SVHCD QUALITY COMMITTEE

AGENDA

WEDNESDAY, AUGUST 23, 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/91601200156?pwd=cXYzdUs2MEZnS2xHVUJyL3phWWdGQT09.

and Enter the **Meeting ID: 916 0120 0156**
Passcode: 891667
To Participate via Telephone only, dial:
1-669-900-9128 or 1-669-219-2599

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 07.26.23	*Kornblatt Idell*	Action
4. PHARMACY QA/PI	*Kutza*	Inform
5. QUALITY INDICATOR PERFORMANCE AND PLAN	*Cooper*	Inform
6. POLICIES AND PROCEDURES	*Cooper*	Inform
7. CLOSED SESSION: a. Calif. Health & Safety Code §32155: Medical Staff Credentialing & Peer Review Report	*Kornblatt Idell*	Action
8. ADJOURN	*Kornblatt Idell*	

SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
July 26, 2023, 5:00 PM
MINUTES
Via Zoom Teleconference

Members Present – Via Zoom	Members Present cont.	Excused	Public/Staff – Via Zoom
Susan Kornblatt Idell Carl Speizer, MD Michael Mainardi, MD Ingrid Sheets, EdD, MS, RN		Carol Snyder Kathy Beebe, RN PhD Judith Bjorndal, MD Howard Eisenstark, MD	Jessica Winkler, DNP, RN, NEA-BC, CCRN-K, CNO Kylie Cooper, RN, BSN, CPHQ, MBA, Quality and Risk Mgmt. John Hennelly, CEO Paul Amara, MD Dawn Kuwahara, RN, BSN Nicolas Hadjiyianni, Lab Manager Louie Lacson, CLS

AGENDA ITEM	DISCUSSION	ACTION
1. CALL TO ORDER/ANNOUNCEMENTS	*Kornblatt Idell*	
	Meeting called to order at 5:07 p.m.	
2. PUBLIC COMMENT	*Kornblatt Idell*	
	None	
3. CONSENT CALENDAR	*Kornblatt Idell*	ACTION

• QC Minutes 06.28.23	Minutes of the 06.28.23 meeting were approved as presented.	**MOTION:** by Mainardi to approve, 2nd by Speizer.. All in favor.
4. LAB QA/PI	*Kuwahara, Hadjiyianni, Lacson*	INFORM
	Ms. Kuwahara presented the LAB QA/PI presentation. Overview given of laboratory staff and Scope of Services. Based on a question from Ms. Sheets Ms. Kuwahara explained that Quest is currently the reference lab used by SVH for those tests that cannot be performed in house. Patients can bring their quest order to SVH to have labs performed. Those with Partnership insurance must go to Quest for their lab draws. Accomplishments regarding the EPIC Beaker project were discussed. This was a great accomplishment for the lab and required 2 full-time staff members to be engaged in the implementation of this project. Challenges that were discussed were staffing and aging equipment. The lifespan on lab equipment is 7 years and some equipment will need to be replaced this fiscal year. Some of the equipment to be replaced will be the hematology analyzers. There is a current recruitment for a Lab Supervisor underway. Ms. Kuwahara reported that due to a significant decrease in COVID testing the forecasted volumes for 2023 have decreased. Dr. Mainardi asked when the UCSF interface will be completed. It was anticipated this July, but this has been pushed out to September. The LAB QAPI was presented. Critical value reporting fell below the target. The fallout was explained by Mr. Hadjiyianni. It was due to critical tests not being documented correctly by the CLS regarding a critical test that was called to the provider. Direct education was done on this. MRSA now has a 2-hour turnaround time as opposed to 36 hours as we are now performing the test via PCR.	
5. QUALITY INDICATOR PERFORMANCE PLAN	*Cooper*	INFORM

	Ms. Cooper shared the quality indicator performance for the month of June 2023. RN blood culture contamination was above the target. There is a specific action plan in place with ED staff regarding this measure. Code stroke called time was above the target, this was attributed to 1 patient that had an atypical presentation and therefore code stroke time called was delayed. ED throughput time significantly improved despite record volumes. Lower acuity could have contributed. Sepsis core measure did not meet the target, fall out attributed to MD not using the Sepsis Order Set in EPIC. Hand Hygiene improvements seen in June. Monthly and Quarterly CIHQ corrective action plans for conditional and standing findings was presented. Improvements seen in Continuous Observation of At Risk Patients, still not meeting goal, education has been provided to ED MD's regarding ordering of close observation. Fall outs in other monitoring plans presented and action plans discussed. Rate my Hospital Scores for June presented.	
6. POLICIES AND PROCEDURES	*Cooper*	INFORM
	Summaries of changes were reviewed for the following policies: Administration of Medications Advanced Directives Contrast Reactions 7630-125 Infection Prevention Program Infection Prevention Risk Assessment Management of Radiographic Contrast Media MRI Code Blue Procedure MRSA Active Surveillance Culture (ASC) Venipuncture by Technologists 7630-237 <u>RETIRE</u> Cardiac Exercise Testing Precautions, Indication and Complications Cardiac Stress Testing Addendum Cardiolite Testing	

	Echocardiogram Procedure Echocardiography with Contrast Fire Safety-Imaging Dept Fire Safety-MRI Myocardial Perfusion Testing Lexiscan Treadmill Test Pediatric Electrocardiogram Performing Complete Transthoracic Echocardiograms, protocol for Dobutamine Stress Testing ECG Interpretation	
7. MEETING DATES FOR THE BALANCE OF 2023	*Kornblatt Idell*	INFORM
	Ms. Kornblatt Idell proposed combining the September/October and November/December Quality Committee Meetings. The September/October meeting will take place on Wednesday, October 25th. The November/December meeting date will be determined. The Committee agreed to the proposed changes. Staff will revise meeting invites, and email updates accordingly.	
8. CLOSED SESSION/REPORT ON CLOSED SESSION	*Kornblatt Idell*	ACTION
a. Calif. Health & Safety Code §32155: Medical Staff Credentialing & Peer Review Report	Dr. Amara presented the Medical Staff Credentialing for review and approval.	**MOTION:** by Speizer to approve, 2nd by Sheets. All in favor.
9. ADJOURN	*Kornblatt Idell*	
	Meeting adjourned at 6:00 p.m.	

Pharmacy Department

Epic-update

Adverse Drug Events

Antimicrobial Stewardship

Controlled Substances

Pyxis Utilization

IV Room

Pharmacy Services

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Epic

- 8 months in
- Staff comfortable with how to use
- Moving on to mining the large amount of data available for QA
  - Outpatient infusion reimbursement
  - Opioid utilization
  - Antimicrobial stewardship

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Adverse Drug Events

- Administration Errors Per 10,000 Doses
- High Risk Med Errors Per 10,000 Doses
- Near Miss %
- Smart Pump- No Drug Selected
- Smart Pump- Hard Alerts
- Smart Pump- Soft Alerts

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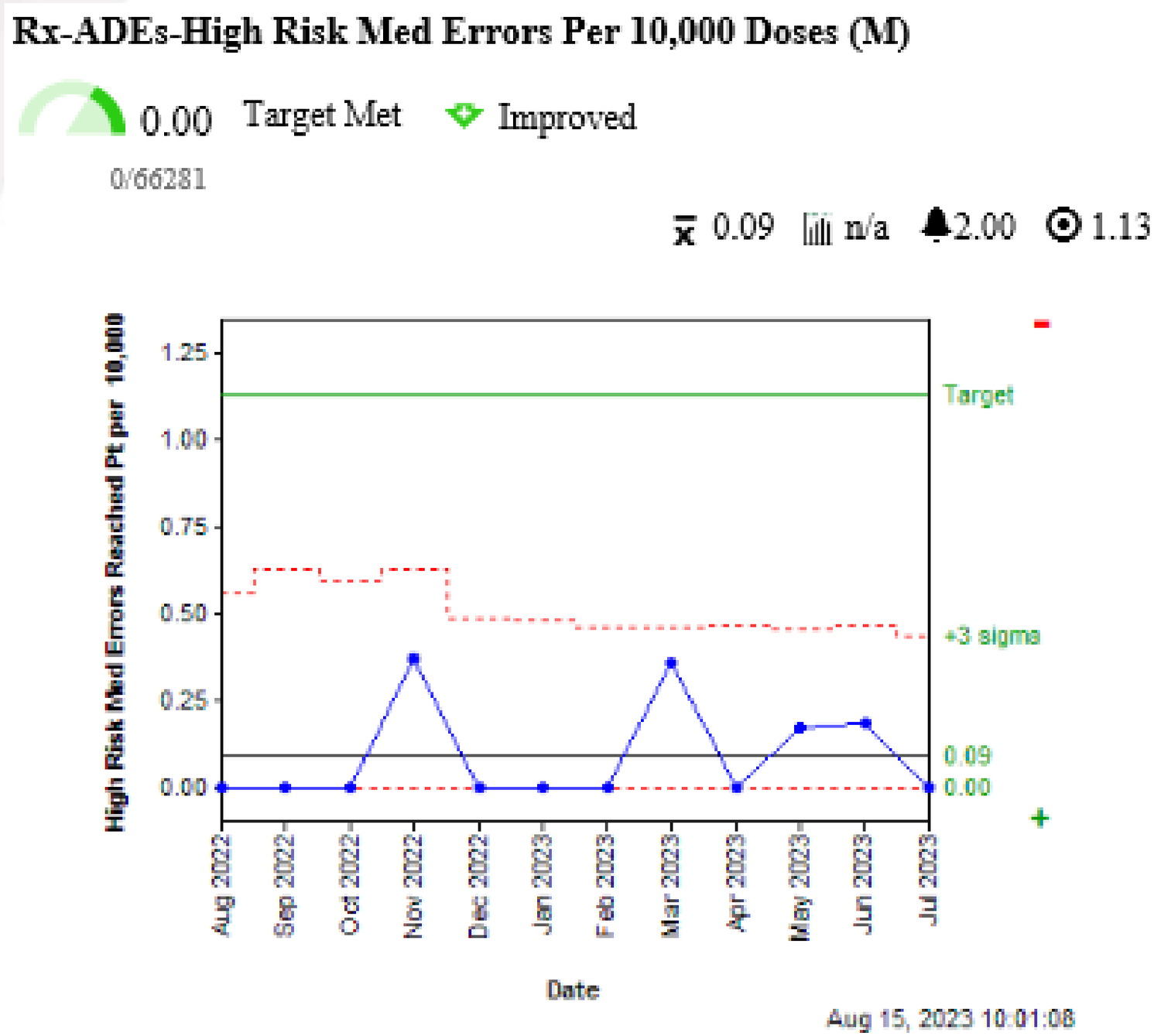

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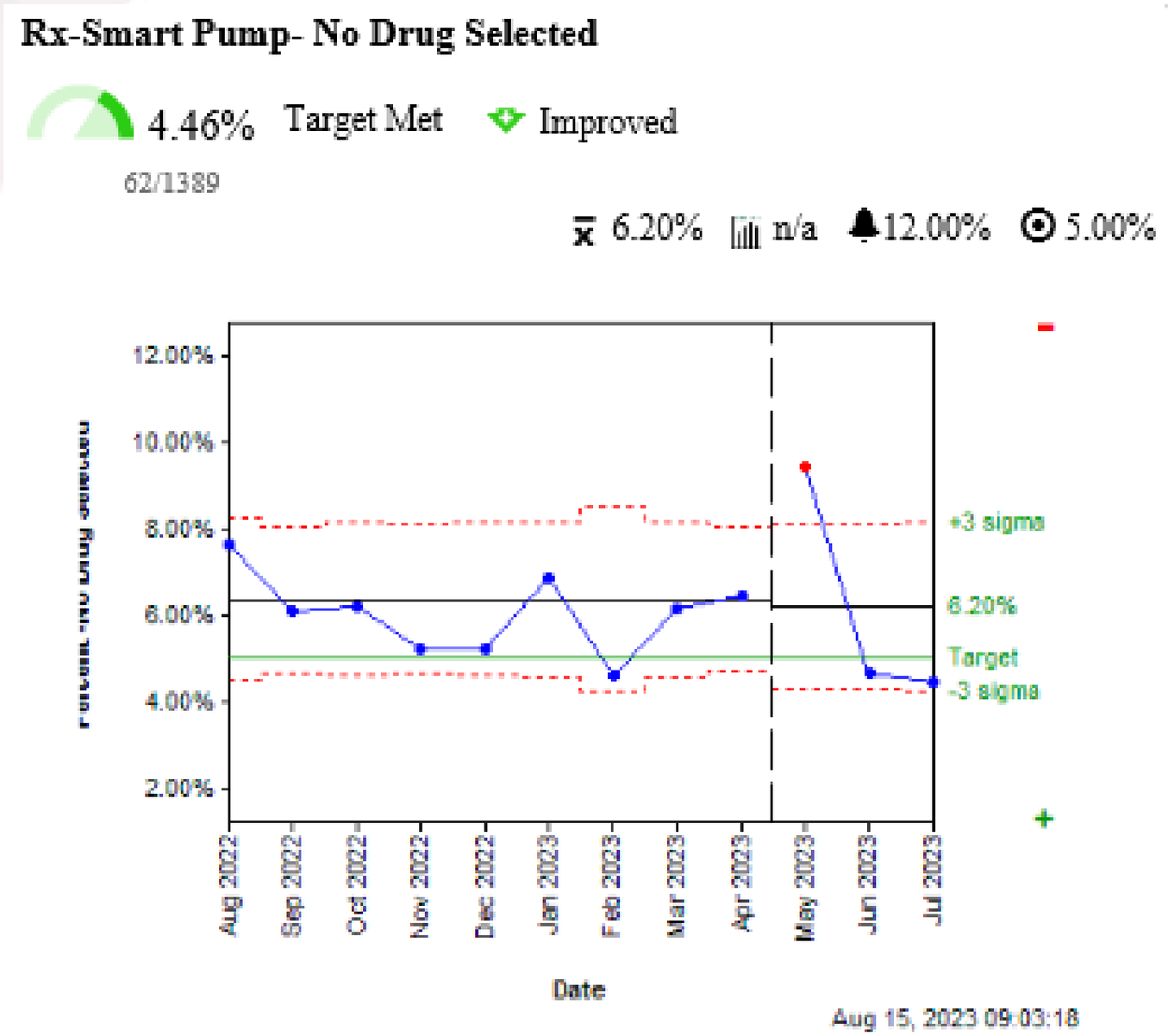

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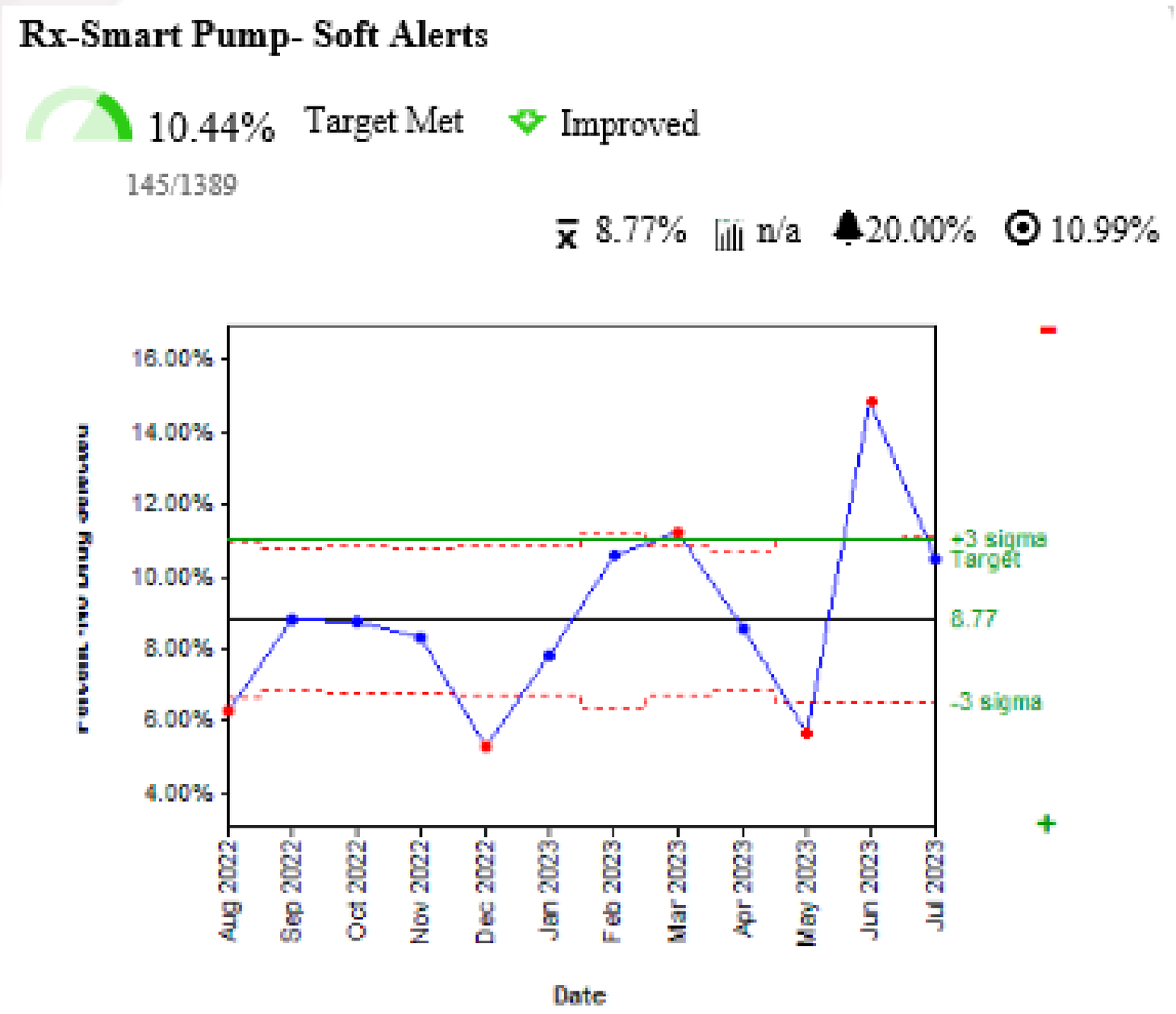

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Antimicrobial Stewardship

- Cefepime DOT
- Ertapenem DOT
- Levofloxacin DOT
- Meropenem DOT
- Pip-Tazo DOT
- Antimicrobial Spend PAPD ($)

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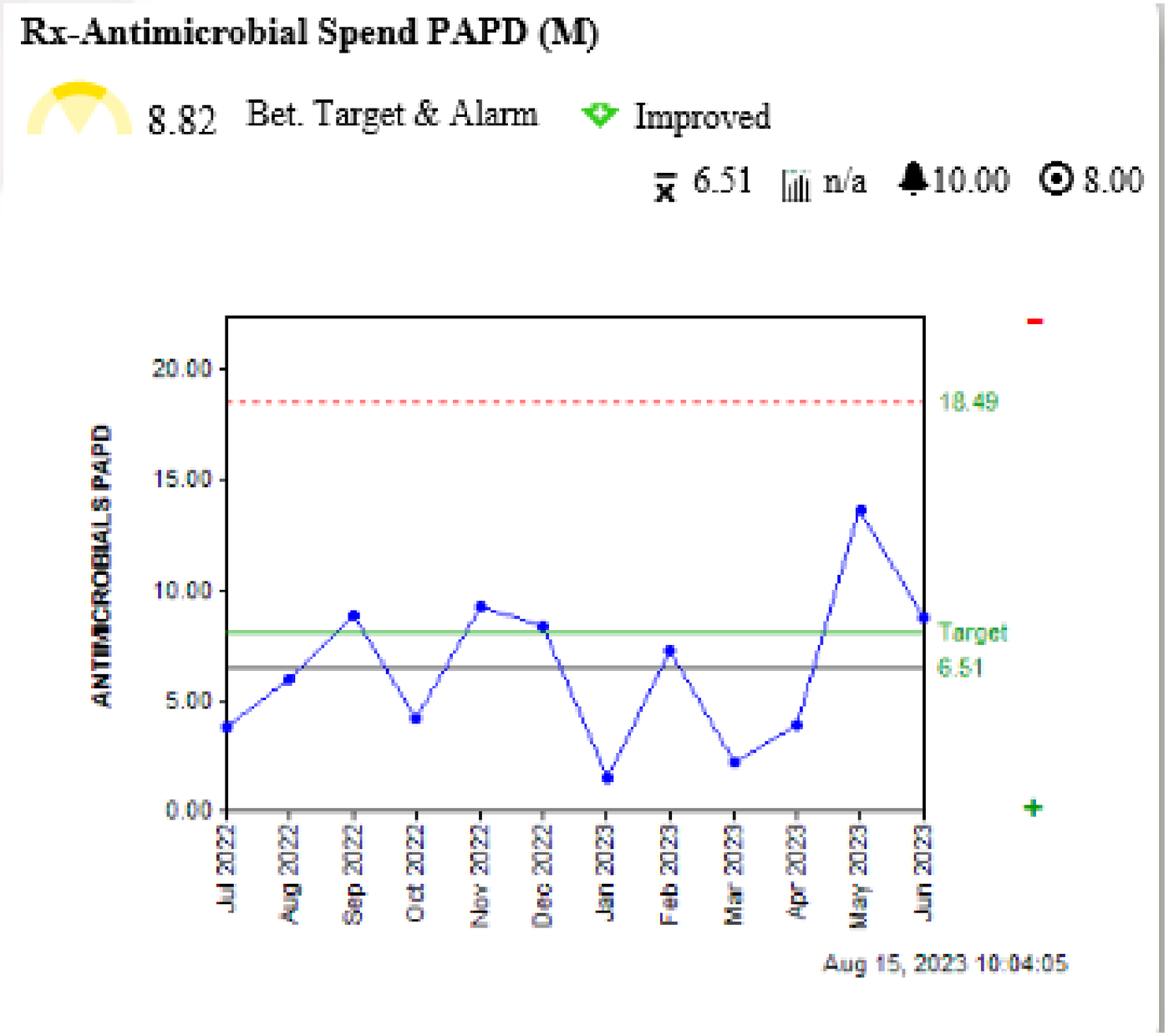

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Controlled Substances

- Controlled Substance Audit-Anesthesia
- Controlled Substance Audit-Inpatient
- C2 Safe Reconciliation
- Nursing Unit Pyxis Reconciliation

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Rx-Controlled Substance Audit-Anesthesia

Rx-Controlled Substance Audit-Inpatient

Med Description	Med Class	Drawer | Subdrawer | Pocket	Quantity	Additions to Stock	Deductions from Stock	Total Pyxis Beginning Inventor	Total Pyxis Ending Inventor	Actual Begin Count	End Count	Reconciliation Total
Atomoxetine 40mg for Rattay, Paul (PATIENTS OWN CONTROLLED DRUG 3) EA				62	62	0	0			0.00
cocaine (GOPRELTO) 40 mg/1 mL (4 mL) Bottle				1	1	2	2			0.00
Dexmethylphenidate 5mg for Rattay, Paul (PATIENTS OWN CONTROLLED DRUG 2) EA				192	192	0	0			0.00
fentaNYL 100 mcg/hr 72 Hour (DURAGESIC) Patch				0	0	4	4			0.00
				0	0	3	3			0.00
				1	1	2	2			0.00
				303	303	70	70			0.00
				30	26	20	24			0.00
				4	4	2	2			0.00

INVENTORY RECONCILIATION WORKSHEET FOR DATE RANGE:

Reconciliation Performed By (Signature):	Christopher Kutza
PIC Signature:	
Date/Time	4/5/2023 10:20am through 6/1/2023 09:08am

WORKSHEET INSTRUCTIONS

Data collection is based on a minimum 90-day look back period.
Enter data fields for the selected period below to determine % variance.
Investigate and resolve variances.
Enter findings/justification below.

DEFINITIONS

Starting Inventory	Inventory based on known physical inventory
Units Purchased	Additions to inventory based on purchase history reports and invoices, including acquisition from wholesaler, 340B, other entities, direct, etc.
Units Distributed / Utilized	Deletions from inventory based on distribution reports
Units Returned	Additions to inventory based on records of returns to the pharmacy
Units Removed to the Expired / Unusable Inventory	Deletions from inventory based on expired medications
Recorded Sales /Transfers	Deletions from inventory based on documentation of sales / transfer to entities outside hospital
Calculated Inventory based on Records	Starting Physical Inventory + Purchases - Utilization + Returns - Outdates and Transfers

CONTROLLED SUBSTANCE INVENTORY CONTROL AUDIT WORKSHEET

Drug Description	Starting Physical Inventory Count 4/5/2023	Units Purchased	Units Distributed / Utilized	Units Compounded In-House	Units Delivered to Clinics	Units Returned to the Physical Inventory	Units Removed to the Expired Inventory	Units Sold or Transferred	Calculated Inventory based on Records	Ending Physical Inventory Count 6/1/2023	% Variance
Belladonna and Opium 60mg supp	0	0	0	0	0	0	0	0	0	0	
Cocaine 4% soln	2	1	1	0	0	1	1	0	2	2	0.00%
Dextroamphet-Amphet 10mg tab	94	0	0	0	0	0	0	0	94	94	0.00%
Fentanyl 100mcg patch	4	0	1	0	0	0	0	0	3	3	0.00%
Fentanyl 1000mcg/20ml vial	42	0	14	0	0	0	0	0	28	28	0.00%
Fentanyl 12mcg patch	2	0	0	0	0	0	0	0	2	2	0.00%
Fentanyl 25mcg patch	3	0	1	0	0	0	0	0	2	2	0.00%

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Pharmacy Department

IV Room

- Cleanroom Certification
- Cleanroom Contact Plates
- Cleanroom End Product Testing
- Cleanroom Glovetip Testing
- Cleanroom Hood Cleaning
- Cleanroom Quantitative Analysis
- Cleanroom Room Cleaning-Daily
- Cleanroom Room Cleaning-Weekly
- Cleanroom Written Competencies

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USP 797

- Changes in how we use different hoods
- Changes in training requirements
- Changes in competency requirements

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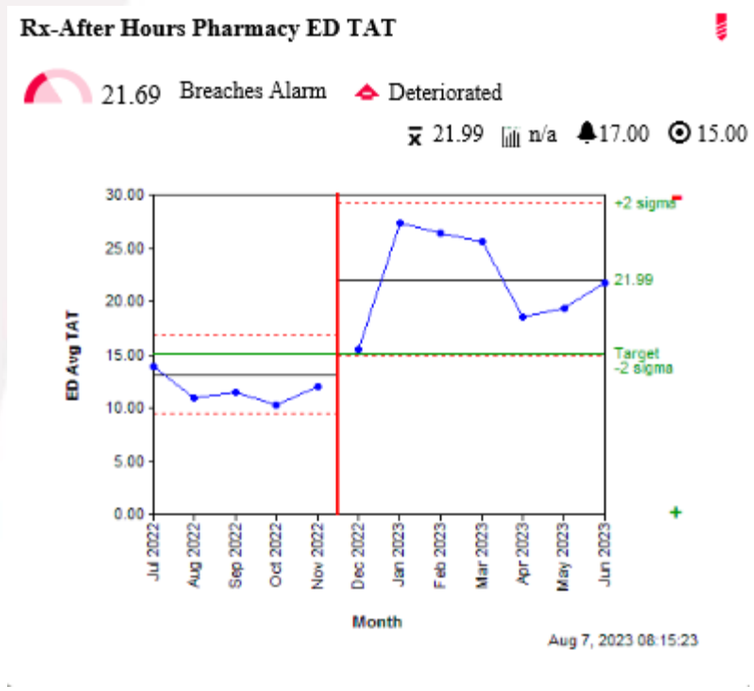
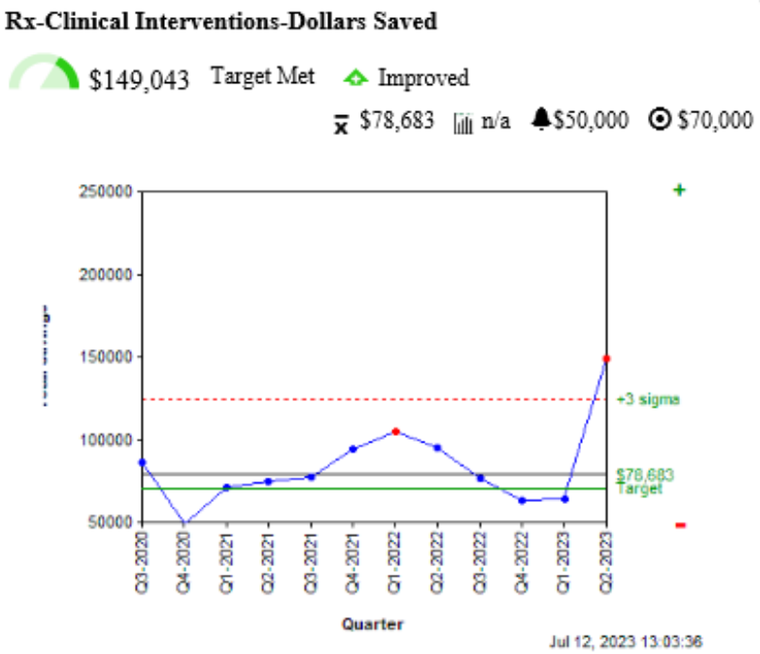
Pharmacy Services

- After Hours Interventions
- After Hours Pharmacy ED TAT
- After Hours Pharmacy Errors
- Clinical Interventions-Dollars Saved





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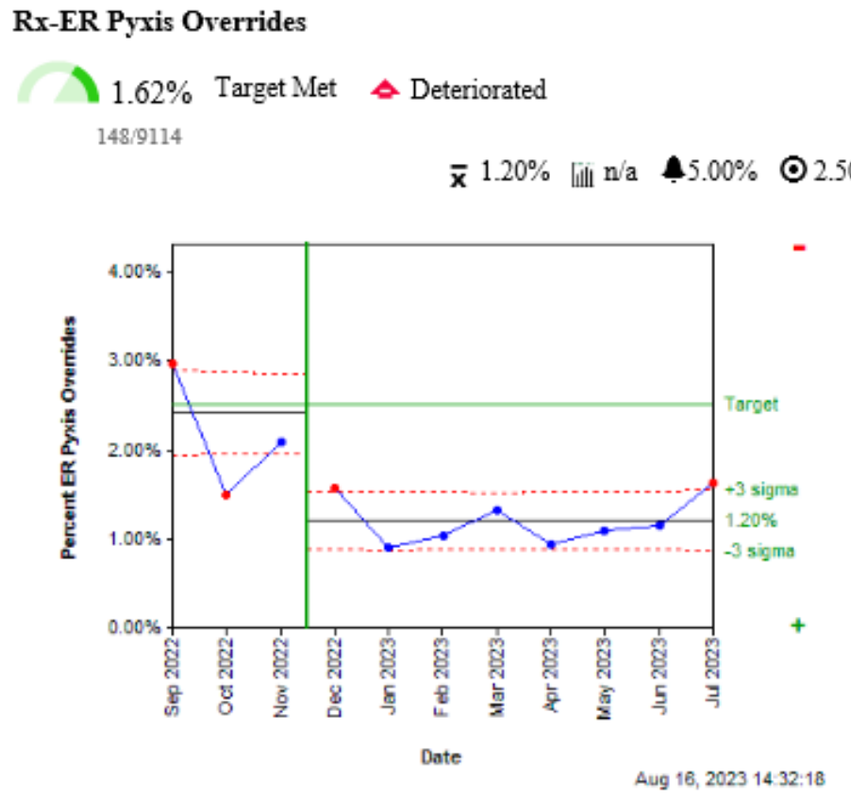
Pyxis

- ER Pyxis Overrides
- Pyxis Overrides
- Pyxis Stockouts



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Quality Indicator Performance & Plan

August Board Quality

Data for July 2023

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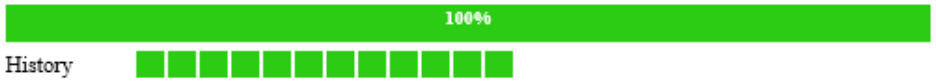
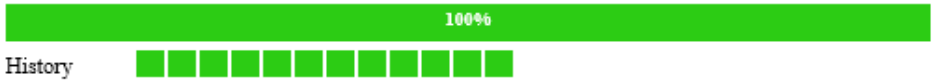
Mortality

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
Acute Care Mortality Rate (M)								
	Target Met	2.2% 1/46	Deteriorated	Jul 2023	15.3%	n/a	n/a	2.7%
COPD Mortality Rate |M|								
	Target Met	0.0% 0/2	No Change	Jul 2023	8.5%	n/a	n/a	0.0%
Congestive Heart Failure Mortality Rate |M|								
	Target Met	0.0% 0/1	No Change	Jul 2023	11.5%	n/a	n/a	0.0%
Pneumonia Mortality Rate |M|								
	Target Met	0.0% 0/2	No Change	Jul 2023	15.6%	n/a	n/a	4.5%
Ischemic Stroke Mortality Rate |M|								
	Target Met	0.0% 0/1	No Change	Jul 2023	13.8%	n/a	n/a	0.0%
Hemorrhagic Stroke - Mortality Rate (M)								
	Target Met	0.0% 0/1	No Change	Jun 2023	0.0%	1.0%	n/a	16.7%

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
Sepsis, Severe - Mortality Rate (M)								
	Target Met	0.0% 0/2	No Change	Jul 2023	25.0%	n/a	n/a	2.6%
Septic Shock - Mortality Rate (M)								
	Target Met	0.0% 0/1	No Change	Jul 2023	25.0%	n/a	n/a	14.8%

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 0/0.007	No Change	Jul 2023	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	Jul 2023	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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Adverse Events Reporting

- Zero Adverse events including Pre-Op/Post Op discrepancies, adverse events from Anesthesia or operative adverse events

Indicator	Performance	Most Recent	Trend	Period				
Adverse Event | SE (M) volume								
100% History	Target Met	0	No Change	Jul 2023	0	1	n/a	0

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Blood Products

Lab | Transfusion Effectiveness (M) 	Target Met	100.0% 4/4	No Change	Jul 2023	100.0%	99.0%	n/a	98.0%
Lab | Transfusion Reaction (M) 	Breaches Alarm	2.2% 1/45	Deteriorated	Jul 2023	0.0%	1.0%	n/a	0.6%

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Significant Medication Errors and Adverse Drug Reactions

- No Adverse Drug Reactions

Indicator	Performance	Most Recent	Trend	Period				
Rx-ADEs-High Risk Med Errors Per 10,000 Doses (M)								
100% History	Target Met	0.00 0/66281	Improved	Jul 2023	1.13	2.00	n/a	0.09
Rx-Administration Errors Per 10,000 Doses Dispensed								
100% History	Target Met	0.15 1/66281	Improved	Jul 2023	1.00	3.00	n/a	0.30

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Patient Falls

Preventable Harm

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
RM ACUTE FALL- All (M) per 1000 patient days								
	Target Met	0.00 0/183	— No Change	Jul 2023	3.75	4.00	n/a	1.61
RM ACUTE FALL- WITH INJURY (M) per 1000 patient days								
	Target Met	0.00 0/183	— No Change	Jul 2023	3.75	4.00	n/a	0.00

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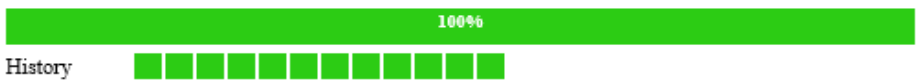
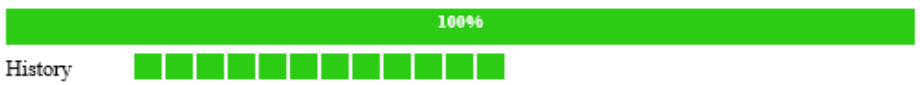
Readmissions

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
30-DV Inpatients - % Readmit to Acute Care within 30 Days (M)								
	Target Met	4.55% 2/44	Improved	Jul 2023	15.30%	15.50%	n/a	5.44%
COPD, CMS Readm - % Readmit within 30 Days, ACA (M)								
	Target Met	0.0% 0/1	No Change	Jul 2023	19.5%	20.0%	n/a	9.4%
HF, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)								
	Target Met	0.0% 0/1	No Change	Jul 2023	21.6%	22.0%	n/a	0.0%
Hip/Knee, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)								
	Target Met	0.0% 0/1	No Change	Jul 2023	4.0%	5.0%	n/a	6.7%
PNA, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)								
	Target Met	0.0% 0/1	No Change	Jul 2023	16.6%	17.0%	n/a	5.0%
Sepsis, Severe - % Readmit within 30 Days (M)								
	Target Met	0.0% 0/2	No Change	Jul 2023	12.0%	13.0%	n/a	0.0%
Septic Shock - % Readmit within 30 Days (M)								
	Target Met	0.0% 0/1	No Change	Jul 2023	13.3%	14.0%	n/a	0.2%

Blood Culture Contamination

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔
Blood Cultures -Contamination Rate |LAB| (M)						
	Target Met	1.3% 1/76	Improved	Jul 2023	3.0%	4.0%
Blood Cultures -Total Contamination Rate (M)						
	Target Met	1.8% 3/170	Improved	Jul 2023	3.0%	4.0%
Blood Cultures -Contamination Rate |RN| (M)						
	Target Met	2.2% 2/89	Improved	Jul 2023	3.0%	3.1%

Month	RN-Contaminated Culture Reports (num)	Blood Cultures Drawn by RN (den)	Percent
Jul 2023	2	89	2.2%
Jun 2023	3	98	3.1%
May 2023	1	111	0.9%
Apr 2023	7	104	6.7%
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%

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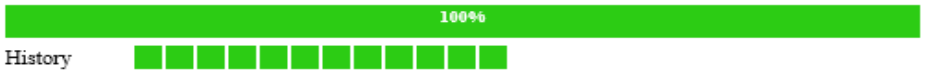
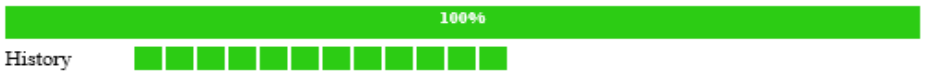
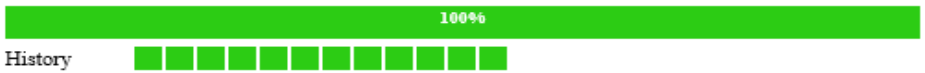
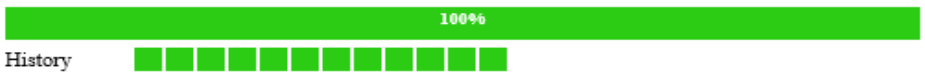
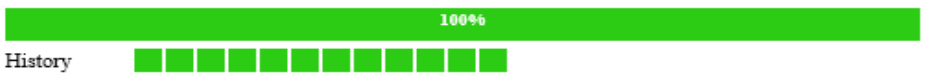
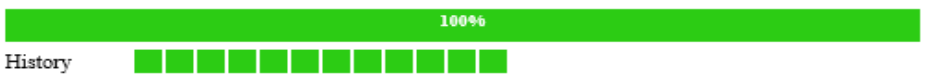
CIHQ Stroke Certification Measures

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
CDSTK-03|Median- Code Stroke Called |M| elapsed time (mins)								
	Target Met	2	Improved	Jul 2023	10	11	n/a	2
CDSTK-04|Median- Door to Phys Eval |M| minutes								
	Target Met	1.50	Improved	Jul 2023	10.00	11.00	n/a	1.50
CDSTK-05|Median- Door to CT Scanner |M|elapsed time (minutes)								
	Target Met	5.50	Improved	Jul 2023	25.00	26.00	n/a	7.50
CDSTK-06|Median- Neuro Consult Contacted |M| minutes								
	Target Met	16.50	Improved	Jul 2023	30.00	31.00	n/a	16.00
CDSTK-07|Median- CT Read by Radiology |M| minutes								
	Target Met	22.50	Improved	Jul 2023	45.00	46.00	n/a	28.75
CDSTK-08|Median- Lab Results Posted |M| minutes								
	Target Met	17.00	Improved	Jul 2023	45.00	46.00	n/a	23.00
CDSTK-10|Median- Door to EKG Complete |M| minutes								
	Target Met	32.00	Improved	Jul 2023	60.00	61.00	n/a	35.25
CDSTK-11|Median-Door to tPA Decision |M| minutes								
	Target Met	33.50	Improved	Jul 2023	60.00	61.00	n/a	41.00
CDSTK-12|Median-Door to tPA |M| minutes								
	Target Undefined	n/a		Jul 2023	60.00	61.00	n/a	36.00

Utilization Management

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
1 Day Stay Rate Medi-Cal |M|								
	Target Met	0.00% 0/11	No Change	Jul 2023	2.61%	5.00%	n/a	1.89%
1 Day Stay Rate-Medicare |M|								
	Target Met	0.00% 0/33	No Change	Jul 2023	8.10%	10.00%	n/a	2.48%
Acute Care - Geometric Mean Length of Stay |M|								
	Bet. Target & Alarm	2.89 28.8687/10	Improved	Jul 2023	2.75	3.23	n/a	3.32
MS-DRG Case Mix Index (CMI) |M|								
	Breaches Alarm	1.33	Deteriorated	Jul 2023	1.55	1.40	n/a	1.41
MS-DRG Case Mix Index (CMI) MEDICARE |M|								
	Breaches Alarm	1.37	Deteriorated	Jul 2023	1.55	1.40	n/a	1.48

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	Jul 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	130.00	Deteriorated	Jul 2023	132.00	140.00	n/a	148.25

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
Core OP 22 ED LWBS Emergency Dept Left Without Being Seen (M)								
	Target Met	0.6% 5/825	Deteriorated	Jul 2023	2.0%	2.5%	n/a	1.1%

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
Core OP-23 - Head CT/MRI Results for STK Pts w/in 45 Min of Arrival (M)								
	Target Met	75.0% 3/4		Jul 2023	72.0%	70.0%	n/a	66.7%

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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	75.0% 3/4	Improved	Jul 2023	81.0%	80.0%	n/a	57.7%
SEPa - Severe Sepsis 3 Hour Bundle (M)								
	Target Met	100.0% 4/4	Improved	Jul 2023	94.0%	90.0%	n/a	82.3%
SEPb - Severe Sepsis 6 Hour Bundle (M)								
	Target Met	100.0% 4/4	Improved	Jul 2023	100.0%	90.0%	n/a	88.2%

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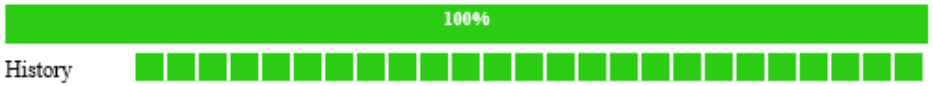
Infection Prevention

Indicator	Performance	Most Recent	Trend	Period				
IC-Surveillance| HAI-C.DIFF Inpatient infections per 10k pt days |M|								
	Target Met	0	No Change	Jul 2023	1	1	n/a	0
IC-Surveillance| HAI-CAUTI Inpatient infections per 10k patient days |M|								
	Target Met	0	No Change	Jul 2023	1	1	n/a	0
IC-Surveillance| HAI-CLABSI Inpatient infections per 10k patient days |M|								
	Target Met	0	No Change	Jul 2023	1	1	n/a	0
IC-Surveillance| HAI-MRSA Inpatient infections per 10k patient days |M|								
	Target Met	0	No Change	Jul 2023	1	1	n/a	0
IC-Surveillance| HAI-SSI infections per 10k pt days |M|								
	Target Met	0	No Change	Jul 2023	1	1	n/a	0
QA-02 | Hand Hygiene Practices Monitored |M|								
	Breaches Alarm	84% 132/158	Deteriorated	Jul 2023	90%	85%	n/a	79%

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CIHQ Corrective Action Plan Monthly Compliance Condition Level Findings

GL-04 | Condition Level Findings Reported to BQC |M|								
100% History	Target Met	100% 4/4	No Change	Jul 2023	100%	95%	n/a	100%
IC-03 | Hair Clippers and Base Clean |M|								
100% History	Target Met	100% 8/8	No Change	Jul 2023	90%	85%	n/a	98%
MM-24 | Pill Crushers Clean |M|								
100% History	Target Met	100% 12/12	No Change	Jul 2023	100%	95%	n/a	100%
QS-10 | Documentation: Continuous Observation of High Risk Pts |M|								
100% History	Breaches Alarm	20% 1/5	Deteriorated	Jul 2023	100%	95%	n/a	20%

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Patient Satisfaction

- HCAHPS reported Quarterly

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PressGaney

Monthly report (copy) INPATIENT

Generated: 8/17/2023 11:38 AM ET
Service Date Range: 4/1/2023 - 6/30/2023
Sonoma Valley Hospital - System (15704)

Inpatient

Questions	Top Box	n	STATE CA Score	All PG Database Score
*Rate hospital 0-10	64.91	57	72.01	70.24
*Recommend the hospital	74.55	55	72.89	69.31
***Comm w/ Nurses Domain Performance**	81.29	57	77.60	78.93
*Nurses treat with courtesy/respect	94.74	57	83.79	85.64
*Nurses listen carefully to you	73.68	57	75.18	76.44
*Nurses expl in way you understand	75.44	57	73.84	74.75
***Response of Hosp Staff Domain Performance**	68.15	50	62.67	63.61
*Call button help soon as wanted it	73.33	45	61.40	62.15
*Help toileting soon as you wanted	62.96	27	64.08	64.43
***Comm w/ Doctors Domain Performance**	86.71	56	78.50	79.27
*Doctors treat with courtesy/respect	92.86	56	83.83	85.46
*Doctors listen carefully to you	83.33	54	77.07	77.78
*Doctors expl in way you understand	83.93	56	74.61	74.57
***Hospital Environment Domain Performance**	59.59	57	62.62	65.81
*Cleanliness of hospital environment	74.55	55	72.94	72.13
*Quietness of hospital environment	44.64	56	52.29	59.44

PressGaney

Monthly report (copy) INPATIENT

Generated: 8/17/2023 11:38 AM ET
Service Date Range: 4/1/2023 - 6/30/2023
Sonoma Valley Hospital - System (15704)

Inpatient

Questions	Top Box	n	STATE CA Score	All PG Database Score
***Comm About Medicines Domain Performance**	56.99	34	61.80	60.27
*Tell you what new medicine was for	76.47	34	74.53	73.93
*Staff describe medicine side effect	37.50	32	49.07	46.59
***Discharge Information Domain Performance**	87.39	52	87.26	86.37
*Staff talk about help when you left	86.54	52	85.60	84.59
*Info re symptoms/prob to look for	88.24	51	88.92	88.17
***Care Transitions Domain Performance**	38.37	57	53.01	52.15
*Hosp staff took pref into account	33.33	57	47.15	46.43
*Good understanding managing health	38.60	57	52.38	51.37
*Understood purpose of taking meds	43.18	44	59.48	58.62

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PressGaney

Monthly report (copy) OAS

Generated: 8/17/2023 11:36 AM ET
Service Date Range: 4/1/2023 - 6/30/2023
Sonoma Valley Hospital - System (15704)

Ambulatory Surgery

Questions	Top Box	n	All PG Database Score	State of California Score
*Facility rating 0-10	87.30	126	87.99	85.79
*Recommend the facility	85.60	125	85.44	83.79
*Communication Domain Performance	93.07	128	92.18	90.21
*Provided needed info re procedure	94.44	126	92.52	90.86
*Instructions good re preparation	96.67	120	94.37	92.96
*Procedure info easy to understand	96.83	126	93.81	92.18
*Anesthesia info easy to understand	96.52	115	94.37	92.47
*Anes side effect easy to understand	80.87	115	85.87	82.54
*Facility/Personal Trtment Domain Performance	96.04	128	97.04	96.08
*Check-in run smoothly	92.06	126	95.44	94.07
*Facility clean	97.64	127	97.99	97.25
*Clerks and receptionists helpful	93.65	126	96.19	94.92
*Clerks and reception courteous	97.66	128	97.52	96.64
*Staff treat w/ courtesy, respect	98.44	128	98.10	97.48
*Staff ensure you were comfortable	96.80	125	96.99	96.10

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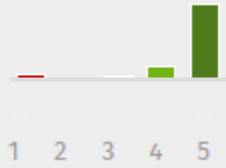
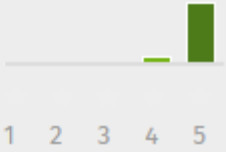
Ambulatory Surgery

Questions	Top Box	n	All PG Database Score	State of California Score
*Discharge Domain Performance	97.71	126	96.79	95.88
*Written discharge instructions	98.35	121	97.68	97.10
*Instructions regarding recovery	87.90	124	87.65	84.55
*Information re subsequent pain	100.00	107	98.43	97.91
*Information re subsequent nausea	100.00	95	98.45	97.84
*Information re subsequent bleeding	100.00	96	98.98	98.42
*Info on response to infection	100.00	94	99.55	99.41
Nurses Overall	91.18	125	89.36	87.45
Nurses concern for comfort	91.87	123	89.85	87.87
Info nurses gave to prep for proc	89.34	122	88.83	86.84
Nurses response concerns/questions	92.37	118	89.43	87.66
Care Provider Overall	80.30	123	84.22	80.17
CP explanation about proc	81.82	121	84.94	81.05
Info CP shared re how proc went	75.42	118	83.00	77.99
CP response to concerns/questions	82.76	116	86.84	83.40
CP expln why proc important	81.25	112	82.06	78.14
Staff worked together care for you	91.06	123	90.37	88.51

Rate My Hospital
Scale 1-5
July Data

Sonoma Valley Hospital / Emergency Department	87	4.513 95% CI: 4.442—4.584	
Sonoma Valley Hospital / Inpatient Care	6	4.881 95% CI: Not enough samples	

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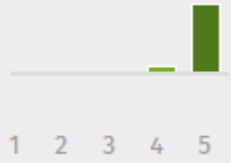
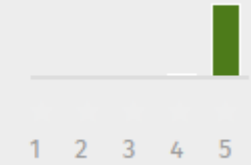
Rate My Hospital
Scale 1-5

Sonoma Valley Hospital / Medical Imaging	169	4.783 95% CI: 4.737—4.829	
Sonoma Valley Hospital / Hand and Physical Therapy	120	4.949 95% CI: 4.932—4.966	

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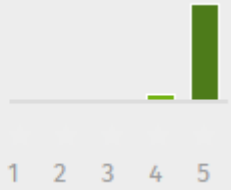
Rate My Hospital
Scale 1-5

Sonoma Valley Hospital / Outpatient Surgery	136	4.816 95% CI: 4.785—4.848	

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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: 08/17/2023 7:32 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: 20

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
Access to Patient Information for Medication Management *Medication Management Policies (MM)*	**Pending Approval**	8/17/2023	0

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

Adverse Drug Events-Quality Assurance *Medication Management Policies (MM)*	**Pending Approval**	8/17/2023	0

Summary Of Changes: **Minor formatting changes; updated date accessed for references; deleted obsolete reference link.**
Moderators: **Newman, Cindi (cnewman)**
Lead Authors: **Kutza, Chris (ckutza)**
ExpertReviewers: **Cooper, Kylie (kcooper)**
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)**

Approved Panel List 7500-04 *Clinical Lab Dept*	**Pending Approval**	8/17/2023	0

Summary Of Changes: **Edited current panels offered**
Added Definition of STAT, ROUTINE and BATCH
Added table of laboratory tests

This is being replaced to include TATs.
Moderators: **Newman, Cindi (cnewman)**
Lead Authors: **Ramos, Karen (kramos)**
Approvers: **Kuwahara, Dawn (dkuwahara) -> 01 P&P Committee - (Committee) -> 02 MS-Medicine Department - (Committee) -> 03 MS-Surgery Department - (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)**

Clozapine REMS Procedure 8390-08 | **Pending Approval** | 8/17/2023 | 0

Pharmacy Dept

Summary Of Changes: **Simplified instructions for registering on the REMS website to simply indicate following instructions on the website since they change on occasion**
Simplified step by step for accessing and confirming patient eligibility by referring to website as above.
Updated REMS phone number
Removed embedded attachments and added separate document attachment

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)**

Controlled Substance Distribution for Anesthesia | **Pending Approval** | 8/17/2023 | 0

Medication Management Policies (MM)

Summary Of Changes: **Updated language to remove obsolete portions of the process referring to the paper anesthesia record that are now electronic in Epic.**

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)**

Fentanyl Patch | **Pending Approval** | 8/17/2023 | 0

Medication Management Policies (MM)

Summary Of Changes: **Updated section on removal and disposal to reflect current practice using Epic**

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)**

Floorstock Medications | **Pending Approval** | 8/17/2023 | 0

Medication Management Policies (MM)

Summary Of Changes: **Clarified areas that are exempt from Profile Override process to include only OR and Medical Imaging to match current practice.**

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)**

Herbal and Natural Product Use | **Pending Approval** | 8/17/2023 | 0

Medication Management Policies (MM)

Summary Of Changes: **Reviewed, no changes. Need to update reviewer section to match current formatting standards**

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)**

High Alert Medications | **Pending Approval** | 8/17/2023 | 0

Medication Management Policies (MM)

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

Intravenous Contrast Admin — **Pending Approval** — 8/17/2023 — 0

Diagnostic Services Dept Policies

Summary Of Changes:	**Updated policy to include protocol language to meet CIHQ standards.** **" Administration of contrast and medications inherent to the examination will be in accordance with the procedures defined in this policy and following protocols used for contrast/medication administration that are based on the type of examination ordered and define the type, dose and route of contrast."** **"** **• The radiologist or LIP reviews the order for radiology procedures with IV contrast to determine and/or modify the appropriate protocol based on the clinical indications for the procedure and patient status. The assigned protocol is entered or indicated in the radiology information system (RIS) or electronic medical record (EMR).** **• For those procedures where a contrast protocol has been established and approved by the Pharmacy and Therapeutics Committee the technologist may administer the contrast, following the established protocol, using a protocol order."** **Added P&T Committee to list of approvers.**
Moderators:	**Newman, Cindi (cnewman)**
Lead Authors:	**Kutza, Chris (ckutza), Young, Dave (dyoung)**
ExpertReviewers:	**Kutza, Chris (ckutza), Medical Director-Diagnostic Radiology**
Approvers:	**Kuwahara, Dawn (dkuwahara) -> 01 P&P Committee - (Committee) -> 03 MS-Surgery Department - (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)**

Monitoring Medication Storage Temperature — **Pending Approval** — 8/17/2023 — 0

Medication Management Policies (MM)

Summary Of Changes:	**Reviewed with no changes; updated date accessed for reference**
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)**

NEW:: Transfusion Transmitted Infectious Disease Notification — **Pending Approval** — 8/17/2023 — 0

Laboratory Services Policies (LB)

Summary Of Changes:	**New to the portal. Policy was found in the department policies and is required for survey and CLIA. Approved by Medical Director in 2020. New: Clarification needed by Board Quality, changed verbiage from virus or parasite to infectious agent and added transfusion transmissible disease marker as well as disposition process of quarantined blood. Did not list all infectious diseases instead included most common.**
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) -> 02 MS-Medicine Department - (Committee) -> 03 MS-Surgery Department - (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)

Pharmacy and Therapeutics Committee	**Pending Approval**	8/17/2023	0
Medication Management Policies (MM)			

Summary Of Changes: **Claified language regarding conflict of interest to separate attachment from body of policy**

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)**

Placenta Disposition	**Pending Approval**	8/17/2023	0
Laboratory Services Policies (LB)			

Summary Of Changes: **Removed Birthplace and added ER.**
>>>>>>>>>Permission for Disposal and Release of Specimens:

- **No tissue may be released to a patient for disposal. (California Health and Safety Code 25157.3 and 25157.5). This is because of hazard of infections or potentially infectious material. If a patient requests to retain the placenta, pathology will only release to a mortuary of their choosing.**

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) -> 02 MS-Medicine Department - (Committee) -> 03 MS-Surgery Department - (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)**

Remote Pharmacist Services	**Pending Approval**	8/17/2023	0
Medication Management Policies (MM)			

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

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)**

Sterile Compounding Procedures 8390-03	**Pending Approval**	8/17/2023	0
Pharmacy Dept			

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

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)**

Surge Planning-Pharmacy	**Pending Approval**	8/17/2023	0
Emergency Preparedness Policies (EP)			

Summary Of Changes: **Made formatting changes; updated list of 503b suppliers to what we are currently using.**

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

Lead Authors: **Kutza, Chris (ckutza), Winkler, Jessica (jwinkler), MANAGER, ED (edmanager)**

Approvers:	**00 Clinical P&P multidisciplinary review -> 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)**			

Vaccine Screening-Pneumococcal and Influenza	**Pending Approval**	8/17/2023	0
Medication Management Policies (MM)			

Summary Of Changes:	**Reviewed, no changes. Please note that the title in the portal is "Vaccine Screening-Pneumococcal and Influenza" whereas the title of the acutal policy is "Influenza Vaccine Screening"**
Moderators:	**Newman, Cindi (cnewman)**
Lead Authors:	**Kutza, Chris (ckutza)**
ExpertReviewers:	**Taylor, Jane (jtaylor)**
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)**

Vancomycin Protocol	**Pending Approval**	8/17/2023	0
Medication Management Policies (MM)			

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

Warming Fluids for IV and Irrigation Purposes, Storage and Handling	**Pending Approval**	8/17/2023	0
Medication Management Policies (MM)			

Summary Of Changes:	**Reviewed, no changes. Deleted attachment embedded in policy and uploaded appropriate documents to portal**
Moderators:	**Newman, Cindi (cnewman)**
Lead Authors:	**Kutza, Chris (ckutza)**
ExpertReviewers:	**Cornell, Kelli (kcornell)**
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)**

SUBJECT: Transfusion Transmitted Infectious Disease Notification	POLICY: LB#8610-138 Page 1 of 5
DEPARTMENT: Organizational	EFFECTIVE: 03/2020
REVISED~~: 02/2023~~:	

NEW POLICY
policy was filed under the Laboratory's department policies and is not in the policy portal. It should be an organizational policy.

WHY:

Policy is required for accreditation and CLIA

OWNER:
Chief Ancillary Officer

AUTHORS/REVIEWERS:
Laboratory Manager
Laboratory Medical Director

SUBJECT: Transfusion Transmitted Infectious Disease Notification	POLICY: LB#8610-138 Page 2 of 5
DEPARTMENT: Organizational	EFFECTIVE: 03/2020
REVISED~~: 02/2023~~:	

PURPOSE:

This policy describes the process for investigating transfusion transmitted infectious disease when information is received after the time of donation that may affect the safety to any donor blood or recipient. Transmission-transmitted infections are predominantly acquired by the transfusion ~~of a virus or parasite~~of an infectious agent, in which a delay generally occurs between transfusion and manifestation of symptoms and signs of infection.

POLICY:

All transfusion transmitted infectious disease agents~~s~~ will be investigated and notification is made to recipients who may have been exposed to a transfusion transmissible disease agent from a blood transfusion.

PROCEDURE:

Blood Productions may be quarantined, returned, or destroyed upon notification by the blood supplier for a variety of reasons. A biological recall indicates the product was incorrectly collected or processed. A market withdrawal is associated with a product that has been delivered to the consignee but now additional information on the donor makes the product unsuitable for transfusion. A traceback is initiated when the supplier finds a donor to have a transfusion transmissible disease agent and contacts the consignees to determine the disposition of past donations from this donor, possibly going back years. Once the process is initiated the response is similar in all cases.

Traceback/Lookback involves:

- Tracking and identification of the location and disposition of blood component products that were manufactured from donations by a particular donor.
- The steps taken to track and quarantine unsuitable blood or blood components.
- The notification of consignees when a previous donor subsequently tests positive for ~~the~~ an ~~most~~ infectious disease marker~~s~~.

Recipient Traceback Notifications

Investigation is conducted to notify recipients who may have been exposed to a transfusion transmissible disease marker from a blood transfusion. Most commonly, confirmatory test is positive for one of the following:

1. Anti-Human Immunodeficiency Virus (HIV)-1
2. Anti-HIV 2
3. HIV Nucleic Testing (NAT)
4. Anti-Hepatitis C Virus (HCV)
5. HCV NAT

HIV TRACEBACK ("LOOKBACK")

When the supplemental (additional, more specific) test for HIV is positive or when the screening test is reactive and there is no available supplemental test that is approved for such use by FDA, the blood bank must notify transfusion recipients of previous collections of blood and blood components at increased risk of transmitting HIV infection, or the recipient's physician of record, of the need for recipient HIV testing and counseling. The blood bank must also notify the recipient's physician of record, or a legal representative or relative if the recipient is a minor, deceased, judged incompetent by a State Court, or if the recipient is competent but State Law permits a legal representative or relative to receive information on behalf of the recipient. Reasonable attempts must be made to perform the notification within 12 weeks after receiving the supplemental test evidence of HIV infection from VITALANT BLOOD SERVICES. (Blood Bank Service).

HCV Traceback ("Lookback")

Requirements are similar for notification for HCV with the exception that notification is not required for patients who are deceased.

A. Recipient Traceback ("Lookback") Notification is received from VITALANT BLOOD SERVICES when:
    - Subsequent to market withdrawal for one of the markers specified above now with a confirmatory test of positive.
    - Donor of a distributed product has an infection requiring traceback.
B. The Blood Bank Clinical Lab Scientist assigned at the time will look up the following and log in Transfusion Transmitted Infectious Disease Investigation Log:
    - Date
    - Donor Identification Number and Component
    - Patient Name
    - Patient Medical Record Number
    - Physician taking care of the patient
C. Quarantine in date blood and blood components as directed on bottom shelf in refrigerator if available. The Blood Bank Service will notify the Lab regarding the disposition of the quarantined blood whether it be destroyed or returned.

D. If confirmatory results are pending, the letter is filed under pending confirmation. If all testing is complete, go to step F.
E. If test is negative, no further action is required. If test is positive, continue to step F.
F. File screen and confirmation together under "Confirmed"
G. Send HIV/HCV Lookback Notification Form to the physician. Reasonable attempts will be made to contact the recipient with 12 weeks. Document date/time for all attempts made to contact appropriate party.
H. When form is returned, note date responded on log.
I. Make a copy for our records and send original Lookback Notification form to Medical Records for patient's chart.
J. File form in "Returned Forms" area of binder.
K. Complete Traceback Recipient Status form with as much information as possible. This form needs to be returned within 60 days. Make a copy for our files, send original to Donor and Client Support Center. If VITALANT BLOOD SERVICES does not received the form back within 60 days, they will send a second (and FINAL) notice for which a response is required in 30 days.

NOTE:

In the event the provider refuses or otherwise fails to notify recipient or is no longer at the facility, the lab will notify the patient. For non-HIV and non-HCV notification letters from VITALANT BLOOD SERVICES, refer the letter to the pathologist who will determine if notification is necessary.

REFERENCES:

Standards for Blood Banks and Transfusion Services 33rd Edition. April 2022
Code of Federal Regulations (CFR) Requirements for HIV/HCV Lookback Requirements

OWNER:
Chief Ancillary Officer

AUTHORS/REVIEWERS:
Laboratory Manager
Board Quality Committee

SUBJECT: Transfusion Transmitted Infectious Disease Notification	POLICY: LB#8610-138 Page 5 of 5
DEPARTMENT: Organizational	EFFECTIVE: 03/2020
REVISED~~: 02/2023~~:	

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