SVHCD QUALITY COMMITTEE

AGENDA

WEDNESDAY, OCTOBER 29, 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 09.26.25	*Daniel Kittleson, DDS*	Action
4. QUALITY COMMITTEE WORK PLAN DRAFT 2026	*Daniel Kittleson, DDS*	Action
5. PATIENT CARE SERVICES DASHBOARD Q3 2025	*Jessica Winkler, DNP, RN, NEA-BC, CCRN-K*	Inform
6. QUALITY INDICATOR PERFORMANCE & PLAN	*Louise Wyatt, RN JD*	Inform
7. POLICIES AND PROCEDURES	*Louise Wyatt, RN JD*	Inform
8. CLOSED SESSION: a. Calif. Health & Safety Code §32155: Medical Staff Credentialing & Peer Review Report	*Daniel Kittleson, DDS*	Action
9. ADJOURN	*Daniel Kittleson, DDS*	

SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
Wednesday, September 24, 2025, 5:00 PM
MINUTES

Members Present	Excused/Not Present	Public/Staff – Via Zoom
Daniel Kittleson, DDS Michael Mainardi, MD Howard Eisenstark, MD Carl Speizer, MD Carol Snyder	Susan Kornblatt Idell Wendy Lee Myatt Kathy Beebe, RN PhD	Jessica Winkler, DNP, RN, NEA-BC, CCRN-K, SVH CNO Whitney Reese, SVH Board Clerk Leslie Petersen, SVH Foundation ED Troy Ashford, MJ, BS, R.T.(R) (MR), SVH Director of Diagnostics Services Alex Rainow, MD, SVH Vice COS Dave Chambers, public

AGENDA ITEM	DISCUSSION	ACTION
1. CALL TO ORDER/ANNOUNCEMENTS	*Daniel Kittleson, DDS*	
Kittleson called meeting to order at 5:00 p.m. October's committee meeting has been moved from 10/22 to 10/29		
2. PUBLIC COMMENT SECTION	*Daniel Kittleson, DDS*	
No public comments		
3. CONSENT CALENDAR	*Daniel Kittleson, DDS*	ACTION
Minutes 08.27.25	*Motion to approve by Mainardi 2nd by Snyder. All in favor.*	
4. IMAGING QA/PI	*Troy Ashford, MJ, BS, R.T.(R) (MR)*	INFORM
Ashford presented the Imaging Department's performance and safety report for August 2024 through July 2025, highlighting strong results and corrective improvements. There were no MRI accidents or near misses, and CT scans for stroke patients were done much faster than the target time. The mammography recall rate was 8.2%, which is within national standards, and earlier data issues have been fixed. An issue with CT radiation settings was corrected (no patients were harmed) and new policies were put in place to prevent changing the settings again. Repeat scans and contrast issues stayed low, and supply checks showed good compliance. Ashford recommended retiring the old 1.5T MRI machine since it's costly to maintain and rarely used.		

5. QUALITY INDICATOR PERFORMANCE & PLAN	*Jessica Winkler, DNP, RN, NEA-BC, CCRN*	INFORM
Winkler presented the July 2025 metrics. The CIHQ corrective action plan noted continuous observation for patients at risk of self-harm, confirming 100% compliance in the Emergency Department. Physicians are now fully aware of the new requirement for a written order to initiate suicide precautions, and Epic documentation workflows have been standardized since early implementation issues were identified. Winkler reported strong performance across the Quality Scorecard, including no hospital-acquired infections, hand hygiene compliance near 90%, and zero blood culture contaminations in August. The ED achieved all stroke and sepsis care targets, including 100% compliance on sepsis bundles, while readmission and mortality rates remained within benchmarks. Overall, SVH's clinical quality outcomes remain strong, with continued focus on maintaining compliance momentum and closing the policy review backlog.		
5. POLICIES & PROCEDURES	*Jessica Winkler, DNP, RN, NEA-BC, CCRN*	INFORM
Winkler presented one policy change. Committee reviewed.		
6. CLOSED SESSION: a. Calif. Health & Safety Code §32155: Medical Staff Credentialing & Peer Review Report	*Alex Rainow, MD*	ACTION
		Motion to approve by Mainardi 2nd by Snyder. All in favor.
7. ADJOURN	*Daniel Kittleson, DDS*	INFORM
		Meeting adjourned at 6:05 p.m.

SVHCD Quality Committee Work Plan 2026

JANUARY 1/28	FEBRUARY 2/25	MARCH 3/25	APRIL 4/29*
• Pharmacy QA/PI - Chris Kutza (postponed from 12/2025) • **Patient Care Services Dashboard 4th Qtr (2025)** • *Quality Indicator Performance and Plan* • *Policies and Procedures* • *Credentialing*	• Surgical Servies QA/PI - Kelli Cornell • *Quality Indicator Performance and Plan* • *Policies and Procedures* • *Credentialing*	• Annual Quality Department Review - Louise Wyatt • *Quality Indicator Performance and Plan* • *Policies and Procedures* • *Credentialing*	• Infection Prevention Annual Risk Assessment / Plan - Stephanie Montecino • **Patient Care Services Dashboard 1st Qtr (2026)** • *Quality Indicator Performance and Plan* • *Policies and Procedures* • *Credentialing*
MAY 5/27	**JUNE 6/24**	**JULY**	**AUGUST 8/26**
• Lab QA/P – Alfred Lugo • *Quality Indicator Performance and Plan* • *Policies and Procedures* • *Credentialing*	• ED QA/PI - Marylou Ehret • *Quality Indicator Performance and Plan* • *Policies and Procedures* • *Credentialing*	No meeting	• Inpatient Services QA/PI - Jane Taylor • **Patient Care Services Dashboard 2nd Qtr (2026)** • *Quality Indicator Performance and Plan* • *Policies and Procedures* • *Credentialing*
SEPTEMBER 9/30*	**OCTOBER 10/28**	**NOVEMBER & DECEMBER combined 12/09**	
• Imaging QA/PI – Troy Ashford • *Quality Indicator Performance and Plan* • *Policies and Procedures* • *Credentialing*	• PT/OT QA/PI - Chris Gallo • **Patient Care Services Dashboard 3rd Qtr (2026)** • *Quality Indicator Performance and Plan* • *Policies and Procedures* • *Credentialing*	No meeting	• Pharmacy QA/PI - Chris Kutza • *Quality Indicator Performance and Plan* • *Policies and Procedures* • *Credentialing*

*please note these meetings are the 5th Wednesday of the month

Patient Care Services Dashboard 2025

Emergency Department	Quality Assurance				
	Q1	Q2	Q3	Q4	Target
Barcode Scanning Rate	82%	87%	91%		>85%
1:1 Obs of High Risk Patients	75%	80%	75%		100%
RN Bld Cx Contamination Rate	2.95%	1.95%	1.8		<3%

Inpatient	Quality Assurance				
Patient Discharge Education (AVS) related to diagnosis	Q1	Q2	Q3	Q4	Target
	72%	87%	91%		90%
Mobility: OOB for Breakfast	67%	48%	50%		90%

Surgical Services	Quality Assurance				
	Q1	Q2	Q3	Q4	Target
Day of Surgery Cx' Cases	2.86%	4.85%	4%		<4%
First Case On-Time Start	58%	60%	92%		80%

All	Medication Safety				
	Q1	Q2	Q3	Q4	Target
Drug Admin Error Rate (per 10,000 admins)	0.14 (n=3)	0.18 (n=6)	0.05 (n=2)		<1

All	Organ and Tissue Donation Referrals				
Missed referral	1	2	0		0
Referral not Timely	0	1	2		0

	Nursing Divison Turnover				
	Q1	Q2	Q3	Q4	Target
ED	0	2	0		≤2
Inpatient	0	1	3		≤2
Surgical Services	0	0	1		≤2
TOTAL	0	3	4		≤4

	Patient Experience				
Emergency Dept	Q1	Q2	Q3	Q4	Target
Q-Reviews	4.72	4.7	4.73		4.5
Inpatient	Q1	Q2	Q3	Q4	Target
Q-Reviews	4.74	4.7	4.69		4.5
Surgical Services	Q1	Q2	Q3	Q4	Target
Q-Reviews	4.79	4.83	4.9		4.5

ED-Inpt	Throughput- Admit Order to Admit Time (Ed-Inpt)				
	Q1	Q2	Q3	Q4	Target
Measure #mins Goal <60mins	51% n=30	48% n=65	52% n=52		80%
Avg / Median Mins	88.49 57	156 65	80 54.5		

SONOMA VALLEY HOSPITAL
Quality Board

October 29, 2025

LOUISE WYATT, RN JD

Director of Quality, Risk Management, Patient Safety,

Infection Control, Case Management & Regulatory

Risk Management/Patient Safety Report

August 2025 Midas Events by Type

Row Labels	Count of Event No.
Behavior Issues (Staff)	1
Behavior Issues, Non-patient/Non-staff	1
CODE ARREST	1
Complication-Medical	1
Complication-Medical-IC	1
Fall-Without Injury	4
Imaging, wrong site scanned	2
LAB	1
MED,ALLERGIC/ADVERSE REACTION	1
MERP-Administration	1
MERP-Prescription order communication	2
OTHER	1
Transfer, Issue-other	1
TREAT/PROCED, DELAYED	2
TREAT/PROCED, NOT FOLLOWED	1
(blank)	
Grand Total	**21**

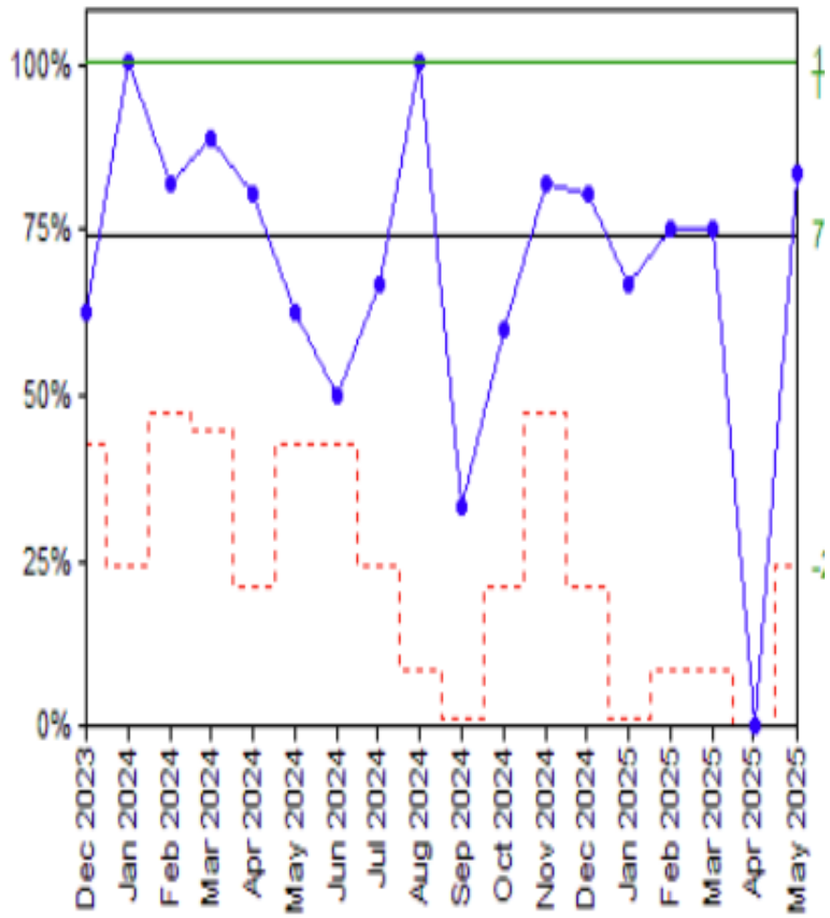
1st QTR 2025	# of Patients
Case Mgt/UR	**1**
Grievance, addressed	1
Emergency Dept.	**5**
Complaint, Patient	1
Complaint, Pt Family	1
Grievance, addressed	2
Grievance-No Findings	1
Laboratory	**1**
Grievance-Staff/Process	1
Physician	**1**
Grievance-No Findings	1
(blank)	
(blank)	
Grand Total	**8**

2nd QTR 2025	# Patients	# Non Patients
ACCOUNTING	**1**	
Grievance-Staff/Process	1	
ADMITTING	**1**	
Grievance, Payer QOC inquiry	1	
Clinic- SVH Specialty Clinics		**1**
Complaint, Pt Family(does not qualify as Grievance)		1
Emergency Dept.	**6**	
Complaint, Pt Family(does not qualify as Grievance)	1	
Grievance, addressed	1	
Grievance-No Findings	2	
Grievance-QM	1	
Grievance-Staff/Process	1	
HALLWAY		**1**
Complaint, Patient (resolved in house)		1
PACU	**1**	
Grievance-No Findings	1	
SPEECH THERAPY		**1**
NO PTREL EVENT, Risk Managemnt		1
(blank)		
(blank)		
Grand Total	**9**	**3**

COMPLAINTS AND GRIEVANCES

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%



<u>Issues Identified with Suicide Precaution Monitoring:</u>

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%**

QUALITY SCORECARD

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
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%	0.23
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	0.52
COPD Mortality Rate |M| 5.6	8.10%	8.5	0%	0%	0%	0%	0%	0%	0%	0%	0%	ND
Congestive Heart Failure Mortality Rate |M|	0.00%	11.5	0%	0%	0%	0%	0%	20%	0%	8.30%	0%	0%
Pneumonia Mortality Rate |M|	4.80%	15.60%	0%	22%	0%	7.10%	0%	0%	0%	0%	0%	0%
Ischemic Stroke Mortality Rate |M|	0.00%	13.80%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Hemorrhagic Stroke - Mortality Rate (M)	33.30%	0%	ND	ND	ND	ND	0%	100%	0%	33%	ND	ND
Sepsis, Severe - Mortality Rate (M)	0.00%	25%	25%	0%	0%	10%	0%	0%	0%	0%	50% (1/2)	0%
Septic Shock - Mortality Rate (M)	30%	25%	43% 3/7	20%	0%	28.60%	ND	33% 3 1/3	0%	0%	0%	33.30%3 (1/3)

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
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	0
PSI 90 (v2023-1) Patient Safety Indicators Composite, ACA - Numerator Volume (M)	0	0	1	0	0	1	0	0	0	0	0	0

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	Aug-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	8.47 (2)*
RM ACUTE FALL- WITH INJURY (M) per 1000 patient days	*1.1*	*3.75*	0	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	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	0.09

FALLS

*2 patient falls/2 visitor 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	Aug-25
IC-Surveillance| HAI-C.DIFF Inpatient infections SIRs |M|	*85*	*1*	0	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	1
IC-Surveillance| HAI-CLABSI Inpatient infections SIRs|M|	*0*	*1*	0	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	0
IC-Surveillance| HAI-SSI infections SIRs|M|	*0*	*1*	0	0	0	0	0	2	0	2	0	0
QA-02 | Hand Hygiene Practices Monitored % of compliance|M|	*90%*	*90%*	98	92	82%	91%	96%	92%	94%	94%	88%	94%

LAB/TRANSFUSIONS

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	Aug-25
Lab | Transfusion Effectiveness (M)	*100%*	*100%*	*100%*	*100%*	*100%*	*100%*	100%	100%	100%	100%	100%	100%
Lab | Transfusion Reaction (M)	*0%*	*0%*	*0%*	*0%*	*0%*	*0%*	0%	0%	0%	100%	0%	2..4%
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%	0%
Blood Cultures -Contamination Rate |LAB| (M)	*2%*	*3%*	0%	0%	0%	0%	1.20%	2.90%	0%	1.50%	2.80%	0%
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%	0%

STROKE

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
CDSTK-03|Median- Code Stroke Called |M| elapsed time (mins)	*5*	*10*	1	8	8	2	1	6	1	2	2	1
CDSTK-04|Median- Door to Phys Eval |M| elapsed time (mins)	*1*	*10*	0	2	0	0	0	2	1	0	1	0
CDSTK-05|Median- Door to CT Scanner |M|elapsed time (mins)	*9*	*25*	1	8	11	6	2	8	2	3	4	2
CDSTK-06|Median- Neuro Consult Contacted |M| elapsed time (mins)	*25*	*30*	8	14	20	14	12	24	7	12	23	23
CDSTK-07|Median- CT Read by Radiology |M| elapsed time (mins)	*26*	*45*	15	30	31	22	19	26	18	20	20	15
CDSTK-08|Median- Lab Results Posted |M| elapsed time (mins)	*25*	*45*	20	21	26	21	19	34	16	22	16	15
CDSTK-10|Median- Door to EKG Complete |M| elapsed time (mins)	*29*	*60*	21	28	25	25	22	30	22	22	19	24
CDSTK-11|Median-Door to tPA Decision |M| elapsed time (mins)	*31*	*60*	19	34	30	30	14	36	24	24	42	29
CDSTK-12|Median-Door to tPA |M| elapsed time (mins)	*74*	*60*	48	ND	ND	48	41	ND	29	39	51	46

ALOS

READMISSIONS

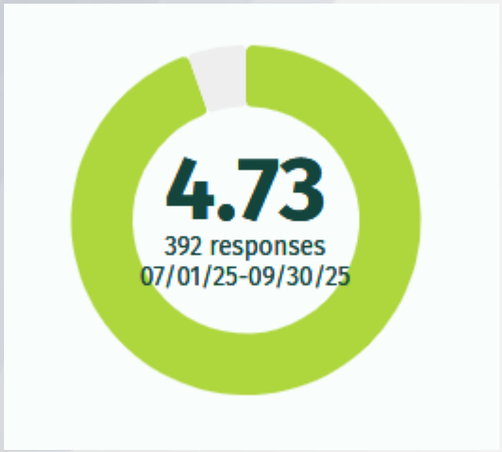
Measures	*2024 Results*	*2025 Target*	25-Jan	25-Feb	25-Mar	Q1.2025	25-Apr	25-May	25-Jun	Q2.2025	Jul-25	Aug-25
Acute Care Risk-adjusted Average Length of Stay, O/E Ratio |M	*0.86*	*0.99*	0.9	0.99	1.01	0.97	1.01	1.02	1.11	1.04	0.87	0.9
Inpatients Risk-adjusted Average Length of Stay, O/E Ratio |M	*0.86*	*0.99*	0.9	0.98	0.97	0.93	1.01	0.96	1.11	0.91	0.88	0.9
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	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	3.14
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%	3.33%
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)	ND
HF, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)	*13.50%*	*21.60%*	0%	0%	0%	0%	0%	0%	33.30 %	10%	10%	0%
Hip/Knee, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M	0%	*4.00%*	0%	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%	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%	0.10%
Sepsis, Severe - % Readmit within 30 Days (M)	0%	12%	0%	0%	0.30%	0.10%	0.50%	0%	0.00%	0.20%	0.00%	0%
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%	0.50%

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
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%	0.20%
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%	100%
Core OP29/ASC9 - Colonoscopy: F/U for Avg Risk Pts (M	100%	*88%*	100%	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	127.5
SEP-1 Early Management Bundle, Severe Sepsis/Septic Shock (M)	*80%*	*81%*	100%	100%	50%	93.80%	100%	100%	80%	78.60%	100%	80% (4/5)
SEPa - Severe Sepsis 3 Hour Bundle (M	*89.30%*	*94%*	100%	100%	75%	100%	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%	100%

CORE OP
Sep 1

Q – REVIEWS 3rd Quarter 2025

Emergency Department



Medical Imaging

Hand and Physical Therapy

Inpatient Care

Outpatient Surgery

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

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: 10/24/2025 3:55 PM

Report Parameters

Filtered by: Document Set: - All Available Document Sets -
Committee: 07 BOD-Quality (P&P Review)
Include Current Tasks: Yes
Include Upcoming Tasks: No

Grouped by: Committee

Sorted by: Document Title

Report Statistics

Total Documents: 24

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
Admission to the Hospital from the ED *Emergency Dept*	**Pending Approval**	10/17/2025	7

Summary Of Changes: **wrote purpose statement; added CMS language about pt PCP and/or family notification; updated language to reflect things documented in EHR and not on paper (such as pt belongings list, etc.) Also added timeframe goals to admit pt, and special considerations for the geriatric population (this is in line with the AFHS. Updated references. authors and reviews**

Moderators: **Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)**
Lead Authors: **Winkler, Jessica (jwinkler), Ehret, Marylou (mehret)**
Approvers: **01 P&P Committee -> 02 MS-Medicine Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Admission-Discharge *SCU (Surgical Care Unit Dept*	**Pending Approval**	10/17/2025	7

Summary Of Changes: **Updated references:**

Added Nurse-to-Patient Ratios

Included ASPAN-recommended ratios: Phase I: 1:1 initially, progressing to 1:2. Phase II: 1:3 or 1:2 for unaccompanied children or higher-acuity patients.

Added language regarding respect for patient rights, and support for family presence, as supported by ASPAN's ethical care guidelines

New language encouraging ongoing quality improvement, clinical inquiry, and the use of evidence-based interventions in the SCU.

Moderators: **Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)**
Lead Authors: **Winkler, Jessica (jwinkler), Cornell, Kelli (kcornell)**
Approvers: **01 P&P Committee -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

ALARA (As Low As Reasonably Achievable) *Diagnostic Services Dept Policies*	**Pending Approval**	10/17/2025	7

Summary Of Changes: **Added : CTDI Alert Management:**

Ensure timely reporting and management of CTDI (Computed Tomography Dose Index) alerts to maintain patient safety and compliance with radiation safety standards.

Moderators: **Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)**
Lead Authors: **Ashford, Troy (tashford)**
Approvers: **01 P&P Committee -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Contrast Extravasation — **Pending Approval** — 10/17/2025 — 7

Diagnostic Services Dept Policies

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

Moderators: **Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)**
Lead Authors: **Ashford, Troy (tashford)**
Approvers: **01 P&P Committee -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Fluoroscan — **Pending Approval** — 10/17/2025 — 7

Surgical Services/OR Dept

Summary Of Changes: **Updated references:**

Removed claims that aprons aren't needed. (now recommended for fluoscan per AORN)

Inserted standard radiation protection advice per AORN: lead aprons, thyroid, eyewear, and dosimetry

Added dosimetry badge monitoring and annual radiation safety training.

Emphasized ALARA principles: pulsed mode, collimation, last-image hold

Clarified positioning of image intensifier and tube to minimize scatter

Moderators: **Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)**
Lead Authors: **Winkler, Jessica (jwinkler), Cornell, Kelli (kcornell)**
Approvers: **01 P&P 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 in Surgical Services — **Pending Approval** — 10/17/2025 — 7

Surgical Services/OR Dept

Summary Of Changes: **Updated references.**

Added statement per AORN recommendations; The perioperative department will implement transmission-based precautions in response to emerging infectious diseases, in coordination with hospital-wide EID plans

Moderators: **Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)**
Lead Authors: **Winkler, Jessica (jwinkler), Cornell, Kelli (kcornell)**
Approvers: **01 P&P Committee -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Latex Allergy Precautions — **Pending Approval** — 10/17/2025 — 7

Surgical Services/OR Dept

Summary Of Changes: **Policy Modernization for Latex-Free Environment:**

Updated the policy to reflect that no latex-containing products are present in the operating room.

Emphasized a facility-wide latex-safe environment, rather than preparing only per patient need.

Risk Identification Clarification:

Retained patient history assessment but noted that universal latex precautions apply regardless of case order or operating room.

Removed outdated practice of scheduling latex cases first or terminally cleaning an OR specifically for latex cases.

Streamlined Precautions:

Removed redundant steps that are no longer applicable in a latex-free facility (e.g., covering cushions, head covers without elastic).

Retained best practices such as allergy band identification, documentation, and communication with anesthesia, pharmacy, and PACU.

Standardization and Responsibility Clarity:

Clarified roles for nurses, anesthesia, and pharmacy in ensuring latex-safe care.

Reinforced the importance of verifying latex-free alternatives and continued vigilance for patients with severe allergies.

Updated Terminology and Guidelines:

Integrated current AORN 2025 and ASPAN 2023–2025 recommendations.

Replaced older language with modern, patient-centered phrasing (e.g., "latex-safe" vs. "latex-free zone").

Reference Section Modernized:

Added up-to-date references in APA format from AORN, AAMI, and ASPAN.

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

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

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

Loaner Instrument Trays from Outside the Facility	**Pending Approval**	10/17/2025	7
Surgical Services/OR Dept			

Summary Of Changes: **Expanded Purpose Statement**

Clarified the intent to ensure standardized, regulatory-compliant processes for receiving and reprocessing loaner trays, with a focus on patient safety.

New Sections Added:

Scope – Defined which departments and personnel the policy applies to (SPD, OR, vendors).

Definitions – Added key terminology (e.g., Loaner Trays, IFU, ANSI/AAMI ST79) to promote clarity and compliance.

Policy Statement – Clearly stated non-acceptance of pre-sterilized trays and requirements for processing all instruments according to IFUs.

Responsibilities – Outlined expectations for vendors, SPD staff, and OR personnel, creating accountability for proper tray handling and documentation.

Enhanced Procedure Section:

Broke down each stage into subsections:

Receiving & Inspection

Decontamination

Inspection & Assembly

Sterilization

Storage & Distribution

Aligned each step with current AAMI ST79 and AORN standards.

Required photo documentation for missing/damaged instruments.

Emphasized traceability with sterilization and patient info labeling.

New Documentation Requirements:

Specified logs and records to be maintained, including:

Tray delivery date/time

IFU verification

Cleaning/sterilization parameters

CI/BI results Defined initials

Patient/case traceability

Late Delivery Protocol:

Introduced a non-conformance section requiring documentation and potential rejection of trays delivered less than 48 hours prior to use.

Quality Assurance Measures:

annual competency checks, and vendor compliance monitoring to ensure consistent adherence.

Updated References:

Replaced outdated 2012 references with current 2023–2025 AORN, AAMI ST79,and CMS, in ADA format.

Moderators:	**Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)**
Lead Authors:	**Winkler, Jessica (jwinkler), Cornell, Kelli (kcornell)**
Approvers:	**01 P&P Committee -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Nutrition and Wound Healing — **Pending Approval** — 10/17/2025 — 7

Food & Nutrition Services Dept Policies

Summary Of Changes:	**Removed Vitamin A from recommended supplementation for wound healing to align with current clinical standards, included that registered dietitian will review wound report each shift to identify patients requiring nutritional assessment.**
Moderators:	**Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)**
Lead Authors:	**Finn, Bridget (bfinn)**
Approvers:	**Drummond, Kimberly (kdrummond) -> 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)**

Pain Management	**Pending Approval**	10/17/2025	7
Targeted Quality & Safety Initiatives Policies (QS)			

Summary Of Changes: **Added purpose statement. Added various pain scales that align with what EPIC has. Clarified assessment and documentation requirements per standards of care, Added definition of mild, moderate, severe pain; Added section on non-pharmacological pain management; added special considerations for the geriatric population (by Becky Spear) and cultural considerations. Reviewed and approved by Drs Cusick (7/15/2025) and Walther (7/25/2025)**

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

Lead Authors: **Winkler, Jessica (jwinkler), Taylor, Jane (jtaylor)**

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)**

Patient Positioning	**Pending Approval**	10/17/2025	7
Surgical Services/OR Dept			

Summary Of Changes: **Updated references.**

Added statement regarding surgeon involvement in positioning per AORN recommendation: Surgeon collaboration: The surgeon must be present for positioning involving specialty tables, fracture tables, or when positioning affects access to the surgical site. For all other procedures, the surgeon must confirm and communicate the required position with the team prior to final patient positioning.

Added statement regarding documentation per AORN recommendation: Documentation: Patient positioning must be documented in the intraoperative record, including position, protective measures used, staff present, and assessment of skin integrity.

Added Statement regarding staff training and competency per AORN recommendation: 8. Staff Training and Competency: All perioperative nursing staff must complete initial and annual competency training on patient positioning in alignment with AORN Guidelines. Staff must be trained and validated before independently positioning patients.

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

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

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

Patient Safety in the Operating Room	**Pending Approval**	10/17/2025	7
Surgical Services/OR Dept			

Summary Of Changes: **References and ownership updated**

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

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

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

Patient's Own Medication Procedure	**Pending Approval**	10/17/2025	7
Pharmacy Dept			

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

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

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)**

Portable Fluoroscopy Usage Policy and Procedure | **Pending Approval** | 10/17/2025 | 7

Diagnostic Services Dept Policies

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

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

Lead Authors: **Ashford, Troy (tashford)**

Approvers: **01 P&P Committee -> 03 MS-Surgery Department - (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 | **Pending Approval** | 10/17/2025 | 7

Pharmacy Dept\Compounding Related

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

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

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)**

Radiation Protection for Patients | **Pending Approval** | 10/17/2025 | 7

Diagnostic Services Dept Policies

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

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

Lead Authors: **Ashford, Troy (tashford)**

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

Radiography in the Surgical Suite | **Pending Approval** | 10/17/2025 | 7

Diagnostic Services Dept Policies

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

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

Lead Authors: **Ashford, Troy (tashford)**

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

Radiologist Availability | **Pending Approval** | 10/17/2025 | 7

Diagnostic Services Dept Policies

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

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

Lead Authors: **Ashford, Troy (tashford)**

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

Registered Dietitian Nourishment Modifications 8340-173 | **Pending Approval** | 10/17/2025 | 7

Food & Nutrition Services Dept Policies

Summary Of Changes: **Removed that MD may order "Nourishment per RD" (Paragon batch order, no longer applicable in Epic), removed that preferences are entered into "likes/dislikes" section of patient tray card as new tray card system does not utilize "likes/dislikes" Modified to indicate that oral supplements may only be discontinued per MD order**

Moderators:	**Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)**
Lead Authors:	**Finn, Bridget (bfinn)**
Approvers:	**01 P&P Committee -> 02 MS-Medicine Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

RETIRE: COVID-19 Monoclonal Antibody Therapy — **Pending Approval** — 10/17/2025 — 7

Medication Management Policies (MM)

Summary Of Changes:	**Recommend retiring this policy. It spoke to processes pertinent to when COVID lockdown measures were in place.**
Moderators:	**Kutza, Chris (ckutza), Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)**
Lead Authors:	**Kutza, Chris (ckutza)**
Approvers:	**01 P&P Committee -> 04 MS-Performance Improvement/Pharmacy & Therapeutics Committee - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Sterile Compounding Procedures — **Pending Approval** — 10/17/2025 — 7

Pharmacy Dept\Compounding Related

Summary Of Changes:	**Reviewed, no changes**
Moderators:	**Kutza, Chris (ckutza), Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)**
Lead Authors:	**Kutza, Chris (ckutza)**
Approvers:	**01 P&P Committee -> 04 MS-Performance Improvement/Pharmacy & Therapeutics Committee - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Surge Planning-Pharmacy — **Pending Approval** — 10/24/2025 — 0

Emergency Preparedness Policies (EP)

Summary Of Changes:	**Updated with additional 503b outsourced compounding companies: Prodigy/Leiters, US Compounding** **Updated with additional direct vendor accounts: FFF Enterprises, KeySource**
Moderators:	**Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)**
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)**

Tourniquet Use of the Pneumatic Tourniquet in the Operating Room — **Pending Approval** — 10/17/2025 — 7

Surgical Services/OR Dept

Summary Of Changes:	**Updated reference** **Expanded contraindications to include severe crush injuries, local infections, or unstable fractures, as per AORN** **Updated statement regarding tourniquet inflation time per AORN guidelines: “Tourniquet inflation time should be limited to the minimum duration necessary for the surgical procedure.** **Recommended maximum inflation times are 60 minutes for upper extremities and 90 to 120 minutes for lower extremities, unless otherwise directed by the surgeon.** **If extended use is anticipated, a deflation period of at least 10–15 minutes should be provided to allow for tissue reperfusion before reinflation.** **Prolonged inflation times beyond recommended limits may increase the risk of nerve injury, muscle ischemia, and postoperative complications.** **The surgical team should monitor inflation duration closely and document any deviations from standard guidelines."**
Moderators:	**Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)**
Lead Authors:	**Winkler, Jessica (jwinkler), Cornell, Kelli (kcornell)**
Approvers:	**01 P&P Committee -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Transporting Monitored Patients	**Pending Approval**	10/17/2025	7
Patient Care Policy			

Summary Of Changes:	**Added purpose statement. Clarified that a physician order is required to remove pt from tele for transport only; added statement that RN must document safety precautions taken for transport, etc..Added reviewers to include MD directors of ED and Inpt**
Moderators:	**Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)**
Lead Authors:	**Winkler, Jessica (jwinkler), Taylor, Jane (jtaylor)**
Approvers:	**01 P&P 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)**