PAJARO VALLEY HEALTH CARE DISTRICT
HOSPITAL CORPORATION

Board Members

- John Friel (Chair)
- Dr. Katherine (Katie) Gabriel-Cox
- Dr. Joe Gallagher
- Jose A. (Tony) Nuñez
- Marcus Pimentel

Closed Meeting Agenda

Wednesday, March 29, 2029-5:00 PM

Kathleen King Community Room - 85 Nielson Street, Watsonville

https://zoom.us/j/93443061917

Phone: +1 669 900 9128 WEBINAR ID: 934 4306 1917

Agenda documents are available for review in person at Watsonville Community Hospital, 75 Nielson Street, Hospital Main Lobby-Visitors Desk; and electronically on the Pajaro Valley Healthcare District's website, at: PVHCDHC.ORG. To view online, visit the Board's website at: **PVHCDHC.ORG** and select the meeting date to view the agenda and supporting documents. Written comments on agenda items may also be submitted to the Board by email or US Mail. Comments received after 4 p.m. on the day of the meeting and before the end of the meeting will be included in the official record.

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Watsonville, CA 95076

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Pajaro Valley Health Care District Hospital Corporation
Closed Meeting Agenda- Wednesday, March 29, 2023

Call to Order

Roll Call

Public Comment on Matters on Agenda

Adjourn to Closed Session

1. **Conference with Labor Negotiators** (Gov't Code 54957.6)
   Agency Negotiator: Allyson Hauck; California Nurses Association (CAN)
   Contact: Allyson Hauck, Chief Human Resources Officer

2. **Hearings/Reports** (Health and Safety Code HSC § 1461 and 32155)
   Reports of Patient Safety and Quality Committee, Medical Staff Credentials Committee, Medical Staff Interdisciplinary Practice Committee and Quality Dashboard.
   Contact: Executive Sponsor-Dr. Angel, Chief of Staff

Adjournment

This agenda was posted in accordance with the California Brown Act. Any materials related to an item on this Agenda submitted to the Board after distribution of the agenda packet will be made available to the public in accordance with Government Section 54957.5.

PAJARO VALLEY HEALTH CARE DISTRICT
HOSPITAL CORPORATION

Board Members

- John Friel (Chair)
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Regular Meeting Agenda

Wednesday, March 29, 2023-5:30 pm

Zoom: https://zoom.us/j/93443061917

Phone: +1 669 900 9128 WEBINAR ID: 934 4306 1917

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Pajaro Valley Health Care District Hospital Corporation
Regular Meeting Agenda- Wednesday, March 29, 2023

Call to Order

Roll Call

Closed Session Report

Agenda Modification Consideration

Public Comment on Matters Not on the Agenda

Time is set aside for members of the public to address the Board on any item not on the Board Agenda (not to exceed two minutes), which is within the subject matter jurisdiction of the Board.

Comments regarding items included on the Agenda will be heard before the item is discussed by the Board.

No action or discussion shall be taken on any item presented except that any Board Member may respond to statements made or questions asked or may ask questions for clarification. All matters of an administrative nature will be referred to staff. All matters relating to the Board will be noted in the minutes and may be scheduled for discussion at a future meeting or referred to staff for clarification and report.

Comments from Board Members

Consent

All items listed under the Consent Calendar are considered and acted upon by one Motion. Members of the public must request that a Board Member pull an item from the Consent Agenda for discussion prior to the start of the meeting.

1. **Minute Approval: February 22, 2023**
   Recommendation: Pass a **Motion** approving the minutes for February 22, 2023.
   Contact: Dawn Bullwinkel, Interim Clerk of the Board, dbullwinkel@watsonvillehospital.com

2. **Policies/Policy Summary Approval: March 2023**
   Recommendation: Pass a **Motion** approving the Policies/Policy Summary.
   Contact: Sherri Torres, Chief Nursing Officer, Sherri_StoutTorres@Watsonvillehospital.com

3. **Cash Advance**
   Recommendation: Receive and file information regarding $1,000,000 cash advance through Central California Alliance for Health.
   Contact: Julie Peterson, Chief Financial Officer

Discussion

4. **Strategic Planning-Discuss Revised Timeline**
   Recommendation: Update by Chartis-a top healthcare strategic advisory firm on status and optional timelines for the Strategic Planning process.
   Contact: Steven Salyer, Chief Executive Officer

5. **Salary for Interim Chief Executive Officer Matko Vranjes**
   Recommendation: Pass a **Motion** approving an annual salary for Interim Chief Executive Officer Matko Vranjes. Current benefits and other terms and conditions of employment will continue during the Interim Appointment
   Contact: Allyson Hauck, Chief Human Resources Officer

6. **Chief Financial Officer Monthly Financial Performance**
   Recommendation: Receive and file.
   Contact: Julie Peterson, Chief Financial Officer

7. **Medical Executive Committees (MEC) Reports March 2023**
   Recommendation: Pass a **Motion** approving 1) MEC March 2023 Credentials Report; 2) MEC March 2023 Interdisciplinary Practice Credentials Report; 3) Medical Staff Items and 4) MERP-YTD 2022.
   Contact: Clay Angel, M.D., Chief of Staff Chair, Medical Executive Committee

Adjournment

This agenda was posted in accordance with the California Brown Act. Any materials related to an item on this Agenda submitted to the Board after distribution of the agenda packet will be made available to the public in accordance with Government Section 54957.5.

PAJARO VALLEY HEALTH CARE DISTRICT
HOSPITAL CORPORATION

Back

Board Report

Meeting Date: March 29, 2023
Report Type: Consent

Minutes Approval: February 22, 2023

Recommendation: Pass a Motion approving the minutes for February 22, 2023.

Contact: Dawn Bullwinkel, Consultant Board Clerk

Analysis

After each Board meeting, the Board Clerk composes the DRAFT minutes noting the action taken by the board. Those DRAFT minutes are presented to the Board Members for their approval as a permanent record of the meeting actions.

Financial Impact: None

Attachments:

A. February 22, 2023 Closed
B. February 22, 2023 Regular

Pajaro Valley Health Care District Hospital Corporation
Closed Session Agenda- Wednesday, February 22, 2023

Call to Order at 5:01 pm

Roll Call: Present-Directors Cox, Gallagher, Nunez, Pimentel and Chair Friel

Closed Session Public Comment-None.

Closed Session

1. **Hearings/Reports** (Health and Safety Code HSC § 1461 and 32155)
   Reports of Patient Safety and Quality Committee, Medical Staff Credentials Committee, Medical Staff Interdisciplinary Practice Committee and Quality Dashboard.
   Contact: Executive Sponsor-Dr. Angel, COS

Adjourned to Closed Session-at 5:03 pm.

This agenda was posted in accordance with the California Brown Act. Any materials related to an item on this Agenda submitted to the Board after distribution of the agenda packet will be made available to the public in accordance with Government Section 54957.5.

Pajaro Valley Health Care District Hospital Corporation
Regular Meeting Minutes- Wednesday, February 22, 2023

Called to Order at 5:18 pm.

Roll Call: Present-Directors Cox, Gallagher, Nunez, Pimentel and Chair Friel

Closed Session Report: None

Agenda Modification Consideration: Supplemental material received and filed.

Public Comment on Matters Not on the Agenda-None

Comments from Board Members-None

Consent Agenda

All items listed under the Consent Calendar are considered and acted upon by one Motion.
Moved/Seconded: Pimentel/Gallagher
Yes: Directors Cox, Gallagher, Nunez, Pimentel and Chair Friel

1. **Assembly Bill 361 Approving the Use of Teleconference Meetings for Board of Directors**
   Action: **Resolution 002-2023** passed making findings and ordering the use of Teleconference Meetings of the Board of Directors due to Covid-19, pursuant to the requirements of Assembly Bill 361.
   Contact: Dawn Bullwinkel, Interim Clerk of the Board, dbullwinkel@watsonvillehospital.com

2. **Minute Approval: December 28, 2022 and January 25, 2023**
   Action: **Motion No. 016-2023** passed approving the minutes of the December 28, 2022 and January 25, 2023.
   Contact: Dawn Bullwinkel, Interim Clerk of the Board, dbullwinkel@watsonvillehospital.com

3. **Policies/Policy Summary Approval: February 2023**
   Action: Policy 2842 pulled by member Gallagher and **Motion No. 017-2023** passed approving the Policies/Policy Summary except for policy 2842.

   Moved/Seconded: Gallegher/Pimentel
   Yes: Directors Cox, Gallagher, Nunez, Pimentel and Chair Friel
   Motion No. 018-2023 passed approving Policy 2842 as amended regarding communications with involved practitioners and external peer reviews.
   Contact: Sherri Torres, Chief Nursing Officer, Sherri_StoutTorres@Watsonvillehospital.com

Discussion

4. **Chief Executive Officer Steven Salyer Oral Report on Operational Hospital Activities**
   Action: Received and filed an oral report from Chief Operating Officer Steven Salyer.
   Contact: Steven Salyer, Chief Executive Officer

5. **Association of California Healthcare Districts (ACHD)**
   Action: Received ACHD presentation given by Cathy Martin, CEO and Sarah Bridge, Senior Legislative Advocate.
   Contact: Steven Salyer, Chief Executive Officer

6. **Medical Executive Committees Reports Report February 2023**
   Moved/Seconded: Friel/Cox
   Yes: Directors Cox, Gallagher, Nunez, Pimentel and Chair Friel
   Action: **Motion No. 019-2023** passed 1) approving Interdisciplinary Practice Credentials Report and 2) approving Medical Staff Items: a) Required current ACLS Certification for Hospitalists, add requirement to Privilege Lists, b) Updated OBGYN Privilege List and c) OBGYN OPPE/FPPE & Triggers.
   Contact: Clay Angel, M.D., Chief of Staff Chair, Medical Executive Committee

7. **Chief Financial Officer Monthly Financial Performance**
   Action: Received and filed Monthly Financial Performance report from Chief Financial Officer, Julie Peterson.
   Contact: Julie Peterson, Chief Financial Officer

Adjourned at 6:30 pm.

PAJARO VALLEY HEALTH CARE DISTRICT
HOSPITAL CORPORATION

Back

Board Report

Meeting Date: March 29, 2023
Report Type: Consent

Title: Policy/Summaries March 2023

Recommendation: Pass a **Motion** approving the Policies and Summary Report of March 2023.

Contact: Sherri Torres, Chief Nursing Officer, Sherri_StoutTorres@Watsonvillehospital.com

Analysis

As required under Title, 22, CMS and The Joint Commission (TJC), a list of regulatory required policies with a summary of changes is provided for your approval.

Financial Impact: None.

Attachment A:
Reports

Watsonville Community Hospital
POLICY APPROVAL SUMMARY REPORT

Committee: Board of Directors
Reporting Period: March 2023

As required under Title, 22, CMS and The Joint Commission (TJC), please find below a list of regulatory required policies with summary of changes that request your approval.

Policy Title	Policy Number	Summary of Changes	Rationale for Change	Approvals & Dates
Emergency Department (ED)				
Massive Transfusion Protocol	XXXX	Policy is updated to meet current evidence based guidelines and updated interdisciplinary hospital wide response process'. replacing is #2240 Rapid Autologous Transfusion System	New Policy: Policy is updated to meet current evidence based guidelines and updated interdisciplinary hospital wide response process'	Author: ED Department/Laboratory Director: CNO: 02/2023 COO:02/23/2023 VP/SR.Leader/CEO: MEC: BOT:

WATSONVILLE COMMUNITY HOSPITAL

Policy Title	Massive Transfusion Protocol	**Policy #**	XXXXX
Responsible	Emergency Department, Labor & Delivery, Intensive Care Unit, Special Procedures, Operating Room, Pediatrics, Anesthesia, Laboratory.	**Revised/Reviewed**	2/23/2023

I. PURPOSE

A. Provision of a standard for the activation and administration of an MTP (Massive Transfusion Protocol) for rapid distribution of blood products for patients with massive hemorrhage. MTPs are a designed system of locally agreed and specific guidelines to mitigate the triad of acidosis, hypothermia and coagulopathy of hemorrhagic shock.

II. POLICY

A. A Provider may choose to request 1-2 units of Emergency Release blood while assessing the need for an MTP. To do so, the Provider will:
   1. Complete the form Emergency Release for Uncrossmatched O Blood.
   2. Call the Blood Bank at extension x1059 with the verbal request and patient sex.
   3. Send a runner to the Blood Bank for immediate pick-up with the yellow copy of the Emergency Release Form.

B. Consider MTP if there is an expected need of greater than two (2) Emergency Release pRBCs (packed Red Blood Cells) or more than ten (10) cross-matched units in 24 hours.

C. A Provider may activate the MTP as indicated, including:
   1. Emergency Department patient with penetrating or blunt trauma, GI bleed, aortic dissection, etc.
   2. Obstetrics patient with Cesarean section complications, postpartum hemorrhage, etc.
   3. Special Procedure patient with GI bleed, complications of colonoscopy, interventional procedure, etc.
   4. Surgical patient with complications from surgical procedure, etc.
   5. ICU patient with hemorrhagic shock, GI bleed, post-surgical bleed, DIC, etc.
   6. Pediatric patient with penetrating trauma, GI bleed, etc.
   7. Deviations from protocol may occur at Provider discretion and are to be documented by the associated units.

D. When MTP is activated, blood products are released as a complete package and should not be modified.

E. Providers and the Blood Bank coordinate to ensure judicious use of blood components.

F. Blood Bank technicians ensure best practice of preparation, inspection, and processing of blood products for prompt and efficient release.

G. Blood product shortages are communicated to the various department chairs in a timely manner for information distribution to all providers.

H. Blood Bank is required to collect an initial sample for blood type and antibody screen at or prior to transfusion. Additional samples, e.g. blood type confirmation, hemograms, are essential throughout the MTP to assess hemostasis.

III. DEFINITIONS

A. Emergency Release is a release of universal product (1-2 units pRBC, type O) for rapid administration prior to blood type and antibody screen completion.
   1. Pediatric Emergency Release is the rapid release of 1 unit pRBC, type O, irradiated, CMV seronegative. A 'Pedi-pack will be pre-filtered by the Blood Bank for the requested volume.
   2. The Pediatrician or Neonatologists will consult with the Laboratory Pathologist if deviating from the expected type O, CMV-negative, irradiated, filtered 'Pedi-pack.'

B. Massive Hemorrhage may include tachycardia, palpitations, tachypnea, pallor, hypotension, reduced arterial pressure and urinary output, acidosis, coagulopathy.
   1. Blood loss is calculated as % of TBV, total blood volume, or estimated volume:

Figure 1. Hemorrhagic Shock Classification

PATIENT TYPE	CLASS	BLOOD LOSS	CLINICAL SEVERITY
Adult [1]	Class I	Up to 15% TBV	Mild
	Class II	15-30% TBV	Mild
	Class III	30-40% TBV	Moderate
	Class IV	>40% TBV	Severe
Postpartum	Vaginal	>500 mL	Hemodynamic instability with any volume loss.
	C-section	>1000 mL	

C. MTP (Adult Massive Transfusion) is the expected need of more than 10 blood products in 24 hours.

D. pedMTP (Pediatric Massive Transfusion) is the expected administration of more than 20 mL/kg pRBC in the first hour of resuscitation, or an expected need of greater than 0.1 units/kg pRBC within the first 12 hours of resuscitation.

E. pRBC (packed Red Blood Cells) is one unit of concentrated red blood cells of a specific blood type.

F. FFP (Fresh Frozen Plasma) is one unit of plasma substrate.

G. Platelets is one unit of concentrated pooled platelets from 4-6 donors.

H. Pediatric is defined as a person less than 12 years of age or less than 50 kilograms.

I. Neonatal is defined as birth-28 days of life.

J. MTP Cooler is the prepared component therapy into a transportable cooler to the patient.
   1. Adult MTP components (patient > 50 kg):
      a) 4 units pRBC.
      b) 4 units of FFP.
      c) 1 unit of pooled platelets (store at room temperature).
   2. Modified MTP components:
      a) 2 units pRBC.
      b) 2 units of FFP.
      c) 1 unit of pooled platelets (store at room temperature).
   3. Ped MTP components (patient < 50 kg):
      a) 10-15 ml/kg of pRBC (Blood type O or type-specific).
      b) 10-15 ml/kg of FFP.
      c) 5-10 ml/kg of pooled platelets (store at room temperature).

IV. PROCEDURES

Table 1. MTP Initiation

	ROLE	EXPECTED RESPONSE – 5 MINUTES
A	**Provider**	1. Identify patient in need of MTP. 2. Enter electronic MTP order set or MTP verbal order to Nurse. 3. Notify potential medical staff consults: Anesthesiologist, Pediatrician, Cardiology, Radiologist, Surgeon, Intensivist, O.R., Pathologist, etc
B	**Nurse**	1. Place MedHost order for MTP. 2. Track blood product order(s) via MedHost or Blood Product Transfusion Physician Order (Form 1522-7060-31). 3. Identify a Runner for the Blood Bank cooler(s).
C	**Unit Clerk**	1. Call Operator to activate MTP via overhead page "Massive Transfusion, Location, Bed #."
D	**Blood Bank**	1. Prepare MTP cooler for transport. a. Males, Females >age 55: O positive. b. Females, reproductive potential: O negative. c. All patients: Group A plasma. d. Switch to ABO type-specific pRBCs ASAP. 2. Communicate any potential concerns to Nurse and Pathologist.
E	**Phlebotomist**	1. Collect 'rainbow' blood samples, deliver to Lab for testing. Phlebotomy will not wait for a line to be placed.
F	**Respiratory Therapist**	1. Report for airway support. 2. Obtain blood gas sample if ordered by provider.
G	**House Supervisor**	1. Obtain rapid transfuser. 2. Coordinate patient transfer to MTP location: a. Special procedure – to ED. b. Med-surg or Telemetry – to ICU. c. OB, OR – to ICU. 3. Plan for if patient transfer to outside hospital for definitive management.
H	**Runner**	1. Report to Nurse to receive blood product orders. 2. Obtain patient demographic label for delivery to Blood Bank.

Table 2. MTP Ongoing

	ROLE	ONGOING TASKS
A	**Provider**	1. Communicate challenges, completion of tasks with nursing, consults. 2. Ensure documentation of details for blood product administration.
B	**Nurse**	1. Obtain 2 large-bore IVs ≥ 18-gauge for large volume rapid infusion. 2. Set up level 1 or Beltmont transfuser to warm blood prior to administration. 3. Collect Laboratory samples at the end of each shipment (blue, purple, gold). 4. Maintain normothermia with ambient temperature control and Bair Huggers. 5. Administer blood products to the patient in the fastest, safest manner. a. Repeat back patient identifiers. b. Repeat back blood product identification.
C	**Unit Clerk**	1. Assist with contacting additional providers, department heads.
D	**Blood Bank**	1. Prepare additional MTP cooler for transport. 2. Track all products leaving the Laboratory. 3. Contact Red Cross for additional blood products as necessary. 4. Communicate challenges, delays, and product shortages promptly. a. 20 minutes to thaw FFP.
E	**Phlebotomist**	1. Collect appropriate blood samples from nurse, deliver to Lab for testing. 2. Act as a Runner if needed.
F	**Respiratory Therapist**	1. Continue airway and blood gas support.
G	**House Supervisor**	1. Continue coordination of care.
H	**Runner**	At each cooler delivery: 1. State patient name, gender, blood type in cooler. 2. Ask provider: “Continue, Stop, or Hold?”

I. Other adjunct therapies and resuscitation measures:

Place appropriate large bore IV catheter.
Avoid hypothermia.
Avoid hypocalcemia.
Avoid acidosis.
Minimize crystalloid administration.
Consider hemostasis in all patients.
Consider reversal of anticoagulants.
Consider TXA in trauma or OB patients.
Consider cryoprecipitate order to Red Cross.

Table 3. MTP Cessation

	ROLE	CESSATION TASKS
A	**Physician**	1. Deactivate MTP. Notify Nurse, House Supervisor, Med Staff Consults. 2. Sign all orders, i.e. Emergency Release, Blood product orders, Transfusion orders, etc.
B	**Nurse**	1. Notify Blood Bank, state if there are blood products to be returned. 2. Determine if blood samples are needed to assess hemostasis.
C	**Blood Bank**	1. Immediately reconcile all products issued and returned. 2. Determine if products can be returned to storage vs. wastage. Document.
D	**Phlebotomist**	1. Assist with tracking and return of all blood products.
E	**Respiratory Therapist**	1. Support respiratory needs as necessary.
F	**House Supervisor**	1. Transfer patient to appropriate location for ongoing resuscitation when stable.
G	**Runner**	Return all unused products to Laboratory Blood Bank ASAP to prevent waste: 1. pRBC on ice packs. 2. **Platelets** at room temp!

V. REFERENCES

1. ATLS Classification of Hemorrhagic Shock. December, 2021.
2. AAST. American Association for the Surgery of Trauma. Safety of the Use of group A Plasma in Trauma: the STAT Study. Nancy M. Dunbar and Mark H. Yazer, Biomedical Excellence for Safer Transfusion (BEST) Collaborative. Transfusion 2017;57 ;1879-1884.
3. Evangelista ME, Gaffley M, Neff LP. Massive Transfusion Protocols for Pediatric Patients: Current Perspectives. J Blood Med. 2020;11:163-172 https://doi.org/10.2147/JBM.S205132.
4. MTP Policy Benchmarks: Natividad Trauma Center, UCSF, Stanford, Regional Medical Center.
5. EM Crit: https://emcrit.org/ibcc/mtp/ . Internet Book of Critical Care. Accessed 2.16.2023.
6. Blood shortages and changes to MTP in COVID pandemic: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8530788/
7. Jennings LK, Watson S. Massive Transfusion. [Updated 2022 Aug 29]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2022 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK499929/

VI. ATTACHMENTS

1. Adult Blood Product Transfusion Physician Orders. Form 152-7060-31.
2. Emergency Release for Uncrossmatched O Negative Blood. Form 152-6133-01.
3. Blood Transfusion Consent. Form 152-7060-100.

WATSONVILLE COMMUNITY HOSPITAL

Policy/Procedure Title	Rapid Autologous Transfusion System	**Manual Location**	PACU		
Policy/Procedure #	2240	**Effective**	10/93	**Page**	1 of 6
Department Generating Policy	Surgery	**Revised**	12/12		
Jane Winning		**Dept/Title**	Surgical Services Director		
Cheryl Moore		**Dept/Title**	Director Laboratory Svcs		
Jennifer Gavin		**Dept/Title**	Pharmacy Director		
Cheryl Richardson		**Dept/Title**	Infection Preventionist		
Sherri Stout-Torres		**Dept/Title**	CNO		
Donna Salvi		**Dept/Title**	CQO		
Aurdra Earle		**Dept/Title**	CEO		
B&T: Paula Quinn, MD		**Dept/Title**	Chair		

I. PURPOSE:

To ensure the proper use of the Rapid Autologous Transfusion System (RATS). To ensure patient safety.

II. POLICY:

A autologous blood recovery system which collects blood, concentrates and washes the red blood cells. It is indicated for use for processing:

Blood shed by a patient during surgery;
Blood collected preoperatively from trauma patients (e.g., traumatic hemothorax);
Blood collected postoperatively from chest or wound drains
Blood collected for the purpose of autologous platelet rich plasma.

The Rapid Autologous Transfusion System will be used on the order of the physician. Operators will be aware of the manufacturer's suggestion regarding contraindications. Each operator will complete the competency review checklist, review policy and procedure, and perform a demonstration of the system if the operator has not actually used the equipment during the period, bi-annually in April and October.

III. PROCEDURE:

A. Obtain informed consent from the patient for cell salvage. This is included on the back of the transfusion consent.

B. All operators will know the contraindications as stated by the manufacturer and rationale thereof. These contraindications include:

1. Use of the Rapid Autologous Transfusion System in the presence of amniotic fluid.
    a. Effect: Contains proteolytic enzymes which could activate clotting.
    b. Recommended Action: DO NOT ASPIRATE INTO SYSTEM.
2. Fecal Contamination
    a. Effect: Sepsis

b. Recommended Action: DO NOT ASPIRATE INTO SYSTEM. Aspiration may be necessary in emergency cases. The use of the Rapid Autologous Transfusion System in these situations is left to physician's discretion.

3. Use of the RATS in the presence of tumor cells.
   a. Effect: Potential of metastasis not well studied. Use of autologous blood, however, reduces exposure to homologous blood products and the potential of suppression.
   b. Recommended Action: DO NOT ASPIRATE INTO SYSTEM. Aspiration may be necessary in emergency cases. Use of the RATS in these situations is left to the physician's discretion.

4. Use of the RATS in the presence of clotting adjunct (monofilament collagen, topical thrombin).
   a. Effect: May activate clotting.
   b. Recommended Action: DO NOT ASPIRATE INTO SYSTEM. **Irrigate wound before resuming salvage.**

5. Use of the RATS in the presence of Betadine.
   a. Effect: Reduces hemoglobin (seems to be a reversible effect). May cause allergic reaction if patient sensitive to iodine.
   b. Recommended Action: DO NOT ASPIRATE INTO SYSTEM. **Irrigate wound before resuming salvage. Thorough wash of salvaged blood.**

6. Use of the RATS in the presence of Fibrin Glue Thrombin.
   a. Effect: May activate clotting.
   b. Recommended Action: DO NOT ASPIRATE INTO SYSTEM. **Irrigate before resuming salvage.**

7. Use of the RATS in the presence of Avitene.
   a. Effect: Platelet Activation.
   b. Recommended Action: DO NOT ASPIRATE INTO SYSTEM.

8. Use of the RATS in the presence of Methyl Methacrylate
   a. Effect: Toxicity, heat produced hemolysis.
   b. Recommended Action: DO NOT ASPIRATE INTO SYSTEM. **Irrigate before resuming salvage.**

9. Use of the RATS in the presence of gastric fluids.
   a. Effect: Proteolytic enzymes - may cause clotting activation.
   b. Recommended Action: DO NOT ASPIRATE INTO SYSTEM. **Irrigate before resuming salvage.**

10. Use of the RATS in the presence of antibiotics not licensed for parenteral use (e.g., Polymyxin Aminoglycosides).
    a. Effect: Potential for serious reaction; may be delivered in higher concentrations (e.g., hypotension, shock).
    b. Recommended Action: DO NOT ASPIRATE INTO SYSTEM. **Irrigate wound copiously with saline before resuming salvage.**

C. RATS System Set-Up

1. Prepare Anticoagulant Solution
   a. Heparin concentration will be 30,000 units to 1000ml 0.9% NaCl.
   b. Medication added labels will be affixed to the anticoagulant.
   c. Heparin shall be used 1:7 with blood loss.
   d. Gentle agitation of reservoir during the procedure is required depending on blood loss.
   e. Amount of anticoagulant used will be documented on operator flow sheet.

2. Collection System
   a. Place reservoir holder and receive split of suction assembly from the sterile filed. Attach and close reservoir outlet clamp.
   b. Connect suction assembly large bore tubing (blue cap) to inlet port (blue cap) on reservoir. Tighten down extra inlet caps.
   c. Connect vacuum line to vacuum port on reservoir and regulate vacuum to 100-150 mmHg.
   d. Spike anticoagulant solution with small bore tubing of the suction assembly and allow 150-200ml of anticoagulant solution to enter reservoir.
   e. Use return option to agitate blood in reservoir periodically.

3. RATS Pack Tubing System
   a. Lift centrifuge cover. Release hold-down locking mechanism and slide hold-down arm to open position.
   b. Open RATS PAK and remove reinfusion bag. Hang from upper arm of IV pole. **Do not** close clamps on bag. Hang wash solution (3L IV 0.9% NaCl) from second IV pole.
   c. Insert centrifuge bowl into turn bowl by aligning slots on side of bowl with three locking pins in turn table. Push bowl straight down until it stops, and then turn clockwise to lock under pins.
   d. Rotate by sliding hold down arm over lip of bowl. Arm should fit flush on top of bowl.
   e. Route tubing from lower port on bowl out through the notch in the right side of centrifuge well to the waste bag. Close slide clamp on waste bag and hang on three hooks on right side of machine.
   f. Route tubing from upper port on bowl through notch in left side of centrifuge well to roller pump.
   g. Lift roller pump cover and insert tubing firmly into process fluid sensor. Be sure it is pushed in securely.
   h. Route tubing through roller pump.
   i. Insert trifurcation assembly into holder on top of machine.
   j. Open valves by pressing down gently on valve top and swinging locking arm away from the top. Route appropriate color coded tubings through valves and close valve covers.

k. Connect red tubing to collection reservoir drain port.
l. Connect yellow tubing to saline wash solution.
m. Connect blue tubing to "crit line" sensor and then connect to reinfusion bag center port.

D. Processing

1. Power on the RATS system. Choose protocol to be used. Present default is ORTHO protocol which we mainly use.

2. Manual Mode:
   a. Fill
      (1) Select fill when fluid level in reservoir reaches:
         (a) 600-1000ml if using standard volume bowl.
         (b) 450-600ml if using low volume bowl.
      (2) Allow bowl to fill until red cell interface reaches mark on metal bar inside the centrifuge bowl (hematocrit will be between 50-60% in the standard bowl and between 45-50% in the low volume bowl).
   b. Wash
      (1) Select “wash” when centrifuge bowl is properly filled.
      (2) Allow minimum one liter. Salinewash. Grossly hemolyzed blood and bowls that are not completely filled will require more volume. **Use minimum 1500ml wash for orthopedic cases**. Continue to wash cells until line from centrifuge bowl to waste bag is crystal clear and the minimum one liter wash has occurred.
   c. Empty
      (1) Select “empty” when wash cycle is complete.

3. Automatic Mode
   Select AUTO when fluid level in reservoir reaches 600-1000ml. RATS will automatically fill bowl to appropriate hematocrit level, then wash with one liter saline and empty into reinfusion bag. The fill cycle should be monitored to avoid premature triggering of the wash cycle caused by grossly hemolyzed blood.

4. Use Concentrate option to bring blood from holding bag back to bowl when adequate amount isn't available in reservoir to process subsequent bowl. Press concentrate under special key.

E. Reinfusion

1. After the blood processing is completed the washed packed red blood cells in the reinfusion bag will be available for reinfusion. Press Purge from Special Option. Invert bag, press pump and hold until air is purged from bag. Press Tally to show volume of RBCs and Hct. Press print. Blood will be reinfused only in the operating room and recovery room. Blood will be given to the anesthesia staff for reinfusion. A Hct >45 is needed to reinfuse. For policy on adverse reactions to blood reinfusion please refer to Blood Administration policy.

   a. Reinfusion bags not connected to the RATS will be labeled with appropriate label and marked with expiration time (six hours after recovery) and Biohazard Label.

b. The unit of processed blood will be given to the anesthesiologist for reinfusion.
c. A 20-40 micro aggregate filter (Pall filter) will be used in accordance with the manufacturer's suggestion.
d. Time of reinfusion will be documented on the Operator's Flow Sheet.

F. Orthopedic Procedures

1. When assembling supplies for an IAT procedure, substitute the "low volume bowl" for the standard volume bowl.

2. Use Ortho Protocol.
Note: Processing in the manual mode will prevent the possible premature triggering of the red cell detector caused by gross hemolysis of the blood in the collection reservoir.

3. Avoid aspiration into the collection reservoir of potentially harmful substances (refer to the Substances and Effects Table).

4. Avoid processing "partially filled" bowls of collected blood.

5. Use a minimum 1500ml wash volume; however, continue to wash until the waste line is clear.

6. After pumping the washed blood into the reinfusion bag, allow the red blood cells to "settle" before beginning reinfusion. This will allow visualization of any fat particles.

7. If fat particles are present, re-process by entering the concentrate mode and re-wash with an additional 1500ml of saline. During this re-wash, change the reinfusion bag to avoid pumping the red blood cells back into a bag coated with "fat."

8. All salvaged blood should be returned to the patient through a 20-40 **micro aggregate filter**.

G. Cleanup and Documentation

1. Print your tally report.
2. Push unload to release the pump tubing. Push shutdown. Turn off machine.
3. Dispose of bags and tubing in Biohazard bags.
4. Change suction tubing each case to ensure clean tip.
5. Wipe down with disinfectant after covering air detector.
6. Make two copies of RATS record one for Recovery Room records, one to blood bank and original to chart

IV. QUALITY REVIEW PROGRAM

A. This will consist of a quarterly review of all cases in which the cell saver was used. The review will focus on the EBL, amount of blood reinfused, and the HCT of the reinfused product. The machine generated HCT will be verified by a laboratory HCT during or after the procedure. If multiple bowls are reinfused, this HCT check will only be performed once during the entire procedure. The values should correlate within a 5% range. This review will occur in the Operative and Invasive Procedures Committee.

Reviewed:	**1st**	**2nd**	**3rd**	**4th**	**5th**
Date:	3/97	3/01	2/04	____9/05_____	____10/06_____
By:	_____	_____	_____	_____	_____

Revised:	**6th**	**7th**	**8th**	**9th**	**10th**
Date:	03/10	_____	_____	_____	_____
By:	J. Winning	_____	_____	_____	_____

PAJARO VALLEY HEALTH CARE DISTRICT
HOSPITAL CORPORATION

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Board Report

Meeting Date: March 29, 2023
Report Type: Consent

Title: Cash Advance

Recommendation: Receive and file Information regarding $1,000,000 cash advance through Central California Alliance for Health.

Executive Summary

Pajaro Valley Health Care District Hospital Corporation has secured a $1,000,000 short term cash advance from Central California Alliance for Health to provide a financial cushion while all recently negotiated payer contracts are implemented.

Background

The Hospital negotiated new payer contracts with all of it's major insurance companies. The contracts are being implemented in a staggered timeline to reduce the disruption of cashflow needed to cover daily operations. There were some delays by some payers in loading contract rates and/or other information into their claims payment systems which results in delays in payment to Watsonville Community Hospital.

The Hospital sought and received approval from Central California Alliance for Health to receive a $1,000,000 cash advance against future claim payments to be received on March 23, 2023.

Financial Impact

The Hospital secured a $1,000,000 cash advance against future claim payments. There is no additional cost to the organization to receive this advance. It is anticipated that the advance will be paid back in two payments, not to exceed $500,000 each. The first payment will be recouped from claims being paid during the week of April 17, 2023. The second payment will be recouped from claims being paid during the week of May 15, 2023. If claim payments during either of these two periods do not cover $500,000, the remaining amount due will be paid in a subsequent week in the same manner (recoupment from claim payment).

PAJARO VALLEY HEALTH CARE DISTRICT
HOSPITAL CORPORATION

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Board Report

Meeting Date: March 29, 2023
Report Type: Discussion

Title: Strategic Planning-Discuss Revised Timeline

Recommendation: Participate in a Mission, Vision and Values Design Workshop facilitated by Chartis, a top healthcare strategic advisory firm.

Contact: Steven Salyer, Chief Executive Officer

Background:

On March 22, 2023, Chartis provided a status update with timelines for the Strategic Planning project outreach. The board directed staff to work with Chartis and return to the board on March 29, 2023, regarding alternate timelines for internal and external outreach in light of the impacts of the severe weather conditions in California.

The Pajaro Valley Health Care District Hospital Board of Directors passed **Motion No. 011-2023** on January 20, 2023, a) approving the proposed engagement agreement with the Chartis Group for strategic planning; and b) directing the CEO to negotiate all possible cost savings with the vendor and request the Hospital Foundation to add Strategic Planning contract funding to their initiatives. Chartis will facilitate a strategic planning process including this workshop that elevates the hospital and healthcare district's health equity impact and preserves access to quality services for the community under a financially sustainable trajectory. The primary deliverable from this project will be a three-to-five-year strategic plan for Watsonville Community Hospital with the Pajaro Valley Health Care District's overall objectives and needs in mind. The strategic plan will include a clear articulation of organizational goals and metrics by which success will be defined.

PAJARO VALLEY HEALTH CARE DISTRICT
HOSPITAL CORPORATION

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Board Report

Meeting Date: March 29, 2023
Report Type: Discussion

Title: Salary for Interim Chief Executive Officer Matko Vranjes

Recommendation: Pass a **Motion** approving an annual salary for Interim Chief Executive Officer Matko Vranjes. Current benefits and other terms and conditions of employment will continue during the Interim Appointment.

Contact: Allyson Hauck, Chief Human Resources Officer

Executive Summary

At a special board meeting held on March 22, 2023, the Board of Directors appointed Matko Vranjes as the Interim Chief Executive Officer, following the resignation of Steven Salyer set for April 10, 2023. Mr. Vranjes will begin the interim appointment on April 11, 2023.

Analysis

Vranjes started his healthcare career at WCH in 1992. For the next three decades, he rose up the ranks on the business administration side of the hospital holding positions in materials management, facilities management, emergency management, compliance and as safety officer for WCH. As Chief Operation Officer, he provides management oversight for the development of quality, integrated, cost-effective medical programs. Under his leadership, he developed and fostered effective collaboration between clinical departments, division, and medical staff leadership to provide an integrated approach to delivering quality services.

Financial Impact:

The salary of $331,250 for the Interim CEO appointment represents a twenty-five percent increase from the current salary for the Chief Operating Officer position of $265,000. There will be no increased fiscal impact to the hospital, as this interim appointment salary is lower than the current CEO salary.

Attachments:

PAJARO VALLEY HEALTH CARE DISTRICT
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Board Report

Meeting Date: March 29,2023
Report Type: Discussion

Title: Update by Chief Financial Officer (CFO)

Recommendation: Receive and file update from Julie Peterson, Chief Financial Officer

Contact: Julie Peterson, Chief Financial Officer

Analysis
At each board meeting the CFO provides the board and the public an update on Financial Performance.

Financial Impact: See attached report.

Attachment A: Financial Performance Report (To be Delivered)

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Board Report

Meeting Date: March 29, 2023
Report Type: Discussion

Title: Medical Executive Committee (MEC) Reports March 2023

Recommendation: Pass a **Motion** approving 1) MEC March 2023 Credentials report; 2) MEC March 2023 Interdisciplinary Practice Credentials report; 3) Medical Staff Items; and 4) Medical Error Reduction Plan (MERP)-2022 report.

Contact: Clay Angel, M.D., Chief of Staff Chair, Medical Executive Committee

Analysis
At each board meeting the board receives reports from the Medical Executive Committee including the Credentials Report and the Interdisciplinary Practice Credentials Report.

Financial Impact: None.

Attachments:
A-Medical Executive Committee Report Summary
B-Medical Error Reduction Plan-2022 Report

WATSONVILLE COMMUNITY HOSPITAL

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Medical Executive Committee Summary – March 21, 2023
ITEMS FOR BOARD APPROVAL

Credentials Committee

INITIAL APPOINTMENTS: (10)

APPLICANT	SPECIALTY / STATUS	DEPT	PRIVILEGES	Effective Date
Avino, Lorianne E, DO	Teleneurology	Medicine	Teleneurology Neurology	03/30/2023 – 02/28/2025
Cohen, David, MD	Teleradiology	Medicine	Teleneurology Neurology	03/30/2023 – 02/28/2025
Davis, Demetrice, MD	Teleradiology	Medicine	Telemedicine Radiology	03/30/2023 – 02/28/2025
Goodstein, Monica, MD	General Surgery	Surgery	General Surgery Fluoroscopy	03/30/2023 – 02/28/2025
Jean-Baptiste, Ryan, MD	Teleradiology	Medicine	Telemedicine Radiology	03/30/2023 – 02/28/2025
Monterroso, Mark, MD	Emergency Medicine	Emergency Medicine	Emergency Medicine Sedation	03/30/2023 – 02/28/2025
Moser, Michael, MD	Teleradiology	Medicine	Telemedicine Radiology	03/30/2023 – 02/28/2025
Nicola, Catalin, MD, PhD	Critical Care	Medicine	Critical Care Sedation	03/30/2023 – 02/28/2025
Pagano, Evan, MD	Pediatric Hospitalist	Pediatrics	Pediatrics	03/30/2023 – 02/28/2025
Phan, An T., MD	Anesthesiology	Surgery	Anesthesia	03/30/2023 – 02/28/2025

REAPPOINTMENTS: (5)

APPLICANT	SPECIALTY / STATUS	DEPT	PRIVILEGES	Effective Date
Brant, Sarah, MD	General Surgery	Surgery	General Surgery; DaVinci Robotic; Wound Care	03/30/2023-02/28/2025
Martinez, Roy, MD	Radiology	Medicine	Radiology	04/01/2023-03/31/2025
Nguyen, Tea, DPM	Podiatry	Surgery	Podiatry Fluoroscopy	04/01/2023-03/31/2025
Nolan, Ryan, MD	General Surgery	Surgery	General Surgery; DaVinci Robotic; Bariatric Surgery; Wound Care	03/30/2023-02/28/2025
Shahid, Noor-E-Ain, MD	Teleneurology	Medicine	Teleneurology Neurology	03/30/2023-02/28/2025
Waddle, Brian, MD	General Surgery	Surgery	General Surgery; Wound Care; Fluoroscopy; Sedation	04/01/2023-03/31/2025

MODIFICATION / ADDITION OF PRIVILEGES:

NAME	SPECIALTY	Privileges
None		

STAFF STATUS MODIFICATIONS:

NAME	SPECIALTY / DEPARTMENT	RECOMMENDATION
Aharonian, Artin, MD	Teleradiology / Medicine	Release from Proctoring and Advance to Telemedicine Staff
Amundson, Janet, MD	Teleradiology / Medicine	Release from Proctoring
Anand, Neil, MD	Teleradiology / Medicine	Release from Proctoring
Herman, Matthew, MD	Teleradiology / Medicine	Release from Proctoring
Herold, Edward, MD	Anesthesia / Surgery	Release from Proctoring and Advance to Active Staff
Hossain, Nagma, MD	Infectious Disease, Telemedicine / Medicine	Release from Proctoring
Lucchesi, Archana, MD	Teleradiology / Medicine	Release from Proctoring
Martin, Andrew, MD	Teleradiology / Medicine	Release from Proctoring
Mischui, Oana, MD	Teleradiology / Medicine	Release from Proctoring
Niemeyer, Patricia, MD	Radiology / Medicine	Release from Proctoring
Obembe, Olufolajimi, MD	Teleradiology / Provisional	Release from Proctoring
Singh, Ajay, MD	Teleradiology / Provisional	Release from Proctoring
Shahid, Noor-E-Ain, MD	Teleneurology / Provisional	Release from Proctoring; Advance from Provisional to Telemedicine
Thomson, Matthew, MD	Teleradiology / Provisional	Release from Proctoring
Kobraei, Edward, MD	Plastic Surgery / Provisional	Voluntary resignation, effective 3/24/2023

TEMPORARY PRIVILEGES:

NAME	SPECIALTY / DEPARTMENT	DATES
Phan, An T., MD	Anesthesiology	03/14/2023 – 03/31/2023
Brant, Sarah, MD	General Surgery	03/25/2023 – 03/31/2023
Nolan, Ryan, MD	General Surgery	03/25/2023 – 03/31/2023
Shahid, Noor-E-Ain, MD	Teleneurology	03/25/2023 – 03/31/2023

INTERDISCIPLINARY PRACTICE COMMITTEE

Initial Appointment: (0)

APPLICANT	SPECIALTY / STATUS	DEPT	PRIVILEGES	Effective Date
None				

REAPPOINTMENT: (0)

APPLICANT	SPECIALTY / STATUS	DEPT	PRIVILEGES	Effective Date
None				

STAFF STATUS MODIFICATIONS: (1)

NAME	SPECIALTY / DEPARTMENT	RECOMMENDATION
Dichupa, Iris, CRNA	Nurse Anesthetist	Release from Proctoring

WATSONVILLE COMMUNITY HOSPITAL

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Medication Error Reduction Plan – 2022

1. Prescribing:

- *Fentanyl Patch – appropriateness of prescribing*
  - **Methodology:** ISMP/High alert medication (and MERP) audits
  - **Evaluation frequency:** monthly, reporting bi-annually
  - **Date of last review:** 3/1/2023
  - **Weakness or deficiencies identified**: Fentanyl patch should not be prescribed in opioid naïve patients
  - **Date identified:** MERP 2015
  - **Has the plan been modified?** No

    If yes …
    - ✓ When:
    - ✓ Weakness identified:
    - ✓ Plan modification:
    - ✓ Follow up:
  - **Annual review:** 3/11+ 9/9/2020, 3/3+7/7+12/8/2021, 3/9/2022, 8/3/2022, 3/1/2023
  - **Does the annual review demonstrate assessment for effectiveness?** YES
    - All patients appropriate for use; RPh consulted if/when "new" in-house initiation of Fentanyl patch. (Majority of patients on prior to admission, validated with home med list.)

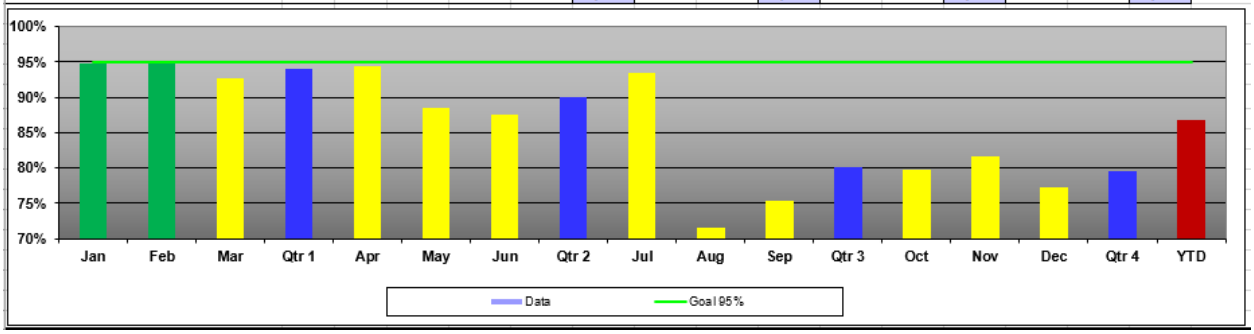
Fentanyl Patch													
2022	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Number of patients	0	1	0	1	2	0	0	0	0	0	0	0	4
RPh validated appropriateness	0	1	0	1	2	0	0	0	0	0	0	0	4
													100%

- *Medication Reconciliation*
  - **Methodology:** Home Medication review as per Leapfrog Patient Safety outline
  - **Evaluation frequency:** Quarterly
  - **Date of last review:** 3/1/2023
  - **Weakness or deficiencies identified:** Clin Rec/Med Rec identified by providers as not being accurate and not being completed in a timely manner; retrospective review
  - **Date identified:** 2014 w/Medication Variance review => June 2019 w/Leapfrog Survey
  - **Has the plan been modified?** Yes

    If yes …
    - ✓ **When**: June 2019: change to Home Medication review (Leapfrog)
    - ✓ **Weakness identified**: retrospective review, not real time interview/evaluation
    - ✓ **Plan modification:** review potential use of EDIS Surescript functionality to assist with improved data availability in generating initial list
    - ✓ **Follow up:** Feasibility to implement Surescript functionality via EDIS .. in process as of 7/2022
  - **Annual review:** 3/11+ 9/9/2020, 3/3+7/7+12/8/2021, 3/9/2022, 8/3/2022, 3/1/2023
  - **Does the annual review demonstrate assessment for effectiveness?** No … Patients "high risk" (e.g., >10 meds on home med list, RPh identifies potential for risk). Average 9.9 medications per patient in 2022. YTD 2022 decrease in accuracy of home med list compared to 2021. Med History (aka Surescripts functionality) activated in ED on 2/1/2023. Continue to review for improvement with new process in place in ED.

Watsonville Community Hospital - 2022 QAPI

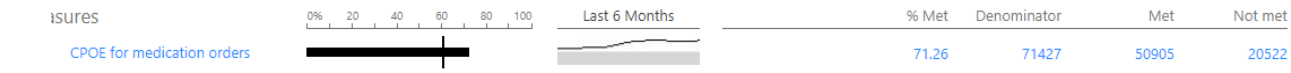
Pharmacy			QAPI Description: MED REC … increase accuracy of initial "Home Med" list													
	2020	2021	Goal	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
N: Total number of medicines documented correctly	1244	1707		199	203	528	218	168	287	274	143	189	204	188	177	2778
D: Total number of medicines that patient have on their initial "home med" list	1345	1892		210	214	570	231	190	328	293	200	251	256	230	229	3202
Number of patient's home meds reviewed		236	30	18	18	49	26	20	32	30	24	29	29	25	24	324
	92%	90%	95%	95%	95%	93%	94%	88.4%	87.5%	93.5%	71.5%	75.3%	79.7%	81.7%	77.3%	86.8%
						94.1% Qtr 1			90.1% Qtr 2			80.1% Qtr 3			79.6% Qtr 4	



- *CPOE (Computerized Physician Order Entry)*
  - **Methodology:** review of CPOE use using BI (Business Intelligence) Tool
  - **Evaluation frequency:** monthly with BI tool evaluation
  - **Date of last review:** 3/1/2023
  - **Weakness or deficiencies identified**: providers use "paper" orders, in lieu of CPOE
  - **Date identified:** MEC 2020
  - **Has the plan been modified?** Yes

    If yes …
    - ✓ When: May 2021
    - ✓ Weakness identified: Target providers not using CPOE
    - ✓ Plan modification: Redo order sets and re-educate on CPOE (clinical informaticist)
    - ✓ Follow up: Order sets in place and education being completed by end of 2021
  - **Annual review:** 3/9/2022
  - **Does the annual review demonstrate assessment for effectiveness?** No
    - In process by Clinical Informatics Team: continue to build order sets, provide re-education and/or support to providers on CPOE
    - Challenges mid 2022: downtimes with EHR, confirming correct data with HIM and CI (recent issues with data stream)
    - In process … manual pull out of Pharmacy protocol orders; MedHost does not currently "pull out" orders via Pharmacy module when modified per "protocol". (MedHost states this "upgrade" will be available soon.)

CPOE YTD 2022 [BI Tool]:



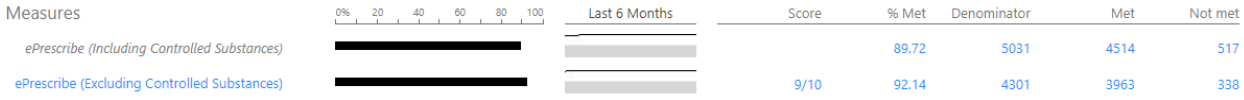
CPOE YTD 2021 [BI Tool]:

2. Prescription order communications

- *ePrescribe*
  - **Methodology:** review of ePrescribe completion using BI (Business Intelligence) Tool
  - **Evaluation frequency:** monthly with BI tool evaluation
  - **Date of last review:** 3/1/2023
  - **Weakness or deficiencies identified**: MedHost limitations during ePrescribe that are not currently resolvable, including controlled substance ePrescribe, character limitations (eg Prednisone tapers), unable to write prescription for non-medication (e.g., glucometer)
  - **Date identified:** 1/2018
  - **Has the plan been modified?** Yes

    If yes …
    - ✓ When: EPCS live 11/16/2021
    - ✓ Weakness identified: eRx for controlled substance not live
    - ✓ Plan modification: go live with EPCS 11/16/2021, provide MedHost support
    - ✓ Follow up: BI tool data
  - **Annual review:** 3/11+ 9/9/2020, 3/3+7/7+12/8/2021, 3/9/2022, 8/3/2022
  - **Does the annual review demonstrate assessment for effectiveness?** YES.
    - Upgrade functionality in MedHost anticipated to improve ePrescribe capability, specifically, ability to ePrescribe controlled substances = started 11/16/2021
    - Mandates to ePrescribe started January 1, 2022

ePrescribe YTD thru 6/2022 [BI Tool]:



Measures	Last 6 Months	Score	% Met	Denominator	Met	Not met
ePrescribe (Including Controlled Substances)			89.72	5031	4514	517
ePrescribe (Excluding Controlled Substances)		9/10	92.14	4301	3963	338

ePrescribe YTD 2021 [BI Tool]:

PIP Measures	Last 6 Months	Score	% Met	Denominator	Met	Not met
ePrescribe (Including Controlled Substances)			64.04	4500	2882	1618
ePrescribe (Excluding Controlled Substances)		7/10	70.48	4049	2854	1195

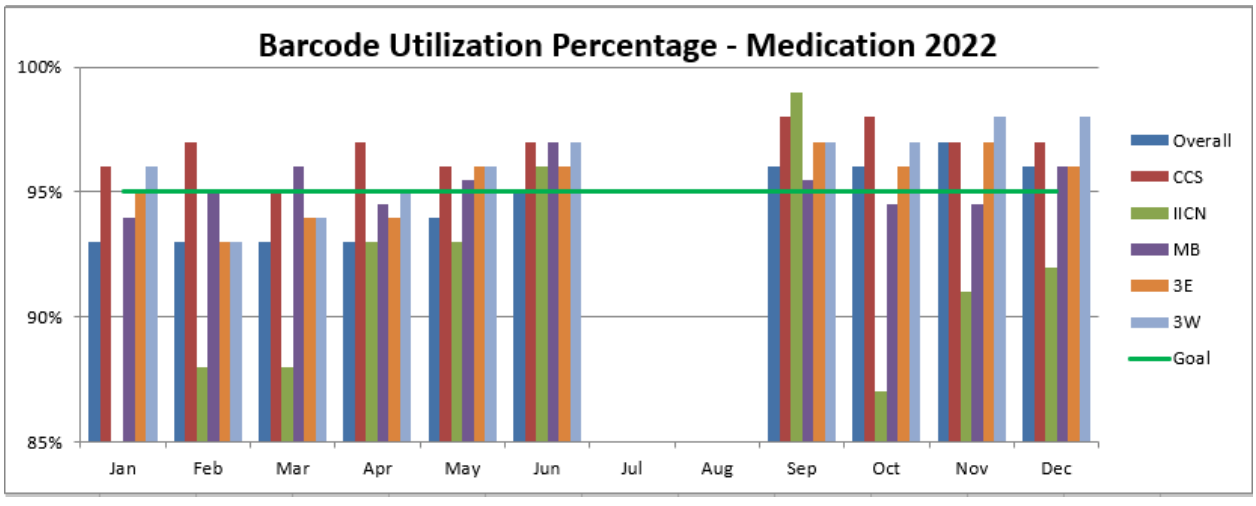
3. Product Labeling

- *BCMA (Bar Code Medication Administration)*
  - **Methodology:** analysis of barcode utilization data from EHR (MedHost)
  - **Evaluation frequency:** monthly data review for outliers
  - **Date of last review:** 3/1/2023
  - **Weakness or deficiencies identified:** Goal > 95%; MedHost/EDIS incompatibility
  - **Date identified:** on-going
  - **Has the plan been modified?** No

    If yes …
    - ✓ When:
    - ✓ Weakness identified:
    - ✓ Plan modification:
    - ✓ Follow up:
  - **Annual review:** 3/11+ 9/9/2020, 3/3+7/7+12/8/2021, 3/9/2022, 8/3/2022
  - **Does the annual review demonstrate assessment for effectiveness?** Yes
    - Issue managed in 2022: ED boarders challenging due to incompatibility of EDIS and MedHost documentation and integration of systems = ED RN's improvement in documentation in eMAR for ED boarders
    - Perinatal Director working with staff on improvement in scan rates
    - Nursing and Respiratory coordinates w/ Pharmacy on items that "do not scan"
    - NOTE: unable to obtain July and August data; MedHost system

Bar Code Utilization - 2022

Medication	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2022 Average
Overall	93%	93%	93%	93%	94%	95%			96%	96%	97%	96%	95%
CCS	96%	97%	95%	97%	96%	97%			98%	98%	97%	97%	97%
IICN	72%	88%	88%	93%	93%	96%			99%	87%	91%	92%	90%
MB	94%	95%	96%	94.5%	95.5%	97%			95.5%	94.5%	94.5%	96%	95%
3E	95%	93%	94%	94%	96%	96%			97%	96%	97%	96%	95%
3W	96%	93%	94%	95%	96%	97%			97%	97%	98%	98%	96%
Goal	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
					EDV*=2%								



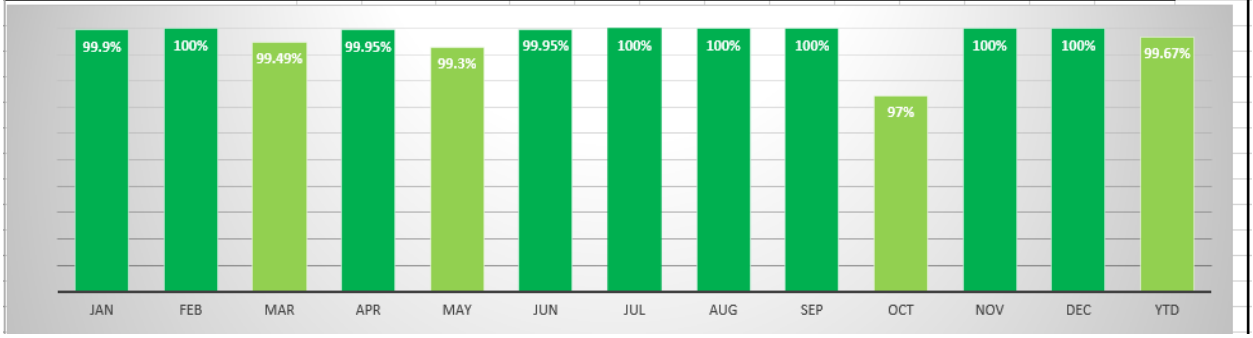
4. Packaging and nomenclature

- *Expired Medication*
  - **Methodology:** GACH (General Acute Care Hospital [Survey]) 11/18 and RPh audit during monthly unit inspection of all areas of facility
  - **Evaluation frequency:** monthly RPh unit inspections, quarterly reporting
  - **Date of last review:** 3/1/2023
  - **Weakness or deficiencies identified:** during GACH/MERP, expired medication were found by inspector
  - **Date identified:** 11/5/2018
  - **Has the plan been modified?** No

    If yes …
    - ✓ When:
    - ✓ Weakness identified:
    - ✓ Plan modification:
    - ✓ Follow up:
  - **Annual review:** 3/11+ 9/9/2020, 3/3+7/7+12/8/2021, 3/9/2022, 8/3/2022
  - **Does the annual review demonstrate assessment for effectiveness?** YES
    - Continue routine goal of "pocket-by-pocket" audit of both central pharmacy (quarterly) and Pyxis (every 6 month), monthly audits of all areas including central pharmacy

Watsonville Community Hospital - 2022

Pharmacy	PI Description: Validate medication available for use are "in date"													
	Goal	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
N: Total medication "in date"		2937	1140	2147	1971	424	2211	2014	3330	1748	2096	3374	2884	26276
D: Total medication checked		2939	1140	2158	1972	427	2212	2014	3330	1748	2151	3374	2884	26349
	100%	99.9%	100%	99.49%	99.95%	99.3%	99.95%	100%	100%	100%	97%	100%	100%	99.67%
2021 = 99.95% (36,357 / 36,378)				99.81%			99.7%			100%			99.1%	
				Qtr 1			Qtr 2			Qtr 3			Qtr 4	



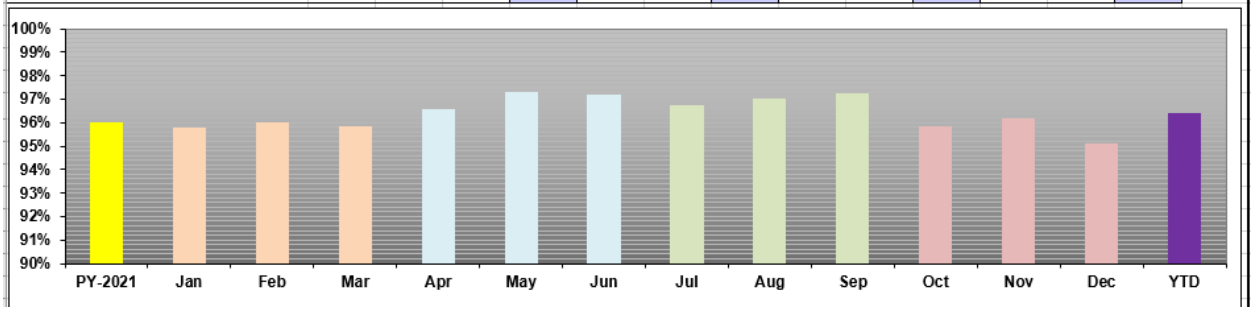
5. Compounding

- *IV Formulary sheet – data review*
  - **Methodology:** monthly manual audit of each IV Master Formulary sheet completed for sterile compounded products
  - **Evaluation frequency:** Monthly
  - **Date of last review:** 3/1/2023
  - **Weakness or deficiencies identified:** IV Master Formulary sheets missing data
  - **Date identified:** 9/2018 => 8/18 data had 17.09% error rate
  - **Has the plan been modified?** No

    If yes …
    - ✓ When:
    - ✓ Weakness identified:
    - ✓ Plan modification:
    - ✓ Follow up:
  - **Annual review:** 3/13+11/13/19, 3/11+ 9/9/2020, 3/3+7/7+12/8/2021, 3/9/2022, 8/3/2022
  - **Does the annual review demonstrate assessment for effectiveness?** Yes
    - Formally incorporated into Pharmacy yearly performance evaluations to hold staff accountable for correct documentation.

Watsonville Community Hospital - 2022 PI

Pharmacy	PI Description: Completion of "IV Formulary" sheets during sterile compounding													
	PY-2021	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
N: Total "Batch" sheets minus missed data	4600	434	336	301	284	286	415	328	291	318	276	277	351	3897
D: Total "Batch" sheets	4792	453	350	314	294	294	427	339	300	327	288	288	369	4043
	96%	95.8%	96.0%	95.9%	96.6%	97.3%	97.2%	96.8%	97.0%	97.2%	95.8%	96.2%	95.1%	96.4%
2020 = 97% (4437 of 4563)				95.9%			97.0%			97.0%			95.7%	
				Qtr 1			Qtr 2			Qtr 3			Qtr 4	



6. Dispensing

- *ED medication variances with controlled substances (CS)*
  - **Methodology:** Medication variance data for CS in ED
  - **Evaluation frequency**: retrospective RPh review daily (for previous day's CS vends); reporting quarterly with medication variance review
  - **Date of last review:** 3/1/2023
  - **Weakness or deficiencies identified:** errors in dispensing (RN vend from Pyxis) of CS for "wrong" patient; NOTE: medication administered to correct patient
  - **Date identified:** 3/14/2018 (w/YTD 2017 medication variance review)
  - **Has the plan been modified?** Yes 3/26/2018; not in 2019

    If yes …
    - ✓ **When:** 3/26/18
    - ✓ **Weakness identified:** patients "held" on Pyxis MedStation may have multiple entries/visits due to 72 hour "hold" time
    - ✓ **Plan modification:** modify "hold" time in Pyxis from 72 to 48 hours
    - ✓ **Follow up:** slight improvement in 3rd and 4th quarter 2018 medication variance data
  - **Annual review:** 3/11/2020, 9/9/2020, 3/3/2021, 7/7/2021, 12/8/2021, 3/9/2022
  - **Does the annual review demonstrate assessment for effectiveness?** YES – improvement noted starting 4th quarter 2021.
    - Confirmed accuracy of reporting with RPh: when RPh complete narcotic reconciliation daily, RPh will document discrepancy in VERGE

	Jan	Feb	Mar	1st QTR	Apr	May	Jun	2nd QTR	Jul	Aug	Sept	3rd QTR	Oct	Nov	Dec	4th QTR	YTD
CS ED	0	0	0	0	0	0	0	0	0	0	1	1	1	1	0	2	3
ED	0	1	2	3	1	0	4	5	0	4	4	8	2	2	7	11	27
2021	*9*	*7*	*8*	***24***	*13*	*7*	*4*	***24***	*9*	*3*	*3*	*15*	*2*	*4*	*5*	***11***	*74*
2020	*7*	*10*	*4*	***21***	*4*	*6*	*5*	***15***	*4*	*13*	*7*	***24***	*9*	*3*	*2*	***14***	*74*

7. Distribution

- *Drug shortages and Recalls:*
  - **Methodology:** alerts via RASMUS/inmar, Cardinal (distributor), CA-BOP
  - **Evaluation frequency:** daily by RPh for recalls; quarterly review to determine "average days to close"
  - **Date of last review:** 3/1/2023
  - **Weakness or deficiencies identified**: continued drug shortages necessitating intervention to prevent disruption in patient care
  - **Date identified:** on-going
  - **Has the plan been modified?** No

    If yes …
    - ✓ When:
    - ✓ Weakness identified:
    - ✓ Plan modification:
    - ✓ Follow up:
  - **Annual review:** 3/13+11/13/19, 3/11+ 9/9/2020, 3/3+7/7+12/8/2021, 3/9/2022, 8/3/2022
  - **Does the annual review demonstrate assessment for effectiveness?** YES – Pharmacy manages inventory: place on back-order, rotate/move stock, sequester for efficiency, check on alternate resources, "divide" for more unit of use doses. Medical Staff involved with critical drug shortages: P&T therapeutic interchanges, prioritize use. Director of Pharmacy provides routine updates with any drug shortages affecting facility.

Recall alert volume:

JAN-2022	FEB-2022	MAR-2022	APR-2022	MAY-2022	JUN-2022	JUL-2022	AUG-2022	SEP-2022	OCT-2022	NOV-2022	DEC-2022	Total
104	78	102	87	90	78	62	91	65	81	67	77	982

Average Days to Close Assignments:

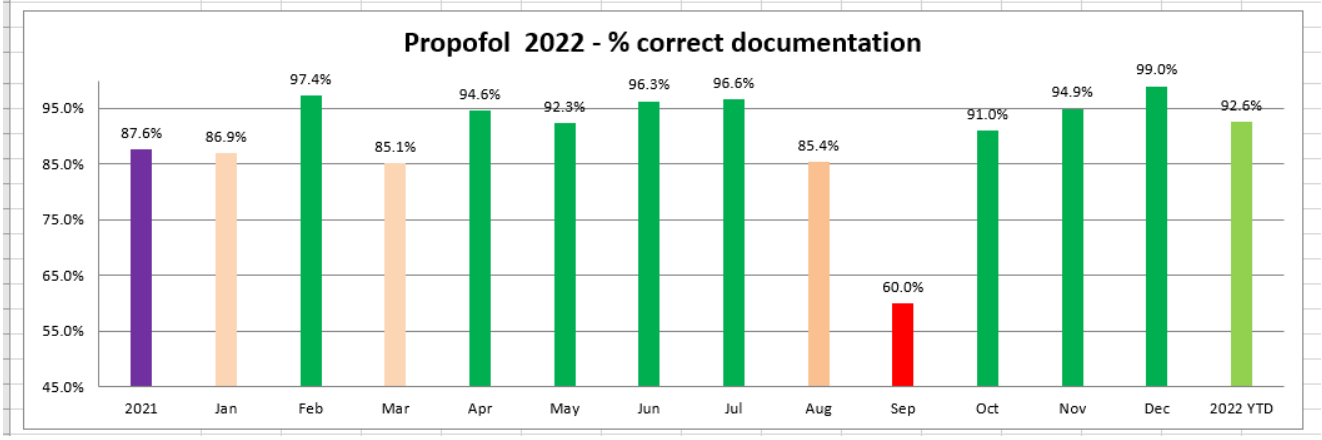
JAN-2022	FEB-2022	MAR-2022	APR-2022	MAY-2022	JUN-2022	JUL-2022	AUG-2022	SEP-2022	OCT-2022	NOV-2022	DEC-2022	Averag
1.65	1.95	1.33	1.25	1.54	1.72	2.37	1.47	3.58	1.23	1.02	0.70	1.61

8. Administration

- *Correct documentation for administration of Propofol continuous infusion in CCU*
  - **Methodology:** High alert medication (and MERP) audits
  - **Evaluation frequency:** monthly, reporting quarterly
  - **Date of last review:** 3/1/2023
  - **Weakness or deficiencies identified:** documentation errors identified during initial audits
  - **Date identified:** March 2018 audits
  - **Has the plan been modified?** No

    If yes …
    - ✓ When:
    - ✓ Weakness identified:
    - ✓ Plan modification:
    - ✓ Follow up:
  - **Annual review:** 3/11+ 9/9/2020, 3/3+7/7+12/8/2021, 3/9/2022, 8/3/2022, 3/1/2023
  - **Does the annual review demonstrate assessment for effectiveness?** Yes for YTD > 90%, improved from YTD 2021
    - SNIII completing audits is also educating on discrepancies immediately following completion of audits.

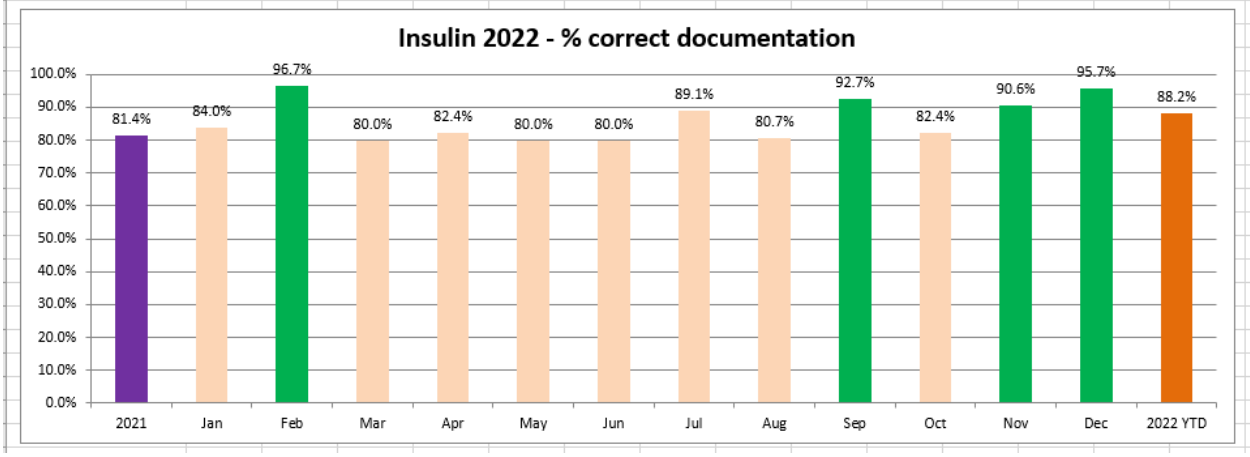
Propofol - 2022	2021	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2022 YTD
Number of patients	71	5	4	2	4	1	6	2	6	2	5	7	5	49
Correct documentation	2602	338	184	57	106	12	232	141	123	3	273	262	191	1922
Total number	2970	389	189	67	112	13	241	146	144	5	300	276	193	2075
% correct	87.6%	86.9%	97.4%	85.1%	94.6%	92.3%	96.3%	96.6%	85.4%	60.0%	91.0%	94.9%	99.0%	92.6%



- *Correct documentation for administration of Insulin continuous infusion in CCU*
  - **Methodology:** High alert medication (and MERP) audits
  - **Evaluation frequency:** monthly, reporting quarterly
  - **Date of last review:** 3/1/2023
  - **Weakness or deficiencies identified:** documentation errors identified during initial audits
  - **Date identified:** March 2018 audits
  - **Has the plan been modified?** No

    If yes …
    - ✓ When:
    - ✓ Weakness identified:
    - ✓ Plan modification:
    - ✓ Follow up:
  - **Annual review:** 3/11+ 9/9/2020, 3/3+7/7+12/8/2021, 3/9/2022, 8/3/2022, 3/1/2023
  - **Does the annual review demonstrate assessment for effectiveness?** Yes – improvement YTD 2022 vs YTD 2021
    - SNIII completing audits is also educating on discrepancies immediately following completion of audits.

Insulin - 2022	2021	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2022 YTD
Number of patients	40	2	5	1	3	2	1	4	4	3	5	4	5	39
Correct documentation	538	42	87	4	28	24	28	82	71	89	70	58	89	672
Total number	661	50	90	5	34	30	35	92	88	96	85	64	93	762
% correct	81.4%	84.0%	96.7%	80.0%	82.4%	80.0%	80.0%	89.1%	80.7%	92.7%	82.4%	90.6%	95.7%	88.2%



9. Education

- *Communication about medication*
  - **Methodology:** HCAHPS (Press Ganey)
  - **Evaluation frequency:** Quarterly
  - **Date of last review:** 3/1/2023
  - **Weakness or deficiencies identified:** Low scores indicative of opportunity for improvement
  - **Date identified:** on-going
  - **Has the plan been modified?** No

    If yes …
    - ✓ When:
    - ✓ Weakness identified:
    - ✓ Plan modification:
    - ✓ Follow up:
  - **Annual review:** 3/11+ 9/9/2020, 3/3+7/7+12/8/2021, 3/9/2022, 8/3/2022
  - **Does the annual review demonstrate assessment for effectiveness?** Yes – consistent for 3 of 4 quarters. Continue to review for sustaining improvement in 2023. NEW in 2022 = My Meds Matter.

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)
Patient Satisfaction Annual and Quarterly (By Received Date)
Communication About Medications - 2022

HCAHPS Domain	Jan-Mar 2022	Apr-Jun 2022	Jul-Sep 2022	*Oct-Dec 2022	CA State Avg
	N=63	N=119	N=134	*N=100	
Communication About Medications	60.69%	53.66%	61.69%	61.44%	63%
Sample Size - N	N=63	N=65	N=79	N=61	
Always	60.69%	53.66%	61.69%	61.44%	
Usually	14.43%	23.52%	22.08%	13.40%	
Sometimes	8.82%	8.63%	5.19%	14.29%	
Never	16.07%	14.19%	11.04%	10.86%	
Tell you what new medicine was for	74.60%	69.23%	70.13%	72.88%	
Sample Size - N	N=63	N=65	N=77	N=59	
Always	74.60%	69.23%	70.13%	72.88%	
Usually	11.11%	18.46%	20.78%	8.47%	
Sometimes	6.35%	6.15%	2.60%	15.25%	
Never	7.94%	6.15%	6.47%	3.39%	
Staff described medicine effect	46.77%	38.10%	53.25%	50.00%	
Sample Size - N	N=62	N=63	N=77	N=60	
Always	46.77%	38.10%	53.25%	50.00%	
Usually	17.74%	28.57%	23.38%	18.33%	
Sometimes	11.29%	11.11%	7.79%	13.33%	
Never	24.19%	22.22%	15.58%	18.33%	

* indicates data collection is in progress
California average met or exceeded
Within 5 points of California average
Below 5 points of California average

10. Monitoring

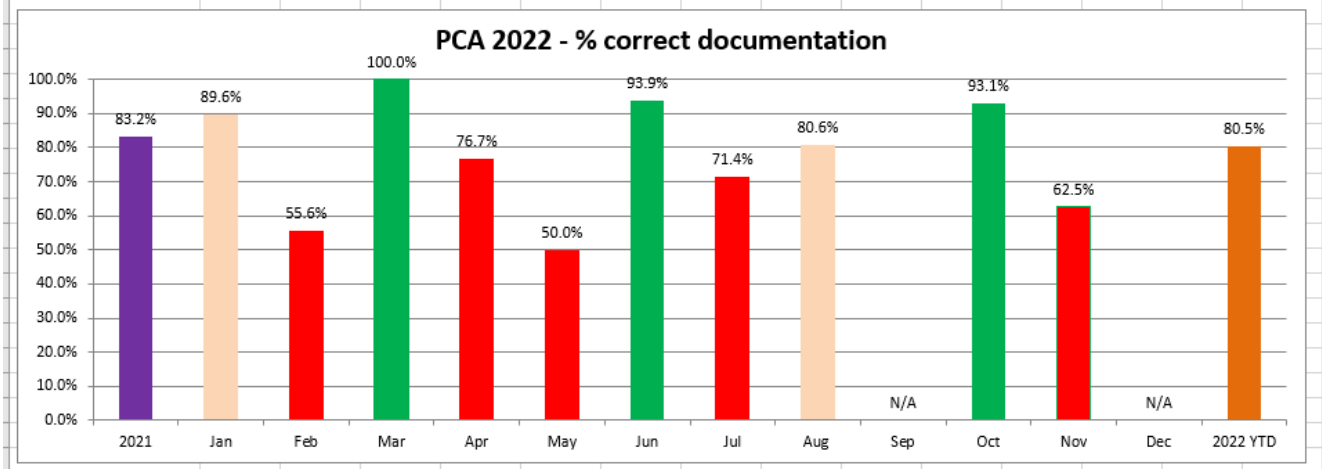
- *Heparin set up and documentation*
  - **Methodology:** Medication variance report/RCA (root cause analysis) completed
  - **Evaluation frequency:** Quarterly
  - **Date of last review:** NEW
  - **Weakness or deficiencies identified:** Error during programming pump for bolus dose of heparin
  - **Has the plan been modified?** No - new

    If yes …
    - ✓ When:
    - ✓ Weakness identified:
    - ✓ Plan modification:
    - ✓ Follow up:
  - Annual review: N/A - new
  - Does the annual review demonstrate assessment for effectiveness? N/A – new
    - Actions to date: Modify policies December 2021: heparin infusions may only be administered in telemetry or higher level of care and bolus to be administered as IV-push (not removed from premixed bag). Nursing and Quality coordination on education to policy changes and review of updated flowsheets (completed April and May of 2022). Heparin drip scenario to be incorporated into "cardiac class" by Education.
    - Pharmacist MUE (medication utilization evaluation) for all heparin drips in house; no noted adverse events post updates above to YTD 2022. Continue to audit and coordinate with Nursing.

- *PCA documentation*
  - **Methodology:** High alert medication (and MERP) audits
  - **Evaluation frequency:** monthly, reporting quarterly
  - **Date of last review:** 3/1/2023
  - **Weakness or deficiencies identified:** reassessment after change missed, documentation every 4 hours per policy
  - **Date identified:** MERP 9/2015
  - **Has the plan been modified?** Yes

    If yes …
    - ✓ **When:** 4/11/2018
    - ✓ **Weakness identified:** Improvement noted but had not been sustained
    - ✓ **Plan modification:** Assign to Staff RN III for audit, education and follow up coordination
    - ✓ **Follow up:** Staff RN III started education in April, included laminated "cheat sheet/card" with all PCA's
  - **Annual review:** 3/11+ 9/9/2020, 3/3+7/7+12/8/2021, 3/9/2022, 8/3/2022, 3/1/2023
    - **Does the annual review demonstrate assessment for effectiveness?** No significant change from YTD 2021
      - SNIII completing audits is also educating on discrepancies immediately following completion of audits.

PCA's - 2022	2021	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2022 YTD
Number of patients	18	1	5	1	6	3	1	2	2	0	1	1	0	23
Correct documentation	306	43	25	8	23	16	107	10	29	0	27	5	0	293
Total number	368	48	45	8	30	32	114	14	36	0	29	8	0	364
% correct	83.2%	89.6%	55.6%	100.0%	76.7%	50.0%	93.9%	71.4%	80.6%	N/A	93.1%	62.5%	N/A	80.5%



- *Pain Assessment and Reassessment*
  - **Methodology:** Monthly controlled substance (CS) audits
  - **Evaluation frequency:** monthly, reported quarterly
  - **Date of last review:** 3/1/2023
  - **Weakness or deficiencies identified:** pain assessment and/or reassessment not documented
  - **Date identified:** on-going
  - **Has the plan been modified?** No

    If yes …
    - ✓ When:
    - ✓ Weakness identified:
    - ✓ Plan modification:
    - ✓ Follow up:
  - Annual review: 3/11+ 9/9/2020, 3/3+7/7+12/8/2021, 3/9/2022, 8/3/2022
  - Does the annual review demonstrate assessment for effectiveness? NO
    - Pharmacy Director reviews documentation at initial Orientation w/all RN's
    - Nursing Directors coordinating on education and real time audits internally

Pain Audits - Summary by Month (2022)

		January		February		March		April		May		June		July		August		September		October		November		December		YTD average	
		A%	R%	A%	R%	A%	R%	A%	R%	A%	R%	A%	R%	A%	R%	A%	R%	A%	R%	A%	R%	A%	R%	A%	R%	A%	R%
PACU	**2022**	**96%**	**85%**	**73%**	**82%**											**97%**	**88%**									**88%**	**85%**
	2021	97%	94%	87%	87%	100%	100%	100%	90%	97%	97%	93%	93%	94%	91%	91%	83%			100%	100%	90%	82%			95%	92%
	2020																					100%	83%			100%	83%
	2019					100%	100%	100%	100%	97%	97%	100%	100%	100%	98%	100%	88%	100%	94%							100%	97%
	2018	96%	79%	76%	81%	90%	93%	94%	100%	98%	98%	100%	93%									100%	100%	100%	99%	94%	93%
	2017	70%	80%	84%	77%	71%	66%	92%	81%	57%	63%	85%	91%	73%	70%	72%	84%	81%	69%	76%	94%	85%	91%	74%	61%	77%	77%
CCU	**2022**	**80%**	**67%**	**92%**	**83%**	**90%**	**53%**	**83%**	**57%**	**93%**	**73%**	**97%**	**80%**	**80%**	**76%**	**70%**	**48%**	**100%**	**75%**							**87%**	**68%**
	2021	60%	40%	78%	62%	60%	40%	81%	68%	63%	22%	73%	58%	98%	66%	83%	67%	59%	59%	86%	79%	77%	53%	100%	82%	77%	58%
	2020	100%	72%	94%	83%	93%	87%	83%	60%	94%	84%	80%	68%	90%	77%	77%	61%	87%	63%	74%	50%	74%	71%	50%	46%	83%	68%
	2019	93%	93%	100%	87%	94%	90%	93%	70%	94%	97%	91%	78%	87%	83%	97%	75%	94%	89%	80%	74%	95%	86%	92%	89%	92%	84%
	2018	93%	90%	100%	83%	93%	97%	83%	80%	97%	90%	77%	84%	90%	83%	98%	87%	92%	85%	97%	85%	100%	93%	97%	80%	93%	86%
	2017	87%	73%	80%	77%	97%	47%	78%	50%	87%	70%	77%	60%	84%	78%	65%	61%	91%	75%	100%	97%	87%	94%	90%	90%	85%	73%
ED	**2022**	**82%**	**71%**	**92%**	**59%**	**84%**	**74%**	**67%**	**70%**	**80%**	**67%**	**69%**	**60%**	**83%**	**49%**	**85%**	**79%**	**88%**	**50%**							**81%**	**64%**
	2021	86%	51%	85%	72%	84%	60%	79%	68%	94%	63%	83%	53%	74%	53%	92%	66%	87%	62%	87%	67%	90%	73%	85%	68%	86%	63%
	2020	92%	78%	94%	84%	91%	91%	90%	85%	89%	81%	97%	76%	82%	74%	86%	77%	90%	70%	82%	73%	85%	65%	87%	77%	89%	77%
	2019	100%	90%	97%	94%	100%	95%	97%	100%	93%	77%	97%	77%	98%	88%	98%	86%	100%	92%	92%	88%	84%	81%	89%	83%	95%	88%
	2018	97%	87%	97%	93%	100%	93%	100%	97%	100%	93%	95%	86%	95%	87%	91%	81%	88%	73%	98%	80%	90%	73%	87%	85%	95%	86%
	2017	80%	77%	97%	90%	93%	90%	90%	74%	79%	47%	86%	76%	86%	78%	97%	91%	96%	82%	100%	81%	98%	84%	94%	71%	91%	78%
MB	**2022**	**82%**	**45%**	**84%**	**48%**	**100%**	**63%**	**100%**	**77%**	**94%**	**69%**	**100%**	**71%**	**92%**	**55%**	98%	**60%**	**92%**	**59%**	**96%**	**57%**					**94%**	**61%**
	2021	96%	74%	95%	68%	95%	64%	98%	48%	95%	57%	93%	72%	90%	73%	100%	94%	93%	67%	93%	79%	97%	65%	95%	56%	95%	68%
	2020	96%	71%	96%	60%	94%	69%	77%	52%	85%	46%	89%	52%	90%	51%	82%	55%	97%	64%	91%	37%	90%	59%	100%	59%	91%	56%
	2019	90%	62%	95%	59%	96%	82%	97%	80%	93%	70%	93%	83%	89%	76%	97%	64%	91%	66%	96%	67%	92%	44%	93%	37%	94%	66%
	2018	89%	80%	95%	67%	92%	68%	91%	65%	93%	50%	100%	55%	90%	52%	95%	41%	90%	32%	93%	13%	94%	68%	95%	67%	93%	55%
	2017	100%	83%	100%	90%	100%	97%	100%	90%	100%	97%	84%	58%	83%	51%	97%	57%	92%	59%	93%	37%	88%	53%	80%	34%	93%	67%
PC	**2022**	**95%**	**49%**	**87%**	**44%**	**97%**	**81%**	**93%**	**47%**	**100%**	**65%**	**100%**	**79%**	**98%**	**53%**	**94%**	**78%**	**87%**	**67%**	**100%**	**77%**	**91%**	**25%**	**75%**	**22%**	**93%**	**57%**
	2021	97%	80%	87%	82%	93%	79%	97%	61%	97%	77%	97%	67%	95%	66%	89%	81%	94%	69%	94%	73%	79%	63%	91%	59%	93%	71%
	2020	89%	53%	87%	62%	80%	51%	85%	67%	93%	83%	83%	87%	97%	73%	83%	75%	98%	73%	88%	70%	-900%	79%	95%	89%	7%	72%
	2019	97%	70%	90%	73%	85%	62%	97%	79%	98%	85%	90%	85%	92%	80%	98%	85%	93%	83%	88%	69%	96%	79%	94%	85%	93%	78%
	2018	90%	83%	72%	63%	83%	73%	93%	80%	93%	81%	90%	85%	84%	91%	84%	81%	84%	73%	82%	67%	70%	80%	87%	50%	84%	76%
	2017	90%	77%	83%	63%	93%	77%	94%	77%	100%	100%	77%	50%	90%	74%	100%	91%	87%	57%	100%	94%	88%	82%	90%	90%	91%	78%
Tele	**2022**	**81%**	**61%**	**91%**	**65%**	**100%**	**67%**	**90%**	**68%**	**80%**	**63%**	**87%**	**50%**	**97%**	**69%**	**85%**	**55%**	**88%**	**78%**	**97%**	**82%**	**81%**	**75%**	**67%**	**16%**	**87%**	**62%**
	2021	91%	67%	90%	79%	90%	67%	98%	86%	90%	79%	90%	65%	98%	88%	87%	85%	89%	87%	90%	67%	97%	61%	91%	78%	92%	76%
	2020	98%	93%	100%	89%	87%	72%	85%	65%	89%	65%	78%	54%	63%	56%	90%	56%	66%	46%	77%	70%	84%	78%	65%	65%	82%	67%
	2019	100%	94%	95%	89%	95%	90%	94%	91%	94%	96%	97%	86%	98%	77%	100%	87%	87%	79%	92%	71%	83%	75%	74%	83%	92%	85%
	2018	96%	86%	92%	77%	87%	87%	98%	95%	86%	77%	97%	90%	79%	78%	98%	86%	97%	90%	98%	89%	83%	69%	87%	61%	92%	82%
	2017	90%	77%	98%	76%	100%	97%	95%	77%	86%	84%	96%	87%	90%	83%	93%	84%	82%	83%	87%	87%	96%	84%	89%	87%	92%	84%
		A% = pain assessed percentage																									
		R% = pain reassessed percentage																									
																				Average combining all units =>						**88%**	**66%**

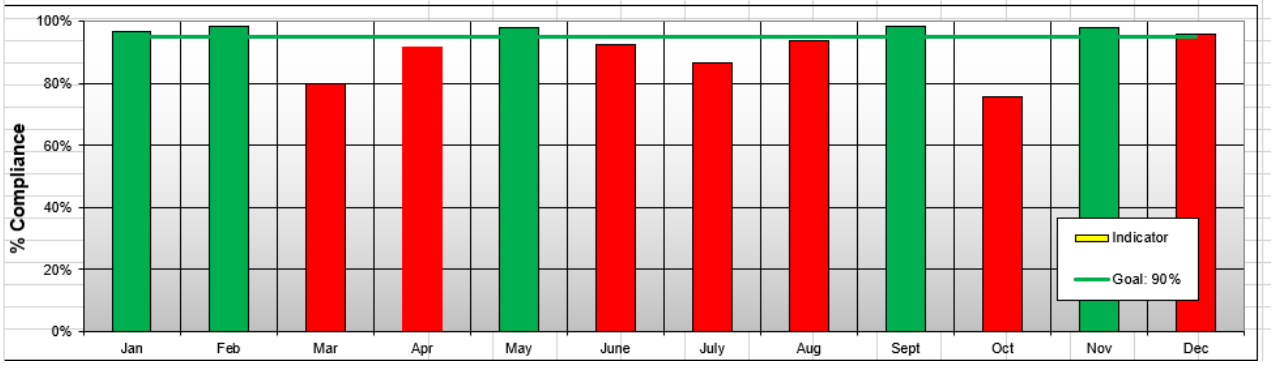
		January	February	March	April	May	June	July	August	September	October	November	December	YTD average
Clinics	**2022**	**100%**												**100%**
Clinics	2021				92%		100%			100%			100%	98%
Clinics	**2020**							79%	71%	73%				**74%**
Clinics	2019		100%			100%	38%	64%	62%	73%	83%			74%

Clinics = Cath Lab, Endo, Special Procedures * correct documentation, not A%/R%

- *Appropriate use of pharmaceutical waste streams*
  - **Methodology:** Monthly audits, pharmacy unit inspections by RPh
  - **Evaluation frequency:** monthly, reported quarterly
  - **Date of last review:** 3/1/2023
  - **Weakness or deficiencies identified:** during Joint Commission survey in 2019, it was identified that "blue" containers were overfilled; during monthly EOC (environment of care) rounds/ RPh unit inspections, medication found in red containers, black containers not labeled correctly
  - **Date identified:** Joint Commission inspection 2019
  - **Has the plan been modified?** No - new

    If yes …
    - ✓ When:
    - ✓ Weakness identified:
    - ✓ Plan modification:
    - ✓ Follow up:
  - Annual review: 9/9/2020, 3/3+7/7+12/8/2021, 3/9/2022, 8/3/2022, 3/1/2023
  - Does the annual review demonstrate assessment for effectiveness? Yes – slight improvement YTD vs 2021; EOC recommendation to narrow review to red container only for 2023 (NOTE: Pharmacists still review during monthly unit inspections and communicate with Nursing Directors if any variation for expectation)
    - Director of Pharmacy includes information during Nursing Orientation
    - Stericycle walk through and re-education during visit

Function: EC Haz Materials & Waste Mgmt	Functional Team Leader: Director of Pharmacy (Jennifer Gavin)												
Indicator	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	
Ensure staff are appropriately using pharmaceutical waste streams to dispose of hazardous drugs (HD) and PPE used for HD	97%	99%	80%	92%	98%	92%	86%	94%	98%	76%	98%	96%	
GOAL: 95%													95
Annual 2021 (92%) - increase to goal of 95%	91%	93%	79%	100%	98%	96%	88%	100%	94%	81%	83%	90%	**92%**
Annual 2020 (88%) - goal 90%													
Number of containers correctly and appropriately being used *(numerator)* : *RED = no meds, BLUE = not overfilled; BLACK = labelled, lid on,*	83	71	60	55	54	48	64	75	62	93	47	49	
Total number of containers checked *(denominator)*	86	72	75	60	55	52	74	80	63	123	48	51	
Quarter Summary			91.8%			94.0%			93%			85%	**92%**
			Qtr 1			**Qtr 2**			**Qtr 3**			**Qtr 4**	**Annual**



11. Use

- *Benzo-sparing ETOH withdrawal – monitor dose use of Precedex, Ativan IV and PO*
  - **Methodology:** Monitor Pyxis vend data
  - **Evaluation frequency:** monthly, reported quarterly
  - **Date of last review:** 3/1/2023
  - **Weakness or deficiencies identified:** Focus on non-ED data; doses vended only (returns incorporated into review)
  - **Date identified:** April 2018 with Benzo-Sparing ETOH withdrawal protocol
  - **Has the plan been modified?** No

    If yes …
    - ✓ **When:**
    - ✓ **Weakness identified**:
    - ✓ **Plan modification:**
    - ✓ **Follow up:**
  - **Annual review:** 3/11+ 9/9/2020, 3/3+7/7+12/8/2021, 3/9/2022, 8/3/2022
  - **Does the annual review demonstrate assessment for effectiveness?** Yes but not to pre-pandemic numbers, overall COVID patient treatment has definitely impacted totals.
    - Education on Benzo-Sparing Alcohol Withdrawal protocol review with VEP group (by KP hospitalists)
    - Continue to watch in 2023

Precedex

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	Total
2022	65	99	49	106	128	76	20	64	3	209	28	70	213	310	87	307	**917**
2021	124	224	59	221	26	81	53	57	49	20	35	30	407	328	159	85	**979**
2020	12	87	48	35	58	67	40	98	166	34	74	222	147	160	304	330	**941**
2019	51	75	114	14	48	34	58	22	43	47	23	42	240	96	123	112	**571**
2018	91	247	57	43	181	56	87	160	22	55	129	56	395	280	269	240	**1184**

Ativan Injectable

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	Total
2022	237	172	120	99	111	82	67	66	100	99	62	86	529	292	233	247	**1301**
2021	159	128	41	181	128	177	106	120	93	93	83	60	328	486	319	236	**1369**
2020	43	57	61	55	112	46	49	125	65	38	80	75	161	213	239	193	**806**
2019	95	40	60	65	95	43	64	31	97	74	42	67	195	203	192	183	**773**
2018	97	116	125	126	166	198	94	77	116	64	122	58	338	490	287	244	**1359**

Ativan ORAL

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	Total
2022	107	64	83	46	125	67	56	46	65	55	68	113	254	238	167	236	**895**
2021	38	26	49	94	73	45	52	59	83	69	63	76	113	212	194	208	**727**
2020	83	66	32	92	128	157	142	74	39	42	40	21	181	377	255	103	**916**
2019	144	44	92	46	61	82	40	125	43	46	44	84	280	189	208	174	**851**
2018	232	176	210	145	145	109	40	90	59	52	141	122	618	399	189	315	**1521**