BOARD QUALITY REVIEW COMMITTEE
MEETING AGENDA

Wednesday, June 23, 2021
4:00 pm Meeting

Meeting participation to be Virtual pursuant to California Governor Newsom’s Executive Order N-29-20

-Please see meeting log-in information below-

PLEASE MUTE YOUR MICROPHONE UPON ENTERING THE VIRTUAL MEETING ROOM AND WHEN NOT SPEAKING

<table>
<thead>
<tr>
<th>CALL TO ORDER</th>
<th>Time</th>
<th>Form A Page</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Establishment of Quorum</td>
<td>1</td>
<td>4:01</td>
<td></td>
</tr>
<tr>
<td>2. Public Comments</td>
<td>15</td>
<td>4:16</td>
<td></td>
</tr>
<tr>
<td>3. Action Item(s)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. *Minutes: Board Quality Review Committee Meeting – April 28, 2021 (ADD A-Pp 13-17)</td>
<td>5</td>
<td>1</td>
<td>4:21</td>
</tr>
<tr>
<td>b. *Adopt Updated 2021 Resolution of Board Quality Review Committee Meeting Dates (ADD B- Pp 19)</td>
<td>5</td>
<td>2</td>
<td>4:26</td>
</tr>
<tr>
<td>4. Standing Item(s)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Medical Executive Committee (MEC) / Quality Management Committee (QMC) Update</td>
<td>10</td>
<td>3</td>
<td>4:31</td>
</tr>
<tr>
<td>Kanchan Koirala, MD, Chair, Quality Management Committee, Palomar Medical Center Escondido</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sam Filiciotto, MD, Chair, Quality Management Committee, Palomar Medical Center Poway</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. New Business</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Contracted Services Triannual Report - (ADD C- Pp 21-24)</td>
<td>5</td>
<td>4</td>
<td>4:36</td>
</tr>
<tr>
<td>Valerie Martinez, BSN, MBA, CIC, CPHQ, NEA-BC, Senior Director, Quality and Patient Safety</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tricia Kassab, RN, EdD, VP Quality/ Patient Safety</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Russ Riehl, District Sr. Dir, Operational Support Svcs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sheila Brown, RN, MBA, Chief Operations Officer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dan Farrow, Sr. Director, Facilities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paul Sas, Chief Administration Officer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Medication Management (Pharmacy) Biannual Report (ADD F- Pp 52-57)</td>
<td>5</td>
<td>7</td>
<td>4:51</td>
</tr>
<tr>
<td>Donna Gelios, Pharm, BCPS, Director, Pharmacy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sheila Brown, RN, MBA, FACHE, Chief Operations Officer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Rehabilitation Services Annual Report (ADDG- Pp 59-66)</td>
<td>5</td>
<td>8</td>
<td>4:56</td>
</tr>
<tr>
<td>William Levensuski MA, OT/L, CHT, Director of Rehabilitation Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Virginia Barragan FACHE, DPT, MOMT, VP Continuum Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Laboratory Services Annual Report (ADD H- Pp 68-76)</td>
<td>5</td>
<td>9</td>
<td>5:01</td>
</tr>
<tr>
<td>Gloria Austria, Director of Laboratories</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jerry Kolins MD, Medical Director Laboratories</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Respiratory Services Annual Report (ADD I- Pp 78-86)</td>
<td>5</td>
<td>10</td>
<td>5:06</td>
</tr>
<tr>
<td>Gloria Austria, Director of Laboratories</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frank Bender, MD, Medical Director</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. Service Excellence (HCAHPS) Biannual Report (ADD J- Pp 88-104)</td>
<td>5</td>
<td>11</td>
<td>5:11</td>
</tr>
<tr>
<td>Mel Russell, RN, MSN, CNO, Palomar Medical Center Escondido</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Joyce Volsch, RN, PhD, CNO, Palomar Medical Center Poway</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Valerie Martinez, RN, BSN, MA, CIC, CHCQ, NEA-BC, Sr. Dir, Quality / Patient Safety</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tricia Kassab, RN, EdD, VP Quality/Patient Safety</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Adjournment to Closed Session</td>
<td>1</td>
<td>5:12</td>
<td></td>
</tr>
<tr>
<td>a. Pursuant to Health and Safety Code Section 32155</td>
<td>10</td>
<td>5:22</td>
<td></td>
</tr>
<tr>
<td>-Events Log</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Adjournment to Open Session</td>
<td>1</td>
<td>5:23</td>
<td></td>
</tr>
<tr>
<td>8. Action Resulting From Closed Session</td>
<td>1</td>
<td>5:24</td>
<td></td>
</tr>
<tr>
<td>9. Public Comments</td>
<td>15</td>
<td>5:39</td>
<td></td>
</tr>
<tr>
<td>FINAL ADJOURNMENT</td>
<td>1</td>
<td>5:40</td>
<td></td>
</tr>
</tbody>
</table>
### Board Quality Review Committee Members:

<table>
<thead>
<tr>
<th><strong>VOTING MEMBERSHIP</strong></th>
<th><strong>NON-VOTING MEMBERSHIP</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Linda Greer, RN – Chairperson, Board Member</td>
<td>Diane Hansen, CPA, President / Chief Executive Officer</td>
</tr>
<tr>
<td>Terry Corrales, RN, Board Member</td>
<td>Sheila Brown, RN, MBA, FACHE, Chief Operations Officer</td>
</tr>
<tr>
<td>Laura Barry, Board Member</td>
<td>Omar Khawaja, MD, Chief Medical Officer</td>
</tr>
<tr>
<td>Kanchan Koirala, MD - Chair of Medical Staff Quality Management Committee for Palomar Medical Center Escondido</td>
<td>Michael Bogert, Chief Financial Officer</td>
</tr>
<tr>
<td>Sam Filiciotto, MD - Chair of Medical Staff Quality Management Committee for Palomar Medical Center Poway</td>
<td>Melvin Russell, RN, MSN, Chief Nursing Officer Palomar Medical Center Escondido</td>
</tr>
<tr>
<td>John Clark, Board Member 1st Alternate</td>
<td>Joyce Volsch, PhD, MS, RN, NEA-BC, Chief Nursing Officer Palomar Medical Center Poway</td>
</tr>
<tr>
<td>John Clark, Board Member 1st Alternate</td>
<td>Kevin DeBruin, Esq., Chief Legal Officer</td>
</tr>
<tr>
<td>David Lee, MD, Medical Quality Officer</td>
<td>Tricia Kassab, EdD, RN, FACHE, Vice President Quality and Patient Safety</td>
</tr>
<tr>
<td>Valerie Martinez, RN, BSN, MHA, CPHQ, CIC – Senior Director, Quality and Patient Safety</td>
<td></td>
</tr>
</tbody>
</table>

**NOTE:** If you have a disability, please notify us by calling 760.740.6333, 72 hours prior to the event so that we may provide reasonable accommodations.

*Asterisks indicate anticipated action. Action is not limited to those designated items.*

1 5 minutes allowed per speaker with a cumulative total of 15 minutes per group. For further details & policy, see attachment.

---

**PLEASE JOIN THE MEETING FROM YOUR COMPUTER, TABLET OR SMARTPHONE**

[https://global.gotomeeting.com/join/438703853](https://global.gotomeeting.com/join/438703853)

Access Code: 438-703-853

**PLEASE MUTE YOUR MICROPHONE UPON ENTERING THE VIRTUAL MEETING ROOM**

New to GoToMeeting? Download the app at:

[https://global.gotomeeting.com/install/438703853](https://global.gotomeeting.com/install/438703853)
TO: Board Quality Review Committee

MEETING DATE: Wednesday, June 23, 2021

FROM: Thea McKenzie, Committee Secretary

Background: Minutes from the Wednesday, April 28, 2021, Board Quality Review Committee meeting are respectfully submitted for approval.

Budget Impact: N/A

Staff Recommendation: Recommend to approve the Wednesday, April 28, 2021, Board Quality Review Committee minutes.

Committee Questions:

COMMITTEE RECOMMENDATION:

Motion: X

Individual Action:

Information:

Required Time:
Board Quality Review Committee
Resolution for Calendar Year 2021

TO: Board Quality Review Committee

MEETING DATE: Wednesday, June 23, 2021

FROM: Thea McKenzie, Committee Secretary

Background: Presenting the updated 2021 Board Quality Review Committee Calendar Resolution for adoption.

Budget Impact: N/A

Staff Recommendation: Recommend to approve updated resolution for calendar year 2021

Committee Questions:

COMMITTEE RECOMMENDATION:

Motion: X

Individual Action:

Information:

Required Time:
TO: Board Quality Review Committee

MEETING DATE: Wednesday, June 23, 2021

FROM: Valerie Martinez, RN, BSN, MHA, CIC, CPHQ, NEA-BC, Senior Director, Quality/Patient Safety
Tricia Kassab, RN, EdD, Vice President, Quality/Patient Safety

Background: The triannual Contracted Services report for calendar year 2020 was provided to the Board Quality Review Committee for review.

Budget Impact: N/A

Staff Recommendation: Informational only

Committee Questions:

COMMITTEE RECOMMENDATION:

Motion:

Individual Action:

Information: X

Required Time:
TO: Board Quality Review Committee

MEETING DATE: Wednesday, June 23, 2021

FROM: Russ Riehl, Senior Director, Operational Support Services
Sheila Brown, RN, MBA, FACHE, Chief Operations Officer

Background: The annual Emergency Management report for calendar year 2020 was provided to the Board Quality Review Committee for review.

Budget Impact: N/A

Staff Recommendation: Informational only

Committee Questions:

COMMITTEE RECOMMENDATION:

Motion:

Individual Action:

Information: X

Required Time:
TO: Board Quality Review Committee

MEETING DATE: Wednesday, June 23, 2021

FROM: Dan Farrow, Senior Director, Facilities
       Paul Sas, Chief Administration Officer

Background: The annual Management of Care Environment (EOC) report for calendar year 2020 was provided to the Board Quality Review Committee for review.

Budget Impact: N/A

Staff Recommendation: Informational only

Committee Questions:

COMMITTEE RECOMMENDATION:

Motion:

Individual Action:

Information: X

Required Time:
TO: Board Quality Review Committee

MEETING DATE: Wednesday, June 23, 2021

FROM: Donna Gelios, Director, Pharmacy
Sheila Brown, RN, MBA, FACHE, Chief Operations Officer

Background: The biannual Medication Management (Pharmacy) report for calendar year 2020 was provided to the Board Quality Review Committee for review

Budget Impact: N/A

Staff Recommendation: Informational only

Committee Questions:

COMMITTEE RECOMMENDATION:

Motion:

Individual Action:

Information: X

Required Time:
TO: Board Quality Review Committee

MEETING DATE: Wednesday, June 23, 2021

FROM: William Levanduski, Director of Rehabilitation Services
Virginia Barragan, FACHE, DPT, MOMT, Vice President Continuum Care

Background: The annual Rehabilitation Services report for calendar year 2020 was provided to the Board Quality Review Committee for review

Budget Impact: N/A

Staff Recommendation: Informational only

Committee Questions:

COMMITTEE RECOMMENDATION:

Motion:

Individual Action:

Information: X

Required Time:
TO: Board Quality Review Committee

MEETING DATE: Wednesday, June 23, 2021

FROM: Gloria Austria, Director of Laboratories
Jerry Kolins, MD, Medical Director Laboratories

Background: The annual Laboratory Services report for calendar year 2020 was provided to the Board Quality Review Committee for review

Budget Impact: N/A

Staff Recommendation: Informational only

Committee Questions:

COMMITTEE RECOMMENDATION:

Motion: 

Individual Action: 

Information: √

Required Time:
TO: Board Quality Review Committee

MEETING DATE: Wednesday, June 23, 2021

FROM: Gloria Austria, Director of Laboratories
      Frank Bender, MD, Medical Director

Background: The annual Respiratory Services report for calendar year 2020 was provided to the Board Quality Review Committee for review

Budget Impact: N/A

Staff Recommendation: Informational only

Committee Questions:

COMMITTEE RECOMMENDATION:

Motion:

Individual Action:

Information: ❌

Required Time:
TO: Board Quality Review Committee  

MEETING DATE: Wednesday, June 23, 2021  

FROM: Mel Russell, RN, MSN, CNO, Palomar Medical Center Escondido  
       Joyce Volsch, RN, PhD, CNO, Palomar Medical Center Poway  
       Valerie Martinez, RN, BSN, MHA, CIC, CPHQ, NEA-BC, Senior Director, Quality/Patient Safety  
       Tricia Kassab, RN, EdD, Vice President, Quality/Patient Safety  

Background: The biannual Service Excellence (HCAHPS) report for calendar year 2020 was provided to the Board Quality Review Committee for review  

Budget Impact: N/A  

Staff Recommendation: Informational only  

Committee Questions:  

COMMITTEE RECOMMENDATION:  

Motion:  

Individual Action:  

Information: X  

Required Time:
# BOARD QUALITY REVIEW COMMITTEE MEETING
## ATTENDANCE ROSTER - CALENDAR YEAR 2021

## VOTING MEMBERS

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>LINDA GREER, RN, Chairperson, Board Member</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TERRY CORALES, RN, Board Member</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LAURA BARRY, Board Member</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KANCHAN KOIRALA, MD, Chair, Medical Staff Quality Management Committee, PMC Escondido</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SAM FILICIOTTO, MD, Chair, Medical Staff Quality Management Committee, PMC Poway</td>
<td>E</td>
<td>E</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>JOHN CLARK, 1&lt;sup&gt;st&lt;/sup&gt; Board Alternate</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## NON-VOTING MEMBERS

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>DIANE HANSEN, CPA, President &amp; CEO</td>
<td>E</td>
<td>E</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SHEILA BROWN, RN, MBA, FACHE, Chief Operations Officer</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OMAR KHAWAJA, MD, Chief Medical Officer</td>
<td>X</td>
<td>E</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MICHAEL BOGERT, Chief Financial Officer</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>JOYCE VOLSCH, PhD, MS, RN, NEA-BC, Chief Nursing Officer, PMC Poway</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MEL RUSSELL, RN, MSN, Chief Nursing Officer, PMC Escondido</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TRICIA KASSAB, EdD, RN, FACHE, Vice President, Quality and Patient Safety</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>VALERIE MARTINEZ, RN, BSN, MHA, CPHQ, CIC, Senior Director, Quality and Patient Safety</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DAVID LEE, MD, Medical Quality Officer</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KEVIN DEBRUIN, Esq., Chief Legal Officer</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Special Session*
ADDENDUM A
**BOARD QUALITY REVIEW COMMITTEE MEETING MINUTES – WEDNESDAY, APRIL 28, 2021**

**AGENDA ITEM**

<table>
<thead>
<tr>
<th>NOTICE OF MEETING</th>
<th>CONCLUSION/ACTION</th>
<th>FOLLOW UP / RESPONSIBLE PARTY</th>
<th>FINAL?</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Notice of Meeting was posted at Palomar Health Administrative Office; also posted with full agenda packet on the Palomar Health website on Tuesday, April 13, 2021, which is consistent with legal requirements.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**CALL TO ORDER**

Pursuant to California Governor Newsom’s Executive Order N-29-20 the meeting was held virtually and was called to order at 4:00 p.m. by Director Linda Greer, RN.

**ESTABLISHMENT OF QUORUM**

- Quorum comprised of Board Directors: Director Linda Greer, RN.; Director Terry Corrales, RN.; Director Laura Barry; and Physician Chair of the Medical Staff Quality Management Committees, Kanchan Koirala, M.D. Palomar Medical Center Escondido.
- Excused Board Absences: Sam Filiciotto, MD, Palomar Medical Center Poway

**PUBLIC COMMENT**

There were no public comments.

**ACTION ITEMS:**

A. * REVIEW / APPROVAL: OPEN/CLOSED SESSION MEETING MINUTES / ATTENDANCE ROSTER – FEBRUARY 24, 2021

The BQRC Open / Closed Session meeting minutes of February 24, 2021, were presented for review and approval. Director Laura Barry motioned for approval, second by Director Terry Corrales, to approve the meeting minutes as submitted. All in favor. None were opposed.

*Motion:* by Director Laura Barry, second by Director Terry Corrales, and carried to approve the meeting minutes of February 24, 2021, as submitted. Roll call voting was utilized.

**See Addendum A for additional information**

Director Linda Greer, RN – Aye
Director Terry Corrales, RN – Aye
Director Laura Barry – Aye
Kanchan Koirala, MD – Aye

N/A

Y
### B. **ADOPT 2021 BOARD QUALITY REVIEW COMMITTEE REPORTING CALENDAR**

The 2021 Board Quality Review Committee (BQRC) Performance Improvement Reporting Calendar was presented for annual review and approval. Director Laura Barry motioned for approval, second by Director Terry Corrales, to approve the 2021 BQRC Performance Improvement Reporting Calendar. All in favor. None were opposed.

*(See Addendum B for additional information)*

<table>
<thead>
<tr>
<th>MOTION:</th>
<th>by Director Laura Barry second by Director Terry Corrales, and carried to approve the 2021 BQRC Performance Improvement Reporting Calendar. Roll call voting was utilized.</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td>Y</td>
</tr>
</tbody>
</table>
| Director Linda Greer, RN – Aye  
Director Terry Corrales, RN – Aye  
Director Laura Barry – Aye  
Kanchan Koirala, MD – Aye                                                           |
| All in favor. None opposed. |                                                                                                                                  |

### C. **ANNUAL REVIEW OF QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT PLAN, 11234**

The Quality Assessment Performance Improvement Plan, 11234, was presented for annual review. Director Laura Barry motioned for approval, second by Director Terry Corrales, to approve the proposed changes as submitted. All in favor. None were opposed.

Chair Linda Greer asked for a short synopsis of the proposed action item. Valerie Martinez provided a short synopsis.

*(See Addendum C for additional information)*

<table>
<thead>
<tr>
<th>MOTION:</th>
<th>by Director Terry Corrales second by Director Laura Barry, and carried to approve the proposed changes as submitted. Roll call voting was utilized.</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td>Y</td>
</tr>
</tbody>
</table>
| Director Linda Greer, RN – Aye  
Director Terry Corrales, RN – Aye  
Director Laura Barry – Aye  
Kanchan Koirala, MD – Aye                                                           |
| All in favor. None opposed. |                                                                                                                                  |

### D. **INFECTION PREVENTION AND CONTROL RISK ASSESSMENT AND SURVEILLANCE PLAN, 15412**

The Infection Prevention and Control Risk Assessment and Surveillance Plan, 15412, was presented for annual review. Director Laura Barry motioned for approval, second by Director Terry Corrales, to approve the proposed changes as submitted. All in favor. None were opposed.

Chair Linda Greer asked for a short synopsis of the proposed action item. Valerie Martinez provided a short synopsis.

<table>
<thead>
<tr>
<th>MOTION:</th>
<th>by Director Laura Barry second by Director Terry Corrales and carried to approve the proposed changes as submitted. Roll call voting was utilized.</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td>Y</td>
</tr>
<tr>
<td>Director Linda Greer, RN – Aye</td>
<td></td>
</tr>
</tbody>
</table>

---

3a- 4.28.2021 BQRC Meeting Minutes-DRAFT 2
Director Laura Barry asked if changes had been made due to COVID. Valerie Martinez confirmed some proposed changes were made due to the pandemic.

*(See Addendum D for additional information)*

<table>
<thead>
<tr>
<th>E. INFECTION CONTROL AND PREVENTION PROGRAM 2020 ANNUAL REVIEW AND PROGRAM ASSESSMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Infection Control and Prevention Program 2020 Annual Review and Program Assessment was provided to the Board Quality Review Committee for annual review. Director Terry Corrales motioned to approve, second by Director Laura Barry, and carried to approve the Infection Control and Prevention Program 2020 Annual Review and Program Assessment as submitted. After a brief discussion, it was noted that action items 3 e-g need motions to approve. Motions were made as noted in the minutes.</td>
</tr>
<tr>
<td><strong>MOTION:</strong> by Director Terry Corrales second by Director Laura Barry, and carried to approve the Infection Control and Prevention Program 2020 Annual Review and Program Assessment. Roll call voting was utilized.</td>
</tr>
<tr>
<td>Director Linda Greer, RN – Aye Director Terry Corrales, RN – Aye Director Laura Barry – Aye Kanchan Koirala, MD – Aye All in favor. None opposed.</td>
</tr>
<tr>
<td>N/A</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>F. 2021 HOME HEALTH (HH) INFECTION CONTROL SURVEILLANCE PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>The 2021 Home Health (HH) Infection Control Surveillance Plan was provided to the Board Quality Review Committee for annual review. Director Laura Barry motioned for approval, second by Director Terry Corrales, and carried to approve the 2021 Home Health (HH) Infection Control Surveillance Plan. After a brief discussion, it was noted that action items 3 e-g need motions to approve. Motions were made as noted in the minutes.</td>
</tr>
<tr>
<td><strong>MOTION:</strong> by Director Laura Barry second by Director Terry Corrales, and carried to approve the 2021 Home Health (HH) Infection Control Surveillance Plan. Roll call voting was utilized.</td>
</tr>
<tr>
<td>Director Linda Greer, RN – Aye Director Terry Corrales, RN – Aye Director Laura Barry – Aye Kanchan Koirala, MD – Aye All in favor. None opposed.</td>
</tr>
<tr>
<td>N/A</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>G. 2021 THE VILLAS AT POWAY (VILLAPO) INFECTION CONTROL SURVEILLANCE PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>The 2021 The Villas at Poway (VillaPom) Infection Control Surveillance Plan was provided to the Board Quality Review Committee for annual review. Director Laura Barry motioned for approval, second by Director Terry Corrales, and carried to approve the 2021 The Villas at</td>
</tr>
<tr>
<td><strong>MOTION:</strong> by Director Laura Barry second by Director Terry Corrales, and carried to</td>
</tr>
<tr>
<td>N/A</td>
</tr>
</tbody>
</table>
Poway (VillaPom) Infection Control Surveillance Plan as submitted.

After a brief discussion, it was noted that action items 3 e-g need motions to approve. Motions were made as noted in the minutes.

*(See Addendum G for additional information)*

<table>
<thead>
<tr>
<th>MOTION</th>
<th>N/A</th>
<th>N/A</th>
<th>Y</th>
</tr>
</thead>
</table>

**STANDING ITEM**

A. **MEDICAL EXECUTIVE COMMITTEE (MEC)/QUALITY MANAGEMENT COMMITTEE (QMC) UPDATE**

Doctor Kanchan Koirala shared an overview of the Medical Executive Committee (MEC) and Quality Management Committee (QMC) meetings with the board, noting the QMC approved a plan for the Quality Team to provide training and educational packages for providers in regards to patient care handling and handoffs, as a result of this year’s failure modes and effects analysis.

**NEW BUSINESS**

A. **ANNUAL REPORT: TRAUMA PROGRAM**

Doctor John Steele presented the Trauma Program Annual Report to the board.

*(See Addendum H for additional information)*

B. **ANNUAL REPORT: STROKE PROGRAM**

Doctor Remia Paduga and Lourdes Januszewicz presented the Stroke Program Annual Report to the board.

*(See Addendum I for additional information)*

C. **ANNUAL REPORT: INFECTION CONTROL AND PREVENTION**

Doctor Sandeep Soni and Valerie Martinez presented the Infection Control and Prevention Annual Report to the board.

*(See Addendum J for additional information)*

D. **BIENNIAL REPORT: REGULATORY UPDATE**

Jami Piearson and Tricia Kassab presented the biennial regulatory report to the board.

*(See Addendum K for additional information)*
**ADJOURNMENT TO CLOSED SESSION**

- **Pursuant to Health and Safety Code Section 32155**
  - Report of Hospital Medical / Quality Assurance Audits

  **MOTION:** N/A

**ADJOURNMENT TO OPEN SESSION**

- Action taken, if any – There were no action items identified in the Executive Session of the meeting.

**PUBLIC COMMENTS**

There were no public comments.

**FINAL ADJOURNMENT** - The meeting adjourned at 5:26 p.m.

**MOTION:** N/A

**SIGNATURES:**

<table>
<thead>
<tr>
<th>COMMITTEE CHAIR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Linda Greer, RN</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>COMMITTEE ASSISTANT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carla Albright (Interim)</td>
</tr>
</tbody>
</table>
ADDENDUM B
RESOLUTION NO.
RESOLUTION OF THE BOARD OF DIRECTORS
OF PALOMAR HEALTH
ESTABLISHING BOARD QUALITY REVIEW COMMITTEE MEETINGS
FOR CALENDAR YEAR 2021

WHEREAS, Palomar Health is required, pursuant to Section 54954 of the California Government Code, Section 5.2.2 of the Palomar Health Bylaws, and Palomar Health Policy 21790 Establishing Board Meeting Dates, to pass a resolution adopting the time, place and location of the Board Quality Review Committee meetings:

NOW, THEREFORE, BE IT RESOLVED by the Board of Directors of Palomar Health that the following schedule of Board Quality Review Committee meetings will apply for calendar year 2021:

Remainder of 2021 BOARD QUALITY REVIEW COMMITTEE MEETING SCHEDULE

- June 23
- August 25
- October 27

Each meeting will be held at 4:00 p.m. Meeting participation will be held virtually pursuant to Governor Newsom’s Executive Order N-29-20

PASSED AND ADOPTED at a regular meeting of the Board of Directors of Palomar Health held on (DATE), by the following vote:

AYES:

NOES:

ABSENT:

ABSTAINING:

DATED:

BY: ________________________
Linda Greer, RN
Chair, Board Quality Review Committee

Terry Corrales, RN
Director, Board Quality Review Committee
ADDENDUM C
Name of Service: Morrison Management Specialists, Inc.

Date of Review: 5/25/21  Name / Title of Reviewer: Russell Riehl, Sr. Director Operational Support Services

Nature of Service (describe): Food and Nutrition Services

<table>
<thead>
<tr>
<th>Evaluation</th>
<th>Met Expectation</th>
<th>Did Not Meet Expectation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Abides by applicable law, regulation, and organization policy in the provision of its care, treatment, and service.</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>2. Abides by applicable standards of accrediting or certifying agencies that the organization itself must adhere to.</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>3. Provides a level of care, treatment, and service that would be comparable had the organization provided such care, treatment, and service itself.</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>4. Actively participates in the organization’s quality improvement program, responds to concerns regarding care, treatment, and service rendered, and undertakes corrective actions necessary to address issues identified.</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>5. Assures that care, treatment, and service is provided in a safe, effective, efficient, and timely manner emphasizing the need to – as applicable to the scope and nature of the contract service – improve health outcomes and the prevent and reduce medical errors.</td>
<td>x</td>
<td></td>
</tr>
</tbody>
</table>

Performance Metrics

<table>
<thead>
<tr>
<th>METRIC</th>
<th>Annual Goal</th>
<th>Met / Did Not Meet</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered Dietitian Documentation</td>
<td>90%</td>
<td>Met</td>
</tr>
<tr>
<td>Registered Dietitian Pressure Injury Documentation</td>
<td>90%</td>
<td>Met</td>
</tr>
<tr>
<td>Tray Accuracy</td>
<td>90%</td>
<td>Met</td>
</tr>
<tr>
<td>Temperature of Food</td>
<td>90%</td>
<td>Met</td>
</tr>
</tbody>
</table>

Performance Metrics – Villa’s Specific

<table>
<thead>
<tr>
<th>METRIC</th>
<th>Annual Goal</th>
<th>Met / Did Not Meet</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adaptive Equipment</td>
<td>90%</td>
<td>Met</td>
</tr>
</tbody>
</table>

Comments: Will be adjusting “temperature of food” metric to HCAPS patient experience data for food temperature for better alignment with patient experiences.

Conclusion (check one)

X Contract service has met expectations for the review period

☐ Contract service has not met expectations for the review period. The following action(s) has or will be taken:

☐ Monitoring and oversight of the contract service has been increased
☐ Training and consultation has been provided to the contract service
☐ The terms of the contractual agreement have been renegotiated with the contract entity without disruption in the continuity of patient care
☐ Penalties or other remedies have been applied to the contract entity
☐ The contractual agreement has been terminated without disruption in the continuity of patient care
☐ Other: ________________________________________________________________________________
Name of Service: Davita Contract Services

Date of Review: June 2021 Name / Title of Reviewer: V. Veronese/Director of Critical Care

Nature of Service (describe): Hemodialysis and Peritoneal Dialysis Services

<table>
<thead>
<tr>
<th>Evaluation</th>
<th>Met Expectation</th>
<th>Did Not Meet Expectation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Abides by applicable law, regulation, and organization policy in the provision of its care, treatment, and service.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>2. Abides by applicable standards of accrediting or certifying agencies that the organization itself must adhere to.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>3. Provides a level of care, treatment, and service that would be comparable had the organization provided such care, treatment, and service itself.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>4. Actively participates in the organization’s quality improvement program, responds to concerns regarding care, treatment, and service rendered, and undertakes corrective actions necessary to address issues identified.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>5. Assures that care, treatment, and service is provided in a safe, effective, efficient, and timely manner emphasizing the need to – as applicable to the scope and nature of the contract service – improve health outcomes and the prevent and reduce medical errors.</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

Performance Metrics

<table>
<thead>
<tr>
<th>METRIC</th>
<th>2nd QTR</th>
<th>3rd QTR</th>
<th>4th QTR</th>
<th>1st QTR</th>
<th>Cumulative Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Machine culture endotoxin report (pass rate) Escondido</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Machine culture endotoxin report (pass rate)</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Comments
Due to weather delays Feb 2021, some cultures did not make it to their destination in time so had to be redrawn. All redrawn samples passed.

Conclusion (check one)

☐ Contract service has not met expectations for the review period. The following action(s) has or will be taken:
(check all that apply):
☐ Monitoring and oversight of the contract service has been increased
☐ Training and consultation has been provided to the contract service
☐ The terms of the contractual agreement have been renegotiated with the contract entity without disruption in the continuity of patient care
☐ Penalties or other remedies have been applied to the contract entity
☐ The contractual agreement has been terminated without disruption in the continuity of patient care
☐ Other: ________________________________________________________________________________
Palomar Health
Review of Contract Service

Name of Service: Cardinal Pharmacy Services

Date of Review: 6/2/2021
Name / Title of Reviewer: Dondreia Gelios, PharmD, BCPS

Nature of Service (describe):

<table>
<thead>
<tr>
<th>Evaluation</th>
<th>Met Expectation</th>
<th>Did Not Meet Expectation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Abides by applicable law, regulation, and organization policy in the provision of its care, treatment, and service.</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>2. Abides by applicable standards of accrediting or certifying agencies that the organization itself must adhere to.</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>3. Provides a level of care, treatment, and service that would be comparable had the organization provided such care, treatment, and service itself.</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>4. Actively participates in the organization’s quality improvement program, responds to concerns regarding care, treatment, and service rendered, and undertakes corrective actions necessary to address issues identified.</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>5. Assures that care, treatment, and service is provided in a safe, effective, efficient, and timely manner emphasizing the need to – as applicable to the scope and nature of the contract service – improve health outcomes and the prevent and reduce medical errors.</td>
<td>x</td>
<td></td>
</tr>
</tbody>
</table>

Performance Metrics

<table>
<thead>
<tr>
<th>METRIC</th>
<th>1 QTR</th>
<th>2 QTR</th>
<th>3 QTR</th>
<th>4 QTR</th>
<th>Cumulative Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost Savings Performance</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
</tr>
<tr>
<td>Patient Safety Performance</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
</tr>
<tr>
<td>Compliance Performance</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
</tr>
</tbody>
</table>

Comments
1. Cost Savings - $2,303,158 less than pre-Cardinal FY18 total (Total Cost of Goods/Salary&Benefits per Pharmacy Adjusted Day FY18 $175.24 vs FY20 $170.23
2. Patient Safety and Compliance - Creation of Nursing Medication Guidelines for WOWs, complete re-haul of infusion center powerplans to meet federal compliance, COVID-19 resources

Conclusion (check one)
X Contract service has met expectations for the review period

☐ Contract service has not met expectations for the review period. The following action(s) has or will be taken:
(check all that apply:
☐ Monitoring and oversight of the contract service has been increased
☐ Training and consultation has been provided to the contract service
☐ The terms of the contractual agreement have been renegotiated with the contract entity without disruption in the continuity of patient care
☐ Penalties or other remedies have been applied to the contract entity
☐ The contractual agreement has been terminated without disruption in the continuity of patient care
☐ Other: ___________________________
Name of Service: Emerald Textiles LLC – Linen Rental Services

Date of Review: 5/25/21

Name / Title of Reviewer: Russell Riehl, Sr. Director Operational Support Services

Nature of Service (describe): Linen Rental Services

Evaluation

<table>
<thead>
<tr>
<th></th>
<th>Met Expectation</th>
<th>Did Not Meet Expectation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td>x</td>
</tr>
</tbody>
</table>

Performance Metrics for Quality Assurance

<table>
<thead>
<tr>
<th>METRIC</th>
<th>Actual Compliance</th>
<th>Compliance Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of pieces ordered versus percentage of pieces delivered.</td>
<td>98.7%</td>
<td>98%</td>
</tr>
<tr>
<td>Components of Plant Tour Checklist (e.g., Soiled Linen Processing; Clean Linen Processing and/or Sanitization; Pack Room; In-service Programs). If deficiencies are found, Emerald has 30 days to correct deficiencies.</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Comments: N/A

Conclusion (check one)

X Contract service has met expectations for the review period

☐ Contract service has not met expectations for the review period. The following action(s) has or will be taken: (check all that apply:

☐ Monitoring and oversight of the contract service has been increased
☐ Training and consultation has been provided to the contract service
☐ The terms of the contractual agreement have been renegotiated with the contract entity without disruption in the continuity of patient care
☐ Penalties or other remedies have been applied to the contract entity
☐ The contractual agreement has been terminated without disruption in the continuity of patient care
☐ Other: ___________________________________________________
ADDENDUM D
**Introduction**


**Situation**

2020 was impacted by the COVID Pandemic. Our normal auditing and analysis of our Emergency Management plans included many real-life situations related to ensuring safe operations during a national/International pandemic.

**Background**

Emergency Management program conducts monthly audits related to our program outcome goals, identifies opportunities, and with committee approval implements changes to improve staff understanding and response planning. Based on the prior year outcomes, goals are adjusted annually for continuous improvement.

**Assessment**

Although the 2020 program assessment is very positive, there were some areas of continued opportunities to improve in 2021. For those areas where consistent achievement of annual goals have been met, new goals for 2021 are implemented.

**Recommendation**

**Safety Management**: Due to current success of current goals measures, 2021 goals focused on injury reporting timeliness, and reduction of workplace violence incidents

**Emergency Management**: Real-time experiences with supply chain impacts during the pandemic highlighted the importance of Disaster Supply inventory and storage. One of our improvement goals is on inventory and staff knowledge to where unit disaster supplies are located.

**Hazardous Materials**: Hazardous material spills are infrequent, yet important to staff, patient, and visitor safety that they are handled correctly. Though our events were low, continued staff auditing around response activities is top priority.
Introduction
The Environment of Care Program is comprised of six Joint Commission Environment of Care plans. Three of these plans fall under the umbrella of Emergency Management and three fall under EOC including, Fire Prevention, Medical Equipment Management and Utilities Management. Each plan has performance improvement goals, which are managed and reported regularly to various committees including Emergency Management, Infection Control and EOC for feedback and recommendations.

Situation
2020 was impacted by the COVID Pandemic. Our normal auditing and analysis of our EOC Management plans included many real-life situations related to ensuring safe operations during the pandemic.

Background
The EOC program conducts monthly audits and training related to our program outcome goals, identifies opportunities, and with committee approval implements changes to improve staff understanding and response planning. Based on the prior year outcomes, goals are adjusted annually for continuous improvement.

Assessment
The 2020 program assessment is overall positive, there were areas of continued opportunities to improve in 2021. For those areas where consistent achievement of annual goals have been met, new goals for 2021 are implemented.

Recommendation
**Fire Prevention**: The Pandemic provided many challenges to fire prevention with the converted patient rooms and additional PPE used. The leadership and staff worked together to maintain a safe and compliant environment. The fire training goal in high risk areas will continue as will fire system failure rates goal.

**Medical Equipment Management**: Bio-med will continue to monitor PM completion rates and will add a goal for staff training. Solutions for equipment tracking will continue to be sought. Being able to locate equipment is essential to maintain equipment. The training will enable in-house staff to do repairs rather than sending them out which will reduce turn-around time.

**Utilities Management**: The goals from 2020 will be kept in place for 2021. Monitoring unplanned utility failures is essential to maintain a safe environment. Elevator entrapment data will demonstrate the PMs are effective. Monitoring floods will assist the facility team to be proactive in predicting and making repairs ahead of water intrusion events.
ADDENDUM E

2020

*Date prepared: April 2021*
Introduction
Permeating every aspect of our medical centers and satellite buildings, the Environment of Care is an essential aspect of patient safety, from the first patient contact, through the assessment, treatment, discharge and continuing care. The Environment of Care overlaps with Infection Prevention and the management of Human Resources, as well as plays an integral part with Performance Improvement, Risk Management, and Patient Safety standards. The objectives of the various Environment of Care Management plans have been to provide a safe, functional, supportive and effective environment for patients, visitors, staff, volunteers and members of our physician community. This is critical to providing quality patient care.

Achieving our objectives is dependent upon performing the following central processes:

- Strategic and on-going master planning by organization leadership (Plan / Design)
- Educating staff about the role of the environment that supports patient care (Teach)
- Implementing various components of design (Implement)
- Measuring standards that we have set for ourselves (Respond)
- Gathering information about our outcomes (Monitoring / Measuring / Evaluating)
- Making decisions about our findings (Improving)

The Environment of Care Management plans address six elements, which include Safety, Security, Hazardous Materials and Waste, Fire Prevention, Medical Equipment and Utilities Management. Emergency Management addresses the Emergency Operations Plan (EOP). There is much diversity in the seven management plan elements, but each have parallels with planning, teaching, implementing, responding, monitoring, and improving. Through the work of our staff, the purpose with the Environment of Care is to ensure ongoing diminishment of risk (e.g., possible loss or injury) within our medical centers and satellite buildings. The Environment of Care Committee provides a leadership framework for the management of risks, promoting a teamwork approach, and ongoing attention to programs, plans, and related activities that point toward risk reduction. Whenever possible, the Environment of Care is integrated with the Occupational Safety and Health Administration (OSHA) objectives (e.g., regulatory requirements), as well as other agencies having jurisdiction, enforcing standards that encourage continued improvement in the workplace.

The Safety Management plan is designed to provide a physical environment wherein risks associated with physical harm and hazards will be minimized for the patient-care population, staff, volunteers, physicians, contracted workers and visitors. It is an accreditation/standards-based and regulatory driven plan. There are fundamental activities inherent in daily routines that support the ability to identify risk prior to any incident. These include formal proactive risk assessments such as accreditation, regulatory or insurer surveys, ongoing environmental surveillance, safety and infection prevention procedures that are based upon accreditation standards and regulations, and ongoing education.

Educating employees to the hazards that may pose risk, or contribute to an injury has been ongoing, as well as the efforts relating to accident investigation post injury. We continue to meet our objective relating to the minimization of risk within the built environment and continue to be poised to provide safety for our patients.

Through a medium of care and respect for everyone who comes to our facilities, the Security Management plan is designed to provide the highest quality safety and security. We strive to provide a challenging work environment for Security staff, as we work to create and support a peaceful environment so that people will feel at ease when they come to our medical centers. Overall, our Security Management program has catapulted into a higher level of awareness since the events of 9-11-01, and subsequent terrorist and security events worldwide, including the increasing Code Gray and Silver incidents at medical facilities. Our Security Management plan has provided a deterrent to criminal activity on our campuses, which has allowed us to meet our objective of promoting a peaceful environment. Security staff are visible in uniforms, and are service oriented to the public, as well as being trained in de-escalation techniques. Security has camera systems and ongoing monitoring that has allowed us to spot activity or trends that have assisted us in reducing security risks. The objectives of the Security Management Plan have been met, and we will continue to promote the reduction of risk throughout the year 2021, focusing on proactive activities, and ongoing education.
Annual Evaluation of Objectives, continued

The objectives of the Hazardous Materials Management Plan are to ensure that information about the risks of hazardous chemicals / materials and wastes used in the facilities are known by affected employees, and to ensure that the information is given to employees in the form of SDS (Safety Data Sheets), education, and labeling. Another objective is to ensure that hazardous waste products do not endanger the health of the environment. Taken together, these objectives minimize the risk of exposures to hazardous chemicals within our facilities and community. Minimization of risk not only applies to our medical centers, but to the community at large (e.g., minimization of spills into the environment). Equally important, is our effort to reduce waste and to use non-hazardous products whenever feasible. Educating employees to the risks relating to hazardous material use, storage and disposal has been a program element designed to meet our objectives. Other activities within the medical centers have contributed to meeting our stated objective, and these include: assessing staff knowledge relative to the hazardous materials and waste management program, manifesting hazardous materials in accordance with regulations, the development of procedures, and the use of appropriate personal protective wear.

The objectives of the Fire Prevention Management plan are to provide a physical environment free from physical harm and hazards created by fire, the risk of fire, or the products of combustion for the patient care population, staff, volunteers, physicians and visitors. The risk of fire carries with it the most significant single threat to the environment of care as our patients are routinely incapable of self-preservation, and must rely on correct staff response and building fire protection features to assure their safety. Compliance with the Life Safety Code supports meeting our objectives, as well as practicing fire drills throughout the medical centers and satellite buildings and testing correct staff response during the drills. Proactively identifying life safety risks during routine surveillance (e.g., observing for doors that do not close and latch properly, wall and ceiling penetrations, illegal latching hardware, etc.) additionally supports meeting this objective. There are programs in place that increase the likelihood of our objectives being met, which include fire equipment testing and maintenance, annual certifications for fire detection and protection systems, and the ongoing monitoring of the Statement of Conditions which identifies any life safety vulnerabilities, and our plans and financial commitment to correct / enhance or minimize them.

The objective of the Medical Equipment Management Plan includes a joint effort of the clinical and non-clinical departments to minimize the risks inherent in the use of medical equipment that is used on our patients, and to ensure proper performance. In order to meet these objectives, multiple programs need to be in place, which include, but are not limited to: risk assessment of all incoming medical equipment, preventive and corrective maintenance programs, “out-of-service” program for equipment that needs repair, and general education of equipment and user / maintainer training programs. Quarterly monitoring of preventive maintenance completion rates for our medical equipment affords us the opportunity to promote quality performance, thereby minimizing the risks associated with medical equipment failures, which supports our patient safety efforts. These programs are in place throughout the medical centers, and have been effective in allowing us to meet the stated objectives.

The objectives of the Utility Management Plan include complying with regulatory-driven and accreditation standards to provide Facilities that are safe, controlled, comfortable, and maintained in accordance with applicable regulation, requirement, and accepted engineering practice. Through a system of procedures, education, and ongoing quality monitoring and evaluation, the objectives are to provide the utility system users and operators with emergency response guidance in the event of a utility system failure, and to promote the reliability and performance of our utility systems. Risks, identified through the use of a computerized data base program, factor adverse equipment experience into the quality assessment, risk management, and utility management functions. Our procedures, preventive maintenance program, education and quality monitoring all support the accomplishment of meeting our stated objectives, and also support our patient safety goals.

One primary objective of the Emergency Operations Plan is to mitigate harm to life and property due to unforeseen circumstances and risks identified in the Hazard Vulnerability Analysis. The Emergency Operations Plan comprehensively describes the organization’s approach to responding to emergencies within the organization or in its community that would suddenly and significantly affect the need for the organization’s services, or its ability to provide those services. The multidisciplinary District Disaster Preparedness Committee has been very active in the design and implementation of the Emergency Operations Plan, and it is expected to continue in this direction in 2021. The plan is intended to identify risks to the organization and addresses how the medical centers are prepared to respond as well as identify strategies in place to mitigate risks. These plan elements and other activities in the medical centers relating to emergency preparedness (e.g., education of staff, disaster exercise implementation / evaluation, and performance improvement demonstrate that the medical centers have been effective in meeting stated objectives.
SAFETY MANAGEMENT
2. Reporting standards further defined for the Environment of Care committee.
3. New PPE items brought in to supplement our existing PPE in response to COVID-19. New items included SHINE PAPR’s, Ford PAPR’s, and elastomeric masks.
4. Safety training videos developed and assigned for all new PPE items brought in to support the response to COVID-19.
5. Facility Manager Environment of Care reports reviewed quarterly by the Environment of Care Committee.
6. Multi-disciplinary environmental surveillance: ongoing, with deficiencies identified and documented in Sentact and issues sent to Director for them to resolve and close out in Sentact.
7. Review of workplace injuries and trends at the EOC / Safety Committee.
9. Cyberterrorism preparedness discussed at the EOC / Safety Committee.

SECURITY MANAGEMENT
2. Code Pink/Purple drills conducted and evaluated with effective outcomes.
3. An Active Shooter (Run, Hide, Fight) video was created and added to HealthStream to provide a virtual training option.

HAZARDOUS MATERIAL MANAGEMENT
2. No spills requiring outside agency assistance reported throughout 2020.
3. A mandatory Hazard Communication Standard (HCS) training class was assigned to all staff to ensure compliance with the Occupational Safety and Health Administration (OSHA) requirement.
4. All HAZMAT vendor operations were centralized under 1 vendor, Stericycle, to help establish better internal oversight and accountability.

MEDICAL EQUIPMENT MANAGEMENT
2. Medical equipment failures and recalls monitored by Biomedical leadership with appropriate actions taken.
3. An “emergent medical equipment transportation to other campuses after business hours” process was implemented by Biomed to help ensure equipment is transferred in a timely manner, regardless of the time of day.
4. Preventive maintenance and corrective maintenance monitored for high risk (including life support equipment) and non-high risk medical equipment.
5. Annual review of the districtwide Medical Equipment Management Plan completed by the EOC / Safety Committee.
6. Annual evaluation of the Medical Equipment plan and program completed: Objectives, Scope, Performance, Effectiveness.

UTILITIES MANAGEMENT
2. Generator testing completed per regulatory standards.
3. Preventive maintenance and corrective maintenance monitored for high risk (including life support equipment) and non-high risk utility equipment.
4. Facility Environment of Care reports reviewed quarterly by the Environment of Care Committee.
5. Utility failures reported to Environment of Care committee, each resolved with follow-up actions documented.
6. Annual evaluation of the Utility Management plan and program completed: Objectives, Scope, Performance Standards and Overall Effectiveness.

EMERGENCY MANAGEMENT
2. District disaster preparedness multidisciplinary committee meetings held with multiple activities accomplished.
3. Hazard Vulnerability Analysis (HVA) reviewed / revised for 2020 with the top five hazards identified for each medical center.
4. Everbridge notification drill completed to coincide with a communications exercises. Over 800 physicians were included in the exercise notification.
5. COVID-19 response coordination of key supplies, such as; PAPR’s, reusable respirators, disinfecting wipes, and pharmaceuticals such as Remdesivir and Bamlanivimab.
6. Ongoing membership with San Diego Healthcare Disaster Coalition (SDHDC) which strengthens whole-community relationships with other San Diego County hospitals, SD County Emergency Medical Services (EMS), SD County Office of Emergency Services (OES), Red Cross, SD County Public Health, and law enforcement agencies.
7. Everbridge emergency notification system used exclusively during exercises and actual events.
8. Disaster surge cart medical supplies inventoried by supply chain staff to ensure expiration dates are monitored and supplies are rotated into the supply stream.
10. Continued collaboration with Kaiser Emergency Management and Rady’s Children’s colleagues to ensure communication is flawless during disaster events.
11. Communications exercise completed at each site in November.
12. Procedures written/updated and reviewed by Disaster Committee members in accordance with CMS disaster preparedness regulations.
EVALUATION: PERFORMANCE STANDARDS

OVERVIEW. The attached data sheets represent the evaluation of established performance standards, areas chosen on one or more of the following criteria:
1. The performance standard represents a measurable area of one of the EOC components.
2. The performance standard indicates a key reflection of the scope of the component.
3. The performance standard represents a high volume activity, or low volume but high risk consequences.
4. The performance standard requires improvement, or the existing process could be enhanced.

Safety Management Plan Performance Standards

The following performance activities were undertaken in 2020:
1. Monitoring of O2 bottles found unsecured during monthly Environment of Care (EOC) rounds
2. Staff knowledge on the meaning of R.A.C.E (Rescue, Alert, Contain, Evacuate/Extinguish) and P.A.S.S (Pull, Aim, Squeeze, Sweep) acronyms during monthly EOC rounds (90% threshold)

Security Management Plan Performance Standards

The following performance activities were undertaken in 2020:
1. Code Red drills are completed with a passing grade and do not require a re-drill (100% threshold)
2. Code Grays to be properly called by staff to PBX emergency line (111) vs. staff calling Security Services directly (100% threshold)
3. Code Greens to be properly called by staff to PBX emergency line (111) vs. staff calling Security Services directly (100% threshold)
4. Staff are observed wearing their name badge according to Palomar Health procedure (Lucidoc #14753) (100% threshold)
5. Conduct at least 2 community events related to Security (1 event every 6 months).
6. Train at least 100 employees each quarter on Security related themes, such as active shooter, safety, security, etc. (100 employees per qtr.)

Hazardous Materials and Waste Management Plan Performance Standards

The following performance activities were undertaken in 2020:
1. Monitoring of hazardous material containers inspected / labeled incorrectly during monthly Environment of Care (EOC) rounds
2. Monitoring of number of hazardous chemical incidents involving outside agency assistance for cleanup
3. Monitoring of number of biohazard waste incidents involving outside agency assistance for cleanup
4. Staff knowledge in obtaining SDS (Safety Data Sheet) information during monthly Environment of Care (EOC) rounds (90% threshold)
5. Inspected landline phones properly display an SDS sticker (90% threshold)
6. Staff knowledge in articulating appropriate steps to take in response to a spill (90% threshold)

Fire Prevention Management Plan Performance Standards

The following performance activities were undertaken in 2020:
1. Monitoring of actual fires reported inside the facilities
2. Monitoring of building and / or protection system monitoring – problems, significant incidents, unexpected repairs
3. Number of high hazard departments trained.
EVALUATION: PERFORMANCE STANDARDS Continued

**OVERVIEW.** The attached data sheets represent the evaluation of established performance standards, areas chosen on one or more of the following criteria:
1. The performance standard represents a measurable area of one of the EOC components.
2. The performance standard indicates a key reflection of the scope of the component.
3. The performance standard represents a high volume activity, or low volume but high risk consequences.
4. The performance standard requires improvement, or the existing process could be enhanced.

### Medical Equipment Management Plan Performance Standards

The following performance activities were undertaken in 2020:

1. Preventative maintenance (PM) completion rate for high risk equipment, including life support equipment (100% threshold)
2. Preventative maintenance (PM) completion rate for non-life support equipment (95% threshold)
3. <5% of unable to locate pieces of medical equipment
4. ≥90% of equipment repairs completed within 30 days
5. Tracking of high value mobile medical equipment (90% Threshold)

### Utility Equipment Management Plan Performance Standards

The following performance activities were undertaken in 2020:

1. Monitoring of facility utility failures (electricity, water, and natural & medical gases).
2. Monitoring of elevator failures
3. Monitoring of flooding events
4. Emergency generator testing compliance per regulatory standards (100% threshold)

### Emergency Operations Plan Performance Standards

The following performance activities were undertaken in 2020:

1. Conduct / manage two disaster drills or actual events per year at each facility according to top Hazard Vulnerability Analysis (HVA) risks and evaluate event using The Joint Commission standards (90% threshold)
2. Staff knowledge in articulating where his or her unit disaster supplies are located during monthly Environment of Care (EOC) rounds (90% threshold)
3. Staff knowledge in articulating where his or her unit emergency and safety response guide is located during monthly Environment of Care (EOC) rounds (90% threshold)
4. Staff knowledge in articulating what actions to take during an earthquake during monthly Environment of Care (EOC) rounds (90% threshold)
5. Staff knowledge in articulating suitable actions to take following a Code Triage activation during monthly Environment of Care (EOC) rounds (90% threshold)
6. Staff knowledge in articulating what action to take when an Everbridge notification is received (90% threshold)
7. Staff is able to identify the location of their departments downtime forms/box (90% threshold)
8. Conduct / attend at least ten emergency management / safety training sessions for staff per quarter
SAFETY MANAGEMENT
The following performance activities were undertaken in 2020:
1. O2 bottles found unsecured during monthly EOC rounding
2. Staff knowledge of R.A.C.E (Rescue, Alarm, Contain, Evacuate / Extinguish), and P.A.S.S (Pull, Aim, Squeeze, Sweep) acronyms (90% threshold)

Evaluation:
1. During monthly Environment of Care (EOC) multidisciplinary rounds, facility operations staff monitored areas for unsecured O2 tanks. Not a single O2 tank was found unsecured at any facility during 2020. Signage was posted at all O2 tank storage locations in 2019 to help remind staff where to put empty and full tanks.

2. During monthly EOC rounds, facility operations staff monitored staff knowledge regarding the R.A.C.E and P.A.S.S acronyms. Our threshold is 90% and was met at each facility in each quarter with the exception of 3Q at The Villas at Poway due to Physical Therapy being closed at the time due to COVID-19 precautions.

Safety Management Plan for Improvement:
- We will continue to monitor unsecured O2 tanks throughout the district during monthly EOC rounds to ensure O2 tanks continue to be stored and transported safely.
- We will continue to ensure that staff are able to define the meanings of RACE and PASS during monthly EOC rounding.

Monitoring to continue on quarterly EOC reports.
**EOC Component:**

**SECURITY MANAGEMENT**

The following performance activities were undertaken in 2020:

1. At least one Code Red drill will be performed once per shift, per quarter, per medical facility (100% threshold)
2. Code Gray’s to be properly called by staff to PBX emergency line (111) vs. staff calling security services directly (100% threshold)
3. Code Green’s to be properly called by staff to PBX emergency line (111) vs. staff calling security services directly (100% threshold)
4. Track and promote increased Code Grey response from departments other than Security (2 extra staff per Code).
5. Conduct at least 2 community events related to Security (1 event every 6 months).
6. Train at least 100 employees each quarter on Security related themes, such as active shooter, safety, security, etc. (100 employees per qtr.)

1. **At least one Code Red drill will be performed once per shift, per quarter, per medical facility (100% threshold):**

   ![Code Red drill performance chart]

2. **Code Gray’s to be properly called by staff to PBX emergency line (111) vs. staff calling security services directly (100% threshold):**

   ![Code Gray call performance chart]
3. Code Green’s to be properly called by staff to PBX emergency line (111) vs. staff calling security services directly (100% threshold):

4. Staff are observed wearing their name badge according to Palomar Health procedure (Lucidoc #14753) (100% threshold):

5. More participation from CPI trained staff during Code Grays:

Evaluation:

3. In order to get appropriate response from the proper teams, staff was tested on how Code Green’s are communicated to Security. The proper procedure is to call the PBX emergency line for a more prompt response. The goal of 100% for 2020 was not met at PMCE in Q1 and Q2, or at PMCP in Q2. No Code Green’s occurred at PMCD or The Villas at Poway in 2020. All failures to follow the procedure prompted department education immediately at the conclusion of the event and department leadership was advised of the deficiency.

4. 25-50 Observations were conducted by Security per quarter, with the vast majority of staff being seen wearing their ID badge appropriately. All staff found to not be following the procedure were spoken with and corrected the behavior without issue.

5. On average every Code Gray at PMC Escondido had greater than 2 Non-Security staff respond to assist. PMC Poway had greater than 3 Non-Security staff respond. Both campuses far exceeded the goal of 2 or more responders per Code Gray.
Security Management
continued

Plan for Improvement:
- We will continue to manage Code Red exercises with the main goal to teach staff how to respond to a Code Red event, and keep people and property safe.
- Code Gray and Code Green monitoring to continue. Staff in-services to continue if the 100% goal is not met.
- To continue improving facility access control Security will continue monitoring staff to ensure they are appropriately displaying their ID badges.
- Staff and community training will not be tracked in 2021.

Evaluation:
6. No community training events occurred in 2020 due to COVID-19. This item will not be tracked in 2021.

7. No security trainings took place in 2020 due to COVID-19. This item will not be tracked in 2021.

6. Conduct at least two community events related to security:

7. Train at least 100 PH employees every quarter on security related themes such as active shooter/safety & security:
EOC Component:
Performance Standard:

HAZARDOUS MATERIALS AND WASTE MANAGEMENT
The following performance activities were undertaken in 2020:
1. Monitoring of the number of hazardous material containers inspected / labeled incorrectly during monthly EOC rounds
2. Monitoring of the number of hazardous chemical incidents requiring outside agency cleanup
3. Monitoring of the number of bio hazardous waste incidents requiring outside agency cleanup

Evaluation:
1. During monthly Environment of Care (EOC) multi-disciplinary rounds, facility operations staff monitored hazardous material containers for inappropriate labeling. All hazardous materials containers inspected were labelled properly.
2. There were no hazardous chemical incidents requiring outside assistance for cleanup in 2020.
3. There were no bio-hazardous waste incidents requiring outside assistance for cleanup in 2020.

Plan for Improvement:
- We will continue monitoring for correct staff response relating to various program elements in our hazardous materials plan, as high levels of compliance promote risk reduction relating to hazardous materials and waste usage.
HAZARDOUS MATERIALS AND WASTE MANAGEMENT

The following performance activities were undertaken in 2020:

4. Staff knowledge on how to obtain Safety Data Sheet (SDS) information: 90% threshold
5. Landline phones properly displaying an SDS sticker (90% threshold)
6. Staff knowledge in spill response

**Evaluation:**

4. During monthly EOC rounds, staff knowledge regarding how to locate Safety Data Sheet (SDS) information was surveyed. Our threshold was 90% and was met at PMCE, in Q1, Q2, and Q3, at PMCP, Q1 and Q3 at PMCD, and Q3 and Q4 at The Villas at Poway. In all instances where staff were not able to provide a suitable answer, just In Time (JIT) training was provided and Sentact “fix-it” tickets were sent to department Leaders for their awareness.

5. During monthly EOC rounds, landline phones were inspected for a properly displayed SDS sticker. Having these stickers on every phone ensures that staff will always have quick access to 3E to be able to obtain SDS information on any spilled item. Almost every area inspected had phones with either no sticker displayed or had an old MSDS sticker. New stickers were made available via Security and Sentact “fix-it” tickets were sent to all department leaders for their awareness.

6. During monthly EOC rounds, staff were surveyed on what steps they should take when discovering a spill. The only deficiency for this question came in Q3 at PMCE, where they came in at 88% on a goal of 90%. Just In Time (JIT) training was provided and Sentact “fix-it” tickets were sent to department Leaders for their awareness.

**Plan for Improvement:**

- We will continue monitoring for correct staff response relating to various program elements in our hazardous materials plan, as high levels of compliance promote risk reduction relating to hazardous materials and waste usage.
**EOC Component:** FIRE PREVENTION MANAGEMENT

**Performance Standard:** The following performance activities were undertaken in 2020:

1. Monitoring of building and / or fire protection systems – failures
2. Number of high hazard departments trained.

**Evaluation:**

1. During 2020, the fire protection System at PMCE was put into bypass mode on 22 occasions. These were all done in conjunction with Siemens performing monthly PM's.

At PMCD the fire protection system was placed in bypass mode a total of 12 times, for the same reason.

At PMCP there were multiple unplanned activations of the fire protection system.
- January – Repairs to duct detectors on the 2nd and 3rd floors.
- June – Repairs to duct detectors and ZAM on the 2nd floor.
- July – Trouble alarms during ATS emergency power shutdown.
- August – Trouble alarms during ATS Normal power shutdown.

Siemens was involved in all events and there was no impact to services.

2. Fire safety training was provided to EVS, FANS, Facilities, and the OR/IR/Cath Lab in 2020. These departments were identified as being high risk for Code Reds.

**Plan for Improvement:**

- We will continue to monitor the fire protection systems in all facilities.
- Fire safety training will continue for identified high risk departments in 2021.
EOC Component: MEDICAL EQUIPMENT MANAGEMENT

Performance Standard:
1. Preventative maintenance (PM) completion rate for high risk medical equipment (100% threshold)
2. Preventative maintenance (PM) completion rate for non-high risk medical equipment (95% threshold)
3. <5% of unable to locate pieces of medical equipment
4. ≥90% of equipment repairs completed within 30 days
5. ≥90% Tracking of high value mobile medical equipment

Evaluation:
1. Biomed failed to meet their 100% goals in Q3 and Q4 for preventative maintenance on high risk medical equipment throughout the district in 2020. A combination of not being able to access equipment actively being used in COVID-19 patient rooms and there being no due PM's in Q3 for The Villas at Poway lead to the goals not being met. Despite not reaching the 100% goal, Biomed was still in regulatory compliance due to COVID-19 related waivers being in place.

2. Biomed consistently met their 95% threshold of preventative maintenance on non-life support equipment throughout 2020.

3. The threshold was met in Q2, Q3, and Q4 on <5% of unable to locate pieces of medical equipment throughout the district. Limited staffing, accessibility, and a modified PM schedule based on a COVID-19 waiver attributed to this goal being missed in Q1.

4. The threshold was not met in Q1, Q2, and Q3 in 2020. Limited staffing was a significant factor in not reaching this goal. Despite not reaching the 100% goal, Biomed was still in regulatory compliance due to COVID-19 related waivers being in place.

5. In 2020, 65.5% of high value medical equipment was tracked by either a manual or technology based process. In 2021 Biomed will be looking at introducing a new tracking system which should enable 100% tracking on all of these devices.

Plan for Improvement:
- We will continue monitoring PM completion rates as high completion rates for both high risk and non high risk medical equipment promotes operational reliability of equipment that is used on our patients, and supports our patient safety goals.

- We will continue to monitor our other goals and watch for any apparent trends or gaps.

- An additional goal to monitor staff training will be added for 2021. An increase in staff training will result in Biomed not needing to send as many items out for repair, instead being able to perform the repairs onsite.
3. <5% of equipment that is unable to be located:

4. ≥90% of equipment repairs completed within 30 days:

5. ≥90% Tracking of high value mobile medical equipment:
Evaluation:
1. Utility failure monitoring includes any significant electricity, water, natural and medical gas failures.

PMCE 1Q2020
• Medical Gas – 8 Repairs were needed to medical gas alarms. Nothing was compromised and the repairs were completed without issue.

PMCE 2Q2020
• Medical Gas – Another 8 Repairs were needed to medical gas alarms. Nothing was compromised and the repairs were completed without issue.

PMCE 3Q2020
• Medical Gas – Another 8 Repairs were needed to medical gas alarms. Nothing was compromised and the repairs were completed without issue.

PMCE 4Q2020
• Medical Gas – Another 8 Repairs were needed to medical gas alarms. Nothing was compromised and the repairs were completed without issue.

PMCP 2Q2020
• Water Failure – Legionella detected in 2 ice Machines. Both machines were sanitized per Manufacturer recommendations and retested as negative.

PMCP 3Q2019
• Water Failure – Legionella detected at the city backflow. The samples showed relatively high concentrations, however this could have been from a variety of factors, such as; stagnant water, hot conditions within the backflow itself, or cross contamination. The vendor recommended no actions to be taken due to the numerous potential impact factors at the offsite facility.

2. Elevator entrapments were monitored throughout 2020, there were a total of 6 entrapments across all facilities.

Plan for Improvement:
- We will continue monitoring, keeping our efforts on prevention, and utility equipment operational reliability which strengthens our patient safety focus.
Evaluation:

3. No flooding events occurred at any facility during 2020.

4. Generator testing, which is considered high risk utility equipment, was completed at 100% at PMCD, PMCP, and The Villas at Poway in 2020. PMCE had 2 monthly PM’s in 2020, where the ATS took greater than 10 seconds to switch to E-Power. The vendor was notified and repairs were made both times. All other months tested at 100%.
In 2020 multiple events occurred in the area of emergency management. The multidisciplinary District Disaster Committee met regularly with a standing agenda developed by the Emergency Manager to address the growth and continual changes of disaster preparedness and the preparedness needs throughout the district and community.

In 2020, Palomar Health planned to participate in several county and statewide exercises:

Typically, all exercises in which the EOP is activated at each facility is evaluated to ensure our 90% objective threshold is met.

PMC E:
1. The Spring 2020 Countywide disaster exercise was cancelled due to the County’s response efforts with COVID-19.
2. The November 2020 Statewide disaster exercise was cancelled due to the States response efforts with COVID-19.
3. The Summer no-notice evacuation exercise was cancelled due to the County’s response efforts with COVID-19.
4. Emergency Management created a communications exercise for the Palomar Health district. Everbridge, satellite phones, radios, TRAIN, and WebEOC were all tested.
   • Event score: 91% with follow up activities identified.

PMC D:
1. The Spring 2020 Countywide disaster exercise was cancelled due to the County’s response efforts with COVID-19.
2. The November 2020 Statewide disaster exercise was cancelled due to the States response efforts with COVID-19.
3. The Summer no-notice evacuation exercise was cancelled due to the County’s response efforts with COVID-19.
4. Emergency Management created a communications exercise for the Palomar Health district. Everbridge, satellite phones, radios, TRAIN, and WebEOC were all tested.
   • Event score: 91% with follow up activities identified.

PMC P:
1. The Spring 2020 Countywide disaster exercise was cancelled due to the County’s response efforts with COVID-19.
2. The November 2020 Statewide disaster exercise was cancelled due to the States response efforts with COVID-19.
3. The Summer no-notice evacuation exercise was cancelled due to the County’s response efforts with COVID-19.
4. Emergency Management created a communications exercise for the Palomar Health district. Everbridge, satellite phones, radios, TRAIN, and WebEOC were all tested.
   • Event score: 91% with follow up activities identified.

Villa Pomerado:
1. The Spring 2020 Countywide disaster exercise was cancelled due to the County’s response efforts with COVID-19.
2. The November 2020 Statewide disaster exercise was cancelled due to the States response efforts with COVID-19.
3. The Summer no-notice evacuation exercise was cancelled due to the County’s response efforts with COVID-19.
4. Emergency Management created a communications exercise for the Palomar Health district. Everbridge, satellite phones, radios, TRAIN, and WebEOC were all tested.
   • Event score: 91% with follow up activities identified.

Satellite Buildings, including Home Health:
1. The Spring 2020 Countywide disaster exercise was cancelled due to the County’s response efforts with COVID-19.
2. The November 2020 Statewide disaster exercise was cancelled due to the States response efforts with COVID-19.
3. The Summer no-notice evacuation exercise was cancelled due to the County’s response efforts with COVID-19.
4. Emergency Management created a communications exercise for the Palomar Health district. Everbridge, satellite phones, radios, TRAIN, and WebEOC were all tested.
   • Event score: 91% with follow up activities identified.

Plan for Improvement (1):
We will continue collaborating with outside agencies to ensure we approach disaster preparedness with a ‘whole community’ approach.

Plan for Improvement (2):
For the disaster exercise and events, debriefings occurred with plans for improvement identified. The Disaster Committee has assumed the responsibility for implementing the improvement actions. We will continue with pre-planning for drills identifying objectives that test stressing our procedures and systems.
Emergency Management Continued…

EOC Component: EMERGENCY MANAGEMENT
Performance Standards:

1. Conduct / manage two disaster exercises or actual events per year at each facility according to top Hazard Vulnerability Analysis (HVA) risks and evaluate event using The Joint Commission standards (90% threshold)
2. Staff knowledge during EOC surveillance rounds in articulating where his or her unit’s disaster supplies are located (90% threshold)
3. Staff knowledge during EOC surveillance rounds in articulating where his / her unit Emergency and Safety Response guide is located (90% threshold)
4. Staff knowledge during EOC surveillance rounds in articulating the actions to take during an earthquake (90% threshold)
5. Staff knowledge during EOC surveillance rounds in articulating what his / her role would be during a Code Triage event (90% threshold)
6. Staff knowledge during EOC surveillance rounds in articulating what actions to take when an Everbridge notification is received (90% threshold)
7. Staff knowledge during EOC surveillance rounds in identifying the location of their departments downtime forms/box (90% threshold)
8. Conduct / attend at least ten emergency management / safety training sessions for staff per quarter.

Evaluation:
1. For the communications exercise in 2020, the threshold of 90% was met consistently at each medical center and satellite building. Action items were identified post event as well as what items went well. These items were forwarded to the Disaster Preparedness Committee for review.
2. During monthly EOC rounds, Emergency Management staff monitored staff knowledge regarding the locations of disaster equipment. Our threshold is 90% and was not met in the 2nd quarter at PMCE, PMCP, PMCD, and Satellite buildings, and again in the 3rd quarter at The Villas. Just in time training was provided and follow up emails were sent to department leadership.
3. During monthly EOC Rounds, Emergency Management staff monitored staff knowledge regarding the locations of departmental Emergency and Safety Response Guides. The 90% threshold was not met in the Q1 & Q2 at PMCD, and again in Q3 at The Villas. Just in time training was provided and follow up emails were sent to department leadership.
4. Staff knowledge during EOC surveillance rounds in articulating actions to take during an earthquake: 90% threshold

<table>
<thead>
<tr>
<th>Quarter</th>
<th>PMC E</th>
<th>PMC D</th>
<th>PMC P</th>
<th>Villa</th>
<th>Satellite</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 2020</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Q2 2020</td>
<td>90%</td>
<td>90%</td>
<td>90%</td>
<td>90%</td>
<td>90%</td>
</tr>
<tr>
<td>Q3 2020</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Q4 2020</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

During monthly EOC rounds, Emergency Management Staff monitored staff knowledge regarding actions to take during an earthquake. The 90% threshold was not met in Q2 at PMCD. Just in time training was provided and follow up emails were sent to department leadership.

5. Staff knowledge during EOC surveillance rounds in articulating what actions to take during a Code Triage event: 90% threshold

<table>
<thead>
<tr>
<th>Quarter</th>
<th>PMC E</th>
<th>PMC D</th>
<th>PMC P</th>
<th>Villa</th>
<th>Satellite</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 2020</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Q2 2020</td>
<td>90%</td>
<td>90%</td>
<td>90%</td>
<td>90%</td>
<td>90%</td>
</tr>
<tr>
<td>Q3 2020</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Q4 2020</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

During monthly EOC rounds, Emergency Management staff monitored staff knowledge regarding actions to take during a Code Triage event. The 90% threshold was not met in Q3 at The Villas. Just in time training was provided and follow up emails were sent to department leadership.

6. Staff knowledge during EOC surveillance rounds in articulating what actions to take when an Everbridge notification is received: 90% threshold

<table>
<thead>
<tr>
<th>Quarter</th>
<th>PMC E</th>
<th>PMC D</th>
<th>PMC P</th>
<th>Villa</th>
<th>Satellite</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 2020</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Q2 2020</td>
<td>90%</td>
<td>90%</td>
<td>90%</td>
<td>90%</td>
<td>90%</td>
</tr>
<tr>
<td>Q3 2020</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Q4 2020</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

During monthly EOC Rounds, Emergency Management staff monitored staff knowledge regarding how to confirm the receipt of an Everbridge notification. The 90% threshold was not met in the Q2 at PMCD, or in the Q3 at The Villas. Just in time training was provided and follow up emails were sent to department leadership.
7. Staff is able to identify the location of their departments downtime forms/box: 90% threshold

<table>
<thead>
<tr>
<th>1 Q 2020</th>
<th>2 Q 2020</th>
<th>3 Q 2020</th>
<th>4 Q 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>PMC E</td>
<td>PMC D</td>
<td>PMC P</td>
<td>Villa</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Satellite</td>
</tr>
</tbody>
</table>

Evaluation:
7. During monthly EOC Rounds, Emergency Management staff monitored staff knowledge on the location of their downtime forms/box. The 90% threshold was not met in the Q3 at The Villas. Just in time training was provided and follow up emails were sent to department leadership.

8. Conduct/Attend at least ten emergency management/safety training sessions for staff per quarter:

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Trainings</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st</td>
<td>2</td>
</tr>
<tr>
<td>2nd</td>
<td>7</td>
</tr>
<tr>
<td>3rd</td>
<td>5</td>
</tr>
<tr>
<td>4th</td>
<td>7</td>
</tr>
</tbody>
</table>

A total of 21 emergency management and safety trainings were conducted for staff across the district in 2020. Numerous trainings were cancelled due to COVID-19 response.
SAFETY. Based upon the objectives, scope and performance standards, outcomes were positive, and thresholds were impressively met for the safety management program at Palomar Health facilities. Based on the high level of commitment to education, surveillance, and ongoing activities, the Management Plan for Safety is highly effective in promoting safety standards for the organization, and in guiding the direction of safety-related activities.

SECURITY. The Management Plan for Security and the security program is effective across the district, in spite of objectives not being met in 2020. Event monitoring will continue in an effort to help meet our goals in 2021. Code Pink (infant abduction) and Purple (child abduction) drills were completed on a routine basis with excellent staff response. For the year 2021, we will continue monitoring security trends to identify areas of risk to the medical centers and satellite buildings, and infant and child abduction security drills, focusing on continued education and effective drill outcomes.

HAZARDOUS MATERIALS. The Management Plan for Hazardous Materials and the overall Hazardous Materials program at Palomar Health facilities is effective, as there were no spills requiring an outside response team. New rounding questions were introduced in 2020 and while there were identified gaps, steps were taken to address the deficiencies and were followed up with communications to leadership. Hazardous waste was manifested in accordance with agencies having jurisdiction. This focus on ongoing education reflects Palomar Health’s commitment to the safety of our employees, especially as it relates to hazardous materials issues. We maintained our multidisciplinary staff spill response team, made up of 9 staff members from various departments.

FIRE PREVENTION MANAGEMENT. Based upon the objectives, scope and performance standards, the Fire Prevention Management plan is effective. Fire drills were completed for the medical centers and satellite buildings, with performance standards monitored, and found to be in compliance throughout the year. Fire equipment inspection, maintenance and testing was completed, with ongoing monitoring of the Statement of Conditions in effect.

MEDICAL EQUIPMENT MANAGEMENT. Based upon the objectives, scope and performance standards, the Medical Equipment Plan and program are effective at the medical centers. Preventive maintenance was monitored quarterly, with established thresholds met in compliance with regulatory waivers. The separation of our inventory (i.e., high risk medical equipment from non-high risk medical equipment) places a higher focus on the safety of our patients, and keeps the Environment of Care closely integrated with Patient Safety standards. The Medical Equipment Plan and program are effective in promoting safe equipment usage for our patients. We will continue to monitor equipment user errors and equipment that is not located for > 30 days and be prepared to observe and report out any trending that may occur.

UTILITY EQUIPMENT MANAGEMENT. All utilities failures or interruptions to services were resolved as quickly and safely as possible to minimize all impact to our ability to provide care to patients in a safe environment. The Utility Equipment Management plan is an effective way to manage the Utility Equipment program based on the successful completion of goals and performance standard monitoring.

EMERGENCY MANAGEMENT. Based upon the objectives, scope and performance standards, the Emergency Management and Operations Plan is effective. Between COVID-19 response activities and other smaller scale responses, all of which were rated as likely risks in our Hazard Vulnerability Analysis, many successes and areas of opportunity were identified. The Disaster Preparedness Committee provided an excellent forum to support response activities and promote preparedness among recognized areas for improvement. This continues to be a highly effective and energetic committee that will continue to meet and oversee the day-to-day emergency planning in 2021. The Hazard Vulnerability Analysis’s are reviewed annually and are found to be an effective tool in prioritizing critical events, and assessing the prioritization against the medical center’s preparedness. Staff were monitored for their knowledge relating to components in our Emergency Operations Plan, and their roles in a disaster, and education was provided when gaps were identified. Palomar Health as a district is actively involved with whole community-wide preparedness activities, which strengthens our ties with agencies having jurisdiction, creating a whole-community approach to Emergency Management.
ADDENDUM F
Expired Compounded Medications

**Situation**
Pharmacy compounded medication found in nursing unit refrigerator with expired beyond use dating (BUD)

**Background**
Ongoing history of medications found outside the pharmacy department with expired BUD. An expired patient specific vancomycin was found on 5w.

**Assessment**
- Pharmacy performs random refrigerator audits monthly (n=50/refrigerator/month).
- Expired compounded medications due to discontinued patient specific medications not returned to pharmacy and Kits with short dated medications

**Recommendation**
1. Reeducate nursing staff on importance of using compounded medications in order sequence.
2. Pharmacy personnel will continue to monitor for appropriate medication dating of compounded medications and Kits outside of the pharmacy.
3. Continue to evaluate commercially available ready to use medications typically compounded by pharmacy.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>PMCE 4</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>99%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>98%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>PMCE 5</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>98%</td>
<td>99%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>PMCE 6</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>99%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>PMCE 7</td>
<td>100%</td>
<td>99%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>99%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>PMCE 8</td>
<td>100%</td>
<td>99%</td>
<td>100%</td>
<td>98%</td>
<td>100%</td>
<td>97%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>99%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>PMCE 9</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>99%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>PMCE OR/PP/CV</td>
<td>100%</td>
<td>99%</td>
<td>99%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>99%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>PMCE ED</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>99%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>98%</td>
<td>100%</td>
<td>98%</td>
</tr>
<tr>
<td>PMCP</td>
<td>100%</td>
<td>99%</td>
<td>99%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>PMCD</td>
<td>100% n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
</tbody>
</table>
New Medication Order Turn Around Time

<table>
<thead>
<tr>
<th>SITUATION</th>
<th>To assess the core issue of untimely availability of newly ordered medications to the nursing units.</th>
</tr>
</thead>
<tbody>
<tr>
<td>BACKGROUND</td>
<td>Numerous complaints from nursing staff that pharmacy is not providing patient medications timely</td>
</tr>
<tr>
<td>ASSESSMENT</td>
<td>Pharmacy assessment of time required to verify medication order once entered by physician. Goal &lt; 60 mins for non-STAT orders.</td>
</tr>
</tbody>
</table>

![Table of data](attachment:image.png)

1. Assess medications readily available on nursing units
2. Reeducate staff to the policy on Medication Administration
3. Further evaluate impact and communication to staff concerning medication shortages
# Diversion Prevention

<table>
<thead>
<tr>
<th><strong>SITUATION</strong></th>
<th>Diversion Prevention</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BACKGROUND</strong></td>
<td>Diversion Prevention is an indicator for Pharmacy to ensure the security of the controlled substances.</td>
</tr>
<tr>
<td><strong>ASSESSMENT</strong></td>
<td>See attached Dashboards</td>
</tr>
<tr>
<td><strong>RECOMMENDATION</strong></td>
<td>The Quality Management Committee approved the request to change from reporting data monthly to quarterly. Board Quality Review Committee’s reports will remain quarterly.</td>
</tr>
</tbody>
</table>
### PMC - Poway

- Controlled substance removal has significantly decreased from previous year average of 1.8% to 1.3%.
- Discrepancies resolved within 24 hours – year average 93.8%
- No transaction cancellations on targeted medications year to date

<table>
<thead>
<tr>
<th>Palomar Medical Center Poway</th>
<th>Diversion Prevention / Controlled Substance QAPI Report</th>
<th>Frequency</th>
<th>Apr-20</th>
<th>May-20</th>
<th>Jun-20</th>
<th>Jul-20</th>
<th>Aug-20</th>
<th>Sep-20</th>
<th>Oct-20</th>
<th>Nov-20</th>
<th>Dec-20</th>
<th>Jan-21</th>
<th>Feb-21</th>
<th>Mar-21</th>
</tr>
</thead>
<tbody>
<tr>
<td>CII Safe</td>
<td>- “All Pyxis CII Safe Events” report reviewed for unusual activity</td>
<td>Daily</td>
<td>100%, n=30</td>
<td>100%, n=31</td>
<td>100%, n=30</td>
<td>100%, n=31</td>
<td>100%, n=30</td>
<td>100%, n=31</td>
<td>100%, n=30</td>
<td>100%, n=31</td>
<td>100%, n=30</td>
<td>100%, n=31</td>
<td>100%, n=30</td>
<td>100%, n=31</td>
</tr>
<tr>
<td></td>
<td>- “Open Discrepancy Report” reviewed</td>
<td>Daily</td>
<td>100%, n=30</td>
<td>100%, n=31</td>
<td>100%, n=30</td>
<td>100%, n=31</td>
<td>100%, n=30</td>
<td>100%, n=31</td>
<td>100%, n=30</td>
<td>100%, n=31</td>
<td>100%, n=30</td>
<td>100%, n=31</td>
<td>100%, n=30</td>
<td>100%, n=31</td>
</tr>
<tr>
<td></td>
<td>- “Pyxis vs CII Safe Compare report” reviewed</td>
<td>Daily</td>
<td>100%, n=30</td>
<td>100%, n=31</td>
<td>100%, n=30</td>
<td>100%, n=31</td>
<td>100%, n=30</td>
<td>100%, n=31</td>
<td>100%, n=30</td>
<td>100%, n=31</td>
<td>100%, n=30</td>
<td>100%, n=31</td>
<td>100%, n=30</td>
<td>100%, n=31</td>
</tr>
<tr>
<td></td>
<td>- CII Safe Pending Destruction Box was included in monthly inventory</td>
<td>Monthly</td>
<td>100%, n=455</td>
<td>99.6%, n=495</td>
<td>99.5%, n=469</td>
<td>99.6%, n=705</td>
<td>98.8%, n=682</td>
<td>98.9%, n=835</td>
<td>98.5%, n=483</td>
<td>97.8%, n=994</td>
<td>99.3%, n=1021</td>
<td>98.4%, n=578</td>
<td>99.4%, n=625</td>
<td>99%, n=917</td>
</tr>
</tbody>
</table>

- **Outlier reviews completed within 10 days**: Monthly - 100%, n=1
- **Count of "Resolved Discrepancies" for the month**: Monthly - n=0
- **Pyxis Override**: Monthly - 2.3%, n=30
- **Other transactions**: Monthly - 0% to 0%

### Diversion Prevention / Controlled Substance QAPI Report

- **Anesthesia CS Compliance**: Monthly - 99.2%, n=122
- **Documentation tracer audits: Controlled Substances [Pyxis removal tied to order and charting event]**: Monthly - 97.9%, n=30
- **Documentation tracer audits: Non-Controlled Substances [Pyxis removal tied to order and charting event]**: Monthly - 96.6%, n=30

### Documentation tracer audits: CII Safe

- **All Pyxis CII Safe Results**: Daily - 100%, n=30
- **Open Discrepancy Report Results**: Daily - 100%, n=30
- **Pyxis vs CII Safe Compare Results**: Daily - 100%, n=30
- **CII Safe Pending Destruction Box**: Monthly - 100%
PMC - Escondido

- Controlled substance removal on significantly decreased from previous year average of 1.9% to 1.3%.
- Discrepancies resolved within 24 hours – year average 88.3%
- 2 transaction cancellations on targeted medications year to date – All investigated with no findings

<table>
<thead>
<tr>
<th>Palomar Medical Center Escondido</th>
<th>Diversion Prevention / Controlled Substance QAPI Report</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CLII Safe</strong></td>
<td>Frequency: Daily, Results: 100% n=30, 100% n=31, 100% n=30, 100% n=31</td>
</tr>
<tr>
<td><em>All Pyxis CLII Safe Events</em> report reviewed for unusual activity</td>
<td></td>
</tr>
<tr>
<td><em>Open Discrepancy Report</em> reviewed</td>
<td>Daily, Results: 100% n=30, 100% n=31, 100% n=30, 100% n=31</td>
</tr>
<tr>
<td><em>Pyxis vs CLII Safe Compare report</em> reviewed</td>
<td>Daily, Results: 100% n=30, 100% n=31, 100% n=30, 100% n=31</td>
</tr>
<tr>
<td>Count of “Resolved Discrepancies” for the month</td>
<td>Monthly results: n=97, n=30, n=31, n=31, n=30, n=31, n=31, n=28, n=31</td>
</tr>
<tr>
<td>All Pyxis CII Safe Events</td>
<td>report reviewed for unusual activity</td>
</tr>
<tr>
<td>Open Discrepancy Report</td>
<td>reviewed</td>
</tr>
<tr>
<td>Pyxis vs CII Safe Compare report</td>
<td>reviewed</td>
</tr>
<tr>
<td>Count of “Resolved Discrepancies” for the month</td>
<td>Monthly results: n=97, n=30, n=31, n=31, n=30, n=31, n=31, n=28, n=31</td>
</tr>
<tr>
<td>CII Safe Pending Destruction Box was included in inventory</td>
<td>Monthly results: 98% n=48, 98% n=50, 100% n=50, 100% n=50, 98% n=50, 98% n=50, 98% n=50, 98% n=50, 98% n=50</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Controlled Substance Pyxis Inventory</th>
<th>Migration Report reviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Controlled Substance Discrepancies Resolved Within 24 hours</td>
<td>Monthly results: 99.8% n=141, 99.1% n=122, 98.6% n=1002, 99.8% n=1000, 99.8% n=1596, 99.2% n=1003, 99% n=1563, 98.8% n=3123</td>
</tr>
<tr>
<td>Controlled Substance Pyxis Inventory</td>
<td>Migration Report reviewed</td>
</tr>
<tr>
<td>Controlled Substance Pyxis Inventory</td>
<td>Monthly results: 99.8% n=141, 99.1% n=122, 98.6% n=1002, 99.8% n=1000, 99.8% n=1596, 99.2% n=1003, 99% n=1563, 98.8% n=3123</td>
</tr>
<tr>
<td><strong>Pyxis Override</strong></td>
<td>Monthly results: 1.9% n=10, 1.8% n=10, 1.2% n=10, 1.1% n=10, 1.1% n=10, 1.2% n=10, 1.3% n=10, 1.2% n=10, 1.1% n=10</td>
</tr>
<tr>
<td>Canceled Transaction Report for drugs that could be tampered with (if of outliers)</td>
<td>Monthly results: 99.8% n=141, 99.1% n=122, 98.6% n=1002, 99.8% n=1000, 99.8% n=1596, 99.2% n=1003, 99% n=1563, 98.8% n=3123</td>
</tr>
<tr>
<td>Documentation tracer audits: Controlled Substances (Pyxis removal tied to order and charting event)</td>
<td>Monthly results: 99.4% n=157, 98.1% n=266, 98.4% n=247, 100% n=240, 98.3% n=287, 99.3% n=293, 100% n=246, 98.3% n=235, 98.5% n=196, 99.2% n=237, 99.2% n=256, 99.6% n=225</td>
</tr>
<tr>
<td>Documentation tracer audits: Non-C S (Pyxis removal tied to order and charting event)</td>
<td>Monthly results: 99.4% n=157, 98.1% n=266, 98.4% n=247, 100% n=240, 98.3% n=287, 99.3% n=293, 100% n=246, 98.3% n=235, 98.5% n=196, 99.2% n=237, 99.2% n=256, 99.6% n=225</td>
</tr>
</tbody>
</table>

**Results**

- Daily 100% n=30, 100% n=31, 100% n=30, 100% n=31, 100% n=31, 100% n=31, 100% n=31, 100% n=28, 100% n=31
- Monthly n=0 n=0 n=0 n=0 n=0 n=0 n=0 n=0 n=0 n=0
- Monthly Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes
- Monthly 90% n=10 57.2% n=7 93.2% n=73 90.6% n=85 95.1% n=81 92.2% n=102 86.7% n=83 76.8% n=69 84.1% n=138 86.4% n=110 87.1% n=93
- Monthly 92.3% n=265 87.9% n=66 93.2% n=73 90.6% n=85 95.1% n=81 92.2% n=102 86.7% n=83 76.8% n=69 84.1% n=138 86.4% n=110 87.1% n=93
- Monthly 98.5% n=265 98.6% n=209 98.4% n=253 98% n=200 90.6% n=255 94.3% n=212 94.6% n=204 91.8% n=255 92.9% n=224 97.3% n=224 97.2% n=250
- Monthly 99% n=196 99.2% n=237 99.2% n=256 97.9% n=224 97.2% n=250
- Monthly 98% n=50 98% n=50 100% n=50 100% n=50 98% n=50 94% n=50 98% n=50 98% n=50 94% n=50 91.6% n=60 96.7% n=60 100% n=60 100% n=60

**Pyxis MedStations**

- Outlier reviews completed within 10 days: Monthly results: 99.8% n=141, 99.1% n=122, 98.6% n=1002, 99.8% n=1000, 99.8% n=1596, 99.2% n=1003, 99% n=1563, 98.8% n=3123, 98.4% n=2771, 98.2% n=2176
- Controlled Substance Pyxis Inventory: Monthly results: 99.8% n=141, 99.1% n=122, 98.6% n=1002, 99.8% n=1000, 99.8% n=1596, 99.2% n=1003, 99% n=1563, 98.8% n=3123, 98.4% n=2771, 98.2% n=2176
- Anesthesia CS Compliance: Inventory of controlled substances stored in the CLII Safe performed per procedure 32532, Pharmacy Controlled Substance Vault, CII safe Pending Destruction Box was included in monthly inventory

**Documentation tracer audits:**

- Controlled Substances (Pyxis removal tied to order and charting event)
- Non-CS (Pyxis removal tied to order and charting event)
ADDENDUM G
Rehabilitation Services

Presented to Board Quality Review Committee

Virginia Barragan, Vice President Continuum Care
June 9, 2021
Rehabilitation Services

- Assessment of the work processes, equipment needs, staff education and ongoing monitoring needed for each quality metric
- Modifications in work processes, equipment use and staff education as needed to achieve national benchmark

**PLAN**

**DO**
- Training of staff on new work processes or competencies
- Implementation of work flow changes using new equipment as needed

**ACT**

**STUDY**
- Ongoing review and audits to check compliance with new processes
## Data - Rehabilitation Services

<table>
<thead>
<tr>
<th>INDICATORS</th>
<th>PALOMAR HEALTH</th>
<th>NATIONAL BENCHMARK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute Care Inpatient Rehab Services</strong></td>
<td>Access to Acute Care (PT/OT/ST)</td>
<td>2.5 patients triaged/day</td>
</tr>
<tr>
<td><strong>Outpatient Cardiac Rehab Services</strong></td>
<td>Access to Care</td>
<td>20 days</td>
</tr>
<tr>
<td><strong>Outpatient Rehab Services</strong></td>
<td>Access to Care</td>
<td>6.3 days</td>
</tr>
<tr>
<td><strong>Cancellation/No Show Rate</strong></td>
<td></td>
<td>8.01 %</td>
</tr>
<tr>
<td><strong>Average Length of Stay</strong></td>
<td></td>
<td>10.6 days</td>
</tr>
<tr>
<td><strong>The Villas Rehab Services</strong></td>
<td>% Discharge to Home</td>
<td>75.63 %</td>
</tr>
<tr>
<td><strong>Average Length of Stay</strong></td>
<td></td>
<td>14.0 days</td>
</tr>
</tbody>
</table>
# Outpatient Rehabilitation Services – Access to Care

<table>
<thead>
<tr>
<th><strong>Situation</strong></th>
<th>Access to care time has increased in FY21 to 6.3 days, compared to benchmark=&lt;5 days</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Background</strong></td>
<td>Outpatient Rehab has typically met/exceeded expectations for timeliness from referral to onsite assessment. Access to Care benchmarks have been established at an industry standard of 5 days or less, from the date a referral is received to the date that a patient is onsite for their initial assessment. This data allows management the opportunity to quickly address trends negatively affecting the patient’s ability to receive timely care.</td>
</tr>
</tbody>
</table>
| **Assessment** | Factors impacting access to care from 7/1/20-present as follows: Pandemic related delays were present throughout 2020 and the primary source of access issues.  
- Patient decisions to delay and/or limit scheduling  
- Clinic hours consolidated due to staffing and safety considerations  
- Reduced clinical and support staff due to Covid  
- Physician office and insurance authorization delays due to Covid  
*All above trends have been in a positive reversal trend from 3/21-present |
| **Recommendation** | 1) Continue hiring and onboarding of PT/OT and Outpatient Care Tech staff  
2) Gradual expansion of available appointment times to pre-pandemic level  
3) Daily Supervisor oversight of access process daily |
# The Villas at Poway Rehab Length of Stay (LOS)

| **Situation** | Length of Stay Benchmark = 12 days or less  
July 2020 through April 2021 average LOS = 14.1 |
|---------------|-----------------------------------------------------------------|
| **Background** | During this period, COVID pandemic resulted in:  
- Higher patient acuity requiring a longer length of stay  
- Limitations in patients out of room, in rehab gym and timely caregiver/family in-person training  
- Delays in transfers (ARU, Board and Care, Assisted Living)  
- Delay in discharges home secondary to patient diagnosis of COVID or family diagnosis of COVID at home |
| **Assessment** | Covid impacts on acuity and throughput had direct impact on LOS. Facility is now open with less barriers which should result in improvements in LOS going forward |
| **Recommendation** | Plan:  
- Collaboration of team with emphasis on medical management of higher acuity patients  
- 48 hour Welcome Meetings with patients and families and Comprehensive Care Conferences which include the physician.  
- Daily Monitoring of any hospital readmissions  
- Ongoing monitoring of the effects of COVID on discharge planning |
FY22 Action Plan - Rehabilitation Services

Palomar Medical Center Escondido & Poway – Acute Care

- Return to full caseload of clinical staff (impact from Covid)
- 2nd floor re-established as acute care with Rehab integration

Outpatient Cardiac Rehabilitation

- Slow return to full class sizes as Covid restrictions are lifted
- Revision of program to address access & needs of higher acuity Phase 2 patients

Skilled Nursing Rehab

- Return to full caseload as SNF admissions increase post-covid
- Continue onboarding of clinical staff (impact from Covid)
FY22 Action Plan - Rehabilitation Services

Outpatient Rehabilitation San Marcos & Poway

- Return to full pre-Covid caseload by summer 2021 (currently 90% for San Marcos and 85% for Poway)
- Onboarding of staff (clinical/support) impact from layoffs and new business
- Implementation of new equipment from foundation donor, emphasis on integrating neurorehabilitation devices across continuum
- Resumption of community based education programs Acute Rehabilitation
- Palomar Health Unit closure with last patient discharged 5.14.21
- Inpatient Rehabilitation Facility – Joint Venture with Kindred licensed and open for patients May 2021
FY22 Action Plan - Rehabilitation Services

District Wide

- Active Engagement in Safe Patient Handling organizational initiative for initial/annual training of clinical staff
- Ongoing training for Speech nurse swallow screening program
- Partnership with Employee Health for Hospital/Satellite ergonomic injury prevention program
ADDENDUM H
Laboratory Annual Presentation
Presented to Board Quality Review Committee

Jerry Kolins, M.D., Laboratory Medical Director
Gloria Austria, District Director Laboratory, Respiratory, EEG Services
June 23, 2021
# Laboratory FY21 Pre-Analytical Quality Indicators

## Table: Pre-analytical Performance Indicators

<table>
<thead>
<tr>
<th>Metrics</th>
<th>Frequency</th>
<th>Target</th>
<th>Units</th>
<th>FY 21</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>July</td>
</tr>
<tr>
<td><strong>Turnaround Time</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NBS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Escondido</strong></td>
<td>Quarterly</td>
<td>95/85</td>
<td>%</td>
<td>99%</td>
</tr>
<tr>
<td><strong>Poway</strong></td>
<td></td>
<td></td>
<td></td>
<td>99%</td>
</tr>
<tr>
<td>ED Order to Draw Response Time</td>
<td>Monthly</td>
<td>17</td>
<td>minutes</td>
<td>19</td>
</tr>
<tr>
<td><strong>Escondido</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Poway</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ED Draw to Receive Response Time</td>
<td>Monthly</td>
<td>8</td>
<td>minutes</td>
<td>11</td>
</tr>
<tr>
<td><strong>Escondido</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Poway</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood Culture Contamination</td>
<td>Monthly</td>
<td>&lt;2.0</td>
<td>%</td>
<td>1.30%</td>
</tr>
<tr>
<td><strong>Escondido</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Poway</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>Monthly</td>
<td>83.4</td>
<td>%</td>
<td>80.6</td>
</tr>
<tr>
<td>Facility Would Recommend</td>
<td>Monthly</td>
<td>61.1</td>
<td>%</td>
<td>40.8</td>
</tr>
<tr>
<td>Told When to Expect Results</td>
<td>Monthly</td>
<td>61.1</td>
<td>%</td>
<td>40.8</td>
</tr>
</tbody>
</table>
# Laboratory FY21 Analytical Quality Indicators

<table>
<thead>
<tr>
<th>Analytical Performance Indicators</th>
<th>FY 21 Monthly Data</th>
<th>Frequency</th>
<th>Target</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metrics</td>
<td>July</td>
<td>August</td>
<td>September</td>
<td>October</td>
</tr>
<tr>
<td>Escondido</td>
<td>Quarterly</td>
<td>Quarterly</td>
<td>Escondido</td>
<td>Escondido</td>
</tr>
<tr>
<td>Poway</td>
<td>Quarterly</td>
<td>Quarterly</td>
<td>Poway</td>
<td>Poway</td>
</tr>
<tr>
<td>ED STAT Perform to Completion</td>
<td>Monthly</td>
<td>Monthly</td>
<td>ED STAT Perform to Completion</td>
<td>ED STAT Perform to Completion</td>
</tr>
<tr>
<td>Escondido Hematology</td>
<td>Monthly</td>
<td>Monthly</td>
<td>Escondido Hematology</td>
<td>Escondido Hematology</td>
</tr>
<tr>
<td>Escondido Chemistry</td>
<td>Monthly</td>
<td>Monthly</td>
<td>Escondido Chemistry</td>
<td>Escondido Chemistry</td>
</tr>
<tr>
<td>Escondido Coagulation</td>
<td>Monthly</td>
<td>Monthly</td>
<td>Escondido Coagulation</td>
<td>Escondido Coagulation</td>
</tr>
<tr>
<td>Escondido Troponin</td>
<td>Monthly</td>
<td>Monthly</td>
<td>Escondido Troponin</td>
<td>Escondido Troponin</td>
</tr>
<tr>
<td>Poway Hematology</td>
<td>Monthly</td>
<td>Monthly</td>
<td>Poway Hematology</td>
<td>Poway Hematology</td>
</tr>
<tr>
<td>Poway Troponin</td>
<td>Monthly</td>
<td>Monthly</td>
<td>Poway Troponin</td>
<td>Poway Troponin</td>
</tr>
<tr>
<td>ED STAT Turn Around Time (Order to Completion)</td>
<td>Monthly</td>
<td>Monthly</td>
<td>ED STAT Turn Around Time (Order to Completion)</td>
<td>ED STAT Turn Around Time (Order to Completion)</td>
</tr>
<tr>
<td>Escondido Hematology</td>
<td>Monthly</td>
<td>Monthly</td>
<td>Escondido Hematology</td>
<td>Escondido Hematology</td>
</tr>
<tr>
<td>Escondido Chemistry</td>
<td>Monthly</td>
<td>Monthly</td>
<td>Escondido Chemistry</td>
<td>Escondido Chemistry</td>
</tr>
<tr>
<td>Escondido Coagulation</td>
<td>Monthly</td>
<td>Monthly</td>
<td>Escondido Coagulation</td>
<td>Escondido Coagulation</td>
</tr>
<tr>
<td>Escondido Troponin</td>
<td>Monthly</td>
<td>Monthly</td>
<td>Escondido Troponin</td>
<td>Escondido Troponin</td>
</tr>
<tr>
<td>Poway Hematology</td>
<td>Monthly</td>
<td>Monthly</td>
<td>Poway Hematology</td>
<td>Poway Hematology</td>
</tr>
<tr>
<td>Poway Troponin</td>
<td>Monthly</td>
<td>Monthly</td>
<td>Poway Troponin</td>
<td>Poway Troponin</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Overall ED TAT %</th>
<th></th>
<th></th>
<th>Overall ED TAT %</th>
<th>Overall ED TAT %</th>
<th>Overall ED TAT %</th>
<th>Overall ED TAT %</th>
<th>Overall ED TAT %</th>
<th>Overall ED TAT %</th>
<th>Overall ED TAT %</th>
<th>Overall ED TAT %</th>
<th>Overall ED TAT %</th>
</tr>
</thead>
<tbody>
<tr>
<td>83%</td>
<td>84%</td>
<td>85%</td>
<td>88%</td>
<td>81%</td>
<td>77%</td>
<td>77%</td>
<td>84%</td>
<td>87%</td>
<td>87%</td>
<td>84%</td>
<td>87%</td>
</tr>
</tbody>
</table>
## Laboratory FY21 Post Analytical Quality Indicators

<table>
<thead>
<tr>
<th>Post- Analytical Performance Indicators</th>
<th>FY 21 Monthly Data</th>
<th>Quality Indicators</th>
<th>Frequency</th>
<th>Target</th>
<th>Units</th>
<th>July</th>
<th>August</th>
<th>September</th>
<th>October</th>
<th>November</th>
<th>December</th>
<th>January</th>
<th>February</th>
<th>March</th>
<th>April</th>
<th>May</th>
<th>June</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-OP Value call</td>
<td>Monthly</td>
<td></td>
<td>%</td>
<td>89%</td>
<td>95%</td>
<td>95%</td>
<td>90%</td>
<td>85%</td>
<td>67%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>96%</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Escondido</td>
<td>Monthly</td>
<td></td>
<td>%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>94%</td>
<td>92%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poway</td>
<td>Monthly</td>
<td></td>
<td>%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>94%</td>
<td>92%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
FY 21 Accomplishments and Process Improvement Focus

Accomplishments
• PMC Poway and Microbiology Laboratories received 2 year accreditation from College of American Pathologists (CAP) and Centers for Medicare and Medicaid Services (CMS)
• Moved and licensed Microbiology and Histology/Cytology/Transcription (Enterprise)
• Improved hand hygiene compliance
• Implementation of high throughput COVID 19 PCR testing, to date 90% of testing performed in-house
• Set up of COVID rapid antigen testing at CSU and Villas at Poway
• Critical value reporting compliance consistently met target
• Blood Culture Contamination rate consistently met target

Process Improvement Focus
• ED STAT TAT (Draw to Receive)
• Pre-op Call on defined abnormal results
• Outpatient experience satisfaction results
### Delay in Draw to Receive on STAT orders from Emergency Department

<table>
<thead>
<tr>
<th><strong>SITUATION</strong></th>
<th>The laboratory at Escondido has not met the target from Draw to Receive for the past 6 months (July 2020 to December 2020) affecting STAT turn around time in the Emergency Department.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BACKGROUND</strong></td>
<td>At PMC Escondido, the performance measure from the time the sample is drawn to receipt in the laboratory is 8 minutes. The outcome has been out of expected target but within 9-10 minutes. However, since July 2020, the expected outcome has been consistently more than 10 minutes.</td>
</tr>
</tbody>
</table>
| **ASSESSMENT** | In review of the process, the following were the identified challenges:  
- At times, there is no dedicated lab assistant scheduled during night shift to receive samples.  
- Unclear lab assistant roles on night shift  
- Batching of STAT samples when tubed to the laboratory  
- Inconsistent process between shifts in the receiving area (Central Processing) |
| **RECOMMENDATION** | • Review night shift staffing matrix  
• Define lab assistant role at night  
• Add a part time 1 night shift lab assistant  
• Standardize process and practice in the processing area with all lab assistants reporting under one supervisor  
• Re-education of phlebotomist on tubing samples as soon as possible to avoid batching |
**PDCA: Order to Receive Turn Around Time on STAT orders from Emergency Department**

**PLAN**
- Lab staff collects and review baseline data
- Lab monitors for trends
- Review night shift staffing matrix
- Assess specimen transit process after STAT collection

**DO**
- Open a part time 1 night shift lab assistant
- Lab assistant reporting re-alignment
  - Consistently report/review performance measure for the quality indicator

**CHECK**
- Lab staff collects data
  - Monitor trends for turn around time improvement
- Review data in 6 months

**ACT**
- Hired and trained night shift lab assistant
### Calling of Lab Results on Abnormal Assays for Patients with Pre-operative Procedures

<table>
<thead>
<tr>
<th>Situation</th>
<th>The lab had not met 100% Pre-op Call Compliance for the past 6 months beginning July 2020.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Background</td>
<td>The laboratory calls defined abnormal laboratory assays on pre-operative lab work to the ordering provider. The purpose of the call is to notify the providers of abnormal lab results for the appropriate patient management prior to surgery.</td>
</tr>
<tr>
<td>Assessment</td>
<td>The laboratory had challenges meeting target because of the following reasons: 1. Pre-op call list did not print daily due to printer problems. 2. No consistent practice of handoff between shifts 3. Challenges in contacting someone at the provider’s office</td>
</tr>
<tr>
<td>Recommendation</td>
<td>1. Address printer issues. 2. Set up a process to forward report print out to an alternate printer as a back up 3. Generate pending report daily to identify missed calls 4. Audit daily pre-op call list prints</td>
</tr>
</tbody>
</table>
PDCA: Calling of Lab Results on Abnormal Assays for Patients with Pre-operative Procedures

- Lab staff collects and review baseline
- Staff interview to review current state process and identify root cause

**PLAN**

- Implement new process training, and education identified

**DO**

- Review handoff procedure with staff
- Work with IT to set up an alternate printer for the daily report print outs as a back up
- Create a report to review pending daily pre op calls
  Educate staff on the pending report review process

**CHECK**

- Lab staff collects data
- Monitor trends for reductions
- Audit and feedback

**ACT**

- Lab staff collects and review baseline
- Staff interview to review current state process and identify root cause
ADDENDUM I
Pulmonary Services

Presented to Board Quality Review Committee

Gloria Austria, District Director Respiratory Care, EEG, LAB
Frank Bender MD  Medical Director
Kerwin Pipersburgh, District Manager Respiratory Care, EEG
Krysti Johnson, District Supervisor Respiratory Care, EEG
Chris Perez, District Supervisor Respiratory Care, EEG

June 23, 2021
FY 21 Accomplishments and Process Improvement Focus

Accomplishments

• New Spontaneous Breathing Trial went live
• Implementation of “B” = Breathing for A to F bundle
• Implementation of new blood gas analyzers
• Improved hand hygiene compliance
• Collaborated with NICU team to improve critical cord gas notification
• Decreased equipment rentals (ventilator, High flow, BiPAP)
• Increased ventilator and High flow equipment inventory
• Made it through COVID surge while running more than 68 vents

Process Improvement Focus

• Decrease Ventilator Associated Events (VAE)
  – Decreasing Infection-Related Ventilator-Associated Complication (IVAC) + rate across the district post COVID
**Ventilator Associated Events (VAE)**

<table>
<thead>
<tr>
<th>SITUATION</th>
<th>Increased number of ventilator days did impact ventilator associated events</th>
</tr>
</thead>
</table>
| BACKGROUND | Overall, Palomar Health’s VAE Q1 results are above threshold  
Ventilator days went up due to COVID in FY 2020  
Poway– ICU 1 IVAC+ SIR not calculated since predicted <1 for Q1 2021  
Escondido – 5W CCU 5 IVAC+ above threshold at SIR 1.842  
Escondido – 4SW TICU 2 IVAC+ below threshold at SIR 0.905  
Escondido – 6W CCU 5 IVAC+ above threshold at 3.581  
All patients except one with IVAC had COVID-19 |
| ASSESSMENT | All patients except one with IVAC had COVID-19  
With a decline in the COVID positivity rate we hope to get back to within threshold for our IVAC across the district |
| RECOMMENDATION | • Respiratory Care Practitioner (RCP) will continue to collaborates with the patient care team daily during rounds to discuss VAP bundle compliance  
• Continued collaboration with physicians to implement the new spontaneous breathing trial (SBT) as best practice  
• Continue to complete 30 VAP bundle audits a month at both campuses to validate compliance  
• Continue to monitor trends using the department quality dashboard  
• Review the root cause of the reported infections |
Ventilator Associated Events

- Respiratory continues to work collaboratively with our physician and nursing partners to reduce patient ventilator days across the district
- RCP staff education on scripting around VAP bundle during daily rounds

- New SBT Go-Live implemented
- Audits with real time feedback is given to practitioners
- Since implementation, positive outcomes have been seen.

- Education in this initiative was given to: RCPs, Nursing in CCU (Esc, Poway), IMC (Esc, Poway), UPC, CEC

- Review of VAE data and Ventilator days to monitor progress
- Monitor trends using the department quality dashboard

- We are continuing to measure VAP bundle during rounds across the district
  - We are continuing to enforce spontaneous awakening trial (SAT) and spontaneous breathing trials, (SBT)
Escondido VAP Bundle Compliance

- DVT prophylaxis initiated
- HOB 30-45 degrees
- Oral Care with CHG
- Daily awakening trial initiated
- Daily spontaneous breathing trial initiated
- PUD prophylaxis initiated

2020Q1  2020Q2  2020Q3  2020Q4  2021Q1
Action Steps

• New Spontaneous Breathing Trial (SBT) Cerner Implementation is complete (4/1/2021)
  ✓ Structured Cerner documentation to track compliance
  ✓ Staff/physician education in progress
  ✓ Monitor documentation compliance (add to RCP quality indicator)

• Respiratory Care Practitioner (RCP) collaborates with the patient care team daily during rounds to discuss VAP bundle compliance

• RCP staff education on scripting around VAP bundle during daily rounds

• Continue to perform 30 VAP bundle audits a month at both campuses to validate compliance
Thank you
ADDENDUM J
HCAHPS and ED Customer Service Data
Presented to Board Quality Review Committee

Mel Russell RN, MSN   CNO
Joyce Volsch PhD, MS, RN, NEA-BC   CNO
Tricia Kassab EdD., RN, FACHE, CPHQ, HACP  VP Quality/Patient Safety

June 2021
| SITUATION | Customer Service Inpatient Data: Timeframe April 2020 – March 2021  
Customer Service ED Data: Timeframe April 2020- March 2021 |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>BACKGROUND</td>
<td>The HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) Survey, also known as the CAHPS® Hospital Survey or Hospital CAHPS®, is a standardized survey instrument and data collection methodology that has been in use since 2006 to measure patients' perspectives of hospital care.</td>
</tr>
</tbody>
</table>
| ASSESSMENT | **PMC Escondido Inpatient** - 2/10 metrics above CMS benchmark or close to CMS benchmark (Overall Rating of Hospital and Would Recommend Hospital).  
**PMC Poway Inpatient** – The following metrics at Poway are above the CMS benchmark for 1-2 quarters (Communication with Nurses/Doctors, Discharge Information and Care Transitions).  
**PMCE Emergency Department** – 4/4 metrics below the National Research Corporation (NRC) benchmark. Although Imaging exceeded expectations above the benchmark the last quarter.  
**PMCP Emergency Department** – 2/4 metrics above or slightly below NRC benchmark (Imaging exceeded expectations, Would Recommend) whereas 2/4 below NRC benchmark (Rate Facility, Seen in a Timely Manner). |
| RECOMMENDATION | **PMC Escondido** is focused on 3 metrics with the lowest scores and highest correlation to overall rating and likelihood to recommend: Get help as soon as wanted; staff took preferences into account and understood how to manage health.  
- Focus on rounding on patients – leaders prioritize new admissions and discharges/ED targets 20 patient rounds per day and RN/MD leader round  
**PMCP** focus on communication with nurses and doctors and responsiveness  
- Focus on rounding on patients – leaders prioritize new admissions and discharges/ED targets 20 patient rounds per day and RN/MD leader round  
- Discharge calls within 24 hours; Timely service recovery |

Passion. People. Purpose.
Would Recommend Hospital

![Graph showingWould Recommend Hospital](image)

- FY20 Q4: 77.7 (n=716 (E), n=158 (P))
- FY21 Q1: 74.6 (n=717 (E), n=190 (P))
- FY21 Q2: 76.5 (n=714 (E), n=168 (P))
- FY21 Q3: 74.5 (n=659 (E), n=151 (P))

Quarter:
- PMC Escondido HCAHPS
- PMC Poway HCAHPS
- CMS HCAHPS Average

Passion. People. Purpose.
Responsiveness of Hospital Staff

![Graph showing responsiveness of hospital staff over different quarters with data points for FY20 Q4, FY21 Q1, FY21 Q2, and FY21 Q3.]

- FY20 Q4: n=672 (E), n=147 (P)
- FY21 Q1: n=661 (E), n=177 (P)
- FY21 Q2: n=669 (E), n=157 (P)
- FY21 Q3: n=609 (E), n=147 (P)

- PMC Escondido HCAHPS
- PMC Poway HCAHPS
- CMS HCAHPS Average
Communication with Doctors

<table>
<thead>
<tr>
<th>Quarter</th>
<th>PMC Escondido HCAHPS</th>
<th>PMC Poway HCAHPS</th>
<th>CMS HCAHPS Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY20 Q4</td>
<td>76.5 (E)</td>
<td>79.4 (E)</td>
<td>82.0</td>
</tr>
<tr>
<td></td>
<td>n=722 (E)</td>
<td>n=726 (E)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>n=160 (P)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FY21 Q1</td>
<td>78.9 (P)</td>
<td>79.5 (P)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>n=191 (P)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FY21 Q2</td>
<td>77.6 (P)</td>
<td>83.2 (P)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>n=167 (P)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FY21 Q3</td>
<td>78.4 (P)</td>
<td>82.0 (E)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>n=663 (E)</td>
<td>n=720 (E)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>n=153 (P)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: E indicates expected performance, P indicates performance.
Room Kept Clean During Stay

<table>
<thead>
<tr>
<th>Quarter</th>
<th>PMC Escondido HCAHPS</th>
<th>PMC Poway HCAHPS</th>
<th>CMS HCAHPS Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY20 Q4</td>
<td>65.3</td>
<td>63.7</td>
<td>76.0</td>
</tr>
<tr>
<td>FY21 Q1</td>
<td>68.3</td>
<td>63.9</td>
<td>76.0</td>
</tr>
<tr>
<td>FY21 Q2</td>
<td>68.0</td>
<td>67.5</td>
<td>76.0</td>
</tr>
<tr>
<td>FY21 Q3</td>
<td>64.3</td>
<td>63.6</td>
<td>76.0</td>
</tr>
</tbody>
</table>

n=720 (E)  n=723 (E)  n=718 (E)  n=653 (E)
n=160 (P)  n=191 (P)  n=166 (P)  n=154 (P)
Discharge Information

<table>
<thead>
<tr>
<th>Quarter</th>
<th>PMC Escondido HCAHPS</th>
<th>PMC Poway HCAHPS</th>
<th>CMS HCAHPS Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY20 Q4</td>
<td>86.0</td>
<td>87.8</td>
<td>87.0</td>
</tr>
<tr>
<td>n=661 (E)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n=143 (P)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FY21 Q1</td>
<td>86.0</td>
<td>86.0</td>
<td>87.0</td>
</tr>
<tr>
<td>n=662 (E)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n=184 (P)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FY21 Q2</td>
<td>86.0</td>
<td>86.0</td>
<td>88.7</td>
</tr>
<tr>
<td>n=678 (E)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n=159 (P)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FY21 Q3</td>
<td>85.2</td>
<td>87.9</td>
<td>87.0</td>
</tr>
<tr>
<td>n=633 (E)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n=141 (P)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Care Transitions

<table>
<thead>
<tr>
<th>Quarter</th>
<th>PMC Escondido HCAHPS</th>
<th>PMC Poway HCAHPS</th>
<th>CMS HCAHPS Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY20 Q4</td>
<td>49.5</td>
<td>50.4</td>
<td>54.0</td>
</tr>
<tr>
<td></td>
<td>54.0</td>
<td>54.0</td>
<td>54.0</td>
</tr>
<tr>
<td>FY21 Q1</td>
<td>51.5</td>
<td>50.2</td>
<td>55.9</td>
</tr>
<tr>
<td>FY21 Q2</td>
<td>51.5</td>
<td>51.5</td>
<td>55.9</td>
</tr>
<tr>
<td>FY21 Q3</td>
<td>48.5</td>
<td>48.1</td>
<td>53.6</td>
</tr>
<tr>
<td></td>
<td>54.0</td>
<td>54.0</td>
<td>54.0</td>
</tr>
</tbody>
</table>
Emergency Department

*Results current as of 05/21/2021*
Were You Seen In A Timely Manner

<table>
<thead>
<tr>
<th>Quarter</th>
<th>PMC Escondido ED</th>
<th>PMC Poway ED</th>
<th>NRC Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY20 Q4</td>
<td>46.2</td>
<td>45.1</td>
<td></td>
</tr>
<tr>
<td>n=2,786 (E)</td>
<td>n=827 (P)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FY21 Q1</td>
<td>46.1</td>
<td>41.8</td>
<td></td>
</tr>
<tr>
<td>n=3,340 (E)</td>
<td>n=1,035 (P)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FY21 Q2</td>
<td>46.3</td>
<td>40.8</td>
<td></td>
</tr>
<tr>
<td>n=2,680 (E)</td>
<td>n=760 (P)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FY21 Q3</td>
<td>46.4</td>
<td>37.9</td>
<td></td>
</tr>
<tr>
<td>n=2,700 (E)</td>
<td>n=751 (P)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Quarter: FY20 Q4, FY21 Q1, FY21 Q2, FY21 Q3

- PMC Escondido ED
- PMC Poway ED
- NRC Average

Top Box Percentage