SVHCD QUALITY COMMITTEE

AGENDA

WEDNESDAY, SEPTEMBER 24, 2025

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/99901004530?from=addon

Meeting ID: 999 0100 4530

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 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	*Daniel Kittleson, DDS*	
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.*	*Daniel Kittleson, DDS*	
3. CONSENT CALENDAR • Minutes 08.27.25	*Daniel Kittleson, DDS*	Action
4. IMAGING QA/PI	*Troy Ashford, MJ, BS, R.T.(R) (MR)*	Inform
5. QUALITY INDICATOR PERFORMANCE & PLAN	*Jessica Winkler, DNP, RN, NEA-BC, CCRN-K, SVH CNO*	Inform
6. POLICIES AND PROCEDURES	*Jessica Winkler, DNP, RN, NEA-BC, CCRN-K, SVH CNO*	Inform
7. ADJOURN	*Daniel Kittleson, DDS*	

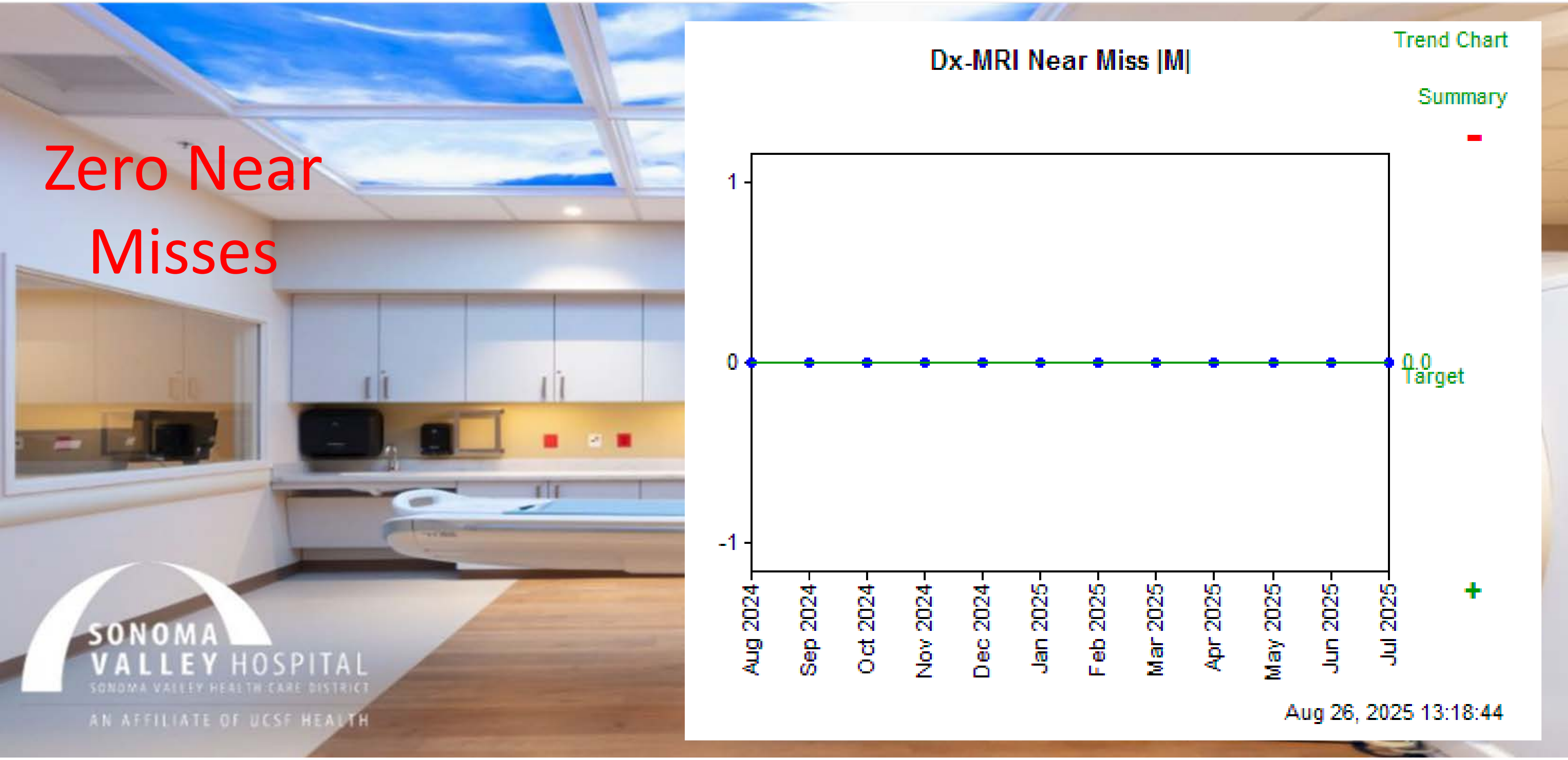
SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
Wednesday, August 27, 2025, 5:00 PM
MINUTES

Members Present	Excused/Not Present	Public/Staff – Via Zoom
Daniel Kittleson, DDS Wendy Lee Myatt Michael Mainardi, MD Kathy Beebe, RN PhD Carol Snyder	Howard Eisenstark, MD Carl Speizer, MD Susan Kornblatt Idell	Louise Wyatt, RN JD, SVH Director of Quality Jessica Winkler, DNP, RN, NEA-BC, CCRN-K, SVH CNO Whitney Reese, SVH Board Clerk Leslie Petersen, SVH Foundation ED

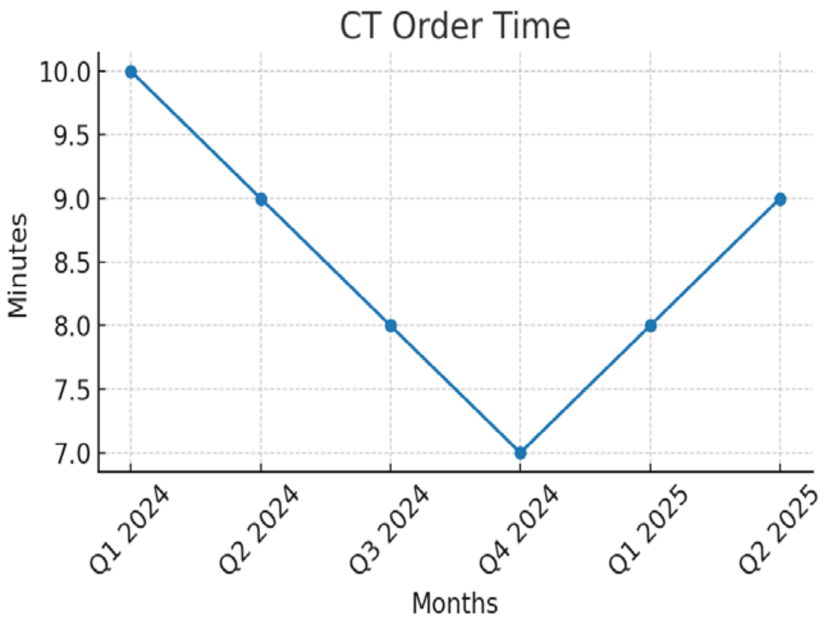
AGENDA ITEM	DISCUSSION	ACTION
1. CALL TO ORDER/ANNOUNCEMENTS	*Daniel Kittleson, DDS*	
Kittleson called meeting to order at 5:00 p.m.		
2. PUBLIC COMMENT SECTION	*Daniel Kittleson, DDS*	
No public comments		
3. CONSENT CALENDAR	*Daniel Kittleson, DDS*	ACTION
Minutes 06.25.25	*Motion to approve by Mainardi 2nd by Lee Myatt. All in favor.*	
4. INPATIENT SERVICES QA/PI	*Jane Taylor RN, MSN, CENP*	INFORM
Taylor presented an update on QAPI and quality initiatives, highlighting four priority measures for 2025: individualized care plans, nursing education at discharge, hand hygiene, and patient mobility, aligned with the Age-Friendly Health System framework. Compliance with individualized care plans is trending at 85–95% against a 90% goal. Discharge education has been strengthened through Epic's after-visit summaries, family involvement, follow-up calls, and staff training, resulting in HCAHPS scores slightly above national averages. Efforts to reduce readmissions, particularly for CHF and COPD, include use of the "My Plan" tool, closer collaboration with pharmacy, and quarterly meetings with local skilled nursing facilities. Hand hygiene compliance remains strong at 80-90%, and mobility documentation is consistent at 80-90%, with a new focus on getting patients out of bed for morning meals. Additional initiatives include "4 eyes in 4 hours" skin assessments, stroke program quality measures (earning AHA Silver Plus recognition), reduction of restraint use, age-friendly environmental improvements,		

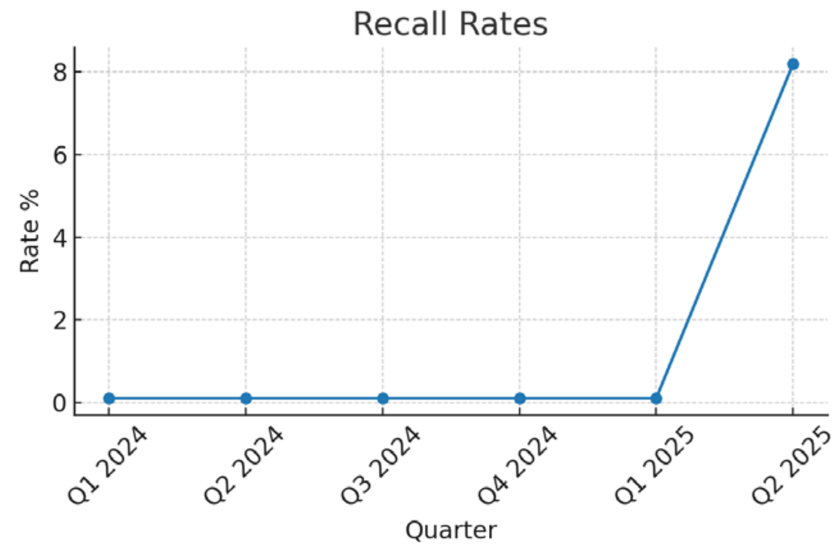
and benefits from the recent ICU remodel. Discussion emphasized the importance of patient/family engagement, follow-up after discharge, SNF readmissions, and collaboration with UCSF neurology.		
5. PATIENT CARE SERVICES DASHBOARD 2ND QTR (2025)	*Jessica Winkler, DNP, RN, NEA-BC, CCRN*	INFORM
Winkler presented the patient care services dashboard, highlighting strong progress in medication safety, documentation, and blood culture contamination rates. Surgical services are addressing challenges with case scheduling, and teams are actively working on strategies to improve efficiency. Compliance with organ and tissue donation referrals is strengthening as staff adapt to new reporting requirements. Nursing turnover was minimal and for positive reasons, reflecting staff advancement and personal opportunities. Patient throughput remains a focus, with continued efforts to streamline processes and enhance patient flow. Overall, the report reflected positive momentum with targeted improvements underway.		
6. QUALITY INDICATOR PERFORMANCE & PLAN	*Louise Wyatt, RN JD*	INFORM
Wyatt presented June data due to reporting lags, noting no significant harm or concerning trends. Policies and procedures are being revamped, with a backlog expected to clear soon, and the new Age-Friendly Health System policy was introduced to align with CMS requirements. Quality metrics overall remain strong, with mortality and safety indicators meeting targets, infection control stable, and readmissions showing improvement, though length of stay and sepsis bundle compliance continue to be areas of focus. The AFHS discussion emphasized the challenge of balancing patient wishes with family expectations, and the Board will begin receiving quarterly reports on this program starting next year.		
5. POLICIES & PROCEDURES	*Louise Wyatt, RN JD*	INFORM
Wyatt presented new policy: • Age-Friendly Health System (AFHS) Committee complimented the policy with appreciation to the authors for putting in a lot of thorough information, integrating it with the EHR datasets and order sets for nurses.		
6. CLOSED SESSION: a. Calif. Health & Safety Code §32155: Medical Staff Credentialing & Peer Review Report	*Daniel Kittleson, DDS*	ACTION
Report was not presented so Committee abstained from recommending approval		
7. ADJOURN	*Daniel Kittleson, DDS*	INFORM
	Meeting adjourned at 6:05 p.m.	

Performance & Safety Overview (Aug 2024 – Jul 2025)



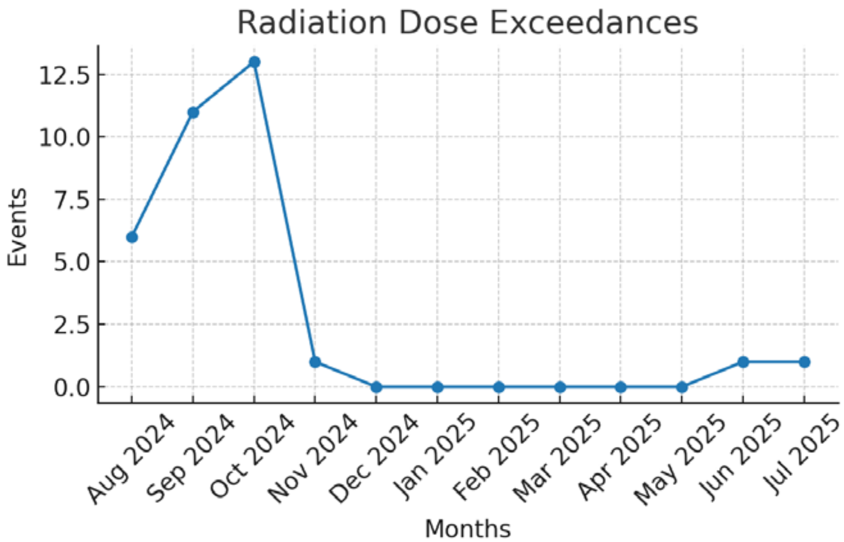
Key Metrics with Trends & Graphs

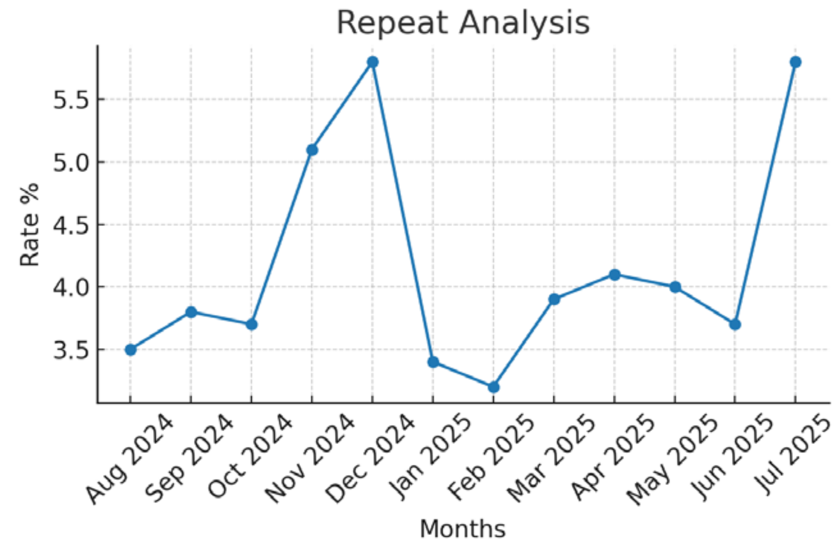




- Performance Range: 7–13 minutes across reported months
- Recent Trend: 2025 shows consistently strong results (7–10 min)
- Target: 29 minutes → performance is well below target all year

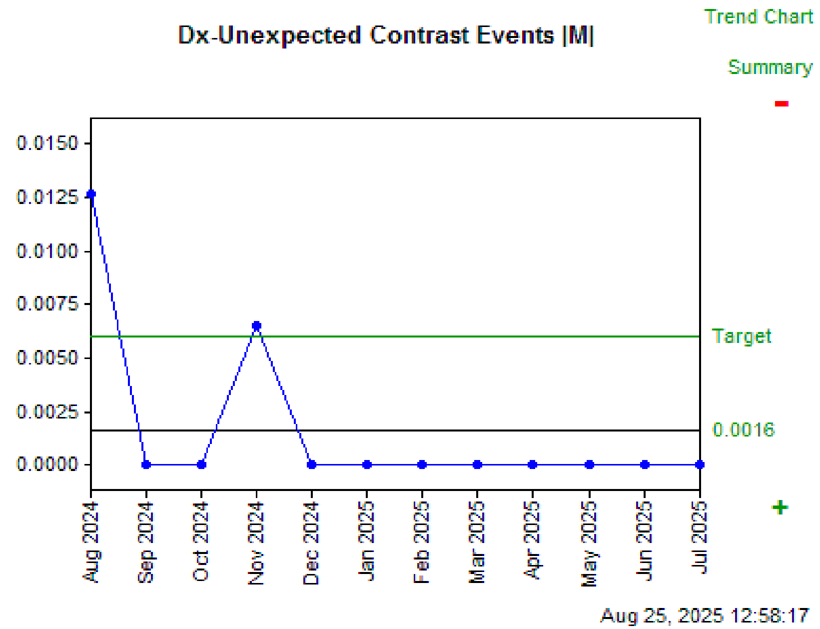
- Q**1 2024 – Q1 2025:** Recall rate consistently **0.1%**, far below target (≤9.0%).
- Q2 2025: Jump to 8.2%, still under target but a sharp increase compared to prior trend.
- Most U.S. practices aim for about **10% or lower**, balancing cancer detection with minimizing unnecessary callbacks.

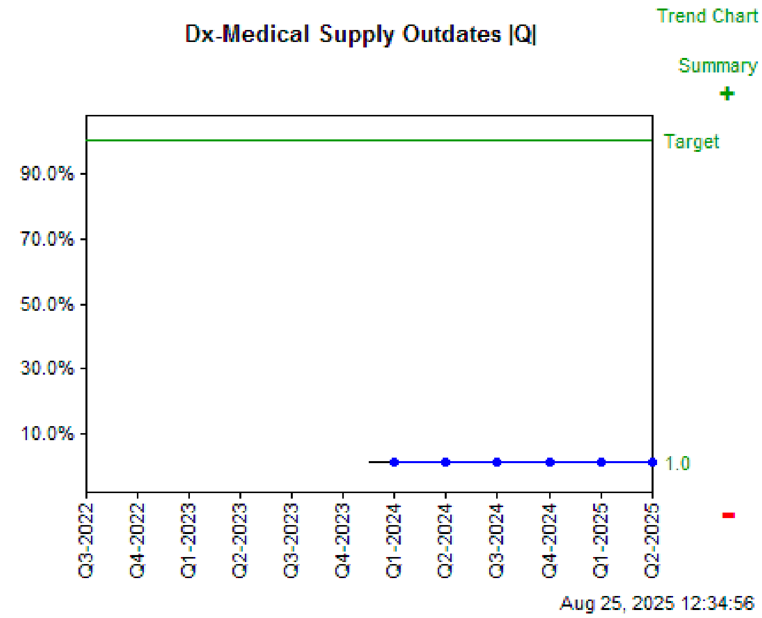




- **Metric:** Number of CTDI radiation dose events exceeding protocol limits.
- **Target:** 0 (no exceeds).
- **Initial concern:** High number of protocol exceedances in Fall 2024.
- **Improvement:** Sustained **zero exceedances for 6 consecutive months** (Dec 2024–May 2025).
- Overall trend demonstrates **effective corrective measures**, but vigilance is necessary.

- Repeat Analysis – Monthly (Aug 2024 → Jul 2025)
- Mostly within range: 3.1% – 4.3% across many months.
- Above target: **Dec 2024** (5.8%), **Nov 2024** (5.1%), **Jul 2025** (5.8%).
- Generally stable, but **occasional spikes above 5%** indicate areas to monitor closely.





- Strong safety record with **rare, isolated events**. Overall trend demonstrates **effective contrast safety management**.
- Unfortunately, the data is skewed, and appropriate measure have been taken to collect the correct data .

- Performance is **stable and predictable**.
- The constant 1.0% suggests **effective inventory management** with minimal waste.
- **Action:** Maintain monitoring to ensure this rate remains low and consistent**.**

SONOMA VALLEY HOSPITAL
SVH Board Quality

September 24, 2025

LOUISE WYATT, RN JD

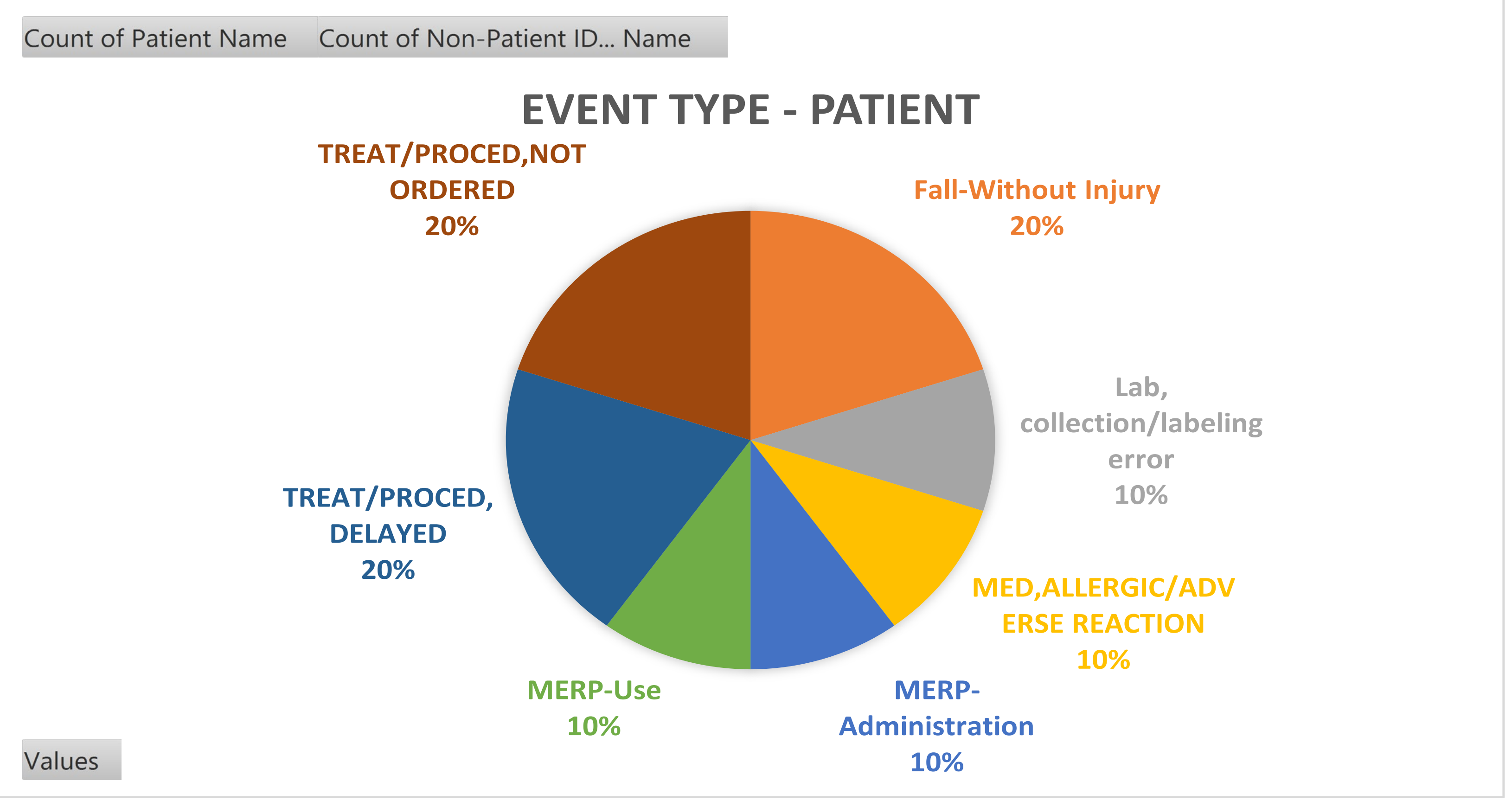
Director of Quality, Risk Management, Patient Safety,

Infection Control, Case Management & Regulatory

Risk Management/Patient Safety Report

July 2025 Midas Events by Type

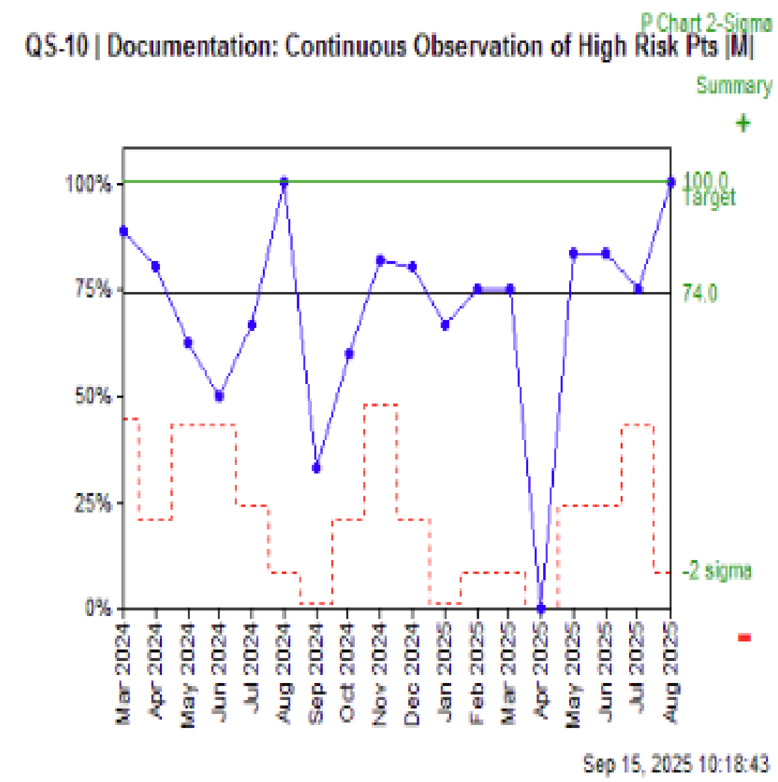
***Falls – no injuries**



Row Labels	Count of Event Type
EMPLOYEE INCIDENT	1
FALL	2
Lab	1
MEDICATION	3
TREATMENT/PROCEDURE	4
Grand Total	11

CIHQ Corrective Action Plan Monthly Compliance Condition Level Findings: Continuous Observation of High Risk of Self Harm Patients

DATE	1:1 Observation for High Risk Patie		Percent
Aug 2025	4	4	100%
Jul 2025	6	8	75%
Jun 2025	5	6	83%
May 2025	5	6	83%
Apr 2025	0	1	0%
Mar 2025	3	4	75%
Feb 2025	3	4	75%
Jan 2025	2	3	67%
Dec 2024	4	5	80%
Nov 2024	9	11	82%
Oct 2024	3	5	60%
Sep 2024	1	3	33%
Aug 2024	4	4	100%
Jul 2024	4	6	67%
Jun 2024	4	8	50%
May 2024	5	8	62%
Apr 2024	4	5	80%
Mar 2024	8	9	89%



Issues Identified with Suicide Precaution Monitoring:

1.MD Orders Required for Suicide Precautions

1. Current policy requires a physician's order to initiate suicide precautions.
2. Physicians reported they were previously unaware of this requirement, noting that suicide precautions have historically been initiated by nursing staff without an MD order.

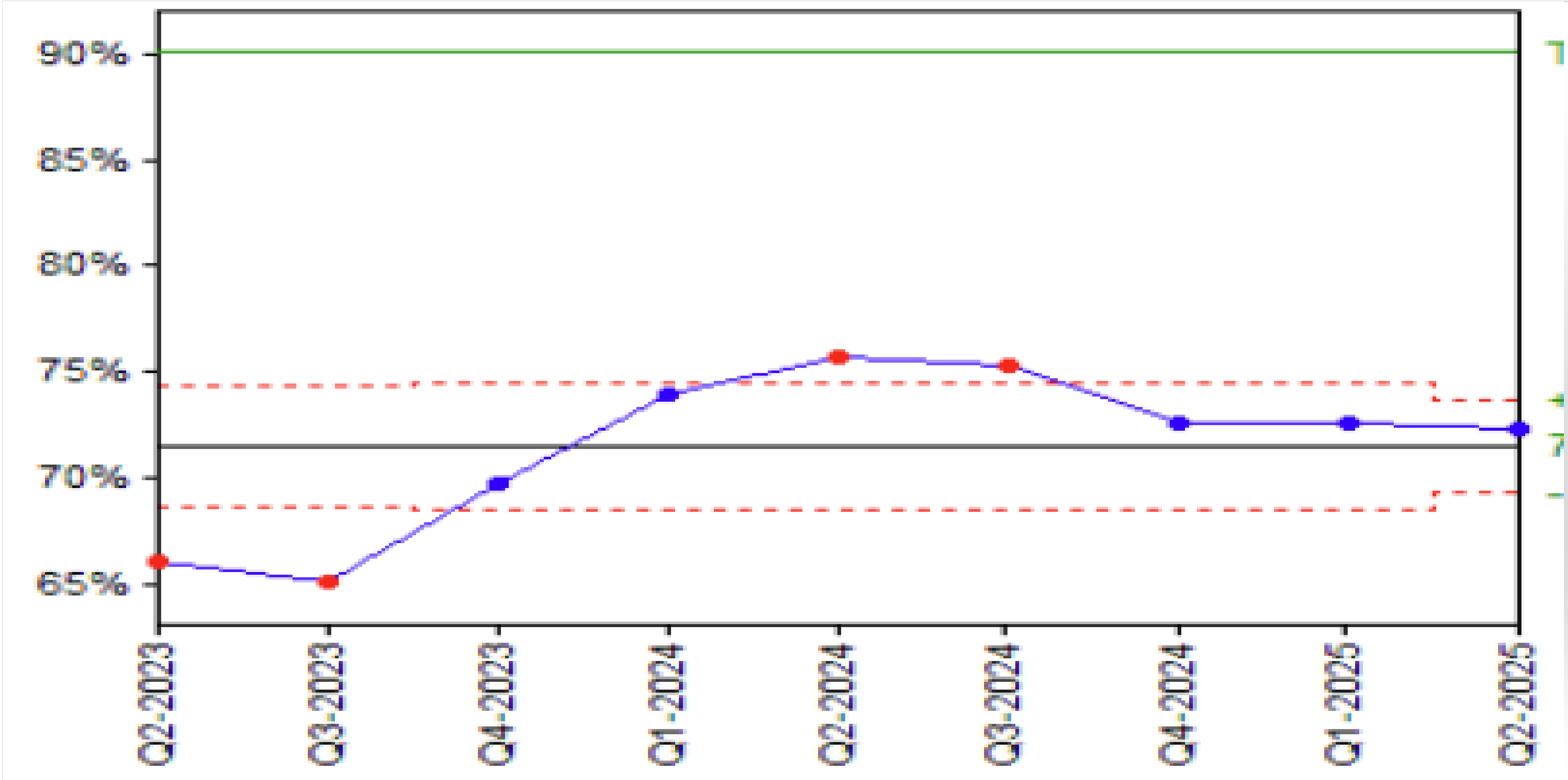
2.Documentation Workflow for Observations

1. Observations by RNs, CNAs, or ED Techs must be charted on the designated flow sheet.
2. The appropriate flow sheet is not automatically visible or intuitive; it must be manually searched for and added to each patient chart.

3.Minimum Documentation Frequency

1. Observations must be documented **at least every 1 hour** (q1h) in accordance with policy and safety standards.

Measures	*2024 Results*	*2025 Target*	25-Jan	25-Feb	25-Mar	Q1.2025	25-Apr	25_May	25-Jun	Q2.2025	Jul-25	Aug-25
Documentation Observation of High Risk Patients	100%	0%	67%	75%	75%	72%	0%	83%	83%	71%	75%	100%



CIHQ Corrective Action Plan: Policies and Procedures Compliance Condition Level Finding

- 6 months of continuous compliance is required.
- Target is 90%
- Action plan: Policies and Procedures assignments for presentation and approval at the monthly Policy and Procedure Committee meeting.

Measures	*2024 Results*	*2025 Target*	Q1.2025	Q2.2025
Policies in Compliance for Reviews	90%	90%	73%	72%

QUALITY SCORECARD

Mortality and PSI 90

Measures	*2024 Results*	*2025 Target*	25-Jan	25-Feb	25-Mar	Q1.2025	25-Apr	25-May	25-Jun	Q2.2025	Jul-25
Risk Adjusted Acute Mortality Rate O/E [M]	*0.70%*	*0.89*	0.72%	0.69%	0.81%	0.74%	0.42%	0.83%	0.00%	0.58	0.87%
Medicare Risk Adjusted Acute Mortality Rate O/E [M]	*0.70%*	*0.89*	0.71%	0.79%	0.47%	0.71%	0.62%	0.79%	0.00%	0.71%	0.99
COPD Mortality Rate |M| 5.6	*8.10%*	*8.5*	0%	0%	0%	0%	0%	0%	0%	0%	0%
Congestive Heart Failure Mortality Rate |M|	*0.00%*	*11.5*	0%	0%	0%	0%	0%	20%	0%	8.30%	0%
Pneumonia Mortality Rate |M|	*4.80%*	*15.60%*	0%	22%	0%	7.10%	0%	0%	0%	0%	0%
Ischemic Stroke Mortality Rate |M|	*0.00%*	*13.80%*	0%	0%	0%	0%	0%	0%	0%	0%	0%
Hemorrhagic Stroke - Mortality Rate (M)	*33.30%*	*0%*	ND	ND	ND	ND	ND	33 (1/1)	ND	33%	ND
Sepsis, Severe - Mortality Rate (M)	*0.00%*	*25%*	25%	0%	0%	10%	0%	0%	0%	0%	50% (1/2)
Septic Shock - Mortality Rate (M)	*30%*	*25%*	43%	20%	0%	28.60%	ND	33%	0%	0%	0%
PSI 90 (v2023-1) Midas Patient Safety Indicators Composite, ACA per 1000 pt days (M)	*0*	*0*	0.01	0	0	0.0004	0	0	0	0	0
PSI 90 (v2023-1) Patient Safety Indicators Composite, ACA - Numerator Volume (M)	*0*	*0*	1	0	0	1	0	0	0	0	0

*ND - No Denominator

Measures	2024 Results	2025 Target	25-Jan	25-Feb	25-Mar	Q1.2025	25-Apr	25-May	25-Jun	Q2.2025	Jul-25
RM ACUTE FALL- All (M) per 1000 patient days	*2.94*	*3.75*	3.17	3.25	0	2.08	0%	0%	0%	0%	3.57
RM ACUTE FALL- WITH INJURY (M) per 1000 patient days	*1.1*	*3.75*	0	0	0	0	0%	0%	0%	0%	0
Rx-ADEs-High Risk Med Errors Per 10,000 Doses (M)	*0.03*	*1.13*	0%	0%	0%	0%	0%	0.08	0.9	0.9	0
Rx-Administration Errors Per 10,000 Doses Dispensed	*0.45*	*1*	0.1	0.1	0.19	0.14	0%	0.33	0%	0.18	0.08

FALLS MEDICATION

Infection Prevention

Measures	*2024 Results*	*2025 Target*	25-Jan	25-Feb	25-Mar	Q1.2025	25-Apr	25-May	25-Jun	Q2.2025	Jul-25
IC-Surveillance| HAI-C.DIFF Inpatient infections SIRs |M|	***85***	***1***	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
IC-Surveillance| HAI-CAUTI Inpatient infections SIRs |M|	***0***	***1***	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
IC-Surveillance| HAI-CLABSI Inpatient infections SIRs |M|	***0***	***1***	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
IC-Surveillance| HAI-MRSA Inpatient infections SIRs |M|	***0***	***1***	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
IC-Surveillance| HAI-SSI infections SIRs |M|	***0***	***1***	**0**	**0**	**0**	**0**	**0**	**2**	**0**	**2**	**0**
QA-02 | Hand Hygiene Practices Monitored % of compliance |M|	***90%***	***90%***	**98**	**92**	**82%**	**91%**	**96%**	**92%**	**94%**	**94%**	**88%**

LAB/TRANSFSUSIONS

BLOOD CULTURES

Measures	2024 Results	2025 Target	25-Jan	25-Feb	25-Mar	Q1.2025	25-Apr	25_May	25-Jun	Q2.2025	Jul-25
Lab | Transfusion Effectiveness (M)	*100%*	*100%*	*100%*	*100%*	*100%*	*100%*	100%	100%	100%	100%	100%
Lab | Transfusion Reaction (M)	*0%*	*0%*	*0%*	*0%*	*0%*	*0%*	0%	0%	0%	0%	0%
Measures	2024 Results	2025 Target	25-Jan	25-Feb	25-Mar	Q1.2025	25-Apr	25_May	25-Jun	Q2.2025	Jul-25
Blood Cultures -Contamination Rate |ED RN| (M)	*3%*	*3%*	2.70%	1.30%	5%	3%	4.20%	1.90%	2.40%	2.90%	1.50%
Blood Cultures -Contamination Rate |LAB| (M)	*2%*	*3%*	0%	0%	0%	0%	1.20%	2.90%	0%	1.50%	2.80%
Blood Cultures -Total Contamination Rate (M)	*3%*	*3%*	1.80%	1.00%	3.30%	2.00%	2.80%	2.30%	2.40%	2.50%	2.30%

STROKE

Measures	*2024 Results*	*2025 Target*	25-Jan	25-Feb	25-Mar	Q1.2025	25-Apr	25_May	25-Jun	Q2.2025	Jul-25
CDSTK-03|Median- Code Stroke Called |M| elapsed time (mins)	*5*	*10*	1	8	8	2	1	6	1	2	2
CDSTK-04|Median- Door to Phys Eval |M| elapsed time (mins)	*1*	*10*	0	2	0	0	0	2	1	0	1
CDSTK-05|Median- Door to CT Scanner |M| elapsed time (mins)	*9*	*25*	1	8	11	6	2	8	2	3	4
CDSTK-06|Median- Neuro Consult Contacted |M| elapsed time (mins)	*25*	*30*	8	14	20	14	12	24	7	12	23
CDSTK-07|Median- CT Read by Radiology |M| elapsed time (mins)	*26*	*45*	15	30	31	22	19	26	18	20	20
CDSTK-08|Median- Lab Results Posted |M| elapsed time (mins)	*25*	*45*	20	21	26	21	19	34	16	22	16
CDSTK-10|Median- Door to EKG Complete |M| elapsed time (mins)	*29*	*60*	21	28	25	25	22	30	22	22	19
CDSTK-11|Median-Door to tPA Decision |M| elapsed time (mins)	*31*	*60*	19	34	30	30	14	36	24	24	42
CDSTK-12|Median-Door to tPA |M| elapsed time (mins)	*74*	*60*	48	ND	ND	48	41	ND	29	39	51

ALOS
READMISSIONS

Measures	*2024 Results*	*2025 Target*	25-Jan	25-Feb	25-Mar	Q1.2025	25-Apr	25-May	25-Jun	Q2.2025	Jul-25
Acute Care Risk-adjusted Average Length of Stay, O/E Ratio |M	*0.86*	*0.99*	0.9	0.99	1.01	0.97	1.01	1.02	1.11	1.04	0.87
Inpatients Risk-adjusted Average Length of Stay, O/E Ratio |M	*0.86*	*0.99*	0.9	0.98	0.97	0.93	1.01	0.96	1.11	0.91	0.88
Medicare Risk-adjusted Average Length of Stay, O/E Ratio |M	*0.79*	*0.99*	0.82	0.97	0.97	0.9	1.09	0.92	0.97	0.99	0.83
Acute Care - Geometric Mean Length of Stay |M	*3.59*	*2.75*	4.15	2.85	3.26	3.22	3.4	2.94	2.97	3.1	2.69
30-DV Inpatients - % Readmit to Acute Care within 30 Days (M	*6.39*	*15.30%*	13.43%	6.35%	7.14%	9.00%	4.41%	8.93%	7.58%	7.41%	8.11%
COPD, CMS Readm - % Readmit within 30 Days, ACA (M	*7.10%*	*19.50%*	0.00%	40%	0.00%	22.20%	0%	16.7	50%	16.70%	100% (1/1)
HF, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)	*13.50%*	*21.60%*	0%	0%	0%	0%	0%	0%	33.30%	10%	10%
Hip/Knee, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M	0%	*4.00%*	0%	0%	0%	0%	0%	0%	0%	0%	0%
PNA, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M	*7.10%*	*13.60%*	8.30%	0%	0%	8.70%	0%	20%	12.50%	12.50%	0%
Sepsis, Simple - % Readmit within 30 Days (M)*	*0.03%*	*0.00%*	0.27%	0%	0%	0.14%	0.14%	0.20%	0.08%	0.12%	0.90%
Sepsis, Severe - % Readmit within 30 Days (M)	0%	12%	0%	0%	0.30%	0.10%	0.50%	0%	0.00%	0.20%	0.00%
Septic Shock - % Readmit within 30 Days (M)	*0.20%*	*13.30%*	0%	0%	0.50%	0.20%	0%	0%	0.20%	0.20%	0.00%

Measures	*2024 Results*	*2025 Target*	25-Jan	25-Feb	25-Mar	Q1.2025	25-Apr	25_May	25-Jun	Q2.2025	Jul-25
Core OP 22 ED LWBS Emergency Dept Left Without Being Seen (M	*0.30%*	*2.00%*	0.40%	0.40%	0.40%	0.40%	0.60%	0.60%	0.10%	0.40%	0.30%
Core OP-23 - Head CT/MRI Results for STK Pts w/in 45 Min of Arrival (M)	*97%*	*80%*	100%	100%	ND	100%	100%	100%	100%	100%	100%
Core OP29/ASC9 - Colonoscopy:F/U for Avg Risk Pts (M	100%	*88%*	100%	100%	100%	100%	100%	100%	100%	100%	100%
Core OP 18b Median Time ED Arrival to ED Departure - Reporting Measure (M	*140*	*132*	154	120	105.5	126	76	113	107	106	118
Measures	*2024 Results*	*2025 Target*	25-Jan	25-Feb	25-Mar	Q1.2025	25-Apr	25_May	25-Jun	Q2.202 5	Jul-25
SEP-1 Early Management Bundle, Severe Sepsis/Septic Shock (M)	*80%*	*81%*	100%	100%	50%	93.80%	100%	100%	80%	78.60%	100%
SEPa - Severe Sepsis 3 Hour Bundle (M	*89.30%*	*94%*	100%	100%	75%	100%	100%	100%	100%	100%	100%
SEPb - Severe Sepsis 6 Hour Bundle (M)	*89.30%*	*100%*	100%	100%	100%	100%	100%	100%	100%	100%	100%

CORE OP
Sep 1

WRAP UP/ QUESTIONS

Document Tasks By Committee

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

Sonoma Valley Hospital
Run by: Newman, Cindi (cnewman)
Run date: 09/18/2025 10:44 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: 1

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

Committee Members: **Newman, Cindi (cnewman), Reese, Whitney (wreese), Wyatt, Louise (lwyatt)**

Current Approval Tasks (due now)

Document	Task/Status	Pending Since	Days Pending
Scope of Service *SCU (Surgical Care Unit Dept*	**Pending Approval**	9/18/2025	0

Summary Of Changes: **Revised for clarity, professionalism, and consistency. Sections were reorganized with clearer headings, and grammar and phrasing were improved throughout. Terminology was standardized, nurse-to-patient ratios were clarified, and job roles were made more consistent. The ASPAN reference was updated to the 2023–2025 standards and formatted in APA style. Minor formatting issues were corrected, and referenced policy numbers were clearly cited.**

Moderators: **Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)**

Lead Authors: **Winkler, Jessica (jwinkler), Cornell, Kelli (kcornell)**

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)**