**SONOMA VALLEY HEALTH CARE DISTRICT**
**QUALITY COMMITTEE**
**REGULAR MEETING AGENDA**
**Wednesday, February 27, 2013**
**5:00 p.m. Open Session**
**(Closed Session will be held upon adjournment of the Open Session)**

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

| AGENDA ITEM | RECOMMENDATION | |
|---|---|---|
| **MISSION STATEMENT**<br>*The mission of the SVHCD is to maintain, improve, and restore the health of everyone in our community.* | | |
| **1. CALL TO ORDER** | Nevins | |
| **2. PUBLIC COMMENT SECTION**<br>*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.* | Nevins | |
| **3. CONSENT CALENDAR:**<br>A. Prior Meeting Minutes January 23, 2013<br>B. Tracking Report for Uncorrected Items | Nevins | Inform/Action |
| **4. UPDATE ON QUALITY TRAINING FOR THE BOARD AND BOARD COMMITTEES** | Nevins/Hirsch | Inform/Action |
| **5. QUALITY REPORT** | Lovejoy | Inform |
| **6. CLOSING COMMENTS** | Nevins | Inform |
| **7. ADJOURN** | | |
| **8. UPON ADJOURNMENT OF THE REGULAR OPEN SESSION** | Nevins | Inform |
| **9. CLOSED SESSION:**<br>Calif. Health & Safety Code § 32155 – Medical Staff Credentialing & Peer Review Report | Smith/Amara | Inform/Action |
| **10. REPORT OF CLOSED SESSION** | Nevins | Inform |

# 3.A.

# MINUTES
# 01.23.13

**SONOMA VALLEY HEALTH CARE DISTRICT**
**QUALITY COMMITTEE**
**REGULAR MEETING MINUTES**
**Wednesday, January 23, 2013**
**Schantz Conference Room**

| Committee Members Present | Committee Members Absent | Community Members Present | Administrative Staff Present |
|---|---|---|---|
| Sharon Nevins, Chair<br>Dr. Jerome Smith<br>Dr. Paul Amara<br>Jane Hirsch<br>Dr. Howard Eisenstark<br>John Perez | Bob Burkhart<br>Brenda Epperly<br>Joel Hoffman<br>Maida Herbst | None | Dr. Robert Cohen, Chief Medical Officer<br>Leslie Lovejoy, Chief Quality & Nursing Officer<br>Mark Kobe, Director of Nursing |

| AGENDA ITEM | DISCUSSION | CONCLUSIONS/ ACTION | FOLLOW-UP/ RESPONSIBLE PARTY |
|---|---|---|---|
| **MISSION AND VISION STATEMENTS** | *The mission of the SVHCD is to maintain, improve, and restore the health of everyone in our community.*<br><br>*The vision of the SVHCD is that:*<br>*SVH will be a nationally recognized, compassionate place of healing and known for excellence in clinical quality. We serve as the guide and indispensable link for our community's health care journey.* | | |
| **1. CALL TO ORDER** | 5:00 p.m. | | |
| **2. PUBLIC COMMENT**<br>*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.* | There was no public comment. | | |
| **3. CONSENT CALENDAR:**<br>A. Tracking Report for Uncorrected Items | | **MOTION:** by Hirsch; second by Eisenstark, to approve the Consent Calendar and carried. All in favor; none opposed. | |

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| AGENDA ITEM | DISCUSSION | CONCLUSIONS/ ACTION | FOLLOW-UP/ RESPONSIBLE PARTY |
|---|---|---|---|
| **4. CREDENTIALING/PRIVILEGES PROCESS AND QUALITY COMMITTEE CHARTER PROCESS & WORDING** | *Dr. Jerome Smith*<br>*Sharon Nevins, Chair* | | |
| | The new Medical Staff Coordinator will start on February 12, 2013. | All in favor, none opposed. | |
| **5. UPDATE ON QUALITY TRAINING FOR THE BOARD AND BOARD COMMITTEES** | *Sharon Nevins, Chair*<br>*Jane Hirsch* | | |
| | Ms. Nevins presented Dr. Howard Eisentark as a new community board member. Ms. Hirsch confirmed that the Director of Quality and Safety at UCSF will be attending the Quality education meeting on April 24, 2013, 5-8 p.m. Dr. Amara suggested inviting the Medical Executive Committee to that session as well. | All in favor; none opposed. | |
| **6. QUALITY REPORT** | *Leslie Lovejoy* | | |
| | Ms. Lovejoy reviewed January priorities, one of which was to hire a qualified candidate for the Medical Staff Coordinator position. She was also interviewing for a Clinical Informatics Trainer. This position will provide ongoing electronic health record training for physicians, patient care staff and ancillary departments. | | |
| **7. STUDER GROUP REPORT** | *Mark Kobe* | | |
| | Mr. Kobe presented the Studer Group report with a very informative presentation. He explained the AIDET process to the Committee and also reviewed the patient satisfaction results for different departments for 2012. All of the information, numbers and graphs had been created, totaled and provided by Press Ganey. The department with the lowest percentile in satisfaction was ACU. Mr. Kobe stated that Michelle Donaldson, the Director of Surgical Services, was in the process of sorting out the issues with that department. | | |
| **8. QUALITY INDICATORS AND DASHBOARD** | *Leslie Lovejoy* | | |
| | Committee members discussed the format and data presentation. Dr. Cohen suggested readdressing Item C when more complete and accurate data is available and deleting this item until then. Dr. Amara suggested adding C-section rates to the surgical data. Changes in format were discussed, and it was decided that Ms. Nevins and Ms. Lovejoy would work on this and bring it back with first quarter data in May. | | Lovejoy, Dr. Smith and Dr. Cohen to improve Item C data. Nevins and Lovejoy to work on format. |
| **9. CLOSING COMMENTS** | *Sharon Nevins, Chair* | | |
| | | | |

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| AGENDA ITEM | DISCUSSION | CONCLUSIONS/ ACTION | FOLLOW-UP/ RESPONSIBLE PARTY |
|---|---|---|---|
| **10. ADJOURN** | *6:26 p.m.* | | |
| **11. UPON ADJOURNMENT OF THE REGULAR OPEN SESSION** | *Sharon Nevins, Chair* | | |
| | There was no comment. | | |
| **12. REPORT OF CLOSED SESSION** | *Sharon Nevins, Chair* | The Credentialing Report was approved to forward to the Board. | |

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# 3.B.

# TRACKING REPORT

| **Quality Committee** | | | | | 27-Feb-13 |
|---|---|---|---|---|---|
| Outstanding Items Log | | | | | |
| | | | | | |
| **Item# & Topic** | **Discussion** | **Follow-up** | **Date Due** | **Complete** | Update/Comments |
| | | | | | |
| 072512-1 Occupational Health & HR | CDPH returned a directed plan of action | Monthly report on progress in Quality Report until completed. | 8/22/12 | | Work in progress; pending completion certificate |

# 5.

# QUALITY REPORT

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

T0: Sonoma Valley Hospital Care District Board Quality Committee
FROM: Leslie Lovejoy, Director, Quality and Resource Management
DATE: 2/21/2013
SUBJECT: Quality Report

February Priorities

1. Regulatory Compliance
2. Medical Staff
3. Infection Control oversight at Palm Drive Hospital/ Surgery Director
4. Board Quality Dashboard Update

1. We received final approval of the Pharmacy MERP program from Dr. Christensen regarding at the beginning of this month. CDPH is requesting a detailed plan for the move into the new building. I have met with Kevin coss and we have an overall structure and plan for the move in terms of responsible person and project activities. We will set an introductory meeting the first of March and develop timelines. We were also notified of a patient complaint through the Joint Commission regarding care in the Skilled Nursing Facility. Although TJC does not accredit our SNF, Melissa Evans did an investigation and provided a response which was accepted. I have attached the complaint and response.

2. Nancy Iredale, our New Medical Staff Coordinator began work on the 12th. She brings approximately 10 years to medical staff office experience to our facility. She is going through her orientation to the job and is learning our processes quickly. She will be great as her degree of comfort improves. Cathe Gagon, RN joined the Quality Department as our new Clinical Informatics Trainer and is currently immersing herself in our electronic health record. She will assume responsibility for communicating, educating and writing all things related to the electronic health record for all staff, physicians and departments.

3. With the resignation of Michelle Donaldson, an opportunity was created to share a Surgery director with Palm Drive Hospital as well as develop Infection control oversight for Palm Drive as well. Pam Reed, the Surgery director is also responsible for Infection control at palm Drive and needs to hand it over as she assumes the role of Director for both hospitals. Courtney McMahon has indicated a wish to increase her hours and will be taking a leadership role in Infection Control at Palm Drive.

4. Sharon and I met to discuss the format and content of the Quality Dashboard for the Board. I will bring the first quarter data in the new format to the May meeting.

5. Topic for Discussion: No report this month. Originally, we were to have out Quality Education this month but that has been scheduled in April.

The Joint Commission Connect™

## Organization response to a complaint

**Incident Number:** 175262
**Incident Date:** 10/31/2012
**Programs:** OME

### Complaint Summary

My father Charles Martin Gavette was a patient at Sonoma Valley Hospital from October 22 to October 26 and at the Sonoma Valley Skilled Nursing Facility from October 26 until his death November 1. I was disappointed at the generally poor level of nursing care in both facilities as well as the medical care at the SNF. This report is in regard to the Sonoma Valley Skilled Nursing Facility (a report on Sonoma Valley Hospital is also being submitted). Dad was admitted to the SNF on the afternoon of October 26 after 4 days in the acute care setting with a diagnosis of community acquired pneumonia and acute renal failure due to obstruction (enlarged prostrate) and metabolic encephalopathy from the renal failure. After four days his pneumonia was resolving, breathing easy, renal failure resolved, and his mentation was clearing well. His hospitalists in the acute setting gave prognoses of Fair rehabilitation potential and "cautious optimism of return to pre-hospital function." His treatment in the SNF led to his death within 5 days. My complaints against this facility are: 1. Given the prognoses from the hospitalists, our understanding was that his admission to the SNF was for recovery/rehabilitation and return home in a functioning state. No one in the SNF met with us to discuss any other course of care so we continued in our belief. I have since learned that the medical director of the facility (who was also my father's primary care physician), Dr. Clinton Lane, spoke to my memory-impaired elderly mother and my non-medical brother 2 days after my father's admission. There was no discussion or questioning of my father's or our wishes, goals, desires for the outcome. He stated very quickly that it was "end of life" care and departed. My mother did not comprehend the statement and my brother was too stunned to question Dr. Lane. When this information was relayed to the rest of the family we did not understand the consequences of the statement. We continued to believe that dad was being treated for recovery. Additionally, there was one meeting after 4 days in the facility with the social worker and palliative care nurse. There was no mention of end of life care or anything other than the goal of getting dad home. We left that meeting still believing that dad was being treated for recovery. We said our goal was to get him home, I now believe they interpreted this as "get him home to die at home." There was never any attempt at clarification My complaint here is the total lack of communication on dad's condition and his treatment goals even after a meeting with the ancillary staff. Additionally, the lack of communication of the MD contributed directly to dad's death as instead of being treated for recovery he was treated for end of life with the reduction of IV hydration and continuation of IV diuretics. Perhaps we needed to strongly pursue the staff/doctor to gather information but we didn't know how to proceed and were of the opinion that dad was still being treated. 2. On Wednesday, October 31, I walked into Dad's room at 3:30 pm. The door to room 107 was ¾ closed as it was still broken (it would not stay open on its own, it needed to be propped open with a chair or held open with a gauze loop attached around the door handle and to a hook in the closet). So the door was almost closed. The curtain was pulled around Dad so that even if the door was open he was not visible. I do not remember if a call light was accessible but even if it was Dad was not in any condition to use it. He in a wheelchair and so obviously exhausted he could not call out for help. I said hello and all he could manage was a soft exhalation with mumbled words. His head was tipped back with his chin tilted towards the ceiling as if he couldn't hold it in a normal position any longer. He was gurgling his secretions as he was now too weak to cough effectively. His feet and lower legs were like blocks of ice and he had only one thin blanket on his lap. (There is much that lead up to this earlier in the day that I would like to relate but space prevents it here). All one had to do was to look at him to see how exhausted he was. I went to the nurses station asking to have him put back in bed and was told the aide was processing an admission and would be with us soon. Forty minutes later someone finally came. My sister informed me dad had been put up in the wheelchair at 10:30 that morning after vigorous physical therapy. She left with my mother at 12:30 after wrapping him in several warm blankets as he was complaining of being cold. That means he was in the chair for over 6 hours. I do not know if someone checked on him or not. If they did they have no observation skills as one look was all that was needed for anyone to determine he needed to get back in bed. My complaint is

that there should have been a system used to ensure he was back in bed after a couple hours at the most, someone with observation skills should have intervened and gotten him back in bed. But most importantly my father was incapable of calling for help yet he was left behind a closed curtain and a closed door. He should have been visible at all times. It seems like this was a case of "out of sight out of mind." 3. Wednesday night after getting Dad back into bed it was very obvious that he had taken a turn for the worse. This was after he had shown progressive improvement. He was no longer able to cough up secretions and spit them into a tissue as he had been able to do. He was too tired to interact with us. He was freezing. We asked for a doctor to come look at him. Dr. Land was called but refused to come. The nurse relayed he would come in for a family meeting at noon the next day. Grabbing for anything, we asked for a chest X-ray thinking perhaps the pneumonia was coming back full force. Dr. Lane refused. We pressed to have the nursing supervisor called or the ER doctor. We contemplated having a private ambulance come take him and drive around the building to the ER entrance. Finally Dr. Lane agreed to a chest X-ray (our thinking was that if the pneumonia was coming back let's start treatment right now as he had been responding so well, also, if the pneumonia was back and showed to be overwhelming then we would be ready to pull back). Lane agreed to the chest x-ray but said he would be in to read it the next day. This made no sense to us as if it showed the pneumonia rearing up we wanted treatment stared now, not in 15 hours. Finally, after having the nurse make more phone calls we had the ER physician agreeing to getting a chest x-ray, reading it, and starting treatment if warranted. The x-ray was taken at 9 pm after 3 hours of trying to get someone to look at dad. By midnight, after begging the nurse for more phone calls, it still had not been read. We finally realized that they had no intention of helping us. It makes sense now that they saw him as end of life care while we thought he was still being treated. I'm sure we just seemed like a family that couldn't come to grips with the inevitable. My complaint is that no one would come look and evaluate my father, not his primary care doctor/SNF director, nursing supervisor, ER personnel and no one told us why. 4. After getting dad back in bed that Wednesday afternoon the nurse came into the room and noted dad's labored breathing. Since he was mouth breathing she removed the nasal cannula and placed a face mask on him. She then turned the oxygen up to 5 liters / minute. I had to remind her that dad had COPD and his oxygen should not be above 2 liters / minute. She agreed and turned it down. My complaint is that she had been dad's nurse all day and should have known his diagnoses. She also should have known that too high an oxygen level in a person with COPD can suppress the respiratory drive. I am concerned she is a danger to her patients as she certainly was a danger to my father. 5. This is a general observation on the SNF. On Wednesday afternoon, October 31, when I saw how bad Dad was looking and went to the nurses station to ask to get him back into bed I noticed there was a man at the nurses station dressed in a padres brown robes. I thought to myself, "this is good, there is someone who may be able to comfort my mother when she comes back this evening and sees how poorly dad is doing." I was completely taken aback when my sister told him how nice it was to have him here for comfort and he replied he only worked here for the paycheck. It was Halloween and he was in costume. Incredibly unprofessional and hurtful and we were watching our father deteriorate. Another staff member was in a baseball uniform and the feeling we got was that they had been watching the SF Giants World Series victory parade all day and we wondered how much care the patients really got. Obviously, my father got very little. Charleen Gavette

**Comments and Analysis**

The investigation of the complaint was completed on 1/17/2013. My findings were as follows: •The above patients was admitted to the Skilled Nursing Facility on 10/26/2012 and expired on 11/1/2012. •The patient met with both Hospice Nurses as well as the Palliative Care Nurse on several occasions. The patient was to be discharged to the care of Hospice on 10/31/2012. •Extensive meetings were held with the SNF Case Manager and the Palliative Care RN prior to his death. The family was involved in these meetings throughout. •The PCP, Dr. Clinton Lane had seen the patient twice in a 5 day period on the SNF. He met with the family and documented their wish to feed the patient. (even though he was assessed by Speech Therapy as having aspirated food and fluids.) •There were 5 Chest X-rays done within a one week period. The Chest X Rays identified CHF, COPD, Rib Fracture (prior to admission from a fall at home), and pleural effusions. This patient's admitting diagnosis was Community acquired Pneumonia. He was treated with IV antibiotics. He had no elevation in WBC's or fever throughout his stay on the SNF. The Chest X Rays were read by the Night Hawk Service after hours. The acute care Hospitalist covered for Dr. Lane after hours per our policy. •The patient was not safe to feed he was assessed to be at a very high aspiration risk. •The patient was NPO but receiving fluids by mouth from the family (per their wish). The Nursing Staff and therapy staff maintained this patient's NPO status. It is well documented that the family was advised by the physician and Speech Therapy of the risk of feeding this patient. •This patient had a Foley catheter placed for Obstructive Uropathy on the

acute unit. His catheter was draining and his kidney functions returned to their baseline. •The Catholic Priest had been on the unit three times in 5 days to give Last Rights, Prayers for the Sick, and Anointing. The Catholic Priest also came to visit family and bless the patient's body after his death on 11/1/2012. •The patient was not a CO2 retainer and had normal CO2 Levels throughout the ER, Acute, and SNF admissions(s). •The Patient was in line of sight of the Nurses station and was visible at all times. He was never left alone behind a closed door. •The Family Refused Physical Therapy after the first session stating that it made him too tired. They also refused to have him up in a chair. •The patient had a stage 2 Pressure ulcer that was well documented. The patient also had an alternating pressure – relief mattress and an additional Accu Max pump on the bed. The patient had very poor nutrition and the family refused turning. Feeding tubes were declined by the family. •The family (daughter) refused discharge with Hospice on 10/31. All equipment had been ordered. The daughter felt that his death at home would be too hard on her mother who suffers from Dementia. •We kept the patient on the SNF as his death was inevitable. •2 RN's were indeed dressed in Halloween costumes. 1 was a Padre and 1 was a baseball player. We have changed our policy and no longer allow Halloween costumes on the SNF. California Department of Public Health Licensing investigated this matter on 1/17/2013. There were no findings of harm or neglect.

**Conclusions**

After the review above, it was felt by the team inolved that the care met and exceeded standards. This was reinforced by the thorough investigation by the State.

**Follow-Up Actions**

Stop the habit of ccostumes for the staff. Educate the team on the pateint complaint and discuss any process issues that they may identify and follow-up. Follow-up with the complainant and provide support and an opportunity to share her story.

**Date Printed:** Wednesday, January 23, 2013

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