SVHCD QUALITY COMMITTEE

AGENDA

WEDNESDAY, FEBRUARY 26, 2025

5:00 pm Regular Session

Held in Person:

SVH Administrative Conference Room

To Participate Via Zoom Videoconferencing, use the link below:
https://sonomavalleyhospital-org.zoom.us/j/99901004530?from=addon

Meeting ID: 999 0100 4530

One tap mobile
+16699009128,,99901004530# US
+12133388477,,99901004530# US

AGENDA ITEM	RECOMMENDATION	
In compliance with the Americans with Disabilities Act, if you require special accommodations to attend a District meeting, please contact the Board Clerk, Whitney Reese, at wreese@sonomavalleyhospital.org, at least 48 hours prior to the meeting.		
MISSION STATEMENT *The mission of the SVHCD is to maintain, improve, and restore the health of everyone in our community.*		
1. CALL TO ORDER/ANNOUNCEMENTS	*Daniel Kittleson, DDS*	
2. PUBLIC COMMENT SECTION *At this time, members of the public may comment on any item not appearing on the agenda. It is recommended that you keep your comments to three minutes or less. Under State Law, matters presented under this item cannot be discussed or acted upon by the Committee at this time. For items appearing on the agenda, the public will be invited to make comments at the time the item comes up for Committee consideration.*	*Daniel Kittleson, DDS*	
3. CONSENT CALENDAR • Minutes 01.22.25	*Daniel Kittleson, DDS*	Action
4. SURGICAL SERVICES QA/PI	*Kelli Cornell, RN*	Inform
5. QUALITY INDICATOR PERFORMANCE & PLAN	*Jessica Winkler, DNP, RN, NEA-BC, CCRN*	Inform
6. POLICIES AND PROCEDURES	*Jessica Winkler, DNP, RN, NEA-BC, CCRN*	Inform
7. CLOSED SESSION: a. Calif. Health & Safety Code §32155: Medical Staff Credentialing & Peer Review Report	*Daniel Kittleson, DDS*	Action
8. ADJOURN	*Daniel Kittleson, DDS*	

SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
Wednesday, January 22, 2025, 5:00 PM
MINUTES
Via Zoom Teleconference

Members Present	Excused/Not Present	Public/Staff – Via Zoom
Daniel Kittleson, DDS Wendy Lee Myatt Carl Speizer, MD Howard Eisenstark, MD Michael Mainardi, MD Carol Snyder Susan Kornblatt Idell Paul Amara, MD, FACOG, via zoom	Kathy Beebe, RN PhD	Jessica Winkler, DNP, RN, NEA-BC, CCRN-K, CNO Whitney Reese, Board Clerk John Hennelly, CEO Marylou Ehret, MSN, RN OCN Leslie Petersen, ED SVH Foundation

AGENDA ITEM	DISCUSSION	ACTION
1. CALL TO ORDER/ANNOUNCEMENTS	*Daniel Kittleson, DDS*	
	Kittleson called meeting to order at 5:01pm.	
2. PUBLIC COMMENT SECTION	*Daniel Kittleson, DDS*	
	No public comments	
3. CONSENT CALENDAR Minutes 10.23.24	*Daniel Kittleson, DDS*	ACTION
	Motion to approve by Eisenstark, 2nd by Lee Myatt. All in favor.	
4. EMERGENCY DEPARTMENT REPORT	*Marylou Ehret, MSN, RN OCN* *Jessica Winkler, DNP, RN, NEA-BC, CCRN-K, SVH CNO*	INFORM
Winkler and Ehret covered various aspects of the Emergency Department operations, including patient survey data, staffing changes, and quality improvement efforts. There was a focus on wait times, patient perceptions, and the correlation between ER staffing adjustments and improved patient flow. Concerns about ambulance offload times were addressed, highlighting Sonoma Valley Hospital's efficiency compared		

to county benchmarks, but also acknowledging ongoing challenges in transferring patients to higher-level care facilities due to ambulance availability and logistical constraints. Additionally, a collaboration with Sonoma Fire Department was discussed, detailing recent training exercises involving mock emergency scenarios, including precipitous births, to enhance staff preparedness. The conversation underscored the complexities of ED operations and the continuous efforts to improve efficiency, patient satisfaction, and emergency response protocols.		
5. LEAPFROG SURVEY EXAMINATION	*Jessica Winkler, DNP, RN, NEA-BC, CCRN-K, SVH CNO*	INFORM
Winkler presented details regarding the latest Leapfrog Survey rating, which SVH had not participated in but were still ranked and had a reduced grade from previous years. It was noted that Leapfrog relies on self-reported data rather than independent audits, raising concerns about the accuracy and fairness of its ratings. Second, participation requires a financial commitment ("pay to play"), which may not provide a clear return on investment. Third, even with high scores, it is unclear whether Leapfrog ratings significantly impact patient choice or hospital reputation. Instead, the leadership team considered alternative ways to showcase quality, such as improving transparency on the hospital's website and sharing meaningful, digestible performance metrics directly with the community. Comparisons were made with other hospitals in the region, examining factors like size, services offered, and accreditation. Concerns were raised about public perception and the need for a strategic response, including a possible letter to the editor, an FAQ on the hospital website, and increased transparency in quality data reporting. Suggestions included simplifying data for public consumption, regularly updating the website with key metrics, and providing context before linking to third-party ratings. It was emphasized that patient satisfaction and word-of-mouth remain the strongest indicators of quality, and efforts should focus on communicating the hospital's strengths clearly and proactively.		
6. QUALITY INDICATOR PERFORMANCE & PLAN	*Jessica Winkler, DNP, RN, NEA-BC, CCRN-K, SVH CNO*	INFORM
Winkler presented the December review showing strong performance in mortality, infection prevention, and readmission rates, with no PSI 90 events. Stroke care met benchmarks except for two delayed TNK administrations. ER throughput was within CMS limits, and colonoscopy numbers declined but are expected to recover. Sepsis care met standards, and patient satisfaction remained high. Medication barcode scanning in the ER fell below target but did not impact accuracy. Nursing turnover was low, and efforts continue to minimize staffing-related patient transfers.		
7. POLICIES AND PROCEDURES	*Jessica Winkler, DNP, RN, NEA-BC, CCRN-K, SVH CNO*	INFORM
	No policy and procedure changes	
8. CLOSED SESSION: a. Calif. Health & Safety Code §32155: Medical Staff Credentialing & Peer Review Report	*Daniel Kittleson, DDS*	ACTION
	Motion to recommend to Board of Directors for approval by Speizer, 2nd by Eisenstark. All in favor.	
9. ADJOURN	*Daniel Kittleson, DDS*	
	Meeting adjourned at 6:20 pm	

PERIOPERATIVE SERVICES BOARD QUALITY REPORT FEBRUARY 2025

Director of Perioperative Services
Kelli Cornell, RN

PERIOPERATIVE SERVICES DEPARTMENT

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

43 FTEs

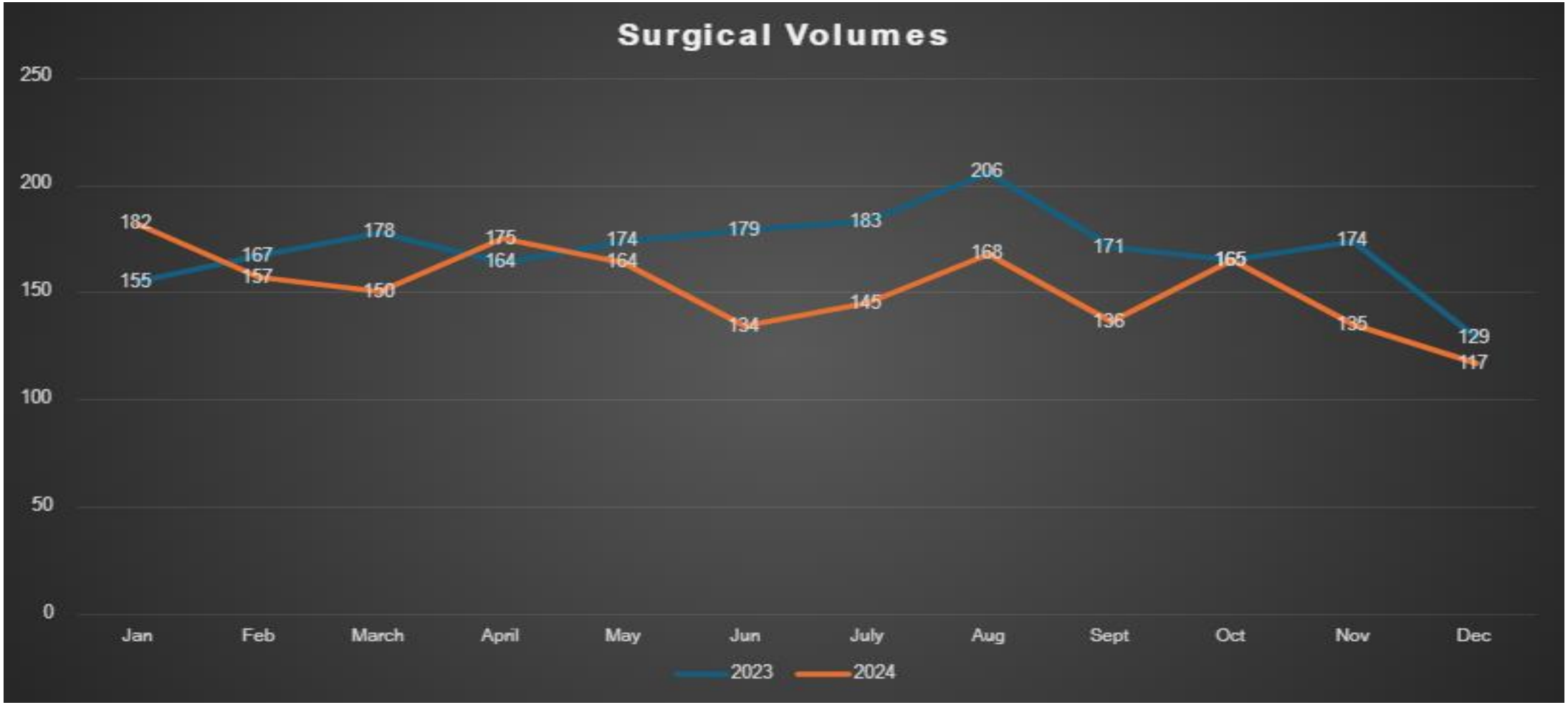
2024 REVIEW

- Feb: Dr. Brown performed his last case, (350 cases per year)
- August: Dr. Walter performed his first case (68 cases in 2024)
- August/September: Hired coordinator/charge nurses to oversee the day-to-day operations of the ACU and OR units.
- October: Dr. Kidd performed her last case. (243 cases in 2024)
- December: fully staffed 43 FTEs

SURGICAL VOLUME 2024

- Total Procedures Preformed in 2024: 1,828
- Compared to 2023: 2,048
- This is *only* 217 less.

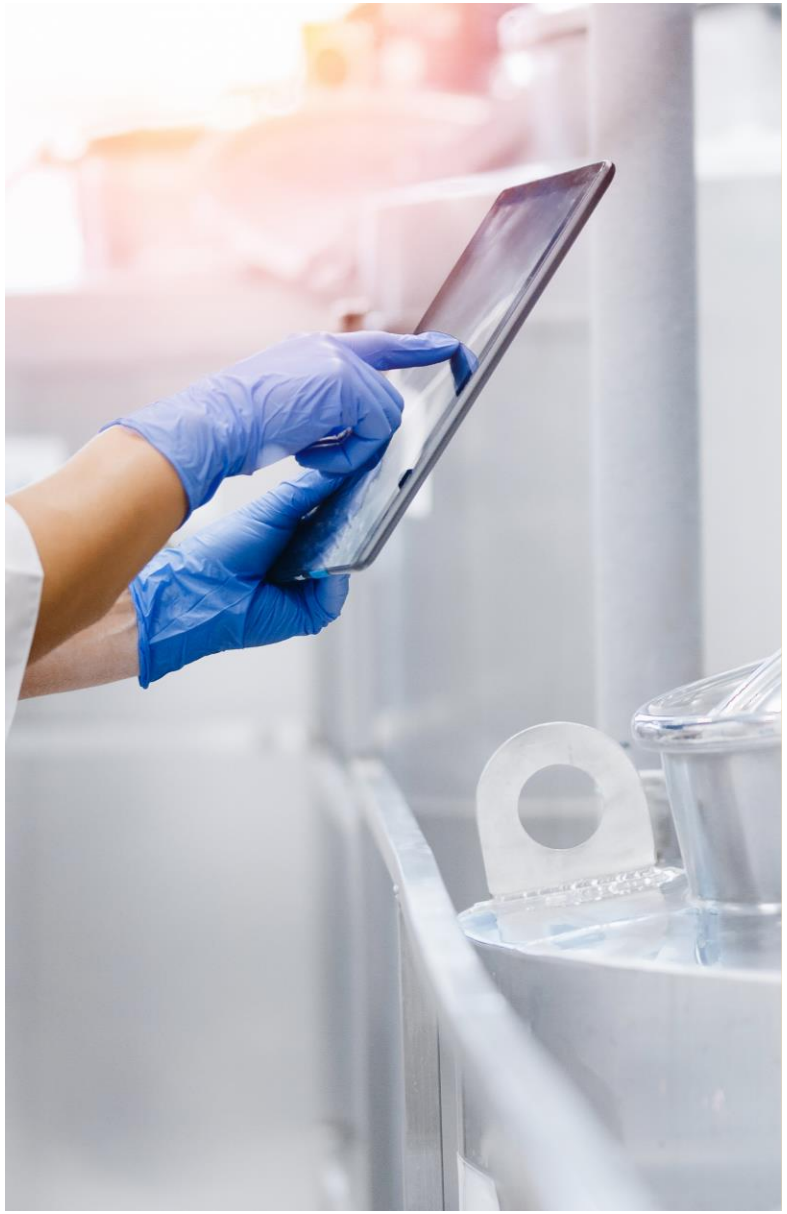
Volumes 2023 vs 2024

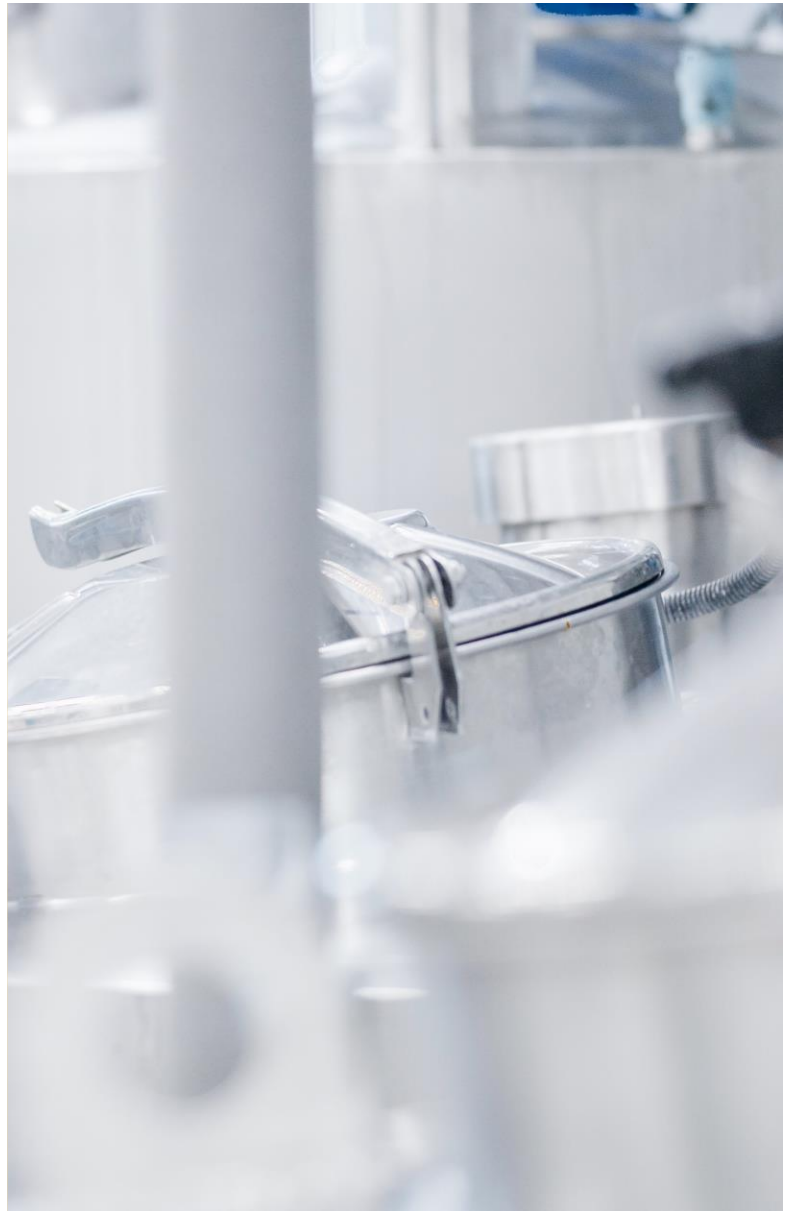


Quality

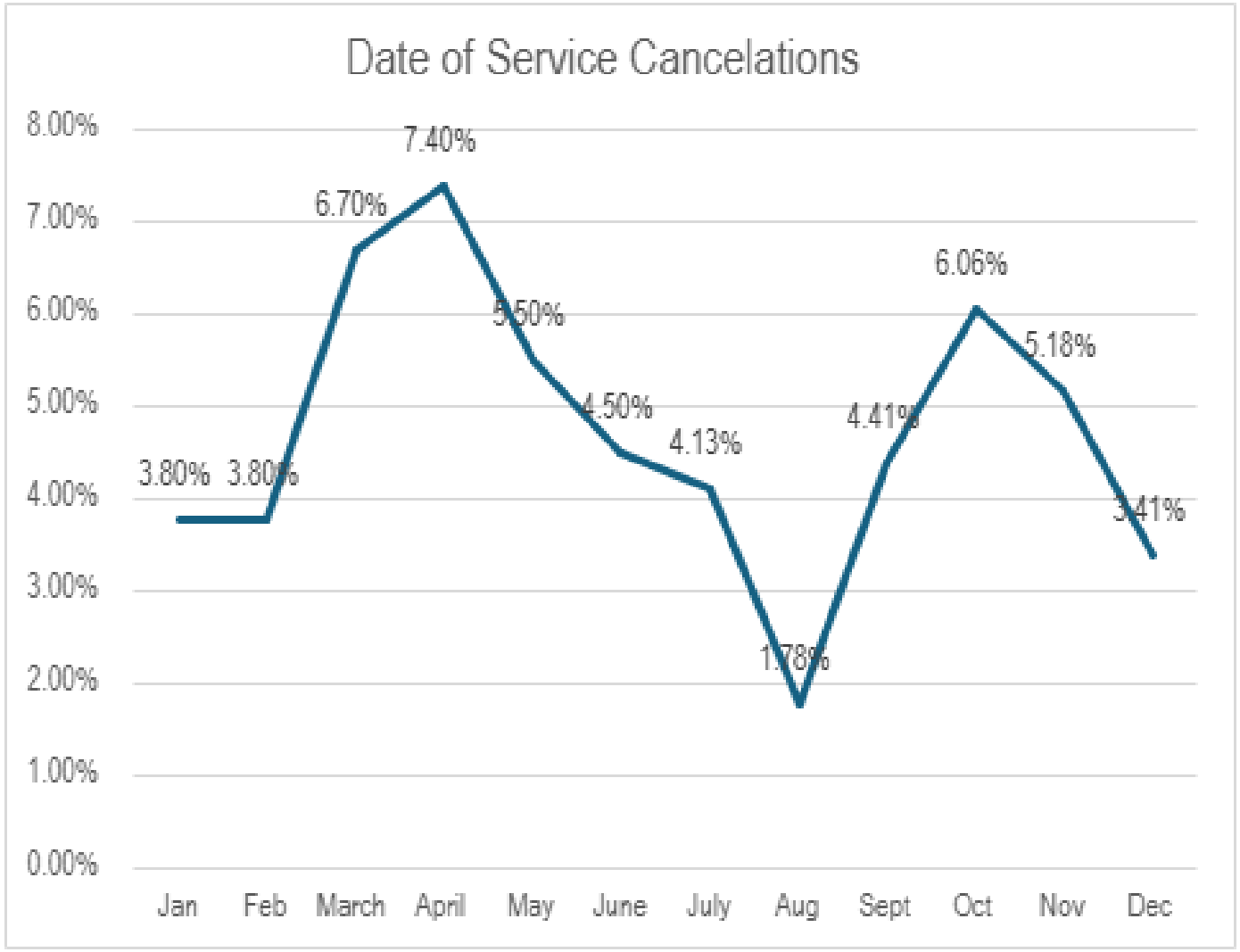
Metrics Tracked in 2024:

- Same day cancelations
- Turnover times
- On time starts

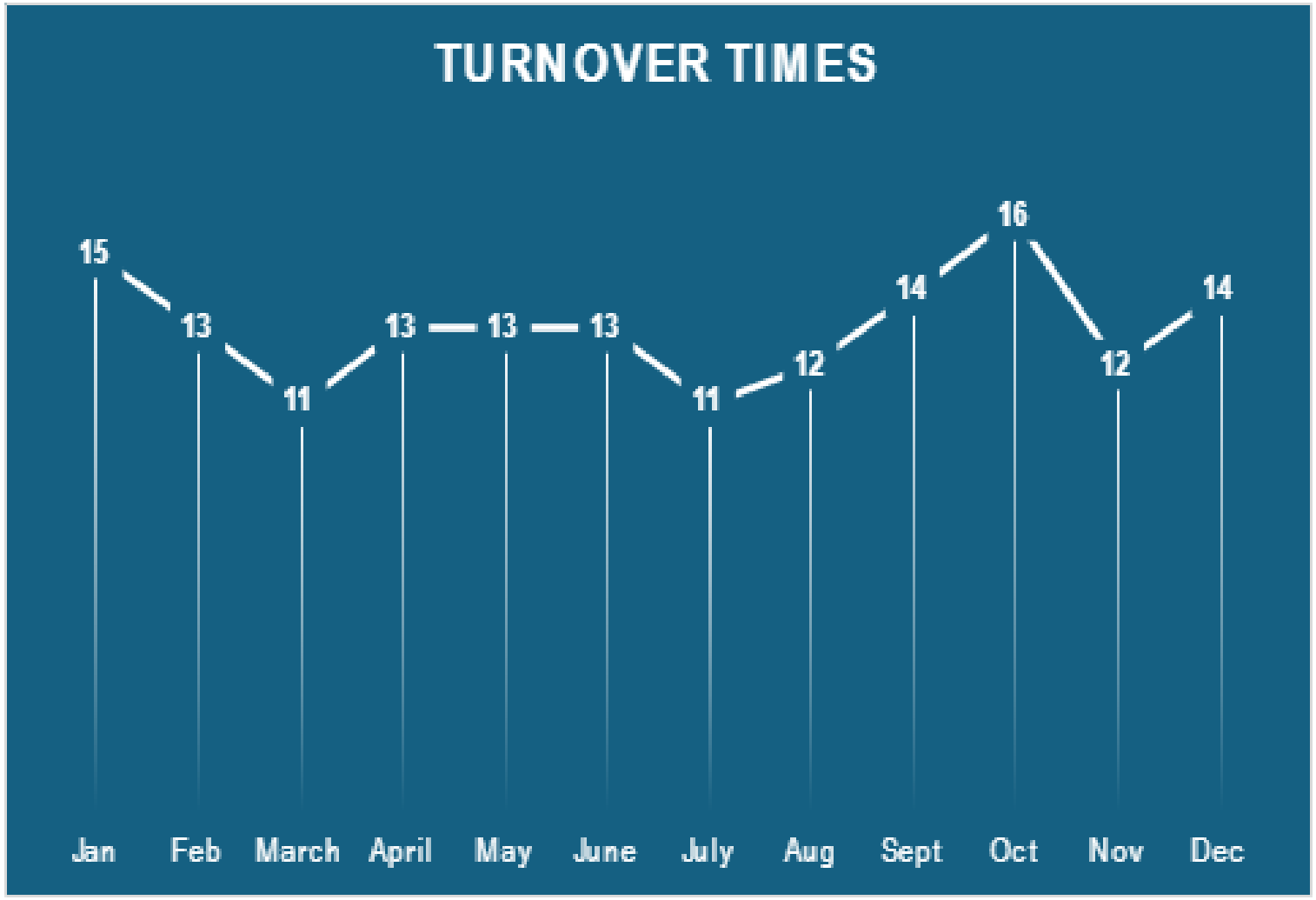




QUALITY METRICS 2024



QUALITY METRICS



National benchmarks 20 to 45 minutes
Median turnover time of 28.5 minutes,
95th percentile achieving 21.4 minutes.

At SVH our monthly average turnover times range between 11-16 minutes.

QUALITY METRICS

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

WHAT'S NEW & WHAT'S NEXT

WHAT'S NEW?

- Dr. Walter: Started 8/2024, has preformed 100 cases
- New Plastic surgeon on the horizon, Dr. Ordon
- New general surgeon Dr. Bir

ROSA ORTHOPEDIC ROBOT

- Total Knee Replacements
- Total Hip Replacements
- 3D anatomical models based on X-rays
- Precision
- Accuracy
- Enhanced recovery

ROSA

- Go live was 1/27/25
- Total Knee and Total Hip replacements
- 5 Successful Robotic Total Joints replaced in 1st month


ROSA
ROSA
ROSA


ROSA
Next
ROSA

What's next:

Quality Tracking

Sterile Processing

IUSS Cycle Tracking

Endoscope repairs

Operating Room

Timeout compliance

In-Brief compliance

Continue 2024 metrics

Post -op

SCD usage post op

Post-op pain

2025 A YEAR OF GROWTH!

- At least 2 new surgeons coming soon
- New plastic surgery and ENT service lines
- Robotics program

Quality Indicator Performance & Plan

Board Quality Presentation for February 2025

Data For January 2025

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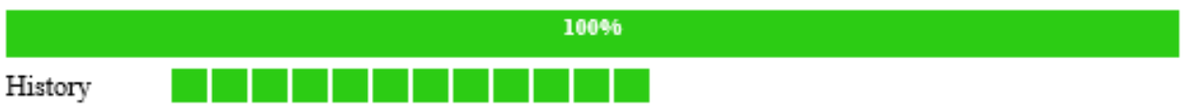
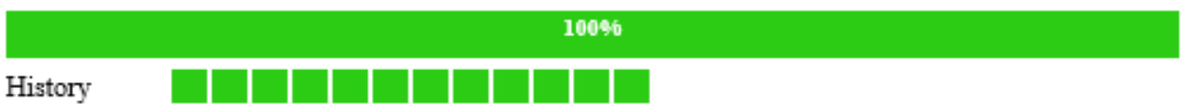
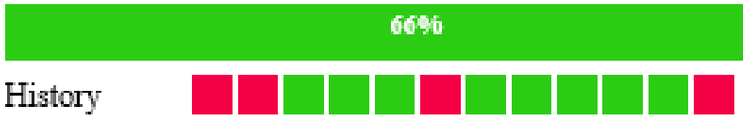
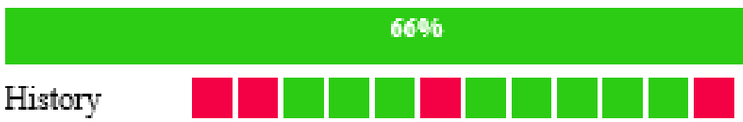
Mortality

Indicator	Performance	Most Recent	Trend	Period	
Acute Care Mortality Rate (M)					
	Breaches Alarm	7.2% 6/83	Deteriorated	Jan 2025	5.0%
COPD Mortality Rate |M|					
	Target Met	0.0% 0/4	No Change	Jan 2025	8.5%
Congestive Heart Failure Mortality Rate |M|					
	Target Met	0.0% 0/2	No Change	Jan 2025	11.5%
Pneumonia Mortality Rate |M|					
	Target Met	0.0% 0/14	Improved	Jan 2025	15.6%
Ischemic Stroke Mortality Rate |M|					
	Target Met	0.0% 0/1	No Change	Jan 2025	13.8%
Hemorrhagic Stroke - Mortality Rate (M)					
	Target Undefined	n/a		Jan 2025	0.0%
Sepsis, Severe - Mortality Rate (M)					
	Breaches Alarm	25.0% 1/4	Deteriorated	Jan 2025	25.0%
Septic Shock - Mortality Rate (M)					
	Breaches Alarm	42.9% 3/7	Deteriorated	Jan 2025	25.0%

AHRQ Patient Safety Indicators

Indicator	Performance	Most Recent	Trend	Period	
PSI 90 (v2023-1) Midas Patient Safety Indicators Composite, ACA (M)					
	 Breaches Alarm	0.01 1/82	Deteriorated	Jan 2025	0.00
PSI 90 (v2023-1) Patient Safety Indicators Composite, ACA - Numerator Volume (M)					
	 Breaches Alarm	1	Deteriorated	Jan 2025	0

- *One PSI 90 event in January*
  - *Post-op complications: complicated emergent ortho pt developed a pulmonary emboli post-op*
  - *CMS Patient Safety & Adverse Events Composite is a summary of varying patient safety events across multiple indicators, monitors performance over time, and facilitates comparative reporting and quality improvement. (https://www.cms.gov/priorities/innovation/files/fact-sheet/bpciadvanced-fs-psi90.pdf)*

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Adverse Events Reporting

Indicator	Performance	Most Recent	Trend	Period	⊙
Adverse Event | SE (M) volume					
100% History	Target Met	0	— No Change	Jan 2025	0

- *No adverse events*

(Severe/Sentinel events; Not PSI 90 events)

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Patient Falls

Indicator	Performance	Most Recent	Trend	Period	⊙
RM ACUTE FALL- All (M) per 1000 patient days					
	Target Met	3.17 1/315	Improved	Jan 2025	3.75
RM ACUTE FALL- WITH INJURY (M) per 1000 patient days					
	Target Met	0.00 0/315	Improved	Jan 2025	3.75

- *Fall rates below target.*

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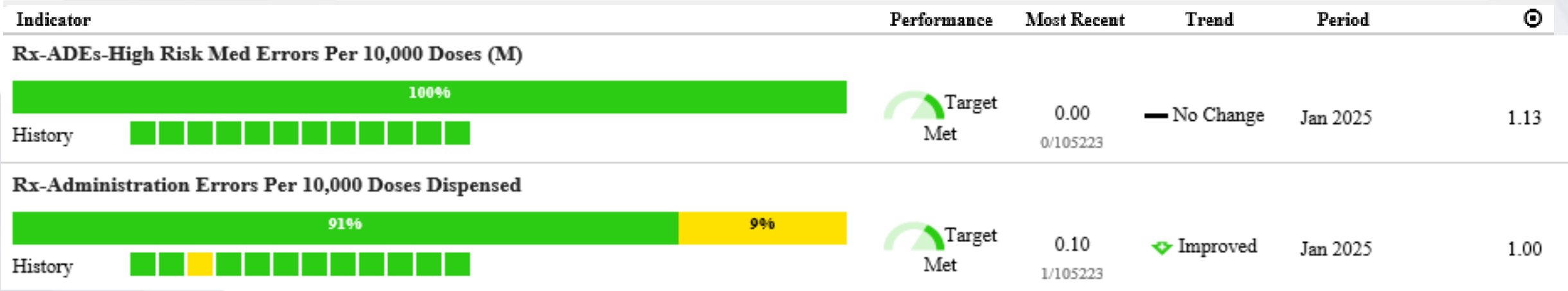
Significant Medication Errors:
High Risk Meds and Administration Errors



Indicator	Performance	Most Recent	Trend	Period	
Rx-ADEs-High Risk Med Errors Per 10,000 Doses (M)					
100% — History	Target Met	0.00 0/105223	No Change	Jan 2025	1.13
Rx-Administration Errors Per 10,000 Doses Dispensed					
91% / 9% — History	Target Met	0.10 1/105223	Improved	Jan 2025	1.00

- *No High Risk Medication Errors*
- *Administration Error Rate below target*

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Infection Prevention

Indicator	Performance	Most Recent	Trend	Period	⊙
IC-Surveillance| HAI-C.DIFF Inpatient infections per 10k pt days |M|					
75% 17% 8%	Target Undefined	n/a		Jan 2025	1.000
History					
IC-Surveillance| HAI-CAUTI Inpatient infections per 10k patient days |M|					
91% 9%	Target Met	0	— No Change	Jan 2025	1
History					
IC-Surveillance| HAI-CLABSI Inpatient infections per 10k patient days |M|					
100%	Target Met	0	— No Change	Jan 2025	1
History					
IC-Surveillance| HAI-MRSA Inpatient infections per 10k patient days |M|					
100%	Target Met	0	— No Change	Jan 2025	1
History					
IC-Surveillance| HAI-SSI infections per 10k pt days |M|					
100%	Target Met	0	— No Change	Jan 2025	1
History					
QA-02 | Hand Hygiene Practices Monitored |M|					
91% 9%	Target Met	98% 49/50	Improved	Jan 2025	90%
History					

- *No HAI , hand hygiene at target goal*

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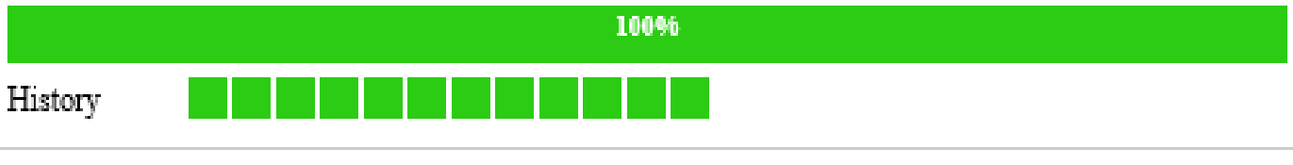
Blood Products: Transfusions

Indicator	Performance	Most Recent	Trend	Period	⊙
Lab | Transfusion Effectiveness (M)					
	Target Met	100.0% 3/3	No Change	Jan 2025	100.0%
Lab | Transfusion Reaction (M)					
	Target Met	0.0% 0/12	No Change	Jan 2025	0.0%

- *Transfusions effective; no transfusion reactions*

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Blood Culture Contamination

Indicator	Performance	Most Recent	Trend	Period	⊙
Blood Cultures -Contamination Rate |RN| (M)					
33% 25% 42% History	Target Met	2.7% 5/185	Improved	Jan 2025	3.0%
Blood Cultures -Contamination Rate |LAB| (M)					
66% 25% 9% History	Target Met	0.0% 0/86	Improved	Jan 2025	3.0%
Blood Cultures -Total Contamination Rate (M)					
50% 33% 17% History	Target Met	1.8% 5/276	Improved	Jan 2025	3.0%

- *Total of 5 contaminated out of 276 samples*
  (n.b. the RN rate only reflects RNs in the ED)

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CIHQ Stroke Certification Measures

Indicator	Performance	Most Recent	Trend	Period	⊙
CDSTK-03|Median- Code Stroke Called |M| elapsed time (mins)	Target Met	1	Improved	Jan 2025	10
CDSTK-04|Median- Door to Phys Eval |M| minutes	Target Met	0	Improved	Jan 2025	10
CDSTK-05|Median- Door to CT Scanner |M|elapsed time (minutes)	Target Met	1	Improved	Jan 2025	25
CDSTK-06|Median- Neuro Consult Contacted |M| minutes	Target Met	8	Improved	Jan 2025	30
CDSTK-07|Median- CT Read by Radiology |M| minutes	Target Met	15	Improved	Jan 2025	45
CDSTK-08|Median- Lab Results Posted |M| minutes	Target Met	20	Improved	Jan 2025	45
CDSTK-10|Median- Door to EKG Complete |M| minutes	Target Met	21	Improved	Jan 2025	60
CDSTK-11|Median-Door to tPA Decision |M| minutes	Target Met	19	Improved	Jan 2025	60
CDSTK-12|Median-Door to tPA |M| minutes	Target Met	48	Improved	Jan 2025	60

All stroke metrics met for the month of January

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Utilization Management

Indicator	Performance	Most Recent	Trend	Period	⊙
MS-DRG Case Mix Index (CMI) [M]					
41% / 59%	Bet. Target & Alarm	1.42	Improved	Jan 2025	1.55
History					
MS-DRG Case Mix Index (CMI) MEDICARE [M]					
33% / 67%	Bet. Target & Alarm	1.42	Improved	Jan 2025	1.55
History					
1 Day Stay Rate Medi-Cal [M]					
100%	Target Met	0.00% 0/6	No Change	Jan 2025	2.61%
History					
1 Day Stay Rate-Medicare [M]					
100%	Target Met	0.00% 0/62	No Change	Jan 2025	8.10%
History					
Acute Care Risk-adjusted Average Length of Stay, O/E Ratio [M]					
100%	Target Met	0.90 314/347.85	Deteriorated	Jan 2025	0.99
History					
Inpatients Risk-adjusted Average Length of Stay, O/E Ratio [M]					
100%	Target Met	0.90 326/363.64	Improved	Jan 2025	0.99
History					
Medicare Risk-adjusted Average Length of Stay, O/E Ratio [M]					
100%	Target Met	0.82 195/238.48	Improved	Jan 2025	0.99
History					
Acute Care - Geometric Mean Length of Stay [M]					
8% / 8% / 84%	Breaches Alarm	4.16 49.9238/12	Deteriorated	Jan 2025	2.75
History					

Case mix index is below target. Medicare adjusted LOS is appropriate, though GMLOS (raw data for all patients) is up. This is due to some challenging admissions, from both an acuity and social perspective

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Readmissions

Indicator	Performance	Most Recent	Trend	Period	
30-DV Inpatients - % Readmit to Acute Care within 30 Days (M)					
History 	Target Met	13.43% 9/67	Deteriorated	Jan 2025	15.30%
COPD, CMS Readm - % Readmit within 30 Days, ACA (M)					
History 	Target Met	0.0% 0/3	No Change	Jan 2025	19.5%
HF, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)					
History 	Target Met	0.0% 0/1	Improved	Jan 2025	21.6%
Hip/Knee, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)					
History 	Target Met	0.0% 0/1		Jan 2025	4.0%
PNA, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)					
History 	Target Met	8.3% 1/12	Deteriorated	Jan 2025	16.6%
Sepsis, Severe - % Readmit within 30 Days (M)					
History 	Target Met	0.0% 0/3	No Change	Jan 2025	12.0%
Septic Shock - % Readmit within 30 Days (M)					
History 	Target Met	0.0% 0/2		Jan 2025	13.3%

Readmission rates below target threshold

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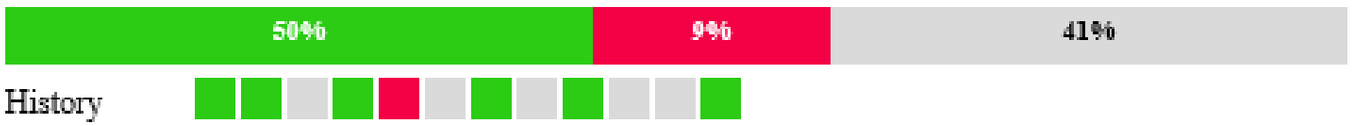
Core Measures

Indicator	Performance	Most Recent	Trend	Period	⊙
Core OP29/ASC9 - Colonoscopy:F/U for Avg Risk Pts (M)					
	Target Met	100.0% 6/6	No Change	Jan 2025	88.0%
Core OP 18b Median Time ED Arrival to ED Departure - Reporting Measure (M)					
	Breaches Alarm	154.00	Deteriorated	Jan 2025	132.00
Core OP 22 ED LWBS Emergency Dept Left Without Being Seen (M)					
	Target Met	0.4% 4/906	Deteriorated	Jan 2025	2.0%
Core OP-23 - Head CT/MRI Results for STK Pts w/in 45 Min of Arrival (M)					
	Target Met	100.0% 2/2		Jan 2025	80.0%

Core Measures target thresholds met in all categories

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Core Measures: Sepsis

Indicator	Performance	Most Recent	Trend	Period	⊙
SEP-1 Early Management Bundle, Severe Sepsis/Septic Shock (M)					
50% 8% 42% History	Target Met	87.5% 7/8	Deteriorated	Jan 2025	81.0%
SEPa - Severe Sepsis 3 Hour Bundle (M)					
66% 34% History	Target Met	100.0% 9/9	No Change	Jan 2025	94.0%
SEPb - Severe Sepsis 6 Hour Bundle (M)					
75% 25% History	Target Met	100.0% 8/8	No Change	Jan 2025	100.0%

- *Sepsis metrics met*

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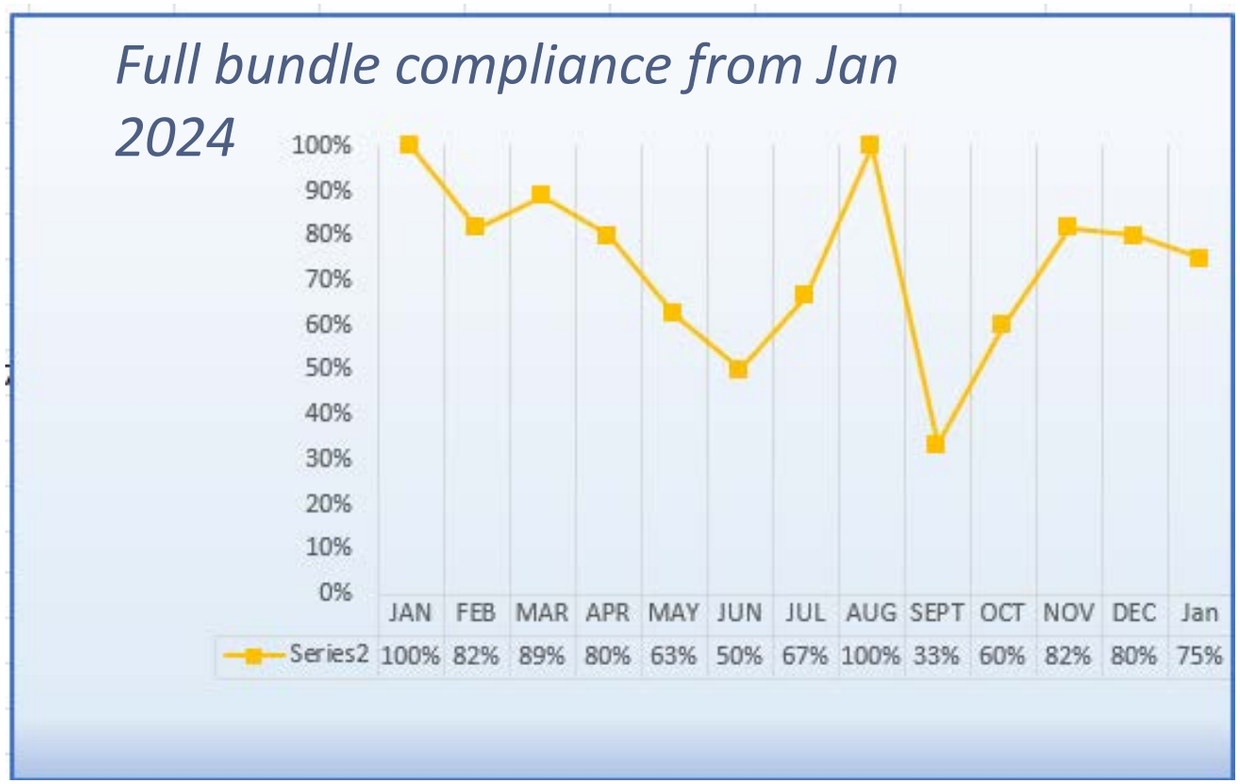
CIHQ Corrective Action Plan Monthly Compliance Condition Level Findings:
Continuous Observation of High Risk of Self Harm Patients

- *4 pts in Jan.*
- *1 missed MD order*
- *Average LOS: 18 hours*
- *Age Range: 9- 67*



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HCAHPS Patient Satisfaction:

Inpatient Ambulatory Surgery

Reported Quarterly

Report for Q4 2024

(please refer to August report for Q2 & November report for Q3)

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PressGaney

Monthly report (copy) INPATIENT

Generated: 2/18/2025 1:03 PM ET
Service Date Range: 10/1/2024 - 12/31/2024
Sonoma Valley Hospital - System (15704)

HCA HPS Q4 2024

Inpatient

Questions	Top Box	n	STATE CA Score	All PG Database Score
*Rate hospital 0-10	73.81	42	73.75	71.36
*Recommend the hospital	80.95	42	74.30	70.53
***Comm w/ Nurses Domain Performance**	85.71	42	79.15	80.03
*Nurses treat with courtesy/respect	92.86	42	85.37	86.37
*Nurses listen carefully to you	83.33	42	76.78	77.66
*Nurses expl in way you understand	80.95	42	75.31	76.06
***Response of Hosp Staff Domain Performance**	81.59	38	64.24	64.78
*Call button help soon as wanted it	75.68	37	63.65	63.29
*Help toileting soon as you wanted	87.50	24	65.08	65.81
***Comm w/ Doctors Domain Performance**	85.37	42	80.28	80.28
*Doctors treat with courtesy/respect	87.80	41	85.47	86.10
*Doctors listen carefully to you	87.80	41	79.15	78.89
*Doctors expl in way you understand	80.49	41	76.21	75.87
***Hospital Environment Domain Performance**	65.85	41	64.14	66.92
*Cleanliness of hospital environment	78.05	41	74.69	73.88
*Quietness of hospital environment	53.66	41	53.62	59.93
***Comm About Medicines Domain Performance**	59.80	33	63.12	61.82
*Tell you what new medicine was for	72.73	33	75.50	75.20
*Staff describe medicine side effect	46.88	32	50.61	48.35
***Discharge Information Domain Performance**	92.11	38	87.91	86.93
*Staff talk about help when you left	97.37	38	86.13	85.26
*Info re symptoms/prob to look for	86.84	38	89.68	88.62
***Care Transitions Domain Performance**	54.90	42	55.33	53.96
*Hosp staff took pref into account	50.00	42	50.04	48.62
*Good understanding managing health	50.00	42	53.94	53.14
*Understood purpose of taking meds	64.71	34	62.27	60.09

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
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OAS CAPS Q4 2024

PressGaney

Monthly report (copy) OAS

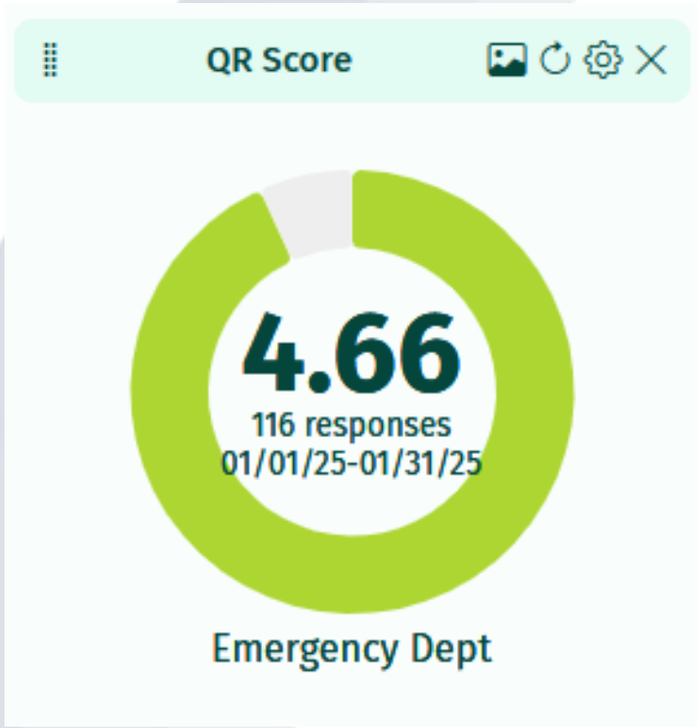
Generated: 2/18/2025 1:04 PM ET
Service Date Range: 10/1/2024 - 12/31/2024
Sonoma Valley Hospital - System (15704)

Ambulatory Surgery

Questions	Top Box	n	All PG Database Score	State of California Score
*Facility rating 0-10	89.36	47	88.29	86.94
*Recommend the facility	86.96	46	85.39	84.60
***Communication Domain Performance**	94.32	48	92.46	91.19
*Provided needed info re procedure	97.92	48	92.80	91.79
*Instructions good re preparation	95.65	46	94.52	93.47
*Procedure info easy to understand	95.83	48	93.96	93.13
*Anesthesia info easy to understand	95.56	45	94.57	93.17
*Anes side effect easy to understand	86.67	45	86.46	84.52
***Facility/Personal Trtment Domain Performance**	96.53	48	97.18	96.35
*Check-in run smoothly	91.67	48	95.80	94.60
*Facility clean	100.00	48	97.97	97.36
*Clerks and receptionists helpful	93.75	48	96.42	95.32
*Clerks and reception courteous	93.75	48	97.70	96.92
*Staff treat w/ courtesy, respect	100.00	48	98.10	97.60
*Staff ensure you were comfortable	100.00	47	97.06	96.32
***Discharge Domain Performance**	99.29	48	96.93	96.37
*Written discharge instructions	100.00	45	97.74	97.51
*Instructions regarding recovery	95.74	47	88.14	86.33
*Information re subsequent pain	100.00	44	98.50	98.15
*Information re subsequent nausea	100.00	40	98.62	98.21
*Information re subsequent bleeding	100.00	38	99.06	98.66
*Info on response to infection	100.00	38	99.56	99.37
Nurses Overall	90.07	48	88.91	87.95
Nurses concern for comfort	86.96	46	89.47	88.35
Info nurses gave to prep for proc	91.67	48	88.36	87.49
Nurses response concerns/questions	91.49	47	88.94	88.01
Care Provider Overall	91.44	48	84.11	81.27
CP explanation about proc	91.67	48	84.73	82.48
Info CP shared re how proc went	89.58	48	83.14	78.73
CP response to concerns/questions	91.30	46	86.57	84.75
CP expln why proc important	93.33	45	81.95	79.06
Staff worked together care for you	97.92	48	90.13	89.23

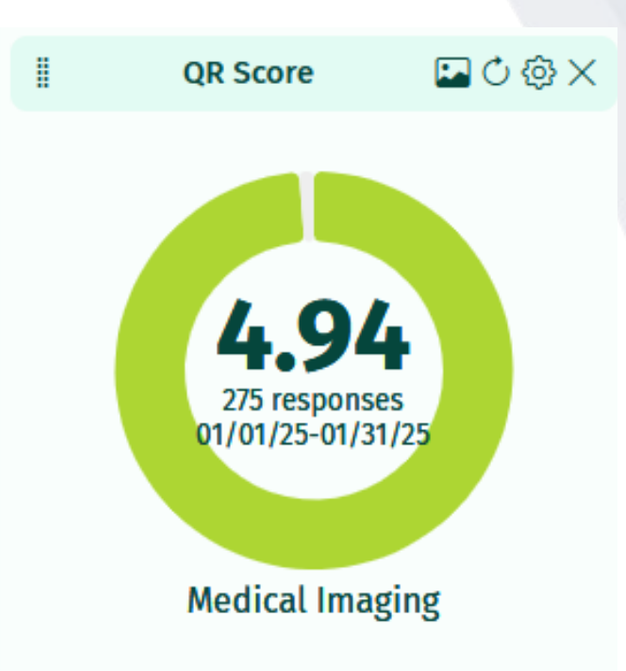
Q Reviews: Rate My Hospital
January 2025

Emergency Department



Outpatient Physical Therapy

Medical Imaging



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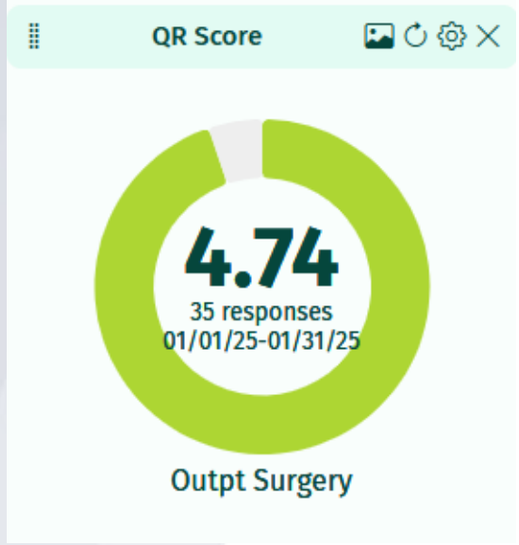
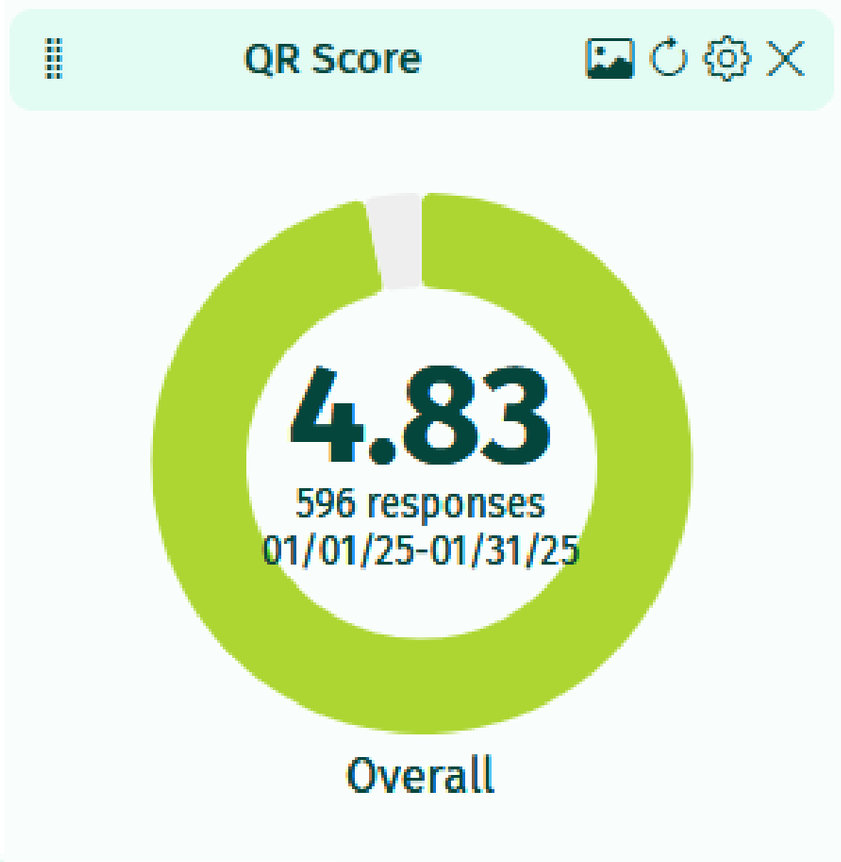
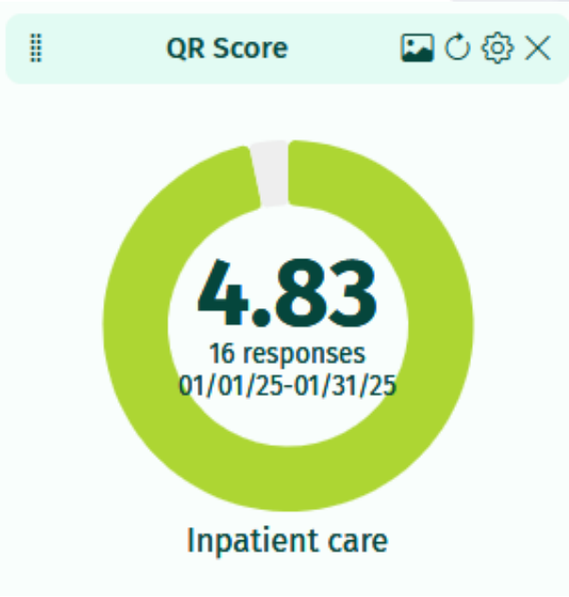
Q Reviews: Rate My Hospital December 2024

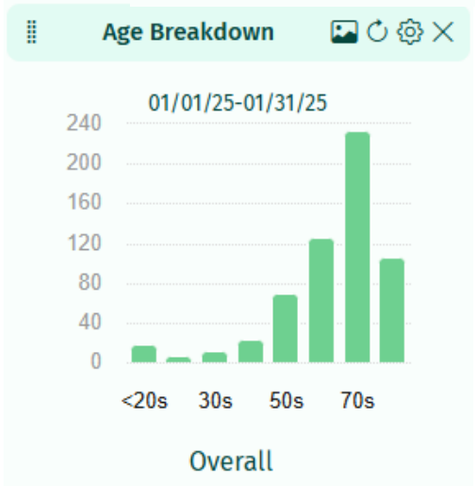
Outpatient Surgery

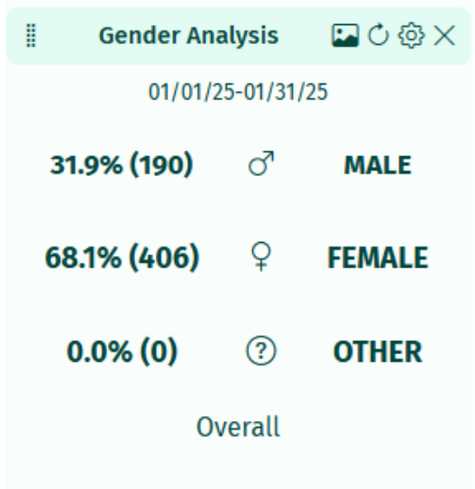




Inpatient Care







SONOMA VALLEY HOSPITAL
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Document Tasks By Committee

Listing of currently pending and/or upcoming document tasks grouped by committee.

Sonoma Valley Hospital

Run by: Reese, Whitney (wreese)
Run date: 02/20/2025 3:43 PM

Report Parameters

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

Grouped by: Committee

Sorted by: Document Title

Report Statistics

Total Documents: 1

Committee: **07 BOD-Quality (P&P Review)**

Committee Members: **Finn, Stacey (sfinn), Newman, Cindi (cnewman), Reese, Whitney (wreese)**

Current Approval Tasks (due now)

Document	Task/Status	Pending Since	Days Pending
NEW: Protocol to Reduce Ambulance Patient Offload Times *Emergency Dept*	**Pending Approval**	1/19/2025	32

Summary Of Changes: **New Policy**
Ambulances and Emergency Medical Services (EMS) personnel must be available to respond to emergencies in the community. At times, delays can occur when first responders are unable to safely offload their patient to the emergency department (ED) and provide for a safe hand off of care. The purpose of this protocol is to outline steps the ED team can take to ensure a timely transfer of care and minimal Ambulance Patient Offload Time (APOT). APOT is defined as the time interval between arrival to the ED and the time the patient is transferred into an ED gurney, bed, chair, or other appropriate location. This protocol is in compliance with California Assembly Bill 40.

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

Lead Authors: **Winkler, Jessica (jwinkler), Ehret, Marylou (mehret)**

ExpertReviewers: **Medical Director-Emergency Dept.**

Approvers: **Winkler, Jessica (jwinkler) -> 01 P&P Committee - (Committee) -> 02 MS-Medicine Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Protocol to Reduce Ambulance Patient Offload Times

DEPARTMENT: Emergency Department

EFFECTIVE: 9/1/2024

REVISED:

NEW POLICY/Protocol

Assembly Bill 40, regarding Ambulance Patient Offload Times (APOT) requires that all hospitals submit a protocol to the Emergency Medical Services Authority (EMSA) that outlines SVH's approach to reduction of APOT.

WHY: Protocol needed to be compliant with AB40. Also, it supports and best practices for good patient outcomes.

OWNER:
Chief Nursing Officer

AUTHORS/REVIEWERS:
Director of Emergency Services

Protocol to Reduce Ambulance Patient Offload Times

DEPARTMENT: Emergency Department

EFFECTIVE: 9/1/2024

REVISED:

PURPOSE:
Ambulances and Emergency Medical Services (EMS) personnel must be available to respond to emergencies in the community. At times, delays can occur when first responders are unable to safely offload their patient to the emergency department (ED) and provide for a safe hand off of care. The purpose of this protocol is to outline steps the ED team can take to ensure a timely transfer of care and minimal Ambulance Patient Offload Time (APOT). APOT is defined as the time interval between arrival to the ED and the time the patient is transferred into an ED gurney, bed, chair, or other appropriate location. This protocol is in compliance with California Assembly Bill 40.

POLICY:
When a patient is brought into the Sonoma Valley Hospital (SVH) ED via EMS, ED staff shall immediately receive and greet the patient, and direct EMS to an assigned room. When all ED rooms are full, the ED Registered Nurse performing triage will assess the patient and determine the most appropriate location for EMS to offload the patient. The goal of this hand off process is always less than thirty minutes. Should the APOT approach or exceed thirty minutes, the following protocol will be activated.

PROCEDURE/PROTOCOL:

1. The Director of Emergency Services and/or the Nursing Supervisor shall be notified immediately when ambulance off-load times are approaching or exceeding 30 minutes.
2. Staffing:
    a. The inpatient units' staffing will be assessed to determine if there are available staff who may float to the ED to assist.
    b. The surgical services department may be assessed to determine if there are available staff who may appropriately float to assist
    c. Nursing leadership (nursing directors, managers, and/or clinical coordinators) may be called to assist in the provision of care if needed.
    d. At the direction of the Nursing Supervisor, the staffing office will begin calling in staff
    e. The Nursing Supervisor may engage Environmental Services staff to facilitate faster room turnover
3. Patient Throughput
    a. ED patients who have admission orders may be prioritized over planned surgical admissions to the inpatient units
    b. Critical Care admissions will be prioritized.

   c. Inpatient nursing leadership will facilitate the admission process by transporting the patient, taking ED report for the primary RN, and/or assuming care of the patient.
   d. Case management may be contacted to expedite the inpatient discharge processes to make room for ED patients
4. Consultations
   a. The admitting hospitalist may be contacted to expedite admissions and/or discharges to facilitate throughput

If an excessive APOT situation is expected to exceed 2 hours, the Policy #EP8610-102 *Surge Policy to Manage Patient Influx*, should be activated. The Administrator on Call will be notified.

Data on APOT is to be reviewed monthly by the Director of Emergency Services.

REFERENCES:

California State Legislature. (2023). *Assembly bill 40: Emergency medical services*. Bill Text - AB-40 Emergency medical services.

Sonoma Valley Hospital. (2022). Policy #EP8610-102: *Surge policy to manage patient influx.*

OWNER:
Chief Nursing Officer

AUTHORS/REVIEWERS:
Nursing Director of Emergency Services
Medical Director of Emergency Services
Board Quality Committee

APPROVALS:
Policy & Procedure Team:
Medicine Committee:
Medical Executive Committee:
The Board of Directors: