
100%	Target Met	0.00 0/258	No Change	Oct 2022	3.75	4.00	n/a	0.31
History								

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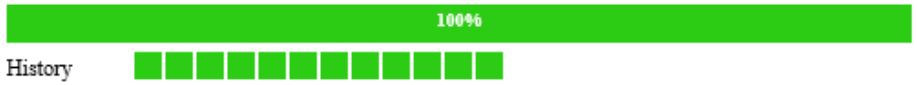
Readmissions

Indicator	Performance	Most Recent	Trend	Period	◎	🔔		✕
30-DV Inpatients - % Readmit to Acute Care within 30 Days (M)								
	Target Met	0.00% 0/48	Improved	Oct 2022	15.30%	15.50%	n/a	8.06%
COPD, CMS Readm - % Readmit within 30 Days, ACA (M)								
	Target Met	0.0% 0/2	Improved	Oct 2022	19.5%	20.0%	n/a	11.1%
HF, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)								
	Target Met	0.0% 0/3	No Change	Oct 2022	21.6%	22.0%	n/a	10.0%
Hip/Knee, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)								
	Target Met	0.0% 0/3	No Change	Oct 2022	4.0%	5.0%	n/a	11.1%
PNA, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)								
	Target Met	0.0% 0/1	No Change	Oct 2022	16.6%	17.0%	n/a	11.5%
Sepsis, Severe - % Readmit within 30 Days (M)								
	Target Met	0.0% 0/1	No Change	Oct 2022	12.0%	13.0%	n/a	0.0%
Septic Shock - % Readmit within 30 Days (M)								
	Target Met	0.0% 0/1	No Change	Oct 2022	13.3%	14.0%	n/a	0.2%

Blood Culture Contamination

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔
Blood Cultures -Contamination Rate |RN| (M)	Target Met	2.7% 2/74	Deteriorated	Oct 2022	3.0%	3.1%
Blood Cultures -Contamination Rate |LAB| (M)	Target Met	2.0% 2/98	Deteriorated	Oct 2022	3.0%	4.0%
Blood Cultures -Total Contamination Rate (M)	Target Met	2.3% 4/172	Deteriorated	Oct 2022	3.0%	4.0%

Month	RN-Contaminated Culture Reports (num)	Blood Cultures Drawn by RN (den)	Percent
Oct 2022	2	74	2.7%
Sep 2022	0	78	0.0%
Aug 2022	2	88	2.3%
Jul 2022	4	89	4.5%
Jun 2022	3	82	3.7%
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%

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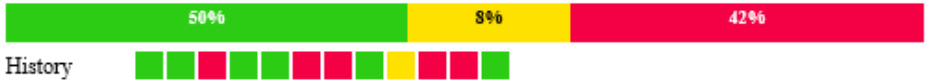
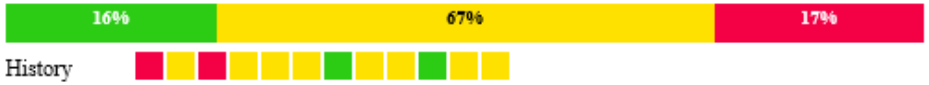
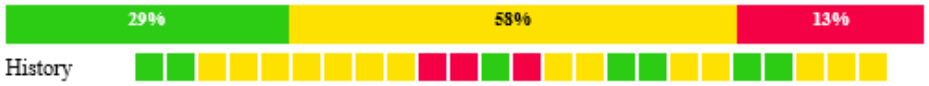
CIHQ Stroke Certification Measures

Indicator	Performance	Most Recent	Trend	Period				
CDSTK-03|Median- Code Stroke Called |M| elapsed time (mins)	Target Met	0	Improved	Oct 2022	10	11	n/a	3
CDSTK-04|Median- Door to Phys Eval |M| minutes	Target Met	0.00	Improved	Oct 2022	10.00	11.00	n/a	1.00
CDSTK-05|Median- Door to CT Scanner |M|elapsed time (minutes)	Target Met	5.00	Improved	Oct 2022	25.00	26.00	n/a	6.00
CDSTK-06|Median- Neuro Consult Contacted |M| minutes	Target Met	5.00	Improved	Oct 2022	30.00	31.00	n/a	18.75
CDSTK-07|Median- CT Read by Radiology |M| minutes	Target Met	23.00	Improved	Oct 2022	45.00	46.00	n/a	27.50
CDSTK-08|Median- Lab Results Posted |M| minutes	Target Met	32.00	Improved	Oct 2022	45.00	46.00	n/a	31.00
CDSTK-10|Median- Door to EKG Complete |M| minutes	Target Met	50.00	Deteriorated	Oct 2022	60.00	61.00	n/a	41.00
CDSTK-11|Median-Door to tPA Decision |M| minutes	Target Met	50.00	Deteriorated	Oct 2022	60.00	61.00	n/a	35.00
CDSTK-12|Median-Door to tPA |M| minutes	Target Met	26.00		Sep 2022	60.00	61.00	n/a	71.00

Utilization Management

Utilization Management

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
1 Day Stay Rate Medi-Cal |M|								
	Breaches Alarm	9.09% 1/11	Deteriorated	Oct 2022	2.61%	5.00%	n/a	6.82%
1 Day Stay Rate-Medicare |M|								
	Target Met	5.56% 2/36	Improved	Oct 2022	8.10%	10.00%	n/a	9.74%
Acute Care - Geometric Mean Length of Stay |M|								
	Bet. Target & Alarm	3.00 29.9806/10	Improved	Oct 2022	2.75	3.23	n/a	3.09
Acute Care Age over 64 - MS-DRG Case Mix Index |M|								
	Bet. Target & Alarm	1.47 52.9363/36	Deteriorated	Oct 2022	1.56	1.40	n/a	1.49
Acute Care- MS-DRG Case Mix Index |M|								
	Bet. Target & Alarm	1.47 77.672/53	Deteriorated	Oct 2022	1.55	1.40	n/a	1.51

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	⊙	🔔		✕
Core OP29/ASC9 - Colonoscopy:F/U for Avg Risk Pts (M)								
	Target Met	100.0% 9/9	— No Change	Oct 2022	88.0%	50.0%	n/a	97.0%
Indicator	**Performance**	**Most Recent**	**Trend**	**Period**	⊙	🔔		✕
Core OP 18b Median Time ED Arrival to ED Departure - Reporting Measure (M)								
	Breaches Alarm	162.00	Deteriorated	Oct 2022	132.00	140.00	n/a	157.00
Indicator	**Performance**	**Most Recent**	**Trend**	**Period**	⊙	🔔		✕
Core OP 22 ED LWBS Emergency Dept Left Without Being Seen (M)								
	Target Met	1.7% 13/784	Improved	Oct 2022	2.0%	2.5%	n/a	2.2%
Indicator	**Performance**	**Most Recent**	**Trend**	**Period**	⊙	🔔		✕
Core OP-23 - Head CT/MRI Results for STK Pts w/in 45 Min of Arrival (M)								
	Target Undefined	n/a		Oct 2022	72.0%	70.0%	n/a	94.1%

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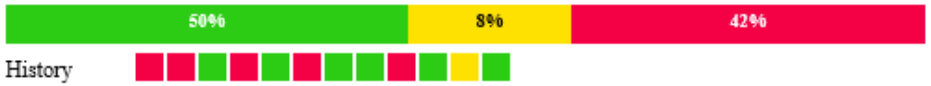
Core Measures Sepsis

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
SEP-1 Early Management Bundle, Severe Sepsis/Septic Shock (M)								
	Target Met	100.0% 4/4	Improved	Oct 2022	81.0%	80.0%	n/a	81.2%
SEPa - Severe Sepsis 3 Hour Bundle (M)								
	Target Met	100.0% 4/4	Improved	Oct 2022	94.0%	90.0%	n/a	91.9%
SEPb - Severe Sepsis 6 Hour Bundle (M)								
	Target Met	100.0% 2/2	Improved	Oct 2022	100.0%	90.0%	n/a	96.4%

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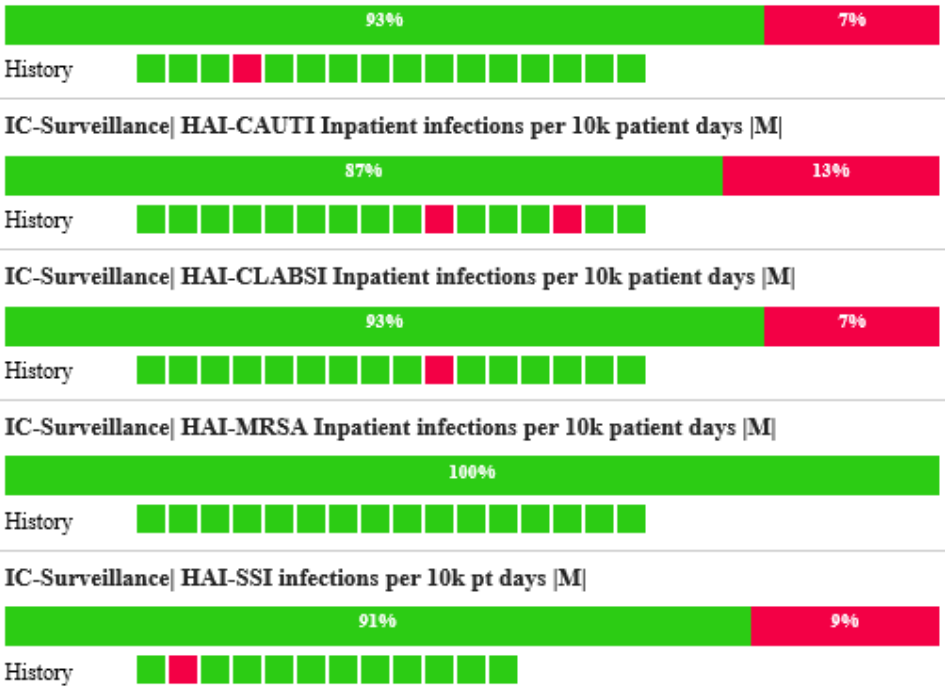
Infection Prevention

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



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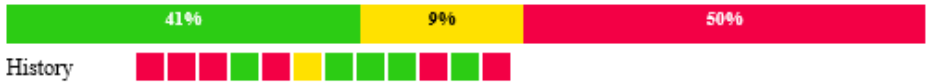
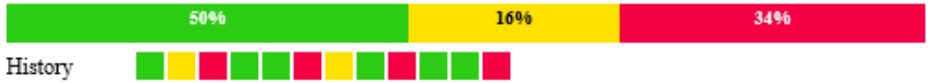
Inpatient Patient Satisfaction
N= 10

Patients' Perspectives of Care Surveys > Hospital -HCAHPS-

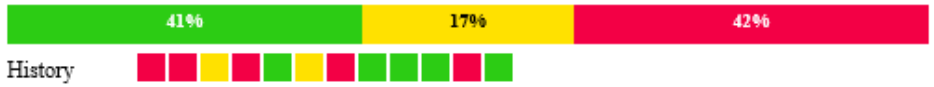
Indicator	Performance	Most Recent	Trend	Period				
01-Rate hospital 0-10 |M| Rank	Bet. Target & Alarm	31	Deteriorated	Sep 2022	50	30	n/a	59
02-Recommend the hospital |M| Rank	Bet. Target & Alarm	35	Deteriorated	Sep 2022	50	30	n/a	74
03-Communication w/ Nurses |M| Rank	Breaches Alarm	21	Deteriorated	Sep 2022	50	30	n/a	50
04-Response of Hosp Staff |M| Rank	Target Met	88	Deteriorated	Sep 2022	50	30	n/a	80
05-Communication w/ Doctors |M| Rank	Breaches Alarm	6	Deteriorated	Sep 2022	50	30	n/a	43
06-Cleanliness of hospital environment|M| Rank	Breaches Alarm	1	Deteriorated	Sep 2022	50	30	n/a	50





HCAHPS

Inpatient Patient Satisfaction

08-Communication About Medicines |M| Rank 	Target Met	68	Improved	Sep 2022	60	30	n/a	47
09-Discharge Information |M| Rank 	Bet. Target & Alarm	40	Deteriorated	Sep 2022	50	30	n/a	50
10-Care Transitions |M| Rank 	Target Met	80	Deteriorated	Sep 2022	50	30	n/a	58

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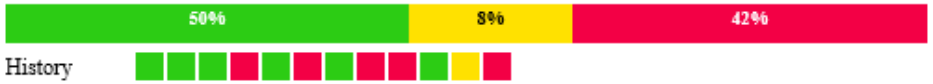
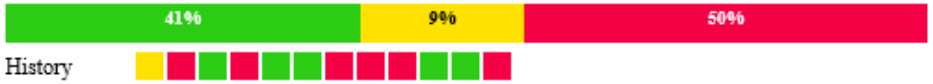
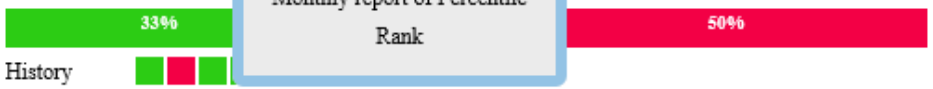
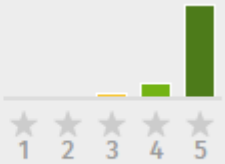
Ambulatory Surgery Patient Satisfaction N= 16

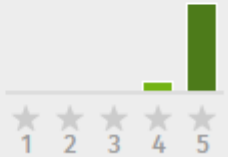
Patients' Perspectives of Care Surveys

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
01-OAS Recommend the Facility |M| Rank								
	Breaches Alarm	5	Deteriorated	Sep 2022	50	30	n/a	49
02-OAS Communication |M| Rank								
	Breaches Alarm	1	Deteriorated	Sep 2022	60	30	n/a	43
03-OAS Facility/Personal Treatment |M| Rank								
	Bet. Target & Alarm	66	Deteriorated	Sep 2022	80	30	n/a	78
04-OAS Discharge |M								
	Breaches Alarm	2	Deteriorated	Sep 2022	70	30	n/a	42
05-OAS Staff treat w/courtesy and respect |M| Rank								
	Breaches Alarm	7	Deteriorated	Sep 2022	60	30	n/a	76
07-OAS Facility Clean |M| Rank								
	Target Met	99	No Change	Sep 2022	60	30	n/a	92
ED-Time Physician Spent With Me Score (M)								
	Target Met	4.61	Improved	Oct 2022	4.50	4.30	n/a	4.51

Monthly report of Percentile Rank

Rate My Hospital
Scale 1-5
September Data

Rank	Department	Responses	Average Score	Score breakdown
1	Sonoma Valley Hospital / Emergency Department	111	4.63 95% CI: 4.49—4.77	

Rank	Department	Responses	Average Score	Score breakdown
1	Sonoma Valley Hospital / Inpatient Care	9	4.88 95% CI: 4.68—5.00	

SONOMA VALLEY HOSPITAL
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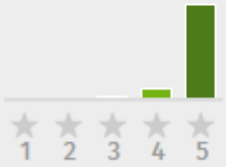
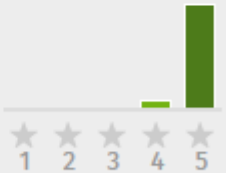
Rate My Hospital Scale 1-5

Rank	Department	Responses	Average Score	Score breakdown
1	Sonoma Valley Hospital / Medical Imaging	185	4.77 95% CI: 4.69—4.84	

Rank	Department	Responses	Average Score	Score breakdown
1	Sonoma Valley Hospital / Hand and Physical Therapy	34	4.86 95% CI: 4.72—4.99	

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
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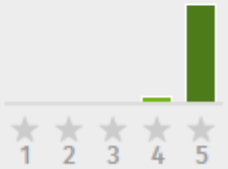
Rate My Hospital
Scale 1-5

Rank	Department	Responses	Average Score	Score breakdown
1	Sonoma Valley Hospital / Outpatient Surgery	45	4.86 95% CI: 4.76—4.97	

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

Document Tasks By Committee

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

Sonoma Valley Hospital

Run by: Finn, Stacey (sfinn)
Run date: 12/09/2022 12:11 PM

Report Parameters

Filtered by: Document Set: - All Available Document Sets -
Committee: 07 BOD-Quality (P&P Review)
Include Current Tasks: Yes
Include Upcoming Tasks: No

Grouped by: Committee

Sorted by: Document Title

Report Statistics

Total Documents: 19

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

Committee Members: **Finn, Stacey (sfinn), Newman, Cindi (cnewman), Woodall, Vivian (vwoodall)**

Current Approval Tasks (due now)

Document	Task/Status	Pending Since	Days Pending
Chromosome Studies *Laboratory Services Policies (LB)*	**Pending Approval**	11/17/2022	22

Summary Of Changes: **Updated Point Of Care transport media and test site**

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

Lead Authors: **Kuwahara, Dawn (dkuwahara), Ramos, Karen (kramos)**

ExpertReviewers: **Medical Director-Lab**

Approvers: **Kuwahara, Dawn (dkuwahara) -> 01 P&P Committee - (Committee) -> 03 MS-Surgery Department - (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
Continuity of Operations Plan (COOP) *Emergency Preparedness Policies (EP)*	**Pending Approval**	11/17/2022	22

Summary Of Changes: **Added CFO, Chief of Support Services, Head of Information Services to reviewers. Added EOP to reference list. Minor grammatical changes**

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

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

ExpertReviewers: **Finn, Stacey (sfinn)**

Approvers: **Hennelly, John (jhennelly) -> 01 P&P Committee - (Committee) -> 02 MS-Medicine Department - (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
ED Log *Emergency Dept*	**Pending Approval**	11/17/2022	22

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

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

Lead Authors: **Brown, Philip (pbrown)**

Approvers: **Winkler, Jessica (jwinkler) -> Medical Director-Emergency Dept. - (Committee) -> 01 P&P Committee - (Committee) -> 02 MS-Medicine Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Glidescope, Cleanning and Processing of | **Pending Approval** | 11/17/2022 | 22

Central Sterile Dept

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

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

Lead Authors: **Winkler, Jessica (jwinkler), Fry, Dana (dfry)**

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

Good Catch Program | **Pending Approval** | 10/11/2022 | 59

Governance and Leadership Policies

Summary Of Changes: **Change of personnel titles**
Changed Acronyms
Simplified process, not longer need to use paper forms. All completed through e-Notification system.
Root Cause Analysis form used if action plan needed.

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

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

ExpertReviewers: **Gatenian, Grigory (ggatenian), Kutza, Chris (ckutza), McKissock, Lynn (lmckissock), Newman, Cindi (cnewman), Winkler, Jessica (jwinkler)**

Approvers: **06 CMO/Designee for signature -> Hennelly, John (jhennelly) -> 01 P&P Committee - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Immediate Use Steam Sterilization | **Pending Approval** | 11/17/2022 | 22

Central Sterile Dept

Summary Of Changes: **Removed verbiage directly related to "One Tray" that was unnecessary.Removed "Flashing" (Flash Sterilization)**

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

Intravenous Contrast Admin | **Pending Approval** | 11/17/2022 | 22

Diagnostic Services Dept Policies

Summary Of Changes: **Updated the "procedure" section to match information that is gathered with our Contrast Screening form.**

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

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

Metabolic and Bariatric Anesthesia Protocol 7430-109 | **Pending Approval** | 11/17/2022 | 22

SCU (Surgical Care Unit Dept

Summary Of Changes: **changed owner and author.**

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

Lead Authors: **Winkler, Jessica (jwinkler), Fry, Dana (dfry)**

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

Packaging Guidelines | **Pending Approval** | 11/17/2022 | 22

Central Sterile Dept

Summary Of Changes: **One grammatical error corrected. Reference updated, and owner/ authors changed**

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

Lead Authors: **Winkler, Jessica (jwinkler), Fry, Dana (dfry)**

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

Pediatric Patient in Surgery,Care of the | **Pending Approval** | 11/17/2022 | 22

Surgical Services/OR Dept

Summary Of Changes: **Reviewed, no changes. Updated author and owner, and reference.**

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

Lead Authors: **Winkler, Jessica (jwinkler), Fry, Dana (dfry)**

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

Pre-Operative Skin Preparation of Patients | **Pending Approval** | 11/17/2022 | 22

Surgical Services/OR Dept

Summary Of Changes: **Changed references, owner, and author/reviewers grammatical, and added new guidelines about handling solution-soaked prep materials to prevent flammability.**

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

Lead Authors: **Winkler, Jessica (jwinkler), Fry, Dana (dfry)**

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

Product Recalls | **Pending Approval** | 11/19/2022 | 20

Governance and Leadership Policies

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

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

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

Approvers: **Hennelly, John (jhennelly) -> 01 P&P Committee - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Release of Blood Products to Nursing | **Pending Approval** | 11/17/2022 | 22

Laboratory Services Policies (LB)

Summary Of Changes: **Updated to reflect Current practices. The competencies removed, CLS does not confirm competency. Competencies are performed annually by nursing staff.**

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

Lead Authors: **Kuwahara, Dawn (dkuwahara), Ramos, Karen (kramos)**

ExpertReviewers: **Medical Director-Lab**

Approvers: **Medical Director-Lab -> Kuwahara, Dawn (dkuwahara) -> Winkler, Jessica (jwinkler) -> 01 P&P Committee - (Committee) -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Sanitation in the OR | **Pending Approval** | 11/17/2022 | 22

Surgical Services/OR Dept

Summary Of Changes:	**changed author and owners updated reference Condensed and clarified lines D4 and D5 to state that all equipment, regardless of used or unused status, will follow the same sanitation protocol. Add reference to EVS terminal cleaning checklist.**
Moderators:	**Newman, Cindi (cnewman)**
Lead Authors:	**Winkler, Jessica (jwinkler), Fry, Dana (dfry)**
Approvers:	**Winkler, Jessica (jwinkler) -> 01 P&P Committee - (Committee) -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Scheduling Surgical Procedures — **Pending Approval** — 11/17/2022 — 22

Surgical Services/OR Dept

Summary Of Changes:	**Made spelling and formatting corrections Updated titles of staff responsible Updated scheduling according to current practice Added that any additions or deletions to block schedule must be approved by Surgery Committee**
Moderators:	**Newman, Cindi (cnewman)**
Lead Authors:	**Winkler, Jessica (jwinkler), Fry, Dana (dfry)**
Approvers:	**Winkler, Jessica (jwinkler) -> 01 P&P Committee - (Committee) -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Scope of Service - Surgery — **Pending Approval** — 11/17/2022 — 22

Surgical Services/OR Dept

Summary Of Changes:	**Removed all references to c-section suite and endoscopy suite as a separate location. Removed redundancies regarding certifications. Updated current title of scheduler. Changed on-call response time from 30 minutes to 40 minutes to reflect policy titled "On Call, Surgery." Typing and grammar corrections made to policy. changes to author and owner, removed reference to obstetrics and pediatric patients removed reference to CRNAs updated reference**
Moderators:	**Newman, Cindi (cnewman)**
Lead Authors:	**Winkler, Jessica (jwinkler), Fry, Dana (dfry)**
Approvers:	**Winkler, Jessica (jwinkler) -> 01 P&P Committee - (Committee) -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Staff Scheduling Practices, Surgery — **Pending Approval** — 11/17/2022 — 22

Surgical Services/OR Dept

Summary Of Changes:	**Changed titles of director and coordinators to reflect current verbiage**
Moderators:	**Newman, Cindi (cnewman)**
Lead Authors:	**Winkler, Jessica (jwinkler), Fry, Dana (dfry)**
Approvers:	**Winkler, Jessica (jwinkler) -> 01 P&P Committee - (Committee) -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Sterile Supplies, Storage of — **Pending Approval** — 11/17/2022 — 22

Central Sterile Dept

Summary Of Changes:	**Changed the maximum allowed humidity for the storage area from 70% to 60%. Updated authors, references, temperature maximum, and distance from the floor.**

Moderators:	**Newman, Cindi (cnewman)**
Lead Authors:	**Winkler, Jessica (jwinkler), Fry, Dana (dfry)**
Approvers:	**Winkler, Jessica (jwinkler) -> 01 P&P Committee - (Committee) -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Traffic Control in the Operating Room	**Pending Approval**	11/17/2022	22
Surgical Services/OR Dept			

Summary Of Changes:	**Reference date updated, authors, and mild grammar changes only made.**
Moderators:	**Newman, Cindi (cnewman)**
Lead Authors:	**Winkler, Jessica (jwinkler), Fry, Dana (dfry)**
Approvers:	**Winkler, Jessica (jwinkler) -> 01 P&P Committee - (Committee) -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

2023 Quality Committee Work Plan

January 1/25	February 2/22	March 3/29	April 4/26
▪ 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 5/24	**June 6/28**	**July 7/26**	**August 8/23**
▪ Imaging QA/PI ▪ Quality Indicator Performance and Plan ▪ Policies and Procedures ▪ Credentialing	▪ ED QA/PI ▪ Quality Indicator Performance and Plan ▪ Policies and Procedures Credentialing	▪ Lab QA/P ▪ Quality Indicator Performance and Plan ▪ Patient Care Services Dashboard 2nd Qtr ▪ Policies and Procedures ▪ Credentialing	▪ Pharmacy QA/PI ▪ Quality Indicator Performance and Plan ▪ Policies and Procedures ▪ Credentialing
September 9/27	**October 10/25**	**November 11/29**	**December 12/20**
▪ PT/OT 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