July 10, 2025

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 - COMMITTEE OF THE WHOLE** of **SALINAS VALLEY HEALTH**[1] will be held **MONDAY, JULY 14, 2025, AT 8:30 A.M., DOWNING RESOURCE CENTER, CEO CONFERENCE ROOM 117, SALINAS VALLEY HEALTH MEDICAL CENTER, 450 E. ROMIE LANE, SALINAS, CALIFORNIA**.

(V*isit* **https://www.salinasvalleyhealth.com/~/about-us/healthcare-district-information-reports/board-of-directors/board-committee-meetings-virtual-link/** *for Public Access Information*).

Allen Radner, MD
President/Chief Executive Officer

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

Committee Voting Members: **Catherine Carson**, Chair, **Rolando Cabrera, MD**, Vice-Chair, **Clement Miller,** Chief Operating Officer, **Carla Spencer, RN**, Chief Nursing Officer; **Alison Wilson, DO**, Medical Staff Member.

Advisory Non-Voting Members: Administrative Executive Team.

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

MONDAY, JULY 14, 2025, 8:30 A.M.
DOWNING RESOURCE CENTER, CEO CONFERENCE ROOM 117

Salinas Valley Health Medical Center
450 E. Romie Lane, Salinas, California

(Visit SalinasValleyHealth.com/virtualboardmeeting for Public Access Information)

AGENDA

1. Call to Order / Roll Call

2. Public Comment

   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.

3. Approve the Minutes of the Quality and Efficient Practices Committee Meeting of June 16, 2025. (CARSON)
   - Motion/Second
   - Public Comment
   - Action by Committee/Roll Call Vote

4. Patient Care Services Update (MILLER)
   - Critical Care Unit Practice Council

5. Emergency Department Report (THOMPSON)

6. Laboratory Services Report (OROSCO)

7. Closed Session

8. Reconvene Open Session/Report on Closed Session

9. Adjournment

   The next Quality and Efficient Practices Committee Meeting is scheduled for **Monday, August 18, 2025 at 8:30 a.m.**

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.

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

The Salinas Valley Health (SVH) Committee packet is available at the Board Meeting, electronically at https://www.salinasvalleyhealth.com/~/about-us/healthcare-district-information-reports/board-of-directors/meeting-agendas-packets/2025/, and in the SVH Human Resources Department located at 611 Abbott Street, Suite 201, Salinas, California, 93901. All items appearing on the agenda are subject to action by the SVH Board.

Requests for a disability related modification or accommodation, including auxiliary aids or Spanish translation services, in order to attend or participate in-person at a meeting, need to be made to the Board Clerk during regular business hours at 831-759-3050 at least forty-eight (48) hours prior to the posted time for the meeting in order to enable the District to make reasonable accommodations.

QUALITY & EFFICIENT PRACTICES COMMITTEE
COMMITTEE OF THE WHOLE
SALINAS VALLEY HEALTH

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
    - Accreditation and Regulatory (RATCLIFF)
2. Quality and Safety Board Dashboard Review (KUKLA)
3. Consent Agenda:
    - Throughput Committee
    - Sepsis Initiative
    - HIM Health Information Management
    - Critical Care Service Line
    - Supply Chain/Materials Management
    - Volunteer/Community Service
    - Diagnostic Imaging
    - Rehab Services-PT/OT
    - Medical-Surgical Cluster, Pediatrics, Inpatient Wound Care Program
    - Transitional Care

ADJOURN TO OPEN SESSION

CALL TO ORDER
ROLL CALL

(Chair to call the meeting to order)

PUBLIC COMMENT

DRAFT SALINAS VALLEY HEALTH[1]
QUALITY AND EFFICIENT PRACTICES COMMITTEE MEETING
COMMITTEE OF THE WHOLE
MEETING MINUTES JUNE 16, 2025

Committee Member Attendance:

Voting Members Present: **Catherine Carson**, Chair, **Clement Miller**, COO, **Carla Spencer,** CNO, and **Alison Wilson, M.D**.

Voting Members Absent: **Rolando Cabrera, M.D.**

Advisory Non-Voting Members Present:
In Person: Allen Radner, M.D., President/CEO.

Other Board Members Present, Constituting Committee of the Whole:
Via teleconference: Rolando Cabrera, M.D. (Attending as a non-voting member) and Victor Rey

Dr. Wilson arrived at 8:34 a.m.
Victor Rey left at 9:13

1. CALL TO ORDER/ROLL CALL

A quorum was present and Chair Carson called the meeting to order at 8:30 a.m. in the Downing Resource Center CEO Conference Room 117.

2. PUBLIC COMMENT

None.

3. APPROVAL OF MINUTES FROM THE QUALITY AND EFFICIENT PRACTICES COMMITTEE MEETING OF MAY 12, 2025.

Approve the minutes of the May 12, 2025 Quality and Efficient Practices Committee meeting. The information was included in the Committee packet.

PUBLIC COMMENT:
None

MOTION:

Upon motion by Committee Member Miller, second by Committee Member Spencer, the minutes of the May 12, 2025 Quality and Efficient Practices Committee Meeting are approved as presented.

ROLL CALL VOTE:
Ayes: Chair Carson, Miller, and Spencer.
Nays: None;
Abstentions: None;
Absent: Dr. Cabrera and Dr. Wilson.

Motion Carried

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

4. PATIENT CARE SERVICES UPDATE: PERINATAL UNIT PRACTICE COUNCIL

Carla Spencer, CNO, introduced Shannon Hernandez, BSN, RNC-MNN, IBCLC, who reported on the following:

- **Council's Purpose:** To identify and implement standards of care, and evidence-based practice specific to the perinatal care area; and to identify and resolve clinical and systems issues impacting or affecting care coordination, a healthy work environment, the delivery of patient-family centered care, patient safety, and clinical outcomes.
- **Current Initiatives:**
    - **Anesthesia RN Role (Ongoing):** Focus on emergent Obstetrics (OB) anesthesia events (STAT/emergent cesareans, OB STAT Crimson and unplanned intubations) to identify opportunities to standardize, clarify, improve collaboration, increase nurse confidence/ competence in emergent situations and support sustainability in the Registered Nurse (RN) response through reinforcing the Anesthesia RN role. A workgroup included Dr. Ozoigbo/Chief of Anesthesia, bedside nurses and Perinatal leadership. Outcomes included reinforced readiness, improved communication, efficiencies and a culture shift empowering nurses and engaging mentorship. The next steps include ongoing skills checks and simulations, orientation integration and conferencing after each OB STAT event.
    - **Postpartum Bladder Management (In progress):** A team of staff, the Perinatal Nurse Educator and physician partners used literature review to standardized postpartum bladder management to reduce hemorrhage risk. A straight catheter decision tree was developed for immediate postpartum recovery and orders added to admission order sets for straight catheter and bladder scan assessment as needed. The decision tree assists with assessing voiding, post void residual, covert vs. overt postpartum urinary retention, CAUTI risk vs. bladder distention risk. E-Learning was assigned. Go-live day is June 19.
    - **OR Warming Protocol (In progress):** A warming protocol for pre and post-operative patients is essential to maintain body temperature, prevent hypothermia & promote healing. A team of Labor & Delivery (L&D) RNs is developing a protocol to standardize processes and to evaluate effective interventions.
- **Next Steps:**
    - Postpartum bladder management implementation
    - Perioperative warming protocol implementation
    - Standardized perinatal Blood Glucose (BG)/Insulin process for gestational diabetes, antepartum
    - Improve Handover Process between L&D & Mother Baby (MB)
    - End-of-case debrief following Cesarean sections
    - Guided imagery use in the L&D operating room (exploring feasibility)

COMMITTEE DISCUSSION: The SVH UTI rate is very low; one in recent history. Recommendation: Consider offering sterile catheterization training. Sterile catheterization training was offered in May 2025. Data is maintained on how often straight catheterization is utilized as well as UTI rates. Chair Carson stated this was a great presentation.

5. CLOSED SESSION

Chair Carson announced that the items to be discussed in Closed Session are *Hearings/Reports* as listed on the closed session agenda. The meeting recessed into Closed Session under the Closed Session protocol at 8:43 a.m.

6. RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION

The Committee reconvened for Open Session at 9:33 a.m. Chair Carson reported that in Closed Session, the *Hearings/Reports* were accepted as follows:

Hearings and Reports

1. Report of the Medical Staff Quality and Safety Committee
    - Palliative Care
    - Leapfrog Report
    - Accreditation and Regulatory
    - Pt Safety Events/RCAs
2. Quality and Safety Board Dashboard Review
3. Consent Agenda:
    - Environment of Care Report & Safety Plans
    - Pharmacy & Therapeutics
    - Falls
    - Pathology Reviews 3-4Q 2024, 1Q 2025

7. ADJOURNMENT

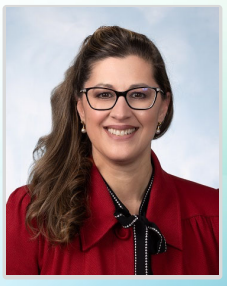
There being no other business, the meeting adjourned at 9:34 a.m. The next Quality and Efficient Practices Committee Meeting is scheduled for **Monday, July 14, 2025** at 8:30 a.m.

_____

Catherine Carson, Chair
Quality and Efficient Practices Committee

Patient Care Services Update

Salinas Valley HEALTH



Presented by:
Carla Spencer, MSN, RN, NEA-BC
Chief Nursing Officer

Date: July 14, 2025

Featuring: Critical Care Unit Practice Council

Kristine Lacanilao & Lorelie Pestillos

Critical Care Unit Practice Council

Salinas Valley HEALTH

Council Membership

- **Chair:** Laurel Black, MSN, RN, CCRN
- **Co-Chair**: David Martin, BSN, RN, PCCN
- **Associate Co-Chair:** Jannica Sebastian, MSN, APRN, FNP-C, PCCN
- **Advisor:** Marie Marbach, MSN, RN, PCCN, Clinical Manager 4T/5T

Members:

- Nichole Harris, MSN, CCRN, RN
- Grant Stephens, BSN, PCCN, RN
- Dante Santoyo, BSN, RN
- Gabriela Morales, BSN, PCCN, RN
- Lorelie Pestillos, BSN, PCCN, RN
- Melanie Morales, BSN, PCCN, RN
- Rosa Alonzo, BSN, PHN, PCCN, RN
- Crystal Jones BSN, PCCN, RN
- Kristine Lacanilao, BSN, PHN, RN

Council Purpose

- To identify and implement standards of care and evidence-based practices specific to critical care, and identify and resolve clinical and systems issues impacting or affecting care coordination, a healthy work environment, the delivery of patient and family centered care, patient safety, and clinical outcomes.

Completed Initiatives:

- Standardized Bedside Shift Handoff Tool
- Open Heart Surgery Education

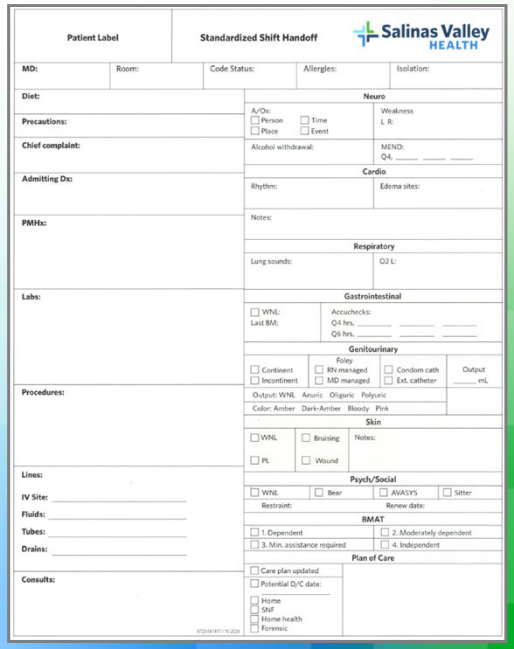
Current Initiatives:

- Alarm Fatigue
- Increase Certification & BSN and Higher Degree Rates in all Critical Care Units

Standardized Bedside Shift Handoff Tool

Background:

- As we transition from Meditech to Epic, it was identified that:
  - The ability to print patient profiles for Shift Handoff will be lost
  - There is an opportunity to decrease incidental overtime by standardizing our bedside Shift Handoff report process



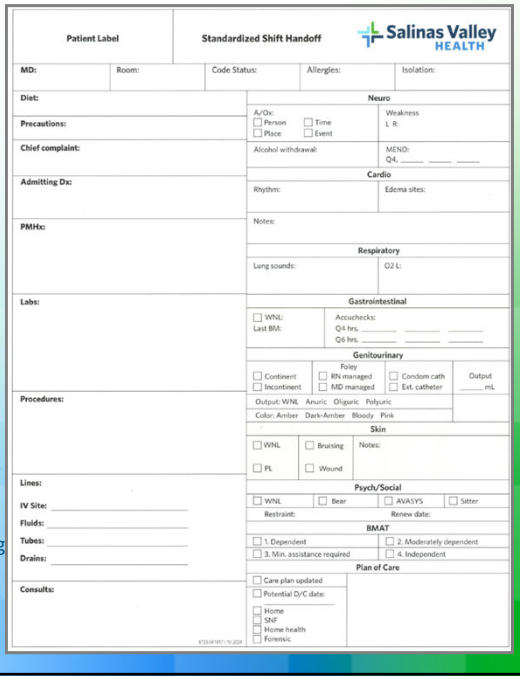
Standardized Bedside Shift Handoff Tool (cont.)

The Intervention:

- A taskforce comprised of unit practice council (UPC) members identified key components of the patient profile, their assessments and patient care they felt were key components to provide in Shift Handoff.
- The taskforce developed a standardized tool to capture key components of the Shift Report ensuring consistency and conciseness among nursing staff in the Progressive Care units

Outcomes/Data:

- Incidental overtime was decreased across the Progressive Care units since the implementation of sheet in June of 2024
- RN's also report more succinct, higher quality reports/handovers, contributing to enhanced patient safety



Patient Label | Standardized Shift Handoff | Salinas Valley HEALTH

MD: | Room: | Code Status: | Allergies: | Isolation:

Diet:
Precautions:
Chief complaint:
Admitting Dx:
PMHx:
Labs:
Procedures:
Lines:
IV Site: _____
Fluids: _____
Tubes: _____
Drains: _____
Consults:

Neuro
A/Ox: ☐ Person ☐ Time ☐ Place ☐ Event
Weakness L R:
Alcohol withdrawal:
MEND: Q4: ____ ____ ____

Cardio
Rhythm:
Edema sites:
Notes:

Respiratory
Lung sounds:
O2 L:

Gastrointestinal
☐ WNL
Last BM:
Accuchecks: Q4 hrs. ____ ____ ____ Q6 hrs. ____ ____ ____

Genitourinary
☐ Continent ☐ Incontinent
Foley: ☐ RN managed ☐ MD managed
☐ Condom cath ☐ Ext. catheter
Output ____ mL
Output: WNL Anuric Oliguric Polyuric
Color: Amber Dark-Amber Bloody Pink

Skin
☐ WNL ☐ Bruising ☐ PI ☐ Wound
Notes:

Psych/Social
☐ WNL ☐ Bear ☐ AVASYS ☐ Sitter
Restraint: Renew date:

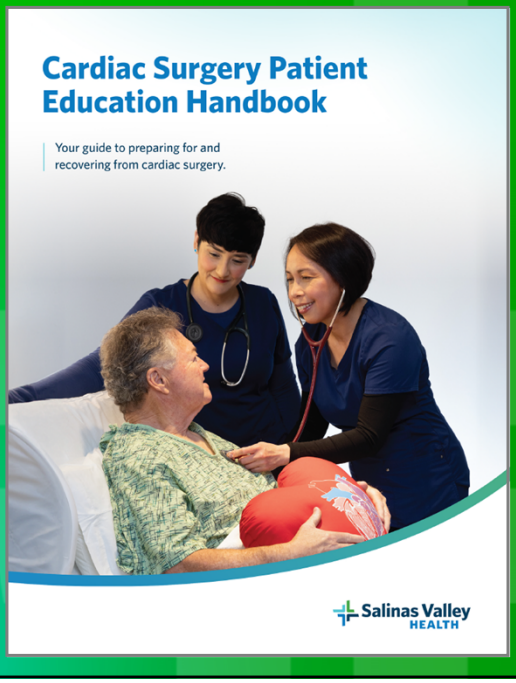
BMAT
☐ 1. Dependent ☐ 2. Moderately dependent
☐ 3. Min. assistance required ☐ 4. Independent

Plan of Care
☐ Care plan updated
☐ Potential D/C date: _____
☐ Home ☐ SNF ☐ Home health ☐ Forensic

Open Heart Surgery Education

Background:

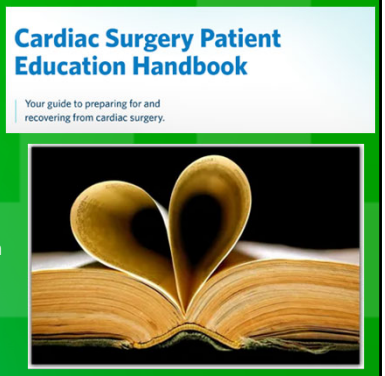
- Staff in the Heart Center (HC) and Intensive Care Unit (ICU) identified the need to update our open heart surgery education for patients and families to current evidence-based standards and practices
- Our education process was multidisciplinary, however each discipline's approach to education varied
  - Videos & education tools were outdated
  - Patient did not receive take-home materials to reinforce the education they received
  - There is inconsistency in the way staff provided and documented education



Open Heart Surgery Education (cont.)

The Intervention:

- A multidisciplinary team of HC RNs, ICU RNs, Cardiothoracic surgeons, physical/occupational therapy (PT/OT), Pre-op, and Cardiac rehab collaborated to identify the important education topics necessary to inform the patient and their family. They developed a process on when/how to educate the patient:
  - Patients with planned surgeries can obtain the *Cardiac Surgery Patient Education Handbook* from the physician's office prior to admission so they can start reviewing the **pre-operative** information. On day of surgery, an ICU RN meets the patient to inform them what to expect in the ICU immediately **post-op**. Once they are transferred to HC, the HC staff and PT/OT will utilize the booklet to further educate and **reinforce teaching until discharge**



Outcomes:

- Greater compliance with charting (for Joint Commission audits), staff nurses report increased ease, uniformity, AND individualization in delivering patient education throughout their hospital stay

Alarm Fatigue Management

Background:

- Reducing alarm fatigue in the hospital is essential:
  - To improve Patient Safety
  - To improve Nurse well-being and efficiency
  - To improve Alarm accuracy and prioritization
  - To improve patient experience (this project was identified as one of the Joint Commission National Patient Safety Goals)

Alarm Fatigue Management (cont.)

Brief Update/Plan:

- We audited baseline data and in a 7 day period:
  - ICU had 40,340 and 1Main had 39,128 **"yellow alarms"**
  - These units haves 13 beds each so that is an average of over 3,000 alarms per patient beds, per day (assuming all beds were full)

Collaborated with key physician stakeholders to identify appropriate monitor limits → Currently working with Leadership, Biomed, and Philips to schedule an implementation date → Education is being provided to staff on the units

Outcomes/Measures to Track:

- Decrease in alarms
- Patient Experience Data

Increase Certification Rates and BSN and higher degrees by 1% in all Critical Care units

Background:

- To maintain Magnet® certification (The Magnet model is made up of five core components: transformational leadership; structural empowerment; exemplary professional practice; new knowledge, innovations, and improvements; and empirical outcomes)
- To increase competency and comfortability of staff nurses

Plan/Update:

- To achieve our goal, council members to promote and encourage:
  - Certification on the units; council members help teach in the Progressive Care Certified Nurse (PCCN) classes
  - Tuition Reimbursement program for BSN and/or MSN programs

We honor our registered nurses who demonstrate their commitment to excellence and contribute to improved patient outcomes through professional board certification in their specialty.

Outcomes/Measures to Track:

- Managers track rates with a goal of achieving a 1% increase by year-end in the number of nurses obtaining a higher nursing degree and/or specialty certification

Next Steps:

Transition to Epic

- Collaborate with Informatics and Practice Council on referral process and project management strategies to implement within Epic
- Printing report sheets from Meditech will be discontinued. We will rely on using standardized bedside report sheets and continuous process improvement
- Continue to motivate RN's to get degrees and certifications
- Promote council work and lead by example to create meaningful, lasting organizational impacts and foster cultural change

Questions?

Emergency Department Report to QIC

Salinas Valley HEALTH

David Thompson BSN, RN
Director of Emergency Services

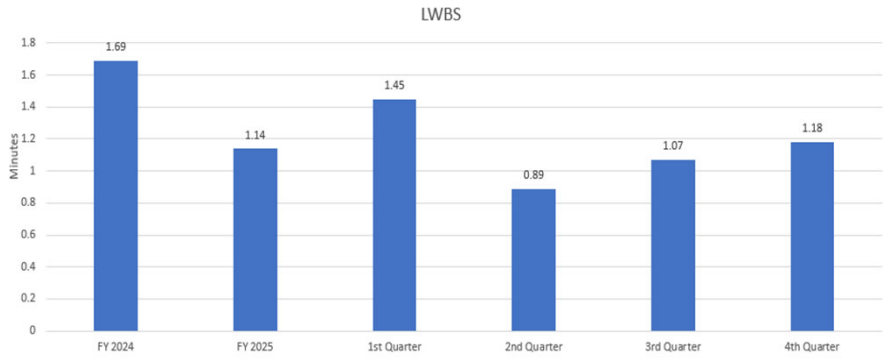
6.2025

Quality / Safety Goals

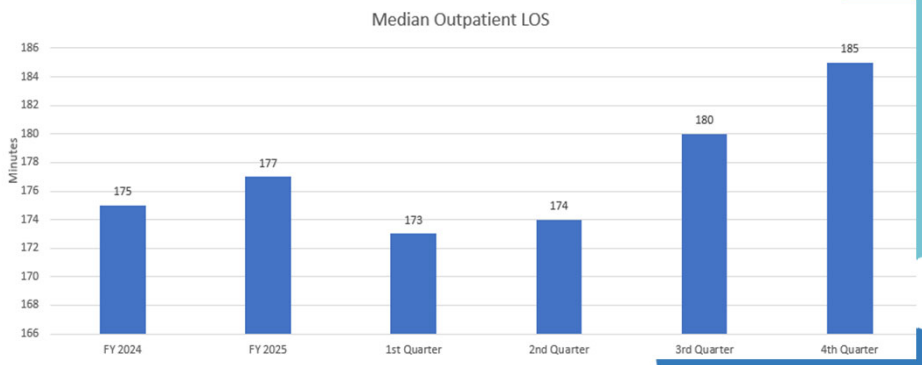
- Left Without Being Seen= <2%
- Median Time Outpatient LOS= <181 minutes
- Median Time Admit Order to ED Department = <74 minutes
- Door to EKG= <10 minutes
- Patient Experience

SECTION TITLE

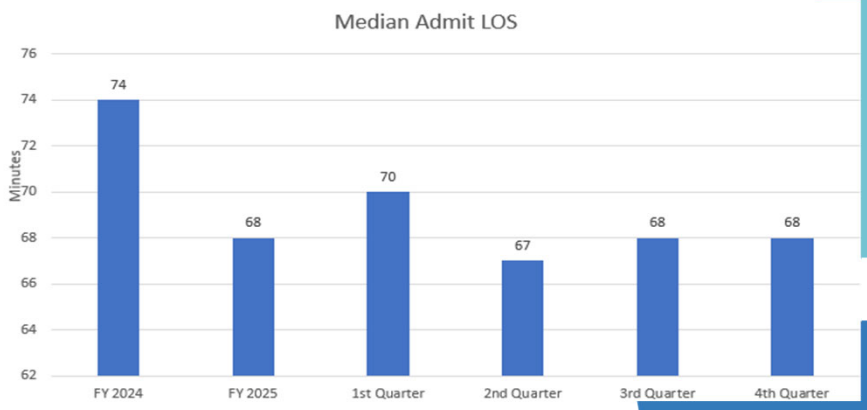
Left Without Being Seen <2%



Median Time Outpatient LOS <181 Minutes

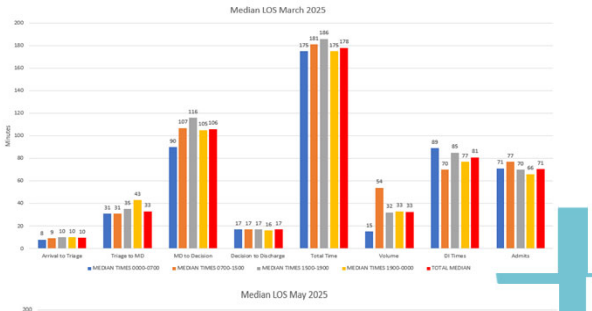


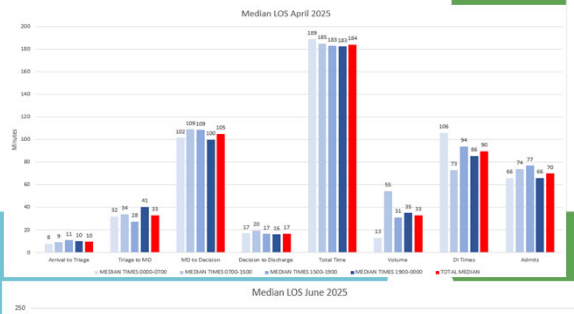
Median Admit Order to Departure <74 Minutes

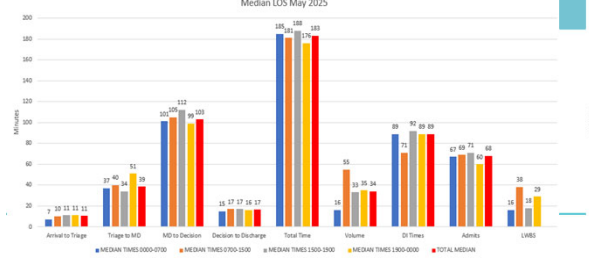


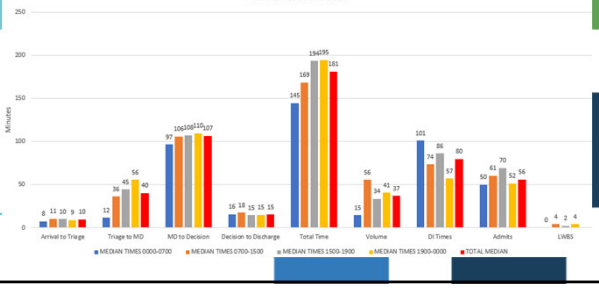
SECTION TITLE

DATA BREAKDOWN







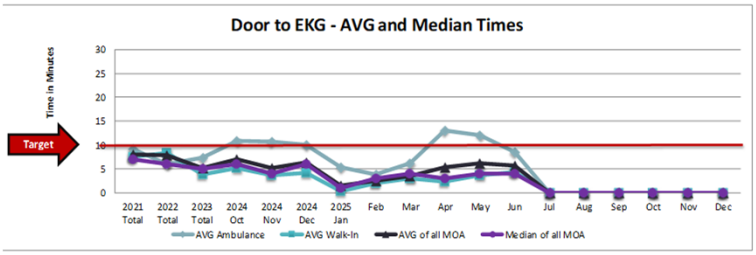


Door to EKG Times <10 Minutes

SVMH Door to EKG - Average and Median Times

2025

	2021 Total	2022 Total	2023 Total	2024 Oct	2024 Nov	2024 Dec	2025 Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
AVG Ambulance	9.2	6.0	7.3	11.0	10.7	10.0	5.4	3.9	6.1	13.1	12.0	8.6							8.9
AVG Walk-In	7.6	8.4	3.8	5.1	3.6	4.2	0.4	2.1	3.1	2.3	3.7	4.4							2.5
AVG of all MOA	8.1	7.8	5.2	7.0	5.3	6.4	1.6	2.6	3.6	5.3	6.2	5.7							4.1
Median of all MOA	7.0	6.0	5.0	6.0	4.0	6.0	1.0	3.0	4.0	3.0	4.0	4.0							3.0



All modes of arrival - % less than 10 min - Goal is ≥ 90%		
2023	1086 / 1228	78%
2024	1155 / 1345	88%
Jan 2025	102 / 103	99%
Feb 2025	61 / 61	100%
Mar 2025	84 / 85	99%
Q1 2025	247 / 249	99%
Apr 2025	81 / 93	87%
May 2025	85 / 105	81%
Jun 2025	32 / 39	82%
Q2 2025	198 / 237	84%
Jul 2025	0 / 0	
Aug 2025	0 / 0	
Sep 2025	0 / 0	
Q3 2025	0 / 0	
Oct 2025	0 / 0	
Nov 2025	0 / 0	
Dec 2025	0 / 0	
Q4 2025	0 / 0	
2025	445 / 486	92%

Door to EKG in Minutes by Mode of Arrival (MOA) for Chest Pain Pts.

Note: Data is based on 100% of all STAT chest pain patients seen in ER (over 18 yo) who had an EKG done.
Will monitor and intervene when Median ≥8 min or total percentage ≤79%

ED Service Line

SERVICE LINE	THRESHOLD	TARGET	MAX	FY25TD TOP BOX	FY25TD RANK
Emergency Department	61.8	62.3	62.8	65.1	36th

EMERGENCY DEPARTMENT EXPERIENCE DASHBOARD

Last Updated: 6/2/25

TOP BOX SCORE	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	FY25TD
Likelihood of recommending	**67.4**	**69.4**	**70.6**	**65.1**	**59.1**	**65.9**	**64.6**	**61.8**	**69.2**	**65.4**	**59.0**	**65.3**
Overall rating of care	65.4	69.2	68.4	63.6	60.9	65.4	62.4	59.7	70.2	64.9	56.3	64.2
Staff cared about you as person	61.2	68.2	67.1	65.4	61.1	63.8	62.5	58.3	67.4	64.5	58.7	63.5
Staff worked together care for you	61.4	70.3	70.3	63.6	62.8	63.0	62.1	59.7	68.3	65.0	57.3	64.1
Arrival Overall	34.5	44.2	39.6	33.3	34.2	35.4	37.2	36.5	38.2	36.5	36.0	36.8
Comfort of waiting area	31.2	41.8	39.0	31.9	29.5	32.9	35.8	33.7	36.4	34.8	32.0	34.4
Waiting time to treatment area	37.7	46.7	40.3	34.8	38.9	37.9	38.6	39.2	39.9	38.3	40.1	39.3
Nurses Overall	63.7	68.6	72.4	68.4	63.5	64.6	63.6	61.5	71.3	67.7	60.9	66.1
Courtesy of nurses	68.6	71.0	75.9	70.5	67.3	65.1	66.4	64.6	73.6	68.3	63.1	68.7
Nurses took time to listen	65.4	69.8	74.1	67.9	65.0	65.2	63.6	64.1	71.9	68.5	63.4	67.2
Nurses' attention to your needs	63.6	68.2	73.2	68.5	63.8	65.3	63.7	60.6	71.7	67.2	62.0	66.3
Nurses' concern for privacy	58.2	66.5	67.2	67.1	58.3	62.8	62.1	57.0	68.6	66.7	55.4	62.8
Nurses' responses to quest/concerns	62.6	67.6	71.8	67.9	63.1	64.3	62.3	61.0	70.9	67.7	60.4	65.5
Doctors Overall	64.9	70.3	69.5	65.0	67.5	70.1	66.4	64.6	70.3	67.5	61.0	67.0
Courtesy of doctors	68.4	72.7	72.0	68.9	71.8	73.7	69.1	67.2	71.9	69.8	64.6	70.0
Doctors took time to listen	66.4	70.9	70.2	66.4	68.8	71.8	67.2	65.5	71.9	70.0	65.5	68.6
Doctors informative re treatment	62.9	69.4	68.9	62.0	66.1	68.3	65.2	62.9	68.9	65.4	58.6	65.3
Doctors' concern for comfort	62.7	68.8	67.9	64.4	63.9	66.7	63.3	61.8	67.9	65.7	56.4	64.5
Doctors include you trtmt decision	64.1	69.3	68.3	63.4	67.1	69.8	66.9	65.4	70.7	66.7	59.9	66.5

SECTION TITLE

Opportunities for Improvement

- With the implementation of modular buildings focus will be on patient experience and patient flow
- Continued collaboration with physician partners
- Increasing educational opportunities for staff, focusing on knowledge gaps
  - Annual Clinical Self-Assessment
  - Critical Care Equipment Days
  - In-house Certified Emergency Nurse review
- EPIC implementation for better analytics

SECTION TITLE

DEPARTMENT/SERVICE
Quality Improvement Reports

LABORATORY

Report to QIC

Lori Orosco, PhD CLS(ASCP)CM
Laboratory Director
Timothy Johnson, MLS(ASCP)CM
Laboratory Quality Assurance and Quality Improvement Supervisor

Salinas Valley HEALTH

Date: June, 2025

Quality / Safety Goals - 2025

- ED Turn Around Times: Troponin, Potassium (surrogate for all STAT BMP tests), Lactate, CBC/PLT, and PT/INR within 50 minutes of order.
  - Serum HCG (qualitative) within 45 minutes of order.
  - Manual Differential within 80 minutes of order.
- Microbiology Turn Around Times: Positive Blood Cultures, AFB stain, CSF stain, Influenza, SARS-CoV-2, *Strep* Group A NAA
  - Positive Blood Culture ID & Sensitivity reported within 62 hrs of collection.
  - Positive Urine Culture ID & Sensitivity reported within 50 hrs of collection.
- Blood Culture contamination rate: Meeting current goal <3%. Continue education, training, and exploring alternative blood diversion devices for new target of <1% contamination rate
- Blood Culture underfill rate: Set target of <=30% aerobic bottles underfilled (<8mL)
- Decrease specimen labeling errors throughout hospital using Vocera Edge for improved efficiency and TAT
- Increased Patient Satisfaction – Press Ganey Reports
- Increased Timely Investigation and Response to RL6/WeCare Events

Data: ER Turn Around Times

INDICATOR	TARGET	OCT	NOV	DEC/ Q4	JAN	FEB	MAR/ Q1
ER TAT: K	≤ 50min	52	52	51	50	51	49
ER TAT: TROP	≤ 50min	55	54	55	53	54	52
ER TAT: Lactate	≤ 50min	43	45	46	45	47	44
ER TAT: HCG-plasma	≤ 45min	43	44	45	43	45	44
ER TAT: CBC	≤ 50min	39	40	40	39	40	38
ER TAT: Manual Diff	≤ 80min	85	90	85	88	87	76
ER TAT: PT/INR	≤ 50min	46	48	51	47	47	47
ER TAT: HCG-urine	≤ 17min	13	13	11	14	13	14
ER TAT: Order to Coll Phleb	≤ 17min	17	18	17	15	16	15
Critical Calls - documented	100%	99.5%	99.6%	99.9%			
SVHMC Labeling Errors	0						5
ED Labeling Errors	0						0

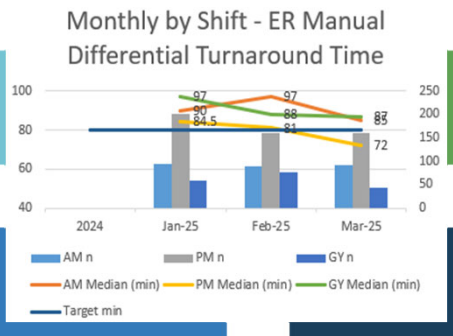
- "Order to Collect" preanalytical metric changed to median measurement to be consistent with other metrics.
- "Order to Collect" hovered around the target TAT for 2024 Q4 and is now comfortably within target range for 2025 Q1.
  - Vocera Edge system implemented in September 2024 but was accompanied by significant system challenges ("bugs").
  - Phlebotomy Supervisor and team have worked diligently to overcome these challenges through awareness and monitoring while "bugs" were/are resolved.
- Troponin TAT performance has consistently been out of range, although the latest month was within 5% of target.
  - Review of "receipt to result" gives a median ~24 min.
  - Working with the manufacturer to determine if we can see if preanalytical or postanalytical factors should be focused on for improvement.
- Review of methods of obtaining rate of adequate critical value notification indicate Meditech/Document Repository does not have a better method and data review (~2000/month) will be manual until Epic implementation.
  - Retroactive review to come.

SVH Laboratory

Data: ER Turn Around Times

- TAT data has traditionally been presented as "overall performance" information and posted for laboratory staff to review.
  - Workflow, type of work, and volumes vary greatly throughout the day.
  - Each shift has unique challenges, staffing, and types of work (ex. AM shift has a large volume of "routine" tests from inpatients during a "morning draw."
  - For certain tests, performance metrics are now split into individual shifts to highlight the different levels of performance and where the greatest opportunities for improvement can be found.
    - This additional shift-specific data is being incorporated into the laboratory QAPI.
- Data and areas for improvement presented to staff at general huddles, department huddles, laboratory leadership meetings, and laboratory leadership quality meetings.

	2024	Jan-25	Feb-25	Mar-25
AM n		95	88	91
AM Median (min)		90	97	85
PM n		202	161	161
PM Median (min)		84.5	81	72
GY n		59	76	43
GY Median (min)		97	88	87
Target min	80	80	80	80



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Data: ER Turn Around Times

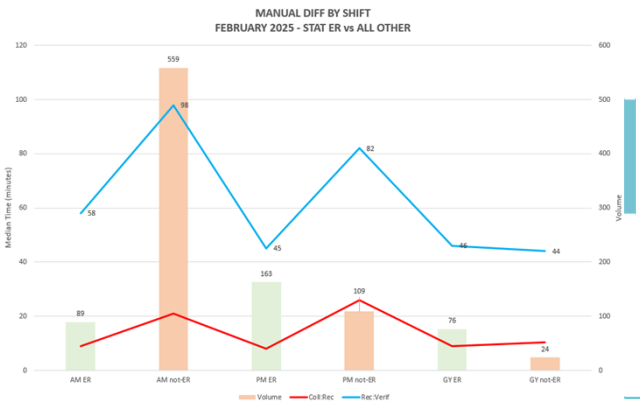
- New method of reviewing preanalytical and assays with persistent performance not meeting quality targets.
- A month of data is used to compile a visual representation of performance across a 24 hour period.
  - Volume, order time, collection time, receipt time, result time is available to look for trends.
  - Targeted review and identification of patterns are brought to laboratory leadership meetings for discussion and suggestions.
  - Multiple months can then be overlapped to distinguish between normal variation and potential trends.

Examples:

SVH Laboratory

Data: ER Turn Around Times

- **Example Use: Hematology Manual Differentials**
  - ED STAT TAT target of 80min order to result was repeatedly exceeded throughout all of 2024.
  - Shift data differences in work loads, differences in the “phases” of the testing process (preanalytical, analytical) reviewed to look for ways to improve STAT prioritization.
  - Hematology Lead CLS, staff education, daily coaching, and repeated performance presentation at huddles



	AM ER	AM not-ER	PM ER	PM not-ER	GY ER	GY not-ER
Ord:Coll	17	333	20	14	22	244
Coll:Rec	9	21	8	26	9	10.5
Rec:Verif	58	98	45	82	46	44
Order:Verify	**97**	461	**82**	157	**88**	305.5
Collect:Verify	**71**	124	**54**	125	**57.5**	55.5
Target	80	80	80	80	80	80
Volume	89	559	163	109	76	24

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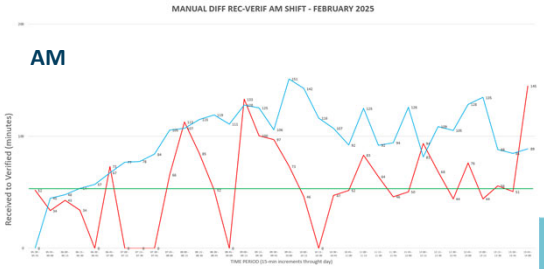
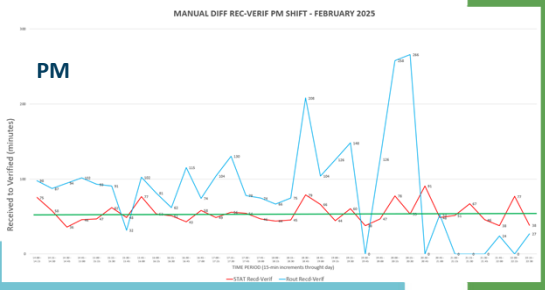
Data: ER Turn Around Times

- **Example Use: Hematology Manual Differentials**
  - Comparison of shifts

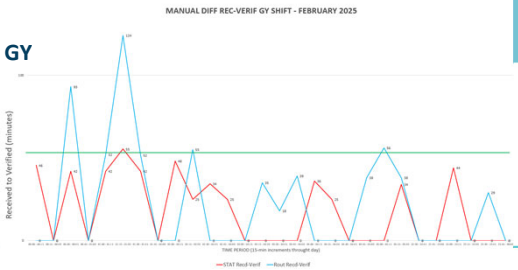
AM



PM



GY



March 2025 is the first time since monitoring began that the ED STAT manual differential TAT was met

ER TAT: Manual Diff	≤	80min	85	90	85	88	87	76

SVH Laboratory

Data: Microbiology Turn Around Times

- Microbiology monitoring was previously performed quarterly and has been moved to monthly, with CSF gram stain TAT excluded.
  - Some retroactive data review still in progress.
- Low volume for CSF gram stain metrics leads to large swings in reported TAT performance, with only ~20 occurrences/quarter.
  - Looking into monitoring performance with a shifting "previous 6 months" review instead.
- Switched from ID NOW platform to GeneXpert for respiratory virus and Strep A testing on 2/11/2025.
  - Maintaining target TAT to minimize impact on ED due to longer test time (~20min).
  - Challenges with the shorter margin for error and different testing/reporting process are in process.

INDICATOR	TARGET		OCT	NOV	DEC/ Q4	JAN	FEB	MAR/ Q1
TAT: AFB Smear	95%	≤ 24hrs	99.1%	99.0%	99.1%	94.9%	98.3%	97.5%
Quarterly TAT: CSF GS	95%	≤ 1hr			94.7%			85.0%
TAT: Pos Blood Cx ID&Sens	≤	62hr	63	58	64	59	62	57
TAT: Pos Urine Cx ID&Sens	≤	50hr	43	43	45	43	44	46
TAT: Pos Bld Culture GS	95%	≤ 1hr					95%	96.5%
TAT: FLU NAA	95%	≤ 1hr	92.7%	88.1%	87.7%	92.9%	72.3%	82.6%
TAT: SARS-COV2 NAA	95%	≤ 1hrs	95.7%	92.3%	92.2%	97.4%	100.0%	100.0%
TAT: Strep Group A NAA	95%	≤ 1hrs	93.0%	93.5%	96.8%	95.5%	88.6%	90.2%
Bld Culture Contam - Adult	≤	3%			1.6%		1.22%	1.0%
Bld Culture Contam - Pedi	≤	3%			0.0%		0.00%	0.0%
% Underfilled BC bottles	≤	30%	32.9%	33.3%	35.2%	36.6%	27.3%	27.2%
Verigene Agree w/C&S	95%	Agree			100.0%		98%	93.5%

SVH Laboratory

Data: Microbiology Blood Culture Contamination Rates

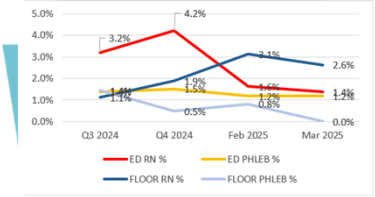
- Currently meeting Adult/Pediatric targets for ALL blood cultures as of March 2025.
  - March 2025 adult contamination rate was 1.02% and hovering over future goal of <1.0%
  - March 2025Phlebotomy Adult contamination rate was **0.88%**
- Phlebotomist contaminations rates are now consistently <2%.
- ED Nursing implemented VI ByPass syringe use and reviewed collection practices.
  - ED nurse-collected contamination halved from Dec 2024 to Feb 2025.
- With phlebotomy contamination rates indicating collection practices are dialed in, the laboratory is starting a trial of a new blood diversion product from Steripath (Steripath Micro) to see if the product can help solidify <1% contamination.
  - Two month trial begins in May 2025.

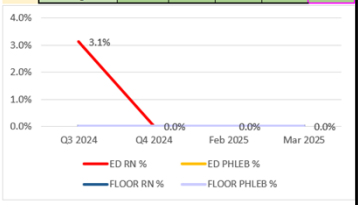
ADULT

	Past 8 Months	Q3 2024	Q4 2024	Feb 2025	Mar 2025
OVERALL	1.5%	1.7%	1.6%	1.2%	1.0%
ED RN	3.0%	3.2%	4.2%	1.6%	1.4%
ED PHLEB	1.4%	1.4%	1.5%	1.2%	1.2%
FLOOR RN	1.9%	1.1%	1.9%	3.1%	2.6%
FLOOR PHLEB	1.1%	1.4%	0.5%	0.8%	0.0%
Target	3%	3%	3%	3%	3%

PEDIATRIC

	Past 8 Months	Q3 2024	Q4 2024	Feb 2025	Mar 2025
OVERALL	0.4%	0.8%	0.0%	0.0%	0.0%
ED RN	1.3%	3.1%	0.0%	0.0%	0.0%
ED PHLEB	0.0%	0.0%	0.0%	0.0%	0.0%
FLOOR RN	0.0%	0.0%	0.0%	0.0%	0.0%
FLOOR PHLEB	0.0%	0.0%	0.0%	0.0%	0.0%
Target	3%	3%	3%	3%	3%





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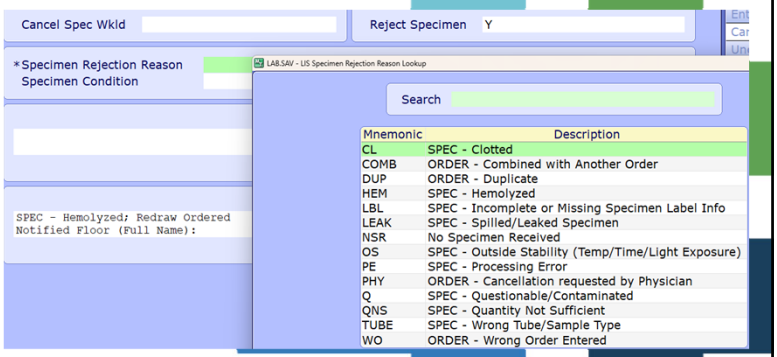
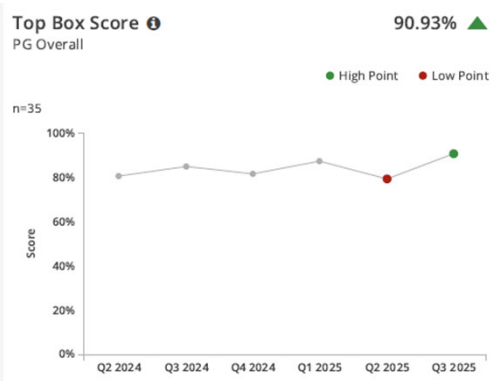
Data: Specimen Labeling Errors

- Specimen labeling errors (unlabeled/incompletely labeled/mislabeled) used to be documented and evaluated manually.
  - New rejection process was created and implemented for better quality data.
  - Issues resulting in a redraw/recollect or order change can be entered into Meditech as part of standard process.
  - Information related to rejected specimens are more easily accessible for review (location, orderer, collector, specimen type, etc.)
  - Standardizes method of documenting rejections and ordering location notification.
- New Rejection Process will be used to present rejection reason breakdowns
  - Currently only presented as "Specimen Labeling" issues for ED review.
  - More elaboration & data to come.



SVH Laboratory

Patient Satisfaction – Press Ganey Survey



Time Period	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025
n	110	67	50	42	37	35
Top Box Score	80.82%	85.15%	81.82%	87.55%	79.53%	90.93%
Percentile Rank	25	65	32	83	14	97

- Press Ganey Survey review has been focused on Outpatient Services due to ease of determining laboratory involvement.
  - Laboratory Clerical Staff and Phlebotomists are routinely given feedback along with any notable comments.
- Reinforce AIDETs training with clerical staff.
- Review of available information specific to the laboratory outside of outpatient services is in process.
  - To work on specifically looking at blood collection satisfaction for inpatients and ED patients.

SVH LABORATORY

CLOSED SESSION

(Report on Items to be Discussed in Closed Session)

RECONVENE OPEN SESSION/
REPORT ON CLOSED SESSION

(Meeting Chair)

ADJOURNMENT