SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
REGULAR MEETING AGENDA
Wednesday, January 29, 2014
5:00 p.m. Regular 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 *The mission of the SVHCD is to maintain, improve, and restore the health of everyone in our community.*		
1. CALL TO ORDER	*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: A. Quality Committee Minutes, 12.19.13	*Hirsch*	Action
4. POLICIES AND PROCEDURES a) Home Care Manual b) Emergency Department (ER) c) Compounding, Sterile (Rx) d) Compounding, Outside (Rx) e) Blood Administration (Lab)	*Kobe*	Action
5. QUALITY REPORTS FOR DECEMBER 2013 & JANUARY 2014	*Kobe*	Inform
6. ROOT CAUSE ANALYSIS	*Cohen*	Inform
7. CLOSING COMMENTS/ANNOUNCEMENTS ❖ QC Meeting dates for remainder of 2014 ❖ QC Input into Strategic Plan	*Hirsch*	
8. ADJOURN	*Hirsch*	
9. UPON ADJOURNMENT OF THE REGULAR OPEN SESSION	*Hirsch*	
10. CLOSED SESSION: Calif. Health & Safety Code § 32155 – Medical Staff Credentialing & Peer Review Report	*Amara*	Action
11. REPORT OF CLOSED SESSION	*Hirsch*	Inform

3.

CONSENT CALENDAR

SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
REGULAR MEETING MINUTES
Thursday, December 19, 2013
Schantz Conference Room

Committee Members Present	Committee Members Present	Committee Members Absent/Excused	Administrative Staff /Other
Sharon Nevins Jane Hirsch Joel Hoffman-by phone John Perez		Howard Eisenstark Robert Cohen M.D. Susan Idell Paul Amara M.D.	Gigi Betta Mark Kobe Leslie Lovejoy

AGENDA ITEM	DISCUSSION	CONCLUSIONS/ ACTION	FOLLOW-UP/ RESPONSIBLE PARTY
1. CALL TO ORDER	*Nevins*		
	Call to order at 5:05pm. A quorum was not present at the meeting and therefore all agenda items will be put forward to the next Quality Committee meeting on 1/29/14 with the exception of Item 4 which was approved with a phone call to Mr. Hoffman and will go the Regular Board meeting for approval on 1/9/14.		
2. PUBLIC COMMENT	*Nevins*		
	None		
3. CONSENT CALENDAR	*Nevins*	Action	
A. QC Meeting Minutes, 11.21.13	Not approved.	No action.	Bring back to QC 1/29/14
4. POLICIES & PROCEDURES	*Lovejoy*	Action	
1. Environment of Care **2.** ED Manual	Mr. Hoffman was present by phone for the approval of these policies.	**MOTION:** by Hirsch to approve and 2nd by Hoffman. All in favor.	Both Policies approved and will go to Board for approval on 1/9/14
5. RESULTS OF ROOT CAUSE ANALYSIS FOR REPORTED SENTINNEL EVENT	*Lovejoy*	Inform	
	Not presented.		Bring back to QC on 1/29/13
6. QUALITY REPORT DECEMBER 2013	*Lovejoy*	Inform	
	Not presented.		Bring back to QC on 1/29/13

AGENDA ITEM	DISCUSSION	CONCLUSIONS/ ACTION	FOLLOW-UP/ RESPONSIBLE PARTY
7. 2013 WORK PLAN	Lovejoy	Inform	
	Not presented.		Bring back to QC on 1/29/13
7. CLOSING COMMENTS	*Nevins*		
	Jane Hirsch has accepted the position of Chair of the Quality Committee and her appointment is effective with the next meeting on 1/29/14. In addition, Kevin Carruth (current Board Member and former Governance Committee Chair) will be returning to the Quality Committee as a member on 1/29/14.		
8. ADJOURN	*Nevins*		
9. UPON ADJOURNMENTOF REGULAR OPEN SESSION	*Nevins*		
10. CLOSED SESSION	*Amara*		
	The Medical Staff Credentialing and Peer Review Report was not approved due to information lacking on items in the report. Ms. Nevins and Ms. Hirsch will invoke Executive Action after discussion with Dr. Amara.		
11. REPORT OF CLOSED SESSION/ADJOURN	*Nevins*		
	Adjourn 5:20 pm The next Regular QC meeting is on January 29, 2014 at 5:00pm		

4.

POLICES & PROCEDURES

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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.

Departmental/Home Care	
APPROVED BY: **Leslie Loyejoy, RN Chief Nursing Officer** Leslie Loyejoy	DATE: 1/17/14
Director's/Manager's Signature Barbara Lee RN MSN	Printed Name **Barbara Lee, RN MSN**

Walter C Prehn MD

Walter Prehn, MD
Medical Director

1/15/14
Date

Kelly Mather
Chief Executive Officer

1/21/14
Date

Sharon Nevins
Chair, Board of Directors

Date

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Policy Submission Summary Sheet

Title of Document: Home Care Administrative Policies and Procedures

New document or revision written by: Barbara Lee RN MSN

Type: Home Care **X Revision (11Chapters) X New (0) Policy**	**Regulatory** **X CMS** **X CDPH** **X TJC** **❑ Other:**
X Departmental: Administrative *(circle which type)*	**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)

All Home Care Administrative Policies and Procedures reviewed and updated as needed to conform to Medicare Conditions of Participation and Joint Commission Standards. See attached Table of Contents.

The following Chapters were revised to reflect changes inherent in the implementation of an electronic medical record in 2013.

Chapter 1: Leadership
Chapter 3: Records Management
Chapter 8: Patient Assessment
Chapter 9: Continuum of Care
Chapter 10: Care, Treatment, and Services

Changed policies were presented to and approved by the Home Care Professional Advisory Group.

Reviewed By	Date	Approved (Y/N)	Comment
Walter Prehn MD	1/15/14	Y	
Barbara Lee RN MSN	1/15/14	Y	
Lisa O'Hara RN	1/13/14	Y	
Sara Glashan RN	1/15/14	Y	
Victoria Lee RN	1/15/14	Y	
Home Care Professional Advisory Group	9/10/13 12/10/13	Y Y	

Table of Contents

Chapter 2 Continued

Chapter 10-CARE, TREATMENT AND SERVICES

Chapter 11
The Joint Commission National Patient Safety Goals

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Departmental/Organizational: EMERGENCY DEPARTMENT (ER)	
APPROVED BY **Leslie Lovejoy, RN CNO**	DATE: **November 2013**
Director's/Manager's Signature Mark Kobe	Printed Name **Mark Kobe, RN Director**

Douglas S Campbell, MD
Chair Medicine ~~Committee~~

12/3/13
Date

Michael Brown, MD
Chair Surgery Committee

1-8-14
Date

D. Paul Amara, MD
President of Medical Staff
Chair, Pharmacy and Therapeutics Committee

1/13/14
Date

Leslie Lovejoy, RN
Chief Nursing Officer, CQO

11-14-13
Date

~~Bill~~ ~~Boerum~~ Sharon Newlos
Chair, Board of Directors

Date

Policy Submission Summary Sheet

Emergency Department Policy and Procedures

New document or revision written by: Mark Kobe, DON

Type **X Revision ❑ New Policy**	**Regulatory** **X CMS** **X CDPH** (formerly DHS) **D TJC** (formerly JCHAO) **❑ Other:**
Departmental: Clinical/Non-clinical *(circle which type)*	**XXXDepartmental** *(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)

The following organizational policy addendum has been revised:

Emergency Operations Plan, Attachment C; Inventory of Assets and Resources. This attachment to the EOP plan was updated to reflect new storage capacity of new 900kW generator

The following ED Department policies have been revised:

7010-1 Triage: revised to update to current emergency severity index levels and to further describe new Charge/Triage Nurse roles and responsibilities
7010-2 Patient Valuables: revised to delineate protocol for ED patients and transfers only
7010-3 Admission from the ED to the Hospital: revised to reflect EHR documentation and duty of Nursing Supervisor to monitor decision to admit to inpatient bed metric. Goal 1 hr.
7010-4 Discharge from the ED: revised to reflect documentation changes for the EHR
7010-5 Telephone Advice: updated, no changes
7010-6 IntraOsseous Device: New policy covering current practice standards

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POLICY AND PROCEDURE
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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: ~~MM8390~~ 8610-117 Sterile Compounding	
APPROVED BY: **Chief Quality Officer** Leslie Lovejoy	DATE: 01/23/2014
Director's/Manager's Signature CK 1/23/14	Printed Name Chris Kutza, Director of Pharmacy

N/A
Douglas S Campbell, MD
Chair Medicine Committee — Date

N/A
Michael Brown, MD
Chair Surgery Committee — Date

Robert Cohen, MD
Chief Medical Informatics Officer — Date

Kelly Mather
Chief Executive Officer — Date

D. Paul Amara, MD
President of Medical Staff
Chair, Pharmacy and Therapeutics Committee — 1/23/14 Date

~~Bill Bocrum~~ Sharon Nevins
Chair, Board of Directors — Date

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Policy Submission Summary Sheet

Title of Document: **Pharmacy Department**
New document or revision written by: Chris Kutza, Director of Pharmacy

Type **X Revision X New Policy**	**Regulatory** ❑ **CMS** ❑ **CDPH** (formerly DHS) ❑ **TJC** (formerly JCHAO) ❑ **Other:**
X Organizational: Clinical *(circle which type)*	**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)

MM8610 **M[illegible]-117 Sterile Compounding—Significantly updated**

MM8610 **M[illegible]-118 IV Compounding Outside the Pharmacy— Reviewed & Updated; name changed from "After Hours" IV Admixture Standardization & Preparation**

Reviewed By	Date	Approved (Y/N)	Comment
Chris Kutza	1/23/14	Y	

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Review and Approval Requirements

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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: ~~MM8390~~ 6618-118 IV Compounding Outside the Pharmacy	
APPROVED BY: **Chief Quality Officer** Leslie Lonyoga	DATE: 01/23/2014
Director's/~~Manager~~'s Signature	Printed Name Chris Kutza, Director of Pharmacy

N/A
Douglas S Campbell, MD
Chair Medicine Committee — Date

N/A
Michael Brown, MD
Chair Surgery Committee — Date

Robert Cohen, MD
Chief Medical Informatics Officer — Date

Kelly Mather
Chief Executive Officer — Date

D. Paul Amara, MD — 1/23/14
President of Medical Staff
Chair, Pharmacy and Therapeutics Committee — Date

~~Bill Bocrum~~ Sharon Nevins
Chair, Board of Directors — Date

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SUBJECT: **IV Compounding Outside of the Pharmacy**	POLICY #MM8610-118
	PAGE 1 OF 2
DEPARTMENT: Pharmacy	EFFECTIVE: 08/2007
APPROVED BY: Director of Pharmacy	REVISED: 01/2014

Purpose:
To define the process in which sterile injectable pharmaceuticals are mixed outside of the pharmacy in such a way as to ensure safe and timely provision of drug therapy to hospital patients and when it is appropriate to do so.

Policy:
Preparation of sterile IV admixtures will be performed within the pharmacy IV room using sterile aseptic technique in accordance with standards required by USP Chapter 797. In the presence of an urgent situation when a delay of more than 15 minutes could compromise patient safety, there is no ready to use product available, and/or during hours when the pharmacy is closed, it may be necessary for nurses to prepare either large volume (LVPs) and/or small volume (IVPB) admixtures. For this to occur as safely as possible, the process will meet the requirements of an immediate use compounded sterile product as defined in policy MM8610-117 Sterile Compounding. IV Push medications that are in unit of use containers (such as powder vials) and are aseptically reconstituted, drawn into a syringe, and immediately administered to the patient outside of the IV room AND doses in which a vial is directly connected to a bag via a manufacturer device (i.e. Minibag Plus or Add-Vantage) are not considered to be compounding.

Procedure:
1. In the circumstance when the pharmacy is closed, and a medication is scheduled to be administered to a patient, that medication is not available as a ready to use item, and it is determined that a medication is NOT urgent or emergent, the nursing supervisor will notify the on-call pharmacist.
    a. The on-call pharmacist will work with the nursing supervisor to develop a plan of action which may include but is not limited to:
        i. The pharmacist coming into the hospital to prepare the dose in the pharmacy IV room
        ii. Contacting the prescriber to change the order to an appropriate and readily available medication
        iii. Holding the dose until the pharmacy is open when clinically appropriate to do so.
2. For select IV medications that are deemed to be urgent or emergent in nature, the pharmacy will create kits that contain the appropriate medication vial(s) or ampoule(s), the appropriate diluents into which the medication is injected, appropriate expiration dating, and labeling with instructions for mixing.
    a. The kits are made for select medications that are typically emergent in nature (i.e. vasopressors, antiarrhythmics, etc) and are not available in a ready to use form.
    b. The kits are checked by a pharmacist before dispensing to nursing unit floor stock/automated dispensing cabinet.

   c. The kits are only intended to be used in situations in which the pharmacy is closed and/or a delay may cause harm to the patient.
3. In the situation in which a medication is needed urgently or emergently and no kit exists, the medication may be compounded by nursing personnel using aseptic sterile technique and administered to the patient within 1 hour.
   a. Any nursing personnel who compound a medication in this situation will be trained and competent to do so.

Technique

1. The admixture will be prepared in a designated clean area used for medication preparation.
2. Personnel preparing the compounded sterile product will remove any watches and jewelry, wash and dry their hands thoroughly, and don gloves.
3. In cases where reconstitution is required, use sterile water for injection or 0.9% sodium chloride for injection as per manufacturer's instructions or the facility sterile compounding master formula list.
   a. Verify that all medication has been fully dissolved before removing contents.
4. For vials and IV bag ports, cleanse top of the vial and port with an alcohol swab before needle penetration.
   a. Enter the vial stopper or IV bag port using a syringe needle with the beveled side up and with slight downward pressure. All such entry ports should be swabbed with 70% alcohol prior to initial puncture.
5. For ampoules, cleanse the neck with a 70% isopropyl alcohol swab prior to opening the ampoule.
   a. Use a filter needle or filter straw to remove desired contents from the ampoule, then change to a regular needle to deliver medication into final bag using the same technique as in #4a above.
6. Used medication vials, ampoules, syringes, and needles will be discarded as per hospital policy.
7. Record the following information on a medication label and affix to the final product:
   a. Patient name and account number.
   b. Name of medication contained in the bag and the amount (e.g. mg, mcg, etc)
   c. If a premade label is available as with a pharmacy kit, affix the premade label to the bag after filling in the required information as indicated on the label.
8. Have a 2nd staff member double check the completed preparation before administering.

Reference:

USP 797
TJC MM 4.20, MM 4.30, IC 1.10
Policy: MM8610-117 Sterile Compounding

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Review and Approval Requirements

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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.

Departmental/Organizational: Blood Product Administration Guidelines Nursing Blood Administration	
APPROVED BY **Leslie Lovejoy, RN CNO**	DATE: **November 2013**
Director's/Manager's Signature Lois Valenzuela	Printed Name **Lois Valenzuela, CLS, Lab Manager**

Douglas S Campbell, MD
Chair ~~Medicine Committee~~ — 12/31/13 — Date

Michael Brown, MD
Chair Surgery Committee — 1/8/14 — Date

D. Paul Amara, MD
President of Medical Staff
Chair, Pharmacy and Therapeutics Committee — 1/23/14 — Date

Leslie Lovejoy, RN
Chief Nursing Officer, CQO — 1/23/14 — Date

~~Bill Beeman~~ Sharon Nelkins,
Chair, Board of Directors — Date

Policy Submission Summary Sheet

Organizational Policy and Procedures

New document or revision written by: Lois Valenzuela

Type **X Revision ❑ New Policy**	**Regulatory** **X CMS** **X CDPH** (formerly DHS) **X TJC** (formerly JCHAO) **❑ Other:**
XXXXOrganizational: Clinical/Non-clinical *(circle which type)*	**Departmental** *(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)

The following policies have been revised:

PCLB8610-1 Nursing Blood Administration Policy
PCLB8610-2 Blood Product Administration Guidelines

These policies were updated and revised in 2012 to reflect the most current national practice. These policies follow the policies of the American Association of Blood Banks.
The Nursing Blood Administration and Blood Products Administration Guidelines describe the processes for the administration of a blood product, monitoring the patient, patient identification and transfusion reactions. Patients can expect that all transfusions will be handled with their rights and safety assured through proper identification, devices and practices that reduce the risk of complications. Complications will be identified early and appropriate interventions will be initiated to assure the best outcome for the patient.

5.

QUALITY REPORTS FOR DECEMBER 2013 AND JANUARY 2014

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
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To: Sonoma Valley Healthcare District Board Quality Committee
From: Leslie Lovejoy
Date: 12/12/13
Subject: Quality and Resource Management Report

December Priorities:
1. Skilled Nursing Facility Annual Survey
2. Staff and Stock status in the new wing
3. Policy and Procedure Infrastructure
4.

1. The Skilled Nursing Facility had their annual licensing and CMS survey on November 15th. It went very well. There were two main areas in need of improvement: when medications are prescribed on admission or during the stay, the physician must state and indication for the medication; and there was a push for a SNF specific Food and Fluids disaster plan. Currently, the SNF has been folded into the hospital disaster plan but it was clear that the expectation is that it now be separate. The Directors of Nutritional Service, Skilled Nursing and Pharmacy have worked on an action plan and monitoring for these issues. It was followed by an Interim Life Safety Survey that focuses on the facility. Shelves near the heat table were discolored and a copper pipe was found to be oxidized and finally a drain pipe was not permanently centered in a drain. The Facilities Director removed and replaced the shelves, cleaned the pipe and centered the drain pipe.
For the most part this was a very good survey. What was different was that the surveyor requested proof, down to an itemized list of tools used, that our actions were implemented. This is a first but according to the surveyor, this will be the trend from now on.

2. We have permission to enter the building and begin the process of stocking the areas and doing the in-service education for new equipment. Mark Kobe is working with his team in the new Emergency Department and I am handling the Surgery Department. We are bringing in the nursing team to look at throughput and assessing staffing needs. I have invited the Anesthesiologists and Surgeons to come to the new department and work on the same issues over the next few weeks. Dr. Hubbell and Mark are doing the same with the Emergency Physicians. I have put in a request for licensing to come on January 9 & 10 but have not heard back.

3. Policy and Procedure Infrastructure

We have made the decision to let the Web based policy and procedure program expire. The process is too big and cumbersome for a small organization. I have tasked a Quality team member with creating a excel spreadsheet process for tracking both organizational and departmental policies and procedures. This will be rolled out to the Leadership in January. I will bring the revised policy and procedure on policies and procedures to this group in January.

Topic for discussion: 2013 Work Plan discussion and evaluation

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
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To: Sonoma Valley Healthcare District Board Quality Committee
From: Leslie Lovejoy
Date: 01/22/14
Subject: Quality and Resource Management Report

January Priorities:
1. Surgery Department
2. Quality Website Development
3. AHRQ Culture of Safety Results
4. Meaningful Use 2 Preparation and Clinical Informatics

1. Surgery Department

We did not move into the new wing this month. The new Perioperative Services Director, Allan Sendaydiego has started orientation and is immersing himself in the "Staff and Stock" process. Staff are in the process of becoming educated to the new equipment and the logistics of the new department.

In addition, as we collapse the Ambulatory Care Unit and Post Anesthesia Recovery into one unit, the Surgical Care Unit, we have been working on a staffing matrix. As the two departments were in different locations, it required additional staff and the work flow was inefficient. Over the past year, the staff of the two areas has been educated to the need for a reduction in staffing when we make the move. After assessing skill needs, current staffing and interviewing each staff member, a matrix has been developed that calls for a 2.1 FTE reduction. We were able to accomplish this by reducing only one position and changing the hours from a variety of 8-10-12 hour shifts into an 8 hour shift only. The redesign and restructure of the department is currently underway. We have designed the flow such that shifts are staggered and that the skill set for the Surgical Care Unit includes all three processes: pre-operative preparation, post anesthesia recovery and post-operative discharge. Each nurse will be responsible for all three processes and indeed the pre-op nurse may recover and discharge the same patient. This is a typical workflow for an ambulatory surgery center.

Finally, one recommendation from the Kurt Salmon Consultants was to entertain the possibility of creating a physician co-management agreement with the surgeons and anesthesiologists. This would assist the hospital in reducing costs in inventory, cost of implants and cost per case that are physician driven and give them accountability for streamlining staffing and throughput. There was an informational meeting help on the 15th to discuss options and it was decided that Kurt Salmon would return in the next few weeks with co-management paperwork from which the

conversation can develop about what this would look like at SVH. It went well and Dr. Cohen has requested follow-up from the meeting participants.

2. Quality Website Development

Bob Kenny and I met to finalize the content of the quality page of the hospital's website. It was decided that we would use the dashboard content items, a report of the Patient Experience and three report cards: Heart Care, Pneumonia Care and Stroke Care. The webpage is expected to be up in early March.

3. AHRQ Culture of Safety Results

We have completed entering the survey data and are in the preliminary stages of creating a report. We will have longitudinal data on our performance over time and this year, we will add the national benchmark data. I anticipate presenting the data to Admin Team, Leadership, Medical Staff Performance Improvement Committee and the Quality Committee in February.

4. Meaningful Use 2 and Clinical Informatics

The hospital is gearing up to prepare for Meaningful Use 2. Additional changes and upgrades to the electronic health record will allow us to report quality measures electronically to The Centers for Medicare Services. This will result in another influx of federal monies back to the hospital sometime later 2014. Our Clinical Informatics Nurse has decided to take another position elsewhere. We have contracted with a highly experienced RN to come in and work with our team to insure that we stay on track. The position is posted and we hope to have applicants soon.

6.

ROOT CAUSE ANALYSIS

Sonoma Valley Hospital
ROOT CAUSE ANALYSIS DOCUMENTATION FORM

SECTION ONE: DESCRIPTION OF EVENT / SERVICE AREA(S) IMPACTED

93y/o female seen in the ED on 7/22 and admitted to the hospital in extremis with a non-ST AMI. Dementia, CHF and ARF. Was transferred to the skilled nursing facility on 7/25 for rehabilitation . On 8/23 fell while in the skilled nursing facility and sustained a L Femur Fracture. On assessment the patient was found to have an elevated creatinine and INR and needed medical clearance for surgery. The patient and the DPOA agent requested surgery and knew the potential risks involved. The surgeon scheduled the surgery for 8/23 but it was delayed until 8/25 to obtain medical clearance by the skilled nursing facility hospitalist. On Sunday, 8/25 the surgery was scheduled for the afternoon. The patient was discharged from the Skilled Nursing Unit at 1300 and brought to OR#1 in her hospital bed. She was pleasantly confused but alert and answering questions. Anesthesia assessed the patient as being an ASA4, noted thread y radial pulses and administered a spinal, (without incident), Ketamine, and Propofol. She was positioned on the fracture table by the surgeon and staff and the staff began to prep the left hip. In the 3-5 minute move from the bed to the table and the monitor reconnection, the patient was found to not have a heart rate and an increased CO2. The patient received 2 doses of epinephrine and three shocks and then was declared deceased by the anesthesiologist and surgeon at 1423. The patient was a DNR. Surgeon notified family, Nursing contacted the Coroner who indicated that it was not a coroner's case and the Anesthesiologist agreed to sign the death certificate.

Service Areas Impacted: ***Skilled Nursing; Surgical Services, Anesthesia Services, Hospital, Medical Staff*** Date RCA Initiated: 09/18/2013 Date RCA Completed: 09/18/2013

Team Members: Robert Cohen, MD CMO; Andrew Solomon, MD, Chief Anesthesia Services; Scott Robinson, MD Anesthesiologist; Michael Brown, MD, Chief Surgery Department, Leslie Lovejoy, RN, Chief Quality & Nursing Officer; Pam Reed, RN, Director Surgical Services; Lynne Teixeira, RN, Nursing Supervisor; Melissa Evans, RN, Director of Nursing Skilled Nursing; Heather Plomteaux, RN Surgical Services; and Nathan Stone, Admitting.

SECTION TWO: FIRST LEVEL INVESTIGATION AND ANALYSIS – Determination of Proximal Cause(s)
(Under the appropriate column, identify factors that led directly to the event.)

Human Factor Issues	Process Breakdown Issues	Equipment Malfunction / Failure Issues	Controllable Environmental Factors	Uncontrollable Environmental Factors	Other Reasons
Date and time of surgery limited resources Decision to not admit for medical work up and do in SNF Use of Code Blue in surgery; having access to ED MD	Discharge from the Skilled Nursing Unit to the Hospital for an acute admission resulted in: 1. No Acute record 2. No H&P by surgeon & no Summation note from SNF Hospitalist.	NONE	Assessment/Reassessment Informed Consent	NONE	Patient's underlying condition resulted in high probability of outcome.

SECTION THREE: SECOND LEVEL INVESTIGATION AND ANALYSIS - Determination of Special Cause(s) Variation

(For each factor identified, determine the underlying process involved. Include in this section the minimum scope of root cause analysis for the specific type of sentinel event identified – per Attachment A of the "CHW System Guidelines for Managing Sentinel Events." Analyze each process to determine what (if any) special cause variation existed that contributed to the event). Include findings of any literature search conducted.

Factor	Underlying Process Involved	Special Cause Variation of the Process	Results of Literature Review
Scheduling of Surgery	Medical clearance of patient for surgery	No special cause variation	
Code Blue in surgery	It is the policy of the surgery department to not call a code blue when resuscitation is required. Contacting the EDMD as a resource when this occurs in the future needs to be explored. Review of the case by RCA team and peer review did not deem this as critical in this case.	No special cause variation	
Lack of an Acute Care record	Lack of communication between medical staff and surgery staff and admitting during the week before the surgery resulted in the patient being discharged from the Skilled Nursing Facility prior to surgery and no acute admission orders, H&P, and elements of an acute care record. Communication breakdown between business office and admitting compounded confusion.	Lack of clarity on plan of care.	
Patient's underlying condition	Medical staff, nursing and social worker clearly documented patient and DPOE decision maker request for the surgery and their acknowledgement of the high probability of not surviving. Medical staff clearly documented the patient's underlying co-morbidities and her ASA status.	Root cause of event is located here.	

SECTION FOUR: THIRD LEVEL INVESTIGATION AND ANALYSIS – Determination of Common Cause Variation

(This section is used to identify common cause variation in systems that underlie the processes previously identified. A rationale / justification must be provided for any question with a "yes" answer)

Human Resource Issues	Information Management Issues	Environmental & Equipment Management Issues	Leadership Issues	Communication Issues	Other Issues
Are staff properly qualified and currently competent in their responsibilities? The surgical team has demonstrated competencies and the surgeon and anesthesiologist is currently credentialed and in good standing on the medical staff. There appears to be a gap in understanding the process of admitting from our SNF for an	*Is all necessary information available when needed? Accurate? Complete? Unambiguous?* No, there was a breakdown in available information as it relates to a complete acute care record. It was very clear from the Skilled Nursing documentation that the patient and decision maker understood that she may not make	*Was the physical environment appropriate for the processes being done?* Yes, all equipment was fully functional and the environment of the OR was appropriate for the procedure.	*Is the culture conducive to risk identification and reduction?* Yes. The hospital has a very aggressive and proactive culture of safety program including risk identification and reduction through our Good Catch program.	*Is there a lack of barriers to the communication of potential risk factors?* Yes. Leadership and Medical Staff leaders actively seek to reduce any perceived barriers; using an SBAR hand off process.	

inpatient surgery.	it through the surgery.				
Is staffing adequate? Yes, the staffing for surgical services was appropriate to a Sunday as was the hospital staffing.	*Is communication among participants adequate?* No, communication between the skilled nursing, surgery and admissions was not clear regarding acute care status.	*Are systems in place to identify environmental and equipment risks?* Yes, the hospital has a robust risk reporting process. We encourage the use of the chain of command. There is a process for biomedical equipment and safety inspections. Staff have been trained on what to look for and how to identify faulty equipment.		*Is the prevention of adverse outcomes adequately communicated as a high priority?* Yes, Patient Safety is a core value at SVH as part of the hospital's culture of safety. Staff are annually trained and safety based behavioral expectations. Our Good Catch program encourages safety risk identification proactively.	
Does planning account for contingencies that would tend to reduce effective staffing levels? Yes, staffing is looked at by need, acuity and takes into account staff wellness and work-life balance.		*Are emergency and failure-mode responses adequately planned and tested?* . Yes, the hospital drills to test emergency and failure mode responses through disaster and all hospital code drills.			
Is staff performance in the operant processes addressed? Yes, through annual competencies and/or performance evaluations.					
Can orientation and inservice training be improved? Yes, both inpatient and skilled nursing staff, and admitting staff will be educated regarding this process.					

SECTION FIVE: CORRECTIVE ACTION PLAN
(Use this section to describe the corrective actions taken on issues (both proximal and root) identified through the root cause analysis)

Findings / Issues Identified	Corrective Actions / Risk Reduction Strategies (identify party(s) responsible and date action implemented)	Measurement Strategies Developed to Assure Corrective Actions Will be Effective
1. Use of Code Blue in the OR	1. CMO to discuss with Medical Staff Department leaders how this process might work. This was discussed in the executive medical leadership meeting on 9/19/13. The ED Medical Director will work with Medical Directors of Surgery and Anesthesia to develop a call process. 2. Add, call to the EDMD when code occurs in OR for back up assistance.	1. Medical Staff committee meeting minutes. 2.Code Blue Records

2. Medical Clearance process for Skilled Nursing patients going for inpatient surgery	1. CMO to bring to medical staff committees for discussion and resolution and report back to Leaders. 2. Peer review process in Anesthesia and Surgery Departments.	1. Medical staff committee meeting minutes 2. Actions taken as part of this Root Cause Analysis
3. Lack of education regarding patient status between Skilled Nursing and Acute Hospital	1. Chief Quality Officer to identify where decision broke down and ensure education is provided to staff, medical staff , and leaders.	1. Staff attestation to receiving education and medical staff minutes.