March 16, 2023

TO: Legal Counsel

News Media
Salinas Californian
El Sol
Monterey County Herald
Monterey County Weekly
KION-TV
KSBW-TV/ABC Central Coast
KSMS/Entravision-TV

The next regular meeting of the **QUALITY AND EFFICIENT PRACTICES- COMMITTEE OF THE WHOLE** of the **SALINAS VALLEY HEALTH**[1] will be held **MONDAY, MARCH 20, 2023, AT 8:30 A.M., DOWNING RESOURCE CENTER, CEO CONFERENCE ROOM, ROOM 117, SALINAS VALLEY HEALTH MEDICAL CENTER, 450 E. ROMIE LANE, SALINAS, CALIFORNIA** or via **TELECONFERENCE** (*visit* **SalinasValleyHealth.com/virtualboardmeeting** *for Access Information*).

Pete Delgado
President/Chief Executive Officer

[1]Salinas Valley Memorial Healthcare System operating as Salinas Valley Health

Committee Members: Catherine Carson, Chair; Rolando Cabrera, MD, Vice Chair; Pete Delgado, President/CEO; Allen Radner, MD, Chief Medical Officer; Clement Miller, Chief Operating Officer; Lisa Paulo, Chief Nursing Officer; Rakesh Singh, MD, Medical Staff Member; Michele Averill, Community Member

QUALITY AND EFFICIENT PRACTICES COMMITTEE
MARCH 2023 - COMMITTEE OF THE WHOLE
SALINAS VALLEY HEALTH[1]

MONDAY, MARCH 20, 2023 8:30 A.M.
DOWNING RESOURCE CENTER, CEO CONFERENCE ROOM 117

Salinas Valley Health Medical Center
450 E. Romie Lane, Salinas, California
or via Teleconference
(Visit SalinasValleyHealth.com/virtualboardmeeting for Access Information)

AGENDA

1. Call to Order / Roll Call

2. Approve the Minutes of the Quality and Efficient Practices Committee Meeting of February 22, 2023. (DELGADO)
   - Motion/Second
   - Action by Committee/Roll Call Vote

3. Patient Care Services Update (PAULO)
   - Report from Oncology Unit Practice Council (MEGHAN ACKERMAN)

4. Public Input

   This opportunity is provided for members of the public to make a brief statement, not to exceed three (3) minutes, on issues or concerns within the jurisdiction of this District Board which are not otherwise covered under an item on this agenda.

5. Closed Session

6. Reconvene Open Session/Report on Closed Session

7. Review of Recent Regulatory and Accreditation Visits

8. Reportable Adverse Events Procedures – Review Final Changes to the Procedure

9. Discussion of Quality/Patient Safety Dashboard Development

10. Adjournment

    The next Quality and Efficient Practices Committee Meeting is scheduled for **Monday, April 17, 2023 at 8:30 a.m.**

[1] Salinas Valley Memorial Healthcare System operating as Salinas Valley Health

This Committee meeting may be attended by Board Members who do not sit on this Committee. In the event that a quorum of the entire Board is present, this Committee shall act as a Committee of the Whole. In either case, any item acted upon by the Committee or the Committee of the Whole will require consideration and action by the full Board of Directors as a prerequisite to its legal enactment.

The Committee packet is available at the Committee Meeting, at www.SalinasValleyHealth.com, and in the Human Resources Department of the District. All items appearing on the agenda are subject to action by the Committee.

Requests for a disability related modification or accommodation, including auxiliary aids or services, in order to attend or participate in a meeting should be made to the Board Clerk during regular business hours at 831-755-0741. Notification received 48 hours before the meeting will enable the District to make reasonable accommodations.

QUALITY & EFFICIENT PRACTICES COMMITTEE
COMMITTEE OF THE WHOLE

AGENDA FOR CLOSED SESSION

Pursuant to California Government Code Section 54954.2 and 54954.5, the board agenda may describe closed session agenda items as provided below. No legislative body or elected official shall be in violation of Section 54954.2 or 54956 if the closed session items are described in substantial compliance with Section 54954.5 of the Government Code.

CLOSED SESSION AGENDA ITEMS

HEARINGS/REPORTS
(Government Code §37624.3 & Health and Safety Code §§1461, 32155)

Subject matter: (Specify whether testimony/deliberation will concern staff privileges, report of medical audit committee, hospital internal audit report, or report of quality assurance committee): _____

1. Report of the Medical Staff Quality and Safety Committee

ADJOURN TO OPEN SESSION

CALL TO ORDER
ROLL CALL

(Chair to call the meeting to order)

SALINAS VALLEY MEMORIAL HEALTHCARE SYSTEM
QUALITY AND EFFICIENT PRACTICES COMMITTEE MEETING
COMMITTEE OF THE WHOLE
MEETING MINUTES
FEBRUARY 22, 2023

SVMHS Board Resolution No. 2023-01, Assembly Bill 361, and guidance from the Monterey County Health Department in response to concerns regarding COVID-19, Board Members of Salinas Valley Memorial Healthcare System, a local health care district, are permitted to participate in this duly noticed public meeting via teleconference and certain requirements of The Brown Act are suspended.

The Quality and Efficient Practices Committee convened at 8:34 a.m. in the Downing Resource Center, CEO Conference Room 117.

Committee Members Present: Catherine Carson, Chair, Michele Averill, Rolando Cabrera, MD, Vice-Chair, Pete Delgado, Clement Miller, Lisa Paulo, Allen Radner, MD, and Rakesh Singh, MD;

Committee Members Absent: None

Other Board Members Present Constituting Committee Of The Whole**:**
Joel Hernandez Laguna and Victor Rey, Jr. *(all via teleconference)*

Also Present: Michelle Childs, Adrienne Laurent, Augustine Lopez and Gary Ray

Rakesh Singh, MD, joined the meeting at 8:37 a.m. and left at 8:57.

Michele Averill joined the meeting at 8:54 a.m.

Pete Delgado joined the meeting at 8:57 a.m.

CALL TO ORDER/ROLL CALL

A quorum was present and Chair Carson called the meeting to order at 8:34 a.m.

APPROVAL OF MINUTES FROM THE QUALITY AND EFFICIENT PRACTICES COMMITTEE MEETING OF JANUARY 23, 2022

Approve the minutes of the Quality and Efficient Practices Committee for the January 23, 2023 meeting, as presented. The information was included in the Committee packet.

No public input received:

MOTION:

Upon motion by Committee member Paulo, second by Dr. Cabrera, the Quality and Efficient Practices Committee minutes of December 12, 2022 were approved.

Ayes: Committee members: R. Cabrera, Paulo, Radner, Carson; Noes: None; Abstentions: Miller; Absent: Committee members Averill and Singh. Motion Carried.

PATIENT CARE SERVICES UPDATE

Lisa Paulo, CNO, congratulated Aniko for being a contributor to the published work Journey to Equity.

Ms. Paulo introduced Night Shift Practice MJ Andalio-Angeles, ADN, RN, FCN (Chair) and Michael Brown, MS, BSN, RN, PCCN (Co-Chair), who provided a report on the Night Shift UPC recent

activities. Council purpose, goals and membership were reviewed. Quiet Champions have been appointed, all night shift staff have been invited to commit to the **S**ilent **H**alls **H**elp **H**ealing (shhh) initiative, Go-live started 11/1/2022, UPC members rounded on night staff November and December, nightshift staff have been provided a personal nightlight, every employee is taking accountability to keep noise levels down. Top Box scores were shared from October/2022 through January/2023 demonstrating scores have increased significantly over this timeframe. Future plans include recruiting new members, sustain successes, create awareness, educate staff in all disciplines, and develop a task force to address environmental issues.

Discussion: When does the UPC meet? Every 2nd Tuesday after night shift. Dr. Radner thinks the UPC is doing a great job because our hospital doesn't have geographic barriers to block noise. Ms. Carson liked the idea of bringing guests who might have a different experience and bring more awareness to Quiet at Night.

PUBLIC INPUT

No public comment received.

CLOSED SESSION

Chair Carson announced that the item to be discussed in Closed Session is *Hearings/Reports – Report of the Medical Staff Quality and Safety Committee*. The meeting recessed into Closed Session under the Closed Session protocol at 8:51 a.m.

RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION

The Committee reconvened Open Session at 9:23 a.m., Chair Carson reported that in Closed Session, the Committee discussed *Hearings/Reports – Report of the Medical Staff Quality and Safety Committee*.

No action taken in the Closed Session.

REPORTABLE ADVERSE EVENTS PROCEDURES

The Salinas Valley Health Reportable Adverse Events Procedure, Attachment A and the CDPH Licensing and Certification Health and Safety Code on Reportable Adverse Events were included in the packet and reviewed. Ms. Carson recommended including the California Licensing and Certification Reportable Adverse Events, and Health and Safety Code, Section 1279.1(b) (1)-(7) in the Procedure. Historically Mr. Delgado has met 1:1 with Board Members to inform them of reportable adverse events. Ms. Carson requested the procedure be revised to include informing the Quality and Efficient Practices Board Committee Chair when there is a determination to report an event that caused harm. Ms. Kukla and Ms. Bailey will incorporate requests into the procedure.

QUALITY/PATIENT SAFETY DASHBOARD DEVELOPMENT

Currently quality data is displayed in the Balanced Scorecard. Ms. Carson requested a dashboard be developed to capture key indicators comparing observed vs. expected data. Because so much data is required by The Joint Commission and California Department of Public Health, the question was

discussed as to which data should be on the display on the dashboard. Mr. Delgado suggested there be at least a "Top Ten" included. Ms. Carson has some ideas and asked committee members to submit ideas to Ms. Kukla or Ms. Bailey. The intent is for the dashboard to be a tool for the hospital leadership to help prioritize quality efforts.

ADJOURNMENT

There being no other business, the meeting adjourned at 9:40 a.m. The next Quality and Efficient Practices Committee Meeting is scheduled for **Monday, March 20, 2023 at 8:30 a.m.**

_____

Catherine Carson, Chair
Quality and Efficient Practices Committee

/KmH

Board Paper: Quality & Efficient Practices Committee

Agenda: Patient Care Services Update
Executive Sponsor: Lisa Paulo, MSN/MPA, RN
Date: March 20, 2023

Pillar/Goal Alignment:

☐ Service ☐ People ☒ Quality ☐ Finance ☐ Growth ☐ Community

QUALITY:

Oncology Practice Council

Meghan Ackerman, BSN, RN, OCN (Chair)
Ashley Folck, BSN, RN, OCN (Co-Chair)
Elena Hermosillo, RN, OCN
Maritess Condalor, BSN, RN
Glaiza Farnal, RN, PHN (Advisor)

Salinas Valley HEALTH

MAGNET RECOGNIZED AMERICAN NURSES CREDENTIALING CENTER

❖ Where We Are

Monthly Oncology Journal Club

- To keep us up to date with current best practices

Monthly Practice Audits

Due to low compliance in Chemo PPE, medication reconciliation and care plan documentation

Practice Audit is being done to these areas

To identify the barriers, intervene and implement change

Recognize Employee of the Quarter

- To showcase their hard work
- To inspire

❖ What We've Done:

Professional Development

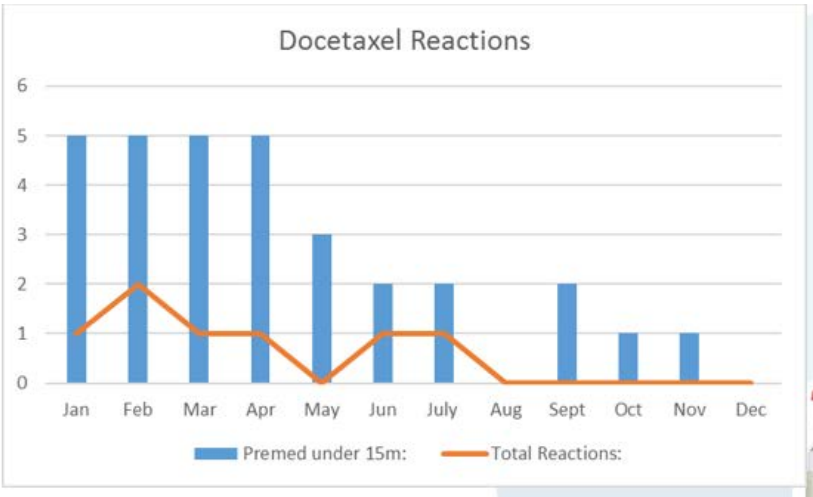
- Outpatient Infusion
  - Increased BSN rates from 45% to 65% (+20%)
  - Increased Certified Nurses from 50% to 55% (+5%)
- Oncology 3rd Tower
  - Increased BSN from 54% to 59% (+5%)

Organizational Goal for Next Year

- To increase BSN & Certification rates by 1%

Improve Practice:

Docetaxel Reactions



Identified the cause of reaction → Implemented change in practice → Decreased the number of reactions

Improve Practice:

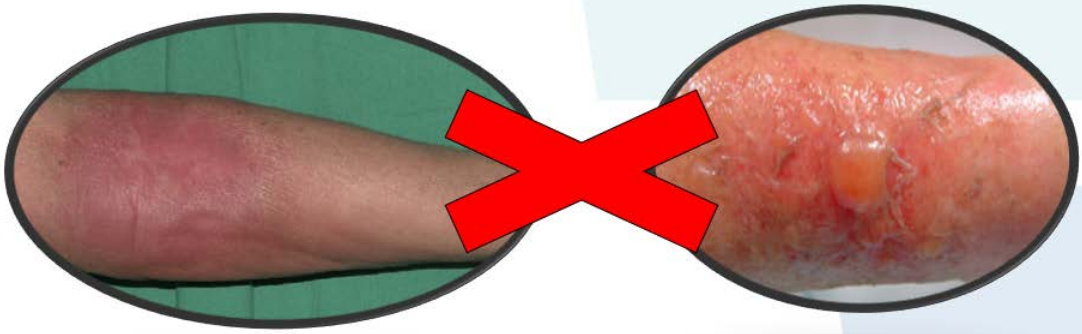
Male Cryopreservation Information

- Made it available for our patients
- Created a process how to utilize it
- Provided education to staff about it

Improve Practice:

Updated Extravasation Policy

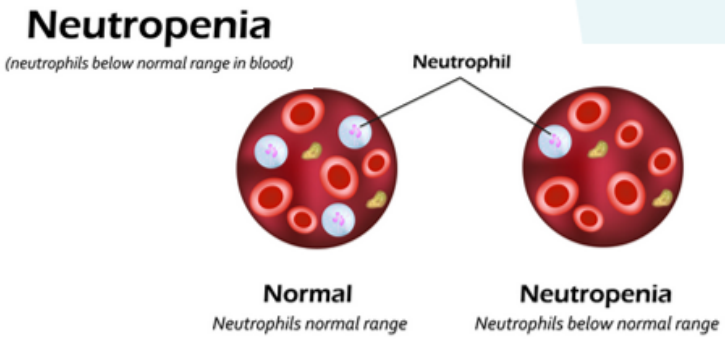
- Created a better process and updated our policy to manage extravasation incidents appropriately



Improve Practice:

Updated Neutropenia Guidelines

- To have a standard guideline when admitting patients with low White Blood Count (WBC)
- To provide appropriate care and prevent risk for infection



❖ What is Coming up:

Hypersensitivity Reaction EBP Project:

- Goal is to increase RN knowledge and confidence and to streamline the response to hypersensitivity reactions

Environmental Monitoring for Chemo Contamination:

- Based on referral to evaluate for chemotherapy exposure and stay ahead of potential state mandates

Oncology Certified Nurse (OCN®) Review Course and Free Take Program:

- Goal is to increase Oncology Certified Nurses and nurse satisfaction through specialized education

PUBLIC INPUT

CLOSED SESSION

(Report on Item to be Discussed in Closed Session)

RECONVENE OPEN SESSION/
REPORT ON CLOSED SESSION

Regulatory and Accreditation Visits Updates February – March, 2023

- 2/13/2023: **EMTALA (CMS) survey** (4 day) pt. complaint - no findings.

SVH Disease Specific Care programs undergo regular recertification visits every two years, where the surveyors look at the structure, processes and outcomes of a program and they make recommendation for advancement.

- 2/21/2023: **TJC – Disease Specific Care - Chest pain** – 2 findings

Surveyor highly complimentary about the hospital and the program: high level of engagement, great program and great outcomes.

1. Failure to follow Clinical Practice guidelines (Heart Score not documented)
2. Assessment / Reassessment not documented

Action plan in process – due 60 days

- 2/28/2023: **CDPH Board of Radiology** – 3 day survey – no findings.
- 2/27/2023: **TJC – Disease Specific Care - Stroke**

  3 findings were related to record keeping of practitioner education and assessment / reassessment documentation and 1 finding related to not having an easy access to reference materials.

  1. Missing documentation of a couple of ED practitioner's education and Core Team education.
  2. Missing Assessment / reassessment documentation
  3. Risk, Benefit, Alternative for medication not documented
  4. Access to reference materials: not readily available.

  Action plan in process - 60 days
- 3/10/2023 **TJC – Disease Specific Care – Total Joint (hip / knee)**

  Surveyor highly complimentary about staff engagement, support from leadership, teamwork and staff verbalizing joy of coming to work and taking care of the community. Exceptional physician engagement is evident. There is evidence of interdisciplinary coordination amongst the different disciplines, and this speaks to a a great performance improvement culture.

  - **Hips** – No findings
  - **Knees-** 1 finding

    1. Failure to follow Clinical Practice guidelines (chemical prophylaxis medication), home medications did not transfer into the inpatient record.

  Action plan in process - 60 days

Status Draft PolicyStat ID 13327202

Last Approved	N/A	Owner	Lea Woodrow: Director of Accreditation and Regulatory Complianc
Last Revised	N/A	Area	Administration
Next Review	N/A		

Serious Reportable Events

I. POLICY STATEMENT

A. Serious Reportable Events also known as an untoward medical occurrence which may or may not result in patient harm are reviewed to determine if the event meets criteria for a sentinel event, serious adverse event, or reportable "never event" and the harm associated with the event.

B. The clinical leader, nursing manager or designee will notify the patient or next of kin that the Serious Adverse Event meets reporting to California Department of Public Health (CDPH).

II. PURPOSE

A. To guide clinical staff with reporting and responding timely to serious adverse events.

B. To comply with public reporting to CDPH of serious adverse events.

III. DEFINITIONS

A. **Action Plan (AP)** is the product of the Comprehensive Systematic Analysis that identifies the strategies the organization intends to implement to reduce the risk of a similar patient safety event occurring in the future..

B. **Adverse Event** is an injury that was caused by medical management rather than the patients' underlying condition. Not all adverse events are the result of medical error.

C. **Adverse outcome** is a result that differs from the anticipated result of a treatment or procedure and results in harm to the patient

D. **CDPH** - California Department of Public Health

E. **Comprehensive Systematic Analysis** (CSA) previously known as Root Cause Analysis -RCA is a comprehensive systematic analysis used to identify the factors that underlie a serious adverse event or sentinel event. A comprehensive systematic analysis focuses primarily on

systems and processes, not on individual performance. The comprehensive systematic analysis will be completed within 45 calendar days of the serious adverse or sentinel event or of becoming aware of the event

F. **Disclosure** a process to provide open and honest communication with patients and families after adverse events or unexpected outcome by the physician or designee.

G. **BETA HEART** – (Healing, Empathy, Accountability, Resolution, Trust) a communication, apology and early resolution approach to adverse harm events.

H. **Just Culture-** a system of shared accountability in which organizations are accountable for the systems they have designed and for responding to the behaviors of their employees in a fair and just manner.

I. **Near Miss** is an event that did not reach a patient.

J. **Never Events** is an adverse event that is reportable under CA Health and Safety Code, §1279.1(b) (1)-(7) ,

K. **PSAT** – Patient Safety Advisory Team – A multidisciplinary administrative team that determine if the event is reportable to CDPH (Never/Sentinel event definitions), requires a full Comprehensive Review or debrief, if the event meets the HEART criteria and the disclosure process.

L. **Sentinel Event** is an unexpected occurrences involving death or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition.

    1. NOTE: The term sentinel event and medical error are not synonymous; not all sentinel events occur because of an error and not all errors result in sentinel events.

M. **Unexpected Adverse Outcome** is an adverse outcome that was not expected to be the result of the patient's treatment and there was harm suffered as a result.

IV. GENERAL INFORMATION

A. All areas licensed under the Salinas Valley Health Medical Center (SVHMC) are subject to the policy and procedure.

B. Under the direction of the Patient Safety Officer (PSO), Patient Safety and/or Risk Management shall collaborate with the responsible unit leaders to conduct an initial investigation of the facts of the event and identify discipline(s) to participate in the review. Specific staff participants will be recommended based on the facts known.

C. Any records, data, and knowledge collected for or by individuals assigned to investigate and review adverse events as part of the Quality Improvement Process and are confidential subject to California SB 1157 and/or the Patient Safety Work product.

D. If an event meets the criteria as a sentinel event or reportable "never event", a Comprehensive Systems Analysis (RCA) may be completed.

E. SVHMC supports a Just Culture philosophy and approach to adverse event investigation and response.

F. If the event is determined not to be a sentinel event, it will be addressed in accordance with established occurrence reporting processes.

G. SVHMC supports disclosure to patients/families as soon after the event as possible. DISCLOSURE OF UNANTICIPATED OUTCOMES POLICY.

H. Salinas Valley Health does not report events to The Joint Commission.

V. PROCEDURE

A. Immediate Action following a serious adverse or sentinel event.

1. Responsibilities of Staff Involved in the event

a. Stabilize the situation including but not limited to the following:

1. Assess the patient and assure their safety.
2. Notify attending physician to examine the patient.

b. If the event involves a medical device, immediately notify Biomedical Engineering to sequester the device(s) that may have been involved in the event. Leave everything intact - i.e. leave pumps on but running into a receptacle, leave equipment in the room, leave all monitors/pumps on. Save syringes/vials/ IV bags/ tubing and/or any other equipment and supplies per. MEDICAL DEVICE INCIDENT REPORTING PROGRAM

c. Notify the Administrative Supervisor and the Unit leader.

d. Document patient assessment and subsequent interventions and the facts surrounding the event in the electronic health record.

e. Enter the event in the safety occurrence reporting system.

2. Responsibilities of Unit Leader / Administrative Supervisor

a. Contact the Patient Safety Officer (PSO) and TigerConnect Page Risk Management Team

b. Determine the need to initiate the Care for the Caregiver process. Assure staff involved in the event are capable of continuing their care assignment.

c. Reinforce confidentiality and security.

d. Inform staff that all media inquiries are to be referred to Media/Public Relations. Facilitate the immediate sequestering of equipment, ensure documentation in the medical record, and conduct further notifications, as needed.

e. Consult with Patient Safety Officer / Risk Management (RM) designee to identify the appropriate contact person to initiate the initial communication with the patient / family in accordance with the DISCLOSURE OF UNANTICIPATED OUTCOMES POLICY

f. Conversations with the patient/family should be witnessed and documented in the medical record.

3. Responsibilities of the PSO / Designee

a. The PSO will notify Regulatory and Accreditation prior to close of business day who will coordinate a Patient Safety Advisory Team (PSAT) meeting to

be scheduled within 24 hours, to include leaders of the involved areas, PSO, Chief Medical Officer / designee if applicable to medical staff , Chief Nursing Officer (if a clinical event), Risk Manager and others as necessary.

b. If event meets criteria as reportable to the California Department of Public Health (CDPH), notification shall be made in accordance with the mandated reporting requirements.

c. If event is determined to be reportable and potentially causing harm to a patient the PSO will notify the Chair of the Board Quality and Efficient Practices Committee and the Board of Directors. After the full investigation is completed and the action plans are implemented, the Board of Directors will receive a detailed report on the sentinel/serious adverse event, through the regular reporting structure.

d. Notify Accounting for further handling related to accounting/billing and charges related to event. Bill will be placed on hold until reviewed in detail. RM will facilitate the ongoing process in collaboration with the Administrative Adjustment Committee.

4. Responsibilities of Risk Manager / Designee

a. Initiate investigation with the leader of the involved unit and begin evaluation of the event.

b. Collaborate with unit director(s) and staff to address immediate communication issues, sequester equipment, etc. as previously described.

c. The Biomedical Department in collaboration with the Risk Manager/ designee will be responsible for receiving and storing the impounded evidence. Medical Device Incident Reporting Program

d. Notify hospital liability carrier of event as needed.

B. Comprehensive Systematic Analysis Process/Root Cause Analysis/Investigation

1. Each sentinel/ adverse event as needed will have a Comprehensive Systematic Analysis/RCA or Investigation.

2. RM facilitates the investigation.

a. Work with the staff and unit leaders to develop recommendations for corrective actions.

b. In collaboration with the unit leaders the Quality Department staff facilitates the measures of successes/compliance with reporting to the appropriate committees.

3. Responsibility of Unit Leader

a. Assure involved staff can participate in the meetings.

b. Define and implement recommended corrective actions, as assigned.

c. Participate in reporting of action plans and effectiveness to respective committee(s).

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

A. California Department of Public Health Reportable Adverse Events Health and Safety Code, Section 1279.1 (b) (1) – (7) https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/Reportable-Adverse-Events.aspx

B. The Joint Commission-Sentinel Events

C. National Quality Forum-Serious Reportable Events

D. CHA Consent Manual E. HSC 1279.1 (b)

Attachments

A: Serious Reportable Events

Approval Signatures

Step Description	Approver	Date
Policy Owner	Lea Woodrow: Director of Accreditation and Regulatory Complianc	Pending

Standards

No standards are associated with this document

History

Comment by Kukla, Aniko: Director Quality & Patient Safety on 3/16/2023, 6:53PM EDT

> Added under section 3 c....and The Board of Directors.

ATTACHMENT A

1. The following are examples of occurrences that would meet the definition of a sentinel event, serious adverse event, including never events, but are not necessarily limited to:

CDPH: CA Senate Bill 1301: Health and safety Code Section 1279.1

(1) Surgical events, including the following:

A. Surgery performed on a wrong body part that is inconsistent with the documented informed consent for that patient. A reportable event under this subparagraph does not include a situation requiring prompt action that occurs in the course of surgery or a situation that is so urgent as to preclude obtaining informed consent.

B. Surgery performed on the wrong patient.

C. The wrong surgical procedure performed on a patient, which is a surgical procedure performed on a patient that is inconsistent with the documented informed consent for that patient. A reportable event under this subparagraph does not include a situation requiring prompt action that occurs in the course of surgery, or a situation that is so urgent as to preclude the obtaining of informed consent.

D. Retention of a foreign object in a patient after surgery or other procedure, excluding objects intentionally implanted as part of a planned intervention and objects present prior to surgery that are intentionally retained.

E. Death during or up to 24 hours after induction of anesthesia after surgery of a normal, healthy patient who has no organic, physiologic, biochemical, or psychiatric disturbance and for whom the pathologic processes for which the operation is to be performed are localized and do not entail a systemic disturbance.

(2) Product or device events, including the following:

A. Patient death or serious disability associated with the use of a contaminated drug, device, or biologic provided by the health facility when the contamination is the result of generally detectable contaminants in the drug, device, or biologic, regardless of the source of the contamination or the product.

B. Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. For purposes of this subparagraph, "device" includes, but is not limited to, a catheter, drain, or other specialized tube, infusion pump, or ventilator.

C. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a facility, excluding deaths associated with neurosurgical procedures known to present a high risk of intravascular air embolism.

D. Any magnetic resonance adverse events may also be reported to the FDA via the Medwatch program.

(3) Patient protection events, including the following:

A. An infant discharged to the wrong person.

B. Patient death or serious disability associated with patient disappearance for more than four hours, excluding events involving adults who have competency or decision making capacity. ***TJC has no time frame***

C. A patient suicide or attempted suicide resulting in serious disability while being cared for in a health facility due to patient actions after admission to the health facility, excluding deaths resulting from self-inflicted injuries that were the reason for admission to the health facility. ***TJC - or within 72 hours of discharge***

(4) Care management events, including the following:

A. A patient death or serious disability associated with a medication error, including, but not limited to, an error involving the wrong drug, the wrong dose, the wrong patient, the wrong time, the wrong rate, the wrong preparation, or the wrong route of administration, excluding reasonable differences in clinical judgment on drug selection and dose.

B. A patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products.

C. Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a facility, including events that occur within 42 days post-delivery and excluding deaths from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy, or cardiomyopathy.

D. Patient death or serious disability directly related to hypoglycemia, the onset of which occurs while the patient is being cared for in a health facility.

E. Death or serious disability, including kernicterus, associated with failure to identify and treat hyperbilirubinemia in neonates during the first 28 days of life. For purposes of this subparagraph, "hyperbilirubinemia" means bilirubin levels greater than 30 milligrams per deciliter.

F. A Stage 3 or 4 ulcer (injury), acquired after admission to a health facility, excluding progression from Stage 2 to Stage 3 if Stage 2 was recognized upon admission.

G. A patient death or serious disability due to spinal manipulative therapy performed at the health facility.

(5) Environmental events, including the following:

A. A patient death or serious disability associated with an electric shock while being cared for in a health facility, excluding events involving planned treatments, such as electric counter shock.

B. Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by a toxic substance.

C. A patient death or serious disability associated with a burn incurred from any source while being cared for in a health facility.

D. A patient death associated with a fall while being cared for in a health facility.

E. A patient death or serious disability associated with the use of restraints or bedrails while being cared for in a health facility.

(6) Criminal events, including the following:

A. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider.

B. The abduction of a patient of any age.

C. The sexual assault / death of a patient / staff, LIP, visitor or vendor within or on the grounds of a health facility.

D. The death or significant injury of a patient or staff member resulting from a physical assault that occurs within or on the grounds of a facility.

(7) An adverse event or series of adverse events that cause the death or serious disability of a patient, personnel, or visitor.

"Serious Disability" means a physical or mental impairment that substantially limits one or more of the major life activities of an individual, or the loss of bodily function, if the impairment lasts more than seven (7) days or is still present at the time of discharge from an inpatient health care facility, or the loss of a body part.

Additional CA SB 1237 Requirements:

1) A facility that uses CT X-ray systems shall notify the department, the affected patient, and the patient's treating physician immediately, in writing, of the occurrence of any of the following events:
   A. Irradiation of the wrong patient or irradiation of a body part other than that intended by the ordering physician and surgeon.
   B. A diagnostic dosage that exceeds by 50 percent or more the protocols established in subdivision (a).

2) Each facility that utilizes therapeutic X-ray systems operating at energies below one million electron volts (MeV) shall notify and report to the department, in accordance with department regulations, and shall also notify the affected patient and his or her treating physician within 10 days, in writing, of the occurrence of any of the following events:
   A. Irradiation of the wrong individual or wrong treatment site.
   B. Any treatment consisting of three or fewer fractions, with the calculated total administered dose differing from the total prescribed dose by more than 10 percent of the total prescribed dose.
   C. Any exposure resulting in a calculated total administered dose differing from the total prescribed dose by more than 10 percent of the total prescribed dose.

3) Each facility that utilizes therapeutic X-ray systems operating with energies at or above one MeV shall notify and report to the department, in accordance with department regulations, and shall notify the affected patient and his or her treating physician within 10 days, in writing, of the occurrence of any of the following events:
   A. Any event involving irradiation of the wrong individual, administration of the wrong type of radiation or the wrong energy, or irradiation of the wrong treatment site.
   B. Any treatment consisting of three or fewer fractions, with the calculated total administered dose differing from the total prescribed dose by more than 10 percent of the total prescribed dose.
   C. Any exposure resulting in a calculated total administration dose differing from the total prescribed dose by more than 20percent of the total prescribed dose.

Additional TJC Sentinel Events: (Not reportable to TJC)

(1) Prolonged fluoroscopy with a cumulative dose >1500 rads to a single field or any delivery of radiotherapy to the wrong body region or > 25% above the planned radiotherapy dose.
(2) Unanticipated death of a full term infant.
(3) Neonatal serum bilirubin >30 milligrams/deciliter

Proposed Data to Display on a Patient Safety and Quality Dashboard SVHMC

Proposed measures/rankings to display:

- **Hospital Compare Data and Star rating**
- **Leapfrog score**
- **Lown Institute Score**

FALL DATA:

- Falls reported to NDNQI (Magnet)
- Falls with injury reported to NDNQI (Magnet)

WOUND CARE DATA

- Pressure injuries reported to NDNQI (quarterly prevalence)
- Pressure injury incidence (overall)
- Reportable Pressure injuries (stg3, 4, and Unstageable)

INFECTION CONTROL DATA CAUTI (org goal)

- CLABSI (org goal)
- CDIFF (org goal)
- MRSA (CMS, Leapfrog)
- SSI's
- Hand Hygiene Data (Overall vs validation info)- org goal

Readmission and Mortality

AMI, COPD, HF, CABG, Pneumonia, stroke, THA/TKA- reported to CMS

Sepsis

Sepsis mortality – from Quantros

Overall Mortality

Overall Mortality index (Quatros)

Medication Safety

- Medication error rates

OB

PC-01: elective deliveries (Merative)

PC-02: Cesarean section rates (CQMCC)

Episiotomy rates (CQMCC)

PC-06: Unexpected Complications in Term Newborns

Diabetes

Hypoglycemia e measures

Stroke and MI

1. Door to needle time (CVA)
2. Door to PCI

Patient and employee Safety

- Workplace violence data
- Employee injury data (sharps injuries, slips, trips and falls)
- Never events reported to CDPH

Others to consider:

Throughput

Health Equity

ADJOURNMENT