SVHCD QUALITY COMMITTEE

AGENDA

WEDNESDAY, APRIL 26, 2023

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/92261747301?pwd=WWg3N090dGtEamZiaFp2MmlvRy9YUT09

and Enter the **Meeting ID: 922 6174 7301**
Passcode: 913906

To Participate via Telephone only, dial:
1-669-900-9128 or 1-669-219-2599
and Enter the **Meeting ID: 922 6174 7301**
Passcode: 913906

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, Monique Crayton, at mcrayton@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 03.22.23	*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 QUARTER	*Winkler*	Inform
7. POLICIES AND PROCEDURES	*Cooper*	Inform
8. CLOSED SESSION: a. Calif. Health & Safety Code §32155: Medical Staff Credentialing & Peer Review Report	*Kornblatt Idell*	Action
9. ADJOURN	*Kornblatt Idell*	

SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
March 22, 2023, 5:00 PM
MINUTES
Via Zoom Teleconference

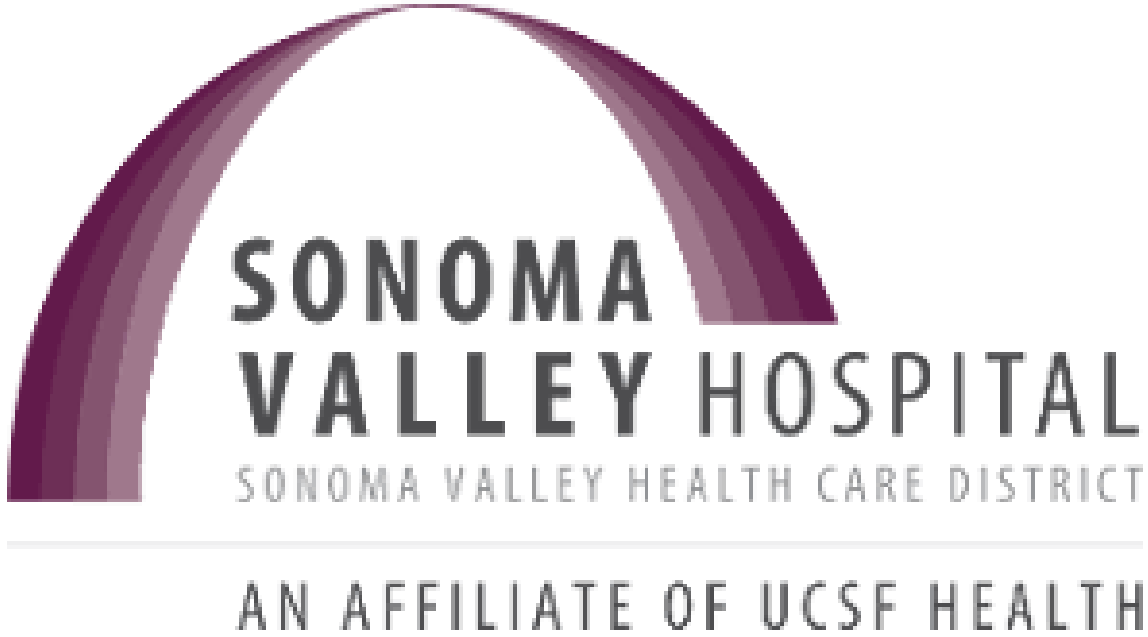
Members Present – Via Zoom	Members Present cont.	Excused	Public/Staff – Via Zoom
Susan Kornblatt Idell Carol Snyder Kathy Beebe, RN PhD Michael Mainardi, MD Howard Eisenstark, MD Ingrid Sheets, EdD, MS, RN Judith Bjorndal, MD	Carl Speizer, MD		Jessica Winkler, DNP, RN, NEA-BC, CCRN-K, CNO Kylie Cooper, RN, BSN, CPHQ, MBA, Quality and Risk Mgmt. John Hennelly, CEO Celia Kruse de la Rosa Sujatha Sankaran, MD, CMO

AGENDA ITEM	DISCUSSION	ACTION
1. CALL TO ORDER/ANNOUNCEMENTS	*Kornblatt Idell*	
	Meeting called to order at 5:01 p.m. The Chair introduced new Board Clerk Monique Crayton.	
2. PUBLIC COMMENT	*Kornblatt Idell*	
	None	
3. CONSENT CALENDAR	*Kornblatt Idell*	Action
• QC Minutes 02.22.23	Ms. Beebe suggested removing the sentence "Those that left without being seen have less severity of illness." from the January minutes (which was previously added as a change at the February meeting). The other members agreed and the Chair said she would follow up at a future meeting.	**MOTION:** by Snyder to approve, 2nd by Sheets. All in favor.
4. ANNUAL QUALITY DEPARTMENT REVIEW	*Cooper*	Inform
	Ms. Cooper gave the annual Quality Department review. SVH received the Silver Plus Award from AHA for stroke care in 2022. Opportunities for	

	improvement included decreasing length of stay and continued collaboration between Quality and the ED to improve sepsis measures (a sepsis task force has been created).	
5. QUALITY INDICATOR PERFORMANCE PLAN	*Cooper*	Inform
	Ms. Cooper shared the quality indicator performance for the months of January/February 2023. She also reported Rate my Hospital scores.	
6. POLICIES AND PROCEDURES	*Cooper*	Inform
	Summaries of changes were reviewed for the following policies: Administration of Medications Audiograms Bipap ST-D Ventilatory Support System Blood and Body Fluid Exposures Body Fluid Exposure Prophylaxis Kit Preparation 8390-06 Breast-Feeding Mothers and Intravenous Contrast Administration 7630-107 Breath Alcohol Testing C-II Controlled Substance Wholesaler Invoice Management Procedure 8390-04 Culture of Safety Department of Transportation Physical Exams Discharge Criteria Drug Testing for Minors Examination Orders Formulary Management Influenza Vaccination 7775-04 Influenza Vaccination Program for Staff and LIPs Investigational Drug Use Lipid Rescue for Local anesthetic Toxicity Maintenance of Pharmacy Equipment Malignant Hyperthermia MRSA Work Status Multi-Dose and Single-Dose Vials	

	Nitrazine Testing for Amniotic Fluid Nourishment Between Meal Snacks Ordering and Prescribing Patient Controlled Analgesia (PCA) PB 840 Ventilator Pharmaceutical Waste Management Pharmacy Staff Competency Assessment 8390-09 Point of Care Testing (POCT) Pre-Placement Physicals Preparation of Methotrexate IM Doses Using ChemoClave System Procedure Professional Credentials & Associations Pyxis Medstation, Management and Use QAPI Procedures Sampling Plan-IV Room QuantiFERON IGRA Texting 7775-15 Rabies Post-Exposure Vaccination Required Certifications Self Administration of Medications Self Referral Testing Sports Physicals Standard Employer Service Rate Transfer of Patients for Diagnostic Imaging Transfer of Patients to the Emergency Room from Occupational Health Travel Medicine Tuberculosis Screening 7775-12 Urine Drug Screening Vaccination Policy Verbal and Telephone Orders Weapons GL8610-200 Yellow Fever Vaccination <u>Retire</u>: Drug Regimen Review for Skilled Nursing Facility Pharmaceutical Care Consulting for Skilled Nursing Facility Position Descriptions Departmental Safety Measures	

	Dr. Eisenstark questioned the use of the words “as needed” in the Discharge Criteria policy. Ms. Cooper said it pertains to discharging patients from surgical care that need additional equipment, for example, a walker. “As needed” was added since not all patients require additional resources on discharge. The wording was acceptable. There were no other comments.	
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 5:38 p.m.	



QUALITY BOARD PRESENTATION-INFECTION PREVENTION PROGRAM 2023

Goals

The goals of the infection prevention program include, but are not necessarily limited to:

• Identifying, reporting, investigating, and controlling infections and communicable diseases in patients and personnel including: Central Line Associated Bloodstream Infection (CLABSI), Ventilator Associated Events (VAE), Non-ventilator-associated Pneumonia, Catheter Associated Urinary Tract Infection (CAUTI), infections with Multi-drug Resistant Organisms (MDRO), Clostridium difficile infections (CDI), Covid-19, surgical site infections (SSI) in accordance with all applicable regulatory standards and requirements

• Hand hygiene performed in accordance with hospital policy

• Preventing or reducing the risk of unprotected exposure to pathogens throughout the organization

• Minimizing the risk of transmitting infections via medical equipment, medical devices, hospital environment and multi-use vials

• Reduce the risk of infection due to prolonged wait times in outpatient areas

• Maintaining a sanitary environment to reduce the risk of fomite-associated infections and communicable diseases

• Ensuring that the hospital-wide quality, performance improvement and training programs address problems identified by the Infection Preventionist, and that subsequent corrective action plans are successfully implemented

• Complying with the MRSA active surveillance requirements of SB 158 • Complying with Cal/OSHA regulations including Bloodborne Pathogen Exposure and Aerosol Transmissible Disease Standards

• Reduce the risk of infections associated with construction

• Maintain a comprehensive water management program to reduce the risk of microbial growth in building water systems and reduce the risk of hospital-acquired legionellosis or other waterborne infections

ANNUAL RISK ASSESSMENT 2023

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.

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- 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:

- **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)

Some Prioritized Risk Assessment categories include:

- Transmission of infection associated with non-compliance with CDC guidelines and CIHQ recommendations for hand hygiene.
- 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.
- 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.
- Community-wide outbreaks of communicable diseases e.g., COVID 19, influenza, measles, pertussis, that carry the potential of adversely impacting operations and service capabilities

Risk ASSESSMENT GRID
Has 3 Categories

INPATIENT
AMBULATORY
OUTPATIENT

Prioritized Risk Description	Risk Assessment			Mitigation Strategies	
	I	A	O		
Transmission of infection associated with non-compliance with CDC guidelines and CIHQ recommendations for hand hygiene (HH). **30 Points**	H	H	H	Information given to patients on admission on the importance of HH. 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.	Goal is >90% compliance Assess compliance through audits. Report compliance rates to PI, Medicine and Surgery Committees, CEO, CNO, Director of Quality, Quality Board.

RISK ASSESSMENT CHANGES UPDATES for 2023

Risk has increased for Candida Auris Infections in Immuno-compromised and elderly patient 2023

CDPH has confirmed that an increase of Candida Auris fungal infections have increased around the world, US and in California

• ESBL • Candida auris **11 points**	H	H	M	Contact precautions initiated for all patients infected or colonized with ESBL or Candida auris. 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.	Goal: ESBL rates are reported quarterly to PI, Medicine and Surgery committees. ASP reviews antibiogram annually 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.

Changes in Risk Assessment for 2023

SVH will have some construction occurring in 2023 with the addition of the MRI Dept. This has caused the risk assessment to increase from MEDIUM RISK to HIGH RISK in all three categories; inpatient, outpatient and ambulatory.

Infection Prevention and Control involvement in construction activities **3 points**	H	H	H	Infection Prevention Risk Assessment complete for all construction activities 2023. Construction workers educated on Infection Prevention practices during safety orientation.	Goal: 100% compliance with Infection Control Risk Assessment (ICRA) and compliance checklist completed before initiating any construction projects. Documentation kept in Engineering.

Public Health Reportable: Local and State

Every hospital is required by law to report certain conditions to public health.
This is done electronically via the lab and with a CMR form via the Infection Control and Preventionist. Public health can conduct contact tracing. Public health will help to manage some cases: for example – a TB patient can't be removed from isolation or discharged from the hospital without the consent of local public health.

Some examples of local and state reportable: **Botulism, Influenza, smallpox, Ebola, candida auris, Carbapenemase-producing organism, Chlamydia trachomatis, syphilis, Meningitis, measles, malaria, rabies, HIV, trichinosis, tuberculosis, yellow fever, West Nile virus and many more.**

There is a class of micro-organisms that are extraordinary, known as MDROs (multi drug resistant organisms) which need special attentions in healthcare.

MDROs: These highly resistant organisms and have a class all their own.

They are split into two categories: Tier 1-routine and Tier two-intensified MDRO control efforts.

Surveillance and Epidemiology – Federal Reporting to NHSN

The hospital is required to report data on CAUTI, CLABSI, CDIFF, SSI, VAP, etc. publicly. This is done by inputting data into the National Health and Safety Network (NHSN).

- Input data monthly.
- Sonoma Valley Hospital has a new module called BUGSY within the new EPIC system. The BUGSY module is used to upload data directly to NHSN.

Sonoma Valley Hospitals: Hospital Acquired Infections (HAI) over the past year.

- 1 CAUTI HAI in 2022
- 1 CLABSI HAI in 2022
- 0 Hospital Acquired C-DIFF Infections in 2022
- SVH reports all Community Acquired C-Diff infections to NHSN
- 0 Vent Associated Events

Thank You!

Sonoma Valley Hospital

Infection Prevention Risk Assessment and 2023 Goals

BACKGROUND

As part of its commitment to quality care and service, Sonoma Valley Hospital, conducts a risk assessment for transmission and acquisition of infectious agents. This risk assessment incorporates an analysis of the following:

1. The geographic location and community environment of the organization, the programs and services provided, and the characteristics of the population served.
2. Analysis of surveillance activities and the results of the organization's infection prevention and control data.
3. Infection prevention standards recommended by Center for Improvement in Healthcare Quality (CIHQ), California Department of Public Health (CDPH), Cal/OSHA, Centers for Disease Control and Prevention (CDC), Association **of Perioperative Registered Nurses (**AORN) and other regulatory bodies.
4. The patient care, treatment, and other services provided by Sonoma Valley Hospital and the inherent risk therein.

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.

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

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:

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 recommendations for hand hygiene (HH). **30 Points**	H	H	H	Information given to patients on admission on the importance of HH. HH education included in hospital and nursing orientation and annual education.	Goal is >90% compliance Assess compliance through audits. Report compliance rates to PI, Medicine and Surgery Committees,

				HH compliance rounds conducted by the Infection Preventionist plus "stealth audits" to obtain hospital-wide compliance data.	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 on admission	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 reported to Medicine, Surgery, Quality

				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.	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	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.

				manufacturer's recommendation. EVS receives training on infection prevention for proper daily, OR, isolation and terminal 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**	NA	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	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

				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. 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.	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. 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	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

				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. 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	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. 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.

				infectious patients are admitted to the hospital.	
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 **15 points**	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 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	Goal: Hospital Acquired MDRO cases are identified and reported quarterly to PI, Medicine and Surgery committees. 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

				required by SB 1058.	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 **11 points**	M	M	M	Contact precautions initiated for all patients infected or colonized with ESBL or Candida auris. Patients are flagged in the system for identification and isolation on subsequent admissions.	Goal: ESBL rates are reported quarterly to PI, Medicine and Surgery committees. ASP reviews antibiogram annually and assesses antibiotic use in accordance with antibiotic guidelines. Antibiotic prescribing

				ESBL and C. auris cases are tracked and reported. Report C. auris to DPH if identified. Follow CDPH guidelines for management of C. auris.	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 the	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.

				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 in 2022 and prior to CIHQ survey	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.	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.

				Provide just in time education at time of auditing. Report line days necessity data to CMO and Chair of Hospitalists.	
• Ventilator Associated Event (VAE) and Hospital-Associated Pneumonia **5 points**	M	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.	Goal: Reduce CAUTI rates to NHSN benchmarks. Reported quarterly to PI, Medicine and Surgery committees.

				Report foley days necessity data to CMO and Chair of Hospitalists.	
• Surgical Site Infections (SSI) **16 points**	M	H	L	Elevated SSI rates (by procedure group) are 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.	Goal: Overall SSI rate <1%. < 2 colon 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	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

				hospital and equipment.	for EVS upon patient discharge.
Infection Prevention and Control involvement in construction activities **3 points**	M	M	M	Infection Prevention Risk Assessment complete for all construction activities 2023. Construction workers educated on Infection Prevention practices during safety orientation.	Goal: 100% compliance with Infection Control Risk Assessment (ICRA) and compliance checklist completed 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

References:
CIHQ Standards, CDC guidelines, AORN.

Owner:
Director of Quality

Author/Reviewers:
Director of Quality
Chief Medical Officer
Infection Preventionist
Quality Committee

Approvals:
Policy & Procedure Team: 4/5/2022
Performance Improvement/
Pharmacy & Therapeutics Committee:4/28/2022
Medical Executive Committee: 5/19/2022
The Board of Directors: 6/2/2022

Quality Indicator Performance & Plan

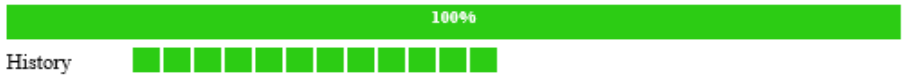
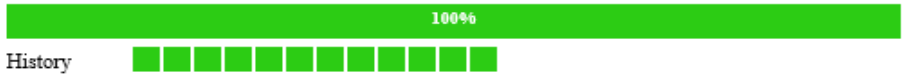
April Board Quality

Data for March 2023

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

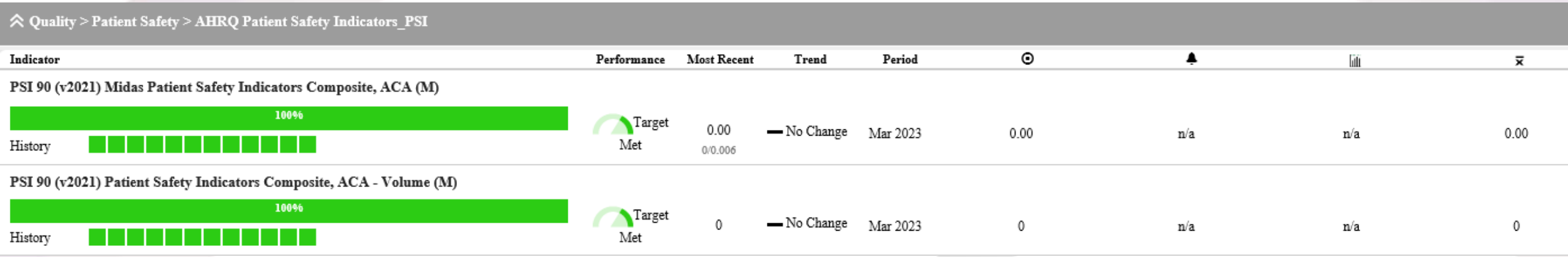
Mortality

Mortality

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
Acute Care Mortality Rate (M)								
	Target Met	6.2% 4/64	Deteriorated	Mar 2023	15.3%	n/a	n/a	2.4%
COPD Mortality Rate |M|								
	Target Met	0.0% 0/2	No Change	Mar 2023	8.5%	n/a	n/a	0.0%
Congestive Heart Failure Mortality Rate |M|								
	Target Met	0.0% 0/7	No Change	Mar 2023	11.5%	n/a	n/a	4.2%
Pneumonia Mortality Rate |M|								
	Target Met	0.0% 0/2	No Change	Mar 2023	15.6%	n/a	n/a	2.3%
Ischemic Stroke Mortality Rate |M|								
	Target Met	0.0% 0/1	No Change	Mar 2023	13.8%	n/a	n/a	0.0%
Hemorrhagic Stroke - Mortality Rate (M)								
	Target Met	0.0% 0/1	No Change	Dec 2022	0.0%	1.0%	n/a	20.0%

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
Sepsis, Severe - Mortality Rate (M)								
	Target Met	0.0% 0/1	No Change	Mar 2023	25.0%	n/a	n/a	2.4%
Septic Shock - Mortality Rate (Q)								
	Breaches Alarm	42.9% 3/7	Deteriorated	Q1-2023	0.0%	n/a	n/a	14.1%

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								
	 Target Met	0.00 0/271	— No Change	Mar 2023	3.75	4.00	n/a	1.84
RM ACUTE FALL- WITH INJURY (M) per 1000 patient days								
	 Target Met	0.00 0/271	— No Change	Mar 2023	3.75	4.00	n/a	0.00

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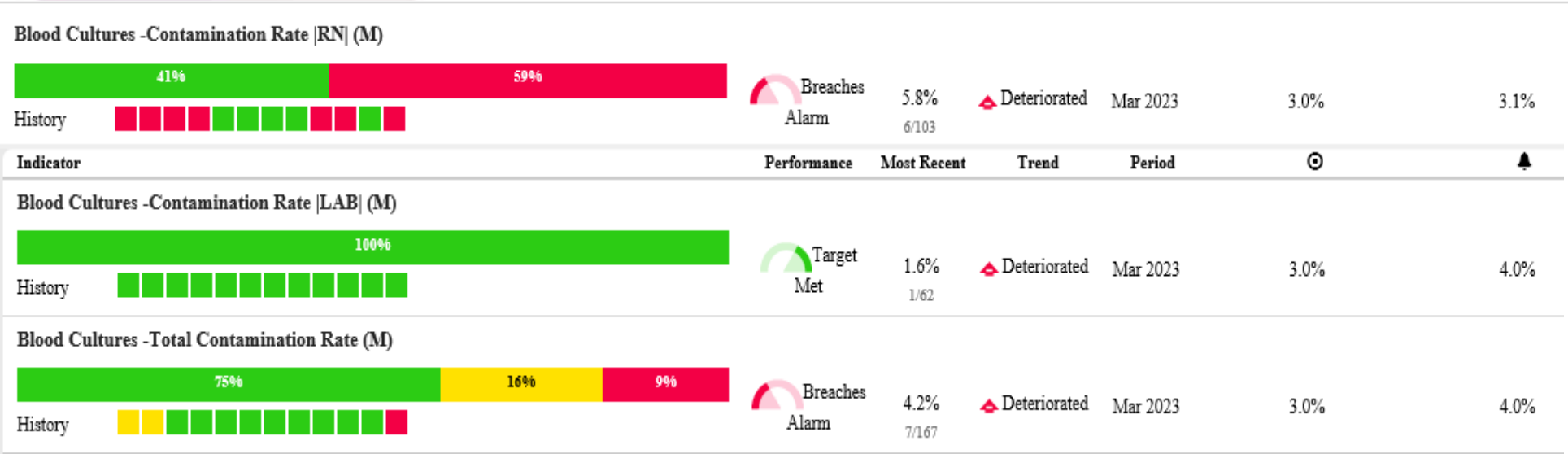
Readmissions

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
30-DV Inpatients - % Readmit to Acute Care within 30 Days (M)								
100% History	Target Met	1.79% 1/56	Improved	Mar 2023	15.30%	15.50%	n/a	5.46%
COPD, CMS Readm - % Readmit within 30 Days, ACA (M)								
75% 9% 16% History	Target Met	0.0% 0/2	No Change	Mar 2023	19.5%	20.0%	n/a	7.4%
HF, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)								
91% 9% History	Target Met	0.0% 0/3	No Change	Mar 2023	21.6%	22.0%	n/a	2.7%
Hip/Knee, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)								
66% 9% 25% History	Target Undefined	n/a 0/0		Mar 2023	4.0%	5.0%	n/a	4.5%
PNA, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)								
83% 8% 9% History	Target Met	0.0% 0/2	Improved	Mar 2023	16.6%	17.0%	n/a	7.5%
Sepsis, Severe - % Readmit within 30 Days (M)								
100% History	Target Met	0.0% 0/1	No Change	Mar 2023	12.0%	13.0%	n/a	0.0%
Septic Shock - % Readmit within 30 Days (M)								
100% History	Target Met	1.0% 1/1	Deteriorated	Mar 2023	13.3%	14.0%	n/a	0.3%

Blood Culture Contamination



Month	RN-Contaminated Culture Reports (num)	Blood Cultures Drawn by RN (den)	Percent
Mar 2023	6	103	5.8%
Feb 2023	2	95	2.1%
Jan 2023	4	88	4.5%
Dec 2022	4	109	3.7%
Nov 2022	3	124	2.4%
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%

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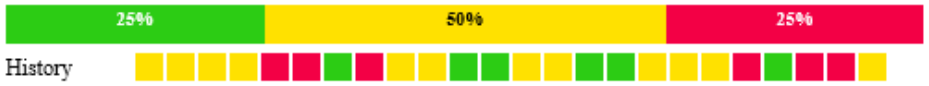
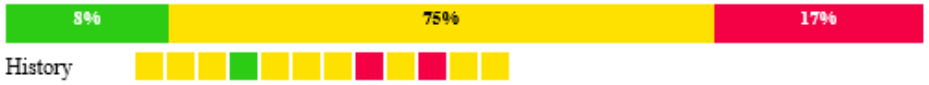
CIHQ Stroke Certification Measures

Indicator	Performance	Most Recent	Trend	Period				
CDSTK-03|Median- Code Stroke Called |M| elapsed time (mins)	Target Met	2	Improved	Mar 2023	10	11	n/a	3
CDSTK-04|Median- Door to Phys Eval |M| minutes	Target Met	1.50	Improved	Mar 2023	10.00	11.00	n/a	1.50
CDSTK-05|Median- Door to CT Scanner |M|elapsed time (minutes)	Target Met	5.00	Improved	Mar 2023	25.00	26.00	n/a	7.75
CDSTK-06|Median- Neuro Consult Contacted |M| minutes	Target Met	11.00	Improved	Mar 2023	30.00	31.00	n/a	16.00
CDSTK-07|Median- CT Read by Radiology |M| minutes	Target Met	30.50	Improved	Mar 2023	45.00	46.00	n/a	29.50
CDSTK-08|Median- Lab Results Posted |M| minutes	Target Met	16.00	Improved	Mar 2023	45.00	46.00	n/a	28.50
CDSTK-10|Median- Door to EKG Complete |M| minutes	Target Met	16.50	Improved	Mar 2023	60.00	61.00	n/a	37.50
CDSTK-11|Median-Door to tPA Decision |M| minutes	Target Met	28.50	Improved	Mar 2023	60.00	61.00	n/a	37.25
CDSTK-12|Median-Door to tPA |M| minutes	Breaches Alarm	76.00		Mar 2023	60.00	61.00	n/a	74.00

Utilization Management

Utilization Management

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
1 Day Stay Rate Medi-Cal [M]								
	Target Met	0.00% 0/14	No Change	Mar 2023	2.61%	5.00%	n/a	4.70%
1 Day Stay Rate-Medicare [M]								
	Target Met	0.00% 0/44	No Change	Mar 2023	8.10%	10.00%	n/a	6.65%
Acute Care - Geometric Mean Length of Stay [M]								
	Breaches Alarm	3.63 32.6854/9	Deteriorated	Mar 2023	2.75	3.23	n/a	3.21
Acute Care Age over 64 - MS-DRG Case Mix Index [M]								
	Bet. Target & Alarm	1.52 65.3954/43	Improved	Mar 2023	1.56	1.40	n/a	1.47
Acute Care- MS-DRG Case Mix Index [M]								
	Bet. Target & Alarm	1.47 85.1662/58	Improved	Mar 2023	1.55	1.40	n/a	1.47

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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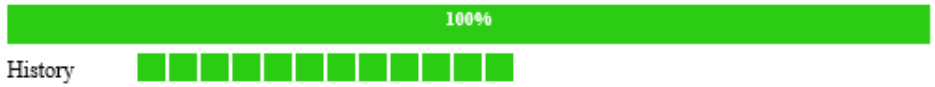
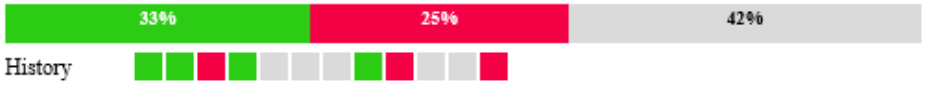
Core Measures

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	Mar 2023	88.0%	50.0%	n/a	100.0%

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
Core OP 18b Median Time ED Arrival to ED Departure - Reporting Measure (M)								
	Target Met	90.00	Improved	Mar 2023	132.00	140.00	n/a	163.25

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
Core OP 22 ED LWBS Emergency Dept Left Without Being Seen (M)								
	Target Met	0.3% 2/668	Improved	Mar 2023	2.0%	2.5%	n/a	1.9%

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
Core OP-23 - Head CT/MRI Results for STK Pts w/in 45 Min of Arrival (M)								
	Breaches Alarm	0.0% 0/1		Mar 2023	72.0%	70.0%	n/a	75.0%

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Core Measures Sepsis

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
SEP-1 Early Management Bundle, Severe Sepsis/Septic Shock (M)								
	Breaches Alarm	28.6% 2/7	Improved	Mar 2023	81.0%	80.0%	n/a	66.7%
SEPa - Severe Sepsis 3 Hour Bundle (M)								
	Breaches Alarm	71.4% 5/7	Improved	Mar 2023	94.0%	90.0%	n/a	85.7%
SEPb - Severe Sepsis 6 Hour Bundle (M)								
	Target Met	100.0% 4/4	Improved	Mar 2023	100.0%	90.0%	n/a	91.1%

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Infection Prevention

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
IC-Surveillance| HAI-C.DIFF Inpatient infections per 10k pt days |M|								
90% 10%	Target Met	0	Improved	Mar 2023	1	1	n/a	0
History								
IC-Surveillance| HAI-CAUTI Inpatient infections per 10k patient days |M|								
90% 10%	Target Met	0	No Change	Mar 2023	1	1	n/a	0
History								
IC-Surveillance| HAI-CLABSI Inpatient infections per 10k patient days |M|								
95% 5%	Target Met	0	No Change	Mar 2023	1	1	n/a	0
History								
IC-Surveillance| HAI-MRSA Inpatient infections per 10k patient days |M|								
100%	Target Met	0	No Change	Mar 2023	1	1	n/a	0
History								
IC-Surveillance| HAI-SSI infections per 10k pt days |M|								
100%	Target Met	0	No Change	Mar 2023	1	1	n/a	0
History								

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Inpatient Patient Satisfaction
Now reporting HCAHPS Quarterly

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Rate My Hospital
Scale 1-5
March Data

Sonoma Valley Hospital / Emergency Department	0	71	4.488 95% CI: 4.406—4.569	
Sonoma Valley Hospital / Inpatient Care	0	4	4.607 95% CI: Not enough samples	

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Rate My Hospital
Scale 1-5

Sonoma Valley Hospital / Medical Imaging	0	208	4.868 95% CI: 4.840—4.897	
Sonoma Valley Hospital / Hand and Physical Therapy	0	110	4.913 95% CI: 4.889—4.937	

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Rate My Hospital
Scale 1-5

Sonoma Valley Hospital / Outpatient Surgery	0	41	4.837 95% CI: 4.788—4.886	

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Medication Scanning Rate	2022- 2023				
	Q2	Q3	Q4	Q1	Goal
Inpatient (ICU/MS)	96.0%	98.0%	96%	95%	≥90%
Pre/Post Op				98%	≥90%
ED	78.3%	85.0%	83.0	80%	≥90%
Preventable med errors R/T Med Scanning	0	1	0	0	≤2

Quality Indicators (QAPI) 2022 - 2023					
	Q2	Q3	Q4	Q1	Goal
Antibx admin within 30"- M/S and ICU	95%	93%	91%	91%	≥90%
Cont. OBS for Psych Pt-ED	90%	100%	100%	100%	100%
Drug Admin Errors- Pharmacy (per 10000 doses)	0.36	0.59	0.37	0.43	<1

Case Management 2022 - 2023					
	Q2	Q3	Q4	Q1	Goal
HCAHPS Care Transitions	45.5	90	45	62/49	53%

Nursing Turnover	2022-2023 Staff/Quarter				
# of RNs	Q2	Q3	Q4	Q1	Goal
RNs, >0.5FTE (n=64)	4 (6.9%)	4 (6.6%)	1 (1.6%)	2 (3.1%)	≤6

Patient Experience: Q-Reviews 2022-2023	2022				
	Q2	Q3	Q4		Goal
RATE MY HOSPITAL- PHYSICAL THERAPY					
Overall score	4.79	4.87	4.9	4.91	≥4.75
RATE MY HOSPITAL-OUTPATIENT SURGERY					
Overall Score	4.81	4.83	4.83	4.84	≥4.75
RATE MY HOSPITAL - ED					
Overall score	4.51	4.66	4.63	4.5	≥4.75
RATE MY HOSPITAL - MEDICAL IMAGING					
Overall score	4.82	4.76	4.82	4.85	≥4.75
RATE MY HOSPITAL-INPATIENT					
Overall score	4.67	4.79	4.66	4.74	≥4.75

Nurse Staffing Effectiveness: Transfers r/t staffing/beds 2022 - 2023	Q2	Q3	Q4	Q1	Goal
	1	1	6	1	≤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: 04/20/2023 3:12 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: 1

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

Committee Members: **Crayton, Monique (mcrayton), Finn, Stacey (sfinn), Newman, Cindi (cnewman)**

Current Approval Tasks (due now)

Document	Task/Status	Pending Since	Days Pending
Nuclear Medicine Emergency Procedures 7630-179 *Diagnostic Services Dept Policies*	**Pending Approval**	4/20/2023	0

Summary Of Changes: **Changed policy name to Radioactive Material Emergency Procedures.**
Added Purpose and Policy sections.
Added details to procedures.
Added Fire and personal decontamination.
Updated RSO information.
Updated author/reviewers.

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)**