Quality Council Minutes
March 18, 2014

Attendance: Jenny Chacon, Sue Currin (Co-Chair), Margaret Damiano, Thomas Holton, Kathy Jung, Jay Kloo, Elaine Lee, Tina Lee, Todd May (Co-Chair), Anson Moon, Sue Schwartz, Shannon Thyne, Lann Wilder.

Excused: Sue Carlisle, Terry Dentoni, William Huen, Valerie Inouye, Shermineh Jafarieh, Rachael Kagan, Iman Nazeeri-Simmons, Baljeet Sangha, Cathryn Thurow, Troy Williams, David Woods.

Guest(s): Kathy Ballou (for Terry Dentoni), Patty Coggan, Jeff Critchfield, Denise Fan, Ken Ferrigno, Manu Multani, Annelie Nilsson, Anh Pham, Charles Ramilo, Rafael Restauro, Dennise Rosas.

TOPIC	DISCUSSION	ACTION
I. ADMINISTRATIVE	• Sue Currin (Co-Chair) and Todd May (Co-Chair) chaired the meeting. • The minutes of the February 18th meeting were presented for approval.	Minutes approved.
II. POLICIES AND PROCEDURES	The following policy and procedures were presented by Jay Kloo, Director of Regulatory Affairs Director. <u>Policy 1.09-Patient Tracking System</u> Annelie Nilsson provided an overview of the new policy concerning the AeroScout patient tracking devices for flight risk patients. These devices provide notification to the SFSD and managers when patients leave their assigned inpatient unit. Additionally, the device will provide the patient with three levels of warning if it detects that the patient is wandering from the unit in up to five languages. The system is currently being piloted in one unit; however additional infrastructure needed for hospital –wide roll out. <u>Policy 3.11-Medical Examiner's Cases</u> No changes made. <u>Policy 3.22- Cytotoxic Agents: Ordering Cytotoxic Therapies</u> Minor changes made. <u>Policy 5.02-Emergency Medical Treatment and Active Labor Act (EMTALA)</u> No changes made.	All policies approved, with revisions as noted. Kathy Jung to provide weekly update, at security meeting, on infrastructure improvements and timeline for roll-out of patient tracking device.

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	<u>Policy 9.07- Infection Control: Orders for Isolation, Examination, Detention and Discharge of Persons Suspected or Confirmed as Having Infection</u> Policy changes include: the TB Controller shall advise SFGH Counsel in writing if a detention order is violated. Council members asked if there was a problem with placing affected patients on detention. Elaine Dekker, Infection Control, indicated that these detention orders were rare. <u>Policy 19.04- Responsibility and Authority to Intervene to Protect Patient Safety: "Stop the Line"</u> Tom Holton, Patient Safety Officer, presented on the new policy which outlines procedures for all staff to report and stop a potential unsafe practice. Dr. Todd May provided revisions to be integrated into the policy under the physician section of the policy. <u>Policy 5.02- Hazard Communication -- Hazardous Materials Management Program</u> Summary of policy changes include: Changes focus on the classification/labeling of chemicals, precautionary measures, replaces Material Safety Data Sheets with Safety Data Sheets with expanded informational requirements, etc. which must be implemented by June 2015.	
III. PERFORMANCE MEASURES REPORTING **Operating Room (OR)**	Patty Coggan, Nurse Manager for the Operating Room, presented on the department's Performance Improvement activities. **<u>OR Efficiency</u>** **AIM:** By November 2014, 80% of 1st cases of the day will be in room by 0730, 90% of cases in room by 0735, and 95% in room by 0740. • Data collected over the last 2 years shows consistent increase in percentage of cases starting by 0730. • Elements contributing to steady improvement included: -Standard work to have services identify a daily "Accountable Resident" for each OR daily. - Team huddle the day before to identify issues. Members asked if there was an analysis of the 10% of cases that are delayed, i.e. reasons for delay. An analysis is currently in process looking at defects impacting delayed cases.	Continue to keep staff well informed of results and progress The delayed case analysis data will be presented during Tier 1 and Tier 2 report outs.

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	Increase OR Caseload **AIM:** Increase overall OR caseload by 3% by December 2014. • Over the last 2 years, the OR has increased overall caseload by 9%. • Factors contributing to increase include: implementation of "Fastrack" model to Ortho Hand service on Fridays, and Ophthalmology on Wednesdays. • Hand cases increased doubled from 4-8 cases and Eye increased from 4-7 case without increases in clinic days or staffing but by building a cohesive team. **There was discussion about the need for additional supplies to accommodate the increased case volume.** **Perioperative Huddle** **AIM:** By March 2013, a multidisciplinary group consisting of PACU/OR/ Surgicenter/SPD and Anesthesia will implement standard work for a "huddle" at the OR front board daily at 2 PM. • The OR implemented a perioperative huddle in December 2012 with standard work for the huddle developed in March 2013. • Compliance with use of the standard work (Huddle checklist) has been 100%. **5S Workplace Organization** Achieve a 5S score of at least Level 3 throughout the Operating Room • Or has sustainede5 minute 5S, with an average of level 3 – level 4 overall 5S Score for past year. **Time-Out** **AIM:** 100% adherence to all components of time-out poster by December 2013. • Weekly audits (about 3-5 per week) monitored adherence to all time-out components. • Audit of five Time Out cases conducted week of March 10, 2014 – 100% use of Time Out Poster. Some questions included: 1) The effectiveness of using a poster vs. a form and 2) Expected timeline for expansion to other procedural areas of the hospital. Patty Coggan indicated that a poster focuses and engages staff. **Lead Time for 2nd Cases** **AIM:** Reduce Lead time for 2nd case patients by revising arrival time to 2 hours	Data collection to monitor Fastrack start times and caseload per session. OR to review Materials and Supplies budget, to ensure that appropriate budgeting for increased supplies is included. Continue to monitor and reinforce. Todd May will provide an update the April Quality Council meeting on the status of the expansion of the time-out poster to other areas.

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	prior to anticipated start time. • Reduced lead time for 2nd case patients by 2 hours and 34 minute (a 30% reduction) by changing the time patients arrived from 0700 to 2 hours prior to anticipated case start time (7:54 vs. 5:25~~AM~~).	
IV. TRANSITIONS TASK FORCE UPDATE	Dr. Larissa Thomas, Dr. Michelle Schneidermann, and Karishma Oza, MPH presented on the improvement work for the Care Transitions Taskforce. The goal of the SFGH Care Transitions Taskforce is to reduce all-cause 30 day readmissions for patients discharged from SFGH by 15% from a baseline of 12.3% to 10.4% by December 2014. It aims to reduce readmissions through: a) Coordination along care continuum; b) Promotion of best practice standards; c) Identification and referral of high risk patients; and d) Provision of timely performance feedback. Work to date for Transitions Taskforce have focused on Inpatient, Outpatient , and High Risk improvement work such as • Partnering with IT to build standard discharge template • Using risk prediction tool based on BOOST 7P's tool • Participating Taking accountability for Ambulatory Care Transitions (TAACT) collaborative: Primary Care-based pilot utilizing complex care management teams to do transitions work. • Admission list developed with IT that is searchable by clinic and primary care Clinic. • Primary Care Integration work focusing on standard for scheduling post-discharge follow-up appointment, and documentation of post-discharge appointments.	Next steps include: 1) Creation of a data dashboard to look at high risk populations; 2) Analysis of readmitted patients; 3) Working with DPH Primary Care Integration Group to scale outpatient interventions.
V. EOC SAFETY/SECURITY REPORT	Captain Ken Ferrigno, San Francisco's Sheriff's Department (SFSD), reported on the latest Environment of Care (EOC)/Security report in response to the CMS plan of correction. He indicated that At-Risk/AWOL Data would be reported at their next quarterly Quality Council update. **SFSD Committee Attendance:** • SFSD maintained 100% attendance at each of its required committees (i.e. Admin Ops, Code Green Taskforce, Employee Health & Safety, Violence Prevention Taskforce Team, etc.).	

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	SFSD Orientation SFSD staff working on the SFGH campus either attend the 8hr orientation training or the 4hr abbreviated training (for part time/overtime/sick coverage staff) • Currently, all SFSD staff that are regularly assigned the SFGH campus have been to the 8hr SFGH Orientation. (100% compliance) • SFSD Staff received SMART training during SFGH Orientation and a separate Code Green training in the Fall of 2013. • 37 SFSD were trained in HICS. (100% completion). **Privacy Compliance** The SFSD Captain or designee conduct random audits of ten taped calls per month from the SFGH SFSD communications center to ensure compliance with confidentiality of protected health information. • Audits from December 2013 thru February 2014 reveal zero patient privacy issues (100% compliance with Privacy Policy) and 94% compliance with documentation accuracy. **Daily Stairwell Check** The SFSD will perform daily stairwell checks, record in SFSD logbook, and report to AOD. • 100% compliant. **Stairwell Alarm Activations** SFSD responds to all Stairwell alarm activations in Bldg. 5. • Compliance with response to all stairwell alarm activations – 100% **Stairwell Alarm Preventive Maintenance** Facilities performs preventative maintenance (PM) every 4 months on the stairwell alarms. • PMs completed on all stairwell alarms between 12/2/13 and 12/7/13. **Surveillance Camera Training** All SFSD supervisors to be trained on the use of the surveillance cameras. • 80% of Supervisors and Dispatcher have been trained. • Two supervisors are currently on Disability and have not yet been	Continue monitoring to ensure that all new SFSD to SFGH receive adequate training. Continue Monitoring. Continue Monitoring.

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	trained. **AeroScout** • DPH IS department to work out the details of operationalizing the AeroScout tracking system. **Code Green Drills** • 10 drills conducted between 1/17/2014 to 2/5/14.	Continue with periodic drills.
VI. HAZARD VULNERABILITY ANALYSIS (HVA)	Lann Wilder, Director of Emergency Management reported on the Disaster Committee's annual Hazard Vulnerability Analysis (HVA) for Quality Council approval. The following seven items were identified as hazards of focus for 2014: • Earthquake • Electrical Power Failure • Epidemic of Disease Outbreak • Medical Multi-casualty • Active Shooter • Water Failure/Drought • Generator Failure (added this year)	Quality Council approved the annual HVA Checklist.
VII. PATIENT SAFETY PLAN/NPSG 2014	Tom Holton, Director of Patient Safety and Elaine Dekker, Infection Control presented on the Patient Safety Plan Progress Report. Some highlights included: • Exceeding hand hygiene compliance goal (95% vs. goal of 92%) • Central Line Improvement Program (CLIP): Goal of all CL inserters will be 100% compliant with CLIP bundle not met (SFGH =99.45, Non-ICU=99.3%, ICU=99.7%). -Emergency Department (ED) in process of developing electronic reporting process. Current systems don't support showing compliance to each component. • Ventilator Associated Pneumonia (VAP): VAP bundle care compliance was lower in lower suspected VAP cases than for audited, general ICU patients (i.e. Oral Care 62%). • Catheter Related Urinary Tract Infections (CAUTI): Goal of decrease CAUTI not met (SFGH increase of 5%, ICU increase of 19%, goal only	Critical Care and Respiratory to provide clarification on bundle rate for VAP bundle rates at April Quality council meeting. Critical Care to provide update at April Council meeting on CAUTI rate.

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	met in non-ICU). • Sepsis Mortality reduced by 18%. Anh Pham, Data Center Analyst, provided an over view of the Hospital-wide Patient Safety Dashboard which displays hospital wide data on harm metrics, as well as unit specific data. These dashboards will be updated monthly and posted on all inpatient units.	
VIII. ANNOUNCEMENTS	No Announcements made.	
NEXT MEETING	**April 15, 2014 7M30B**	