



October 8, 2026

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, OCTOBER 12, 2026, AT 8:30 A.M., DOWNING RESOURCE CENTER, CEO CONFERENCE ROOM 117, SALINAS VALLEY HEALTH MEDICAL CENTER, 450 E. ROMIE LANE, SALINAS, CALIFORNIA.**

(For Public Access Information Visit <https://www.salinasvalleyhealth.com/about-us/healthcare-district-information-reports/board-of-directors/board-committee-meetings-virtual-link/>.)

A handwritten signature in black ink, appearing to read "Allen Radner", is positioned above the printed name.

Allen Radner, MD
President/Chief Executive Officer

Committee Voting Members: **Catherine Carson**, Chair, **Rolando Cabrera, MD**, Vice Chair, **Clement Miller**, Chief Operating Officer, **Carla Spencer, RN**, Chief Nursing Officer and **Richard Gerber, MD**, Medical Staff Member

Advisory Non-Voting Members: Cheryl Pirozzoli, Community Member

**QUALITY AND EFFICIENT PRACTICES COMMITTEE
COMMITTEE OF THE WHOLE
SALINAS VALLEY HEALTH¹**

**MONDAY, OCTOBER 12, 2026, 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 September 14, 2026. (CARSON)

- Motion/Second
- Public Comment
- Action by Committee/Roll Call Vote

4. Patient Care Services Update (SPENCER)

- Report from Night Shift Unit Practice Council (DICKERSON)

5. Patient Safety Plan (GROOTERS)

- Staff Report
- Committee Questions to Staff
- Public Comment
- Committee Discussion/Deliberation
- Motion/Second
- Action by Committee/Roll Call Vote

6. Performance Improvement Reports

- Nutritional Services (NADER)
- Laboratory Services (JOHNSON)

¹Salinas Valley Memorial Healthcare System operating as Salinas Valley Health

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, **November 9, 2026** 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.

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/2026/>, 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 831-759-3208 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. Quality and Safety Board Dashboard Review (SYED)

ADJOURN TO OPEN SESSION

CALL TO ORDER
ROLL CALL

(Chair to call the meeting to order)

PUBLIC COMMENT

DRAFT SALINAS VALLEY HEALTH¹
QUALITY AND EFFICIENT PRACTICES COMMITTEE MEETING
COMMITTEE OF THE WHOLE
MEETING MINUTES SEPTEMBER 14, 2026

Committee Member Attendance:

Voting Members Present: **Catherine Carson**, Chair, **Rolando Cabrera, M.D.**, Vice Chair, **Carla Spencer**, CNO, **Richard Gerber, M.D.**, Medical Staff Member, and **Clement Miller**, COO

Voting Members Absent: None

Advisory Non-Voting Members Present:

In Person: Allen Radner, MD, CEO, Alysha Hyland, CAO, Tim Albert, M.D., CCO, Cheryl Pirozzoli, Family/
Patient Advisor, Rakesh Singh, MD, VP
Via Teleconference: Michelle Childs, CHRO

Other Board Members Present, Constituting Committee of the Whole:

Via Teleconference: Victor Rey Jr, Joel Hernandez Laguna

1. CALL TO ORDER/ROLL CALL

A quorum was present and Chair Carson called the meeting to order at 8:32 a.m. in the Downing Resource Center, CEO Conference Room 117.

2. PUBLIC COMMENT: None.

3. APPROVAL OF THE AMENDED MINUTES FROM THE QUALITY AND EFFICIENT PRACTICES COMMITTEE MEETING OF AUGUST 17, 2026

Approve the minutes of the August 17, 2026 Quality and Efficient Practices Committee meeting. The information was included in the Committee packet.

PUBLIC COMMENT: None.

COMMITTEE MEMBER DISCUSSION: None.

MOTION:

Upon motion by Vice Chair Cabrera, and second by committee member Carla Spencer the minutes of the August 17, 2026 Quality and Efficient Practices Committee Meeting are approved as presented.

ROLL CALL VOTE:

Ayes: Chair Carson, Vice Chair Cabrera Spencer, Miller, Dr. Gerber;

Nays: None;

Abstentions: None;

Absent: None.

Motion Carried.

¹Salinas Valley Memorial Healthcare System operating as Salinas Valley Health

4. PATIENT CARE SERVICES UPDATE: REPORT FROM THE CRITICAL CARE UNIT PRACTICE COUNCIL

Carla Spencer, CNO, introduced a member of her team to present an update on the Perioperative Clinical Practice Council. Mikhail Brown, MS, BSN, RNII, PCCN, gave an overview of the FY 2027 smart goals and initiatives. Two charts were presented highlighting RN BSN or higher degree and RN professional board certification data. Mikhail also reviewed board certification preparation classes, the Professional Development & Education Fair, and nurse recognition activities. She then presented nurse turnover data and compared our organization's turnover rates with the national average. Lastly, she reviewed our strategic retention and engagement efforts.

A full report was included in the packet.

COMMITTEE MEMBER DISCUSSION: Chair Carson asked for clarification on board certification and what it takes to reach that. Mikhail Brown noted that he believes the stay interview will have the largest impact.

5. ACCREDITATION & REGULATORY UPDATE

Kimothy Sparks, JD, RN, Interim Director of Accreditation & Regulatory Compliance presented the dates for the Mock Survey and the Triennial TJC Survey. He overviewed the preparations: Initiate the Accreditation Readiness Committee (ARC), Survey Pocket Card, Logistics Planning, Weekly Safety Rounds, Tracer Activity, and Chapter Focused Meetings

A full report was included in the packet.

COMMITTEE MEMBER DISCUSSION: None.

6. PERFORMANCE IMPROVEMENT REPORTS:

- **PERINATAL UNITS:** Julie Vasher, Director of Women and Children Services Labor and Delivery, provided an update on the enhancing developmental care in the NICU. She then overviewed the Labor & Delivery NTSV, Post C/S Huddle, and Mother Baby Human Donor Milk. She talked about the Mother- Baby POST Birth Alert Bracelet and Lactation. Lastly, she went over what is on the horizon: OB Specific withdrawal protocol, white noise use in NICU, and high risk blood cooler CCHD – reliability.
- **CASE MANAGEMENT:** Troy Scott, Director of Case Management, provided an overview of the notification of admission, data analysis and continuous improvement plans NOA, barriers/challenges, Medicare Outpatient Observation Notice MOON, and EPIC Impact on NOA and MOON Completion.
- **ENVIRONMENTAL HEALTH AND SAFETY PROGRAM:** Jeff Wardwell, Vice President Emergency Management Safety Security, presented the Environmental Health and Safety overview, regulatory, standards, and accreditation, program hierarchy & governance, safety risk management cycle, and the program performance review. Lastly, he compared safety, fire safety, security, emergency management, hazardous materials & waste, utilities, and medical equipment in 2025 and 2026.

Full reports were included in the packet.

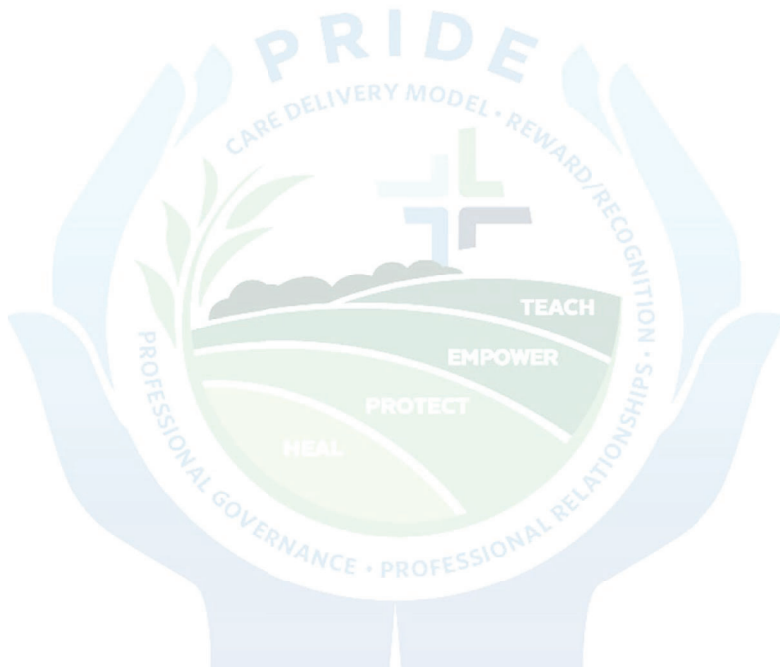
COMMITTEE MEMBER DISCUSSION: In regards to the Perinatal Unit presentation, Chair Carson asked how they are noting their documentation. Julie Vasher explained they have paper checklists but now also integrate the documentation into EPIC. Julie Vasher also noted that white noise has already been added to the NICU. Regarding Case Management, Chair Carson noted that patients must be notified of the MOON notice. In regards to Environmental Health and Safety Program, Chair Carson asked whether all fire drills are being tracked for Joint Commission. Sophia Sanchez noted that they are tracked on the dashboard. Chair Carson asked whether a mold assessment is being conducted following the flood in the basement.

7. ADJOURNMENT

There being no other business, the meeting adjourned at 9:45 a.m. The next Quality and Efficient Practices Committee Meeting is scheduled for Monday, **October 12, 2026** at 8:30 a.m.

Catherine Carson, Chair
Quality and Efficient Practices Committee

PATIENT CARE SERVICES UPDATE



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

Featuring: Night Shift Practice Council
Monday, October 12, 2026

Night Shift Practice Council Members

COUNCIL LEADERSHIP

Hannah Dickerson, BSN, RN, CMSRN
Chair

Rizelle Legaspi, BSN, RN
Co-Chair

Raymundo A. Morales, BSN, RN, PCCN
Associate Co-Chair

Glenda Alinio, BSN, RN, PCCN
Advisor

COUNCIL MEMBERS

Michael L. Brown, MS, BSN, RN, PCCN

Ludy Lim, MSN, RNC-LRN

Isabel Cervantes, RN

Yasmin Fernandez Rodriguez, RN, CMSRN

Fides Tugaoen, BSN, RN, PCCN, CMSRN

David Castro Rangel, RN

Corinna Neemia, CNA

Council Purpose

Provide clinical leadership

Identify and implement standards of care and evidence-based practice specific to night shift.

Collaborate across departments

Improve night shift processes through multidisciplinary collaboration to support positive outcomes.

Increase employee engagement

Engage employees who work off-shift hours in council activities and practice improvement.

NIGHT SHIFT PRACTICE COUNCIL | 2026 BOARD UPDATE

FY26 Council Goals & Accomplishments

GOAL 1 | RESTFULNESS OF HOSPITAL ENVIRONMENT ✖ NOT MET: 57.3 (but ↑)

Increase the inpatient domain top-box score from the FY25 baseline of 57.2 to ≥57.8 by the end of FY26.

GOAL 2 | SAFETY CULTURE: PREVENTION AND REPORTING ✔ MET: 4.15

Increase the organization-level score for night shift staff from the 2025 baseline of 4.10 to ≥4.13 in 2026.

NIGHT SHIFT PRACTICE COUNCIL | 2026 BOARD UPDATE

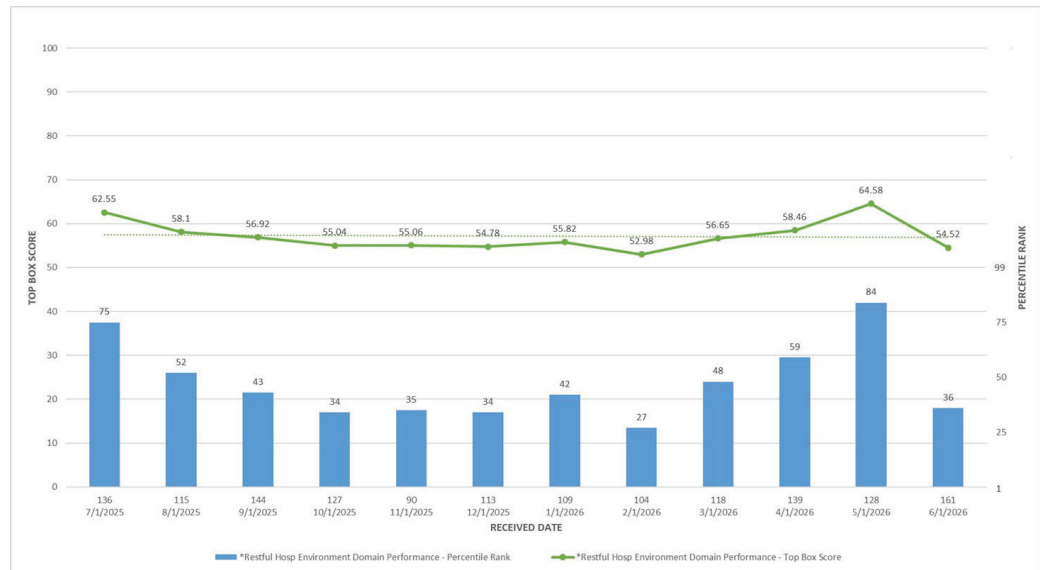
FY26 Council Goals & Accomplishments

FY26 goal was not met, but the score increased from the previous year.

Variation in data suggests inconsistent adoption of practices.

FY27 Focus:

Move from implementation of new interventions to reinforcing and sustaining practices.



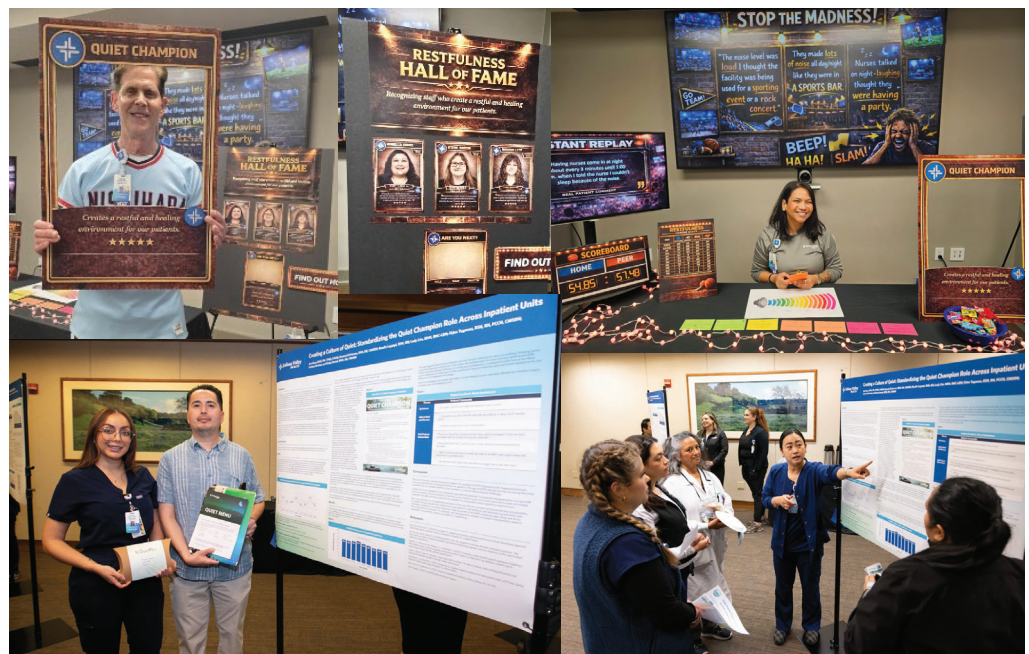
NIGHT SHIFT PRACTICE COUNCIL | 2026 BOARD UPDATE

FY26 Council Goals & Accomplishments

Existing interventions are in place to support a Restful Environment.

Council focused **hardwiring and reinforcing existing practices**, including the Quiet Menu and Quiet Champion, through:

- Quarterly unit rounding
- Staff engagement and education
- Professional Development Fair participation
- Poster Expo presentation



NIGHT SHIFT PRACTICE COUNCIL | 2026 BOARD UPDATE

FY26 Council Goals & Accomplishments

Support Night Shift Staff Wellness

- ✓ Created a **Night Shift Staff Wellness Guide** to equip our team with practical tools, strategies, and support tailored specifically to their needs.
- ✓ Created a STARNet Community page for Night Shift Staff as a venue to connect with fellow night shifters and share tips and resources.
- ✓ Integrated into new hire and New Graduate RN orientation.



On behalf of the Night Shift Practice Council, we are excited to share this **Night Shift Staff Wellness Guide** created especially for our Salinas Valley Health team. Working nights comes with unique challenges, but also unique strengths. This guide was developed with your well-being in mind, to support you not only at work, but also in how you rest, refuel, move, and connect outside of work.

Inside, you'll find practical tips and strategies gathered from a variety of trusted sources online, as well as from your own colleagues who work the night shift and generously shared what has worked for them. These are real-life strategies tested by those who understand the demands, sacrifices, and resilience it takes to care for others while the rest of the world sleeps. Look for the  symbol for information specific to Salinas Valley Health.

Our purpose is simple: to help you feel supported, energized, and balanced so you can thrive both on and off shift. We hope this guide serves as a helpful resource you can return to anytime you need new ideas, encouragement, or reminders that you're not alone.

Thank you for all that you do.

With gratitude,
Night Shift Practice Council



NIGHT SHIFT PRACTICE COUNCIL | 2026 BOARD UPDATE

FY26 Recent Accomplishments

SEPTEMBER 2026

Improved Access to Thickened Liquids & Food During Night Shift

Night Shift Council partnered with Nutrition Services to improve access to **thickened liquids, meals, and snacks** for patients during night shift.

Staff surveying identified key barriers:

- ✓ **Thickened liquids:** Not routinely stocked on inpatient units, creating an access barrier for patients who need them during night shift.
- ✓ **Food supply:** Units reported borrowing food stock from other units when supplies ran low.
- ✓ **Workflow opportunity:** Staff reported using unit-stocked food for patients even when the Room Service option was available.

Outcome: Council findings informed Nutrition Services improvements and staff education through WIN-TIP 496.

NIGHT SHIFT PRACTICE COUNCIL | 2026 BOARD UPDATE

FY27 Council Goals

GOAL 1 | RESTFULNESS OF HOSPITAL ENVIRONMENT

Increase the inpatient domain top-box score from the FY26 baseline of 57.3 to ≥ 57.8 by the end of FY27.

GOAL 2 | SAFETY CULTURE: PREVENTION AND REPORTING

Increase the organization-level score for night shift staff from the 2026 baseline of 4.15 to ≥ 4.16 in 2027.

NIGHT SHIFT PRACTICE COUNCIL | 2026 BOARD UPDATE

FY27 Projects

Support Restfulness of Hospital Environment

- Prepare for the planned **relaunch** in collaboration with nursing leadership.
- Continue **quarterly unit rounding** to reinforce quiet practices and identify barriers

Promote Night Shift Staff Engagement

- Integrate Night Shift Staff Wellness into New Graduate education as a scheduled session.
- Increase engagement on the Night Shift Staff Community page.
- Increase awareness of the Night Shift Council and promote the referral process to help identify and address night-shift-specific opportunities.

NIGHT SHIFT PRACTICE COUNCIL | 2026 BOARD UPDATE

Thank you

Night Shift Practice Council

NIGHT SHIFT PRACTICE COUNCIL | 2026 BOARD UPDATE

Patient Safety Program Plan

Amy Grooters, RN, NE-BC

Patient Safety Manager



Purpose

- Proactive, organization-wide framework for patient safety at Salinas Valley Health
- Zero preventable harm
- Just Culture
- Prioritization of safe patient care practices; ensuring systems, resources, policies and culture is in line with established healthcare and quality frame works:
 - Patient Safety Structural Measures
 - National Performance Goals
 - Health and Safety Code

Scope

- Reduces risk and eliminates preventable harm
 - Acknowledge that risks to patients impact outcomes
 - Promote a culture of safety
 - Creation of a non-punitive, transparent approach for reporting, analyzing, and evaluating errors and problems
- Applies across all sites, services, and departments under SVHMC
- Encompasses patients, visitors, volunteers, students, all staff, including medical staff

3

Patient Safety Structural Measures

- CMS attestation-based measure evaluating a healthcare organizations total-system approach to safety
- 5 Domains
 - Leadership Commitment to Eliminating Preventable Harm
 - Strategic Planning and Organizational Policy
 - Culture of Safety and Learning Health Systems
 - Accountability and Transparency
 - Patient and Family engagement

4

National Performance Goals

- The Joint Commission – 14 Goals
- Examples include:
 - Correct patient receives the correct care at the correct time
 - Leadership fosters a culture of safety
 - Hospital maintains workplace and patient safety
 - Mediation Management program that focuses on safety

5

Health and Safety Code

- Patient Safety and antidiscrimination requirements
- Examples include:
 - Reporting of patient safety events (RLDatix)
 - Culture of Safety
 - Monitoring of sociodemographic disparities

6

Thank you

Status **Draft** PolicyStat ID **20679865**



Origination 1/1/2022
Approved N/A
Expires N/A

Owner Amy Grooters:
Patient Safety Manager
Area Plans and Program

Patient Safety Program Plan

I. PURPOSE

- A. The purpose of the Patient Safety Program Plan is to establish a proactive, organization-wide framework for patient safety at Salinas Valley Health Medical Center (SVHMC), under Salinas Valley Health (SVH). The plan is designed to create a comprehensive, organization-wide framework dedicated to achieving zero preventable harm and fostering a Just Culture. The Patient Safety Plan supports the mission, vision, and strategic plan of SVH.
- **SVH Mission:** It is the mission of Salinas Valley Health to provide quality healthcare to our patients and to improve the health and well-being of our community.
 - **SVH Vision:** A community where good health grows through every action, in every place, for every person.
- B. The organization prioritizes safe patient care practices and ensures systems, resources, policies, and culture are in-line with established healthcare quality and safety frameworks, such as the Patient Safety Structural Measures (PSSM) established by the Centers for Medicare & Medicaid Services (CMS), and the National Performance Goals (NPG) established by The Joint Commission (TJC).

II. GUIDING PRINCIPLES

- A. All staff, physicians, volunteers, patients, patient's families and their support persons are accountable and have a role to play in patient safety.
- B. Implementation of this plan is dependent on integrating validated safe practices across all departments in the hospital.
- C. A safe and secure work environment for staff, volunteers and physicians contributes to safe patient care.

- D. That patients and families are aware of safety practices and expectations and feel encouraged to ask for clarification of process or procedure.

III. SCOPE

- A. The scope of the organizational Patient Safety Program Plan at SVMH establishes a comprehensive, organization-wide framework designed to develop, implement, and evaluate a robust patient safety system. The program actively reduces risk and eliminates preventable harm by fostering an environment that encourages:
- Recognition and acknowledgment of risks to patient safety and medical/health care errors that impact outcomes.
 - The initiation of actions to promote a culture of safety throughout the facility, including the safe integration of technology.
 - Creation of a non-punitive, transparent approach for reporting, analyzing and evaluating errors and problems.
 - Facilitation of sharing knowledge to effect behavioral changes.
 - Implementation of proactive practices that decrease variation and waste, alongside the rapid redesign of unsafe care processes in response to validated adverse events.
 - Interdisciplinary communication, collaboration, and organization-wide education regarding patient safety and error reduction.
- B. The Patient Safety Program is an organization-wide initiative that applies universally across all sites, services, care settings, and departments (both patient care and non-patient care) under SVHMC.
- **Populations Encompassed:** The program directly encompasses the entire hospital community, including patients, visitors, volunteers, students, and all categories of staff, including the Medical Staff.
 - **Functional Reach:** The program spans all administrative, medical staff, nursing, and support activities, ensuring that patient safety priorities are deliberately integrated into the new design and redesign of all relevant organizational processes, functions, and services.
- C. SVH supports a Just Culture philosophy and approach to adverse event investigation and response. SVHMC has adopted the BETA Healthcare Group Just Culture Algorithm for responding to the behaviors of their employees in a fair and just manner. (Appendix A).
- D. To satisfy and exceed national benchmarks, the scope of the Patient Safety Program incorporates the CMS Patient Safety Structural Measures (PSSM) framework. This structure ensures that SVHMC prioritizes safety across five foundational domains:
1. **Leadership Commitment to Eliminating Preventable Harm:** Senior leadership and the SVHMC Board of Directors set the tone, oversee safety self-assessments, hold organizational leadership accountable for outcomes, and maintain safety as a key

institutional value.

2. **Strategic Planning and Organizational Policy:** Integration of patient safety priorities into the organization's strategic vision, quality and process improvement plans, and daily operational workflows.
 3. **Culture of Safety and Learning Health System:** Regular assessment of safety culture, deployment of team communication training, and utilization of data infrastructure (such as electronic health record data and tiered safety huddles) to track precursor events and serious safety incidents.
 4. **Accountability and Transparency:** Utilization of communication and resolution programs to respond thoroughly and transparently when unexpected events occur.
 5. **Patient and Family Engagement:** Meaningful incorporation of patients and families as active partners in safety, including leveraging feedback mechanisms to inform continuous improvement.
- E. The scope of the program operationalizes The Joint Commission National Performance Goals (NPGs) to maintain rigorous compliance and drive clinical excellence. Key performance objectives integrated into the safety scope include:
1. Ensuring the correct patient receives the correct care at the correct time.
 2. Fostering a governance-backed culture of safety.
 3. Prioritizing infection prevention and control, medication management safety, safe prescribing practices, and pain management.
 4. Respecting patient rights to safe, informed care while addressing specialized clinical risks such as suicide risk reduction, safe imaging services, and clinical staffing competency.
- F. Staff are required and encouraged to report all safety incidents, near-misses, hazardous conditions, and sentinel events via the electronic Incident Reporting System. Evaluations of reported events focus on investigating system, process, and design flaws (the "how" of errors) rather than placing blame on individuals (the "who" of errors).
- G. The Patient Safety Program Plan is evaluated and reviewed annually and will include objectives to meet SVHMC's annual patient safety goals and Strategic Plan:
1. The Patient Safety Plan is approved by the SVHMC Quality and Safety Committee, Medical Executive Committee and the Quality and Efficient Practice Committee of the Board and the Board of Directors on an annual basis.
 2. The Board of Directors delegates the responsibility for SVHMC Patient Safety Program oversight to the SVHMC Medical Executive Committee and the Quality and Safety Committee.
 3. The designated Patient Safety Officer for SVHMC has administrative responsibility for the program and reviews and updates the Patient Safety Plan as needed.

IV. OBJECTIVES and GOALS

- A. The overarching goal and objective of the Patient Safety Program Plan is to cultivate a proactive, transparent, and highly-reliable safety culture with a goal of zero preventable harm, empowering staff to speak up, report errors, and deliver high-quality care to every patient, all the time.
- B. Support and encourage a culture of safety through an environment where employees can report safety concerns, near misses, and incidents without the fear of blame or retribution, and trust that the information will be used for improvement.
- C. A team of appropriately skilled healthcare professionals (e.g. physicians, nurses, pharmacists, risk management, and frontline staff), within the organization, will conduct standardized Root Cause Analysis (RCA) for all significant patient safety events.
- D. Proactive risk assessments will be conducted for all new programs and services, or conducting one on a topic of interest, at eighteen-month intervals.
- E. Integration of a process to conduct analysis of patient safety events, which include the following sociodemographic factors, to identify disparities in these events:
 - Age
 - Race
 - Ethnicity
 - Gender identity (when voluntarily provided)
 - Sexual orientation (when voluntarily provided)
 - Preferred language spoken
 - Disability status
 - Payor
 - Sex
- F. Maintain continuous patient safety competence across all hospital personnel and affiliated medical staff. Deliver comprehensive patient safety training to newly hired staff during orientation, and supplement annually. Training includes event reporting, Just Culture principles, hazard identification and team communication strategies.
- G. Systematically address racism, discrimination, and implicit bias to eliminate its impact on patient health and safety including, but not limited to:
 - Monitoring sociodemographic disparities in patient safety events and developing interventions to remedy known disparities.
 - Encourage facility staff to report suspected instances of racism and discrimination.

V. PATIENT SAFETY PROGRAM ORGANIZATIONAL STRUCTURES/ RESPONSIBILITIES

- A. The SVHMC operational structure is aligned to meet the function of the Patient Safety Program. The goals and objectives of the Patient Safety Program are integrated into the functions of each of the following organizational / operational groups: Quality & Safety Committee of the Medical Staff, Medical Executive Committee, Quality and Efficient Practices Committee of the Board and the SVHMC Board of Directors. At all levels, SVHMC leaders provide the foundation for an effective patient safety system by: promoting learning; motivating staff to uphold a fair and just safety culture; providing a transparent environment in which quality measures and patient harms are freely shared with staff; modeling professional behavior; removing intimidating behavior that might prevent safe behaviors; and providing the resources and training necessary to take on improvement initiatives.
 1. **Board of Directors**
 - a. The SVHMC Board of Directors (the Board), through the approval of this document, authorizes the establishment of a planned and systematic approach to preventing and addressing patient safety. The Board delegates the implementation and oversight of this program to the Patient Safety Officer. It is the ultimate responsibility of the Board to ensure quality and safe patient care throughout the organization. Key responsibilities of the Board regarding Patient Safety are seen in activities such as:
 - i. Approves the Patient Safety Program Plan.
 - ii. Reviews SVHMC performance on key quality and safety indicators including sentinel/never events, and holds senior leadership, physician leadership, mid-level management, and frontline caregivers directly accountable for results.
 2. **Patient Safety Officer**
 - a. The Patient Safety Officer is responsible for assuring that this program is implemented and evaluated throughout the organization. As such, the Patient Safety Officer will establish the structures and processes necessary to accomplish this objective.
 - b. The Patient Safety Officer will review, and in collaboration with relevant leaders, identify and implement actions as necessary for all critical events within 5 days of the event. The Patient Safety Officer or designee will review non-critical incidents for trends / patterns or concerns and share with appropriate leaders, Quality Management and/or medical staff as necessary.
 - c. The Patient Safety Officer communicates and collaborates with Administration, department leaders and others as necessary, in an effort to ensure coordination in reduction of harm, promotion of safe practices, and a safe culture of reporting.

- d. Oversees the Culture of Safety survey as defined by the organization.
- e. Meets routinely with leaders and staff on the Patient Safety Program goals, objectives and outcomes.
- f. Is available to all persons under SVHMC when questions or concerns are raised concerning the safety of patients. Collaborates with the Environmental Health and Safety Officer for other safety concerns.

3. Patient Safety Advisory Team (PSAT)

- a. This ad-hoc committee comprises key representatives from leadership to:
 - i. Evaluate reported events related to patient safety and quality care that occur within SVHMC to determine whether the event is treated as a sentinel event and/or is reportable according to state and regulatory requirements.
 - ii. The Regulatory and Accreditation team oversees the PSAT process and collaborates with the Quality and Risk Departments for evaluation of events as necessary.

4. Staff

- a. To achieve the goal of delivering safe and high quality care, employees are given the empowerment with responsibility and authority to actively participate in SVHMC's Patient Safety Program. SVHMC uses department level resources or educational resources to conduct focused patient safety monitors, support additional education and awareness, and to provide timely feedback on patient safety issues and the effectiveness of our patient safety program. The Patient Safety Committee supports staff to embed quality and patient safety initiatives into consistent daily practice and to assist management in monitoring compliance and progress toward a goal.

VI. PATIENT SAFETY PROGRAM ELEMENTS

- A. Design or Re-design Processes – When a new process is designed (or an existing process is modified), the organization will use information from both internal and external sources to reduce medical errors and incorporate this information into its design or re-design strategies.
- B. Identification of Potential Patient Safety Issues – As part of its planning process, the organization regularly reviews the scope and breadth of its services. Attendant to this review is an identification of care process that, through the occurrence of an error, would have a significant negative impact on the health and well-being of the patient. Areas of focus are processes identified through:
 - 1. A review of the literature.
 - 2. The organization's performance improvement program.
 - 3. Occurrence reports and sentinel events.
 - 4. The result of findings by regulatory and/or accrediting agencies.
 - 5. Patient Safety Organizations (PSO), including but not limited to Press Ganey, NQF,

The Joint Commission Safety / Sentinel Event Alerts, ECRI, National Patient Safety Foundation, RLDatix, etc.

- C. Performance Related to Patient Safety – Once potential issues have been identified, the organization will establish performance measures to address those processes that have been identified as "high risk" to patient safety.
 - 1. Performance measurement data will be collected, aggregated, and analyzed as necessary to determine if opportunities to improve safety and reduce risk are identified. If so, the organization will prioritize those processes that demonstrate significant variation from desired practice, and allocate the necessary resources to mitigate the risks identified.
- D. Opportunities to reduce errors that reflect the performance of the individual care provider are addressed, as appropriate, through the Medical Staff peer review process or through the organization's human resource policy(s).
- E. Proactive Risk Assessments – The organization is committed to utilizing proactive risk assessments to identify potential hazards, analyze their likelihood and impact, and develop strategies to prevent or mitigate harm before incidents occur.
- F. Reporting of process/system failure and/or medical/health care errors and response.
 - 1. The organization is committed to responding to errors in care in a manner that supports the patient's rights, clinical needs, emotional needs, and protects the patient and others from any further risk. The facility will strive to preserve information critical to understanding the proximal and/or root cause of the error. The organization has established policies and procedures to address the following:
 - Medical/health errors and occurrences, including sentinel events, will be reported internally to the appropriate administrative or medical staff entity.
 - Errors will be reported to external agencies in accordance with applicable local, state, and federal law, as well as other regulatory and accreditation requirements.
 - Taylor Farms Family Health and Wellness Incidents resulting in hospitalization or death will be reported to The Compliance Team (TCT) within 48 hours.
 - 2. The organization has established mechanisms to report the occurrence of medical errors both internally and externally, per policy and through the channels established by this plan. External reporting will be performed in accordance with all state, federal and regulatory body rules, laws and requirements. Immediately upon identification, the patient care team member(s) will:
 - Perform necessary interventions to protect and support the patient's clinical condition.
 - As appropriate to the occurrence, perform necessary interventions to contain the risk as to not reach others
 - Contact the patient's attending physician and other physicians, as appropriate, to report the error, carrying out any physician orders as necessary,

- Preserve any information (including physical) or equipment related to the error. Examples of preservation of physical information are: removal and preservation of blood unit for a suspected transfusion reaction; preservation of IV tubing, fluid bags and/or pumps for a patient with a severe drug reaction from IV medication; preservation of medication label for medications administered to the incorrect patient. Preservation of information includes documenting the facts regarding the error on an occurrence report and in the medical record as appropriate to organizational policy and procedure;
 - Report the process/system failure or medical/health care error to the staff member's immediate supervisor.
 - Submit an occurrence report in the occurrence reporting system (RLDatix).
 - Any individual in any department identifying a process/system failure and/or potential patient safety issue will immediately notify his or her supervisor and document the findings in an occurrence report or contact the Patient Safety Officer.
3. Staff response to process/system failures and/or medical/health care errors is dependent upon the type of error identified.
 4. The Sentinel Event Policy will determine the organizational response to process/system failures and/or medical/health care errors and occurrences.
 5. Supporting staff involved in errors – An effective Patient Safety Program cannot exist without optimal reporting of process/system failures and medical/health care errors and occurrences. Therefore, it is the intent of this institution to adopt a non-punitive, just culture approach in its management of failures, errors and occurrences.
 - All personnel are required to report suspected and identified medical/health care errors, and should do so without the fear of reprisal in relationship to their employment. This organization supports the concept that errors occur due to a breakdown in systems and processes, and will focus on improving systems and processes, rather than disciplining individuals involved in errors and occurrences. A focus will be placed on remedial actions to ensure an appropriate course of action to prevent reoccurrence rather than punish/place blame on staff.
 - As part of this organization's culture of safety and quality, any staff member who has concerns about the safety or quality of care provided by the organization may report these concerns to The Joint Commission or the California Department of Public Health. The organization supports the staff member's right to report these concerns and will take no disciplinary or retaliatory action against the staff member for reporting a safety or quality of care concern.
 - Staff will be queried regarding their willingness to report medical/health care errors via the Patient Safety Culture Survey. The goal of the survey is to validate the following:
 - a. Staff and leaders value transparency, accountability, and mutual

- respect.
 - b. Safety is everyone's first priority.
 - c. Behaviors that undermine a culture of safety are not acceptable, and thus should be reported to organizational leadership by staff, patients, and families for the purpose of fostering risk reduction.
 - d. Collective mindfulness is present, wherein staff realize that systems have the potential to fail and staff are focused on finding hazardous conditions or close calls at early stages before a patient may be harmed. Staff does not view close calls as evidence that the system prevented an error but rather as evidence that the system needs to be further improved to prevent any defects.
 - e. Staff who do not deny or cover up errors, but rather want to report errors to learn from mistakes and improve the system flaws that contribute to, or enable, patient safety events. Staff know that their leaders will not focus on blaming providers involved in errors, but rather focus on the system issues that contributed to, or enabled, the patient safety event.
 - f. By reporting and learning from patient safety events, staff create a learning organization.
 - The organization recognizes that individuals involved in an error may need emotional and psychological support. The organization has defined processes to assist employees and members of the Medical Staff.
 - a. Employees can be referred to the organizations "Employee Assistance Program" for assistance.
 - b. Members of the Medical Staff can be referred to the "Physician Health/Well Being Committee" for assistance.
- G. Educating the Patient on Error Prevention – The organization recognizes that the patient is an integral part of the healthcare team. Patients will be educated about their role and responsibility in preventing medical errors.
 1. The Patient Safety Program includes a survey of patients, their families, volunteers and staff (including medical staff) opinions, needs and perceptions of risks to patients and requests suggestions for improving patient safety.
 - H. Informing the Patient of Errors in Care – Patients, and when appropriate their families, are informed about the outcomes of care, including unanticipated outcomes, or when the outcomes differ significantly from what was anticipated. The Attending physician / other physician is responsible for assuring that the patient is informed of errors in care.
 - I. Dissemination of Information – Lessons learned from root cause/comprehensive causative analysis, system or process failures, and the results of proactive risk assessments shall be disseminated to appropriate staff that provides care, treatment and service pertinent to the specific issue.

VII. PATIENT SAFETY PLAN MANAGEMENT

A. Patient Safety Program Resources

1. Designated resources have been provided to assist the organization in meeting the goals and objectives of the Patient Safety Program and to facilitate the implementation of the Patient Safety Program Plan.
2. The Risk Management, Quality Management, Patient Safety Divisions and all Departments are the primary source of support for patient safety improvement activities within SVHMC. These departments include staff to assist with the integration of event investigation, data management, analysis, clinical processes and patient outcomes.
3. SVHMC is committed to providing psychological support to staff involved in serious patient safety events or critical/sentinel events. Sources of support include:
 - Human Resources
 - Employee Assistance Program
 - Clinical Social Work Department
 - Rights and Ethics Committee

B. Patient Safety Problem Identification, Notification & Resolution Process

1. When a situation occurs that may risk patient safety, SVHMC staff is requested to report unusual occurrences and/or unexpected events as outlined in the [ADVERSE EVENTS - REPORTABLE](#) Policy using any of the following reporting mechanisms:
 - Online Occurrence/Event Report or may elect to notify Administration directly.
 - a. Direct Notification can include:
 - Notification to Department manager/supervisor
 - Notification to the Patient Safety Officer
 - Notification to Administrative Supervisor
 - Notification to Quality, Risk, Infection Control
2. When a situation arises that requires immediate response to a patient safety event, the staff makes any necessary changes to prevent further harm to the patient, communicates with the patient and/or patient's family and notifies the Administrative Supervisor. The Administrative Supervisor is responsible for informing the Administrator on-call, the Patient Safety Officer or their designee. [DISCLOSURE OF UNANTICIPATED OUTCOMES POLICY](#)

C. Patient Safety Program – SVHMC Staff & Medical Staff Education

1. SVHMC communicates patient safety information throughout the organization to effect behavioral changes in itself and other healthcare organizations. Examples of communication methods include:
 - Posters in key locations.

Patient Safety Program Plan. Retrieved 9/28/2026. Official copy at <https://svmh.policystat.com/policy/20679865/>. Copyright © 2026 Salinas Valley Health Page 10 of 12

- Medical Staff intranet portal.
 - Patient Safety on STARnet (<http://starnet/>)
 - Patient Safety Awareness Events.
 - Leadership, medical staff and employee meetings.
2. Education programs are designed and provided to the staff upon hire and on an ongoing basis to provide timely information regarding the Patient Safety Program, its annual goals, objectives, and accomplishments. Education includes the staff member's right to report any safety or quality of care concerns to The Joint Commission and the California Department of Public Health. Because the optimal provision of healthcare is provided in an interdisciplinary manner, staff will be educated and trained on the provision of an interdisciplinary approach to patient care.
 3. Ongoing education is provided through various mechanisms such as but not limited to:
 - In-service training to increase knowledge of patient safety requirements
 - In-service training to encourage reporting of unanticipated adverse events and near-misses and in identifying patient safety events that should be reported.
 - Educational updates addressing patient safety issues, including Sentinel Event Alerts.
 - Patient Safety Awareness activities.
 - Computer-based learning modules.

D. Patient Safety Program Patient & Community Education

1. Patients are given information about their rights and responsibilities while receiving services. Patients, and when appropriate their families, are informed about the outcomes of care, treatment and services, including unanticipated outcomes.
2. Patients may be given patient safety awareness materials, such as The Joint Commission's "Speak Up" brochure.

VIII. REFERENCES

- A. Center for Medicare Services (CMS) Conditions of Participation
- B. Joint Commission Sentinel Event Policy
- C. The Joint Commission Standards.
- D. To ERR is Human: Building a Safer Health System
- E. Crossing the Quality Chasm: A New Health System for the 21st Century
- F. OIG Report on Medical Error 12-00
- G. HSC §442.5, HSC §1254.4, HSC §1255.8, HSC §1279.6, HSC §1279.7, HSC §1288.6, HSC §1288.7, HSC §1288.8, HSC §1288.9, HSC §1288.95
- H. National Patient Safety Foundation

Patient Safety Program Plan. Retrieved 9/28/2026. Official copy at <https://svmh.policystat.com/policy/20679865/>. Copyright © 2026 Salinas Valley Health Page 11 of 12

The Three Duties

DUTY TO AVOID CAUSING UNJUSTIFIABLE RISK OR HARM

- values-focused
- "conduct unbecoming"
- see all five behaviors

DUTY TO FOLLOW PROCEDURAL RULES

- reliability-focused
- "the recipe"
- see only three of the five behaviors

DUTY TO PRODUCE OUTCOMES

- mission-focused
- "the cake"
- cannot see the five behaviors

The Five Behaviors

HUMAN ERROR

Unintended conduct; inadvertently doing other than what was intended: a slip, lapse, or mistake

ACCEPT

AT-RISK BEHAVIOR

A choice where risk is not recognized, or is mistakenly believed to be justified

COACH

RECKLESS

Conscious disregard of a substantial and unjustifiable risk of harm

DISCIPLINARY SANCTION

KNOWLEDGE

Knowingly causing harm (sometimes justified)

DISCIPLINARY SANCTION

PURPOSE

A purpose to cause harm (never justified)

DISCIPLINARY SANCTION

Evaluate All Independent of the Actual Outcome



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Nutrition Services

2026 Initiatives and Performance Improvement Plan

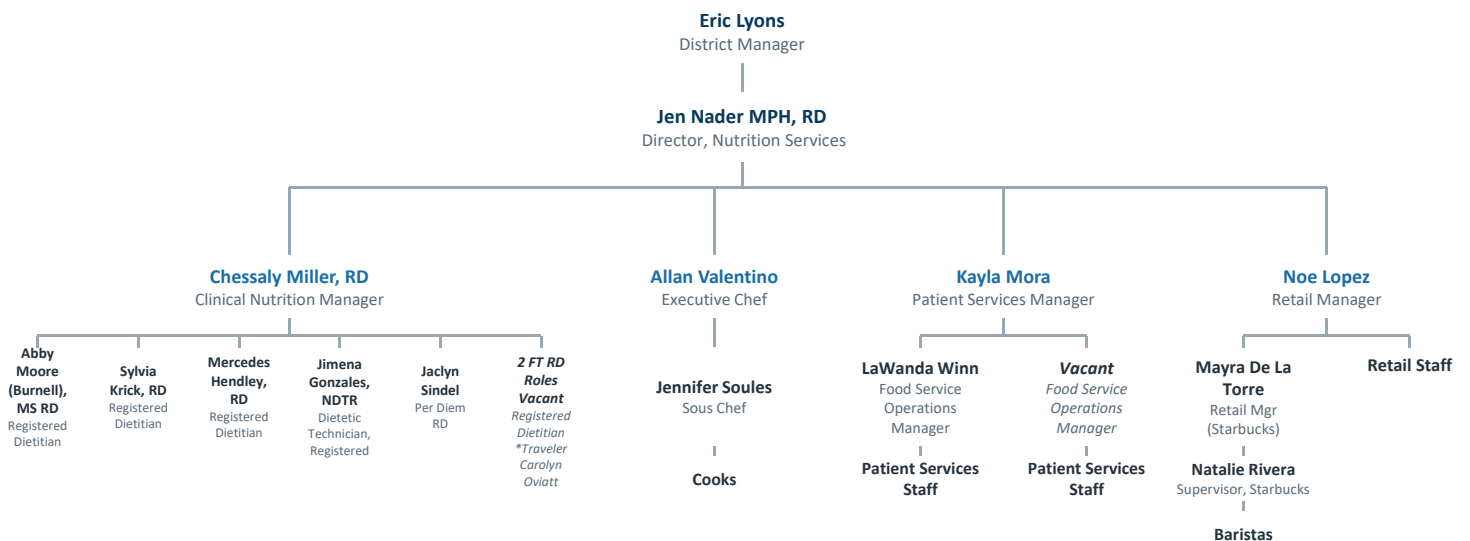


Jennifer Nader, MPH, RD
Director, Nutrition Services

October 1, 2026



Nutrition Services Department Overview



What We're Doing – Clinical Nutrition

- Assessing RD Competency
 - Quarterly RD Chart Audits, new RDs or below 90% are audited monthly, SVH RDs generally exceed 98%
- Malnutrition Diagnosis
 - Audits of Nursing Nutrition Screening Tool
 - Did nursing complete the screen within 24hrs?
 - Did the patient screen score trigger RD evaluation?
 - Was referral sent to RD?
 - Did RD assess patient within 24-48 hours?
 - Tracking Malnutrition Diagnosis with Coding Team, Messaging MDs with Diagnosis
 - Confirming appropriateness of diagnosis through chart audit process

Malnutrition Initiative

Purpose: To enhance malnutrition documentation to improve patient outcomes and reimbursement

Process:

- RNs complete screen to identify high risk patients upon admission
- RDs screen patients, document potential malnutrition, share findings with MDs via Epic messaging
- Malnutrition diagnosis must also be documented by MD for reimbursement

Why this Matters:

- Clinical Outcomes (Identification triggers early targeted interventions)
 - ✓ Lower length of stay
 - ✓ Lower readmission rates
 - ✓ Reduces patient complications
- Financial Impact
 - Accurate diagnosis can increase hospital reimbursement \$2,000 - \$10,000 (varies based on payor and severity of condition)

Clinical Metrics — Competency + Identifying Malnutrition

Quality indicators for identifying malnutrition, RD/MD malnutrition diagnosis agreement rate, June through August 2026

Other Clinical Metrics (2026)

RD Chart Audit Compliance

Q1
100%

Q2
98.3%

Q3
99.3%

Nursing Nutrition Screens Completed

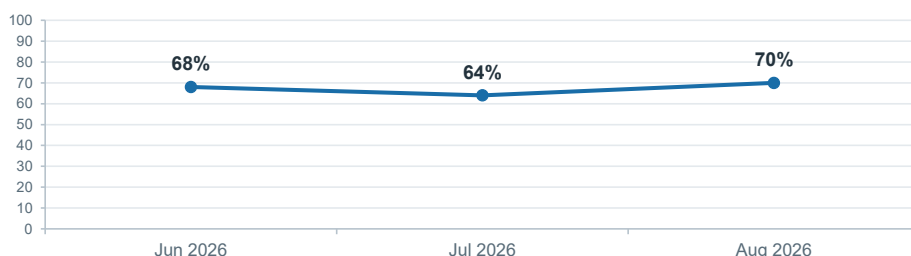
Q1
96%

Q2
97.7%

Q3
96.2%

2026 to date: 773/796

RD/MD Percentage Agreement in Malnutrition Diagnosis



Where things stand

70%

Latest score (Aug 2026)

64%

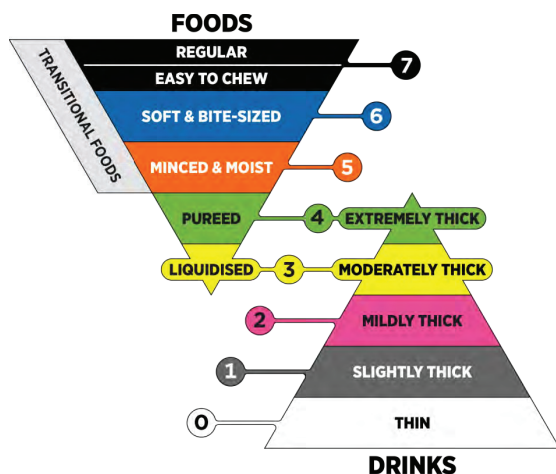
July 2026 dip, before rebounding

+2 pts net change, June → August

What We're Doing – Food Services

- Test Trays
 - Dietitians complete minimum of 12 test trays evaluations per month; patient services also complete 4 per month
- Tray Accuracy
 - 3 sessions of tray accuracies during meal service (15 trays at each session) – 45 trays per week
- Epic/CBORD Interface
 - Diet technician role added for maintenance of software to ensure accuracy of system and interface
 - Diet clerks validating orders in Epic for each order
- Monitoring Daily Quality Metrics
 - Temperature of hot and cold foods, safety measures in place (cut gloves, hair nets, etc.)
 - Correct procedures in place
- Monthly Sanitation Audits
 - RD or Certified Dietary Manager completes
- In-services and Training
 - IDDSI food preparation, monthly in-services

International Dysphagia Diet Standardization Initiative (IDDSI)



What Is IDDSI?

IDDSI is a global framework, created by an international team of clinicians and scientists, that standardizes how texture-modified foods and thickened liquids are labeled and prepared for people with dysphagia — replacing inconsistent, facility-specific terms with one common language of 8 levels (0–7).

Benefits for Nutrition Services QA

Patient safety: consistent textures reduce choking and aspiration risk across shifts and staff.

Common language: dietitians, SLPs, nursing, and kitchen staff all use the same terms and tests.

Auditable standards: validated flow, fork, and spoon tests give QA a repeatable way to verify prep.

Fewer errors at handoff: clear level numbers/colors cut mistakes when patients move between units.

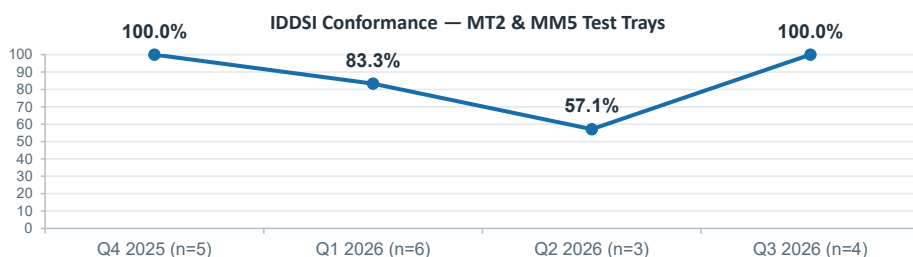
Regulatory alignment: supports Joint Commission, CMS, and state survey expectations for dysphagia diets.

Test Tray Program

Test Tray Program: 150 total evaluations year to date, 17 non-conformances, 99.9% tray accuracy)

Test Trays Evaluated	Q4 2025 37	Q1 2026 39	Q2 2026 42	Q3 2026 32
Top Non-Conformances	Temperature 10	Accuracy 4	Appearance 3	

IDDSI conformance for Mildly Thick Liquids (MT2) and Minced & Moist (MMS) test trays, by quarter.



Where things stand

57.1% low (Q2) → 100% latest (Q3)

Correction Process

- Investigated the Q2 2026 dip in conformance
- Expanded sample coverage for these diets
- Reinforced IDDSI prep standards with staff
- Established clinical + operations training program

Next steps...

MD/RD Alignment for Malnutrition Diagnosis

- Work with physician leadership on plan.

Continued Improvement of Epic/CBORD Interface

- Diet orders, food allergies

Achieving 100% Compliance on Daily Monitoring Activities

DEPARTMENT/SERVICE Quality Improvement Reports

LABORATORY

Report to QSC

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



Date: October 01, 2026

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Quality / Safety Goals - 2027

- Laboratory currently tracks 38+ quality indicators & continues to expand
- Focus is on three general categories
 - TATs
 - Blood Cultures
 - MTP process

CATEGORY	QUALITY INDICATOR
Turnaround Times	ER TAT: POTASSIUM <=50 mins of Order
	ER TAT: HCG (Serum) <=45 mins of Order
	TAT: CSF Gram Stain <1 hr of Receipt
	TAT: Chlamydia & Gonorrhea PCR >=95% within 2 hr of Receipt
	ER TAT: Type & Screen <=80 min of Order
	STAT TAT: Type & Screen <=80 min of Order
Blood Cultures	Blood Culture Contamination - Adult <3%
	Blood Culture Contamination - Pediatric <3%
MTP Process	MTP Process: Activation Elements 100%
	MTP Process: Ordered in EHR 100%
	MTP TAT: Ordered in EHR 100%
	MTP TAT: Blood Products/cooler ready <=5 min of MTP Order
	MTP TAT: Runner present in Blood Bank for pickup <=7 minutes of MTP Activation
	MTP Process: Transfused blood products follow recommended ratio (4:4:1)
	MTP Process: Blood Bank notified of deactivation 100%

Quality / Safety Goals - 2027

- Turnaround Times:** Timely results assist clinicians with patient assessment and can directly impact patient outcomes.
 - Selected targets:** ER Potassium, ER HCG (serum; qualitative), CSF Gram stain, GeneXpert Chlamydia/Gonorrhea PCR, ER & All STAT Type and Screens
 - Selected due to historical TAT challenges and potential clinician/patient impact.
- Blood Culture contamination rate:** Switched from Kurin product to Steripath Micro
 - Blood culture contamination is consistently close to 1% but additional efforts needed to reach <=1% consistently.
- MTP Process:** MTP process and familiarity in all locations/shifts has been an area of challenge that escalated with Epic.
 - New laboratory process for tracking certain elements implemented, tracked, and presented at Transfusion Committee.

SVH Pathology/Laboratory

Data: Blood Bank Metrics

- Starting ~Oct 2025, general review, revision, and updating of the SVHMC Blood Bank/Transfusion Services coinciding with Epic**
 - Procedures reviewed and re-written.
 - Multiple training & in-services related to workflow and new SoftBank software (Meditech replacement for Blood Bank).
 - Review of past performance, antibody screen/equipment issues, physician complaints, WeCares, and general discussion at Transfusion Committee is guiding ongoing changes.
 - Continue working on skill and judgement level of staff.
- Developed new MTP assessment log to capture & quantify elements**
 - New data approach tracking discrete MTP elements to reviewing MTP events as a whole
 - Summary tables for all MTP events documented for Transfusion Committee review & discussion.
 - MTP occurrence steadily declining with new “Emergent Blood” order and OB Cooler implementation.

INDICATOR	TARGET	MAY	JUN/ Q2	JUL	AUG
MTP: Activation Elements	100%	83%	83%	50%	100%
MTP: Ordered	100%	100%	100%	100%	100%
MTP TAT: Ordered <=2 min	100%	100%	100%	50%	100%
MTP TAT: 1st Cooler <=5 min	100%	50%	100%	0%	100%
MTP TAT: Runner Arrival <=7 min	100%	100%	100%	50%	100%
MTP: Deactivation	100%	100%	50%	50%	0%
MTP: Product Wastage	0%	0%	8%	0%	0%
STAT TAT: Type & Screen	≤ 80min	85	92	82	84
Emergent TAT: RBC Ready		3	7	3	7
Antibody Screen & Workup	100%	100%	100%		

Date	Activation	Duration (hr:min)	Location	Units Issued	Units Transfused	Units Wasted	Comments
8/11/2026	13:22	2:20	Cath Lab / Surgery	8 RBC 8 Plasma 2 Platelets	4 RBC 2 Plasma 2 Platelets	None	- Called OR to ask for MTP Orders - 1st cooler ready in 4 min from MTP order - OR asking Blood Bank to bring coolers - Both MTP coolers ended up in OR (no cooler left in Blood Bank) - OR indicated blood spilled on cooler - After ~40 min into the MTP, OR RN called asking for 2x RBC (during MTP) - Blood Bank followed up with OR multiple times regarding deactivation

SVH Laboratory

Data: ER Turn Around Times

• Potassium used as an indicator for BMP

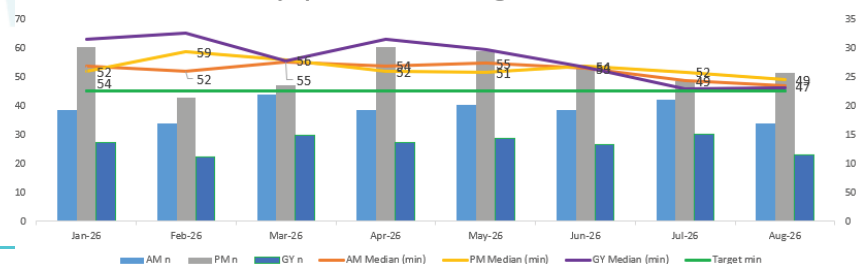
- Improvement of other contributing factors ("Order to Collect", "Collect to Receive", changing result release rule) are not reflecting in the overall TAT.
- Working with the Chemistry vendor on software to review times for specimen loading to result release.

• Hcg (qualitative) TAT is consistently above the 45 min target

- This is a serum test requiring clotting time that makes this target harder to meet.
- Working with the Specimen Processing staff to set timers and to prioritize delivery to Chemistry for handling.

INDICATOR	TARGET	JAN	FEB	MAR/ Q1	APR	MAY	JUN/ Q2	JUL
ER TAT: K	≤ 50min	57	55	57	56	54	55	53
ER TAT: TROP	≤ 50min	59	53	53	53	51	52	49
ER TAT: Lactate	≤ 50min	43	37	40	41	41	42	40
ER TAT: HCG-plasma	≤ 45min	56	57	55	54	54	53	48
ER TAT: CBC	≤ 50min	38	40	39	37	38	38	36
ER TAT: Manual Diff	≤ 80min	78	80	80	79	77	83	77
ER TAT: PT/INR	≤ 50min	50	50	53	50	49	49	48
ER TAT: HCG-urine	≤ 17min	11	11	10	10	10	11	12
ER TAT: Order to Coll Phleb	≤ 17min	20	18	20	17	21	18	17
ER TAT: Coll to Rec Phleb	≤ 8min	8.0	8.5	8.0	8.0	7.6	7.8	7.6
Critical Calls - documented	100%	94.3%	96.1%	96.0%	96.3%	99.4%	98.5%	99.5%

Monthly by Shift - ER Serum Hcg Turnaround Time



SVH Laboratory

5

Data: Microbiology Turn Around Times

• Continue efforts to ensure staff prioritizes STAT GeneXpert testing in preparation for additional tests impactful to the Emergency Department

- Education, monitoring, shift-specific focusing, reviewing workflow that may contribute to delays, investigating trends (individuals, shifts, instrument issues)

• CSF Gram stain is manual testing requiring several steps, drying periods, and experience/skill-based examination & interpretation

- Implementation of a molecular assay for meningitis/encephalitis is planned to replace this quality indicator as a more useful measure of initial/time-sensitive CSF assessment

GC/Chlamydia PCR	2025	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
N		48	55	64	73	64	65	65	70
D		55	61	65	79	68	74	71	77
%		87.3%	90.2%	98.5%	92.4%	94.1%	87.8%	91.5%	90.9%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%

CSF GS TAT	2025	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
N	89			29			32
D	98			32			39
%		90.8%		90.6%			82.1%
Target	95%	95%	95%	95%	95%	95%	95%

SVH Laboratory

6

Data: Microbiology Blood Culture Contamination Rates

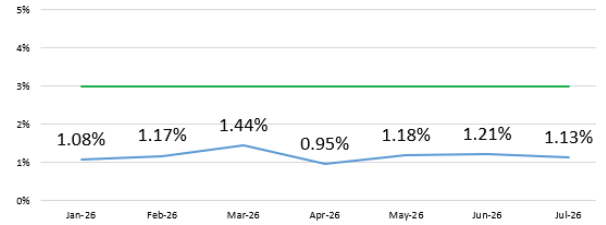
• Currently meeting Adult/Pediatric targets for ALL blood cultures as of July 2026.

- April 2026 OVERALL adult contamination was **0.95%**.
- Several instances of individual collector groups going <1% with ED nursing being the most notable (Jun – Jul; **0.63%** & **0.65%**).
- Individual collector data (contamination, underfill rate, and phlebotomy order to collect times provided to ED & Laboratory leadership for 1:1 review

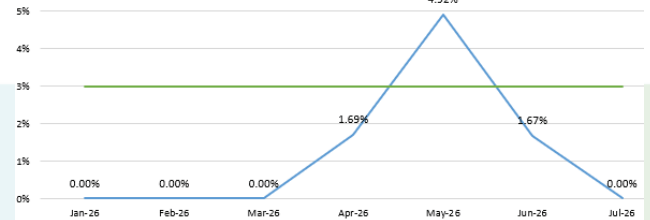
• Move to Single-Site Sampling planned for end of October

- Pending Epic build finalization & nursing education period.
- Will include method of documenting collection site & if a blood diversion device (Steripath) was used.
- Instead of historical “2x sets of blood cultures, a single “set” of blood culture bottles containing all 3x bottles.
- Help improve blood culture collection time before antibiotic administration.

Monthly - Adult Blood Culture Contamination Rate



Monthly - Pediatric Blood Culture Contamination Rate



	2025	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
ED Phleb %		0.80%	0.75%	1.20%	1.10%	0.83%	1.52%	1.15%
Floor Phleb %		0.98%	1.51%	1.56%	0.34%	1.74%	0.84%	1.42%
Overall Phleb %		0.85%	0.98%	1.30%	0.94%	1.08%	1.32%	1.23%
ED RN %		2.02%	2.29%	3.72%	0.72%	2.00%	0.4%	0.4%
Floor RN %		1.03%	2.63%	0.00%	0.00%	0.00%	2.0%	2.5%
Overall RN %		1.81%	2.36%	3.25%	0.67%	1.74%	0.63%	0.65%
Target	3%	3%	3%	3%	3%	3%	3%	3%

SVH Laboratory

Barriers/Challenges

- Some data availability challenges related to Epic/associated software data extraction/association.
- Pending vendor-specific software availability to help pin down lost time when processing ED Chemistry tests.
- Stabilizing laboratory staffing/shifts.
- New laboratory staff with limited experience are gaining familiarity with correct workflow, expectations, tracking of outstanding specimens/tests with Epic, and handling unexpected situations.

Next Steps

- Continue review and standardization of all laboratory processes.
- Implement more standard and laboratory-wide processes/procedures to facilitate consistent workflow/responsibility by staff.
- Implement new instrumentation & automation lines that will improve workflow and TATs.
- Continue exploring opportunities for improvement and data availability through Epic tools.
- Work with current MTP education & drill initiative from nursing.
- Implement Single-Site Sampling of Blood Cultures.

CLOSED SESSION

*(Report on Items to be
Discussed in Closed Session)*

*RECONVENE OPEN SESSION/
REPORT ON CLOSED SESSION*

(Meeting Chair)

ADJOURNMENT