SVHCD QUALITY COMMITTEE

AGENDA

WEDNESDAY, FEBRUARY 25, 2026

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/91652223647?from=addon

Meeting ID: 916 5222 3647

One tap mobile
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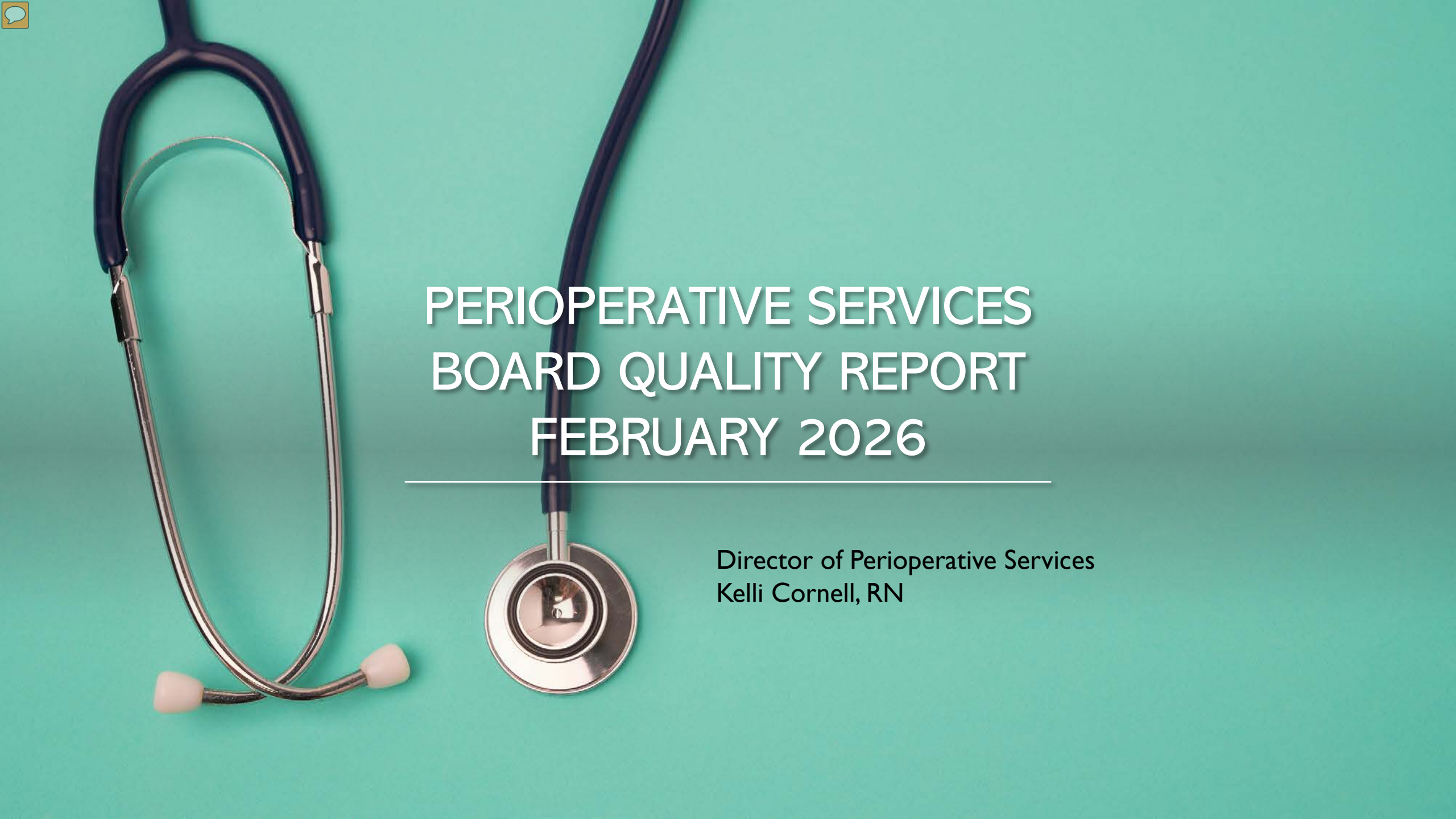
+19712471195,,91652223647#

AGENDA ITEM		
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.*		
3. CONSENT CALENDAR • None – no quorum for Jan. meeting	*Daniel Kittleson, DDS*	Action
4. PERIOPERATIVE SERVICES QA/PI	*Kelli Cornell, RN*	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	*Alex Rainow, MD*	Action



PERIOPERATIVE SERVICES BOARD QUALITY REPORT FEBRUARY 2026

Director of Perioperative Services
Kelli Cornell, RN

PERIOPERATIVE SERVICES DEPARTMENT WHO ARE WE?

- Surgical scheduling
- Nurse navigation
- Pre-operative
- Post-operative
- Outpatient infusion
- Operating room x3
- Sterile processing
- 43 FTEs

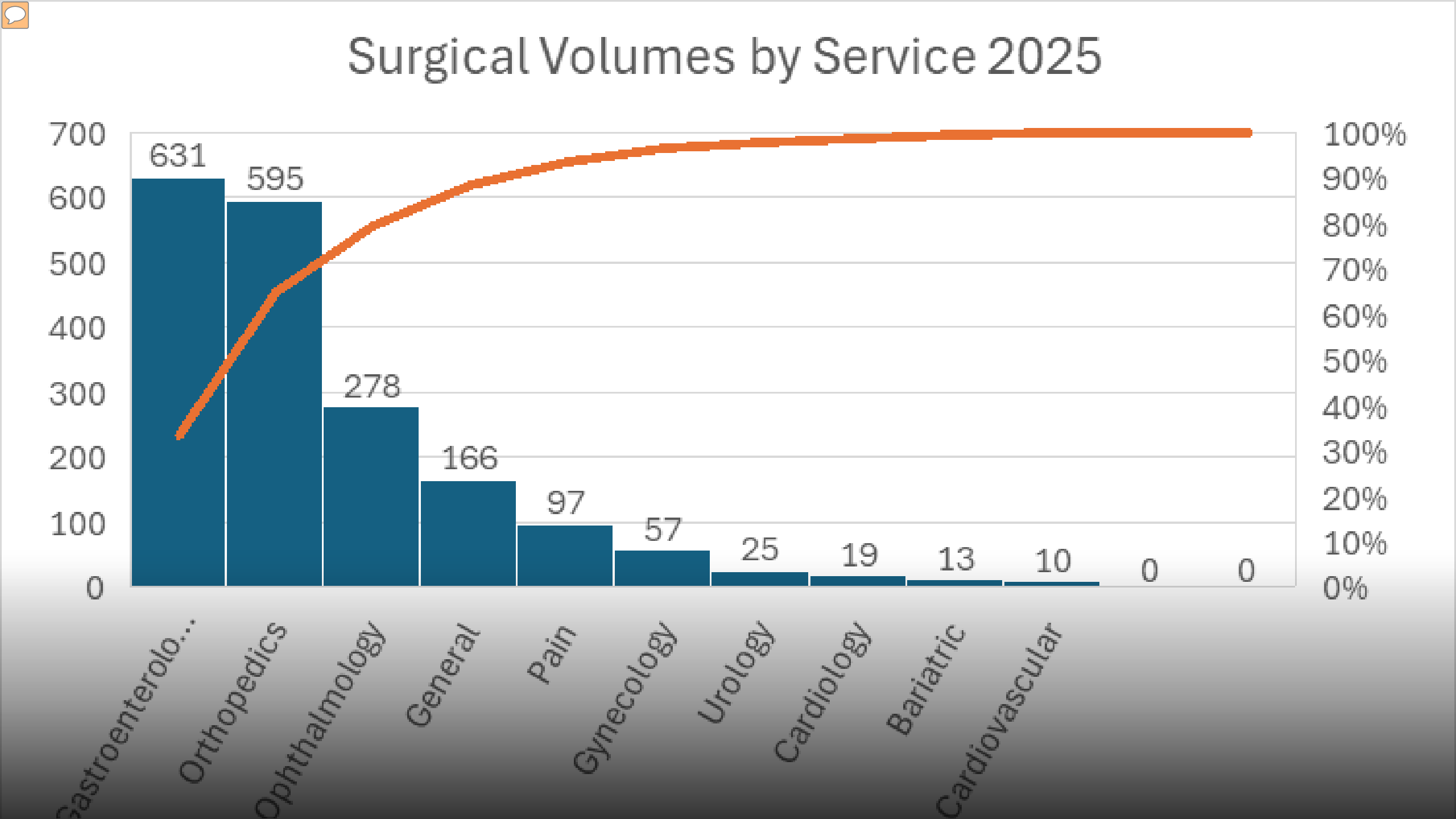
2025 REVIEW

- Clinical coordinator staffing model
- Growth of Robotics program (52 cases total joints)
- Outpatient infusion growth
- Volumes increasing
- Raised money for Stryker equipment (install started this week!)

VOLUMES

- **Total Procedures preformed**
- 2025: 1,891
- 2024: 1,828
- 2023: 2,048
- **Total Outpatient infusions performed**
- 2025: 683
- 2024: 584
- 2023: 486

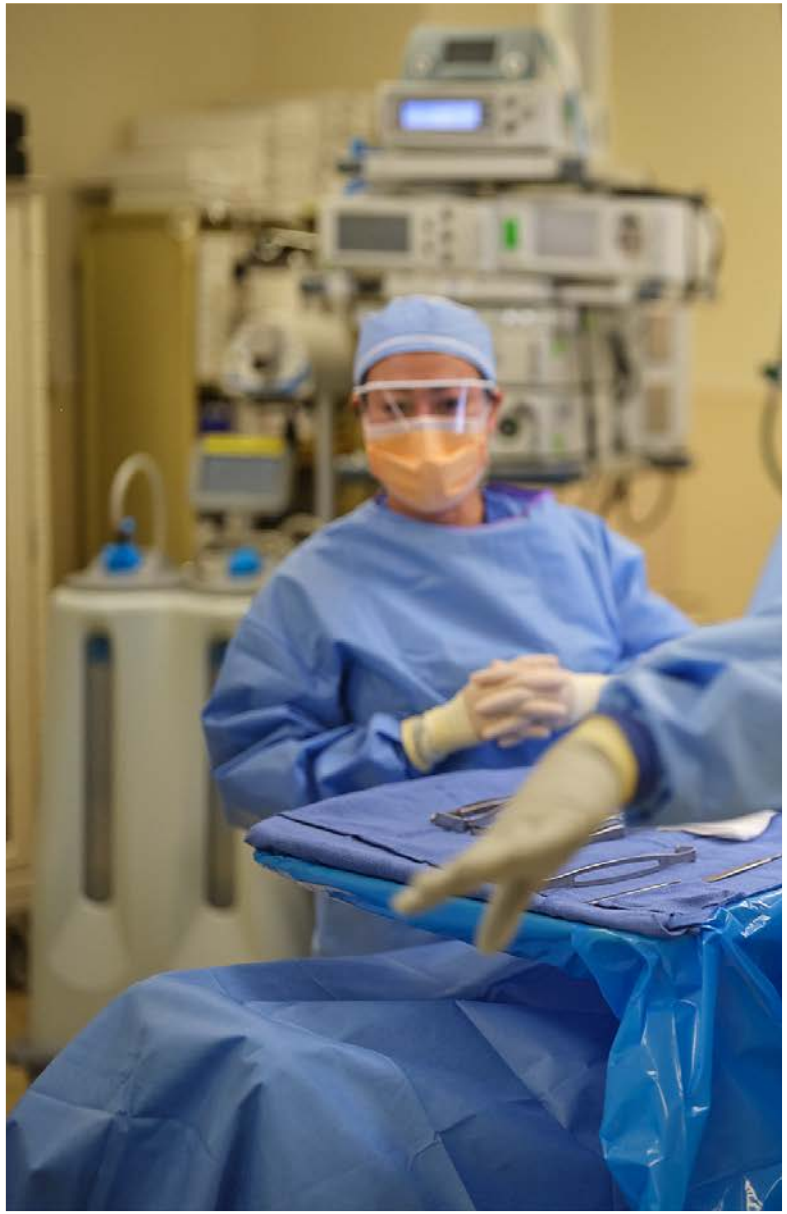
Surgical Volumes by Service 2025



Quality

Metrics Tracked in 2025:

- IUSS cycle tracking and compliance
- Endoscope handling and repair rates
- Surgical time-out compliance
- In-brief compliance
- Post-operative SCD utilization
- Post-operative pain assessment and tracking



What we found:

- **IUSS cycle tracking:**
  - 2024=112 cycles
  - 2025= 51 cycles

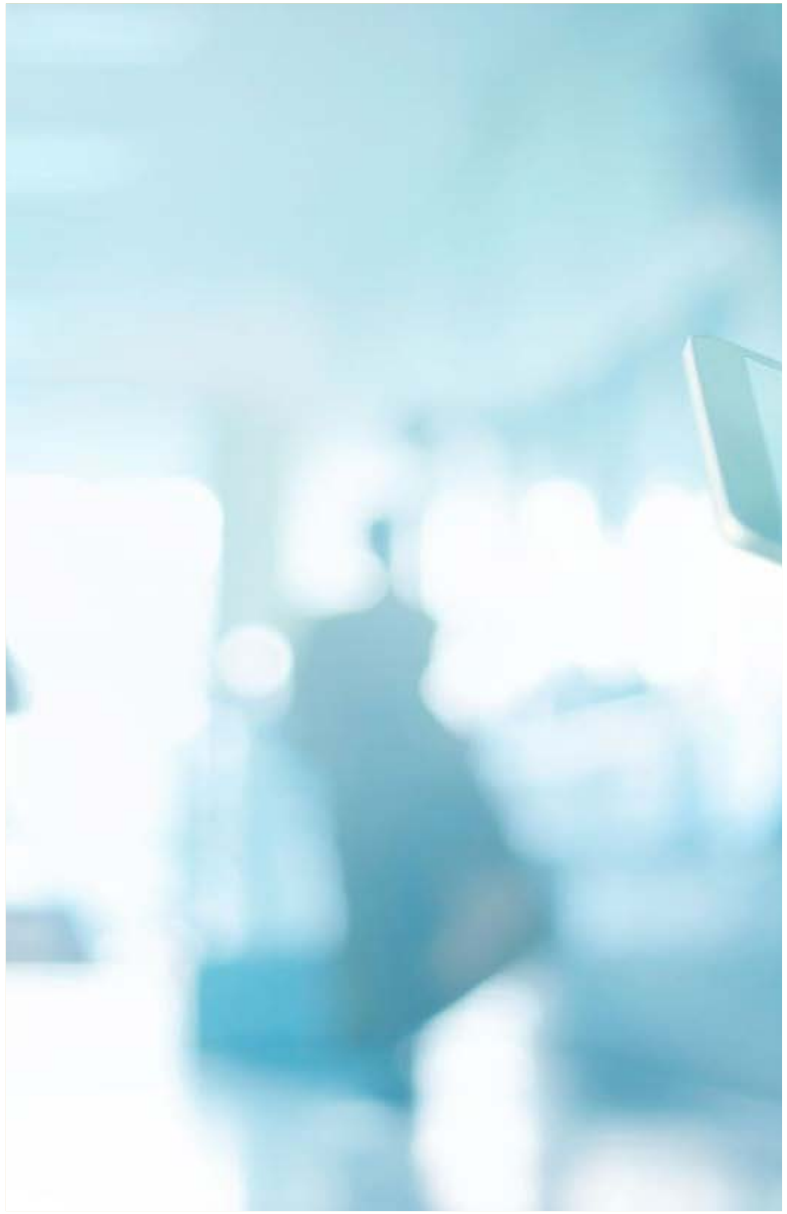
  45% reduction
- **Endoscope handling and repair rates**
  - 2024 = 3
  - 2025 = 6

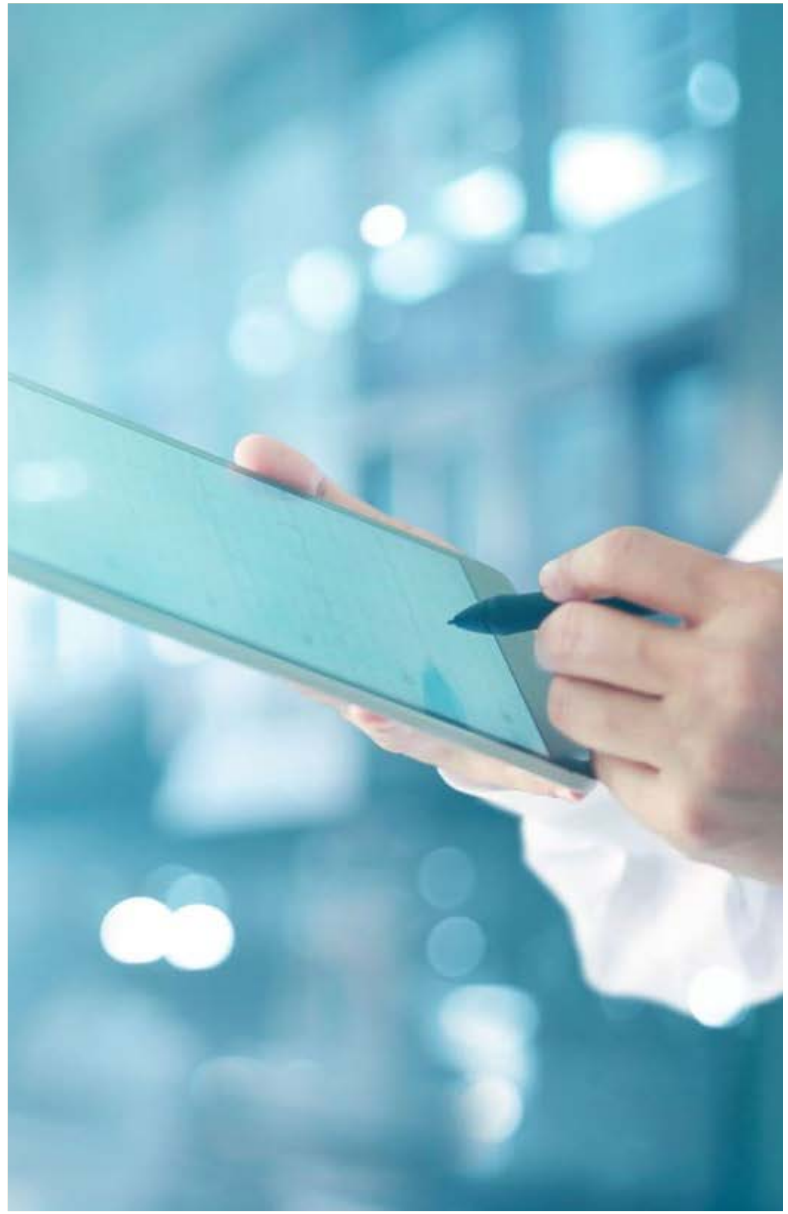
Operating Room

How did we do?

- Surgical time-out compliance
- 96% Compliant
    - 1 outlier (noisy room)

- In-brief compliance
- 78.5% Compliant
    - 6 outliers Doctor not yet I the room.





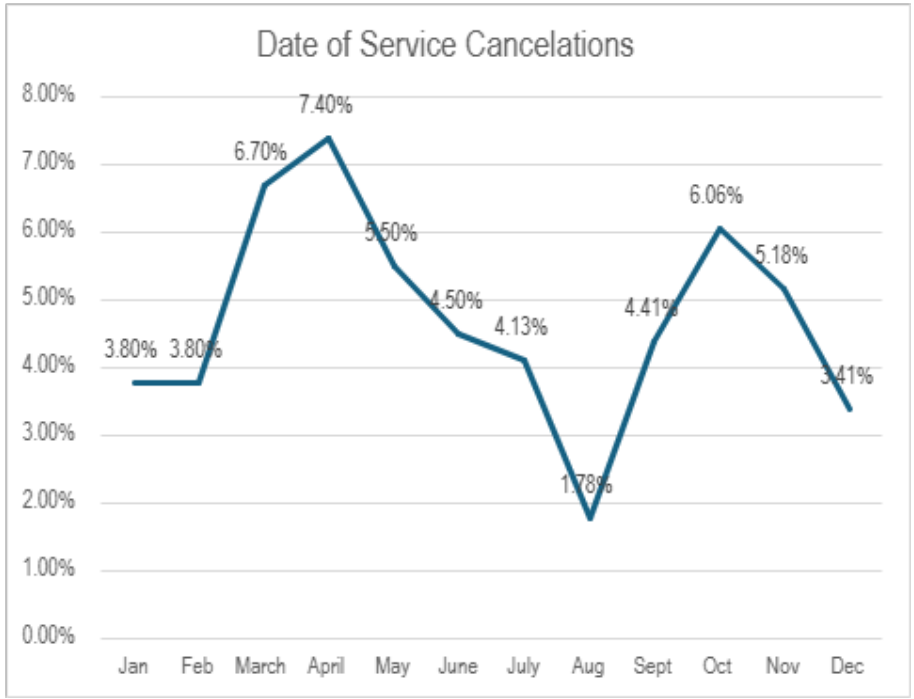
SURGICAL CARE UNIT

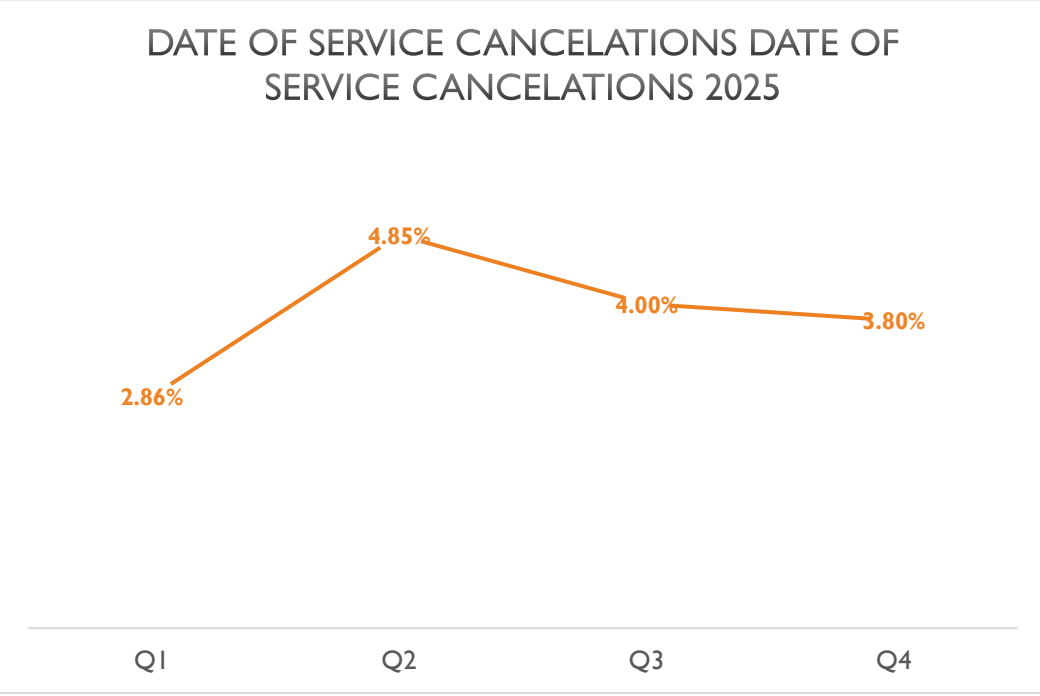
- Metrics Tracked in 2025:

- Post-operative SCD utilization
  - 100%

- Post-operative pain assessment and tracking
  - Track total joint post op pain
  - 30 mins & 1 hour
  - Goal 5/10 or less
  - 30min = 90%
  - 1hr = 80%

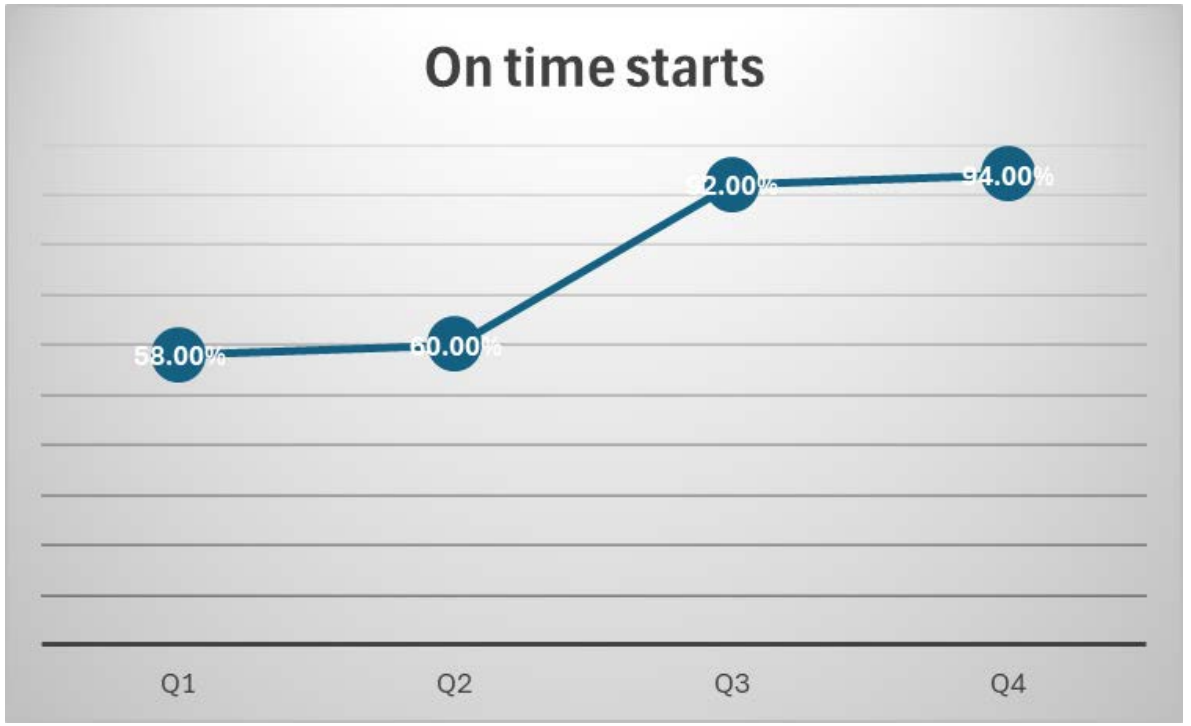
QUALITY METRICS 2024-2025





2024

2025



QUALITY METRICS

- Benchmarks:
- High performing organizations aim for 90% or better
- Median 64.3%

What's next for 2026?

Sterile Processing:

- IUSS
- Sterilization Error rates

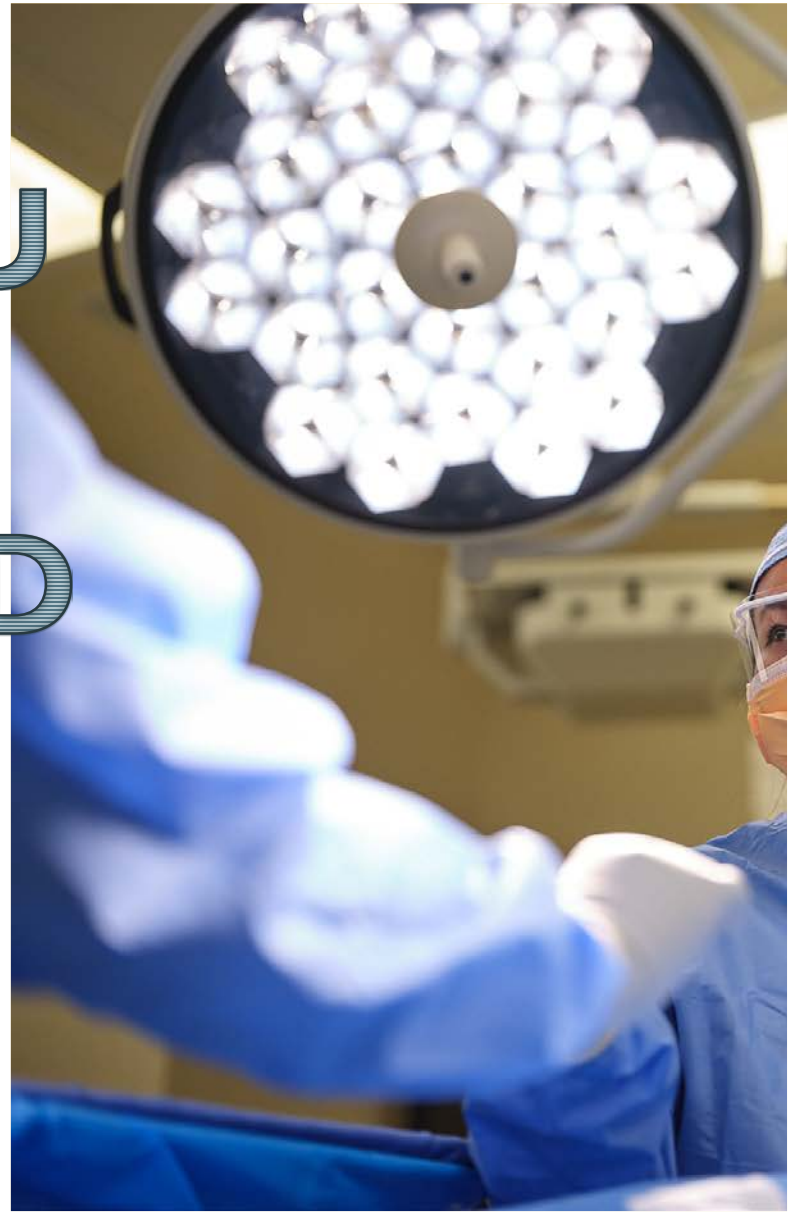
Operating Room:

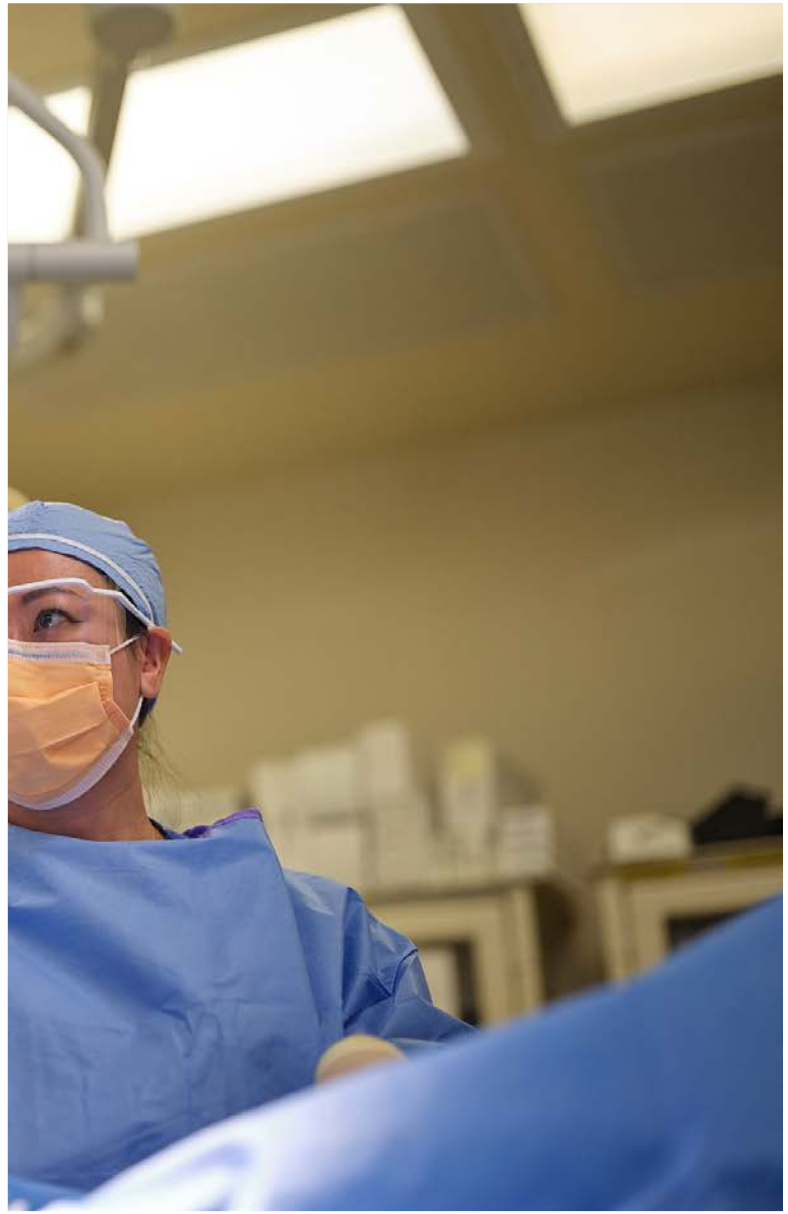
- Time out compliance
- First Case On Time Starts
- SSI
- Complication

SCU

- Patient Satisfaction
- Length of Stay
- Pain management

THANK YOU FOR YOUR CONTINUED SUPPORT





SVH Board Quality Report
February 25, 2026

Louise Wyatt, RN JD

Director of Quality, Risk Management, Patient Safety,
Case Management, Infection Prevention and Regulatory

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SONOMA VALLEY HEALTH CARE DISTRICT
HEALING HERE AT HOME

CIHQ Survey 2026
Survey window March 9th – May 9th, 2026

Key Focus Areas

- Life Safety & Environment of Care
- Infection Prevention and Safe Practices
- Patient Rights & Grievance Processes
- Medication Management
- Emergency Management
- Data Reporting & Performance Improvement (QAPI)

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CIHQ Survey 2026 (cont.)

In Progress

- Final policy validations
- Cross-department tracers
- Environment of Care rounding
- Staff readiness drills
- Upload of required documents to CIHQ portal
- Binder completion

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CIHQ Survey 2026 (cont.)

Next Steps

- Final document preparation for surveyors
- Weekly readiness huddles with leadership
- Weekly environmental rounds
- Maintain survey readiness

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January 2026Risk Events

Row Labels	No. of Events
AWOL/AMA	1
COMMUNICATION	1
COMMUNICATION-Critical Results	1
EQUIP/MED DEVICE	1
Fall-Without Injury	2
Good Catch-Other	1
Lab, delay	1
MERP-Administration	2
MERP-Prescribing	2
PRIVACY/CONFIDENTIALITY	1
Transfer, Issue with available on-call service	1
UM, Inappropriate transfer from ED	1
Grand Total	**15**

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QUESTIONS?

Thank you!

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Mortality Measures	2025 Results	2026 Targets	26-Jan	Comments
Risk Adjusted Acute Mortality Rate O/E [M]	0.7	≤ 0.95	0.42 3/7.1468	
Patient Safety Measures				
Age Friendly Mobility	98.35%	90%	98.76%	New Metric
SDOH Inpatient Screening	ND	≥ 70%	ND	New Metric - ND
PSI 90 (v2023-1) Patient Safety Indicators Composite, ACA - Numerator Volume (M)	0	0	0	
Bar Code Scanning Rate	94.60%	95%	96.80%	New Metric
Falls without injury (numeric value)	12	0	2	New Metric
Falls with injury (numeric value)	0	0	0	New Metric
Pressure Injuries ≥ Stage 2(numeric value)	0	0	0	New Metric
Critical Lab Value Reporting (IP, OP, and ED Critical values Called within 30 minutes, read back and documented per policy)	98.80%	≥ 93%	ND	New Metric - ND
HAI Infectious Disease Measures				
IC-Surveillance| HAI-C.DIFF Inpatient infections |M|	1	0	1	
IC-Surveillance| HAI-CAUTI Inpatient infections |M|	1	0	0	
IC-Surveillance| HAI-CLABSI Inpatient infections |M|	0	0	0	
IC-Surveillance| HAI-MRSA Inpatient infections |M|	0	0	0	
IC-Surveillance| HAI-SSI infections |M|	0	0	0	
Stroke Measures				
CDSTK-05|Median- Door to CT Scanner |M|elapsed time (mins)	3	≤ 25	10	
CDSTK-06|Median- Neuro Consult Response |M|elapsed time (mins)	ND	20 Mins	ND	New Metric - ND
CDSTK-12|Median-Door to tPA |M| elapsed time (mins)	48	≤ 60	16	
Utilization Review				
Acute Care Risk-adjusted Average Length of Stay, O/E Ratio |M	0.95	≤ 1.00	0.97	
Observed/Expected Length of Stay	0.8	≤ 1.00	0.89	New Metric
All cause Readm - % Readmit within 30 days, ACA (M)	10.92%	≤ 14%	9.9% 7/71	
COPD, CMS Readm - % Readmit within 30 Days, ACA (M)	16.70%	≤ 22%	0% 0/9	
HF, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)	7.40%	≤ 20%	0% 0/4	
PNA, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M	10.50%	≤ 17%	33.3% 2/6	
Sepsis, Simple - % Readmit within 30 Days (M)*	0.17%	≤ 20%	0.2% 2/5	
READM-30-Hip-Knee30-day readmission rate following elective primary Total Hip N/A Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	0%	≤ 0.95	0% 0/1	
CoreOpMeasures				
Core OP 22 ED LWBS Emergency Dept Left Without Being Seen (M	0.30%	≤ 3.0%	0.2% (2/937)	
Core OP-23 - Head CT/MRI Results for STK Pts w/in 45 Min of Arrival (M)	94%	≥ 85%	NA	
Core OP29/ASC9 - Colonoscopy:F/U for Avg Risk Pts (M	100%	≥ 90%	100%	
Core OP 18b Median Time ED Arrival to ED Departure - Reporting Measure (M	117.5	≤ 260 min	110.32	
Sepsis Measures				
SEP-1 Early Management Bundle, Severe Sepsis/Septic Shock (M)	85.20%	≥ 70%	100% (1/1)	
CIHQ Action Plan Measures (2023)				
Documentation Observation of High Risk Patients	74.30%	100%	ND	
Policies in Compliance for Reviews	78%	90%	Qtrly	
QA-02 | Hand Hygiene Practices Monitored % of compliance|M|	93%	≥ 90%	88%	

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: 02/22/2026 1:58 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: 2

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
NEW: Prevention of CAUTI, Urinary Catheter Insertion, Maintenance & Removal *Patient Care Policy*	**Pending Approval**	12/23/2025	61

Summary Of Changes: **This is a new policy which combined insertion policy with IC Policy Prevention of CAUTI in order to replace and RETIRE stand alone Insertion Policy**

- **Specifies indications for urinary catheterization based on location of care (Med-Surg/ICU vs Perioperative vs ED)**
- **Reorganized the flow of information to assist with decision making**
- **Allows for insertion and removal to be guided by physician order OR nurse driven protocol**
- **Includes more detail in the proper technique of urinary catheter insertion**
- **Addition of steps for specimen collection and urinary catheter removal**
- **Addition of troubleshooting urinary catheters for both males and females**

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)**

RETIRE: Prevention of Catheter Associated Urinary Tract Infections *Infection Prevention & Control Policies (IC)*	**Pending Approval**	12/23/2025	61

Summary Of Changes: **RETIRE this stand-alone policy replacing with Policy updated and consolidated with the Patient Care policy for insertion and maintenance.**

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

Lead Authors: **Wilder, Ashley (awilder)**

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)**

SUBJECT: Prevention of CAUTI, Urinary Catheter Insertion, Maintenance & Removal	POLICY: IC8610-2502
	Page 1 of 7
DEPARTMENT: Organizational	EFFECTIVE:
REVISED:	

NEW POLICY
This policy has been created to provide an updated, evidence-based hospital-wide policy and procedures for the insertion, maintenance and removal of urinary catheters as well as the prevention of catheter-associated urinary tract infections (CAUTI).

WHY:
A new urinary catheter policy has been developed to update existing guidelines and streamline protocols by consolidating two retired policies into a single, comprehensive document.

This replaces 2 Policies that were outdated---

OWNER:

Chief Nursing Officer

AUTHORS/REVIEWERS:
Manager Patient Care Services
Infection Preventionist
Medical Director, Patient Care Services
Multidisciplinary Clinical Review Team
Chief Nursing Officer
Board Quality Committee

SUBJECT: Prevention of CAUTI, Urinary Catheter Insertion, Maintenance & Removal	POLICY: IC8610-2502
	Page 2 of 7
DEPARTMENT: Organizational	EFFECTIVE:
REVISED:	

PURPOSE:
An Indwelling Urinary Catheter (IUC), also known as a Foley catheter, is a flexible tube that is passed through the urethra into the bladder to continuously drain urine through a closed system, into a collection bag. Some patients require an Intermittent Straight Catheterization (ISC) in which the catheter is inserted, urine is drained, and the catheter is removed. The purpose of this policy is to provide evidence-based guidance that addresses urinary catheter use, insertion, maintenance, and removal. . Foley catheter insertion is a sterile procedure performed by a Registered Nurse or a physician. Care of a Foley catheter is performed by either a Registered Nurse or a Patient Care Assistant who has been oriented to this procedure.

POLICY:
This policy outlines considerations specific to Sonoma Valley Hospital (SVH) and our patient population. For an in-depth review of IUC and ISC insertion instructions for specific types of patients, readers are referred to Ebsco Dynamic Health on the SVH intranet.

SCOPE
This policy applies to all locations within the hospital where patient care is performed. It is specific to those patients who require an IUC or ISC.

Special Population: Older Adults
This policy aligns with the principles of Age-Friendly Health Systems and Geriatric Emergency Department (GED) accreditation by prioritizing safe, evidence-based care that reduces harm in older adults. The criteria-based catheter insertion limits catheter uses to specific, evidence-based indications to avoid unnecessary insertion and patient harm. This Nurse-Driven protocol allows nurses to remove catheters based on clinical criteria, promoting timely removal and reducing infection and delirium.

PROCEDURE:
The following is a list of indications for insertion of urinary catheterization. It is not all-inclusive and thus requires nursing assessment and a physician order for initial insertion.

1) Indications for inserting a urinary catheter
- **a)** Urinary retention, or bladder outlet obstruction (may be IUC or ISC)
- b) Accurate measurement of urinary output in critically ill and/or incontinent patients
- c) Required immobilization secondary to trauma or surgery (for example: potentially unstable thoracic or lumbar spine, multiple traumatic injuries such as pelvic fractures)
- d) To assist in the healing of open sacral or perineal wounds in an incontinent patient, in collaboration with the Wound Care RN
- e) Epidural catheter in place
- f) To improve comfort for end-of-life care if needed

Surgical procedures requiring urinary catheterization (Following is a list of contraindications for insertion of a urinary catheter. It is not all-inclusive and requires a nursing assessment of patient needs and consult with the physician.

2) Contraindications for urinary catheterization

a) Incontinence that does not require output measurement
b) Morbid obesity
c) Patient request
d) Medication use, such as use of anticoagulants or lab test results indicating coagulopathies (alert treating clinician of increased bleeding risk)

3) Maintenance of IUC

a) Proper hand hygiene is key to preventing infection. Always wash hands before and after any contact with the patient.
b) Standard precautions, including use of gloves (and gown/eye protection if splashing is anticipated) during any manipulation of the catheter or collecting system.
c) Peri-care should be performed routinely, at least once per shift and whenever the patient has been incontinent.
d) Avoid use of adult diapers/incontinence briefs or extra towels between the legs as this may increase risk of infection
e) The constant free flow of urine into the collection bag is essential to patient comfort and infection prevention. Ensure the tubing is never bent, kinked or looped. Always hang the collection bag below the level of the bladder as this will prevent the backflow of urine.
f) Avoid allowing the urine to overflow in the collection bag. Regular emptying, at least every six hours, (or one-two hours in critically ill patients) and as needed is key.
g) Bladder irrigation is not recommended to treat a clogged catheter. If an obstruction is anticipated (as might occur with bleeding after prostatic or bladder surgery.) Continuous bladder irrigation, to prevent obstruction, may be necessary. This is done at the direction of the physician order.

4) Special Considerations.

a) Before inserting an IUC, consider using an external urinary device, such as Purewick © or condom catheter instead of IUC.
b) Programmed toileting, which includes placing the patient on the bedpan or commode every 2-4 hours while awake may reduce risk of retention, and need for IUC.
c) Consult with pharmacy for review of medications that may cause urinary retention or diuresis.
d) IUC are not intended for long term use. It is a goal of care to remove at the earliest opportunity. A nurse driven protocol directs the RN on removal criteria and post-removal monitoring. The protocol is embedded in the order within the electronic health record (EHR) and is attached to this policy for reference.

e) If a patient presents with or develops a urinary tract infection (UTI) and has an ICU or develops a catheter-associated UTI while hospitalized: remove indwelling urinary catheter promptly and only replace catheter if patient meets an indication.

5) Assessment and Documentation

a) The need for an IUC must be continually assessed for complications related to CAUTI by nursing. Criteria for continuing an IUC will be documented in the EHR:
   i) Upon admission or transfer to another unit
   ii) Each shift

6) Specimen Collection

a) If a urine sample is needed, after verifying the physician order, obtain aseptically:
   i) If a small volume of fresh urine is needed (i.e. for urinalysis or culture) cleanse the needleless sampling port with disinfectant and aspirate the urine, using a sterile syringe.
   ii) If a large amount of urine is needed for special analyses (not culture) a sample from the drainage bag can be used.

7) Infection Prevention:

Patients with an IUC are at increased risk of CAUTI. The SVH Infection Prevention (IP) program ensures adherence to best practices and implements strategies to prevent, control, and monitor infection. Strategies based on a facility risk assessment to enhance appropriate use of IUC and reduce risk of CAUTI include, but are not limited to:

a) ***QAPI***: The Infection Preventionist and individual department nurse leaders will create and implement Quality Assurance/Process Improvement (QAPI) plans that monitor urinary catheter usage, and develop corrective action plans or process improvement plans when the need arises.
b) ***Education and Training***. The Infection Preventionist and Clinical Education Coordinator collaborate to ensure that healthcare personnel are given periodic in-service training (bi-annually) and training upon new hire, regarding technique and policy for IUC. Additionally, education about CAUTI, and other complications of urinary catheterization, and alternatives to urinary catheters.
c) ***Antimicrobial Stewardship***. The Infection Preventionist attends monthly antimicrobial stewardship meetings and reviews cases of CAUTI
d) ***Patient Rounds***: Attendance of the Infection Preventionist on daily interdisciplinary rounds to
   i) Asess appropriate utilization of urinary catheters
   ii) Identify and encourage removal of urinary catheters that no longer meet criteria
   iii) Ensure adherence to infection prevention best practices, such as hand hygiene, placement of the urine collection bag, specimen collection, etc.

e) Surveillance and Reporting

i) Infection Prevention uses a standardized methodology for performing CAUTI surveillance. This includes monthly audits of nursing documentation, and a tally of catheter use days

ii) All instances of hospital acquired CAUTI will be logged into the event reporting system for further investigation Infection Prevention prepares a quarterly CAUTI report, that is shared with each department's leadership team

Data on n CAUTI is shared throughout the organization in monthly meetings (Board Quality, Medicine and Surgical Committees, and staff meetings) .

REFERENCES:

Institute for Healthcare Improvement. (2011). *How-to guide: Prevent catheter-associated urinary tract infections.* Institute for Healthcare Improvement. https://www.urotoday.com/images/catheters/pdf/IHIHowtoGuidePreventCAUTI.pdf

California Department of Public Health. (2019). *Catheter-associated urinary tract infection prevention.* California Department of Public Health. https://www.cdph.ca.gov/Programs/CHCQ/HAI/CDPH%20Document%20Library/10h_CAUTI.Prevention_Approved2.22.19.pdf

Centers for Disease Control and Prevention. (2019). *Guideline for prevention of catheter-associated urinary tract infections, 2009* (last updated June 6, 2019). U.S. Department of Health and Human Services, CDC. https://www.cdc.gov/infectioncontrol/guidelines/cauti/index.html

ATTACHMENT:

Providence Adult Indwelling Urinary Catheter Removal Protocol, October 2024

OWNER:

Chief Nursing Officer

AUTHORS/REVIEWERS:

Infection Prevention
Director Patient Care Services
Medical Director, Patient Care Services
Multidisciplinary Clinical Review Team
Chief Nursing Officer
Board Quality Committee

SUBJECT: Prevention of CAUTI, Urinary Catheter Insertion, Maintenance & Removal	POLICY: IC8610-2502
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DEPARTMENT: Organizational	EFFECTIVE:
REVISED:	

APPROVALS:
Policy & Procedure Team:
Medicine Committee:
Surgery Committee:
Performance Improvement/
Pharmacy & Therapeutics Committee
Medical Executive Committee:
The Board of Directors:

Attachment A