SVHCD QUALITY COMMITTEE

AGENDA

WEDNESDAY, January 24, 2024

5:00 p.m. Regular Session

Held in Person:

SVH Administrative Conference Room

To Participate Via Zoom Videoconferencing
use the link below:
https://sonomavalleyhospital-org.zoom.us/j/97397094695

Meeting ID: 973 9709 4695
One tap mobile
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AGENDA ITEM	RECOMMENDATION	
In compliance with the Americans with Disabilities Act, if you require special accommodations to attend a District meeting, please contact the Interim Board Clerk, Stacey Finn, at sfinn@sonomavalleyhospital.org or 707.935.5005 at least 48 hours prior to the meeting.		
MISSION STATEMENT *The mission of the SVHCD is to maintain, improve, and restore the health of everyone in our community.*		
1. CALL TO ORDER/ANNOUNCEMENTS	*Kornblatt Idell*	
2. PUBLIC COMMENT SECTION *At this time, members of the public may comment on any item not appearing on the agenda. It is recommended that you keep your comments to three minutes or less. Under State Law, matters presented under this item cannot be discussed or acted upon by the Committee at this time. For items appearing on the agenda, the public will be invited to make comments at the time the item comes up for Committee consideration.*	*Kornblatt Idell*	
3. CONSENT CALENDAR • Minutes 12.06.23	*Kornblatt Idell*	Action
4. ED QA/PI	*Winkler*	Inform
5. PATIENT CARE SERVICES DASHBOARD Q4	*Winkler*	Inform
6. WORKPLACE VIOLENCE PROGRAM	*McKissock*	Inform
7. QUALITY INDICATOR PERFORMANCE & PLAN	*Cooper*	Inform
8. POLICIES AND PROCEDURES	*Cooper*	Inform
9. CLOSED SESSION: a. Calif. Health & Safety Code §32155: Medical Staff Credentialing & Peer Review Report	*Kornblatt Idell*	Action
10. ADJOURN	*Kornblatt Idell*	

SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
December 6, 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 Judith Bjorndal, MD Howard Eisenstark, MD Ingrid Sheets, EdD, MS, RN		Michael Mainardi, MD Kathy Beebe, RN PhD	Jessica Winkler, DNP, RN, NEA-BC, CCRN-K, CNO Kylie Cooper, RN, BSN, CPHQ, MBA, Quality and Risk Mgmt. Dawn Kuwahara RN BSN, Chief Ancillary Officer Jane Taylor, RN, Director of Patient Care Services David Young, Director of Imaging John Hennelly, CEO Sujatha Sankaran, MD Chief Medical Officer Stacey Finn, Medical Staff Manager David Chambers, community member

AGENDA ITEM	DISCUSSION	ACTION
1. CALL TO ORDER/ANNOUNCEMENTS	*Kornblatt Idell*	

	Meeting called to order at 5:00 pm. Ms. Kornblatt Idell reported the resignation of the Board Clerk. Ms. Finn will be filling in until a permanent replacement is found. She also reported that workplace violence will be presented at next month's meeting. Ms. Kornblatt Idell spoke about how the Board of Directors values the input from community, staff and committee members. She said input is critical to fulfilling our healthcare mission. To continue with ongoing community engagement the January meeting will be held in person at the Hospital. There will remain a Zoom option for staff and community members.	
2. PUBLIC COMMENT	*Kornblatt Idell*	
	None	
3. CONSENT CALENDAR	*Kornblatt Idell*	ACTION
• QC Minutes 10.25.23		**MOTION:** by Bjorndal to approve, 2nd by Eisenstark. All in favor.
4. 2024 Quality Committee Work Plan	*Kornblatt Idell*	ACTION
	Ms. Kornblatt Idell presented the draft 2024 work plan.	**MOTION:** by Speizer to recommend approval by the Board, 2nd by Eisenstark. All in favor.
5. IN PATIENT SERVICES QA/PI	*Taylor*	INFORM
	Ms. Taylor presented In Patient services QA/PI – The key topics in the quality assurance plan were: • Nursing plan of care- compliance reported at 86.7% • Antibiotic Administration – compliance reported at 92.66% • Surgical Drian Removal – compliance reported at 100%. This metric will be replaced with hand hygiene in 2024.	

	• Respiratory Medication – compliance reported at 89.1% In 2024 the focus for QA/PI will be: • Individualized care plans • Nursing education upon discharge • Hand Hygiene • Patient mobility Process improvements for 2024 Age friendly Health System – Geriatric 4 Ms project (What Matters, Medications, Mentation, and Mobility). Epic Optimization – new PI projects utilizing EPIC reports and data collection processes.	
5. PATIENT CARE SERVICES DASHBOARD Q3	*Winkler*	INFORM
	Ms. Winkler presented the quarter three patient care services dashboard. • Medication scanning rates met all the goals with the ED being the outlier. • Quality Indicators (QAPI) 2023 met all the goals except for continuous observation for Psych patients in the ED. • Drug administration – met the goals. • Case Management – met the goals. • Nursing turnover – met the goals. • Patient Experience – All departments with the exception of the ED met the targets	
6. IMAGING QA/PI	*Young*	INFORM
	Mr. Young reported on the 2023 Quality measures for Imaging. • CT Tube Quality Control – Continues to have opportunities for improvement. • Contrast Extravasation/Reactions met the goals except for the month of November. The fall out was related to two patients in one week with reactions. • Wrong Site/Side – All of the months met the target except for November.	

	• Repeat Analysis – All months were within the goal of <5%. • MRI Safety – All months met the goal. • CT Dose Tracking – All months met the goal. The 2023 Performance Improvement goals were met. • Stroke – Door to CT <25 min • Stroke – Door to Radiologists Report <45 min CIHQ Quality measures were met. • Contract Protocols • Albuterol Orders	
7. QUALITY INDICATORS PERFORMANCE & PLAN	Cooper	
	Ms. Cooper reported the metrics for October. Mortality – was at 1.3%, one death of a medically complicated patient. Pt Safety – There were no events, all targets met. Blood Products – Transfusion effectiveness had one fall out of the hemoglobin not being rechecked and one transfusion reaction. Readmission One readmission, which was an improvement on the previous month. Blood culture contamination showed improvement. CIHQ Stroke Certification measures were all met. Utilization Management – Average length of stay had a slight increase but remained improved. Core Measures – ED arrival to departure time showed significant improvement. This is directly related to the new ED physician group and their improved processes and engagement. The Outpatient CT w/in 45 minutes of arrival had one fall out. This was due to the initial clinical presentation not being a clear stroke. Sepsis Core Measures had one fall out because a Lactate was not ordered.	

	Infection Prevention - No hospital acquired infections. Hand hygiene continues to be worked on and is showing improvements. CIHQ corrective action plan – The hair clippers and pill crushers will fall off the monitoring because we have continuously met the target for six months. Continuous observation of high-risk patients continuously have opportunities for improvement. Patient Satisfaction – Mr. Winkler reviewed the various domains of in-patient and ambulatory satisfaction. Several showed higher scores than the state and national scores. Rate My Hospital Scores for October were 4.6 out of 5 stars for ED, In Patient was 4.88 out of 5. Medical Imaging was at 4.86. Hand and Physical Therapy was at 4.95. Outpatient surgery was at 4.89.	
7. POLICIES AND PROCEDURES	*Cooper*	INFORM
	Summaries of changes were reviewed for the following policies: Access to Medication when the Pharmacy is closed. Clinical nursing procedures Critical care transport Hoyer lift Labeling medications on and off sterile field Medication Reconciliation Medication shortages Pharmaceutical Representatives Post procedure instructions procedure Pregnant patients Rapid sequence intubation (RSI) kit Renal dosing Pharmacy protocol REITRE – Antimicrobial Stewardship Monitoring Procedure RETIRE – MRI, patient preparation. REITRE – Scheduling biopsies procedure	

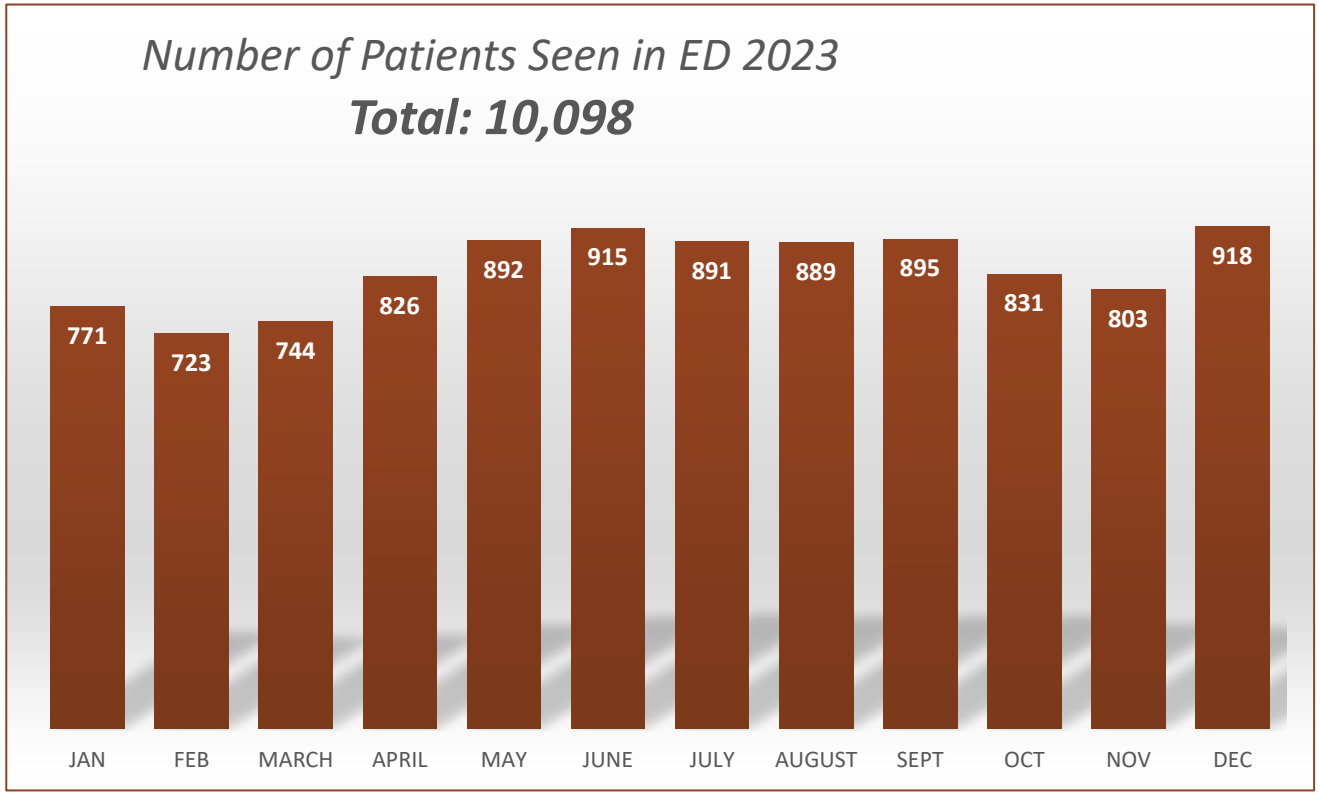
	RETIRE – Scribes in the Emergency Department Scheduling procedures The committee accepted all the policies as presented and recommended for Board approval.	
8. CLOSED SESSION/REPORT ON CLOSED SESSION	*Kornblatt Idell*	ACTION
a. Calif. Health & Safety Code §32155: Medical Staff Credentialing & Peer Review Report	Ms. Finn presented the Medical Staff Credentialing for review and approval.	**MOTION:** by Eisenstark to approve, 2nd by Speizer. All in favor.
9. ADJOURN.	*Kornblatt Idell*	
	Meeting adjourned at 6: 09p.m.	

Emergency Department
Report to the Board Quality

JANUARY 2024

JESSICA WINKLER, DNP, RN, NEW-BC, CCRN

ED Volume: 2023



Admits: 8.64% (*n*=872)

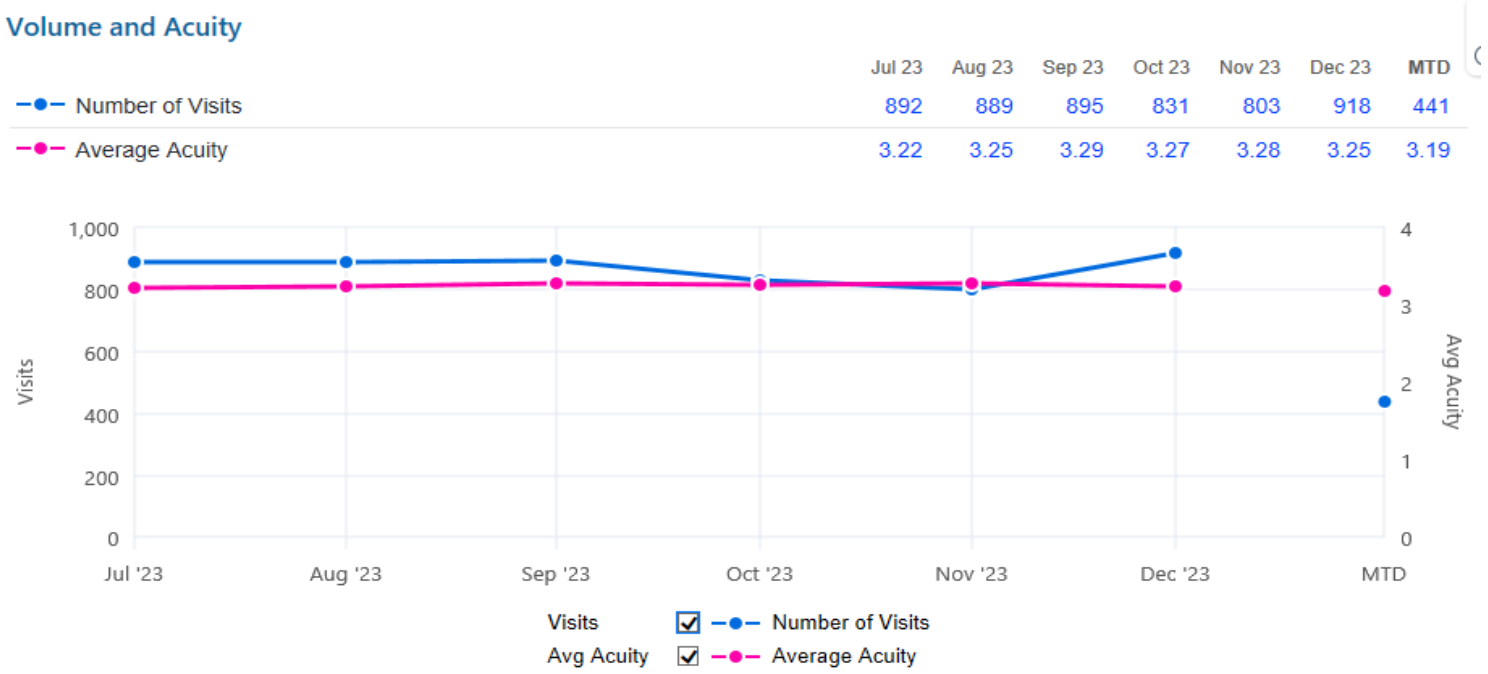
Transfer to Higher Level of Care (HLOC): 7% (*n*=750)

Left Without Being Seen(LWBS): 2% (*n*=226)

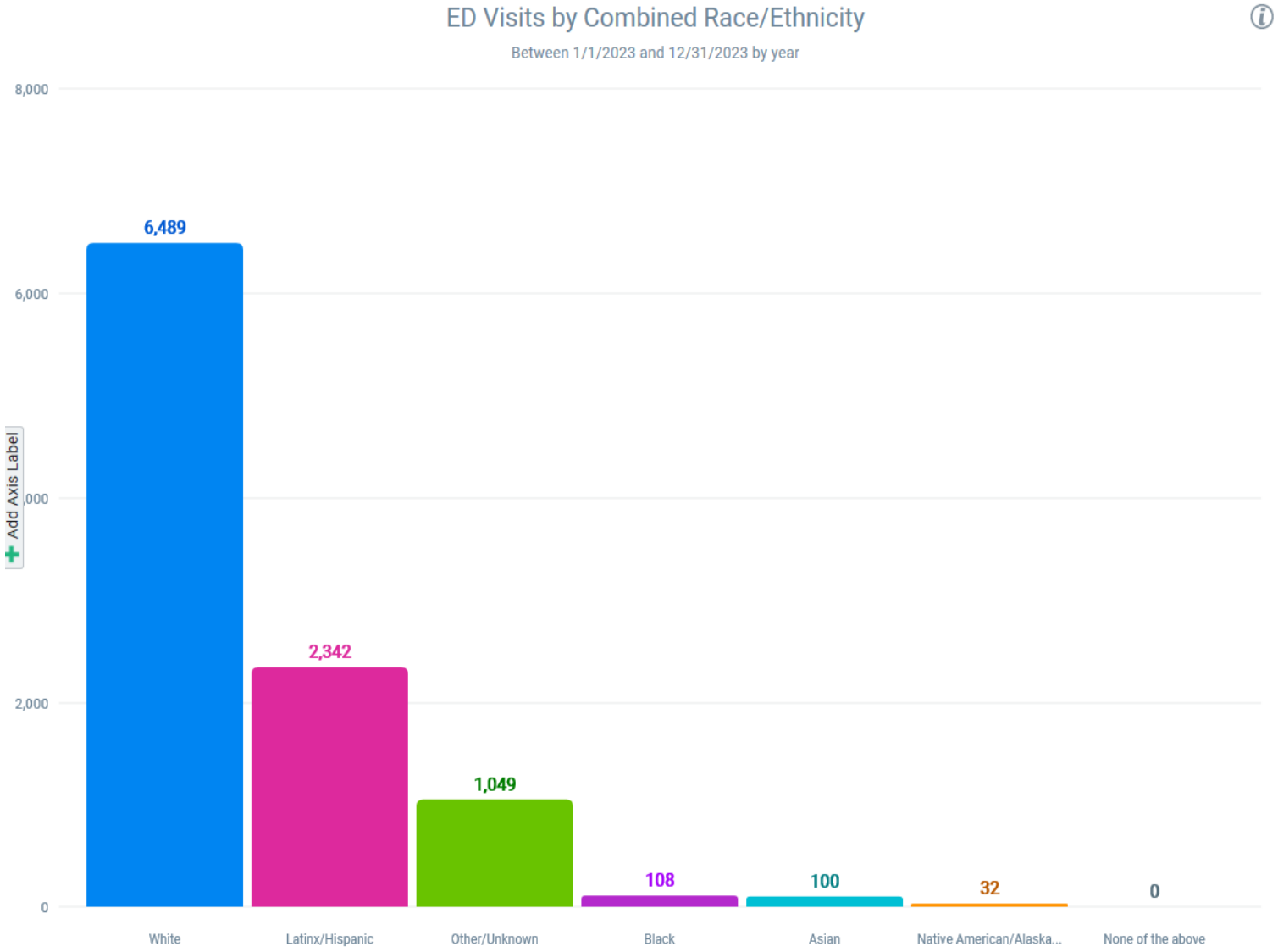
Against Medical Advice (AMA): 1% (*n*=87)

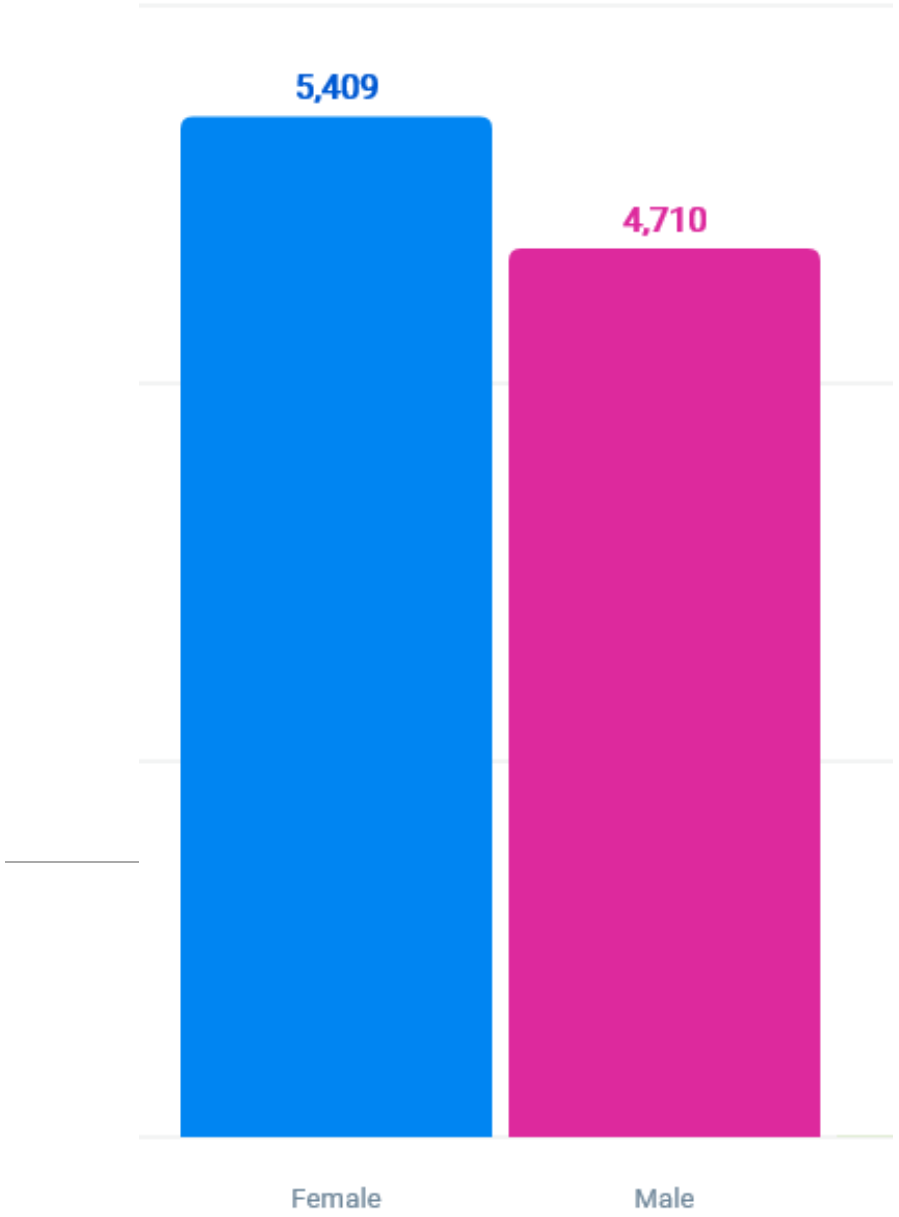
Who We See: Acuity

Emergency S Index

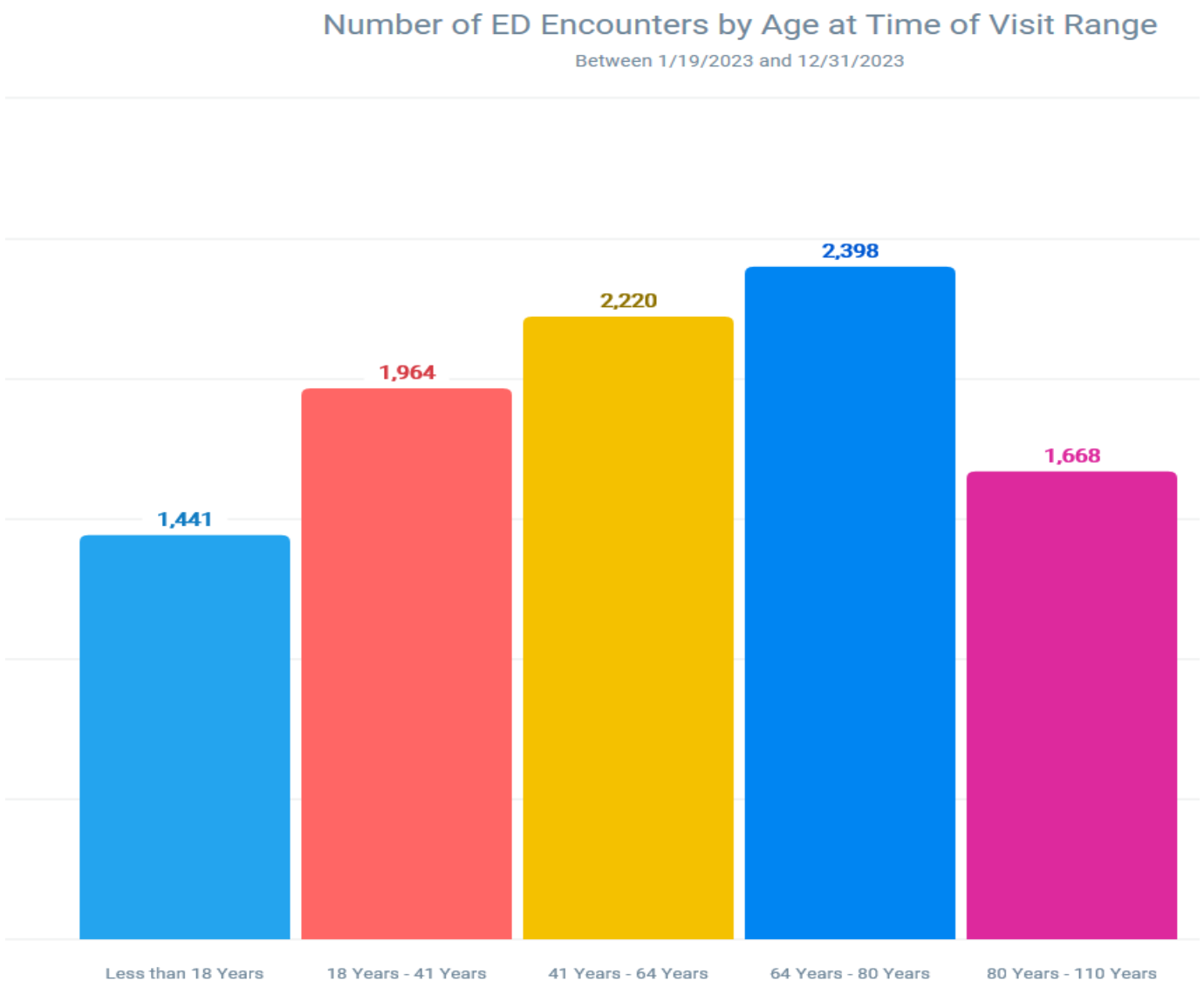


Who We See: Common Diagnoses



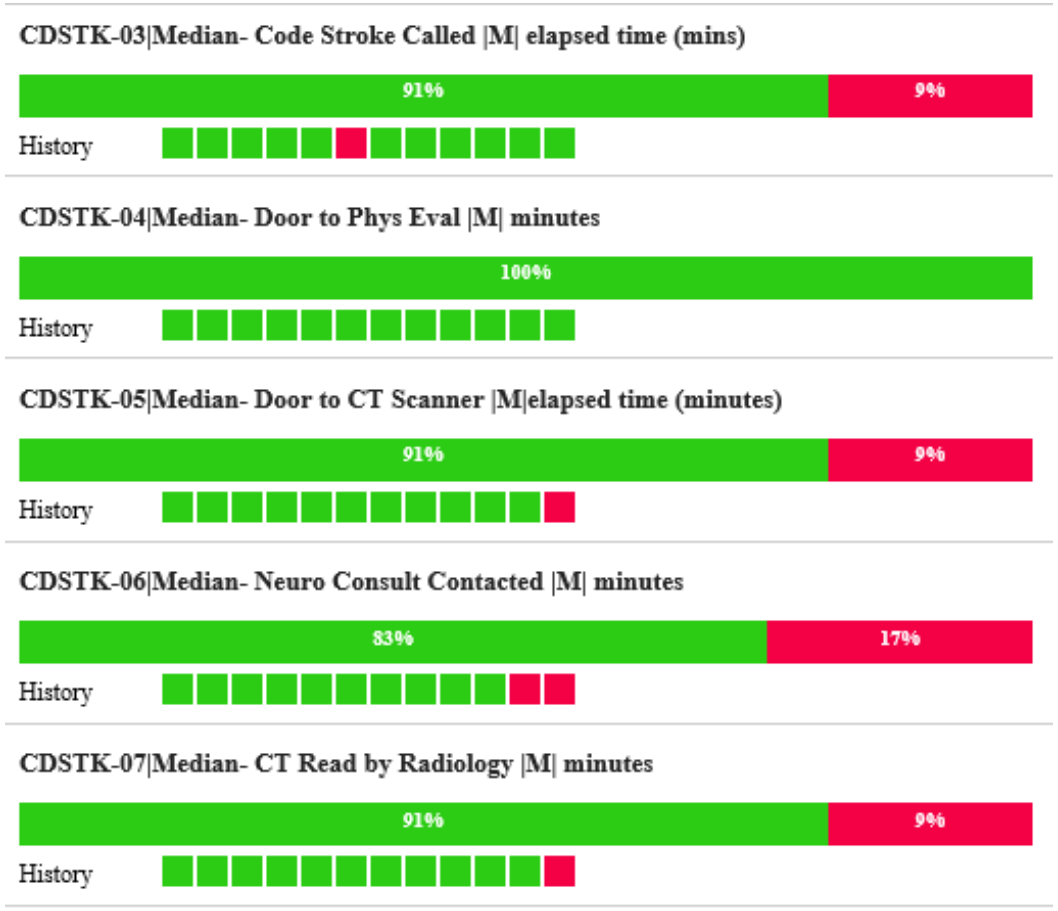


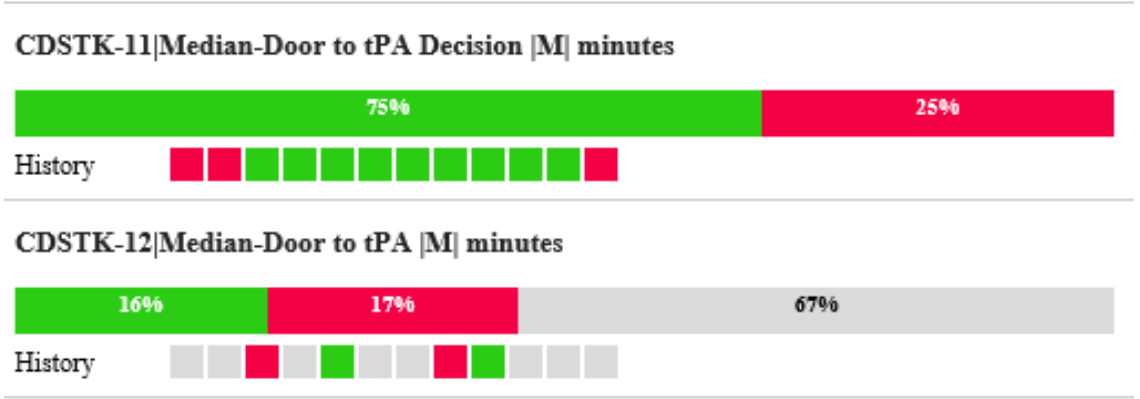
WHO WE SEE: DEMOGRAPHICS



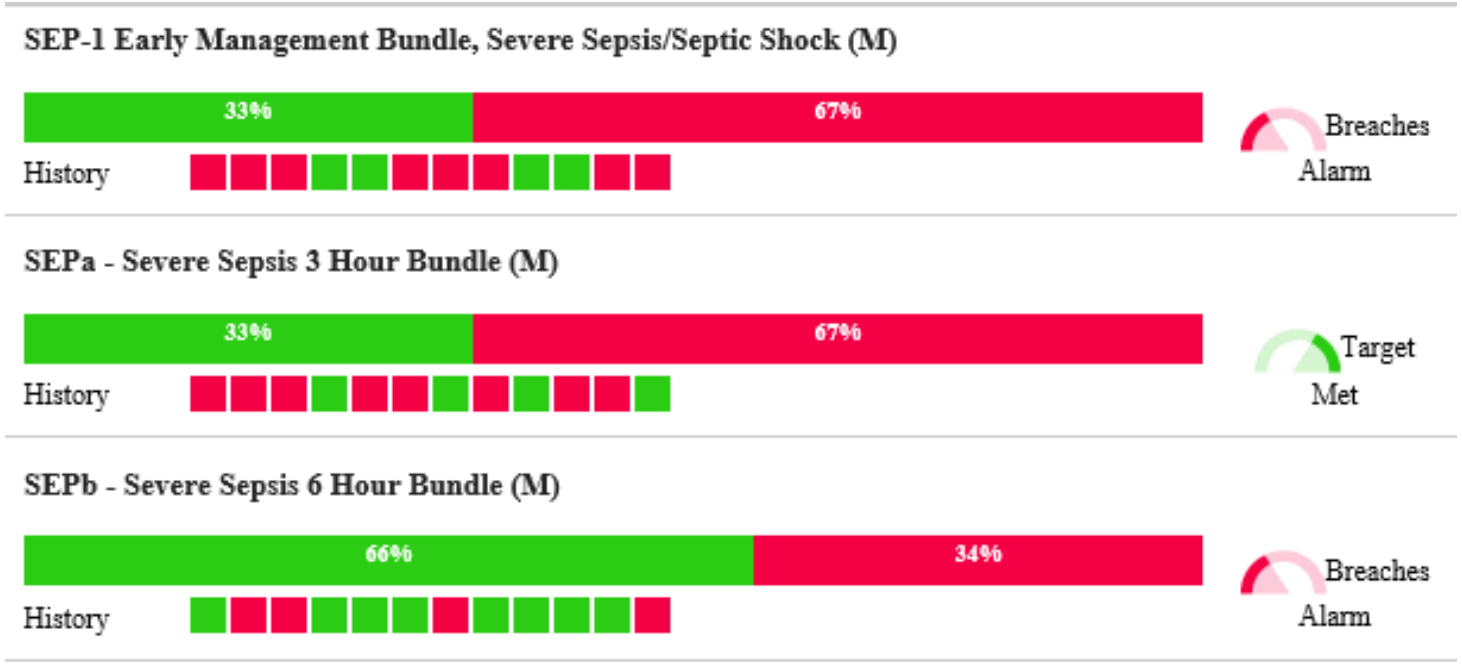
Who We See: Demographics

QAPI: Stroke 2023

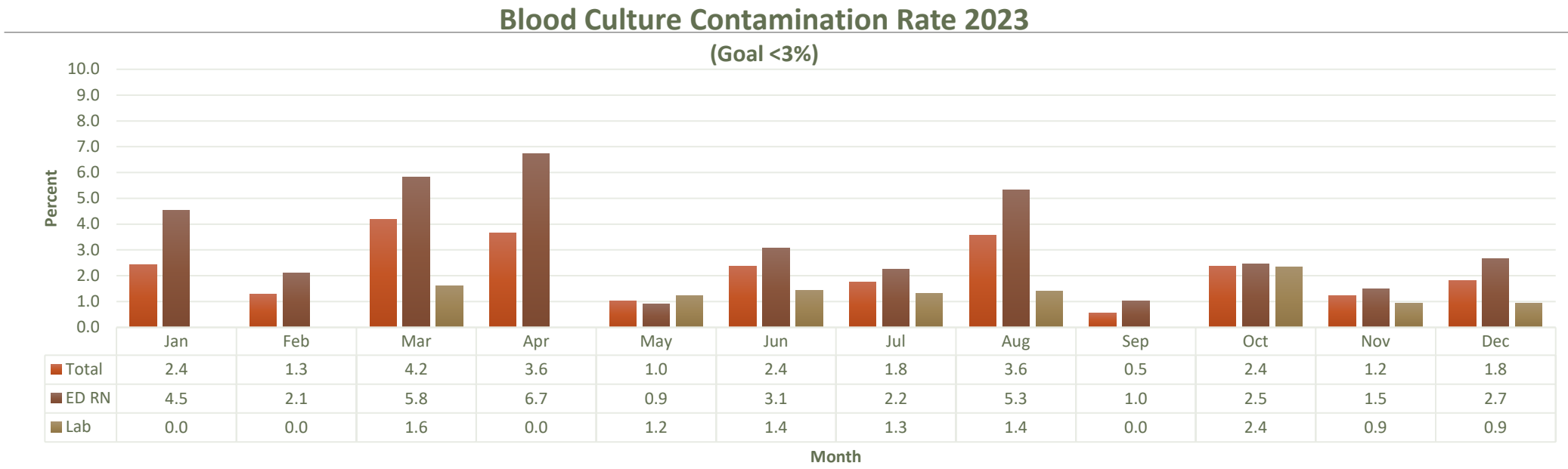




QAPI: Sepsis Bundles 2023



QAPI: Blood Culture Draws 2023



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Total	2.4	1.3	4.2	3.6	1.0	2.4	1.8	3.6	0.5	2.4	1.2	1.8
ED RN	4.5	2.1	5.8	6.7	0.9	3.1	2.2	5.3	1.0	2.5	1.5	2.7
Lab	0.0	0.0	1.6	0.0	1.2	1.4	1.3	1.4	0.0	2.4	0.9	0.9

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Total Blood Cultures Processed	166	156	167	192	193	168	170	168	186	212	245	219	**2242**
Total Contamination Rate (percent)	***2.4***	***1.3***	***4.2***	***3.6***	***1.0***	***2.4***	***1.8***	***3.6***	***0.5***	***2.4***	***1.2***	***1.8***	***2.1***
Blood Cultures Drawn by ED RN Staff	88	95	103	104	111	98	89	94	97	122	134	112	**1247**
Contaminated Culture Reported	4	2	6	7	1	3	2	5	1	3	2	3	**39**
ED RN Contamination Rate (percent)	*4.5*	*2.1*	*5.8*	*6.7*	*0.9*	*3.1*	*2.2*	*5.3*	*1.0*	*2.5*	*1.5*	*2.7*	***3.1***

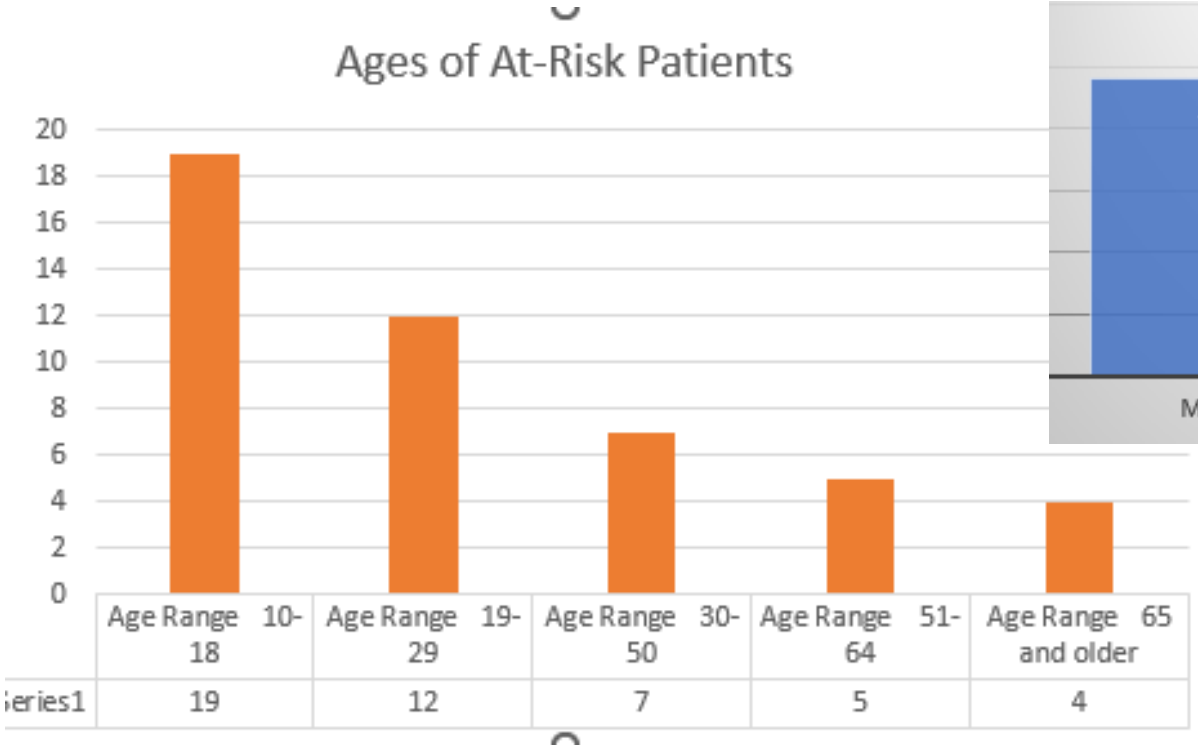
QAPI: Documenting Observation of High-Risk Patients
May – December 2023

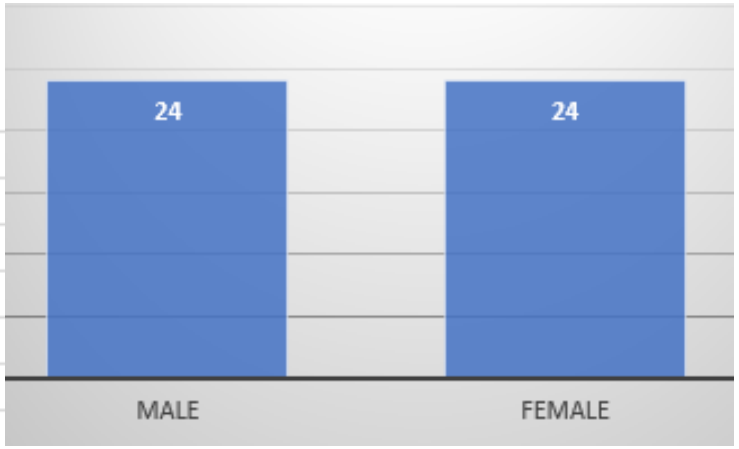
48 patients needing continuous observation for safety

Evenly Distributed between Male/Female

Age range: **12 – 74**

LOS in ED: 3hours – 7 days

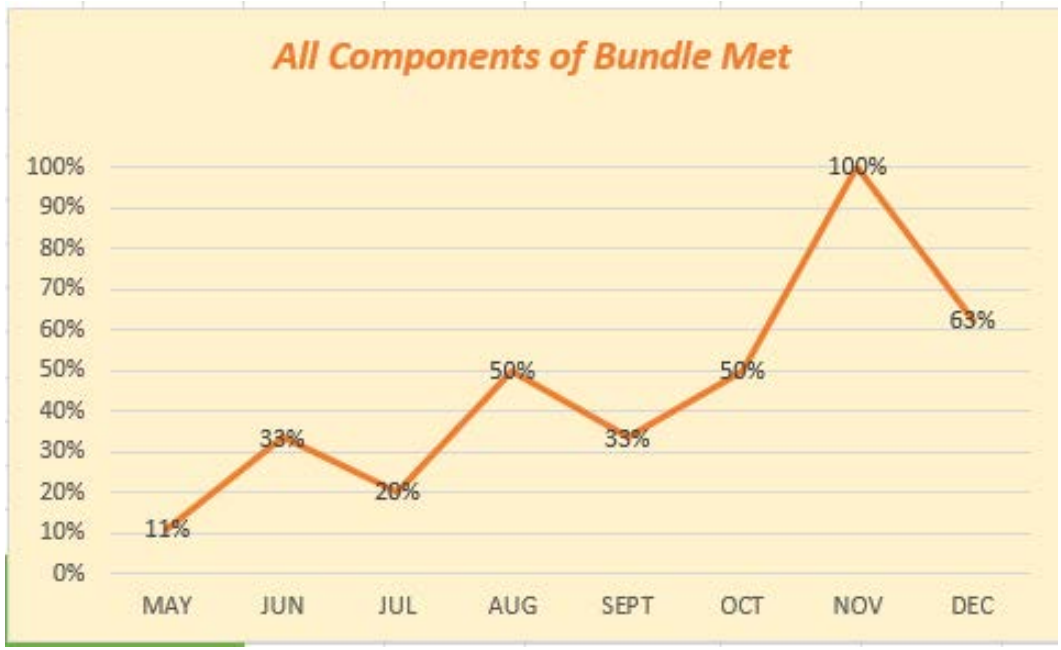


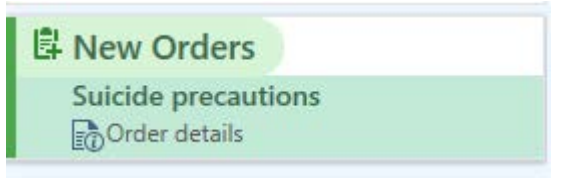


QAPI: Documenting Observation of High-Risk Patients

Recommendations from CIHQ findings

Created an audit bundle consisting of 3 components: MD order, finding and utilizing specific flow sheet, documenting every hour or more





	1145	1200	1215
Suicide-Psych Observations			
Type	q 15 min checks	q 15 min checks	Other (Com…
Reasons for Observation	Suicide precauti…	Suicide precauti…	Suicide precauti…
Behavior	Compliant	Compliant	Compliant
Affirms Safety	Yes	Yes	Yes
Mental Status	Oriented X3	Oriented X3	Oriented X3
Answers Questions	Yes	Yes	Yes
Activity/Location	In room	In room	In room
RN/Therapist Assessment q2h	Done	Done	Done
RN/Therapist Assess Next Due			
RN/Therapist Only			
Thought Process	Organized	Organized	Organized
Thought Content	Non-psychotic	Non-psychotic	Non-psychotic
Mood	Euthymic	Euthymic	Euthymic

Process Improvement:
Left Without Being Seen - 2023

Process Improvement:

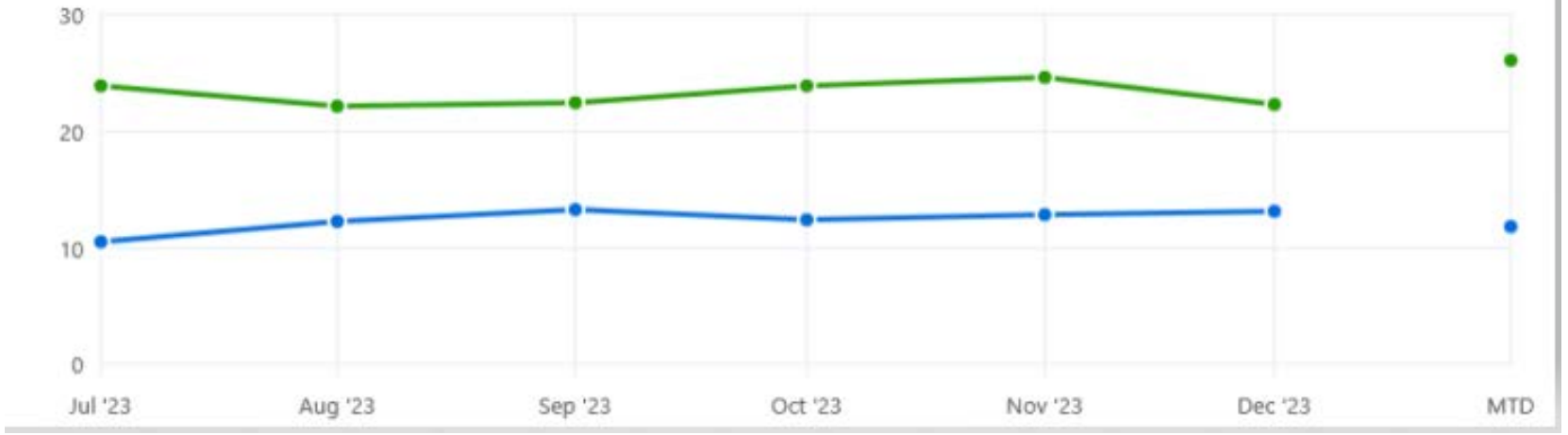
Median time from Arrival to Triage Goal: <10 mins

Median time from Arrival to MD: Goal: <35 mins – but our goal is 10minutes!

Median time from Arrival to being placed in ED Room: Goal: <30 mins

If we can get the entire process started sooner, perhaps people would be more willing to wait

	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	MTD
Arrival to Triage Start	10m	12m	13m	12m	12m	13m	11m
Arrival to Provider	23m	22m	22m	23m	24m	22m	26m
Arrival to Roomed	5m	6m	8m	10m	9m	10m	9m



Process Improvement

Defining	Defining the role of the Triage RN
Changing	Changing the workflow – and culture – of the Triage and Resource RNs
Implementing	Implementing NIOs- Nurse Initiated Orders.

2023 Challenges

- Epic Implementation
  - Learning the new system
  - How to document to have valid data
- New ED MD Group
  - New expectations, ideas, and goals
  - Workflow changes
- Nursing Director

2024 Aims

- Continue improving quality metrics
  - Stroke, Continuous Obs, Sepsis,
- Focus on Epic data input/output
  - Time stamps
- Focus on LWBS
  - Engage Registration team
  - NIOs
- Workgroup on throughput
  - Triage—ED Care – Inpatient Admission
  - Triage – ED Care -- Transfer

Where We've Been and Where We're Going!

Medication Scanning Rate	2023				
	Q1	Q2	Q3	Q4	Goal
Inpatient (ICU/MS)	95%	96%	96%	96%	≥90%
Pre/Post Op	98%	94%	96%	97%	≥90%
ED	80%	78%	83%	84%	≥90%
Preventable med errors R/T Med Scanning	0	0	2	0	≤2

Quality Indicators (QAPI) 2023					
	Q1	Q2	Q3	Q4	Goal
Antibx admin within 30"- M/S and ICU	91%	93%	94%	92%	≥90%
Cont. OBS for Psych Pt-ED**New Bundle Q2, May-June	100%	20%	34%	67%	>90%
Drug Admin Errors-Pharmacy (per 10000 doses)	0.43 *(n=19)*	0.12 *(n=19)*	0.35 (n=18)	0.64 (n=22)	<1

Case Management 2023					
	Q1	Q2	Q3	Q4	Goal
Patient Choice Form Completed	94%	93%	93%	95	90%

Nursing Turnover	2023 Staff/Quarter				
# of RNs	Q1	Q2	Q3	Q4	Goal
RNs, >0.5FTE (n=64)	2 (3.1%)	3 (4.8%)	2 (3.4%)	4 (6.6%)	≤5

Patient Experience: Q-Reviews 2023	2022				
	Q1 4.74	Q2 4.78	Q3 4.78	Q4 4.81	Goal
RATE MY HOSPITAL- PHYSICAL THERAPY					
Overall score	4.91	4.92	4.94	4.92	≥4.75
RATE MY HOSPITAL-OUTPATIENT SURGERY					
Overall Score	4.84	4.81	4.83	4.88	≥4.75
RATE MY HOSPITAL - ED					
Overall score	4.5	4.6	4.61	4.61	≥4.75
RATE MY HOSPITAL - MEDICAL IMAGING					
Overall score	4.85	4.87	4.81	4.87	≥4.75
RATE MY HOSPITAL-INPATIENT					
Overall score	4.69	4.83	4.83	4.67	≥4.75

Nurse Staffing Effectiveness: Transfers r/t staffing/beds					
2022 - 2023	Q1	Q2	Q3	Q4	Goal
	1	1	0	1	≤0

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

Workplace Violence Prevention Program

Sonoma Valley Hospital

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
HEALING HERE AT HOME

Definition of a Workplace Violence Event

Any situation involving use of physical force against an employee by a patient or other person on the premises that results in, or has the high likelihood of resulting in, injury, psychological trauma, or stress, regardless of whether the employee sustains an injury AND regardless of the offender's intentions. Additionally, any use of a firearm or other dangerous weapon, regardless of whether the employee sustains an injury.

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Workplace Violence Prevention – Written Plan

- Initial Workplace Violence Prevention (WVP) plan was published/distributed to all staff in early 2018; revised in 2019 & 2021. Available in the HRIS Employee Portal.
- The plan provides information and guidelines on the procedures for incident response, post-incident response & investigation, identification of the types of incidents and the corresponding reporting requirements to the state (Cal-OSHA), and support to be provided for victims.
- The plan also identifies program responsibilities/accountability, the identification of the WVP Program Taskforce, and required training for all staff.

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Workplace Violence Prevention - Training

- All new hires review/complete WVP Competencies as part of their 1st Day Orientation.
- Online training course is required of all new hires within the first 30 days of employment.
- Annual online training course is required of all staff.
- Conflict Resolution/De-escalation workshops provided for all staff in 2023
- Management of Aggressive Behavior (MOAB) was provided to key staff (Code Grey Team, ED Staff, Nursing Supervisors, etc.) pre-COVID; not available during the pandemic, but new options now available and being explored.

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Workplace Violence Incident Reporting

- Every workplace violence incident is reported by staff involved and submitted to the Safety Officer, who completes the report to Cal-OSHA.
- WVP Taskforce meets quarterly to review all reported incidents, discuss/review completed investigations, and discuss corrective actions and/or additional needs as appropriate.
- The number of reported incidents each quarter is relatively low (2-3 per quarter) and none have involved a firearm or other weapon.
- Incidents most commonly occur due to intoxication/withdrawal or other cognitive decline conditions; no serious injuries to staff have occurred.

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Quality Indicator Performance & Plan

January Board Quality

Data for November/December 2023

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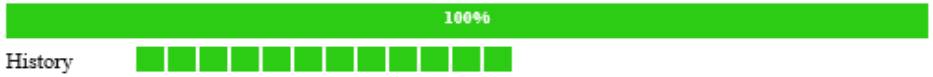
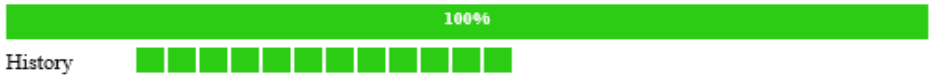
Mortality

Mortality

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
Acute Care Mortality Rate (M)								
	Target Met	10.4% 8/77	Deteriorated	Dec 2023	15.3%	n/a	n/a	3.8%
COPD Mortality Rate |M|								
	Target Met	0.0% 0/4	No Change	Dec 2023	8.5%	n/a	n/a	0.0%
Congestive Heart Failure Mortality Rate |M|								
	Target Met	0.0% 0/5	No Change	Dec 2023	11.5%	n/a	n/a	0.0%
Pneumonia Mortality Rate |M|								
	Target Met	12.5% 1/8	Deteriorated	Dec 2023	15.6%	n/a	n/a	3.9%
Ischemic Stroke Mortality Rate |M|								
	Target Met	0.0% 0/2	No Change	Dec 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	14.3%

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
Sepsis, Severe - Mortality Rate (M)								
	Breaches Alarm	33.3% 2/6	Deteriorated	Dec 2023	25.0%	n/a	n/a	12.8%
Septic Shock - Mortality Rate (M)								
	Breaches Alarm	60.0% 3/5	Deteriorated	Dec 2023	25.0%	n/a	n/a	23.3%

AHRQ Patient Safety Indicators

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
PSI 90 (v2021) Midas Patient Safety Indicators Composite, ACA (M)								
	Target Met	0.00 0/0.01	— No Change	Dec 2023	0.00	n/a	n/a	1.27
PSI 90 (v2021) Patient Safety Indicators Composite, ACA - Volume (M)								
	Target Met	0	— No Change	Dec 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%	Target Met	0	— No Change	Dec 2023	0	1	n/a	0
History								

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Blood Products

Lab | Transfusion Effectiveness (M)								
	Target Met	100.0% 3/3	Improved	Dec 2023	100.0%	99.0%	n/a	94.0%
Lab | Transfusion Reaction (M)								
	Target Met	0.0% 0/23	No Change	Dec 2023	0.0%	1.0%	n/a	0.9%

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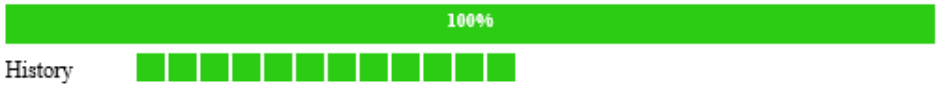
Significant Medication Errors and Adverse Drug Reactions

- 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 0/65040	Improved	Dec 2023	1.13	2.00	n/a	0.10
Rx-Administration Errors Per 10,000 Doses Dispensed								
91% 9%  History	Target Met	0.46 3/65040	Improved	Dec 2023	1.00	3.00	n/a	0.40

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Patient Falls
Preventable Harm

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
RM ACUTE FALL- All (M) per 1000 patient days								
83% / 17% History	Bet. Target & Alarm	3.98 1/251	Deteriorated	Dec 2023	3.75	4.00	n/a	0.93
RM ACUTE FALL- WITH INJURY (M) per 1000 patient days								
100% History	Target Met	0.00 0/251	No Change	Dec 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	5.63% 4/71	Improved	Dec 2023	15.30%	15.50%	n/a	5.06%
COPD, CMS Readm - % Readmit within 30 Days, ACA (M)								
66% 17% 17%  History	Target Met	0.0% 0/4	No Change	Dec 2023	19.5%	20.0%	n/a	9.1%
HF, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)								
91% 9%  History	Target Met	0.0% 0/5	No Change	Dec 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 Met	0.0% 0/1		Dec 2023	4.0%	5.0%	n/a	7.7%
PNA, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)								
91% 9%  History	Target Met	0.0% 0/7	No Change	Dec 2023	16.6%	17.0%	n/a	2.1%
Sepsis, Severe - % Readmit within 30 Days (M)								
100%  History	Target Met	0.0% 0/3	No Change	Dec 2023	12.0%	13.0%	n/a	0.0%
Septic Shock - % Readmit within 30 Days (M)								
100%  History	Target Met	0.0% 0/2	No Change	Dec 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	0.9% 1/106	Deteriorated	Dec 2023	3.0%	4.0%
Blood Cultures -Total Contamination Rate (M)						
	Target Met	1.8% 4/219	Deteriorated	Dec 2023	3.0%	4.0%
Blood Cultures -Contamination Rate |RN| (M)						
	Target Met	2.7% 3/112	Deteriorated	Dec 2023	3.0%	3.1%

Month	RN-Contaminated Culture Reports (num)	Blood Cultures Drawn by RN (den)	Percent
Dec 2023	3	112	2.7%
Nov 2023	2	134	1.5%
Oct 2023	3	122	2.5%
Sep 2023	1	97	1.0%
Aug 2023	5	94	5.3%
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%

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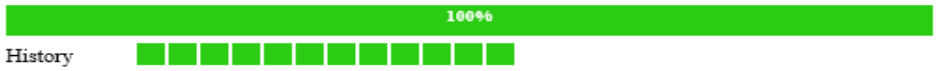
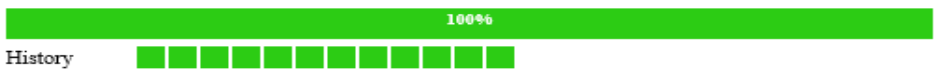
CIHQ Stroke Certification Measures

Stroke > Code Stroke Elapsed Time

Indicator	Performance	Most Recent	Trend	Period				
CDSTK-03|Median- Code Stroke Called |M| elapsed time (mins)	Target Met	5	Deteriorated	Dec 2023	10	11	n/a	4
CDSTK-04|Median- Door to Phys Eval |M| minutes	Target Met	1	Deteriorated	Dec 2023	10	11	n/a	1
CDSTK-05|Median- Door to CT Scanner |M|elapsed time (minutes)	Breaches Alarm	44	Deteriorated	Dec 2023	25	26	n/a	8
CDSTK-06|Median- Neuro Consult Contacted |M| minutes	Breaches Alarm	38	No Change	Dec 2023	30	31	n/a	19
CDSTK-07|Median- CT Read by Radiology |M| minutes	Breaches Alarm	59	Deteriorated	Dec 2023	45	46	n/a	29
CDSTK-08|Median- Lab Results Posted |M| minutes	Bet. Target & Alarm	45	Deteriorated	Dec 2023	45	46	n/a	22
CDSTK-10|Median- Door to EKG Complete |M| minutes	Target Met	40	Deteriorated	Dec 2023	60	61	n/a	37
CDSTK-11|Median-Door to tPA Decision |M| minutes	Breaches Alarm	69	Deteriorated	Dec 2023	60	61	n/a	39
CDSTK-12|Median-Door to tPA |M| minutes	Target Undefined	n/a		Dec 2023	60	61	n/a	68





Utilization Management

Utilization Management

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
MS-DRG Case Mix Index (CMI) |M|								
	Bet. Target & Alarm	1.45	Improved	Dec 2023	1.55	1.40	n/a	1.39
MS-DRG Case Mix Index (CMI) MEDICARE |M|								
	Breaches Alarm	1.25	Deteriorated	Dec 2023	1.55	1.40	n/a	1.45
1 Day Stay Rate Medi-Cal |M|								
	Target Met	0.00% 0/14	No Change	Dec 2023	2.61%	5.00%	n/a	0.00%
1 Day Stay Rate-Medicare |M|								
	Target Met	0.00% 0/49	No Change	Dec 2023	8.10%	10.00%	n/a	0.00%
Medicare Risk-adjusted Average Length of Stay, O/E Ratio |M|								
	Target Met	0.69 147/213.67	Improved	Dec 2023	0.99	1.00	n/a	0.87
Acute Care - Geometric Mean Length of Stay |M|								
	Bet. Target & Alarm	2.89 37.597/13	Improved	Dec 2023	2.75	3.23	n/a	3.18

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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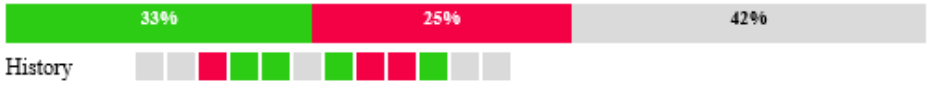
Core Measures

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
Core OP29/ASC9 - Colonoscopy:F/U for Avg Risk Pts (M)								
	Target Met	100.0% 8/8	— No Change	Dec 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)								
	Breaches Alarm	168.50	Deteriorated	Dec 2023	132.00	140.00	n/a	148.75

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
Core OP 22 ED LWBS Emergency Dept Left Without Being Seen (M)								
	Target Met	0.2% 2/818	Improved	Dec 2023	2.0%	2.5%	n/a	0.5%

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
Core OP-23 - Head CT/MRI Results for STK Pts w/in 45 Min of Arrival (M)								
	Target Undefined	n/a		Dec 2023	72.0%	70.0%	n/a	69.2%

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Core Measures Sepsis

Core Measures > Sepsis -SEP-1-

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
SEP-1 Early Management Bundle, Severe Sepsis/Septic Shock (M)								
	Breaches Alarm	57.1% 4/7	Improved	Dec 2023	81.0%	80.0%	n/a	61.8%
SEPa - Severe Sepsis 3 Hour Bundle (M)								
	Target Met	100.0% 7/7	Improved	Dec 2023	94.0%	90.0%	n/a	82.4%
SEPb - Severe Sepsis 6 Hour Bundle (M)								
	Breaches Alarm	85.7% 6/7	Deteriorated	Dec 2023	100.0%	90.0%	n/a	90.0%

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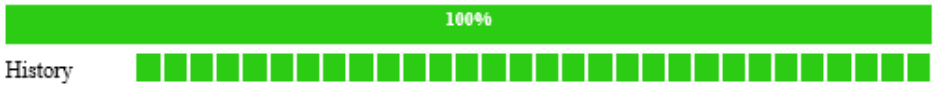
Infection Prevention

Indicator	Performance	Most Recent	Trend	Period				
IC-Surveillance| HAI-C.DIFF Inpatient infections per 10k pt days |M|								
	Target Met	0	No Change	Dec 2023	1	1	n/a	0
IC-Surveillance| HAI-CAUTI Inpatient infections per 10k patient days |M|								
	Target Met	0	No Change	Dec 2023	1	1	n/a	0
IC-Surveillance| HAI-CLABSI Inpatient infections per 10k patient days |M|								
	Target Met	0	No Change	Dec 2023	1	1	n/a	0
IC-Surveillance| HAI-MRSA Inpatient infections per 10k patient days |M|								
	Target Met	0	No Change	Dec 2023	1	1	n/a	0
IC-Surveillance| HAI-SSI infections per 10k pt days |M|								
	Target Met	0	No Change	Dec 2023	1	1	n/a	0
QA-02 | Hand Hygiene Practices Monitored |M|								
	Target Met	96% 48/50	Improved	Dec 2023	90%	85%	n/a	84%

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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	Dec 2023	100%	95%	n/a	100%
IC-03 | Hair Clippers and Base Clean |M|								
100% History	Target Met	100% 4/4	No Change	Dec 2023	90%	85%	n/a	98%
MM-24 | Pill Crushers Clean |M|								
100% History	Target Met	100% 4/4	No Change	Dec 2023	100%	95%	n/a	100%
QS-10 | Documentation: Continuous Observation of High Risk Pts |M|								
12% 88% History	Breaches Alarm	62% 5/8	Deteriorated	Dec 2023	100%	95%	n/a	42%

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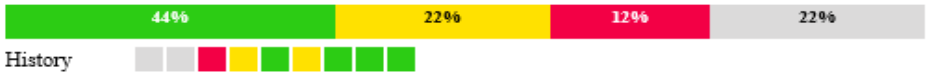
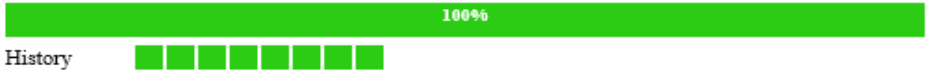
CIHQ Corrective Action Plan Standard Level Deficiencies Quarterly Report

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
GL-04 | Policies in Compliance for Review |M|								
100% History	Breaches Alarm	70% 648/930	Improved	Dec 2023	90%	85%	n/a	66%
GL-04 | Condition Level Findings Reported to BQC |M|								
100% History	Target Met	100% 4/4	No Change	Dec 2023	100%	95%	n/a	100%
IC-03 | Hair Clippers and Base Clean |M|								
100% History	Target Met	100% 4/4	No Change	Dec 2023	90%	85%	n/a	98%
IC-03 | Ice Machines Cleaned|M|								
100% History	Target Met	100.0% 24/24	No Change	Dec 2023	100.0%	95.0%	n/a	100.0%
IC-03 | OP Rehab Deep Clean Complete |M|								
100% History	Target Met	100.0% 1/1	No Change	Dec 2023	100.0%	95.0%	n/a	100.0%
IC-03 | Pt Care Floors Clean|M|								
100% History	Target Met	100.0% 21/21	No Change	Dec 2023	100.0%	95.0%	n/a	100.0%
MM-24 | Pill Crushers Clean |M|								
100% History	Target Met	100% 4/4	No Change	Dec 2023	100%	95%	n/a	100%
CE-03 | Pull Cord Compliance |M|								
100%	Target							

CIHQ Corrective Action Plan Standard Level Deficiencies Quarterly Report

CE-07 | Presence of spill kit where formalin used|M|		Target Met	100.0% 10/10	No Change	Dec 2023	100.0%	95.0%	n/a	73.8%
CE-09 | Appropriate Storage of Supplies (Bio-Hazard Bag Use) |M|		Target Met	100% 4/4	No Change	Dec 2023	90%	85%	n/a	96%
CE-09 | Expiration of Hand Sanitizer Stored Supplies|M|		Target Met	100% 28/28	No Change	Dec 2023	100%	95%	n/a	100%
CE-09 | Opened EKG electrodes dated |M|		Target Met	100% 4/4	No Change	Dec 2023	90%	85%	n/a	100%
CE-11 | Monitoring Temperature and Humidity Logs|M|		Breaches Alarm	79.8% 217/272	Deteriorated	Dec 2023	100.0%	95.0%	n/a	65.8%
DC-04 | Patient Choice Form Completion |M|		Target Met	95% 18/19	Deteriorated	Dec 2023	90%	85%	n/a	95%
IC-09 | Safe Transport of Used Surgical Supplies |M|		Breaches Alarm	75% 3/4	Deteriorated	Dec 2023	100%	95%	n/a	93%
IC-10 | MedStaff Antimicrobial Stewardship Training Monitoring |M|		Breaches Alarm	33% 10/30	Improved	Dec 2023	100%	90%	n/a	18%

CIHQ Corrective Action Plan Standard Level Deficiencies Quarterly Report

MM-11 | Dextrose 10% in Broselow Carts |M| 	Target Met	100.0% 2/2	No Change	Dec 2023	100.0%	95.0%	n/a	66.7%
MM-21 | Albuterol Orders Complete |M| 	Target Met	100.00% 17/17	No Change	Dec 2023	90.00%	85.00%	n/a	100.00%
MM-21 | Medication/Contrast Protocol Usage |M| 	Target Met	100.00% 30/30	No Change	Dec 2023	90.00%	85.00%	n/a	100.00%
MM-22 | PRN Pain Parameter Instructions |M| 	Target Met	100.0% 29/29	No Change	Dec 2023	100.0%	95.0%	n/a	97.8%
MM-26 | Unlabeled lidocaine multidose vials |M| 	Target Met	0.00% 0/4	No Change	Dec 2023	0.00%	0.05%	n/a	0.00%
MR-05 | Vital Signs for TNK Patients |M| 	Target Undefined	n/a		Dec 2023	100%	95%	n/a	100%
MS-09 | Privileges for Telehealth Providers Monitored |M| 	Target Met	100% 10/10	No Change	Dec 2023	100%	90%	n/a	100%
NU-03 | Monitor Exp Dates in Patient Nutrition Areas |M| 	Target Met	100% 4/4	No Change	Dec 2023	90%	85%	n/a	100%

CIHQ Corrective Action Plan Standard Level Deficiencies Quarterly Report

NU-06 | Nutrition Orders by MD Only |M|								
75% 13% 12%	Target Met	100% 14/14	No Change	Dec 2023	90%	85%	n/a	97%
History								
PR-02 | IMM Signed Within 48 hours |M|								
58% 42%	Target Met	100.0% 57/57	No Change	Dec 2023	90.0%	85.0%	n/a	100.0%
History								
PR-03 | Family Notification of Hospitalization |M|								
8% 8% 42% 42%	Bet. Target & Alarm	89.5% 51/57	Improved	Dec 2023	90.0%	85.0%	n/a	79.1%
History								
QA-01 | Contracted Services QAPI Review |M|								
75% 13% 12%	Target Met	90% 9/10	No Change	Dec 2023	90%	85%	n/a	89%
History								
QA-02 | Hand Hygiene Practices Monitored |M|								
25% 16% 25% 34%	Target Met	96% 48/50	Improved	Dec 2023	90%	85%	n/a	84%
History								
QA-02 | Monitor & Report High Risk Problem Prone areas |M|								
87% 13%	Target Met	100% 1/1	No Change	Dec 2023	90%	85%	n/a	100%
History								
QS-07 | Accuracy in Patient Identification |M|								
37% 12% 38% 13%	Breaches Alarm	83% 5/6	Improved	Dec 2023	90%	85%	n/a	90%
History								
RS-07 | Timely MD Order for Restraint |M|								
62% 12% 13% 13%	Target Met	100% 9/9	No Change	Dec 2023	90%	85%	n/a	94%
History								
RS-12 | MedStaff Restraint Policy Review Monitoring |M|								
50% 38% 12%	Bet. Target & Alarm	94%	No Change	Dec 2023	100%	90%	n/a	67%
History								

Patient Satisfaction

- HCAHPS reported Quarterly

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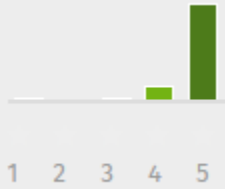
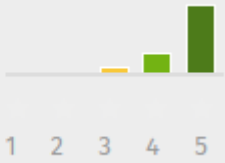
Rate My Hospital
Scale 1-5
November/December Data

Sonoma Valley Hospital / Emergency Department	186	4.601 95% CI: 4.558—4.644	
Sonoma Valley Hospital / Inpatient Care	20	4.562 95% CI: Not enough samples	

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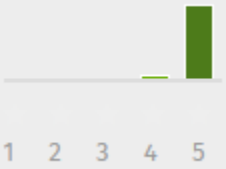
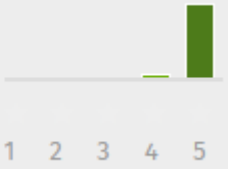
Rate My Hospital
Scale 1-5

Sonoma Valley Hospital / Medical Imaging	412	4.874 95% CI: 4.857—4.892	
Sonoma Valley Hospital / Hand and Physical Therapy	263	4.906 95% CI: 4.888—4.924	

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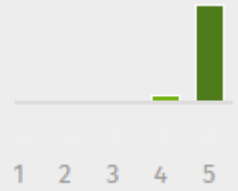
Rate My Hospital
Scale 1-5

Sonoma Valley Hospital / Outpatient Surgery	77	4.879 95% CI: 4.852—4.906	

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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: Finn, Stacey (sfinn)
Run date: 01/19/2024 8:27 AM

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: 18

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

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

Current Approval Tasks (due now)

Document	Task/Status	Pending Since	Days Pending
Admission and Discharge Criteria By Unit *Patient Care Policy*	**Pending Approval**	1/18/2024	1

Summary Of Changes: **Reviewed. no changes required.**
Moderators: **Newman, Cindi (cnewman)**
Lead Authors: **Taylor, Jane (jtaylor)**
ExpertReviewers: **00 Clinical P&P multidisciplinary review, Medical Director-Patient Care Services**
Approvers: **Winkler, Jessica (jwinkler) -> 01 P&P Committee - (Committee) -> 02 MS-Medicine Department - (Committee) -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Antimicrobial Stewardship *Medication Management Policies (MM)*	**Pending Approval**	1/18/2024	1

Summary Of Changes: **Removed attachment from body of policy so that it is a separate attached document**
Moderators: **Kutza, Chris (ckutza), 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)**

Body Fluid Exposure Prophylaxis Kit Preparation 8390-06 *Pharmacy Dept*	**Pending Approval**	1/18/2024	1

Summary Of Changes: **Updated regimen to be prepared to remove Kaletra and add Tivicay per current guidelines. Removed embedded attachment and added new version as 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)**

Cancellation No Show *Rehabilitation Services Dept*	**Pending Approval**	1/18/2024	1

Summary Of Changes:	**Changes to policy reflect CMS guidance and attempt for an equitable method of compliance. Corrected draft for Speech therapy contact for in person scheduling will be at Hand and Physical Therapy clinic.**
Moderators:	**Newman, Cindi (cnewman)**
Lead Authors:	**Gallo, Christopher (cgallo)**
Approvers:	**Kuwahara, Dawn (dkuwahara) -> 01 P&P Committee - (Committee) -> 02 MS-Medicine Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Controlled Substance Management — **Pending Approval** — 1/18/2024 — 1

Medication Management Policies (MM)

Summary Of Changes:	**Minor formatting changes. Corrected definition of CSOS to include only CII controlled substances. Updated verbiage in CSOS section to include revocation process. Updated DEA form 222 process references to reflect current version and process as required by the DEA. Updated annual inventory section to reflect the need to perform the inventory at a specific time of day. Updated requirement for inventory reconciliation to include other drugs as required by state law.**
Moderators:	**Kutza, Chris (ckutza), 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)**

CT Abdomen & Pelvis, Oral Preparation — **Pending Approval** — 1/18/2024 — 1

Diagnostic Services Dept Policies

Summary Of Changes:	**Reviewed Policy, no content changes. Updated Authors and Reviewers, and abbreviations..**
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)**

CT Scanner Quality Control — **Pending Approval** — 1/18/2024 — 1

Diagnostic Services Dept Policies

Summary Of Changes:	**Reviewed Policy, no content changes. Updated Author and Reviewers, and abbreviation..**
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)**

Discrepancy, Emergency Department and Radiologist — **Pending Approval** — 1/18/2024 — 1

Diagnostic Services Dept Policies

Summary Of Changes:	**Reviewed Policy, no substantive changes made. Updated Owner, reviewers and authors and abbreviations..**
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)**

Dosimetry	**Pending Approval**	1/18/2024	1
Diagnostic Services Dept Policies			

Summary Of Changes:	**Removed references to Nuclear Medicine technologists since we don't have any anymore.** **Changed reference to physicists and physicist companies instead of specific companies.** **Updated timelines for badge reporting requirements.** **Updated owner, reviewers and authors.**
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)**

Gastrograffin Oral Prep for Adult ED patients	**Pending Approval**	1/18/2024	1
Diagnostic Services Dept Policies			

Summary Of Changes:	**Reviewed Policy, no content changes** **Updated Authors and Approvers and abbreviation.**
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)**

Infection Control Water Management	**Pending Approval**	1/18/2024	1
Infection Prevention & Control Policies (IC)			

Summary Of Changes:	**All current practices are up to date," Revised date July 2019"** **Policy is reflecting current requirements.** **It was suggested by Plant Ops Manager "•The policy states that we need to check for Legionella regularly. This isn't required and the policy should be updated to reflect current requirements..** **" The current policy states We would provide regular testing IF we were to have one positive Legionella lab result from a HAI" or two in a six month timeframe.** **The regular testing would only happen if there was a confirmed outbreak of two or more HAI, Legionella tests.** **No changes made to this policy, Only chage to policy is the updated from 2003 to July 2019.**
Moderators:	**Newman, Cindi (cnewman)**
Lead Authors:	**Montecino, Stephanie (smontecino)**
ExpertReviewers:	**12-Safety Committee, Drummond, Kimberly (kdrummond), Lantican, Jhon (jlantican), Sankaran, Sujatha (ssankaran)**
Approvers:	**Cooper, Kylie (kcooper) -> 01 P&P Committee - (Committee) -> 04 MS-Performance Improvement/Pharmacy & Therapeutics Committee - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Inspection of Nursing Units and Medication Storage Areas	**Pending Approval**	1/18/2024	1
Medication Management Policies (MM)			

Summary Of Changes:	**Reviewed, no changes**
Moderators:	**Kutza, Chris (ckutza), Newman, Cindi (cnewman)**
Lead Authors:	**Kutza, Chris (ckutza)**
ExpertReviewers:	**Winkler, Jessica (jwinkler)**
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)**

Preparation of Methotrexate IM Doses Using ChemoClave System Procedure *Pharmacy Dept*	**Pending Approval**	1/18/2024	1

Summary Of Changes: **Removed policy attachment from body of policy to be a separate document.**

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)**

Rehabilitation Services with Patients in Contact Isolation Management *Infection Prevention & Control Policies (IC)*	**Pending Approval**	1/18/2024	1

Summary Of Changes: **added revised date of 11/23**

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

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

ExpertReviewers: **Sankaran, Sujatha (ssankaran)**

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

RETIRE:: Adult Hypoglycemia Protocol *Patient Care Policy*	**Pending Approval**	1/18/2024	1

Summary Of Changes: **Recommend retire as obsolete---replaced by new Epic protocols for Hypoglycemia which are going through approval workflow.**

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

Lead Authors: **Taylor, Jane (jtaylor)**

ExpertReviewers: **Medical Director-Patient Care Services**

Approvers: **Winkler, Jessica (jwinkler) -> 01 P&P Committee - (Committee) -> 02 MS-Medicine Department - (Committee) -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Scope of Service - Pharmacy Department *Medication Management Policies (MM)*	**Pending Approval**	1/18/2024	1

Summary Of Changes: **Updated weekend hours of operation to be 0730-1600**

Moderators: **Kutza, Chris (ckutza), 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)**

Surgical Hand Scrub-Antisepsis *Surgical Services/OR Dept*	**Pending Approval**	1/18/2024	1

Summary Of Changes: **Removed outdated recommendation for long versus short hand scrub.**
Added updated AORN recommendations for surgical hand scrub versus surgical hand rub.
Changed policy reviewer to Director of Perioperative Services.
Reference updated to most recent recommended practice by the AORN.

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

Lead Authors: **Cornell, Kelli (kcornell)**

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

Universal Protocol		**Pending Approval**	1/18/2024	1
Patient Care Policy				

Summary Of Changes:	**Updated wording to match verbiage used in Epic EMR.** **For example "Sign-in" changed to "Briefing".** **Changed author from "Manager" to Director of Perioperative Services.**
Moderators:	**Newman, Cindi (cnewman)**
Lead Authors:	**Cornell, Kelli (kcornell)**
ExpertReviewers:	**Medical Director-Surgical Services**
Approvers:	**Winkler, Jessica (jwinkler) -> 01 P&P Committee - (Committee) -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**