SVHCD QUALITY COMMITTEE MEETING

AGENDA

WEDNESDAY, APRIL 27, 2016

5:00 p.m. Regular Session

(Closed Session will be held upon adjournment of the Regular Session)

Location: Schantz Conference Room
Sonoma Valley Hospital – 347 Andrieux Street, Sonoma CA 95476

AGENDA ITEM	RECOMMENDATION	
In compliance with the Americans with Disabilities Act, if you require special accommodations to attend a District meeting, please contact the District Clerk, Gigi Betta at ebetta@svh.com or 707.935.5004 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	*Hirsch*	
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.	*Hirsch*	
3. CONSENT CALENDAR • QC Minutes, 3.23.16	*Hirsch*	Action
4. ANNUAL SKILLED NURSING REPORT	*Evans*	Inform
5. ANNUAL HOME CARE REPORT	*Lee*	Inform
6. Q1 PATIENT CARE SERVICES DASBOARD	*Kobe*	Inform
7. POLICY & PROCEDURES ✓ Pharmacy Policies: MM 8610-155-6 ✓ Multiple Policies, April 2016: 7010-01 & 6171-154	*Lovejoy*	Action
8. QUALITY REPORT Quality & Resource Management Report April 2016	*Lovejoy*	Inform/Action
9. CLOSING COMMENTS/ANNOUNCEMENTS	*Hirsch*	
10. ADJOURN	*Hirsch*	
11. UPON ADJOURNMENT OF REGULAR OPEN SESSION	*Hirsch*	
12. CLOSED SESSION: • Calif. Health & Safety Code § 32155 Medical Staff Credentialing & Peer Review Report	TBD	Action
13. REPORT OF CLOSED SESSION	*Hirsch*	Inform/Action
14. ADJOURN	*Hirsch*	

3.

CONSENT

+

SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
MINUTES
Wednesday, March 23, 2016
Schantz Conference Room

Committee Members Present	Committee Members Present cont.	Members Not Present	Admin Staff /Other
Jane Hirsch Carol Snyder Michael Mainardi Cathy Webber	Ingrid Sheets Susan Idell Joshua Rymer Howard Eisenstark	Brian Sebastian, M.D. Kelsey Woodward	Leslie Lovejoy Robbie Cohen, M.D. Mark Kobe Gigi Betta

AGENDA ITEM	DISCUSSION	ACTION
1. CALL TO ORDER/ANNOUNCEMENTS	*Hirsch*	
	The meeting was called to order at 5:00pm	
2. PUBLIC COMMENT	*Hirsch*	
	No public comment.	
3. CONSENT CALENDAR	*Hirsch*	Action
• QC Minutes, 02.24.16		**MOTION** by Mainardi to approve Consent and 2nd by Rymer. All in favor.
4. POLICY & PROCEDURES	*Lovejoy/Kobe*	Action
• PC8610-165 *Sara Lite Sit to Stand* lift (new) • 8640-173 Neutropenic Precautions (new) • 8640-174 Credit Card Use in Café (new) • IC8610-140 Infection Prevention Program (revised) • CE8610-151 Injury Prevention Program (revised) • IC8610-141 Influenza Vaccine Program (revised) • QA8610-106 PI Improvement Plan (revised) • Multiple Pharmacy Policies Feb. 2016 (revised)		**MOTION** by Idell to approve Policies and 2nd by Mainardi. All in favor.
5. QUALITY & RESOURCE MANAGEMENT REPORT FOR MARCH 2016	*Lovejoy*	Inform/Action
	Ms. Lovejoy covered the top priorities for March 2016 which include orientation of two new Quality team members, CALHEN project team development, annual staff performance evaluations and the PRIME Grant application.	**MOTION** by Was this inform only?

AGENDA ITEM	DISCUSSION	ACTION
	The PRIME grant application award would allow the Hospital to begin development of a new healthcare delivery system.	
6. INFECTION CONTROL	*Mathews*	Inform/Action
• Annual Evaluation • Infection Prevention Program • Infection Control Dashboard • Infection Control Risk Assessment	Ms. Mathews presented an in depth report on the Infection Prevention Dashboard and metrics. In the interest of time, full presentations of the Infection Prevention Program Policy and Risk Assessment Report were not given.	**MOTION** by Mainardi to approve IC Report and 2nd by Sheets. All in favor.
7. ANNUAL REPORT OF CONTRACT ADMINISTRATION & EVALUATION	*Lovejoy*	*Inform/Action*
	CIHQ and CMS require completion of an annual evaluation of each Hospital contract. Ms. Lovejoy gave background on the annual contract evaluation process and distributed an example of the standardized evaluation tool used in this process. A full list of Patient and Non-Patient Care Contracts was made available to the Committee in hardcopy.	**MOTION** by Eisenstark to approve and 2nd by Mainardi. All in favor.
8. CLOSING COMMENTS	*Hirsch*	
9. ADJOURN	*Hirsch*	
10. UPON ADJOURNMENT OF REGULAR SESSION	*Hirsch*	
11. CLOSED SESSION	*Cohen, M.D.*	Action
• Calif. Health & Safety Code § 32155 Medical Staff Credentialing & Peer Review Report • 4th Q 2015 Quality Dashboard	There was no Medical Staff Credentialing & Peer Review Report. Fourth quarter Quality Dashboard results were discussed.	
12. REPORT OF CLOSED SESSION	*Hirsch*	Inform/Action
13. ADJOURN	*Hirsch*	
	Meeting adjourned at 6:45pm	

4.

2015 ANNUAL QUALITY REPORT SVH SKILLED NURSING FACILITY

2015 Annual Quality Report for Sonoma Valley Hospital's Skilled Nursing Facility

SONOMA
VALLEY HOSPI
SONOMA VALLEY HEALTH CARE S
Healing Here at

Regulatory Requirements

- Sonoma Valley Hospital's D/P SNF is regulated by the California Department of Public Health Licensing Division, Life Safety Code Division, Office of Statewide Hospital Planning and Development (OSHPD), Cal OSHA, Title 22 California Code of Regulations, and The Department of Health and Human Services Centers for Medicare and Medicaid Services.

QAPI –Key Elements

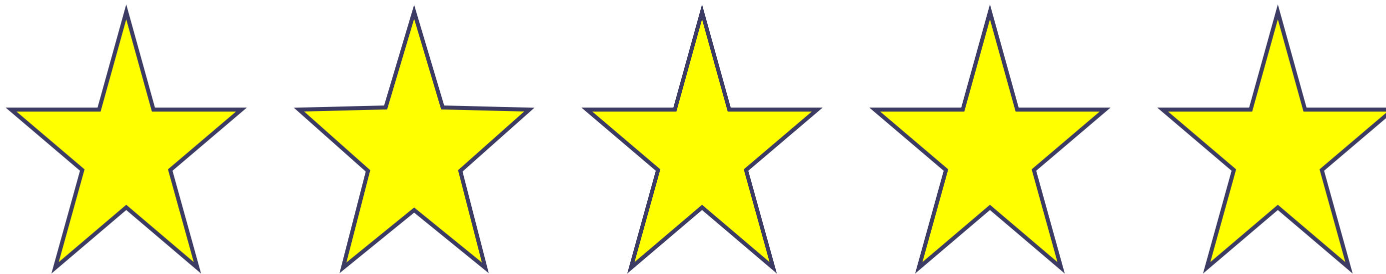
- PDSA (“Plan, Do, Study, Act”)
- RCA (Root Cause Analysis)
- PI (Performance Improvement Committee)
- Safety Committee
- LEM (Leadership Evaluation Manager)
- Quality Control Monitoring

Key Elements of our QAPI Program

- Key elements of our Performance improvement (PI) system include Quality Monitoring for high risk- high volume, high risk-low volume, and problem- prone patients. Our plans are based on industry standards and Best Practices and revised quarterly based on results.

Medicare's 5 – Star Rating System

- Medicare.gov *Nursing Home Compare* website provides a "5 -star rating system for consumers to make informed decisions about Skilled Nursing Facilities.
- Ratings are based on Health Inspections, staffing ratios and quality measures.
- After our most recent survey in November, 2015, Sonoma Valley Hospital's D/P SNF is currently rated as a 5 – Star SNF.



Medicare.gov | Nursing Home Compare

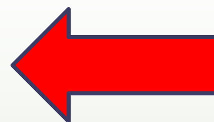
The Official U.S. Government Site for Medicare

Star rating summary

Much Above Average

Above Average

Much Above Average



Below Average

Medicare.gov | Nursing Home Compare

The Official U.S. Government Site for Medicare

	SONOMA VALLEY HOSPITAL DP/SNF	CALIFORNIA AVERAGE	NATIONAL AVERAGE
Percent of short-stay residents who self-report moderate to severe pain. ***Lower*** *percentages are better.*	34.7%	12.7%	17.2%
Percent of short-stay residents with pressure ulcers that are new or worsened. ***Lower*** *percentages are better.*	0.4%	0.8%	1.2%
Percent of short-stay residents assessed and given, appropriately, the seasonal influenza vaccine. ***Higher*** *percentages are better.*	96.5%	81.8%	81.5%
Percent of short-stay residents assessed and given, appropriately, the pneumococcal vaccine. ***Higher*** *percentages are better.*	96.5%	81.7%	81.9%
Percent of short-stay residents who newly received an antipsychotic medication. ***Lower*** *percentages are better.*	1.4%	1.6%	2.2%

MDS 3.0 Facility Level Quality Measure Report

(Certification And Survey Provider Enhanced Reports)

D: CA010000233
258
ame: SONOMA VALLEY HOSPITAL DP/SNF
: SONOMA, CA
calculated on: 03/14/2016

Report Period: 05/01/15 - 10/31/15
Comparison Group: 03/01/15 - 08/31/15
Run Date: 03/14/16
Report Version Number: 2.00

shes represent a value that could not be computed
short stay, L = long stay
ncomplete; data not available for all days selected
s an indicator used to identify that the measure is flagged

Description	CMS ID	Data	Num	Denom	Facility Observed Percent	Facility Adjusted Percent	Comparison Group State Average	Comparison Group National Average	Compa Gro Natio Perce
evere Pain (S)	N001.01		42	138	30.4%	30.4%	12.7%	17.4%	8
evere Pain (L)	N014.02		0	6	0.0%	0.0%	6.0%	9.1%	
s Ulcer (L)	N015.01		0	3	0.0%	0.0%	6.7%	6.4%	
e Pres Ulcer (S)	N002.02		2	147	1.4%	1.1%	0.8%	1.3%	6
aints (L)	N027.01		0	6	0.0%	0.0%	1.1%	0.8%	
	N032.01		0	6	0.0%	0.0%	30.3%	44.8%	
j Injury (L)	N013.01		0	6	0.0%	0.0%	1.7%	3.4%	
Med (S)	N011.01		0	107	0.0%	0.0%	1.7%	2.4%	
Med (L)	N031.02		3	6	50.0%	50.0%	14.2%	17.7%	9
/Hypnotic (L)	N033.01		1	3	33.3%	33.3%	9.2%	9.2%	9
affect Others (L)	N034.01		4	6	66.7%	66.7%	19.1%	23.2%	9
x (L)	N030.01		1	6	16.7%	16.7%	1.3%	5.7%	9
	N024.01		0	6	0.0%	0.0%	4.2%	5.3%	
t/Left Bladder (L)	N026.02		1	6	16.7%	20.4%	4.0%	3.9%	9
se B/B Con (L)	N025.01		1	3	33.3%	33.3%	43.9%	45.9%	2
Loss (L)	N029.01		2	6	33.3%	33.3%	6.9%	8.0%	9

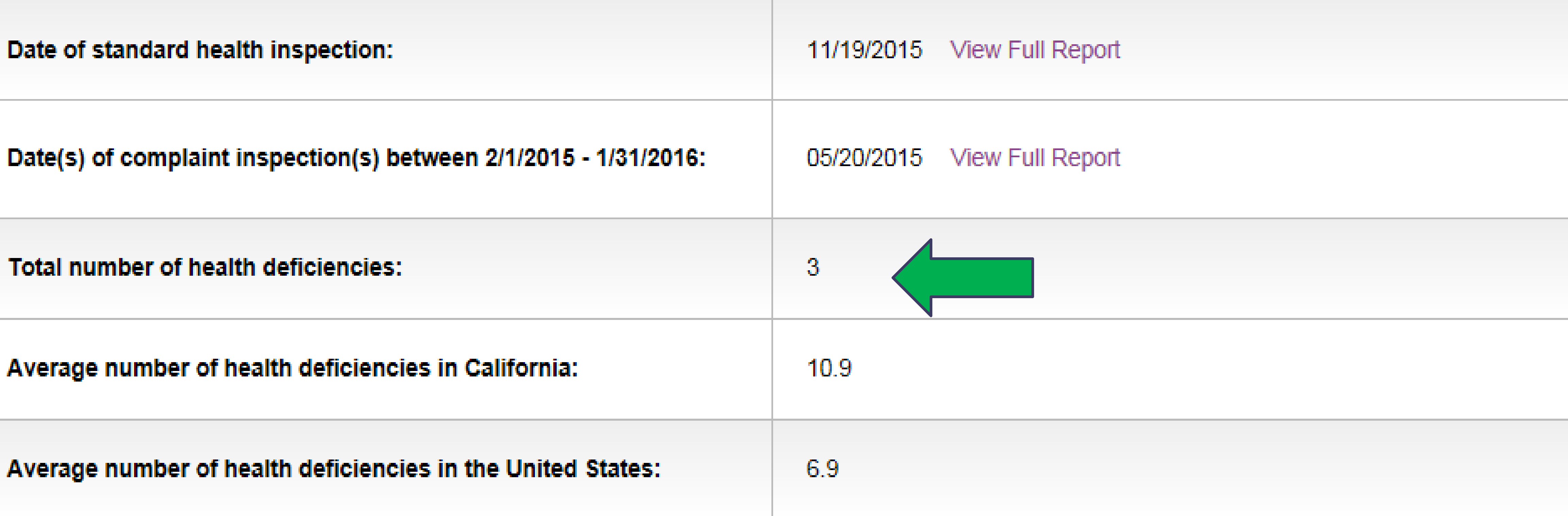
CMS Data is Obtained through the MDS

Data sources

The data come from 2 sources:

1. **CMS's health inspection database** - Includes the nursing home characteristics and health deficiencies issued during the 3 most recent state inspections and recent complaint investigations. Data about staffing and penalties made against nursing homes also come from this database.
2. **National database known as the Minimum Data Set (MDS)** - Data for quality measures come from the MDS Repository. The MDS is an assessment done by the nursing home at regular intervals on every resident in a Medicare- or Medicaid-certified nursing home. Information is collected about the resident's health, physical functioning, mental status, and general well-being. These data are used by the nursing home to assess each resident's needs and develop a plan of care.

All of these data are reported by the nursing homes themselves. Nursing home inspectors review it, but don't formally check it to ensure accuracy. This information changes frequently as residents are discharged and admitted, or residents' conditions change. The information should be interpreted cautiously and used along with information from the Long Term Care Ombudsman's office, the State Survey Agency, or other sources



Date of standard health inspection:	11/19/2015 View Full Report
Date(s) of complaint inspection(s) between 2/1/2015 - 1/31/2016:	05/20/2015 View Full Report
Total number of health deficiencies:	3
Average number of health deficiencies in California:	10.9
Average number of health deficiencies in the United States:	6.9

View all health inspections

- **Mistreatment: 0 deficiencies found**
- **Quality Care: 0 deficiencies found**
- **Resident Assessment: 0 deficiencies found**
- **Resident Rights: 0 deficiencies found**
- **Nutrition and Dietary: 1 deficiency found**
- **Pharmacy Services: 0 deficiencies found**
- **Environmental: 2 deficiencies found**

Federal and CA Survey 11/19/2015

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 3/14/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENNTIFICATION NUMBER: 555258	(X2) MULTIPLE CONSTRUCTION A. BUILDING ________ B. WING ________	(X3) DATE SURVEY COMPLETED 11/19/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SONOMA VALLEY HOSPITAL DP/SNF	**347 ANDRIEUX ST SONOMA, CA 95476**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

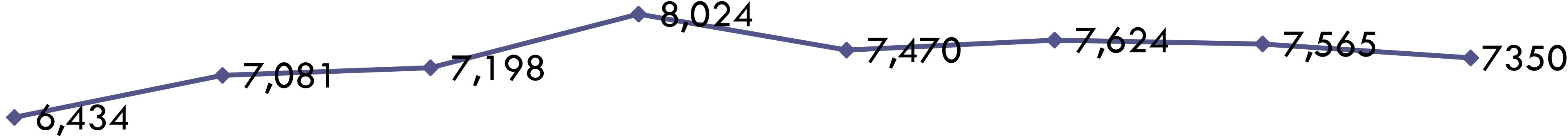
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0371 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Store, cook, and serve food in a safe and clean way** Deficiency Text Not Available
F 0441 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Have a program that investigates, controls and keeps infection from spreading.** Deficiency Text Not Available

1.Chorine concentration in the dishwasher too low. Action Plan complete with daily monitoring by Dietary Manager.
2. Pasta not dated. Action Plan complete with monthly monitoring of out-dates by Dietary Manager.
3. Nurse did not disinfect scissors *before* and *after* entering patient room. Action Plans complete, SNF DON conducts random audits and reports incidence of non – compliance on QAPI log.

Trends in Growth

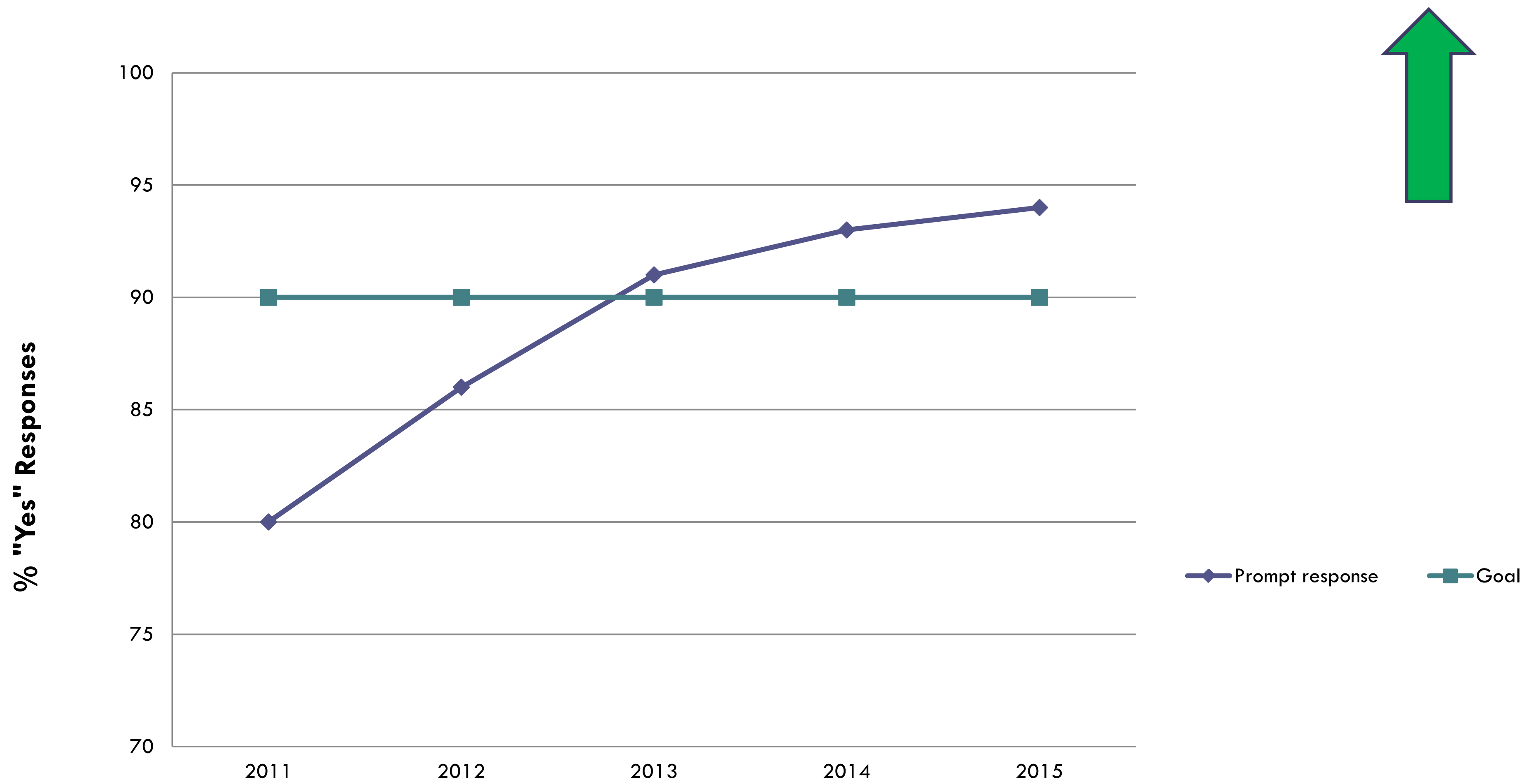
Patient Days

Volume



2008 2009 2010 2011 2012 2013 2014 2015

Patient Satisfaction



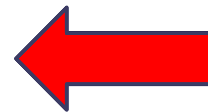
All Falls in 2015

- The average rate of falls in a Nursing home is 1.5% per 1,000 patient days annually. Our 2015 fall rate was 1.48% per 1000 pt. days.
- Certain patient populations are particularly vulnerable to falls such as stroke patients. It is estimated that 5% of stroke patients will fall during their rehabilitation which increases the fall rate to 3.4% per 1,000 patient days.

From 1/1/2015 to 12/31/2015

Skilled Nursing	
Event Types	Count of EVENT NO.
FALL,BATHROOM@	2
Fall-Without Injury	2
FALL W/THERAPIST@	2
Fall-With Injury	1
FALL,UNWITNESSED@	1
FALL,CHAIR/WHEELCHAIR@	1
FALL,ROOM@	1
FALL,OUT OF BED@	1
Grand Total	11

Falls	*SNF Pt Days*	*Rate per 1000 pt days*
11	7430	1.480485

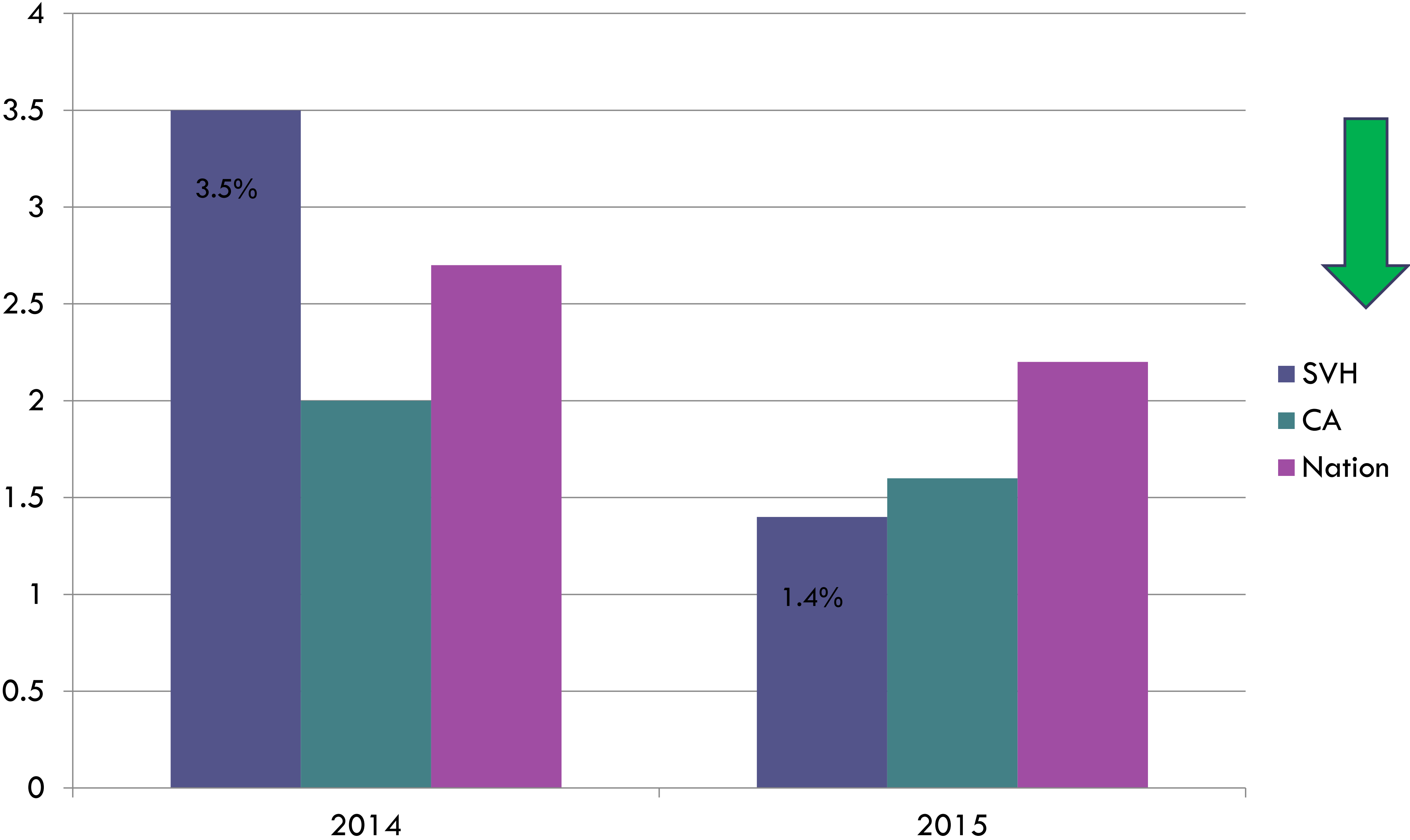


Psychotropic Drug Rates on the SNF

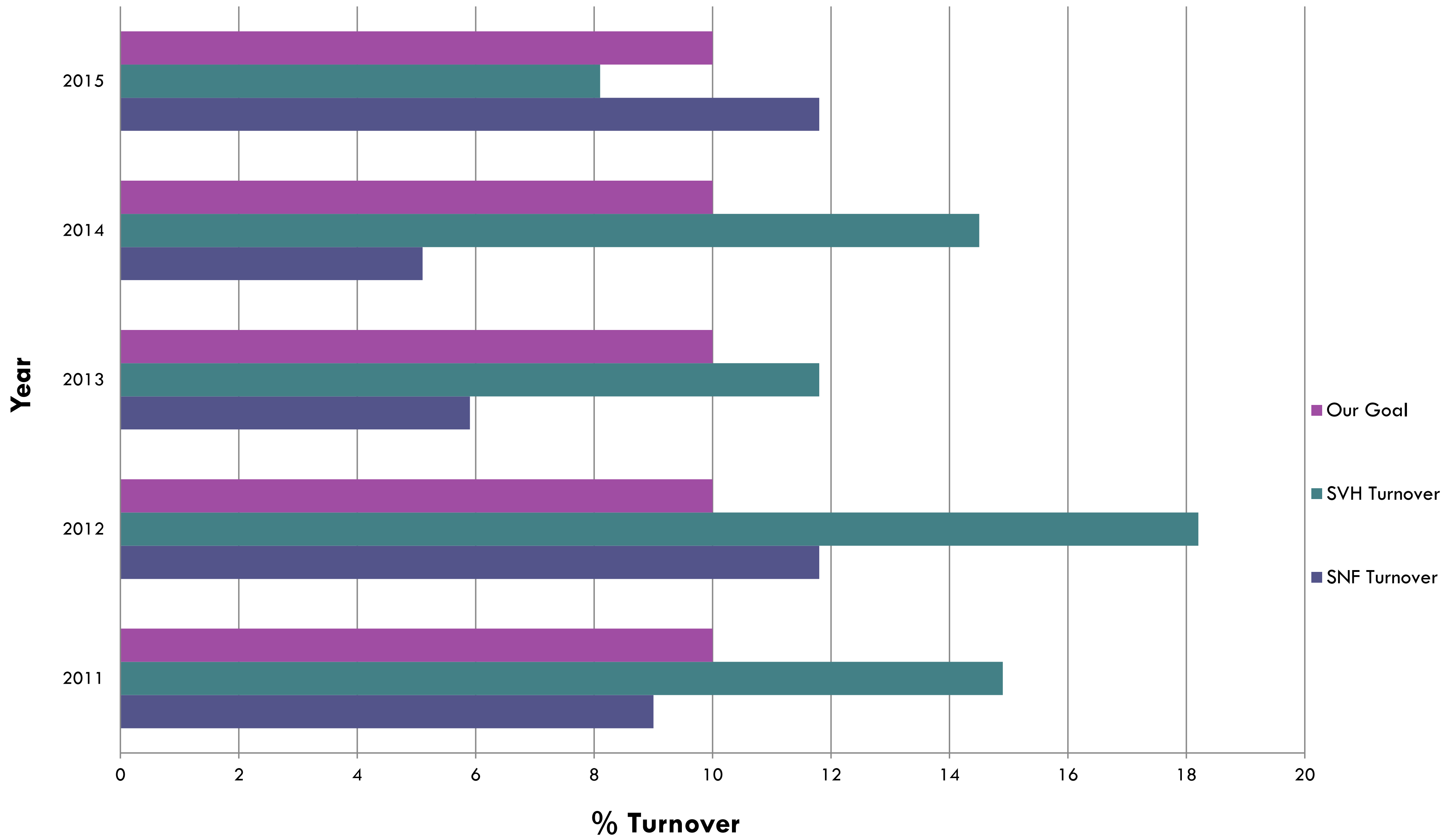
- Psychotropic drug use was 3.5% for Short Stay patients in our SNF in 2014. This is above the CA and National average of 2.0% and 2.7 % respectively.
- During 2015 we reduced our use of antipsychotic medication use to 1.4% which is lower than the CA average of 1.6% and the National average of 2.2%.

(Results derived from MDS data and CASPER reports).

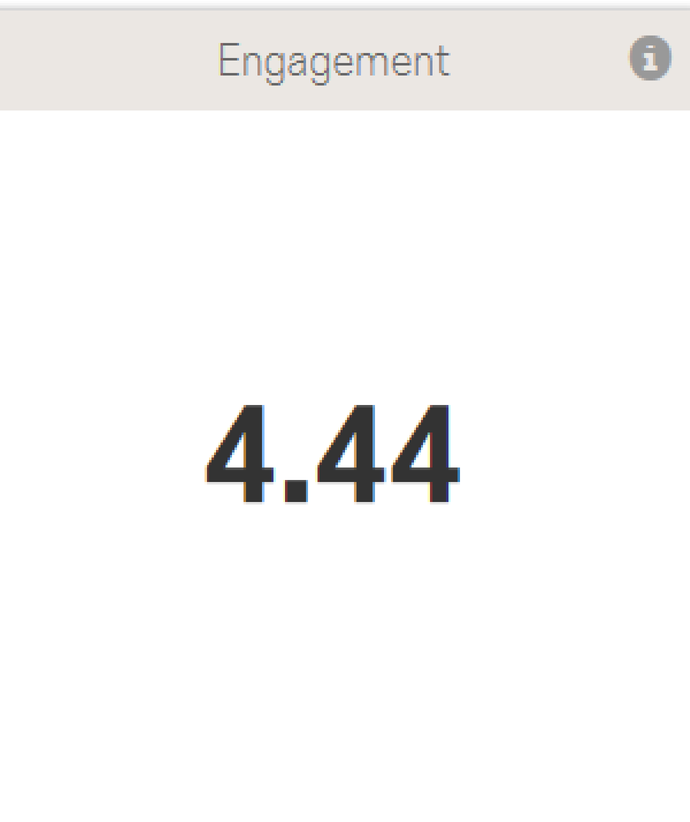
% Short Stay Patients Who Newly Received Antipsychotic Medication

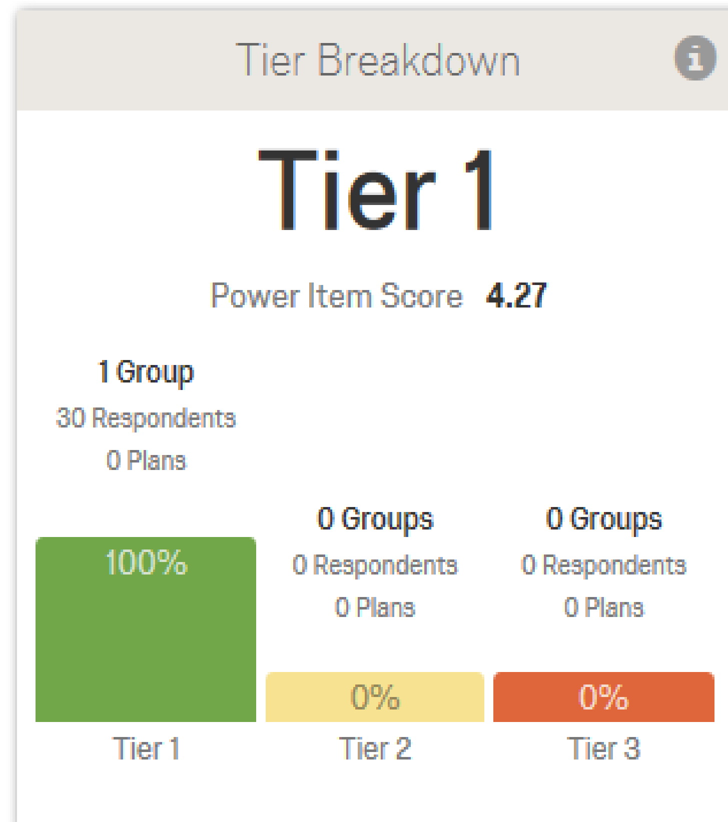


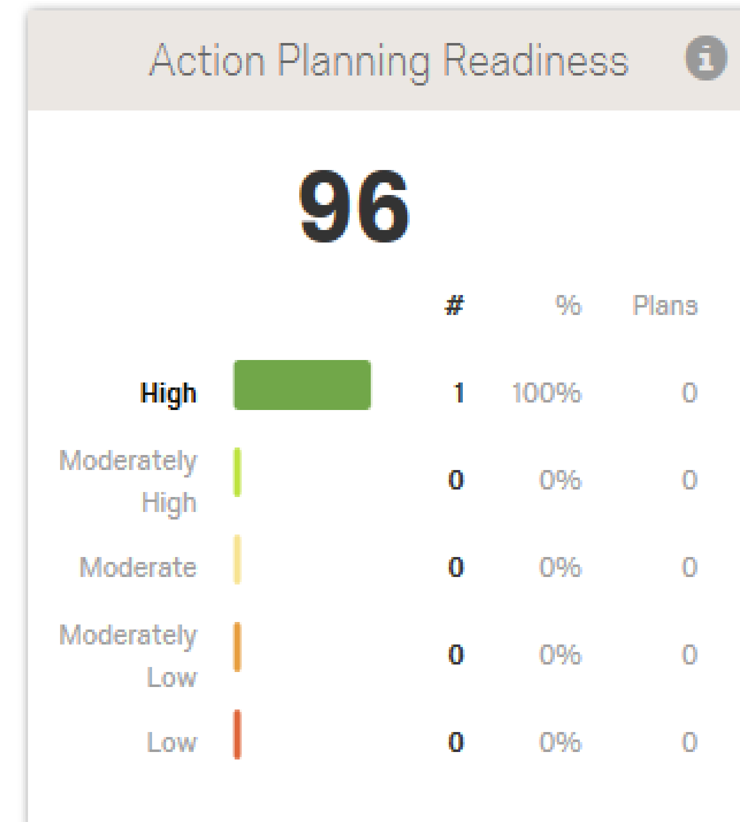
% Employee Turnover

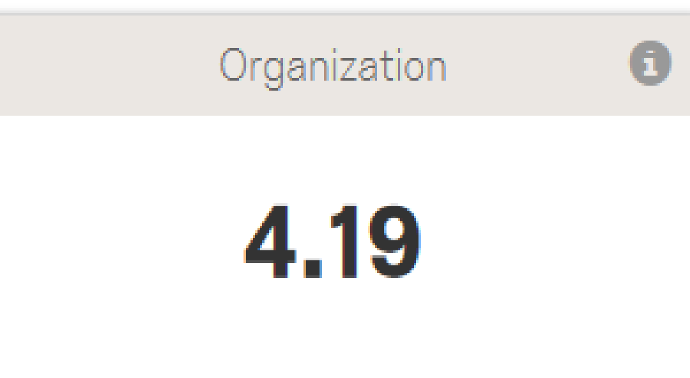


2016 Skilled Nursing Staff Engagement Results

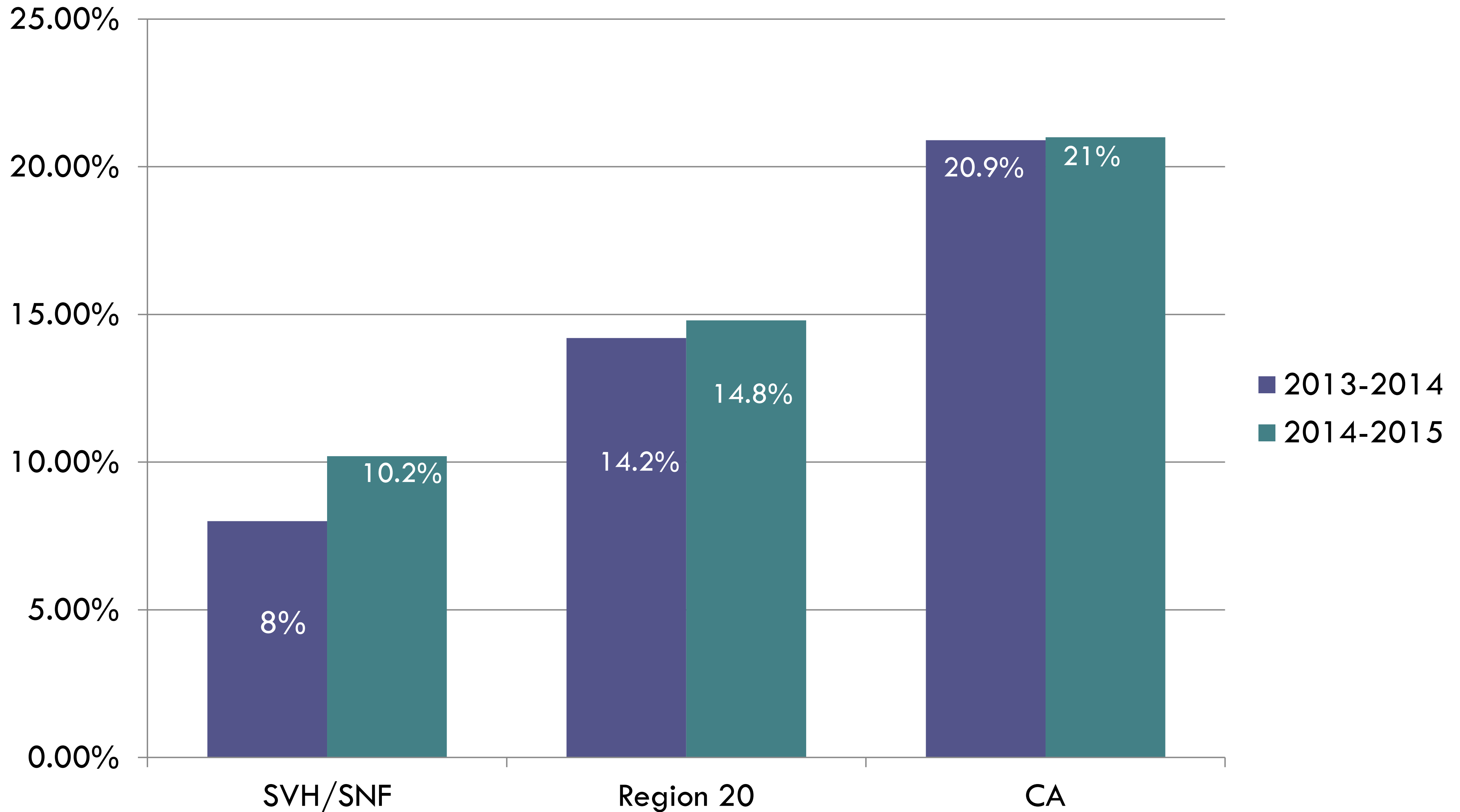








Health Services Advisory Group (HSAG) 30 day Re-admission Rates from SNF to Acute Care Hospitals



30 day readmission rate

- The 30 day readmission rate from the SNF discharge back to an acute care hospital was 8.0% in 2014, (compared to 14.2% for our region and 20.9% for CA).
- In 2015 the 30 day readmission rate rose to 10.2% for SNF discharge back to an acute care hospital, (compared to 14.8% for our region and 21% for CA).

Data derived from Health Services Advisory Group, Medicare Fee for Service Hospital Readmissions Report , January, 2016.

Strategic Challenges on the SNF

- Small, 27 bed D/P SNF in an acute care setting.
- Have several patients who refuse to leave and are now "Residents".
- Extensive training has been required to avoid over utilizing resources that decrease our profitability.
- District owned, we accept patients with no insurance.
- Managed Care increasingly involved in approving SNF days.
- All RN Nursing staff is more expensive than hiring LVN's.
- HPPD's are higher than most SNF's due to acuity, (approx. 6.2 HPPD compared to the 3.2 HPPD State requirement.)

Strategic Advantages of the SNF

- Close proximity to acute hospital and ER.
- All of the acute care services are available to us.
- Electronic Medical Records, bar code scanning for medication.
- Frequent MD visits and all RN staff allow for the admission of more acutely ill patients.
- 24 hour physician and pharmacy available.
- History of strong community support.

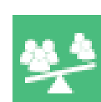
The Future -Quality Initiatives for SNF's

- The American Health Care Association (AHCA) has broadened Its Quality Initiatives to further improve the quality of care in America's Skilled Nursing Facilities. These areas are aligned with the Centers for Medicare & Medicaid Services (CMS) QAPI program and federal mandates such as the Five Star rating and the Improving Medicare Post – Acute Care Transformation (IMPACT) Act.

THE GOALS (2015-2018)

LEARN MORE AT http://qualityinitiative.ahcancal.org

IMPROVE ORGANIZATIONAL SUCCESS BY:



Increasing Staff Stability

Decrease turnover rates among nursing staff (RN, LPN/LVN, CNA/LNA) by 15% or achieve/ maintain at or less than 40% by March 2

Adopting Customer Satisfaction Questionnaire & Measure

At least 25% of members will measure and report long-stay resident and family satisfaction and/or short-stay satisfaction using th Core-Q survey.

Reducing the Number of Unintended Health Care Outcomes by March 2018

IMPROVE SHORT-STAY/POST-ACUTE CARE BY:

Safely Reducing Hospital Readmissions

Safely reduce the number of hospital readmissions within 30 days during a skilled nursing center stay by an additional 15% or achi maintain a low rate of 10% by March 2018.

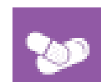
Improving Discharge Back to the Community

Improve discharge back to the community by 10% or achieve and maintain a high rate of at least 70% by March 2018.

Adopting Functional Outcome Measures

25% of members will adopt the use of the mobility and self-care sections of the CARE tool and report functional outcome measure using LTC Trend Tracker^{SM}.

IMPROVE LONG-TERM/DEMENTIA CARE BY:



Safely Reducing the Off-Label Use of Antipsychotics

Safely reduce the off-label use of antipsychotics in long-stay nursing center residents by an additional 10% by Dec. 2015; 15% by De

Safely Reducing Hospitalizations

Safely reduce hospitalizations among long-stay residents by 15% or achieve/ maintain a low rate of 10% or less by March 2018.

5.

2015 ANNUAL QUALITY REPORT FOR SVH HEALING AT HOME

Annual Quality Report 2015

Accomplishments:

1. Outcomes and Process Measures:
   - Trended Outcomes Analysis
   - Trended Process Measures
   - Quarterly Clinical Record Review
   - Potentially Avoidable Outcomes Analysis
2. Infection Control Plan:
   - No Health Care Associated Infections in 2015
   - Hand Hygiene Surveillance= 96%
3. Patient Satisfaction (HHCAHPS)
   - Above Benchmarks in 3 domains:
     - Patient Care
     - Communication
     - Specific Care Issues
   - Five Star in Patient Satisfaction on Home Health Compare
4. Smooth ICD-10 Transition

Projects and Challenges:

1. Updating all Clinical Policies and Procedures
2. Sustaining Improvement with staffing changes

PI Projects:

2015: Improvement in Dyspnea

- Developed Breathlessness Assessment Tool
- In-service on Differential Diagnosis, Assessment and Treatment
- Taught correct use of Pulse Oximeters and Incentive Spirometers
- Developed Clinical Pathway and Patient Handouts
- Improved Dyspnea Outcome from 67.6% (January 2015) to Cumulative Annual of 72.1%

2016: Patient Education

- Multidisciplinary
- Completed and Piloting Clinical Pathway with new teaching tools
- In-services planned for improved use of existing software tools: Patient Care Notes and UpToDate

OCS HomeCare
now part of ABILITY

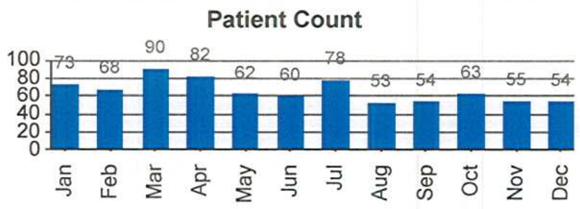
Trended Outcomes Analysis

Prepared for: Sonoma Valley Hospital Home Care Program (557041)
Represents: January 2015 - December 2015
Provider Number: 557041
Branch ID: N

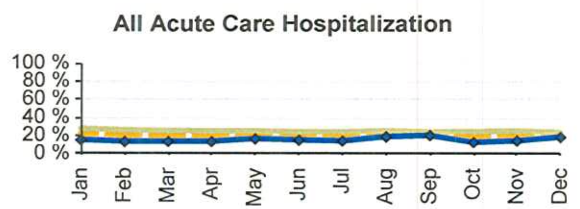
Legend: Your Agency (bars) — Your Agency (line) — State — National

Utilization Outcomes

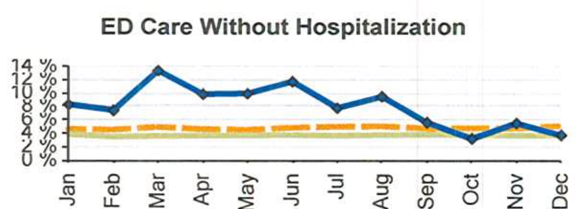
Patient Count



All Acute Care Hospitalization



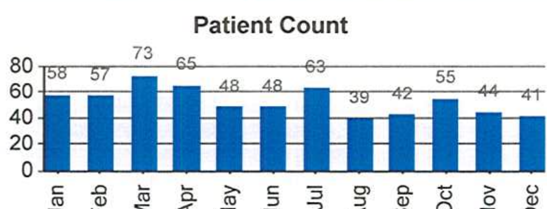
ED Care Without Hospitalization



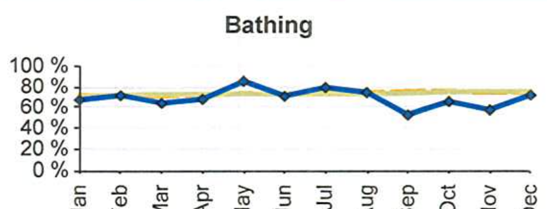
Improvement Outcomes

A missing data marker indicates that data is not available for the month

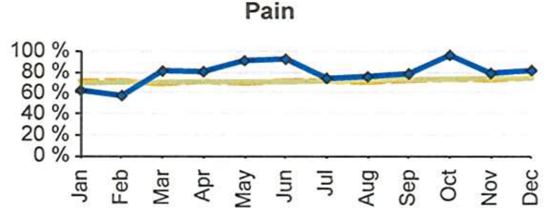
Patient Count



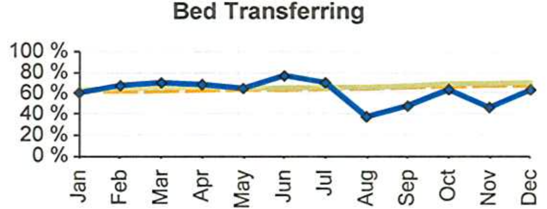
Bathing



Pain

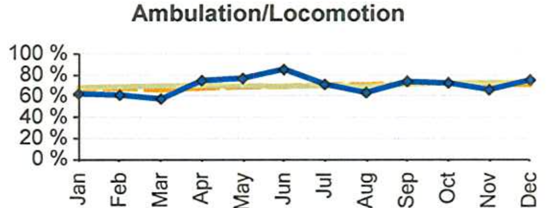


Bed Transferring

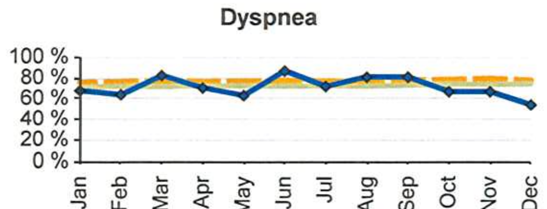


Status of Surgical Wound

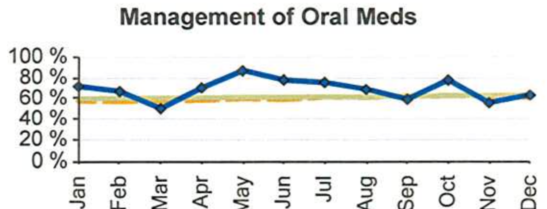
Ambulation/Locomotion



Dyspnea



Management of Oral Meds



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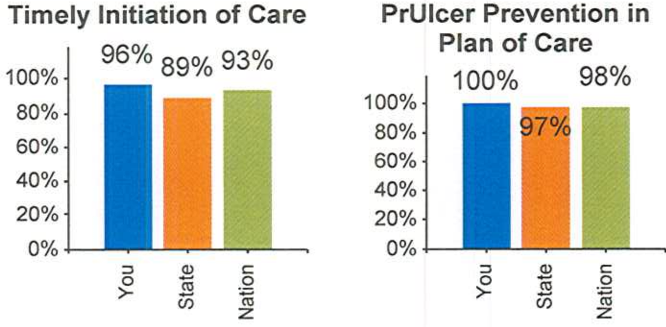
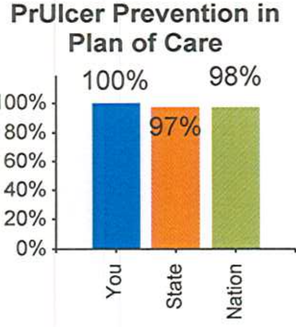
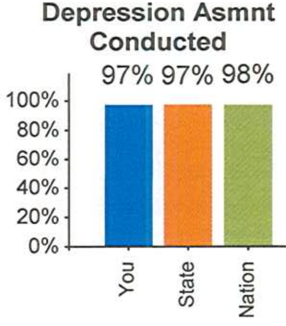
Trended Process Measures

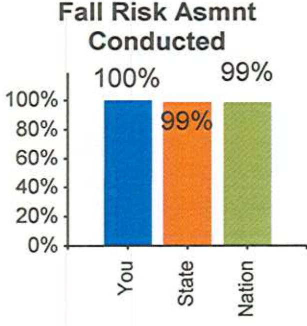
Prepared for: Sonoma Valley Hospital Home Care Program (557041) **Provider Number:** 557041
Represents: January 2015 - December 2015 **Branch ID:** N

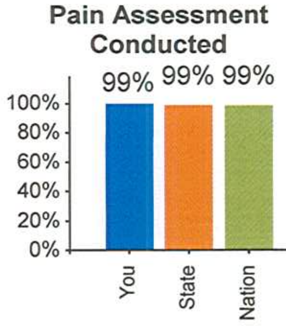
Measures Collected at SOC & ROC - Cumulative

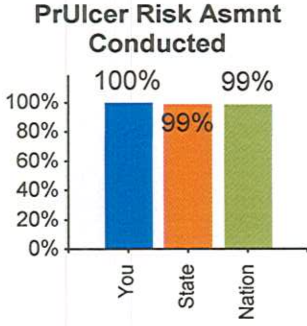




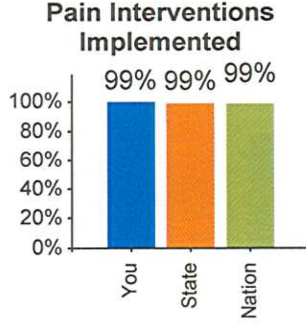


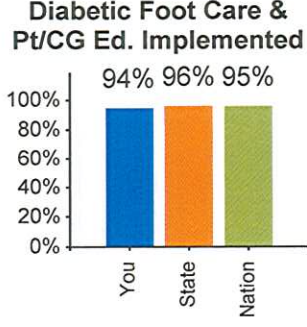


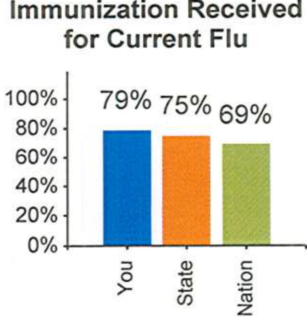


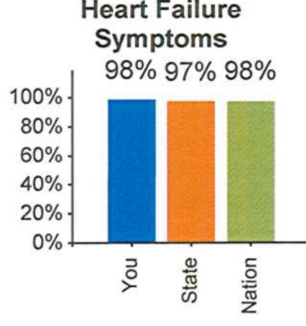


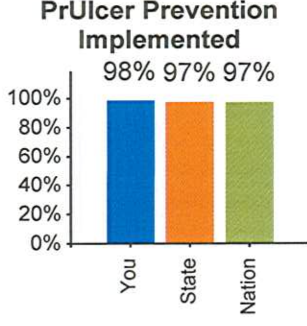
Measures Collected at Transfer & Discharge - Cumulative

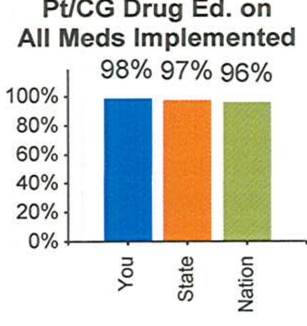


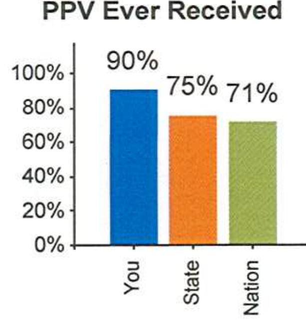












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Corporation

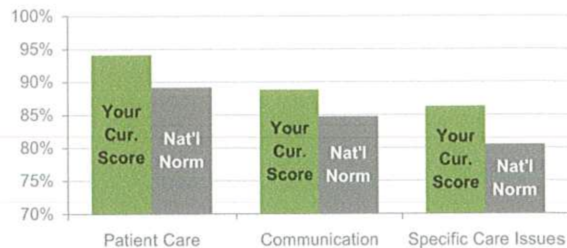
Satisfaction Snapshot - Overview

Prepared for: Sonoma Valley Hospital Home Care Pr (40 patients)
Provider Number: 557041 Branch ID: N/A
Current Patient Care Period: Sep 2015 - Nov 2015

National: (31,189 patients)
State: (1,034 patients)
Current Survey Period: Oct 2015 - Feb 2016

1.06

A score over 1 indicates that your agency's overall performance is better than the national norm, on average



Individual Questions	Your Agency: Previous 3-month Score	Your Agency: Current 3-month Score	Trend*	Current Benchmarks: State**	Current Benchmarks: National**
Overall Rating of Care - responses of 9 or 10	**84%**	**92%**	▲	**81%**	**86%**
Likelihood to Recommend - Definitely Yes	**89%**	**85%**	▼	**75%**	**80%**
Patient Care	**88%**	**94%**	▲	**86%**	**89%**
Providers informed & up-to-date - Always	67%	91%	▲	69%	74%
Treated gently - Always	93%	93%	▼	89%	92%
Courtesy and respect - Always	95%	98%	▲	93%	95%
Problems with care - No	96%	95%	▼	94%	96%
Communication	**80%**	**89%**	▲	**81%**	**85%**
Inform on care and services - Yes	86%	98%	▲	86%	91%
Inform on arrival time - Always	79%	85%	▲	79%	81%
Easy to understand - Always	79%	85%	▲	82%	84%
Listen carefully - Always	79%	85%	▲	83%	86%
Get help when contacting office - Yes	100%	93%	▼	90%	94%
Timeliness to get help from office - Same day	54%	87%	▲	68%	75%
Specific Care Issues	**81%**	**86%**	▲	**76%**	**80%**
Discuss home set up for safety - Yes	75%	93%	▲	72%	76%
Discuss medications - Yes	82%	93%	▲	82%	86%
See medications - Yes	70%	88%	▲	76%	81%
Talk about pain - Yes	91%	95%	▲	87%	92%
Discuss purpose of medications - Yes	81%	83%	▲	78%	84%
When to take medications - Yes	89%	84%	▼	73%	79%
Side effects of medications - Yes	81%	68%	▼	65%	68%
Number of completed surveys	58	40		1,034	31,189
Number of surveys sent	151	147		5,020	113,818
Survey response rate	**38%**	**27%**		**21%**	**27%**

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*Trend indicators will populate when the Previous 3-month Score contains a full 3 months of data
**State and National Benchmark is for the previous 6-month survey period

QUARTER 4, 2015

SUMMARY

The fourth quarter clinical record review was conducted as part of an ongoing review to determine the adequacy and completeness of the plan of care and clinical record. The review was completed by Janet Payne, RN, Chart Review Nurse, Lisa O'Hara, RN, Quality Management Coordinator, and Deborah Taylor, PT.

SAMPLE SELECTION

Thirty home health care records were randomly selected for the quarterly clinical record review. This is greater than 10% of the average daily census. Start of care, recertification, discharge and multidisciplinary cases were included.

SURVEY QUALIFIERS

Indicators included:

Documentation completeness and accuracy of the referral form; patient consents including the Medicare Notice of Non-coverage form and the HHCCN; 485; homebound status; Medication Profile; drug/drug interaction alerts and resolution; visit notes; care plan; care provided matches care ordered; HHA supervision; OASIS accuracy; patient teaching and patient-caregiver response to teaching; the documentation of progress toward the patient's short term goals; appropriate follow-up to falls; Rehab Therapy Summary on Medicare patients; Face to Face on Medicare patients; Agency Discharge Summary complete; interdisciplinary referral done within 7 days of signed MD order, and interdisciplinary communication.

RESULTS*

1. In six records the signed HHCCN form was missing.
2. Twelve records were missing a Care Team discipline in the Attributes section.
3. Documentation of the patient's homebound status was missing in one record.
4. In one record, coordination of care between disciplines was not clearly documented.
5. One record was missing a discipline discharge summary.
6. In one record the 30 day Rehab summary was missing.
7. Two records were missing the signed Notice of Medicare Non-coverage form.
8. In one record, documentation was not provided as to why the patient was not admitted to home care within 48 hours.
9. Two records did not have documentation that the MD was notified of the start of care and proposed plan.

*Please note, whenever possible, the above deficiencies were corrected and staff received remediation immediately.

QUARTER 4, 2015

ANALYSIS AND ACTIONS

1. Results will be presented to staff at the next Team Meeting and individual staff members have been counseled.
2. An additional in-depth focused chart audit was done this quarter on twenty-eight start of care and discharge records to determine appropriate utilization of services, process and outcome measures. A copy of the audit tool is included in this report. The review was completed by Janet Payne RN Chart Review Nurse, Lisa O'Hara RN Quality Management Coordinator. The results are positive but continue to reveal urinary incontinence and transferring documentation are minimal. In-services to be presented at a Team Meeting regarding incontinence and patient transfers, ambulation and safety. The Patient Education PI Team will discuss and develop patient education materials to include these two identified opportunities for improvement.
3. The ICD-10 Coding System which began 10/1/2015, proved to be a smooth transition. A few billing issues were identified; solutions were immediately sought, and the identified issues were corrected. No issues were identified for the month of December.
4. A new multidisciplinary PI Project will begin the first quarter of 2016. The team will focus on patient education. The first task assigned to this team will be the completion of the dyspnea clinical pathway. Due to staffing changes, the pathway is still in progress with the goal of completion being the first quarter of 2016. The Patient Education PI team will report to the QAPI management team.
5. The Quality Control indicators were 100% this quarter.
6. The two deficiency items received from our state survey by the California Department of Public Health (CDPH) in 06/2014, HCA supervision and patient care provided matches care ordered by physician, are already indicators monitored by the Quality Department and reported as a component of this report. The result of these two indicators for the year of 2015 is 100% compliance. These items will continue to be monitored but not formally reported as the agency has maintained 100% compliance for 18 months.
7. Two deficiencies were received at the Standard Recertification Survey by the CDPH in 09/2014. Both deficiencies are being tracked. Patient health information is secured in locked file cabinets at the end of the business day was monitored daily and was 100% compliant for one month. On-going, intermittent compliance checks are done by the Quality Department and documented. Current compliance is 100%. The second deficiency, supervised clinician home visits conformity with the Infection Control Bag Policy, are 100% complete. Therefore, this will only be monitored during annual supervisory visits with the Clinical Manager or designee as required by our policy.
8. ***HHAI infections*** have notably decreased over the past year. Our rate for the year of 2015 is 0%.

9. ***Potentially Unavoidable Events Analysis:***
   a. ***Fall Reporting***
   Over the past quarter, 35 patient falls have been reported in the home health department which is the same number as third quarter. Of those 35, none of the falls were witnessed by a home care staff person; all patients had a fall risk reduction assessment and/or prevention education performed (i.e. Tinetti or MACH 10 assessment, medication management related to falls); all patients were receiving a therapy service or an interdisciplinary referral was initiated; twenty-four of the falls occurred during ambulation; all the falls were predominantly during the night; twenty-four of the falls were related to balance issues; in thirteen of the falls the patient complained of weakness; in seven of the falls, patients had symptoms of confusion and/or a diagnosis of dementia; eleven patients sustained minor injuries, which were treated by the reporting clinician, six of the eleven were skin tears; two patients were evaluated in the emergency room (one patient had four falls total); one patient suffered a closed hip fracture (see below *Emergent Care for Fall*); two patients were admitted; and all patients fell at their place of residence. These charts were intensively reviewed. Appropriate preventative safety measures were implemented and clinician follow-up intervention was documented. No trends were identified. The plan is to continue to monitor for trends and the effectiveness of home care fall reduction strategies.
   b. ***Emergent Care for Fall***
   Two patients were seen in the ED after a fall or accident at home during this quarter. Of these, 1/2 had 8 identified fall risk factors and 1/2 had 5 fall risk factors. Both of these patients had a formal fall assessment score of 4 or higher. Both of these patients had Physical Therapy and MSW services. All appropriate interventions were done and the fall report, including notification of MD, was documented. Both patients were admitted to the hospital after the fall. One of these patients had a total of four falls due to impulsivity, intentional tremors, and dementia. The patient was admitted after one of the falls. The family wanted the patient kept in the home with his wife and 24 hour caregivers even though he continued to fall. The other patient suffered a closed hip fracture and moved out of the area to be with family after discharge. No trends were identified.
   c. ***Medication Error Reporting***:
   There were 13 medication errors in the third quarter. All errors were made by the patient or caregiver and all errors were reported to the MD in a timely manner. 9/13 errors were an omission; 3/13 errors were the wrong dose; 1/13 was the wrong time. There were no serious outcomes and all patients received education. No trends were

identified. Plan is to continue to monitor and mitigate medication errors made in the home care setting.

d. ***Development of UTI***
Four patients fell into this category. 4/4 scored a 2 or higher on the OASIS for bathing ability; 2/4 had four risk factors identified; 2/4 had three risk factors identified; 1/4 had a foley catheter in the hospital, 3/4 had a UTI within fourteen days of discharge; 4/4 received timely care, antibiotics and instruction; and 4/4 have been discharged for goals met.

e. ***Emergent Care for Wound Infections, Deteriorating Wound Status***
Two patients were seen in the ED and admitted to the hospital this quarter for wound problems. These charts were intensively reviewed. Analysis showed that risk factors were identified in both of these cases which included current or past wound infection, co-morbidities such as diabetes, lifestyle risk factors, nutritional deficits, low Braden score, and wound care provided by caregiver. Appropriate interventions by the home health clinician were documented in both cases. These included antibiotic therapy, appropriate wound care, instruction in nutrition, reportable signs and symptoms, hand hygiene and follow-up OASIS if required. Of note, one patient was sent to the ED on the nursing SOC visit and admitted for bilateral lower leg cellulitis. The other patient was seen by SVH Wound Care RN. The home health nurse sent the patient to the ED two days later and the patient was admitted for wound infection and debridement.

f. ***Discharge to the Community with an Unhealed Stage II Pressure Ulcer***
One patient was identified in this category. The patient had a long history of dementia, Parkinson's, failure to thrive and a Stage II pressure ulcer on his hip at admission. The patient was transitioned to hospice eleven days later. All appropriate care and communication was documented.

g. ***Substantial Decline in Management of Oral Medications***
The patient that fell into this category had a long history of mental illness and had been noncompliant with taking her medications. Patient was admitted to the hospital after she decided to stop taking all of her psychotropic medications. Appropriate clinician intervention and action was documented; i.e. medication instruction, RN and MSW referral and MD communication.

QUARTER 4, 2015

PLAN

1. Present results of this report to staff at the next Team Meeting.
2. Quality is providing on-going feedback to clinicians individually and as a group on a regular basis regarding their documentation. Continue monitoring remaining survey deficiencies as an element of this report.
3. Put into action Patient Education PI Team, Quarter 1, 2016.

QUARTER 4, 2015

HOME HEALTH CARE ASSOCIATED INFECTIONS

Date	Visit ID	Infection	Reviewed by Lisa O'Hara, RN Quality Coord.	Home Health Associated Infection Y/N?
10/08/2015	1001140562	UTI E.coli	YES	NO
10/26/2015	1001143125	CA-UTI Citro. amalonaticus	YES	NO
10/28/2015	1001143547	UTI E. coli	YES	NO
11/14/2015	1001146136	Skin MRSA	YES	NO
11/22/2015	1001147117	CA-UTI Serratia marcescens	YES	NO
12/06/2015	1001148848	Skin MRSA	YES	NO
12/11/2015	1001149791	Skin MRSA	YES	NO
12/16/2015	1001150328	UTI E. coli	YES	NO
12/17/2015	1001150584	CA-UTI Staph.epidermidis	YES	NO
12/19/2015	1001150585	CA-UTI E. coli	YES	NO
12/22/2015	1001151118	CA-UTI Kleb oxytoca	YES	NO
12/22/2015	1001151075	Sputum E.coli	YES	NO
12/31/2015	1001152146	Skin MRSA	YES	NO

***Reference*:**
February 2008. *APIC/HICPAC Surveillance Definitions for Home Health Care and Home Hospice Infections.* Retrieved from URL 10/08/2014.
www.apic.org/Resource_/TinyMceFileManager/Practice_Guidance/HH...

6.

PATIENT CARE SERVICES DASHBOARD 2016

Patient Care Services Dashboard 2016

Medication Scanning Rate	2015-2016				
	Q4	Q1	Q2	Q3	Goal
SNF	80.6%	81.0%			80%
Acute	83.1%	87.0%			90%
ED	82.4%	91.0%			90%

Falls (Per 1000 days)	2015-2016				
	Q4	Q1	Q2	Q3	50th %tile
SNF	1.6	1.0			
Acute	3.3	3.5			
TOTAL	2.5	2.3			2.32%

Hospital Acquired Pressure Ulcer Incidents (Per 1000 admissions)	2015-2016				
	Q4	Q1	Q2	Q3	National
SNF	0.5	0.0			3.17
Acute	0.0	0.0			3.68

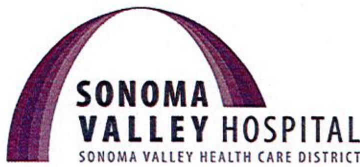
Nursing Turnover	2015-2016 RNs/Quarter				
	Q4	Q1	Q2	Q3	Goal
SNF (n=15)	1	0			≤1
Acute (n=92)	2	0			≤3
Healing at Home (n=18)	2	1			≤1
Total Nursing Turnover	5	1			≤5

Professional RN Certification	2015-2016				
	Certification		Higher Education		
*2015 Accomplishments	SVH	Goal	Undergrad (Bachelors)	Graduate (Masters)	PostGrad (PhD)
Emergency (CEN) (n=24)	0	1	14%		
ICU (CCRN) (n=17)	2	3	31%	6%	
The Birthplace (n=17)	1	2	62%	19%	
Med Surg (MSRN) (n=19)	1	2	42%	6%	
Surgery (AORN, ASPAN) (n=15)	4	5	66%		
SNF (Gerontology, Palliative care, Long-term care, Resident Assessment Coordinator) (n=15)	10	11	57%	7%	7%
Case Management (n=8)	2	3	63%		12%
Healing at Home (n=18)	2	3	50%	11%	

*2015: Received $25K from grateful patient; funded wound care certification for SNF RN and SNF RN; RAC cert x2 SNF; Funded attendance at Risk Conference; purchased Continuing Education modules for SVH Certified Nursing Assistants. Surgery RN received BSN; sponsored two RNs for telemetry training

7.

POLICY & PROCEDURES



POLICY AND PROCEDURE
Approvals Signature Page

Review and Approval Requirements

The SVH departmental/organizational policies and/or procedures on the attached list have been reviewed and approved by the following organizational leaders for meeting all of the following criteria. All of these policies and procedures are:

- Consistent with the Mission, Vision and Values of the Sonoma Valley Health Care District
- Consistent with all Board Policy, Hospital Policy and Hospital Procedures
- Meet all applicable law, regulation, and related accreditation standards
- Consistent with prevailing standards of care
- Consistent with evidence-based practice

We recommend their acceptance by the Quality Committee and that the Quality Committee forward them to the Sonoma Valley Health Care District Board with a recommendation to approve.

Organizational: Pharmacy Polices MM8610-151 Parenteral Nutrition Protocol & MM8610-156 Electrolyte Replacement Protocol	
APPROVED BY: **Director of Pharmacy**	DATE: **4-11-16**
Director's/Manager's Signature	Printed Name **Chris Kutza**

Brian Sebastian, MD
Chair, P.I. & P.T. Committees — Date

Leslie Lovejoy, RN
Chief Quality & Nursing Officer — Date

Keith J. Chamberlin, MD MBA
President of Medical Staff — Date

Kelly Mather
Chief Executive Officer — Date

Jane Hirsch
Chair, Board of Directors — Date

Policy Submission Summary Sheet

Title of Document: **Organizational Policy**
New Document or Revision written by: **Chris Kutza**
Date of Document: **4-11-16**

Type: X Revision ❑ New Policy	**Regulatory:** X CIHQ X CDPH X CMS ❑ Other:
Organizational: X Clinical ❑ Non-Clinical	❑ **Departmental** ❑ **Interdepartmental** (list departments effected)

Please briefly state changes to existing document/form or overview of new document/form here:
(include reason for change(s) or new document/form)

MM8610-151 Parenteral Nutrition Protocol- Revised to reflect new phosphorus reference range

MM8610-156 Electrolyte Replacement Protocol- Revised to reflect new phosphorus reference range

Reviewed; no changes by:	Date	Approved (Y/N)	Comment
Policy & Procedure Team	n/a		
Surgery Committee	n/a		
Medicine Committee	4/14/2016	YES	Chris to present
P.I. or P. T. Committee	n/a		
Medical Executive Committee	4/21/2016	YES	
Board Quality	4/27/2016		
Board of Directors	5/05/2016		

SUBJECT: Parenteral Nutrition Protocol	POLICY #MM8610-151
DEPARTMENT: Organizational	EFFECTIVE: 04/88
APPROVED BY: Director of Pharmacy	REVISED: 07/15, 02/16, 4/16

Purpose:
To assure appropriate ordering of parenteral nutrition (PN) solution and baseline laboratory data in a standardized manner.

Policy:
When a prescriber orders parenteral nutrition (PN) per protocol, the nutrition support team (NST), which consists of the pharmacist and registered dietitian (RD), will monitor patient-specific laboratory and clinical parameters and use this information to determine PN formulas and administration, and any subsequent adjustments.

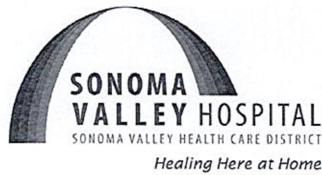
Procedure:
Pharmacist's Responsibilities:

1. The order for PN per protocol must be received by the pharmacist no later than 18:00 on weekdays and 14:00 on weekends and holidays. Otherwise it will be initiated the following morning.
2. When an order is received from the prescriber to initiate PN per protocol, the NST will implement the protocol, including applicable laboratory tests and procedures, and modify formulation as necessary.
    a. If the prescriber does not wish the NST to adjust the formulation or infusion rate without first contacting him/her, the prescriber must indicate this on the initial order.
3. Using the PN monitoring guidelines discussed in this policy in the section titled "Parenteral Nutrition Monitoring and Formulation', an order will be placed per protocol by the pharmacist for labs, the initial formulation, and any subsequent changes.
    a. The pharmacist will attempt to use one of the standard PN formulas (appendix C) to meet the nutritional needs of the patient.
        i. This may be accomplished via adjustments to the volume and rate of infusion, or adding ingredients to the standard bag when reasonable to do so.
    b. If patient needs cannot be accommodated using a standard formula, a custom formula may be created (appendix C).
4. The RD will be notified of the PN Protocol in order to evaluate patient's protein/caloric requirements.
    a. A nutritional assessment is performed by the RD with the first 48 hours.
    b. Recommendations based on the RD's assessment will be used in determining the initial formula when available before the PN is to start.
    c. The RD may recommend changes to the initial formulation based on their assessment if not completed before the PN is started.
    d. The pharmacist will take the recommendations into account when making changes to the PN formula.

e. Nutrition support should be started at approximately 50% of the estimated needs for a patient to avoid side effects.
    i. If there are recommendations in the patient's record the recommended solution can be utilized with a rate roughly half the goal rate.

f. In the absence of dietician recommendations the pharmacist may initiate parenteral nutrition using Clinimix 4.25/5 % with or without electrolytes.

5. A PN Monitoring Form (appendix A) is initiated and maintained for each patient begun on PN therapy.
    a. The following information is initially recorded within the first 24 hours as a baseline.
        i. Patient information and current nutritional evaluation.
        ii. Initial PN additive ingredient information (the PN recipe is entered on the formulation record after calculations are made).
        iii. Rate schedule and predicted caloric intake.
        iv. Baseline laboratory parameters.
6. The pharmacist will complete a Parenteral Nutrition Compounding Form (Appendix B) to be used as reference by the pharmacy technician preparing the PN bag.
7. The pharmacist will monitor lab parameters and record the results on the monitoring record.
    a. Monitoring of lab values will be performed as follows:
        i. Baseline:
            1) Patient weight
            2) TPN Panel (includes complete metabolic panel (CMP), Mg, Phos, Cholesterol, Triglycerides)
            3) Prealbumin if PN anticipated to last >7 days
        ii. Routine:
            1) I/O daily
            2) Weight daily
            3) CBC weekly
            4) PT/INR weekly
        iii. Formula specific:
            1) Peripheral PN (Dextrose ≤10%, < 900mOsm/L)
                a. TPN Panel Q Monday
                b. Basic Metabolic Panel (BNP), Mg, & Phos Q Wednesday & Friday
            2) Central PN (Dextrose >10%, ≥ 900mOsm/L)
                a. TPN Panel Daily x3 days, then Q Mon-Wed-Fri
                b. Glucose QPM x3 days, then Q Tues-Thurs-Sat-Sun



iv. Other labs may be ordered as per the guidelines and recommendations in this policy in the section titled "Parenteral Nutrition Monitoring and Formulation".

b. Should laboratory results indicate the need for adjustments to the formula, the pharmacist will make necessary changes and will document the adjustments via a patient care order per protocol.
   i. The pharmacist may order supplemental electrolytes to be administered separate from the PN per the electrolyte replacement protocol guidelines.
c. Only electrolytes, vitamins, and minerals are to be routinely added to the PN solution.
   i. Compatible medications such as insulin and H-2 blockers may be added to the formulation if the patient's clinical condition requires it.
d. Once a patient's PN is infusing, no additions or changes in composition (dextrose, amino acids) or content (electrolytes, vitamins, minerals, etc.) will be made to the bag.
   i. Patients acutely requiring additional therapy (i.e., electrolytes or insulin) will receive such therapy by bolus, infusion into another IV line, or by piggyback.
   ii. Formulation changes shall be considered to take effect with the next container to be prepared.

Registered Dietitian's Responsibilities:

1. The RD shall be alerted that PN has been ordered.
   a. The RD shall complete nutrition assessment within 48 hours of receiving a dietary consultation notice.
2. In collaboration with the patient's physician, the RD shall calculate calorie, protein, and fluid needs for each patient and will provide the pharmacist with recommendations regarding PN formulation, initiation, and goal rate required to meet pt nutritional needs (see policy #8340-164 Nutritional Assess/Practice Guidelines: Adult/Geriatric).
3. The RD will complete a follow-up nutrition assessment to reassess the patient's nutritional status at least every 3 days for patients receiving PN, or more often as clinically necessary.

Parenteral Nutrition Monitoring and Formulation:

Individual patient protein, energy, and fluid requirements should be determined from the calculations described below and used to select the appropriate solution. Since most individuals who are candidates for parenteral nutrition are receiving other IV therapy, additional fluid needs can be met through concurrent IV access

INDICATIONS FOR PARENTERAL NUTRITION (PN) IN ADULTS

Cases in which PN is frequently used:

1. A patient with good nutritional reserve, but it is anticipated that the GI tract would not be available for nutritional support for at least 7 to 10 days.
2. A patient who is severely malnourished or severely catabolic, but it is anticipated that the GI tract would not be available for nutritional support for 5 to 7 days.

Cases in which PN may be helpful:

1. A patient under moderate physiological stress from major surgery, trauma, burns, etc., but it is anticipated that the GI tract would not be available for nutritional support for at least 5 days.
2. A patient with inflammatory bowel disease, who is not responding to medical therapy.
3. An immunocompromised patient with poor nutritional status and documented malabsorption on medical management, who is not responding to enteral therapy.

Cases in which PN has little or no value:

1. A patient who has minimal stress or trauma and it is anticipated that the GI tract would be available for nutritional support within 5 days.
2. A patient with good nutritional reserves in whom the use of PN would be less than seven (7) days.
3. End stage, terminally ill patients, who are at comfort care level.

ENERGY (CALORIE) REQUIREMENTS

The amount of energy needed is a function of basal needs (those required to do daily metabolic work), plus an additional amount for healing or repair of nutritional deficits and any activity. Basal needs vary depending on weight, height, age, and sex. The caloric requirements of most individuals can be met by giving an additional 30-40% of calories above basal needs. Feeding in excess of caloric requirements will not improve nutritional status more quickly and may lead to complications of fatty liver and CO_2 retention. Energy requirements may change during the course of illness, and therefore continued monitoring and reassessment of requirements are necessary to avoid complications of under- or over-feeding patients.

When estimating energy requirements, the patient's actual body weight (ABW) should be used unless the patient fits one of the following categories:

1. Over-hydrated and/or edematous but not obese-use ideal body weight (IBW):
   a. *Females: 100 lb for the first 5 ft plus 5 lb for each additional inch over 5ft.*
   b. *Males: 106 lb for the first 5 ft plus 6 lb for each additional inch above 5 ft.*
2. Obese, defined as greater than 120% of ideal body weight, use adjusted body weight:
   a. Adjusted Body Weight (kg)= IBW + 0.25 (ABW-IBW)

Estimation of daily basal needs:

The following estimates are a quick guide meets the needs of most patients. They are based on stress level, activity, and degree of malnutrition. Although these calculations are useful, they are only estimates and require adjustments according to weight changes.

- *25-30 Kcal/kg body weight for* ***non-ambulatory or sedentary adults.***
- *30-35 Kcal/ kg body weight for* ***slightly hypermetabolic patients, for weight gain, or for an anabolic patient.***
- *35 Kcal/kg body weight for* ***hypermetabolic or severely stressed patients or patients who have malabsorption.***

PROTEIN REQUIREMENTS

The goal of protein supplementation is to minimize the degree of net nitrogen loss. Since protein reserves do not exist in the body, protein must be continually replenished. Protein requirements can be estimated as a function of patient weight. If the patient is obese, (>30% of IBW), use MAW to calculate requirements. Excessive protein supplementation results in urea genesis and a subsequent rise in BUN.

Normal Renal Function

Maintenance -	*0.8-1 gm* of protein/kg/day
Moderate Stress -	*1.2-1.3 gm* of protein/kg/day
Severe Stress -	*1.3-1.5 gm* of protein/kg/day

Renal Failure

Mild Renal Failure (CrCl ≤ 50 ml/min)
Moderate Renal Failure (CrCl 20-30ml/min)
Severe Renal Failure (CrCl ≤ 10ml/min)

Based on Creatinine Clearance

CrCl 41-50 ml/min-	0.8-1 *gm* of protein/kg/day
CrCl 26-40 ml/min-	0.8 *gm* of protein/kg/day
CrCl 11-25 ml/min-	0.6 *gm* of protein/kg/day
CrCl ≤ 10 ml/min-	0.5 *gm* of protein/kg/day

Hepatic Failure - Begin at 1 gm of protein/kg/day increase as tolerated to 1.5-2gm of protein/kg/day

Hepatic failure with Encephalopathy - 0.6-0.8 gm of protein/kg/day (no less than 40 gm /day)

Measurement

Serum albumin is the most commonly used plasma protein to determine nutritional status. Albumin is a good measure of serum protein stores, but since the half-life is so long and the body pool is large, it is not a very accurate predictor of short term responses to nutritional support. Serum albumin is also limited in its usefulness as a

nutritional marker because it can be affected by stress, inflammation, fluid status, surgery, or supplemental albumin. Pre-albumin also has been reported to be sensitive indicator for nutritional status because it can show changes at a time when the more commonly evaluated, longer half-life plasma proteins do not change. It is also limited in its use because it is markedly affected by stress and inflammation and it is not always available for laboratory assay at every hospital. It is recommended to monitor pre-albumin weekly in the hospitalized patient as a marker for protein repletion. In general, rises in serum proteins are considered as evidence of nutritional recovery. However, interpretation of plasma protein concentration changes can be confounded in the hospitalized patient; an increase plasma concentration may reflect protein anabolism, decreased catabolism, change in intravascular/extravascular body water compartments, or a combination of each.

If baseline triglycerides higher than 300 mg/dl, fat emulsion will be used 2-3 times weekly for prevention of fatty acid deficiency and not as a calorie source.

PreAlbumin (Normal prealbumin: 17 to 34 mg/dl)

- Prealbumin is the best marker of malnutrition
- Short serum half-life--2 days
- Less affect by liver disease than other proteins
- Not affected by hydration status
- Not affected by Vitamin Deficiency (except zinc)

Interpretation in Malnutrition

- Protein Malnutrition Diagnosis
  - Prealbumin <5 mg/dl: Predicts poor prognosis
  - Prealbumin <10 mg/dl: High risk
    - ✓ Requires aggressive nutritional supplementation
  - Prealbumin <15: Increased risk of malnutrition.
    - ✓ Monitoring recommended twice weekly.
- Protein Malnutrition Monitoring
  - Findings suggestive of adequate nutritional support
    - ✓ Prealbumin level rising 2 mg/dl per day
    - ✓ Prealbumin level returns to normal by 8 days
  - Findings requiring intense nutritional (e.g. TPN)
    - ✓ Prealbumin level rises <4 mg/dl in 8 days
  - No need to monitor pre-Albumin with liver failure; liver failure causes decrease concentration of pre-Albumin levels.

<u>FLUID REQUIREMENTS</u>

Fluid requirements may be estimated as follows:

- Fluid volume in ml/day = 1500 ml+([20 ml/kg][ABW-20kg])
- Or 1 ml per 1 cal in normal PN patients
- *Or 30-35 ml/kg body weight (adult)*
- *Minimum fluid intake should be approximately 1500 ml/day.*

ELECTROLYTES

Electrolyte requirements in patients receiving parenteral nutrition are specific and influenced by nutritional status. Standard electrolyte supplementation for a stable adult patient, without organ failure, is outlined below. Correction of significant electrolyte imbalance in unstable patients should be made via the PN solution, a separate infusion, and/or IV bolus doses.

- The preferred standard solution for initiation of therapy will be Clinimix E 4.25/5 containing the following electrolytes:

Electrolyte	per liter PN
Na+	35 mEq
K+	30 mEq
PO4---	15 mM
Cl-	39 mEq
Mg++	5 mEq
Ca++	4.5 mEq
Acetate	70 mEq

- Acetate may be utilized as the counter ion for sodium and potassium in acidotic patients and will be added as needed to balance excess Na and K (Na and K available as NaCl, KCl, or NaAc, KAc).
- A custom solution may be specified later or at the initiation of therapy however due to clean room procedures compounding may only occur during specified hours.

Guidelines for Formulation Adjustment:

- Refer to individual electrolytes for adjustment recommendations

Laboratory parameters are assessed as follows:

- Central PN (final dextrose conc > 10%, ≥900 mOsm/L): TPN panel daily for 3 days, then M-W-F (plus supplement blood glucose monitoring)
- Peripheral PN (final dextrose conc ≤ 10%, <900 mOsm/L): TPN panel x 1, then weekly (Mondays) and Panel 7 twice weekly (Wed & Fri)
- In case of unstable electrolytes or glucose, additional monitoring may be warranted.

The pharmacist should use the lab data in conjunction with the following guidelines to monitor glucose & electrolytes. Unless the physician's orders state "no protocol," the electrolyte formulation may be regularly adjusted to maintain Na, K, Mg, Ca, Cl & PO_4 levels within normal

limits. It is preferable to make small changes in reaction to electrolytes "trends" rather than wait for levels to fall outside the normal range. Once the patient is stable the cholesterol and triglycerides can be monitored once weekly.

In cases where an electrolyte is outside of its "extended" normal range (see below), the physician must be consulted before making a formulations change. The physician is also consulted when there are "unexplained" acute changes in glucose or electrolytes.

- "Extended" Goal Ranges for Electrolytes
  Sodium 130-160 mEq/L
  Potassium 3.4-5.3 mEq/L
  Chloride 90-110 mEq/L
  Magnesium 1.5-2.4 mEq/L
  Phosphorus 2.2-4.6 mEq/L
  Calcium (adjusted) 8.2-10.6 mEq/L

Sodium (136-145 mEq/L, or mmole/L)
Hyponatremia:
- Dilutional hyponatremia: extracellular fluid compartment expands with no increase in sodium. (for example: cirrhosis, CHF, and nephrosis or the administration of albumin or mannitol)
    - *Treatment:* Salt and water restriction by decreasing sodium and/or rate of PN administration plus diuretics.
- Sodium depletion hyponatremia: presents as a low serum sodium concentration without edema. (example: mineralocorticoid deficiencies, sodium wasting renal disease)
    - *Treatment:* Increase Na^+ in PN solution or addition of sodium chloride tablets as a supplement.

Hypernatremia:
- Loss of fluids: for example in diabetes insipidus where free water is lost or in gastroenteritis where fluid is lost via vomiting or diarrhea. Other signs of dehydration include elevated hematocrit or BUN/creatinine ratio >20.
    - *Treatment:* Hydration via starting another IV infusion and/or increasing the PN rate.
- Excessive salt intake: for example in patients receiving IV administration of hypertonic salt solution.
    - *Treatment:* Discontinue the hypertonic solution and/or decrease Na+ in PN solution.

Potassium (3.5-5.1 mEq/L, or mmol/L)
Hypokalemia:

- High level glucose administration can lead to hyperglycemic osmotic diuresis or in conjunction with insulin production can cause an intracellular shift of potassium. Other potential causes include use of diuretics, protracted vomiting and/or severe diarrhea with decreased food intake, loss of acid, loss of sodium, and the development of alkalosis.
  - *Treatment:* Treat underlying causes, stabilize glucose/insulin and/or increase the K^+ in PN solution (in acute cases give IV bolus doses of potassium). Bolus dose should not occur within 4 hours of blood draw to monitor K+.

Hyperkalemia:

- Can result from decreased renal excretion of potassium, exogenous potassium ingestion, or excessive cellular breakdown such as hemolysis, burns, crush injuries, surgery, and infections
  - *Treatment:* Assure that lab value is not erroneous due to cell lysis in test tube. Eliminate/treat underlying cause, reduce K^+ in PN solution.

<u>Chloride (98-107 mEq/L, or mmol/L)</u>

- No real diagnostic value other than to validate serum sodium concentration.

Hypochloremia:

- May result from excessive gastrointestinal loss of chloride-rich fluid (e.g., vomiting, diarrhea, gastric suctioning, or intestinal fistulas). Hypochloremia may also result from significant diuresis accompanying metabolic alkalosis
  - *Treatment:* Treat underlying cause, increase Cl^- in PN solution.

Hyperchloremia:

- May be indicative of a hyperchloremic metabolic acidosis. Clinically, hyperchloremia in the absence of metabolic acidosis is seldom encountered because chloride retention is usually accompanied by sodium and water retention
  - *Treatment:* Generally, alteration in the serum concentration of chloride is seldom the primary indicator of a major medical problem. Assess for acidosis, decrease Cl^- in PN solution.

<u>Calcium (8.6-10.3 mg/dL)</u>

- Since calcium is predominantly bound to albumin, assessment should be based on "corrected" calcium levels as follows:
  - Adjusted Ca++ = Observed Ca++ + 0.8(4 - observed albumin)

Hypocalcemia:

- Usually due to a deficiency in either the production or response to parathyroid hormone (e.g. hypoparathyroidism) or vitamin D (e.g. related to gastrectomy, chronic pancreatitis, or small bowel disease). Some enzyme stimulating drugs (e.g. Phenobarbital, phenytoin, rifampin) can cause a decrease in production of 25-hydroxycholecalciferol. Chronic renal disease can also cause hypocalcemia
  - *Treatment:* Treat underlying cause and/or increase Ca++ in PN solution.

Hypercalcemia:

- May be due to malignancy, hyperparathyroidism, paget's disease, milk-alkali syndrome, granulomatous disorders, thiazide diuretics, or vitamin D intoxication.
    - *Treatment:* Eliminate the underlying cause and/or decrease Ca++ in PN solution. Increasing phosphorus (if hypophosphatemic) can lower calcium.

Phosphate (2.5-5.0 mg/dL)

Hypophosphatemia:

- High level glucose administration can lead to hyperglycemic osmotic diuresis or in conjunction with insulin production can cause an intracellular shift of phosphorus. Other causes include malabsorption, renal phosphate losses secondary to hyperparathyroidism accompanying hypocalcemia and vitamin D malabsorption. Also, aluminum-containing antacids can cause decrease in serum phosphate concentration.
    - *Treatment:* Eliminate the underlying cause, stabilize glucose and/or increase the phosphorous in PN solution.

Hyperphosphatemia:

- Most commonly caused by renal insufficiency, although hypervita-minosis D and hypoparathyroidism are also significant causes.
    - *Treatment:* Reduce phosphorus in PN solution. Increasing calcium (if hypocalcemic) can lower phosphorus.

Magnesium (1.9-2.7 mg/dL)

Hypomagnesemia:

- Generally due to decreased intake. Other factors similar to hypokalemia. Also hypercalcemia & hypophosphatemia can increase Mg++ loss, as can use of aminoglycosides, amphoterecin & osmotic diuretics
    - *Treatment:* Treat underlying cause and/or increase Mg++ in PN solution (if acute can use IV bolus therapy of 8-16mEq). Note: up to 50% can be lost in urine during repletion, thus repletion should occur over days rather than over hours. Follow-up Mg++ levels should be drawn at least 4 hours after last bolus dose.

Hypermagnesemia:

- Most likely related to reduced renal elimination. Can also be related to hypothyroidism or concurrent use of lithium.
    - *Treatment:* Reduce Mg++ in PN solution.

Glucose (70-105 mg/dL)

Hypoglycemia:

- Most likely due to abrupt discontinuation of PN infusion or decrease in glucose concentration with continued insulin production or misadjustment of insulin dose.
    - *Treatment:* Treat the underlying cause and/or give additional dextrose.

Hyperglycemia:

- Blood glucose of 120-200 mg/dL is generally acceptable while receiving PN. Levels between 200 & 250 mg/dL can be acceptable, but warrants urine glucose measurement to monitor for glucosuria. The dextrose concentration is a concern in diabetic (or borderline) patients.
    - *Treatment:* Cover with sliding scale insulin and/or add insulin to PN solution.

Vitamins and Minerals

- (MVI Adult) "MVI-13" 10 ml daily (Formulation listed below)

Vitamin	Amount	Vitamin	Amount
A	3,300 units(1 mg)	Niacin	40 mg
C	100 mg	Riboflavin(B2)	3.6 mg
D	200 units(5mcg)	Thiamine(B	3 mg
E	10 units(I0 mg)	Pyridoxine(B6)	4 mg
Folic acid	400 mcg	B12	5 mcg
Pantothenic acid	15 mg	Biotin	60 mcg
Phytonadione	150 mcg		

Trace Elements

- Once daily
    - Standard formula (Zinc 3mg, Copper 1.2mg, Manganese 0.3mg, Chromium 12mcg)

Reference:

- http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=search&db=PubMed&term=Beck [AU] AND 2002 [DP]
- Am Fam Physician [TA] *Beck (2002) Am Fam Physician 65(8):1575-8*
- http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=search&db=PubMed&term=Bernstein [AU] AND 1995 [DP] AND Nutrition [TA] *Bernstein (1995) Nutrition 11:170*
- "The Hitchhikers Guide to Parenteral Nutrition Management for Adult Patients", Practical Gastroenterology, July 2006
- Policy #8340-164 Nutritional Assess/Practice Guidelines: Adult/Geriatric
- Policy #MM8610-156 Electrolyte Replacement Protocol

Appendix:
Appendix A: Parenteral Nutrition Monitoring Record

PARENTERAL NUTRITION MONITORING RECORD (v02/2016)

PATIENT INFORMATION
Name:______________ Rm#________ MD:______________ Route: P C ID#________ MR#________

NUTRITIONAL ASSESSMENT
Total Cal./day__________ Tot. Protein__________Gm/day IBW__________Kg Actual BW __________Kg Ht(in.)__________

NUTRITIONAL VALUATION
Std PPN _____(0.7 cal/ml; 0.028 gm prot./ml) Modified: D______%______ml, AA ______%______ml, F______%______
__________Cal/ml, __________Gm protein/ml. Tot. Cal. Per btl/bag__________Tot. prot. Per btl/bag__________Gm

INITIAL ADDITIVE ORDERS		ADDITIVE CHANGES												
Na	mEq per Liter													
K	mEq													
Ca	mEq													
Mg	mEq													
Cl	mEq													
PO4	mMol													
Regular Insulin	Units													
Other														
SCHEDULE														
Date														
Rate (ml/hr)														
MONITORING PARAMETERS														
Sodium	(136-145 mg/dl)													
Potassium	(3.5-5.1 mg/dl)													
Chloride	(98-107mg/dl)													
Glucose	(70-105mg/dl)													
BUN	(7-25 mg/dl)													
Creatinine	(0.6-1.3 mg/dl)													
Tot. Protein	(6.4-8.9 gm/dl)													
Albumin	(3.5-5.7 gm/dl)													
Calcium*	(8.6-10.3 mg/dl)													
Phosphorus	(2.5-5.0 mg/dl)													
Cholesterol	(<200 mg/dl)													
Triglyceride	(<150 mg/dl)													
Magnesium	(1.9-2.7mg/dl)													
Other:														
MONITORING RECORD														
Pharmacist Initials														

*Adjusted for Albumin (4-Albumin level) x 0.8 + measured Ca++

Appendix B: Parenteral Nutrition Compounding Form

NAME: ROOM#: DATE: MD:

Enter final [Electrolyte] & Base Formula Volumes to get Additive Volumes

ELECTROLYTES [Current Bag]	CONC	INITIAL ADDITIVES	
Na in mEq/L (55)			
K in mEq/L (40)			
Cl in mEq/L (55)			
Ca in mEq/L (8)			
Mg in mEq/L (8)			
PO4 in mM/L (10)		MVI-13 ml/day	
Regular Insulin in units/bag (0)		TRACE ELEM ml/day	

BASE FORMULA	VOL (ml)			
Dextrose %		ACETATE mEq/L		
Amino Acids 8.5 %		Calories from dextrose	Total protein	grams/day
Amino Acids 10 %				
Amino Acids 15 %		Calories from lipid		
Lipid %		Calories total/day		
Total Volume	0			

SCHEDULE												
BTL/BAG #												
DATE												
TENTATIVE TIME DUE												
RATE (mL/HR)												
NUMBER OF HRS (predicted)												
ENTER AA Volume												
DEXTROSE % (ml)												
INTRALIPID % (ml)												

FORMULATION/BAG[CALC]	VOL (ml)	VOLUMES COMPOUNDED											
NaCl (4 mEq/ml)	0.0	0.0											
Na Acetate (2 mEq/ml)													
Na Phos (Na 4 mEq/ml, P 3	0.0	0.0											
KCl (2 mEq/ml)	0.0	0.0											
K Acetate (2 mEq/ml) in ml	0.0	0.0											
K Phos (K 4.4 mEq/ml, P 3 mMol/ml)													
MgSO4 (4 mEq/ml)	0.0	0.0											
CaGluconate (0.465 mEq/ml)	0.0	0.0											
MVI-13	0	0											
Trace Elements	0	0											
No Insulin													

CALCULATION

BTL/BAG#

INITIALS

PREPARATION RECORD												
DATE												
TIME												
TECH												
PHARM												

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
Healing Here at Home

SUBJECT: Parenteral Nutrition Protocol	POLICY #MM8610-151
	PAGE 14 OF 14
DEPARTMENT: Organizational	EFFECTIVE: 04/88
APPROVED BY: Director of Pharmacy	REVISED: 07/15, 02/16, 4/16

Appendix C: Parenteral Nutrition Order Form

PARENTERAL NUTRITION ORDERS

Peripheral or Central	Central Administration Only	Custom (Central or Peripheral)
☐ Clinimix E 4.25/5 (Amino Acids 4.25%/Dextrose 5%)	☐ Clinimix E 5/25 (Amino Acids 5%/Dextrose 25%)	☐ Custom
Amino Acids 42.5 g/L	Amino Acid 50 g/L	________ % Amino Acid
Dextrose 50 g/L	Dextrose 250 g/L	________ % Dextrose
Sodium 35 mEq/L	Sodium 35 mEq/L	Sodium ________ mEq/L
Potassium 30 mEq/L	Potassium 30 mEq/L	Potassium ________ mEq/L
Magnesium 5 mEq/L	Magnesium 5 mEq/L	Magnesium ________ mEq/L
Calcium 4.5 mEq/L	Calcium 4.5 mEq/L	Calcium ________ mEq/L
Phosphate 15 mMol/L	Phosphate 15mMol/L	Phosphate ________ mMol/L
Acetate 70 mEq/L	Acetate 80 mEq/L	Acetate ________ mEq/L
Chloride 39 mEq/L	Chloride 39 mEq/L	Chloride ________ mEq/L
☐ Multivitamin 10ml	☐ Multivitamin 10 ml	Fat Emulsion ______ % ______ ml
☐ Standard Trace Elements 1ml	☐ Standard Trace Elements 1m	☐ Multivitamins 10 ml
☐ Regular Insulin ________ units/L	☐ Regular Insulin ________ units/L	☐ Standard Trace Elements 1ml
		☐ Regular Insulin ________ units/L
		Total Volume = ____________
Total Calories/L = 340	Total Calories/L = 1050	Total Calories/L= ____________

Lipids:
☐ Fat Emulsion _____ % ________ ml ______ times per week

Route of Administration:
☐ Central or PICC
☐ Peripheral Line (do not exceed final conc. of 10% dextrose for peripheral line)

Rate of Administration and IV Solutions:
☐ Initial parenteral nutrition rate: ______ ml hr, Increase by _____ ml/hr every _____ hrs to a goal rate of ______ ml/hr (per dietitian recommendation)
☐ Decrease the rate of the other IV solution(s) proportionately as parenteral nutrition rate increases.
☐ D/C previous IV solution(s) when parenteral nutrition reaches goal rate of ________ ml/hr
☐ Other IV solution and rate: ____________________
☐ Other: ____________________

Standard Laboratory & Nursing Orders:
Baseline:
☐ Weigh patient
☐ TPN panel*
☐ PreAlbumin (if parenteral nutrition anticipated duration >7 days)
☐ Mg, Phos (only)
Routine:
☐ For PPN (final conc. of dextrose ≤10%) draw TPN panel* q Monday, BMP every Wednesday/Friday
☐ For TPN (final conc. of dextrose >10%) draw TPN panel* qam x3 days, then qM-W-F; Accu-chek glucose every pm x3 days, then T-Th-Sat.-Sun. in am
☐ I/O and weights daily
☐ CBC and PT every Monday
☐ Accu-chek glucose q________
☐ Sliding scale regular insulin (indicate scale): ____________________ units q ____ hr

*TPN panel=CMP, Mg, P, Chol, & Trigl.

SUBJECT: Electrolyte Replacement Protocol	POLICY #MM8610-156
DEPARTMENT: Organizational	EFFECTIVE: 2/10
APPROVED BY: Director of Pharmacy	REVISED: 2/16, 4/16

Purpose:
To standardize the replacement of Potassium, Magnesium and Phosphorus in ICU patients.

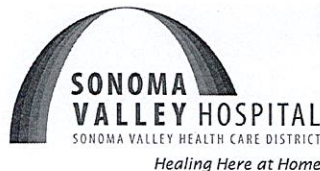
Policy:
Upon orders by a prescriber to initiate the “Electrolyte Replacement Protocol” the guidelines set forth in this protocol will be implemented. Nursing and pharmacy will collaborate per this protocol to provide appropriate replacement electrolytes to the patient based on lab values for potassium, phosphorus, and/or magnesium. This protocol is intended for ICU patients only and will not be used on any patient meeting exclusion criteria.

Protocol:
Exclusion Criteria:
- Age <18 years old
- Serum creatinine >2mg/dL
- Weight <45kg
- Diabetic ketoacidosis

Potassium:

Serum Potassium (mmol/L)	Oral Dose[1] (Adminster Tab or Liquid if able to tolerate PO)	IVPB Dose[2] Peripheral: 10meq/hr max rate Central: 20meq/hr max rate
>3.9	No Dose	No Dose
3.6 - 3.9	20meq q2h x 2 doses	40meq total
3.1 - 3.5	20meq q2h x 3 doses	60mEq total
2.6 - 3.0	20meq q2h x 4 doses	80mEq total
<2.5	Contact MD	

[1]The oral route will be used when possible or reasonable to do so
[2]Continuous cardiac monitoring is recommended when the infusion rate exceeds 10meq/hr



Phosphorus:

Serum Phosphorus (mg/dl)	Sodium Phosphate or Potassium Phosphate IVPB Doses (infuse 15mMol over 4 hrs or 30mMol over 6hrs)
≥2.6	No Dose; supplement any K+ shortage w/ KCL
2.0-2.5	15mMol Phosphate (as Sodium) in 250ml NS over 4 hrs
Unless K <3.9, then use	15mMol Phosphate (as Potassium) in 250ml NS over 4hrs (**reduce** K+ dose by **20**meq)
≤1.9	30mMol Phosphate (as Sodium) in 500ml NS over 6hrs
Unless K <3.9, then use	30mMol Phosphate (as Potassium) in 500ml NS over 6 hrs (**reduce** K+ dose by **40**mEq)

Magnesium:

Serum Magnesium (mg/dl)	Magnesium Sulfate IVPB Dose
≥2.3	No Dose
2.0-2.2	1 gm over 30 minutes
1.7-1.9	2 gms over 60 minutes
1.4-1.6	3 gms over 90 minutes
1.0-1.3	4 gms over 2 hrs
<1.0	6 gms over 3 hrs

Labs:

- Draw serum potassium, phosphorus, and/or magnesium daily as indicated while on protocol.
- If ≥60meq potassium or ≥4gm magnesium administered:
  - Draw post dose levels 2 hours after last IV dose infused.
  - Draw post dose levels 4 hours after last oral dose administered.

Procedure:

1. A prescriber will place an order to initiate the "Electrolyte Replacement Protocol" and indicate which electrolytes to be maintained per protocol (i.e. potassium, magnesium, and/or phosphorous.
   a. If ordered via computer physician order entry (CPOE) all orders will be automatically placed with instructions for administration except phosphorus replacement.
   b. If ordered via a paper order, the pharmacist will enter the order into the CPOE system as applicable.

2. The pharmacy will enter an "Electrolyte Protocol-ICU" order into the patient's medication profile to indicate that the protocol is active.
3. Applicable electrolyte levels will be ordered by nursing according to the protocol above.
4. Once the lab values are available the appropriate electrolytes will be administered to the patient according to lab values and the protocol tables defined above.
   a. Premixed preparations of applicable electrolyte solutions will be used whenever available.
   b. If a premix or ready-to-use solution is not available, the pharmacy will prepare the dose(s).
      i. In this case, the nurse will notify the pharmacist of the need for compounding and provide a copy of the Electrolyte Replacement Medication Administration Record as a communication tool.

5. Nursing procedure:
   a. The nurse taking care of the patient may use the Electrolyte Replacement Medication Administration Record to assist in the tracking administration of doses and lab values.
   b. Nursing documentation of dose administration will occur on the patient's electronic medication administration record (eMAR).
   c. The nurse will order and schedule follow-up labs to be drawn as outlined in the protocol.
   d. If pharmacy is closed and phosphorus level is <1.5, nursing supervisor to call on-call pharmacist to arrange for dose preparation within 3 hours.

Reference:

- UpToDate Online (accessed 8/31/2015)
- Global RPh (accessed 8/31/2015)

Attachments:

- Attachment A: Electrolyte Replacement Medication Administration Record

Attachment A: Electrolyte Replacement Medication Administration Record

<table>
<tr><td colspan="2">Record Serum Level Results</td><td colspan="8">Record Time of Electrolyte Doses Given in Response to Serum Level Results Based on Protocol Tables Below
(MUST DATE / TIME AND WRITE ORDERS FOR DOSES ADMINISTERED EACH TIME AN ELECTROLYTE PROTOCOL IS INITIATED)</td><td rowspan="3">POST INFUSION LEVEL</td></tr>
<tr><td colspan="2">Date:</td><td rowspan="3">Date:
Time:
K ____ mEq
( ) PO
( ) IV
____ RN initial</td><td rowspan="3">Date:
Time:
K ____ mEq
( ) PO
( ) IV
____ RN initial</td><td rowspan="3">Date:
Time:
K ____ mEq
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Time:
K ____ mEq
( ) PO
( ) IV
____ RN initial</td></tr>
<tr><td colspan="2">Time:</td></tr>
<tr><td>K+ (mmol/L)</td><td>If K≤3.9 and Phos≥2.6, see <u>only</u> Table A</td><td>K+ (mmol/L)</td></tr>
<tr><td>Phosphorus (mg/dl)</td><td>If Phos≤2.5, <u>also</u> see Table B</td><td colspan="4">Date:
Time:
Phosphate ________ mM in 250ml NS IV over ______ hrs as ( ) Na ( ) K
________ RN initial</td><td colspan="4">Special Note:
Any phosphate containing solution is <u>NOT</u> compatible with calcium containing solutions. Infuse separately or flush line between infusions.</td><td>Phosp (mg/dl)</td></tr>
<tr><td>Mg++ (mg/dl)</td><td>If Mg≤2.2, see Table C</td><td colspan="3">Date:
Time:
Mg_____ Gms IV over ______ minutes ________
RN initial</td><td colspan="3">Date:
Time:
Mg_____ Gms IV over ______ minutes ________
RN initial</td><td colspan="2">Date:
Time:
Mg_____ Gms IV over ______ minutes ________
RN initial</td><td>Mg++ (mg/dl)</td></tr>
</table>

RN Initials	RN Signature

Labs

- Draw serum potassium, phosphorus, and/or magnesium daily while on protocol
- If ≥60meq potassium, ≥30mMol phosphate, or ≥4gm magnesium administered:
  - Draw post dose levels 2 hours after last IV dose infused.
  - Draw post dose levels 4 hours after last oral dose administered.

Table A

Serum Potassium (mmol/L)	Oral Dose (KCL 20meq tab or UD Elixir)	IVPB Dose Periph: 10meq/hr Central: 20meq/hr
>3.9	No Dose	No Dose
3.6 - 3.9	1 q2h x 2 doses	40mEq
3.1 - 3.5	1 q2h x 3 doses	60mEq
2.6 - 3.0	1 q2h x 4 doses	80mEq
<2.5	Contact MD	

Table B

Serum Phosphorus (mg/dl)	IVPB Dose (infuse 15mMol over 4 hrs or 30mMol over 6hrs)
≥2.6	No Dose Supplement any K+ shortage w/ KCL
2.0 – 2.5	15mMol Phosphate (as Sodium) 1 vial in 250ml NS over 4 hrs
Unless K <3.9, then use	15mMol Phosphate (as Potassium) (reduce K+ dose 1 vial in 250ml NS over 4hrs by 20meq)
≤1.9	30mMol Phosphate (as Sodium) 2 vials in 500ml NS over 6hrs
Unless K <3.9, then use	30mMol Phosphate (as Potassium) (reduce K+ dose 2 vials in 500ml NS over 6 hrs by 40mEq)

Table C

Serum Magnesium (mg/dl)	Magnesium Sulfate IVPB Dose
≥2.3	No Dose
2.0 - 2.2	1 Gm over 30 minutes
1.7 – 1.9	2 Gms over 60 minutes
1.4 – 1.6	3 Gms over 90 minutes
1.0 – 1.3	4 Gms over 2 hrs
<1.0	6 Gms over 3 hrs

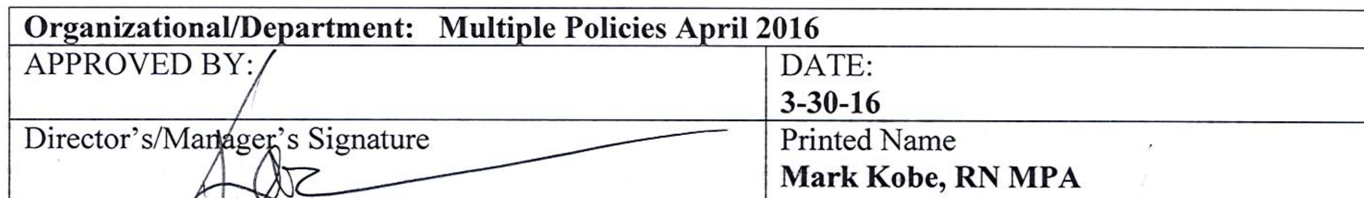
Policy and Procedure - Approvals Signature Page

Review and Approval Requirements

The SVH departmental/organizational policies and/or procedures on the attached list have been reviewed and approved by the following organizational leaders for meeting all of the following criteria. All of these policies and procedures are:

- Consistent with the Mission, Vision and Values of the Sonoma Valley Health Care District
- Consistent with all Board Policy, Hospital Policy and Hospital Procedures
- Meet all applicable law, regulation, and related accreditation standards
- Consistent with prevailing standards of care
- Consistent with evidence-based practice

We recommend their acceptance by the Quality Committee and that the Quality Committee forward them to the Sonoma Valley Health Care District Board with a recommendation to approve.



Organizational/Department: Multiple Policies April 2016	
APPROVED BY:	DATE: **3-30-16**
Director's/Manager's Signature	Printed Name **Mark Kobe, RN MPA**

Douglas S Campbell, MD
Chair Medicine Committee
Date

Michael Brown, MD
Chair Surgery Committee
Date

Keith J. Chamberlin, MD MBA
President of Medical Staff
Date

Kelly Mather
Chief Executive Officer
Date

Jane Hirsch
Chair, Board of Directors
Date

Policy Submission Summary Sheet

Title of Document: **Multiple Policies – April 2016**

New Document or Revision written by:

Date of Document: **3-30-16**

Type: ❑ Revision X New Policy	**Regulatory:** ❑ CIHQ X CDPH X CMS ❑ Other:
Organizational: X Clinical X Non-Clinical	X **Departmental** ❑ **Interdepartmental** (list departments effected)

Please briefly state changes to existing document/form or overview of new document/form here:
(include reason for change(s) or new document/form)

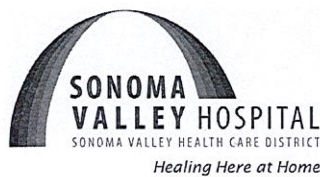
Emergency Department Policy:

7010-01 Emergency Initial Assessment Triage- Revised; updated OB patients less than 20 weeks EGA will be evaluated in the ED and those over 20 weeks will be escorted to OB unit for an obstetrical assessment; OB patients may receive MSE by a qualified RN.

Birthplace Department Policy:

6171-154 Triage of Pregnant Patient Presenting to the ED – Retire; This policy outlining triage in the ED for the OB patients can be discontinued because of the Standardized Procedure for OB RNs to perform the MSE. The elements of the triage policy are included in the ED policy #7010-1, Emergency Initial Assessment/Triage

Reviewed by:	Date	Approved (Y/N)	Comment
Policy & Procedure Team	03/15/2016	Yes	
Surgery Committee	04/06/2016	yes	
Medicine Committee	04/14/2016	YES	
P.I. or P. T. Committee	n/a		
Medical Executive Committee	04/21/2016		
Board Quality	04/27/2016		
Board of Directors	05/05/2016		



Purpose:

This policy and procedure will ensure patient's rights and clarify patient's initial assessments/triage. **Emergency Medical Treatment and Labor Act (EMTALA), COBRA and Health Insurance Portability and Accountability Act (HIPPA) laws** will be followed.

Policy:

All Patients who present in the Emergency Department (ED) will receive a complete Medical Screening Examination (MSE). The initial assessment will be done by a qualified Emergency Department Nurse and a final Medical Screening Exam (MSE) by a Physician. Obstetrical patients may receive a MSE by a registered nurse who is determined to be the qualified medical personnel for certain patients.

Procedure:

A. A qualified Emergency Department Registered Nurse (EDRN) one who will have a minimum of six (6) months recent emergency nursing experience and have completed competency validation, will perform and record an initial assessment on patients who present to the ED and assign the appropriate triage level based on this initial assessment.

B. There will always be one (1) dedicated/unencumbered nurse for triage. If the census and/or acuity of patients exceeds the limit of the staff nurses ratio the nursing supervisor or ER manager will be called to assist.
Between the hours of 10:00AM and 10:00PM, this nurse will be stationed in Triage. They will be responsible for triaging patients and monitoring the waiting room.
The triage nurse may go to the back and assist with quick assignments; patient discharges, medication administration to help facilitate the flow of patients through the ED.

C. The initial assessment provides the following:

1. Is defined as a tiered process of increasingly complex medical evaluations to identify or rule out the existence of an Emergency Medical Condition, and if such condition exists, to provide stabilizing medical treatment.
2. Is the same for all individuals with similar signs and symptoms.
3. Is performed regardless of payor status, HMO/PPO membership, or insurance.

D. Patients will be placed in one of five levels based on the initial assessment for the purpose of prioritizing further care. Triage level is not a measure of total nursing workload; it is a measure of presentational acuity.

E. Emergency Severity Index 5 levels of triage are as follows:

Level 1 Requires immediate life-saving intervention: airway, emergency medications, or other hemodynamic interventions (IV, supplemental O2, monitor, ECG or labs DO NOT count); and/or any of the following clinical conditions: intubated, apneic, pulseless, severe respiratory distress, acute mental status changes or unresponsive.

Unresponsiveness is defined as a patient that is either:
(1) nonverbal and not following commands (acutely); or
(2) requires noxious stimulus

Level 2 High risk situation is a patient you would put in your last open bed
Severe pain/distress, confused/lethargic is determined by clinical observation and/or patient rating of greater than or equal to 7 on 0-10 pain scale.
Level 3 patients with vital signs outside accepted parameters >8yrs HR>100 RR>20, 3-8yrs HR>140 RR>30, 3m-3yrs HR>160 RR>40, <3mos HR>180 RR>50, All ages SaO2 <92%, 1-28 days of life with fever >100.4, 3mos-3yrs consider ESI 2 with fever >100.4

Level 3 Patients who are predicted to require 2 or more resources

Level 4 Patients who are predicted to require 1 resource

Level 5 Patients are predicted to require no resources

F. Obstetrical patients will be handled in the following manner:

1. If a pregnant patient presents to the ED with significant trauma, shock, or immediate threat of loss of life or limb, the patient will remain in the Emergency Department. The OB unit will be consulted and respond with appropriate equipment to the ED.
2. Patients presenting to the ED with an EGA of less than 20 weeks will be evaluated in the ED.
3. Pregnant patients with an EGA of greater than 20 weeks stating that they are in labor will be facilitated via escort to the OB Department for an obstetrical assessment.
4. The ED Staff will call the OB Unit to inform them of the patient's current status before leaving the ED.
5. Upon completion of the OB Assessment and clearance, the patient will be escorted back to the ED for the continuation of care if indicated by the MSE performed by the Obstetrical Nurse.

6. The OB Provider or Staff will provide information both verbally and in written form validating the patient's status before movement of the patient to the Emergency Department.

Resources: Labs (blood,urine), ECG, X-rays CT-MRI-ultrasound angiography, IV fluids (hydration), IV,IM or nebulized medications, Specialty consultation, Simple procedure =1 (lac repair, Foley cath), Complex procedure = 2 (conscious sedation)

Not resources: History & physical (including pelvic), Point-of-care testing, Saline or heplock, PO medications, Tetanus immunization, Phone call to PCP, Simple wound care (dressings, recheck), Crutches, splints, slings

All patient weights will be taken in Kg

For more examples and in-depth explanation of the **Emergency Severity Index (ESI) A Triage Tool for Emergency Department Care** go to the link provided below to access the Implementation Handbook.

References:

1. http://www.esitriage.org/
2. Emergency Nurses Association, Clinical Practice Guideline, December 2011, ena.org
3. Sonoma Valley Hospital Organizational Policy #PC8610-209 – Standard Procedure for Medical Screening Exam for the Obstetrical Patient performed by the RN.

8.

QUALITY AND RESOURCE MANAGEMENT REPORT

To: Sonoma Valley Healthcare District Board Quality Committee
From: Leslie Lovejoy
Date: 04/27/16
Subject: Quality and Resource Management Report

April Priorities:

1. Review of reports and dissemination of information
2. Preparation for unscheduled hospital licensing surveys
3. Annual review of projects and determination of top organizational PI projects

1. *Review of reports and dissemination of information*

- Attached please find the 4th quarter Good Catch Awards Summary.
- We received Value Based Purchasing data from the Centers for Medicare and Medic-Cal Services regarding our performance for FY 2017 Values Based Performance. Our composite Patient Safety Indicators Score came in at 0.44 while the achievement threshold (median index value for all hospitals) came in at 0.77 and the best performing decile index value came in at 0.54. The lower the composite value, the higher the quality of care. Thus, we meet and exceed top decile performance. The indicators are the same ones that are on the Quality Dashboard: pressure ulcer rate, iatrogenic pneumothorax, central venous catheter related bloodstream infection rate, post-op hip fracture, peri-op PE/DVT rate, post-op sepsis rate, post-op wound dehiscence and accidental puncture or laceration rate. The data range was from December 2013 through June 2015.
- Another portion of Value Based Purchasing involves performance on Outcomes of care, specifically 30 day mortality rates for acute myocardial infarction, heart failure and pneumonia. Sonoma Valley Hospital's performance was found to be in the top decile of survival rates among all hospitals with measure results and minimum case size (n=25) for FY 2017 (October 2010-June 2012 data). Also very good news.
- What this all means is that the hospital will earn back all of the $$ Medicare holds back and quite possibly addition $$. I expect that CMS will publish their final results and the incentive $$ in October as they have done every year.

2. *Preparation for unscheduled hospital licensing surveys*

The State Department of Health Services has mandated that each of the district offices conduct unscheduled licensing surveys to one third of the hospitals they oversee this year and then every three years. Past practice was that the state would come in when the Joint Commission or another deemed status agency and conduct a licensing survey as part of the total package. That stopped quite awhile ago and the state has determined that it needs to happen on a more regular basis. The focus on the survey will be compliance with the Medication Error Reduction Program and a review of current compliance with plans of corrections and complaint surveys held over the past three years. The leadership team was educated to the new survey process and we have completed a

binder of documentation regarding action plans and quality monitoring. To complete the loop the attached table provides follow-up on the deficiencies and actions I have shared with you in the past.

3. *Annual review of projects and determination of top organizational PI projects*

The Administrative Team, with input from leadership and medical staff identified 5 organization –wide PI projects for 2016-2017 and will carry over 4 additional projects. Per CIHQ/CMS standards, projects are chosen based on the impact of processes on patient safety, the volume of the process, the impact the process has on patients, employees, our business and whether we have both the internal and external resources to address the process. I have attached the decision matrix and a sample project request form to help understand the process.

Topic for discussion this meeting:

- Annual Home Care Report
- Annual Skilled Nursing Report

GOOD CATCH AWARDS

The following employees were recognized for identifying and reporting potential safety issues affecting patient care or employee/visitor safety.

Employee	Safety Issue Identified	Actions Taken to Prevent Harm
Sara Ornelas, Sarah Whyte (Med Surg) 15-939	Bariatric patient told to crush all meds. One of the meds long-acting bupropion 450mg dose; this dose crushed & given at once could trigger a seizure. Sara Whyte caught this potential medication error prior to patient leaving.	Talked to pt & physician for alternate instructions.
Marta Suarez Lopez (Med Surg) 15-1043	During Skills Lab RN/CPOE training, RN reported an example of insulin dosing in ED not prompting for RN co-sign.	The pharmacist corrected the electronic system to require the co-sign= Already fixed
Katherine Howarth (Med Surg) 15-955	Conflicting diet orders for Bariatric patients. NPO and Bariatric clears 15-30ml Q 15-30mins.	MD notified and RN changed orders to prevent feeding patient too soon, Orders closely monitored to prevent errors.
Yee Huen Hsu (Pharm) 15-1087	Attending MD was not updated upon transfer to SNF from the acute unit.	Admitting department was contacted for an MD update. Unit secretary was notified to monitor correctness of attending MD on profile.
Yee Huen Hsu (Pharm) 15-908	Attending MD was not updated on patient's profile to reflect hospitalist care in absence of Dr Bozzone. RPH discovered the mistake during weekly drug regimen review at SNF.	Unit secretary was notified to monitor correctness of attending MD on profile.
Bernice Pruitt (Med Surg) 15-1185	I wrote a telephone order for Dr Burchett for IV Invanz 1 Gm every 24 hours x nine days for this patient who would be returning to outpt infusion (ACU) daily beginning 12/16, but I mistakenly wrote IV Zosyn 1 Gm daily.	Tele tech Bernice Pruitt was assisting me to set pt up for the daily infusion & caught my antibiotic error. The order was corrected and MD signed

2013-2015 POC QM Documentation

2013 Skilled Nursing Licensing Survey & Interim Life Safety

Action	***Quality Indicators***	***Compliance demonstrated/Date Retired***
1. Self Administration of Medications	1. # of residents self administering medication who have the following elements documented: • Physician's order • Medication Self Administration Care plan documentation • Documented ITP approval Denominator: total number of residents 2. Documentation of training of nursing staff to monitor for any and all medications at the resident's bedside or in their room	All staff have been trained to the policy. The SNF DON has monitored and documented compliance monthly on the QC document for a period of 1 year. 100% compliance . ***This POC is Retired.***
2. Medication order forms	1. Weekly audits of MARs will take place to ensure that 100% of medication orders include an indication for use. For 3 months at 100%, then 1 MAR audit for each month to ensure continued compliance.	The SNF Pharmacy consultant monitored all admissions to SNF both from SVH acute unite and from outside facilities. Charts were monitored weekly and 100% compliance was attained for documentation of drug indication on MAR (from 11/18/2013 until 3/18/2014. ***This POC is retired. The SNF now has Electronic MARS that reflect drug indications.***
3. Drain outlet for 3 part sink in Dietary Department	1. Drain pipe remains centered in the drain outlet is monitored weekly for 1 month for 100% compliance; then quarterly if no failures during the first month.	Drain removed and replaced by a permanent fixture. Air gap established. 100% compliance **Retired 4/22/14**
4. Proper use and storage of mops in chemical closet of dietary department	1. 100% of dietary staff have been educated to the policy on the proper use and storage of mops in their department. 2. Compliance of procedure will be documented in daily rounds of the Food Services Manager.	Staff education at Monthly staff meeting and 10 minute meeting. 100% of staff educated. **Retired 4/22/14**
5. Quantity of Disaster menu food.	1. Food Services Manager reviews checklist quarterly to ensure compliance with every six months rotation of disaster food.	Disaster menu revised and process updated. Shelf life log maintained for all items **On going**
6. Corridor doors close and latch	1. Monitoring and recording, during fire drills, that all corridor and resident doors fully close and latch correctly.	During monthly fire drill we distribute an exercise/observation form to the nurses' station. In this form one of the points (#8) reads: "Did fire doors self-close and latch. If the answer is No, the door is identified and a work order is issued after the review of the fire drill paper. **Ongoing process.**

2013 Complaint Surveys

Topic	***Quality Indicators***	***Compliance demonstrated/Date Retired***
8/13 HIPAA fax to another facility	1. 100% of employees take and pass at a score of 80% the annual Health Stream Competency regarding HIPAA Privacy Act 2. Privacy Officer maintains a log of HIPAA violations that originates either from self reporting or by those discovering the violation. This is reported quarterly to the Compliance Committee.	1. 100% compliance 2. Paper logs in binders for 2013 located in the HIM department
9/13 HIPAA ED faxing of patient information	1. Write a fax procedure for the ED dept that uses autofaxing technology within the electronic health record. 2. Teach the ED clerks the use of the auto faxing technology. 3. HIM will audit ED faxing using the electronic record internal tracking of user faxing and documents faxed to ensure compliance with use of technology.	1. Completed 10/31/13 2. Completed 10/31/13 3. HIM to perform audit
9/13 HIPAA CardioPul disclosure of employee's health status	1. 100% of employees take and pass at a score of 80% the annual Health Stream Competency regarding HIPAA Privacy Act 2. Privacy Officer maintains a log of HIPAA violations that originates either from self reporting or by those discovering the violation. This is reported quarterly to the Compliance Committee.	1. 100% compliance 2. Paper logs in binders for 2013 and 2014 located in the HIM department

2014 Skilled Nursing Licensing & Interim Life Safety Surveys

Topic	***Quality Indicators***	***Compliance demonstrated/Date Retired***
1. Multiple IC issues and Food Shelf Life in Dietary	1. ICN to in-service staff semi-annually on infection control procedures. 2. RD to in-service staff monthly on Food Safety and perform monthly food safety audits to be filed in Manager's office. 3. All staff educated on IC policies including glove use, shelf life guidelines, proper storage procedures and proper labeling and dating of food. 4. All staff record will record refrigerator and freezer temperatures in the SNF patient food refrigerator.	ICN attended Department staff meeting to inservice staff 3/18/15 and 12/10/15 Shelf life guide updated 10/14/15 RD participating in monthly audits and presenting at Monthly staff meeting 10 minute meetings addressed one part of food safety at a time i.e.; Safe Zone for food, Label and dating, storing, thawing, reheating, etc. SNF temp logs 100% for 6 months. **On going**

2. Sanitation of glucometers	100% compliance with the correct glucometer disinfection method by direct observation daily.	The DON conducted random, daily audits for 1 year. 100% compliance ***This POC is retired as of 12/1/2015.***
3. Improper/inconsistent washing and sanitization of floor mop heads	1. EVS Lead will monitor the laundry facility's to ensure that mops are not being laundered and provide weekly report to EVS Manager and at the Lead team meetings.	100% compliance **Retired 1/19/2016 – Changed Linen Service Company for mops**
4. Inconsistent monitoring of cleaning fluid concentrations	3. 100% of failing dispensers will be labeled as out of service until repaired.	100% of failing dispensers as now labeled as out of service until repaired. Note: Ecolab inspections are now Quarterly. **Ongoing**
5. Insufficient disaster water storage.	1. Quarterly checks for expiration and stock rotation by Nutritional Services Manager	Shelf life log revised and stock rotated based on best buy date. **On going**
6. Corridor doors close and latch inconsistently; use of laundry carts obstructing closure	100% of preventive maintenance and safety inspections are completed monthly. Random monthly checks of door obstructions, on the spot education and report results to Safety Committee.	Safety Officer tracks the monthly check with results as part of the department's QA/PI program. The need to schedule additional in-services is evaluated Quarterly. Safety rounds are being performed with an increased frequency and are reported to the Safety Committee for review at their Quarterly meetings. Ongoing process with regular Safety Round inspections. **Monthly Safety Officer inspections Retired 4/1/16 after 100% compliance demonstrated**
7. Failure of smoke detector when activated outside room 107	100% of fire safety testing will be completed prior to due dates and repairs made as identified.	Director of Facilities monitored the Engineering Fire Safety tracking spreadsheet showing testing compliance is conducted prior to the due dates and that corrective action is taken for any device failures. **Retired 1/1/16**

2014 Complaint Surveys

Topic	***Quality Indicators***	***Compliance demonstrated/Date Retired***
3/14 HIPAA Admin disclosure of minor PHI	1. 100% of employees take and pass at a score of 80% the annual Health Stream Competency regarding HIPAA Privacy Act 2. Privacy Officer maintains a log of HIPAA violations that originates either from self reporting or by those discovering the violation. This is reported quarterly to the Compliance Committee.	1. 100% compliance 2. Paper logs in binders for 2013 located in the HIM department

6/14 Perioperative death involving SNF patient with hip fracture DOS: 8-25-13	1. 100% of SNF patients requiring inpatient surgery will be admitted to the acute hospital. 2. 100% of SNF patients going to surgery with have an updated H & P in the record over 6 months.	100% compliance on both indicators. **Retired 01/2015**
12/14 Pressure Ulcer in SNF	1. 100% review weekly of all patients with wounds to ensure all elements of the policy have been documented. For 12 months	100% compliance met. ***Monitoring was completed on 2/1/2016. All processes remain in effect.***
12/14 Patient Fall with hip Fracture in SNF	1. 100% compliance with fall risk care plans daily for 12 months.	The SNF DON has monitored for Fall Risk patient during morning report M-F for a period of 1 year. Care Plans have been monitored weekly during IDT meeting for 1 year. 100% compliance met. ***This POC is retired as of 2/1/2016, however all processes remain in place.***
12/18 EMTALA transfers	1. We will review 100% of all transfers from the Emergency Department, using a non-CCT ambulance and and emergency department registered nurse, to other acute care hospitals over a period of three months for appropriateness of transfer, stabilization prior to transfer, and appropriate documentation of calls to and from on-call physicians in the medical record. After the three months, the hospital will monitor 50% of all transfers, using a non-CCT ambulance and and emergency department registered nurse, for another nine months, ending November 30, 2015.	100% ongoing monitoring of all transfers for the ED. 100% compliance to policy. Monitoring continues beyond November 2015 due to importance of EMTALA transfer issues. **Ongoing process**
12/18 ED MD EMTALA training	1. Beginning January 02, 2015, all emergency department physician credentialing files will include documentation of required EMTALA education for current and new emergency department physicians. 100% of Emergency Department physicians will have documentation of EMTALA training in their file. This will be monitored monthly.	100% of ED physicians have had EMTALA education **Ongoing process**
12/18 ED RN EMTALA training	1. Beginning December 2, 2014, we will monitor nursing compliance with EMTALA training requirements on an annual basis and all new nurses will receive EMTALA training prior to providing patient care in the emergency department.	100% of RNs and new hires will have EMTALA training requirement **Ongoing process**

2015 Skilled Nursing Licensing & Interim Life Safety Surveys

Topic	***Quality Indicators***	***Compliance demonstrated/Date Retired***
Dishwasher chlorine level	1. Daily checks for compliance with chlorine level range x 30 days for 100% compliance; then monthly review of logs.	Levels monitored for 30 days. 100% compliant for sanitizer levels. **Ongoing process**
Storage of dry food	1. Biweekly walk through with focus on labeling and dating for 100% compliance. 2. Monthly Food Safety audit completed.	Walk through continues and Monthly Audit completed after meeting 100% compliance. **Ongoing process**
Equipment cleaning	1. Daily M-F rounding to ensure proper cleaning of stethoscopes and scissors and monitoring of equipment cleaning log for 100% compliance for 6 months.	The SNF DON rounds Mon – Fri noting all incidences of improper cleaning. All incidences of improper cleaning will be noted on the "Equipment Cleaning Log" and submitted to QAPI on a quarterly basis. ***This POC will remain in effect until 5/15/2015.***
Fire door obstruction	1. Quarterly safety rounds find no fire door obstructions 100% of the time.	Fire Door obstruction and clear egress path is being monitored during the regular quarterly safety rounds in the Unit. 2016 schedule: Jan, April, July and October. **Ongoing process.**

2015 Complaint Surveys

Topic	*Quality Indicators*	*Compliance demonstrated/Date Retired*
6/17 for a 2012 retained patellar guard	1. 100% of all scrub techs and circulating nurses were educated to the policy entitled" The Count: sponges, sharps and instruments". 2. 100% of all new hires will be educated to this policy.	100% OR Techs and RNs educated to Counts policy **On going**
12/13 HIPAA /web breach delay in reporting	1. 100% of employees take and pass at a score of 80% the annual Health Stream Competency regarding HIPAA Privacy Act 2. Privacy Officer maintains a log of HIPAA violations that originates either from self reporting or by those. 3. All breaches to be reported within 5 days to CDPH	1. 99.74% due to one person incomplete due to long term intermittent leave 2. Paper logs in binders for 2013 located in the HIM department 3. 100% compliance
10/28 Verbal and electronic orders cosigned, dated and times within 30 days	1. HIM to report weekly number of paper verbal/telephone orders prior to 30 days in need of cosigning, dating and timing. Compliance is 100%	Reports show improvement with current orders being signed but some orders have been problematic with physicians reporting not being able to see, working with IT to resolve. Medical records send notices to physicians to complete the orders before the physician is put on suspension.
10/28 retained sponge	1. Documentation audits using the Surgery Safety Checklist; daily by direct observation x 1 week of all cases; random observation of 50% of cases for next two weeks; random observation of 25% of cases for 1 month until 100% has been achieved; then random observation of 10% of cases for continued compliance.	98% overall compliance rate. Will continue to monitor. **On going**
10/28 IUSS	1. Use of IUSS will meet threshold of less than or equal to 5%	Identified instrument sets that frequently undergo IUSS Completed on 7/14/15 Purchased One Tray to increase fluid dissipation capability Purchased on 8/15/2015 **Threshold met. Ongoing process**

10/28 containment of soiled instruments for transport	1. Observation of 5 cases per week until proper usage of new product reaches 100%; then add to weekly rounding.	Initiated on 10/14/15; 100% compliance. **Completed on 12/30/15**
10/15 Pressure Ulcer Care Plan 10/15 Nursing Care Plans	1. 100% of nursing staff educated to policy" Care Plan Preparation" with attestation. 2. Audit 30 charts per month for compliance with Wound Care RN contact and photographing of appropriate patients. Threshold is 95% for 90 days; then 15 a month for 90 days for 95% compliance; then random. 3. Audit 30 charts per month for documentation that shows: Individualized Care Plans a. Discharge Care Plan initiated on admission b. Skin Care Plan initiated when wound are found or when appropriate c. Restraint Care Plans when restraints are used d. Unstable Blood Glucose Care plan initiated when appropriate Threshold is 95% for 90 days; then 15 a month for 90 days for 95% compliance; then random.	1. Attestations are located in Med/Surg for all nurses. 2 & 3. The attached audit results are listed for 100% audit of ICU inpatient records. Because we have not reached our threshold for the initial 90 days – the plan is to continue auditing 100% until we reach 95% compliance for 90 days and then on to 15 charts monthly.

END

Sonoma Valley Hospital

Quality Assessment/Performance Improvement Project Prioritization and Approval Grid

2016-2017

Score of 18 or greater chosen as high risk areas for performance improvement activities for this year

Type of Risk	Indicator or Activity	Rationale	Depts	Problem Pron	PT Safety	Volume	Impact	Internal Resources	External Resources	Total Score	Outcome
				High Prob 5	Hi/Low Risk Score 5 - 1	Hi/Low 5 - 1	Hi/Low Impact 5 - 1	Weak Resources 1 ←→	Strong Resources 5		Approved/tabled/ Not approved
Hi Vol, Hi Risk Risk, & PP	***Sepsis Project***	CALHEN study; CMS core measure; readmissions impact	Nursing, Medical Staff, Lab,Pharmacy, CIT/IT	4	5	3	4	5	0	21	
Leads	**Kobe, Hubbell & Verducci MDs; Dr. Cohen (ES)**										
Hi vol, Hi Risk, & PP	***Iatrogenic Delirium Project***	CALHEN study; will go full houses rather than just ICU	Nursing, Medical Staff, Rehab, Pharmacy, CIT/IT	3	5	3	5	4	0	20	
Leads	**Dunn, Streeter MD.; Lovejoy (ES)**										
Hi Vol, Hi Risk, & PP	***C. difficile Project***	CALHEN study; small project with community education	Nursing, Medical Staff, Lab, Pharmacy, EVS, Nutritional Services CIT/IT	3	5	5	5	4	0	22	
Leads	**Mathews, Sebastian MD; Lovejoy (ES)**										

Hi Risk, & PP	**IP Optimization Project**	Improve patient outcomes by increasing efficiencies.	Financial Services, Nursing, Medical Staff	3	2	3	4	5	0	17	
Leads	**Donaldson, Denton**										
Hi vol, & PP	**New Service: 1206 B Clinic**	Provided needed specialty services to community	Financial Services, IT, EVS, Facilities	3	2	3	4	5	0	17	
Leads	**Donaldson, Jensen**										
Projects	***Carried Over***		***Comments***								
	Population Health: Care Transitions	Lovejoy/Cohen	50% completed								
	Paragon 12.1 & 13 Upgrade	Sendaydiego	Not started								
	Home Care Transforma-tion Project	Lee/Donaldson	pending interface								
	Email Encryption	Sendaydiego/ Seyfert	In process								