SVHCD QUALITY COMMITTEE

AGENDA

WEDNESDAY, DECEMBER 3, 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

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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 10.29.25	*Daniel Kittleson, DDS*	Action
4. PT/OT QA/PI	*Christopher J. Gallo, PT MSPT*	Inform
5. QUALITY INDICATOR PERFORMANCE & PLAN	*Louise Wyatt, RN JD*	Inform
6. POLICIES AND PROCEDURES	*Louise Wyatt, RN JD*	Inform
7. ADJOURN	*Daniel Kittleson, DDS*	
CLOSED SESSION: Calif. Health & Safety Code §32155: Medical Staff Credentialing & Peer Review Report	*Daniel Kittleson, DDS*	Action

SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
Wednesday, October 29, 2025, 5:00 PM
MINUTES

Members Present	Excused/Not Present	Public/Staff
Daniel Kittleson, DDS Susan Kornblatt Idell Wendy Lee Myatt Michael Mainardi, MD Howard Eisenstark, MD Carol Snyder	Carl Speizer, MD Kathy Beebe, RN PhD	Jessica Winkler, DNP, RN, NEA-BC, CCRN-K, SVH CNO Whitney Reese, SVH Board Clerk Patrick Okolo III, MD MPH, SVH CMO Louise Wyatt, RN JD, SVH Director of Quality, Risk Management & Patient Safety, Infection Prevention and Case Management Leslie Petersen, SVH Foundation ED Alex Rainow, MD, SVH Vice COS Dave Chambers, public

AGENDA ITEM	**PRESENTER**	**ACTION**
1. CALL TO ORDER/ANNOUNCEMENTS	*Daniel Kittleson, DDS*	Called to order at 5:00pm
2. PUBLIC COMMENT SECTION	*Daniel Kittleson, DDS*	No public comments
3. CONSENT CALENDAR	*Daniel Kittleson, DDS*	ACTION
Minutes 09.26.25	*Motion to approve by Eisenstark, 2nd by Mainardi. All in favor.*	
4. QUALITY COMMITTEE WORK PLAN DRAFT 2026	*Daniel Kittleson, DDS*	
For 2026 and moving forward the Quality Committee will meet on the *last* Wednesday (instead of the 4th Wednesday)	*Motion to approve by Eisenstark, 2nd by Lee Myatt. All in favor.*	
5. PATIENT CARE SERVICES DASHBOARD Q3 2025	*Jessica Winkler, DNP, RN, NEA-BC, CCRN*	INFORM
Winkler presented the Q3 Patient Care Services Dashboard, highlighting solid progress across several clinical areas, strong patient satisfaction, and continued improvements in workflow. Some metrics remain challenging, but staff are making steady efforts, and upcoming changes (such as added support for inpatient coordination) are expected to further strengthen performance. Overall, the quarter reflected advancement and ongoing commitment to quality care.		

6. QUALITY INDICATOR PERFORMANCE & PLAN	*Louise Wyatt, RN JD*	INFORM
Wyatt reviewed the recent patient safety and risk management activity, noting that overall event levels were low and no clear patterns of concern emerged. A few falls occurred without injury, and staff continue to refine reporting practices and system accuracy. Most behavioral or conduct-related issues were minor and resolved through routine follow-up, and complaints and grievances remained limited, with most resolved quickly before escalating. Quality and safety indicators remained strong overall, with no significant adverse trends and continued progress in areas like infection prevention, hand hygiene, and length-of-stay management.		
7. POLICIES & PROCEDURES	*Louise Wyatt, RN JD*	INFORM
Wyatt presented and the committee reviewed.		
8. ADJOURN	*Daniel Kittleson, DDS*	Adjourned at 6:06pm
CLOSED SESSION: Calif. Health & Safety Code §32155: Medical Staff Credentialing & Peer Review Report	*Alex Rainow, MD*	ACTION
Motion to approve by Mainardi, 2nd by Eisenstark. All in favor		

Rehab Services Report 2025

Current YTD Review

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Therapy Staff

- Director of Rehabilitation Services
- Lead Physical Therapist - 1.0
- Physical Therapists OP- 5.0
  IP- 1.0
- PT Assistants OP- 2.0
- Speech Therapy IP/OP- .8
- Occupational Therapy OP- .6
- Support Staff 3.6
- Pending – Interviewing for Clinical Coord, PT, PTA

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Scope of Services

Physical Therapy

- Rehabilitation
- Movement
- Pelvic health
- Pilates
- Vestibular/Concussion
- Pediatric

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Speech Therapy

- Speech and language
- Swallow
- Cognition
- LSVT
- Dementia
- Pediatric speech and language delay/disorders

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Occupational Therapy

- Rehabilitation
- Post-op care including hand wound care
- Static and dynamic splinting
- ADL training

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Accomplishments

- Staffing – **Staff Retention/Pending Additions**
- **Vestibular/Concussion Program**
- **Pelvic Health Program**
- **Pediatric Physical Therapy**
- **Mentoring students- internships, observation hrs**
- **Participation in Community Events: Back to School, Harvest Fair, Cogir talk**
- **Rate My Hospital last quarter(9/30/25)- 4.92 , 264 comments**

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Challenges

Staffing- Loss of OT per diem, adding new staff

Space/noise and equipment issues as we awaited expansion.

OP PT-Volume of patients continues to be greater than our capacity- wait time 6+ wks. (Most given opportunity to move up via cancellation list - closer to 2 wk wait)

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Volumes

- OP Rehab Visits

	FY 2021	FY 2022	FY 2023(Epic)	FY 2024	FY 2025
PT	10059	11523	10225	12384	16796
OT	1321	870	1620	2236	2345
ST	455	631	574	632	898
Totals	11835	13024	12419	15252	20039

- IP Visits

PT	1534	1758	1880	3099	2334
ST	414	415	407	416	386

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2025 Rehab Services Quality Data

Rehab Services

Indicator	Performance	Most Recent	Trend	Period				
Rehab Services IP| Fall Prevention EDU |M|								
History 	Target Met	100% 32/32	No Change	Oct 2025	90%	80%	n/a	93%
Rehab Services IP| Orthostatic condition for ortho post-ops|M|								
History 	Bet. Target & Alarm	89% 8/9	Deteriorated	Oct 2025	90%	80%	n/a	90%
Rehab Services IP| Speech Therapy-Use of FOIS tool |M|								
History 	Target Met	100% 24/24	No Change	Oct 2025	90%	80%	n/a	95%
Rehab Services| Outpatient Therapy Chart Audits |M|								
History 	Bet. Target & Alarm	89% 25/28	Deteriorated	Oct 2025	90%	80%	n/a	94%

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Goals for 2026

- Provide the highest quality care to the community
- Additional Staff-PT, PTAs, SLP
- Reduced wait time for OP
- Wellness-based community offerings- Pilates, Golf, Transitional training

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SONOMA VALLEY HOSPITAL
QUALITY BOARD REPORT

December 3, 2025

LOUISE WYATT, RN JD

Director of Quality, Risk Management, Patient Safety, Infection Control, Case Management & Regulatory

Risk Management/Patient Safety Report

Row Labels	Count of Event No.
AWOL/AMA	2
BEHAVIOR ISSUES	3
COMMUNICATION	1
COMPLICATION	2
CRITICAL RESPONSE	3
DX,DIAGNOSTIC TEST	4
EMPLOYEE INCIDENT	2
FALL	6
Fall - nonpatient	1
INFECTION ISSUES	1
INJURY	1
Lab	1
MEDICATION	10
PATIENT SAFETY	1
SECURITY/VALUABLES	1
TRANSFER	1
TREATMENT/PROCEDURE ISSUE	10
Grand Total	**50**

3rd Quarter E-Notification Events by Class

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	Sep-25	Q3 2025	Oct. 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%	0.56%	0.59	0.47
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	0.71%	0.77	0.53
COPD Mortality Rate |M| 5.6	8.10%	8.5	0%	0%	0%	0%	0%	0%	0%	0%	0%	ND	0%	0%	0%
Congestive Heart Failure Mortality Rate |M|	0.00%	11.5	0%	0%	0%	0%	0%	20%	0%	8.30%	0%	0%	0%	0%	0%
Pneumonia Mortality Rate |M|	4.80%	15.60%	0%	22%	0%	7.10%	0%	0%	0%	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%	0%	0%	0%	0%	0%
Hemorrhagic Stroke - Mortality Rate (M)	33.30%	0%	ND	ND	ND	ND	0%	100%	0%	33%	ND	ND	ND	ND	ND
Sepsis, Severe - Mortality Rate (M)	0.00%	25%	25%	0%	0%	10%	0%	0%	0%	0%	50%	0%	0%	0%	0%
Septic Shock - Mortality Rate (M)	30%	25%	43%	20%	0%	28.60%	ND	33%	0%	0%	0%	33.3% (1/3) admitted with pneumonia, septic shock, COVID-19, and elevated troponin	0%	14.30%	16.7% (1/6) 95 YO - moved to comfort care

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	Sep-25	Q3 2025	Oct. 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	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	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	Sep-25	Q3 2025	Oct. 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%	3.75 (1/267)	8.47 (2/237)	0	4.05 (3/740)	0
RM ACUTE FALL- WITH INJURY (M) per 1000 patient days	1.1	3.75	0	0	0	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	0.8	0.3	0.8
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	0	0.06	0.23

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	Sep-25	Q3 2025	Oct. 25
IC-Surveillance| HAI-C.DIFF Inpatient infections SIRs |M|	2	1	0	0	0	0	0	0	0	0	0	0	0	0	1
IC-Surveillance| HAI-CAUTI Inpatient infections SIRs |M|	0	1	0	0	0	0	0	0	0	0	0	1	0	1	0
IC-Surveillance| HAI-CLABSI Inpatient infections SIRs|M|	0	1	0	0	0	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	0	0	0
IC-Surveillance| HAI-SSI infections SIRs|M|	0	1	0	0	0	0	0	2	0	2	0	0	0	0	0
QA-02 | Hand Hygiene Practices Monitored % of compliance|M|	90%	90%	98	92	82%	91%	96%	92%	94%	94%	88%	94%	96%	93%	0.96%

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	Sep-25	Q3 2025	Oct. 25
Lab | Transfusion Effectiveness (M)	100%	100%	100%	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%	0%	1.20%	0%
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%	3.40%	1.80%	3.90%
Blood Cultures - Contamination Rate |LAB| (M)	2%	3%	0%	0%	0%	0%	1.20%	2.90%	0%	1.50%	2.80%	0%	0%	0.60%	1.20%
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%	2.20%	1.50%	2.70%

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	Sep-25	Q3 2025	Oct. 25
CDSTK-03|Median- Code Stroke Called |M| elapsed time (mins)	5	10	1	8	8	2	1	6	1	2	2	1	3	2	4
CDSTK-04|Median- Door to Phys Eval |M| elapsed time (mins)	1	10	0	2	0	0	0	2	1	0	1	0	0	0	2
CDSTK-05|Median- Door to CT Scanner |M|elapsed time (mins)	9	25	1	8	11	6	2	8	2	3	4	2	3	3	9
CDSTK-06|Median- Neuro Consult Contacted |M| elapsed time (mins)	25	30	8	14	20	14	12	24	7	12	23	23	20	24	29
CDSTK-07|Median- CT Read by Radiology |M| elapsed time (mins)	26	45	15	30	31	22	19	26	18	20	20	15	22	19	28
CDSTK-08|Median- Lab Results Posted |M| elapsed time (mins)	25	45	20	21	26	21	19	34	16	22	16	15	26	19	26
CDSTK-10|Median- Door to EKG Complete |M| elapsed time (mins)	29	60	21	28	25	25	22	30	22	22	19	24	28	23.6	43
CDSTK-11|Median-Door to tPA Decision |M| elapsed time (mins)	31	60	19	34	30	30	14	36	24	24	42	29	19	30	48
CDSTK-12|Median-Door to tPA |M| elapsed time (mins)	74	60	48	ND	ND	48	41	ND	29	39	51	46	49	48.6	52

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	Sep-25	Q3 2025	Oct. 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	0.82	0.85	0.92
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	0.97	1.11	0.91	0.88	0.9	0.83	0.91	0.91
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	0.75	0.8	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	2.97	2.96	3.06
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%	7.46%	6.47%	8.70%
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	0%	25% (1/4)	0%
HF, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)	13.50%	21.60%	0%	0%	0%	0%	0%	0%	33.30%	10% (1/10)	10%	0%	ND	20% (1/5)	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%	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%	0%	0%	50% (1/2)
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%	0.20%	0.15%	0.20%
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%	0%	0%	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%	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	Aug-25	Sep-25	Q3 2025	Oct. 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%	0%	0.20%	0.7% (6/866)
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%	100%	100%	ND
Core OP29/ASC9 - Colonoscopy:F/U for Avg Risk Pts (M	100%	88%	100%	100%	100%	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	116	116	81

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	Sep-25	Q3 2025	Oct. 25
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)	81% (9/11)	84.20%	33.3% (1/3)
SEPa - Severe Sepsis 3 Hour Bundle (M	89.30%	94%	100%	100%	75%	100%	100%	100%	100%	100%	100%	100%	87.50%	92.90%	0%
SEPb - Severe Sepsis 6 Hour Bundle (M)	89.30%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	87.50%	92.90%	100%

CORE OP

Sep 1

CIHQ Corrective Action Plans:

1. Documentation Observation of High-Risk Patient

1.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.

2.Minimum Documentation Frequency

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

2. Policies in Compliance for Reviews

Percent of policies and procedures compliance rate

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	Sep-25	Q3 2025	Oct. 25
Documentation Observation of High Risk Patients	100%	100%	67%	75%	75%	72%	0%	83%	83%	71%	75%	100%	60%	73%	100%
Policies in Compliance for Reviews	90%	90%				73%				72%				71%	

Patient Satisfaction Q-Reviews 3rd Quarter 2025

Third-quarter Q-Reviews, the texting survey, demonstrated high patient satisfaction across all five participating departments.

Emergency Department

Medical Imaging

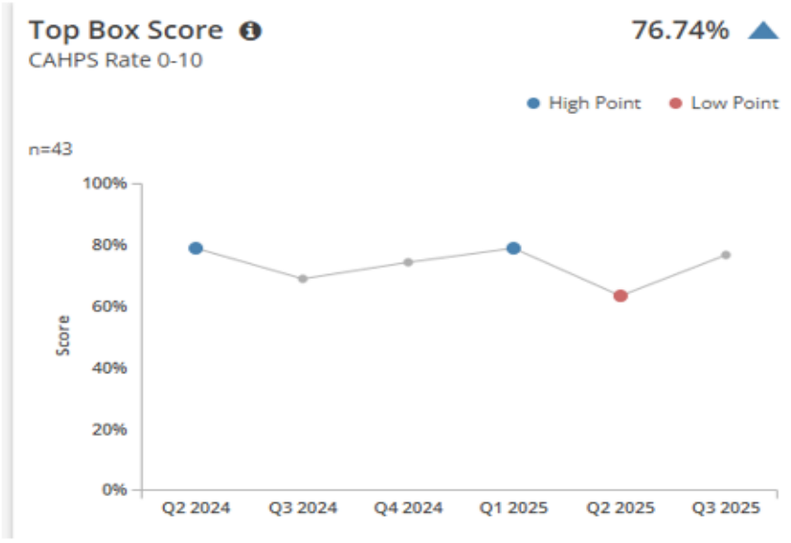
Hand and Physical Therapy

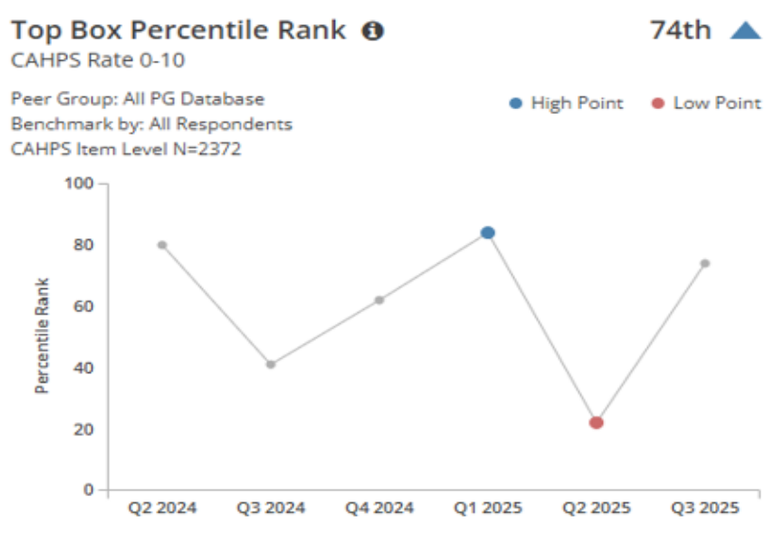
Inpatient Care

Outpatient Surgery

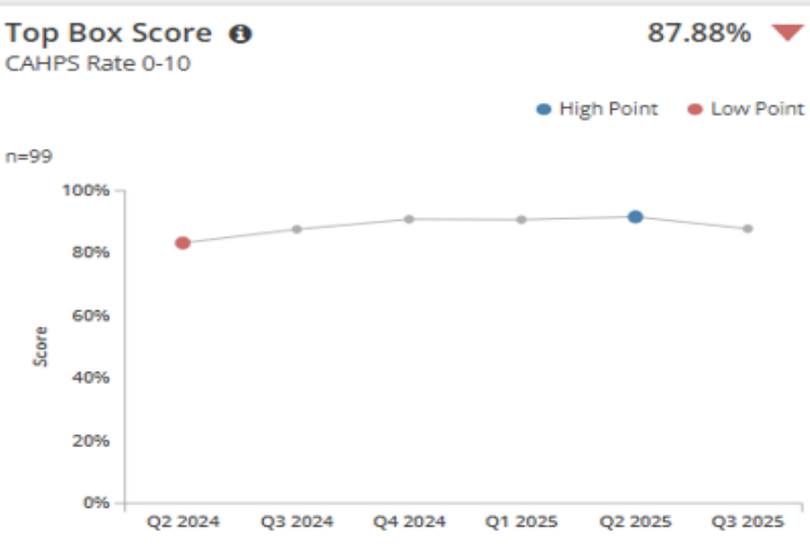
Press Gainey – 3rd Quarter Inpatient

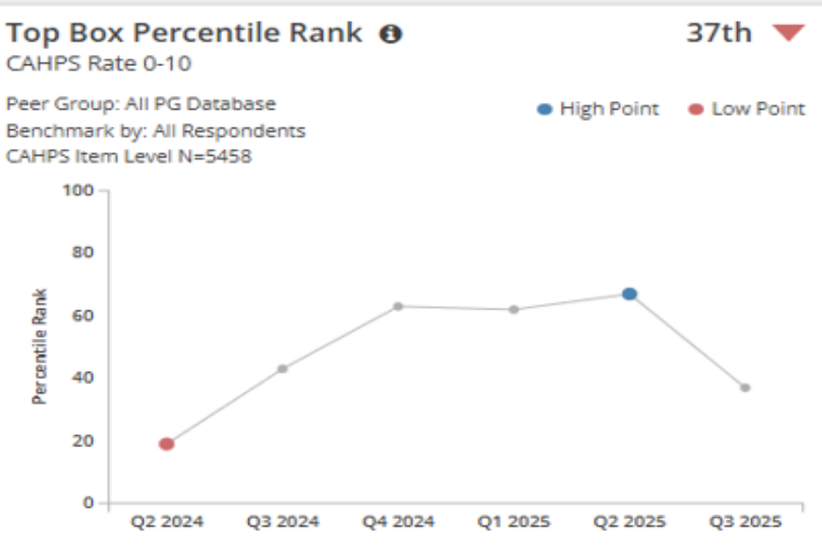
Press Gainey scores for inpatient showed significant improvement in all nine domains, except for a slight decline in communication regarding medications. Overall, the inpatient score improved from 64.29% to 76.74%. Ambulatory scores showed a slight decline, dropping from 91.51% in the second quarter to 87.88%, primarily associated with nursing, care provider, and facility/personal treatment overall scores.

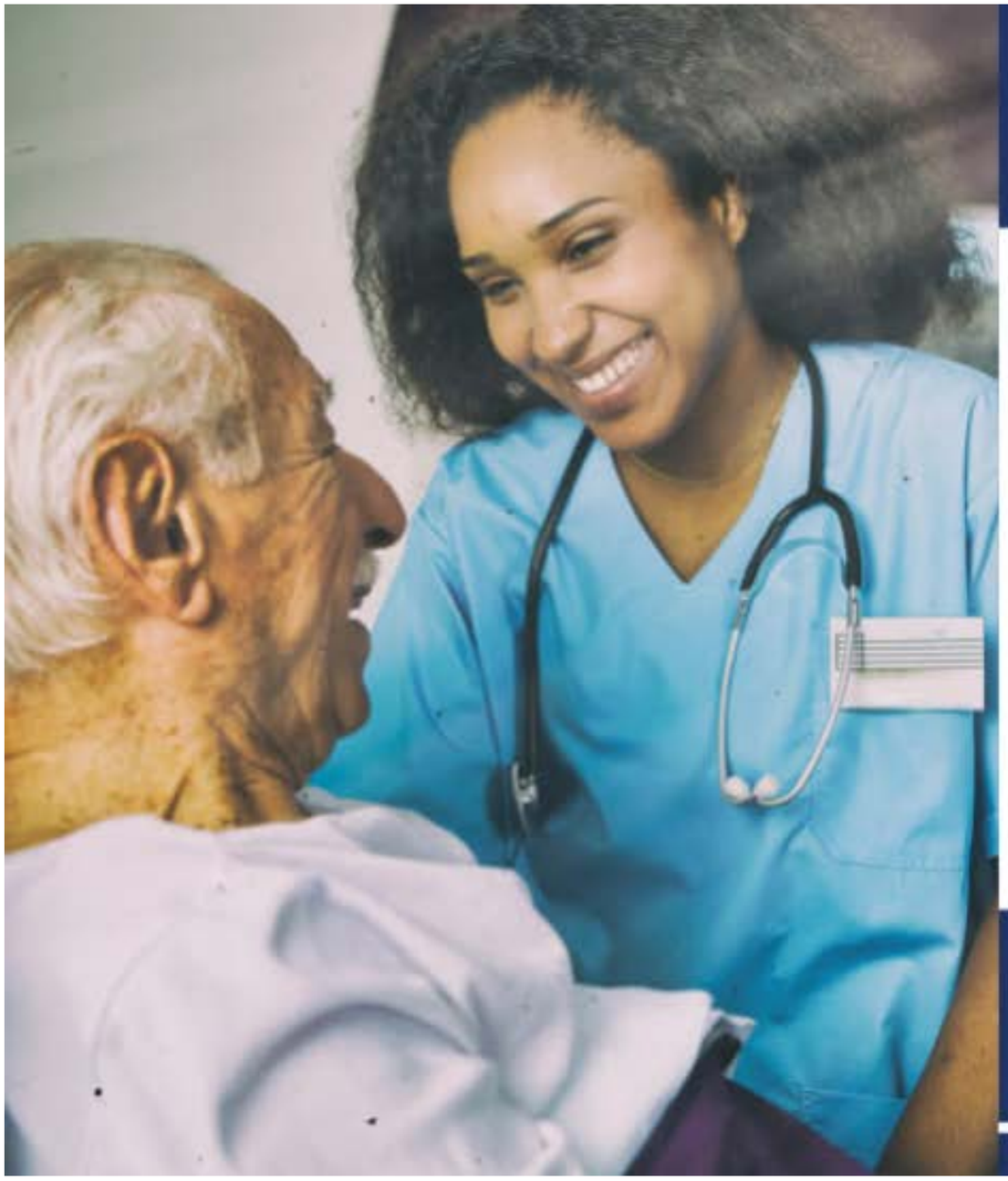




Press Gainey – 3rd Quarter Ambulatory







LEAPFROG

HOSPITAL SAFETY GRADE

A B C D F

2024 Leapfrog Hospital Survey Results

Leapfrog Hospital Safety Grade assigns hospitals an **A–F letter grade** based on **detailed** patient safety measures.

Measures:

1. Process/Structural Measures (50%)

- Medication Safety with Computerized Physician Order Entry (CPOE)
- ICU staffing by intensivists
- Nursing workforce and hand hygiene compliance
- Safety leadership and culture

2. Outcome Measures (50%)

- Hospital-acquired infections (CLABSI, CAUTI, MRSA, C. diff)
- Surgical complications
- Falls and pressure ulcers
- CMS PSI-90 composite (adverse events)

Data Collection

Hospitals **voluntarily complete the Leapfrog Hospital Survey**, reporting on safety practices and quality measures.

Sections Required:

- Patient Rights & Ethics
- Medication Safety
- Maternity Care
- Physician & Nurse Staffing
- Patient Safety Practices
- Managing Serious Errors
- Hospitals must also complete the **CPOE Evaluation Test** if they report having CPOE. [

Additional data is pulled from **CMS (Centers for Medicare & Medicaid Services)** and other national sources for hospitals that do not participate in the survey

Leapfrog Survey Participation Analysis

Hospitals Decline to Participate:

1. Data Sources Default to CMS

- Leapfrog still assigns a **Hospital Safety Grade** using publicly available data from **CMS (Centers for Medicare & Medicaid Services)** and other national sources.

2. Potential Impact on Grade

Lower grades assigned:

- Hospitals cannot demonstrate compliance with Leapfrog's standards beyond CMS data.
- Missing measures (like CPOE effectiveness or ICU staffing) are scored as **"Not Met"** or **zero points**.

Impact on Hospitals that submit survey:

Resource Intensive

- Requires **significant staff time** across multiple departments (Quality, Nursing, Pharmacy, IT).
- Coordination and data validation will be challenging.
- Meeting Leapfrog standards will require **process changes and/or financial investments** (Hiring an ICU intensivist and current ICU staffing).
- CPOE Evaluation Test is rigorous and requires training, multiple departments collaboration including a medical staff representative.
- No direct financial incentive payout.

WRAP UP/ QUESTIONS

Document Pending Action

Listing of documents where you are involved in any step of the workflow that require someone's action related to review, revision, authoring, or approval. The report groups documents by current status and lists document titles, number of days they have been in the current status and names of staff or committees that are required to complete current step.

Sonoma Valley Hospital

Run by: Wyatt, Louise (lwyatt)
Run date: 11/29/2025 10:59 AM

Report Parameters

Filtered by: Document Set: all applicable
Committee: 07 BOD-Quality (P&P Review)
Include Summary of Changes: Yes

Past Review Date: Yes
Include Pending Authoring: Yes
Include Pending Expert Review: Yes
Include Pending Approval: Yes
Include Pending Publishing: Yes

Grouped by: Status

Sorted by: Document Title

Report Statistics

Authoring:	0
Expert Reviewer:	0
Approval:	13
Pending Publishing:	0
Past Due:	0
Total Documents:	13

Approval

Document: **Anesthesia Coverage and Availability** Days Pending: 8
Location: **Anesthesia Dept Policies** Pending Since: 11/21/2025

Requires action of:

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

Summary of Changes:

Updated website where the anesthesia service provider is available.

Document: **Change in Patient Condition** Days Pending: 8
Location: **Patient Care Policy** Pending Since: 11/21/2025

Requires action of:

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

Summary of Changes:

Reviewed. Updated references to current CIHQ guidelines. Removed step to notify AOC or CMO as there are mechanisms in place for this notification via event eNotification system for reviewing care. Added purpose statement, added that the hospitalist is an acceptable alternative if the surgeon is not available, and that in cases of sharp decline to call RR; also clarified that a phone call is required, not email or text;

Document: **Chromosome Studies** Days Pending: 8
Location: **Laboratory Services Policies (LB)** Pending Since: 11/21/2025

Requires action of:

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

Summary of Changes:

Reviewed, no changes.

Document: **Code Blue - Management for Patient Emergency** Days Pending: 8
Location: **Emergency Code Alerts Policies** Pending Since: 11/21/2025

Requires action of:

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

Summary of Changes:

Added purpose statement. Clarified that in certain areas (such as ED or OR) Code Blue may not be paged overhead; added Pharmacist and Social Worker (if available) to the response team. Clarified who is responsible for what documentation. Clarified if a code blue more than 250 yards from hospital property (ie, employee parking lots), 911 should be called.

Reviewed by
Medical Director of ED
Director of Hospitalists
Code Blue Committee

Document: **Compounding Nonsterile Drug Products** Days Pending: 8
Location: **Medication Management Policies (MM)\Compounding Policies** Pending Since: 11/21/2025

Requires action of:

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

Summary of Changes:

-Updated the scope to include adding of flavoring to an oral liquid as NOT being considered compounding
-Updated that the annual review of SOPs and QA program is by the pharmacist in charge
-Minor formatting changes.

Document: **ED Log** Days Pending: 8
Location: **Emergency Dept** Pending Since: 11/21/2025

Requires action of:

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

Summary of Changes:

Added a purpose statement and clarified the policy wording to reflect the workflow in Epic, specifically that the Patient Access rep is responsible to ensure that all pts are registered, regardless of method of arrival or discharge disposition, so that the EMTALA log run via the EHR is accurate and complete. Also clarified that the ED RN or ED Tech must always document a disposition (including if the pt was LWBS, left before triage, left AMA, or eloped). Updated reference to include EMTALA and Title 22

Document: **IV Compounding (Non-Pharmacy Location)** Days Pending: 8
Location: **Medication Management Policies (MM)\Compounding Policies** Pending Since: 11/21/2025

Requires action of:

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

Summary of Changes:

Updated beyond use date to be 4 hours from the time of preparation to match current regulations.

Document: **Pharmacy Staff Competency Assessment** Days Pending: 8
Location: **Pharmacy Dept** Pending Since: 11/21/2025

Requires action of:

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

Summary of Changes:

Reviewed, no changes

Document: **Pressure Ulcer Wound Care Assessment and Management** Days Pending: 8
Location: **Patient Care Policy** Pending Since: 11/21/2025

Requires action of:

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

Summary of Changes:

Added purpose statement, shortened policy by adding referrals to Ebsco for in-depth explanations and video demonstrations, removed definitions of various stages of wounds as the RNs are not responsible for staging (and this info is available in Ebsco). Added that all inpatient admissions require thorough assessment by 2 RNs and clarified documentation requirements including frequency of assessments; added a section on Special Populations to include older adults, updated references (added surgery committee to the approval workflow) Added updated copy of Braden Scale for Risk Assessment

Document: **QAPI Procedures for Sterile Compounding Quality Assurance program** Days Pending: 8
Location: **Pharmacy Dept\Compounding Related** Pending Since: 11/21/2025

Requires action of:

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

Summary of Changes:

-added verbiage "Random observations of compounding personnel for adherence to proper compounding practices by the supervising pharmacist, and provision of ongoing feedback as needed." to comply with updated regulatory requirements
-updated lab used for qualitative testing to Fairfield Labs
-removed comments about adverse events and complaints and replaced with a more comprehensive section that contains required regulatory verbiage
-updated references to include additional state statute
-Uploaded new attachments for Sterile Compounding Training Program SOP; IV Room Cleaning Log; IV Hood Cleaning & Filter Change Record that contain updated requirements

Document: **Sterile Compounding** Days Pending: 8
Location: **Medication Management Policies (MM)\Compounding Policies** Pending Since: 11/21/2025

Requires action of:

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

Summary of Changes:

-Updated section on annual review of SOPs to state that the pharmacist in charge is responsible for the review.
-Updated section on oversight and responsibility to include methods used by the pharmacist to ensure quality and accuracy
-Updated section on immediate use compounding to include required regulatory language, documentation requirements, and allowed exception for equipment failure
-Updated references to include applicable state statute
-Uploaded updated attachment "Sterile Compounding Training Program SOP"

Document: **Stroke Admission Transfer Guidelines** Days Pending: 8
Location: **Patient Care Policy** Pending Since: 11/21/2025

Requires action of:

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

Summary of Changes:

Clarified the diagnosis of stroke to "suspected or confirm stroke", removed references to tPA and changed to "intravenous thrombolytic medication" as tPA is not used at SVH; removed language that the transfer was to go specifically to a primary or comprehensive stroke center and replaced with a "higher level of care to a facility providing neurosurgical services". Updated reference.
Reviewed/Approved by

Dr Cusick 9/26
Marylou Ehret 9/25
Jane Taylor 9/25

Document:	**Treat and Transfer of Patients**	Days Pending:	8
Location:	**Governance and Leadership Policies**	Pending Since:	11/21/2025

Requires action of:

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

Summary of Changes:

Changed title to Transfer of Patients (to include process for all patients, not just to imply ED pts). Added purpose statement that focuses on safe transfer when needed. Added the decision to transfer is made "after careful medical screening, treatment and stabilization, and upon interdisciplinary consultation (physician, surgeon, nursing supervisor as appropriate)..." Added that case management may assist with the transfer process. Removed language that the nursing supervisor approves the transfer. Added proper reference to CMS rule, removed reviewer names (kept titles only). Added sentence that criteria for transfer may also include the request by pt insurance (e.g. Kaiser) and that the transfer reason and process must meet EMTALA and CDPH requirements