SVHCD QUALITY COMMITTEE

AGENDA

WEDNESDAY, March 27, 2024

4:30 pm Closed Session

5:00 pm Regular Session

Held in Person:

SVH Administrative Conference Room

To Participate Via Zoom Videoconferencing
use the link below:
https://sonomavalleyhospital-org.zoom.us/j/97100197319

Meeting ID: 971 0019 7319

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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 Board Clerk, Whitney Reese, at wreese@sonomavalleyhospital.org, 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. CLOSED SESSION: a. Calif. Government Code §54956.9: Conference with Legal Council – Anticipated Litigation	*Kornblatt Idell*	
4. CONSENT CALENDAR • Minutes 02.28.24	*Kornblatt Idell*	Action
5. ANNUAL QUALITY DEPARTMENT REVIEW	*Cooper*	Inform
6. QUALITY COMMITTEE CHARTER	*Kornblatt Idell*	Action
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
February 28, 2024, 5:00 PM
MINUTES
Via Zoom Teleconference

Members Present – In Person	Excused	Public/Staff – Via Zoom
Carl Speizer, MD Carol Snyder Howard Eisenstark, MD Ingrid Sheets, EdD, MS, RN Kathy Beebe, RN PhD Michael Mainardi, MD Sujatha Sankaran, MD CMO Susan Kornblatt Idell		John Hennelly, CEO, via zoom Stacey Finn, Medical Staff Manager, via zoom Kelli Cornell, RN, Director of Perioperative Services Denise Kalos, via zoom Judith Bjorndal, MD via zoom Paul Amada, via zoom Kylie Cooper, RN, BSN, CPHQ, MBA, Quality and Risk Mgmt.

AGENDA ITEM	DISCUSSION	ACTION
1. CALL TO ORDER/ANNOUNCEMENTS	*Kornblatt Idell*	
	Meeting called to order at 5:00 pm. Welcome to Whitney Reese, new Board Clerk Thank you to Stacey Finn for filling in with Board Clerk duties in interim	
2. PUBLIC COMMENT	*Kornblatt Idell*	

	None	
3. CONSENT CALENDAR	*Kornblatt Idell*	ACTION
• QC Minutes 01.24.24	Noted that Judy Bjorndal is not a member of the committee, just a silent attendee.	**MOTION:** by Eisenstark to approve, 2nd by Speizer. All in favor.
4. SURGICAL SERVICES QA/PI	*Cornell*	INFORM
	The perioperative department cares for our patients in pre-op and post-operative care settings within the same area. We also support a growing outpatient infusion service within the same area utilizing the same staff. We have 3 large state of the art operating rooms, a sterile processing department conveniently seated right next to the operating rooms. As well as in-house scheduling for surgical services as well as outpatient infusion. We currently have 35 FTEs, not counting Cornell. Surgical Services offered: Orthopedics, General, Gastroenterology, Ophthalmology Urology, Gynecology, Cardiology, Pain. Potential to accommodate plastics, ENT, spine, and vascular surgery as well. Accomplishments of 2023: • Addition of needed staff including: Perioperative Services Director (Cornell), Full time Nurse Navigator, Fully staffed Sterile Processing Department • Busy infusion service has grown from 40 in January to 76 in December • Successful conversion and adaptation to EPIC Challenges: • Managing a growing infusion service in the same space as pre-op and recovery patients • Dr. Brown leaving creating uncertainty within the department. January 2024 we preformed 182 cases up from 155 last year. Quality Metrics: While we can definitely work on the first case on time starts. We are still in the data collection phase to learn why these cases are not making it in the room at 0730 and what	

	we can do about it. Date of Service Cancelations are something to monitor to ensure our patients are properly optimized before surgery and Room turnovers are above benchmark which is 20mins. We are doing well in this area. Goals for 2024: • Growth of total joint program • Reduce Date of Service Cancelations • Increase first case on time starts • Maintain turnover times • Active participation in age-friendly initiative across the spectrum of care	
5. QUALITY COMMITTEE CHARTER	*Kornblatt Idell*	ACTION
	Discussion focused on ensuring clarity, consistency, and relevance in the committee's charter along with other board committee charters, with attention to terminology, reporting requirements, and governance procedures. Specific changes include: • Standardizing the term "governance board" vs. "governing board." • Considering the terminology of "triple healthcare" and suggesting revisions to better reflect the aims of the organization. • Discussed whether references to the hospital should be substituted with references to the Sonoma Valley Health Care District. • Standardizing language across different sections of the charter, particularly regarding committee membership and compliance with board policies. • Remove “patient care contracts.” • Clarified the role of the committee in reviewing policies and procedures, emphasizing oversight rather than direct input. • Add a charter review requirement (every 3 years). • Discussed voting procedures and quorum requirements, including the definition of a majority of voting members.	

6. QUALITY INDICATOR PERFORMANCE & PLAN	Cooper	INORM
	Mortality rate decreased from 10% in December to 4.5%, with three comfort care patients. No patient safety indicator events or adverse events occurred. Blood transfusion reactions and effectiveness were both 100%. No significant medication errors, adverse drug reactions, or patient falls were reported. Readmissions improved to 2.86%, with no significant issues identified. Stroke measures returned to target levels, aided by an increase in code strokes from 5 to 14 in January. Utilization management showed an increase in complexity of illness, with a CMI of 1.59 in January and an average length of stay of 4.52 days. Core measures, including follow-up and ED turnaround time, were generally met, although three patients left without being seen. Patient satisfaction ratings were generally positive, with high scores in areas like communication with nurses, cleanliness, and discharge information. However, care transitions and medication communication showed room for improvement. Efforts to improve patient education and discharge processes, particularly involving pharmacy collaboration, were discussed. Outpatient surgery facilities received positive ratings, with high scores in communication and personnel treatment. January patient survey scores for various departments, including emergency department, outpatient surgery, medical imaging, and hand/physical therapy, were generally high, indicating satisfaction with services.	
7. POLICIES AND PROCEDURES	*Cooper*	INFORM
	The following policies were presented for recommendation for approval by the Board of Directors: • Compounding Nonsterile Drug Products: Policy to match newly updated revision to USP 795. Replaces Policy 8610-137 Compounding Drug Products)	

	• IV Compounding (Non-Pharmacy Location): Major changes to current policy. This replaces MM8610-118 IV Compounding Outside the Pharmacy. Per USP 797 • QAPI Procedures for Sterile Compounding Quality Assurance program. (Sampling Plan-IV Room): Significant reorganization and content updates to ensure policy meets requirements from updated USP 797 standards. • Sterile Compounding (USP 797): Significant changes to content and organization of original policy due to large revision of USP 797 standards. • Transfusion Transmitted Infectious Disease Notification: Policy is required for accreditation and CLIA	
9. ADJOURN	*Kornblatt Idell*	
	Meeting adjourned at 6:10p.m.	

Annual Quality Report

Year Ending 2023

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Quality Department

- Department Members

- Director of Quality

Quality Systems & Analytics

Infection Prevention/Employee Health

- Case Management and Social Work department reports to Director of Quality
- Director of Quality reports to CMO

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Who do we care for?
ED Metrics

- 9222 visits in 2023
- 54% Female 46% Male
- 31% of ED patients are over age of 70 vs 27% aged 20-50 years of age
- 10% of ED patients less than 10 years of age
- 43% Single
- 28% of all ED patients identify as Hispanic
- English (81%) and Spanish (17%) predominate languages spoken

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Who do we care for?
Inpatient Metrics

- 827 inpatient admissions in 2023
- 54% Female 46% Male
- 64% of inpatients are over age of 70
- 25% Single, 35% Married, 15% widowed
- 11% of all inpatients identify as Hispanic
- English (92%) and Spanish (7%) predominate languages spoken

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Who do we care for?
Inpatient Metrics

- Length of Stay higher in 80-89 age group and in those who are married. Non-Hispanic length of stay double the length of stay vs Hispanic Patients
- 63% of Readmissions are patients aged 70-100 years
- 63% of readmissions are female
- 87% of readmissions are non-Hispanic patients
- 36% of readmissions are married patients

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Quality Overview

- Metrics measured and reported monthly to Board Quality
  - Mortality
  - AHRQ Patient Safety Indicators
  - Adverse Events
  - Blood Products
  - Medication Errors
  - Patient Falls
  - Readmissions
  - Blood Culture Contamination
  - Stroke Certification Measures
  - Utilization Management
  - Core Measures- Sepsis/ED/Stroke/Colonoscopy
  - Infection Prevention
  - Inpatient and Outpatient Satisfaction

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Quality Success 2023

- Mortality Rates below benchmark 2023
- Falls with injury zero incidents 2023
- Improvement in Sepsis measures vs 2022
- Significant improvement in Blood Culture contamination rates
- Successful accreditation survey as Stroke Ready Hospital with excellent stroke care
- Successful CMS accreditation survey by the Center of Improvement in Healthcare Quality (CIHQ)

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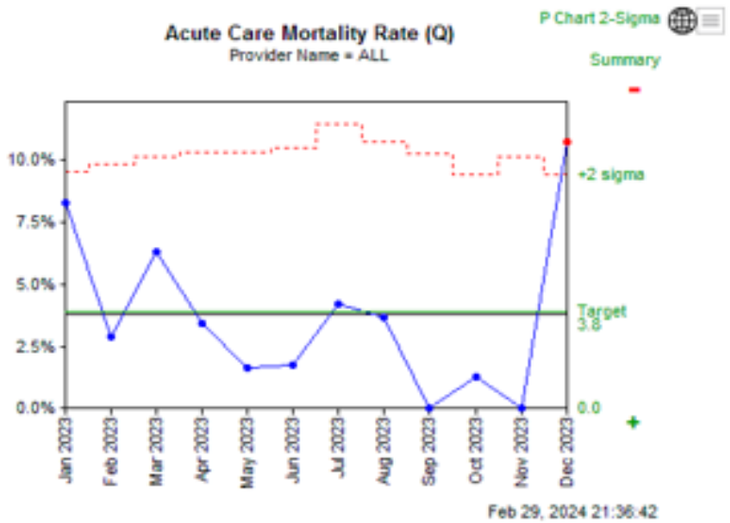
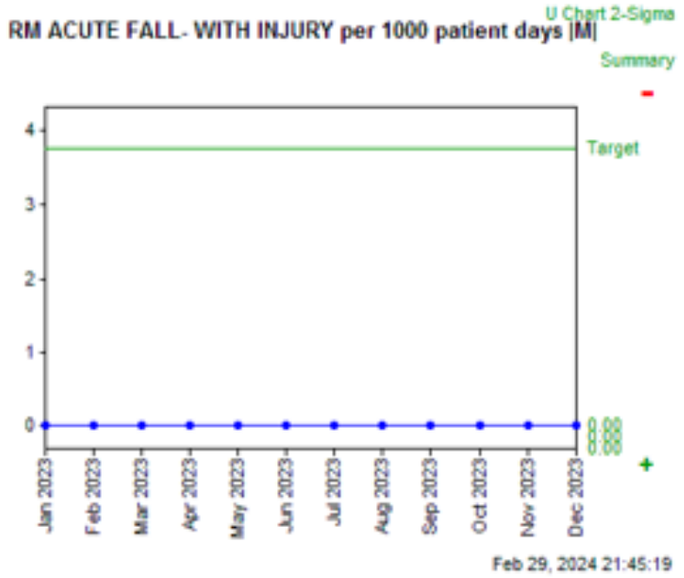
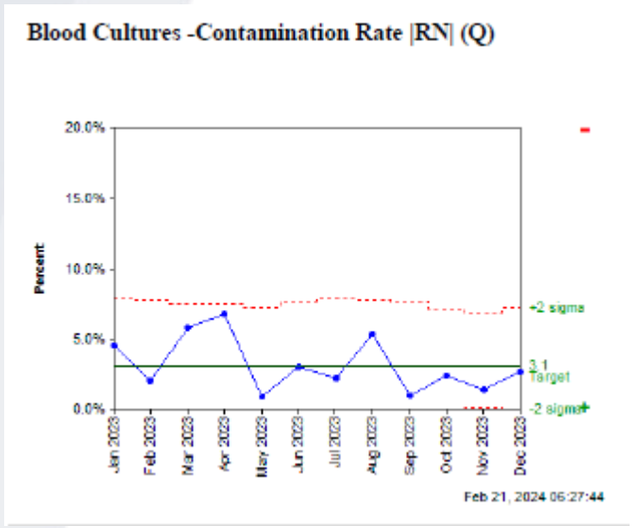
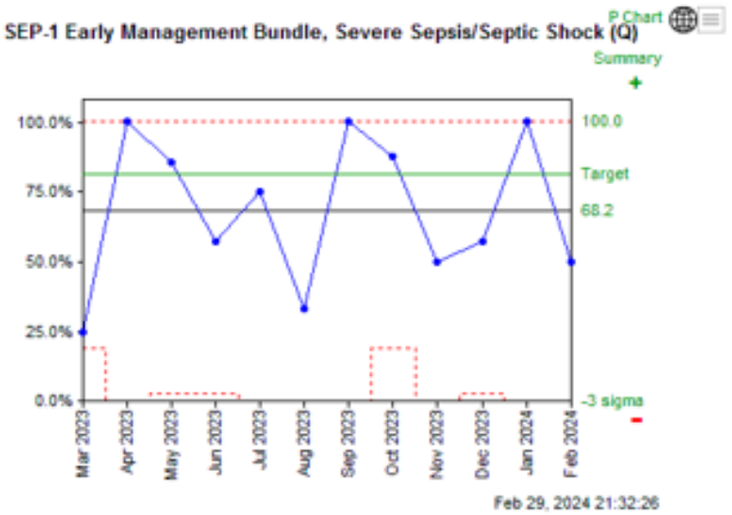
Success data









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Opportunity for improvement in 2024

- Decrease length of stay
- Decrease Readmission rates
- Continue our journey of improving compliance with Sepsis Bundles

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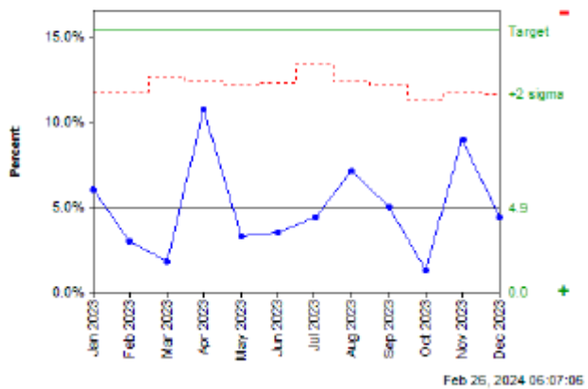
Opportunity Data

DV Inpatients - % Readmit to Acute Care within 30 Days (Q)



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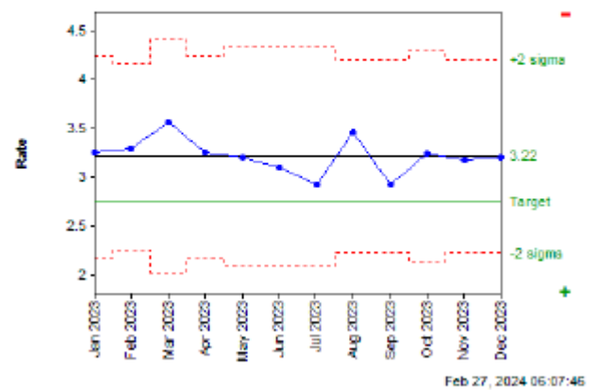
Acute Care - Geometric Mean Length of Stay |QQ|



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Clinical Quality Review

- Director of Quality performs a weekly thorough quality review of all:
  - readmissions
  - hospital acquired infections
  - surgical site infections
  - frequent ER visits
  - Unanticipated events
- The reviews are then referred to departments or medical staff to review and institute plans of correction when indicated.

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Peer Review Support

- Director of Quality, through clinical quality review, patient grievances, or referrals, completes the Peer Review form and refers to appropriate medical director for follow up
- This has allowed for a more robust peer review process at SVH. On average there are 1-2 peer review cases that are reviewed by the Medical Executive Committee each month
- Results of the peer review are shared with the identified provider via a follow up letter with outcomes of the peer review and recommendations by MEC

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Grievance/Risk Management

- All patient grievances and/or complaints are investigated immediately upon receipt
- Patient grievances are received via letter, phone calls or verbally in-person. All grievances are entered into our risk management system (MIDAS) and are followed by the Director of Quality
- All grievances receive a letter within 7 days acknowledging receipt and a second letter within 30 days with follow up results of investigation and resolution
- Monitors all risk events entered by staff and refers to department managers as needed for follow up and action

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Risk Events 2023

- SVH uses MIDAS Health Analytics that provides a comprehensive suite of solutions that makes it easier to manage risk and also improve performance
- Any staff member can enter a risk event in MIDAS
- Any unusual occurrence that occurs in the hospital should be entered as a risk event
- 217 Risk events entered for 2023
- Risk events after investigation are assigned a harm level

0	0-NONE (No Harm)
1	1-MINOR TEMPORARY (Minimal Temporary Harm)
2	2-MINOR PERMANENT (Minimal Permanent Harm)
3	3-MODERATE TEMPORARY (Moderate Temporary Harm)
4	4-MODERATE PERMANENT (Moderate Permanent Harm)
5	5-MAJOR (Severe Temporary/Permanent Harm)
6	6-DEATH (as a result of this event)

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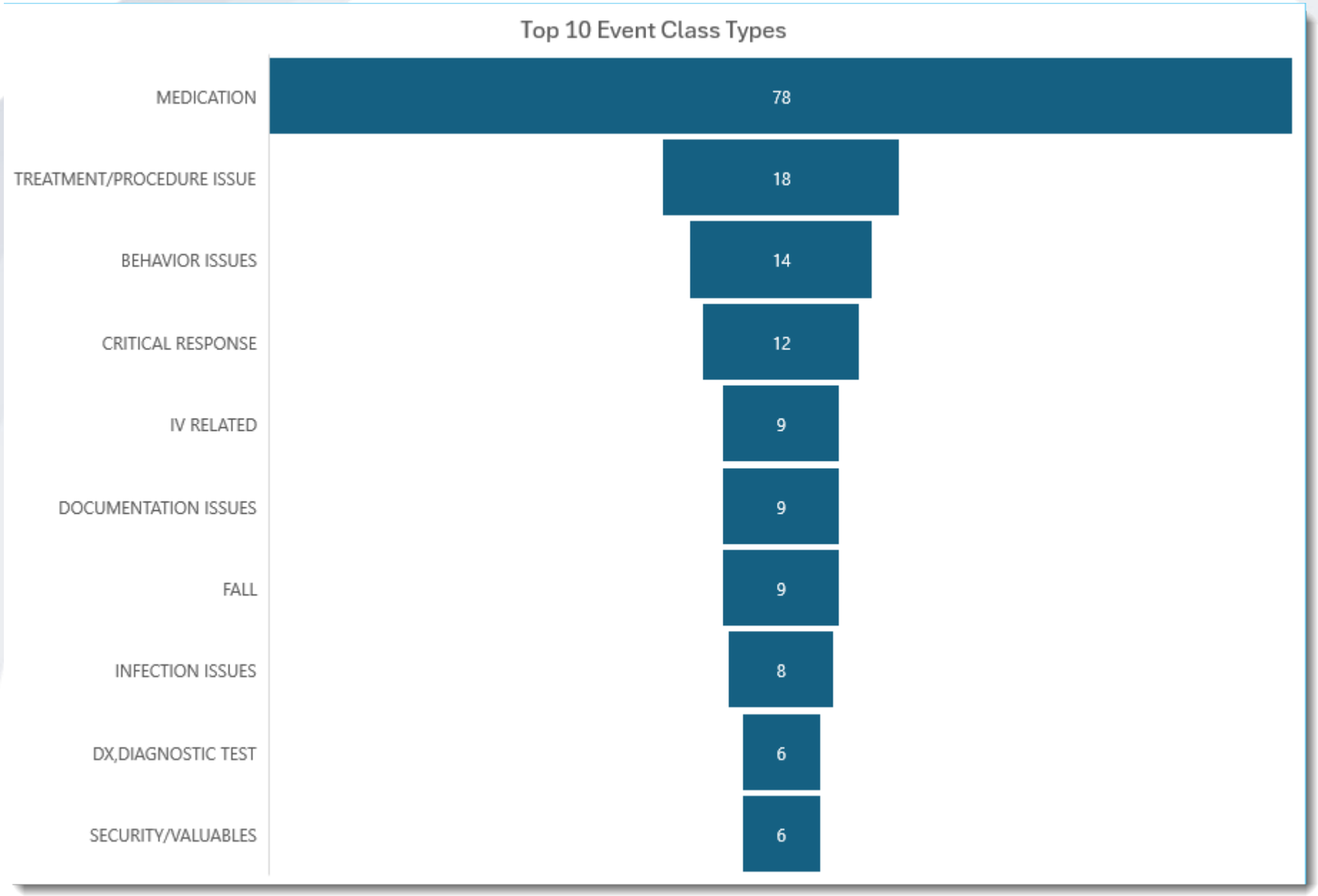
Event Types



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Risk Events 2023

- 90% of events were categorized as either no harm (65% of all events) or minimal temporary harm (25% of all events entered
- 36% of all events entered were medication related

MEDICATION	78
1-MINOR TEMPORARY (Minimal Temporary Harm)	1
D-Medication Event, intervention to eliminate possible harm	5
A-Medication Event, could have resulted in error	15
B-Medication Event, discovered before reaching patient	21
C-Medication Event, no harm	36

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Questions??

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SUBJECT: Quality Committee Charter	POLICY: QA8610-108
DEPARTMENT: ORGANIZATIONAL	PAGE 1 EFFECTIVE: 09.03.20
REVISED: 03.27.24	

NEW POLICY

OWNER:
Director of Quality

AUTHORS/REVIEWERS:
Director of Quality
Board Quality Committee Chair person

APPROVALS:
Policy & Procedure Team:
Board Quality Committee:
The Board of Directors:

SUBJECT: Quality Committee Charter	POLICY: QA8610-108
DEPARTMENT: ORGANIZATIONAL	PAGE 2 EFFECTIVE: 09.03.20
REVISED: 03.27.24	

PURPOSE:

The Board Quality Committee is responsible for guiding and assisting the Executive Leaders, Medical Staff, and the Governing Board in fulfilling their responsibility to oversee safety, quality, and effectiveness of care at Sonoma Valley Hospital; and to meet or exceed standards and regulations that govern health care organizations.

RESPONSIBILITIES:

The Committee has three broad sets of responsibilities.

- To directly oversee quality assurance and improvement processes are in place and operating in the hospital.
- To enhance quality across and throughout the patient care, technical, and operation areas of Sonoma Valley Hospital. This encompasses all aspects of the interface and experience between patients, families, and the community. This also includes coordination and alignment within the organization.
- To assure continual learning and skills development for risk surveillance, prevention, and continuous improvement.

The committee examines all activities against the Institute of Medicine's Six Aims for Improvement: safe, effective, patient/family-centered, efficient, timely, and equitable. This also aligns with the strategic plan of Sonoma Valley Hospital.

POLICY:

Oversight

As the governing body, the Governing Board is charged by law and by accrediting and regulatory organizations (e.g., Center for Improvement in Healthcare Quality CIHQ) with ensuring the quality of care rendered by Sonoma Valley Hospital through its various divisions and departments. The Committee has the delegated authority to establish accountability in medical staff and management to assure improvement is occurring and targeted outcomes are achieved. To help meet this responsibility, the Board Quality Committee exists to:

- Develop the quality goals and blueprint (priorities and strategies) for Sonoma Valley Hospital, using an inclusive and data driven-process.

- Review and monitor patient safety, risk mitigation, quality assurance, and improvement plans and progress.

- Have the authority to initiate inquiries, studies, and investigations within the purview of duties assigned to the Committee.

- Perform, on behalf of the Governing Board and Medical Staff Leadership, such other activities as are required by the CIHQ, Centers for Medicaid and Medicare Services (CMS), and other external accrediting and regulatory bodies.

- Render reports and recommendations to the Executive Leadership Committee of Sonoma Valley Hospital and SVH Medical Staff on its activities.

- Review all new and updated hospital patient care policies for adherence to quality and safety priorities.

- Review all Medical Staff credentialing.

Quality Integration

- The Committee monitors the quality assurance and improvement activities of Sonoma Valley Hospital's entities to enhance the quality of care provided throughout the hospital or medical center system and encourage a consistent standard of care. Monitored activities include but are not limited to:
    - Quality Performance Indicator Set
        - Mortality
        - Preventable Harm Events
        - Healthcare Acquired Infections
        - Medication Events
        - Never Events
        - Core Measures
        - Readmissions
        - Utilization Review
    - Patient Experience
    - Accreditation & Regulatory Standards
    - Quality Assurance Performance Improvement
    - Culture of Safety
    - Risk Event Reports
    - Policies & Procedures

- The Committee ensures the coordination and alignment of quality initiatives throughout Sonoma Valley Hospital.

- The Committee conducts annual reviews of the following key areas:
    - Improvement goal achievement
    - Clinical outcomes (priorities and improvement)
    - Patient Safety/Event Analysis/Risk Trending
    - Culture of Patient Safety
    - Accreditation and Regulatory Reviews
    - Emergency Operations Plans

- The Committee monitors the progress of quality assurance and improvement processes and serves as champion of issues concerning quality to other committees.

- The Committee identifies barriers to improvement for resolution and systematically addresses and eliminates barriers and excuses.

PROCEDURE:

All Committee meetings will have a Standard Agenda, which will include:

- Quality Performance Indicator Set
- Clinical Priorities (clinical outcomes/process improvement), including:
    - Quality Assurance Performance Improvement
    - Patient harm
    - Patient safety (adverse event reduction, healthcare acquired infection reduction, risk mitigation)
    - Performance to accreditation and regulatory standards and requirements
    - Patient Experience
    - Culture of Safety
    - Policies and Procedures
    - Medical Staff Credentialing

SUBJECT: Quality Committee Charter	POLICY: QA8610-108
DEPARTMENT: ORGANIZATIONAL	PAGE 5 EFFECTIVE: 09.03.20
REVISED: 03.27.24	

Rules

Charter Review	Will be reviewed/revised, at a minimum, every three years. Changes will be submitted to the Board of Directors for approval.
Authority to Act	In compliance with the Charter and as directed by Executive Leadership and the District Board
Meeting Schedule	At least ten meetings per year

Voting Members:	The Board Quality Committee shall have at least seven and no more than nine voting members.
	• Two Board members
	  o One of whom shall be the QC chair, the other the vice-chair.
	• Must be staffed by Director of Quality, Chief Medical Officer, and Chief Nursing Officer.
	  o At the request of the QC Chair, other SVH Staff may be requested to attend.
	• At least four and no more than six members of the public are selected by the Governing Board.

Quorum Requirement:	Half plus one member present.
Chair	One of the appointed Board Members
Composition	Voting Committee Members, Presenters, CEO, Chief Medical Officer (CMO) and Chief Nursing Officer (CNO), Director of Quality

REFERENCES:

www.ihi.org/improvement-areas/triple-aim-population-health
www.ihi.org/insights/quintuple-aim-why-expand-beyond-triple-aim

Quality Indicator Performance & Plan

Board Quality Presentation March 2024

Data For February 2024

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Mortality

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
Acute Care Mortality Rate (M)								
100% History	Target Met	4.8% 3/62	Deteriorated	Feb 2024	15.3%	n/a	n/a	3.6%
COPD Mortality Rate |M|								
91% 9% History	Target Met	0.0% 0/2	No Change	Feb 2024	8.5%	n/a	n/a	0.0%
Congestive Heart Failure Mortality Rate |M|								
100% History	Target Met	0.0% 0/3	No Change	Feb 2024	11.5%	n/a	n/a	0.0%
Pneumonia Mortality Rate |M|								
83% 17% History	Breaches Alarm	25.0% 1/4	Deteriorated	Feb 2024	15.6%	n/a	n/a	5.1%
Ischemic Stroke Mortality Rate |M|								
100% History	Target Met	0.0% 0/2	No Change	Feb 2024	13.8%	n/a	n/a	0.0%
Hemorrhagic Stroke - Mortality Rate (M)								
85% 15% History	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)								
75% 25% History	Target Met	0.0% 0/1	No Change	Feb 2024	25.0%	n/a	n/a	13.2%
Septic Shock - Mortality Rate (M)								
66% 34% History	Breaches Alarm	40.0% 2/5	Improved	Feb 2024	25.0%	n/a	n/a	27.6%

AHRQ Patient Safety Indicators

Indicator	Performance	Most Recent	Trend	Period				
PSI 90 (v2023-1) Midas Patient Safety Indicators Composite, ACA (M)								
	Breaches Alarm	22.79 0.433/0.019	Deteriorated	Feb 2024	0.00	n/a	n/a	3.35
PSI 90 (v2023-1) Patient Safety Indicators Composite, ACA - Numerator Volume (M)								
	Breaches Alarm	1	Deteriorated	Feb 2024	0	n/a	n/a	0

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Adverse Events Reporting

Indicator	Performance	Most Recent	Trend	Period				
Adverse Event | SE (M) volume 100% History	Target Met	0	No Change	Feb 2024	0	1	n/a	0

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Blood Products

Lab | Transfusion Effectiveness (M) 75% 25% History	Target Met	100.0% 7/7	— No Change	Feb 2024	100.0%	99.0%	n/a	94.7%
Lab | Transfusion Reaction (M) 83% 17% History	Target Met	0.0% 0/35	— No Change	Feb 2024	0.0%	1.0%	n/a	0.8%

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Significant Medication Errors and 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 0/62246	Improved	Feb 2024	1.13	2.00	n/a	0.11
Rx-Administration Errors Per 10,000 Doses Dispensed								
91% 9% History	Target Met	0.32 2/62246	Deteriorated	Feb 2024	1.00	3.00	n/a	0.37

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Patient Falls

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
RM ACUTE FALL- All (M) per 1000 patient days								
83% / 17%	Target Met	0.00 0/229	— No Change	Feb 2024	3.75	4.00	n/a	0.95
History								
RM ACUTE FALL- WITH INJURY (M) per 1000 patient days								
100%	Target Met	0.00 0/229	— No Change	Feb 2024	3.75	4.00	n/a	0.00
History								

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Readmissions

Readmissions

Indicator	Performance	Most Recent	Trend	Period				
30-DV Inpatients - % Readmit to Acute Care within 30 Days (M)								
	Target Met	11.32% 6/53	Deteriorated	Feb 2024	15.30%	15.50%	n/a	5.29%
COPD, CMS Readm - % Readmit within 30 Days, ACA (M)								
	Breaches Alarm	50.0% 1/2	Deteriorated	Feb 2024	19.5%	20.0%	n/a	13.0%
HF, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)								
	Target Met	0.0% 0/2	No Change	Feb 2024	21.6%	22.0%	n/a	2.9%
Hip/Knee, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)								
	Target Met	0.0% 0/1	No Change	Feb 2024	4.0%	5.0%	n/a	9.1%
PNA, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)								
	Target Met	0.0% 0/3	No Change	Feb 2024	16.6%	17.0%	n/a	0.0%
Sepsis, Severe - % Readmit within 30 Days (M)								
	Target Undefined	n/a		Feb 2024	12.0%	13.0%	n/a	0.0%
Septic Shock - % Readmit within 30 Days (M)								
	Target Met	0.0% 0/2	No Change	Feb 2024	13.3%	14.0%	n/a	0.1%

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Blood Culture Contamination

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔
Blood Cultures -Contamination Rate |LAB| (M)						
100% / History	Target Met	1.1% 1/94	Improved	Feb 2024	3.0%	4.0%
Blood Cultures -Total Contamination Rate (M)						
66% 25% 9% / History	Bet. Target & Alarm	3.2% 6/186	Deteriorated	Feb 2024	3.0%	4.0%
Blood Cultures -Contamination Rate |RN| (M)						
58% 8% 34% / History	Breaches Alarm	5.8% 5/86	Deteriorated	Feb 2024	3.0%	3.1%

Month	RN-Contaminated Culture Reports (num)	Blood Cultures Drawn by RN (den)	Percent
Feb 2024	5	86	5.8%
Jan 2024	1	93	1.1%
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%

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CIHQ Stroke Certification Measures

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
CDSTK-03|Median- Code Stroke Called |M| elapsed time (mins)								
91% 9% History	Target Met	10	Deteriorated	Feb 2024	10	11	n/a	4
CDSTK-04|Median- Door to Phys Eval |M| minutes								
100% History	Target Met	8	Deteriorated	Feb 2024	10	11	n/a	2
CDSTK-05|Median- Door to CT Scanner |M|elapsed time (minutes)								
91% 9% History	Target Met	12	Deteriorated	Feb 2024	25	26	n/a	8
CDSTK-06|Median- Neuro Consult Contacted |M| minutes								
83% 17% History	Target Met	21	Improved	Feb 2024	30	31	n/a	22
CDSTK-07|Median- CT Read by Radiology |M| minutes								
91% 9% History	Target Met	30	Deteriorated	Feb 2024	45	46	n/a	28
CDSTK-08|Median- Lab Results Posted |M| minutes								
91% 9% History	Target Met	26	Improved	Feb 2024	45	46	n/a	24
CDSTK-10|Median- Door to EKG Complete |M| minutes								
100% History	Target Met	21	Improved	Feb 2024	60	61	n/a	35
CDSTK-11|Median-Door to tPA Decision |M| minutes								
91% 9% History	Target Met	36	Improved	Feb 2024	60	61	n/a	36
CDSTK-12|Median-Door to tPA |M| minutes								
25% 17% 58% History	Target Undefined	n/a		Feb 2024	60	61	n/a	59

Utilization Management

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		⧖
MS-DRG Case Mix Index (CMI) |M|	Bet. Target & Alarm	1.45	Deteriorated	Feb 2024	1.55	1.40	n/a	1.42
MS-DRG Case Mix Index (CMI) MEDICARE |M|	Bet. Target & Alarm	1.44	Deteriorated	Feb 2024	1.55	1.40	n/a	1.47
1 Day Stay Rate Medi-Cal |M|	Target Met	0.00% 0/5	No Change	Feb 2024	2.61%	5.00%	n/a	0.00%
1 Day Stay Rate-Medicare |M|	Target Met	0.00% 0/48	No Change	Feb 2024	8.10%	10.00%	n/a	0.00%
Medicare Risk-adjusted Average Length of Stay, O/E Ratio |M|	Target Met	0.79 102/128.57	Deteriorated	Feb 2024	0.99	1.00	n/a	0.85
Acute Care - Geometric Mean Length of Stay |M|	Breaches Alarm	3.28 29.5329/9	Improved	Feb 2024	2.75	3.23	n/a	3.32

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Core Measures

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
Core OP29/ASC9 - Colonoscopy:F/U for Avg Risk Pts (M)								
100% History	Target Met	100.0% 13/13	No Change	Feb 2024	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)								
25% 8% 67% History	Breaches Alarm	161.00	Deteriorated	Feb 2024	132.00	140.00	n/a	146.75
Indicator	**Performance**	**Most Recent**	**Trend**	**Period**	⊙	🔔		✕
Core OP 22 ED LWBS Emergency Dept Left Without Being Seen (M)								
100% History	Target Met	0.7% 5/714	Deteriorated	Feb 2024	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)								
50% 25% 25% History	Target Met	100.0% 1/1	No Change	Feb 2024	72.0%	70.0%	n/a	75.0%

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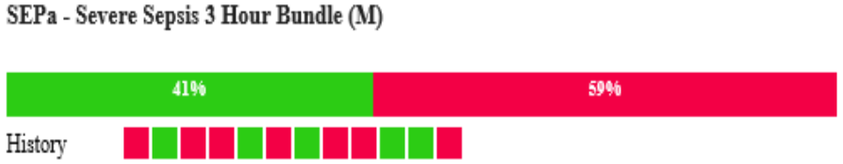
Core Measures Sepsis

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		⧖
SEP-1 Early Management Bundle, Severe Sepsis/Septic Shock (M)								
	Breaches Alarm	60.0% 3/5	Deteriorated	Feb 2024	81.0%	80.0%	n/a	69.1%
SEPa - Severe Sepsis 3 Hour Bundle (M)								
	Breaches Alarm	60.0% 3/5	Deteriorated	Feb 2024	94.0%	90.0%	n/a	83.8%
SEPb - Severe Sepsis 6 Hour Bundle (M)								
	Target Met	100.0% 2/2	No Change	Feb 2024	100.0%	90.0%	n/a	91.5%

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Infection Prevention

Infection Prevention

Indicator	Performance	Most Recent	Trend	Period				
IC-Surveillance| HAI-C.DIFF Inpatient infections per 10k pt days |M|								
90% / 10% — History	Target Met	0	No Change	Feb 2024	1	1	n/a	0
IC-Surveillance| HAI-CAUTI Inpatient infections per 10k patient days |M|								
90% / 10% — History	Breaches Alarm	1	Deteriorated	Feb 2024	1	1	n/a	0
IC-Surveillance| HAI-CLABSI Inpatient infections per 10k patient days |M|								
96% / 4% — History	Target Met	0	No Change	Feb 2024	1	1	n/a	0
IC-Surveillance| HAI-MRSA Inpatient infections per 10k patient days |M|								
100% — History	Target Met	0	No Change	Feb 2024	1	1	n/a	0
IC-Surveillance| HAI-SSI infections per 10k pt days |M|								
91% / 9% — History	Target Met	0	No Change	Feb 2024	1	1	n/a	0
QA-02 | Hand Hygiene Practices Monitored |M|								
41% / 16% / 25% / 18% — History	Target Met	92% 55/60	Deteriorated	Feb 2024	90%	85%	n/a	85%

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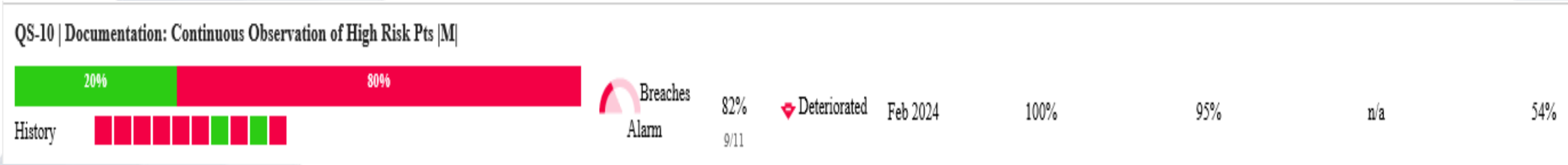
CIHQ Corrective Action Plan Monthly Compliance Condition Level Finidings



DATE	1:1 Observation for High Risk Patie		Percent
Feb 2024	9	11	82%
Jan 2024	6	6	100%
Dec 2023	5	8	62%
Nov 2023	4	4	100%
Oct 2023	3	6	50%
Sep 2023	2	6	33%
Aug 2023	2	4	50%
Jul 2023	1	5	20%
Jun 2023	2	6	33%
May 2023	1	9	11%

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Patient Satisfaction

HCAHPS reported quarterly

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Rate My Hospital
Scale 1-5
February Data

	Question Responses	Average Score
Sonoma Valley Hospital / Emergency Department	91	4.647 95% CI: 4.584—4.710

	Question Responses	Average Score
Sonoma Valley Hospital / Inpatient Care	7	4.976 95% CI: Not enough samples

	Question Responses	Average Score
Sonoma Valley Hospital / Outpatient Surgery	46	4.935 95% CI: 4.909—4.960

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Rate My Hospital
Scale 1-5
January Data

	Question Responses	Average Score
Sonoma Valley Hospital / Medical Imaging	212	4.901 95% CI: 4.881—4.921

	Question Responses	Average Score
Sonoma Valley Hospital / Hand and Physical Therapy	150	4.933 95% CI: 4.909—4.957

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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: Reese, Whitney (wreese)
Run date: 03/23/2024 9:19 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: 8

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

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

Current Approval Tasks (due now)

Document	Task/Status	Pending Since	Days Pending
Admission to the Hospital from the ED *Emergency Dept*	**Pending Approval**	3/21/2024	2

Summary Of Changes: **Removed reference to "Administrative Coordinator" and changed it to "House Supervisor." Added language that patient must be notified of admission and to ask patient if they want a family member or their personal physician notified of admission. Added ED RN to complete disposition assessment (a specific feature of EHR). Updated references, added Authors/Reviewers and Approvers.**

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

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

Approvers: **Winkler, Jessica (jwinkler) -> 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)**

Infection Control Mandatory Reporting *Infection Prevention & Control Policies (IC)*	**Pending Approval**	3/21/2024	2

Summary Of Changes: **No changes, no revisions made. Policy is current**

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

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

ExpertReviewers: **Kidd, Sabrina (skidd)**

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)**

NEW: Imaging Vascular Access and Use of Vascular Lines and Ports for Contrast Administration *Diagnostic Services Dept Policies*	**Pending Approval**	3/21/2024	2

Summary Of Changes: **This new policy combines and updates two older policies:**

- **Central Venous Catheters: Power Injection of Contrast 7630-117**
- **Central Lines, PICC Lines 7630-115**

WHY:
Replacing with new policy makes it easier to refer to one policy when needed. It also ties in with our hospital policy on CVC and Implanted Port Access PC8610-120.

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)**

Nuclear Medicine Safety Measures — **Pending Approval** — 3/21/2024 — 2

Diagnostic Services Dept Policies

Summary Of Changes:	**Added section for Misadministration of Radioisotopes (taken from old policy 7630-167) Added references to Nuclear Regulatory Commission.**
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)**

Retire: Central Lines, PICC Lines 7630-115 — **Pending Approval** — 3/21/2024 — 2

Diagnostic Services Dept Policies

Summary Of Changes:	**Retire policy. Combining this policy with policy 7630-117 Central Venous Catheters: Power Injection of Contrast into a new updated policy.**
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)**

Retire: Central Venous Catheters Power Injection 7630-117 — **Pending Approval** — 3/21/2024 — 2

Diagnostic Services Dept Policies

Summary Of Changes:	**Retire policy. This policy is being combined with 7630-115 in a new updated policy.**
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)**

RETIRE: Misadministration of Radioisotopes — **Pending Approval** — 3/21/2024 — 2

Diagnostic Services Dept Policies

Summary Of Changes:	**Retire policy. The necessary details were added to policy 7630-185.**
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)**

Trophon Environmental Probe Reprocessor (EPR) — **Pending Approval** — 3/21/2024 — 2

Diagnostic Services Dept Policies

Summary Of Changes:	**Reviewed policy. No substantial changes made.**

	Updated title. **Updated owner, authors, reviewers.**
Moderators:	**Newman, Cindi (cnewman)**
Lead Authors:	**Young, Dave (dyoung)**
ExpertReviewers:	**Medical Director-Diagnostic Radiology**
Approvers:	**Kuwahara, Dawn (dkuwahara) -> 01 P&P Committee - (Committee) -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

SUBJECT: Imaging Vascular Access and Use of Vascular Lines and Ports for Contrast Administration	POLICY: RD7630-2401 Page 1 of 7
DEPARTMENT: Medical Imaging	EFFECTIVE:
REVISED:	

NEW POLICY
This new policy combines and updates two older policies:

- Central Venous Catheters: Power Injection of Contrast 7630-117
- Central Lines, PICC Lines 7630-115

WHY:

Replacing with new policy makes it easier to refer to one policy when needed. It also ties in with our hospital policy on CVC and Implanted Port Access PC8610-120.

OWNER:
Chief Ancillary Officer

AUTHORS/REVIEWERS:
Director of Diagnostic Services
Radiology Medical Director
Board Quality Committee

SUBJECT: Imaging Vascular Access and Use of Vascular Lines and Ports for Contrast Administration	POLICY: RD7630-2401 Page 2 of 7
DEPARTMENT: Medical Imaging	EFFECTIVE:
REVISED:	

PURPOSE:

Safe intravenous access, for the injection of intravenous contrast, is vital in obtaining high quality contrast enhanced or angiographic studies. Proper technique is used to avoid the potentially serious complications of contrast media extravasation, damage to the catheter and/or air embolism. When the proper technique is used, contrast medium can safely be administered intravenously by power injection.

POLICY:

Injection methods vary depending on vascular access and type of examination. Injections of contrast media can be by hand or by power injector. Stable intravenous access is necessary.

Power Injections
When contrast is administered by a power injector, a flexible plastic cannula is required, no metal needles. In addition, the flow rate should be appropriate for the gauge of the catheter used. An antecubital or large forearm vein is the preferred venous access site for power injection. Distal venipuncture sites should be avoided for power injection.

It is the responsibility of the technologist to determine if the vascular device/catheter (CVC, PICC) is power injectable prior to using it. Two identifiers are to be used for verification.

a. Catheter/implant identification provided by the patient; i.e. implant care, key chain or ID bracelet.
b. Visualization on chest xray or CT scout. The letters “CT” must be clearly visible.
c. Procedure note in the EHR confirming the type of catheter/port placed.
d. Palpation – the ports can be identified by shape or other identifying marks (bumps).
e. Labeling – the catheter is labeled on the hub, extension leg, junction and clamp ID tag. Some catheters have the words “No CT” marked on the lumen. These are not to be used for power injection.

The following criteria are **not** to be used in confirmation of a vascular device/catheter.

a. The nurse accessed the port.
b. The nurse stated that the catheter/port is power injectable.
c. The patient states that the catheter/port is power injectable.

1) Peripheral IV
Doctors, nurses and radiology technologists can insert peripheral IV catheters in the patients arm for the purpose of contrast administration. A peripheral intravenous line (20 gauge) in the antecubital or forearm area is preferred when power injections are needed in adults.

2) PICCs (peripherally inserted central catheters)
PICCs that are power injectable are clearly marked "power injectable" and have a maximum flow rate printed on the catheter lumen or hub itself. They can be power injected by a licensed practitioner or RN and should only be used according to manufacturer's guidelines in the presence of appropriately trained personnel.

3) Chest Ports and Central Lines (CVC)
Contrast may be injected through a power central port or CVC. A physician's or authorized prescriber's order is required for accessing a power injectable port or CVC. These lines may only be accessed and connected to the contrast line by a licensed practitioner or RN.

PROCEDURE:

A Radiology technologist may administer intravenous contrast media under the general supervision of a physician. This policy applies for all areas in Medical Imaging where intravenous iodinated and MRI contrast media is given. To provide for the safe administration of contrast media, those persons administering contrast media and those performing the imaging procedures must have an understanding of indications for use of contrast media as well as the potential side effects (contrast reactions) and their management.

ED and Inpatients
The sending department needs to establish or confirm IV patency prior to sending the patient to Medical Imaging.

Peripheral IV
A peripheral intravenous line (20 gauge) in the antecubital or forearm area is preferred when power injections are needed. Although 22-gauge catheters may be able to tolerate flow rates up to 5 ml/sec, the 20-gauge or larger catheter is preferable for flow rates of 3 ml/sec or higher. When a 22-gauge catheter is used, the technologist should adjust the injection rate to < 3.0 cc/sec in adults (2.0 cc/sec. in pediatrics) to suit the smaller bore catheter.

A small peripheral line IV of 24 gauge, should only be used for contrast by hand injection.

Before initiating the injection, the position of the catheter tip should be checked for venous backflow by withdrawing blood and flushing with normal saline. A saline test flush may be used to test the power injection. Standard procedures should be used to clear the syringe and pressure tubing of air before connecting to the catheter. A critical step in preventing significant extravasation is direct monitoring of the venipuncture site by palpation during the initial portion

of the contrast medium injection. If no problem is encountered during the initial injection, the individual monitoring the injection exits the CT scan room before the scanning begins. If extravasation is detected, the injection is stopped immediately. If the patient complains of pain the injection should be stopped and the patient examined for signs of extravasation.

PICCs (peripherally inserted central catheters)
Power injection of contrast media through some peripheral central venous catheters can be performed safely as long as certain precautions are followed. PICCs that are power injectable are clearly marked “power injectable” and have a maximum flow rate printed on the catheter lumen or hub itself.

1. Before using a PICC line an antecubital or large forearm vein should be considered before selecting the peripheral venous catheter.
   a. A peripheral IV must be used for all CT Angiograms, Pulmonary Embolus, Dedicated Liver, Renal Mass and Pancreatic studies.
2. The CT tech should check to see if the patient has a recent chest x-ray to verify proper location of the catheter tip. This can also be done with a scout picture on the CT scanner.
3. The technologist should make all attempts to verify the type of PICC by looking in the EMR, often times the PICC’s have been placed at a hospital with records associated in our EMR.
4. Before connecting the PICC to the power injector the catheter should be tested for venous backflow. Occasionally backflow will not be obtained because the catheter tip is positioned against the wall of the vein in which it is located. If this is the case the PICC cannot be used.
5. If saline can be injected through the catheter without abnormal resistance or discomfort then contrast media can be administered through the catheter safely.
6. For questions regarding injection safety though a PICC line refer to the Radiologist or the manufactures guidelines for the catheter.

It cannot be assumed that all vascular catheters including peripherally inserted central catheters (PICC) can tolerate a mechanical injection. A number of manufacturers have produced power injector compatible vascular catheters that should be clearly marked. In order for a PICC line to be used for power injection of contrast it must be approved for use with a power injector. Most catheters can be identified by the tag at the hub labeled “CT”.

Prior to connecting to a power PICC the technologist and RN should:

a. Verify patient identity and the contrast being used.
b. Visually inspect the external portion of the line for integrity and proper position.
c. Check that the line flushes properly with normal saline.

Chest Ports

- Verify that there is an authorized prescriber’s order to access the power injectable port.

- Coordinate with nursing to prepare and access the port.
- Verify identification of the port as described in this policy. If the technologist is unable to clearly identify the port as power injectable, peripheral access will be used unless directed otherwise by a radiologist.
- Ensure that the power injector settings DO NOT exceed the maximum flow rates and pressure settings provided by the manufacturer.
- The RN should follow policy #PC8610-120 Central Venous Catheter/Implanted Port Access and Management.

Prior to connecting to a power port the technologist and RN should:

a. Verify patient identity and the contrast being used.
b. Visually inspect the external portion of the line for integrity and proper position.
c. Check that the line flushes properly with normal saline.

Central Lines

- A peripheral IV must be used for all CT Angiograms, Pulmonary Embolus, Dedicated Liver, Renal Mass and Pancreatic studies.
- Verify that there is an authorized prescriber's order to access the central line.
- Coordinate with nursing to prepare and access the line.
- Central line catheters should not be used until the psi and flow rating have been verified. If the product manufacturer and model cannot be determined, the psi and flow rate information may be available on the manufacturers website. Contact the radiologist for approval to use the CVC for power injection.
- Verify identification of the line as described in this policy. If the technologist is unable to clearly identify the line as power injectable, peripheral access will be used unless directed otherwise by a radiologist.
- Ensure that the power injector settings DO NOT exceed the maximum flow rates and pressure settings provided by the manufacturer.
- The RN should follow policy #PC8610-120 Central Venous Catheter/Implanted Port Access and Management.

Prior to connecting to a power line the technologist and RN should:

a. Verify patient identity and the contrast being used.
b. Visually inspect the external portion of the line for integrity and proper position.
c. Check that the line flushes properly with normal saline.

Dialysis catheters

- Dialysis catheters are NOT to be used.

IV cannulas inserted into the Internal or External Jugular Vein

- Short IV cannulas placed in the jugular vein should not be power injected by the technologist or RN because of the dangers of extravasation in the neck. The preference is to attempt a peripheral IV in the patient for contrast administration. If this is not possible and it is deemed necessary for the patient to receive a contrast scan, then contact the Radiologist. The line will be checked for blood return and flushed with saline bolus. It can only be hand injected by an RN or MD for contrast enhanced scan but not for a CT angiogram.

Injection Guidelines

1. An electronic order for an imaging study is placed by a referring physician in the electronic medical record.
2. The radiology team will review the imaging study order, determine whether the study requires iodinated contrast administration or not, and select an appropriate imaging protocol. This protocol will be for the technologist to follow when performing the examination.
3. Upon arrival to the department, the patient completes the “Patient Screening Form For Iodinated Contrast.”
4. The radiology technologist reviews the completed form and notifies the Radiologist of any contraindications or serious risk factors noted. The pharmacist may be consulted as necessary.
5. Most patients have some degree of anxiety and fear concerning imaging procedures. The radiology technologist questions the patient regarding their expectations, explains the iodinated contrast procedure and reassures the patient. The patient should be offered the opportunity to speak with a radiologist if questions persist or anxiety seems pronounced.
6. The radiology technologist check orders for contrast administration, verify the five rights (right patient, right medication, right dose, right route, right time). Dosage is determined by scan protocol and body weight per manufacturer's recommendations.
7. Transient minor reactions such as warm flushing and altered sense of taste are common. Before beginning injection, the radiology technologist explains that these may occur and reassures the patient.
8. The patency of the IV catheter is checked by flushing with 0.9% normal saline (using the injector at the same rate as the actual contrast injection). If there is resistance, pain, or the catheter does not flush, do not proceed. Otherwise, connect the fluid filled high-pressure tubing to the catheter at the hub closest to the catheter. Contrast flow is manually tested to ensure patency. Proceed with contrast injection.

9. At the completion of the injection, the catheter is flushed with 10cc or more 0.9% normal saline, the high-pressure tubing is disconnected, and the IV site is inspected for any swelling or indication of extravasation. The patient is observed for any indications of contrast reaction throughout the administrative process.

Key Points

- The supervising physician must be physically present in the facility or office suite and available in order to provide immediate medical intervention to prevent or mitigate injury to the patient in the event of an adverse contrast reaction.
- Iodinated intravenous contrast media are pharmaceuticals and have potentially dangerous and life-threatening adverse reactions.
- Most major and minor reactions will occur in patients without any known risk factors. Virtually all life-threatening reactions occur immediately or within 20 minutes after contrast injection.
- All areas where contrast is given must be equipped with emergency treatment supplies required for the treatment of common contrast reactions.
- A clinically significant event and its treatment should be documented in the radiology report and patient's medical record. Counseling about future contrast media administration and the possible need for future premedication should be directly communicated to the patient as well as the patient's referring physician, if possible. Unforeseen events, extravasation or reactions should be documented in the hospital incident/occurrence reporting software.

REFERENCES:
ACR Manual on Contrast Media, 2023, ACR Committee on Drugs and Contrast Media
SVH Policy PC8610-120

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