SV Continuous Quality Improvement Agenda & Minutes

Date and Time: 01/15/2026, 1430-1600 Location: Virtual - Microsoft Teams
Meeting ID: 226 320 768 700 7 Passcode: FD2sx9CB
Facilitator: Scott Berry
Co Facilitator: Alex Olivera

1. **Introductions**
    a. No introductions made.
2. **Call to order**
    a. 2:31 pm
3. **Approval of Agenda or modifications**
    a. Approver/Second: Dr. Skotzko/Cyanne
4. **Approval of Minutes**
    a. December Minutes
    b. Approver/Second: Dr. Skotzko/Tyler
5. **Review of Action Items**
    a. Per Dr. Skotzko, "safety planning" is the preferred language as opposed to "contracting" In the S&R Reports. **Kelsey** to implement that language in future presentations **– Complete**
    b. Patients' Rights Advocate Monitoring: Certification Hearing Results: Confirm if contract with Smith Waters Group is fully executed. **Paul** to discuss adding requirement in the contract to submit reports with Certification Hearing Results to SV-CQI with Emi.
        i. Up and running. Trying to schedule a meet and greet with Smith Waters Group to answer questions and provide SV with an overview of what they are doing & how they are doing it. A good line of communication is needed for contacting them. There has been trouble reaching them. A phone line that does not go to voicemail is needed. Jessica sent questions to Paul that have been forwarded to the Smith Waters Group. Hopefully a response is received, and Paul will disseminate the information. More to come.
    c. **Scott Irvin & Dr. Skotzko** to collaborate on identifying a way to inform the Inpatient MDs of outstanding charts to be completed and signed while they are on call to avoid multiple email requests while they are out of the office.
        i. Scott Irvin & Dr. Skotzko both did a follow up & spoke to SV Ward Clerks. Dr. Skotzko & Scott are vigorously working to help SmartCare work to the highest level of its abilities. If more of the treatment planning is done in SmartCare, & the MDs to learn how to utilize the message function, messages can be sent to the MDs. The messages show up in widgets on the desktop. It is a great way for the MDs to have the ability get required tasks done before they leave versus getting notified after they've gone & wait for tasks to be completed

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when they come back for their rotation. To be discussed further at the SV Manger's Meeting. Follow up progress at next month's SV CQI meeting.

d. Dietary Monitoring Report – Dietician (**Ashlyn Taylor**) Report was not presented in the December meeting. **– Complete**
   i. Accuracy of dietary rand card: 83%
   ii. RDN was notified of Nutrition Screens of "5" or more within 24 hours: 70%
   iii. RDN Response within 24 hours: 71%
   iv. Correct label and dating and dented can removal: 70%
   v. 100% in three categories:
      1. Percentage of high-risk patients with a dietary questionnaire completed,
      2. Dietary staff correctly fills out quaternary ammonium logs
      3. Monthly dietary and food quality control inspections completed by RDN
   vi. Work needed to increase numbers in categories 1, 2, 3 & 7 of report.
      1. To improve numbers 1, 2, and 3 Tyler will initiate some education regarding the proper policy & procedure for the nutritional screening. An e-mail was sent out yesterday, to be followed up with an in-service training.
   vii. Action Item: Scott Berry to identify the performance goal ranges for the Dietary Monitoring Report. Possibly part of SV Indicator Dashboard.

e. QI Tracking Forms – Gina
   i. All QI-55 Tracking forms for SV have been resolved.

f. General Discussions around shared communications that need to be communicated to larger groups i.e. Audit, Staffing Changes that need to be reported to DHCS, Program changes etc.

6. Monthly Agenda Item

a. Seclusion and Restraint – Kelsey
   i. S&R Log
      1. Six patients with Nine S&R events in December 2025
         a. 1st patient with two separate events on 12/2
            i. 2nd event was from 3:10-6:25, & lasted 3 hours & 15 minutes, which is long. Further evaluation determined that the patient was being hostile & threatening to

staff, slamming doors, pulling on the nursing station window, and swung their fist at an RN. Resulting in patient being placed into S&R for danger to others. During that time the patient continued to yell & threaten to hurt staff. It is documented in the 15-minute RN checks, that release criteria was repeatedly explained to patient, but they continued to be hostile & threatening to staff until 6:25 when they were able to plan for safety.

b. 2nd patient with one event on 12/2
c. 3rd patient with two separate events on 12/3
d. 4th patient with two separate events on 12/6 & 12/9
e. 5th patient with one event on 12/29
f. 6th patient with one event on 12/31

ii. S&R Dashboard

1. 73 minutes was the Average Minutes in Seclusion for Dec. 2025. Which is above the 45-minute goal, and an increase from last month's Average of 27 Minutes in Seclusion.
    a. Overall Mean (Average) Minutes in Seclusion Jan. 2024 - Dec. 2025 is 45 with a Median of 39
2. 42 minutes was the Average Minutes in Restraints for Dec. 2025. Which is just under the 45-minute goal. This is also a from last month's Average of 28 Minutes in Restraints.
    a. Overall Mean (Average) Minutes in Restraints Jan. 2024 - Dec. 2025 is 39.2 with a Median of 37.5

b. Infection Control– Pamela
    i. December 2025: 18 admissions, 4 patient report of potential infections, 3 patient with 3 actual infections.

c. Medical Staff Credentialing Report – Teresa
    i. No New (Initial Appointments)
    ii. Reappointments
        1. Rajdip Barman, MD - SV/CSU: Approved 12/31/25
        2. Julienne Aulwes, MD – Adult OP Med Clinic: Approved 1/7/26

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3. Panrapee Mahautmr, MD - SV/CSU: Surveys sent 1/9/26. Probably will not be presented until February.

d. Medical Record Reports – Scott Irvin
   i. Chart Completion Report
      1. On a 13 Week streak of having 100% rate of chart completion within 14 days post discharge.
      2. Dec. 2025
         a. Average days to audit a chart after discharge: 3
         b. Average days to complete a chart after discharge: 10
      3. Jan. 2026
         a. Charts waiting to be audited: 3
         b. Audited charts waiting for completion: 5
         c. Incomplete Charts 14 days after discharge: 0
      4. Action Item: Scott Irvin to add columns to report form to record average of days taken to complete a chart monthly, and average of days taken to audit charts monthly.

7. Quarterly Agenda Items

a. SV Staff Training Completion Report FY 25-26 Q2 – Alex Olivera
   i. Complied based on assigned courses in Relias, not on CEU Requirements.
      1. Psychiatrists 87% (Down from 95% in Q1)
      2. MH Worker
         a. CSU MH Worker 88% (Up from 58% in Q1)
         b. SV MH Worker 30% (Down from 34% in Q1)
      3. SV Nursing 68% (= to Q1)
      4. MH Clinician
         a. Discharge Planner 100% (= to Q1)
         b. Supervising MH Clinician 100% (Up from 50% in Q1)
         c. BH Clinician I 100% (Up from 20% in Q1)
         d. BH Clinician II 63% (Up from 20% in Q1)

b. Morbidity and Mortality Report and Reviews – Mariette Franklin
   i. Dr Skotzko to recommend minor changes to the policy and how M&Ms are done presently. Currently the cases are reviewed by the medical director & then one of the other OP Psychiatrist's. There is not a current process requiring Jail or Inpatient MDs to participate in reviews. Would like to expand

process to make sure that M&Ms get reviewed by all providers that attend the medical staff meetings. From there Dr. Skotzko would complete the M&M review form & submit it to Emi for signature.

1. Action Item: Alex to schedule meeting with Mariette and Dr. Skotzko to discuss potential changes to the tracking and reporting.

ii. Dr. Skotzko is currently working on reviewing five cases. To better understand whether each case was avoidable or not, she's trying to make sure to include any areas that systems issues may have had an impact, if there is a loss of follow-up, or if there is lack of documentation.

iii. Qtr. 2 FY 25-26 - 2 New cases necessitating M&M Review

1. 2 Death M&Ms, 0 Jail M&Ms
    a. 2 Death M&Ms, & 0 Jail M&Ms are pending assignment.
        i. 2 Last contact Outpatient, 0 Last contact Inpatient
        ii. 0 Deaths within 30 days of SV Discharge
        iii. 2 Death within 30 Days of BH Encounter
        iv. 1 Cases with Simple Departure from Standard of Care, 3 with Insufficient documentation
2. 15 Cases Assigned/In Progress
    a. 10 Death M&Ms, & 5 Jail M&Ms are pending assignment.
3. 9 of Previous Open Cases Complete in Q2 have been closed
    a. 6 M&M Review Recommendations from closed reviews
4. 4 QI Tracking forms issued for deficiencies
    a. 1 closed 10/15/25, 3 open

c. Acute Transfers – Mariette Franklin

i. FY25-26 Q2: (2) acute care transfers, (1) labs hypernatremia 116, (1) hypotension and bradycardia

ii. Acute Transfers used to be attached to the M&M Report. Alex is working on making a standalone Acute Transfer report.

d. Peer Review: Psychiatric Prescriber/MDs – Scott Berry

i. Currently not having success in getting completed reviews back from MDs. Dr. Skotzko spoke to functionalities within SmartCare that can be utilized for the peer review process. Actively trying to figure out a better way than asking MDs to go into SmartCare & review cases. Moving forward to try to figure out

a way where MDs will respond & QI will be able to get the data needed versus just showing continued disengagement.

ii. Action Item: Dr. Skotzko, Scott Berry, and Scott Irvin to collaborate to figure out a better way to do to do evaluation of physicians for peer reviews.

e. SV Patient Satisfaction Report – Alex Olivera
   i. 24 Surveys and comments received in the Q2 which is slightly lower than 27 in Q1.
   ii. 9 of 10 metrics remained above the 72% HPL
   iii. Response Rate increased slightly for the quarter to 40% in Q2 but still lower than FY24-25 47% average.
   iv. Comments were largely positive this quarter with 85% selecting positive scores. Patients selecting best possible score up from 50% in Q1.
      1. 7 of 10 Questions Positive Responses improve or increased from Q1 values.
      2. Question 1 Positive Responses increased from 70% on Q1 to 100% in Q2
      3. Question 2 Positive Responses increased from 61% on Q1 to 73% in Q2
      4. Question 6 Positive Responses increased from 56% on Q1 to 80% in Q2
   v. Questions 2, 3 & 7 Negative Responses increased over 10%
   vi. 8 or 10 Questions Negative Responses improved from Q1 values.
   vii. Question 2 Negative Responses remain above the performance goal at 12% in Q2 but show great improvement from 22% in Q1
   viii. Question 3 Negative Responses remain above the performance goal at 15% in Q2
   ix. Question 7 Negative Responses remain above the performance goal at 12% in Q2 but show improvement from 16% in Q1
   x. Questions 2, 5, 6, 8, & 9 Neutral Responses increased or remained over 15%
   xi. Starting Jan. 1, 2026, there has been a transition to using the CMS PIX Survey in lieu of the SV Patient Satisfaction Survey. Required to track CMS PIX Survey responses in relation to discharges.
      1. There have been nine discharges since Jan. 1st, but only 2 PIX forms have been received.

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2. Per explicit instructions in the new CMS process, surveys should not be entered in the patient's chart. All surveys whether they were fully completed or not, should be submitted to QI via the SV Comment box in the Day Room.
    a. Action item: Update SV-21 SV Discharge Checklist by adding new CMS PIX Survey.
    b. Action item: Remove SV Patient Satisfaction Surveys (Spanish & English) from DHHS Bulletin Board. Complete MR T to upload CMS PIX Surveys (English & Spanish when translation is complete) to DHHS Bulletin Board.

f. Medication Reconciliation- Amy Giacomini
    i. Reviewed 30 Charts. Numbers were very good this month.
        1. 100% of forms were initiated within 24 hours of admission, showing continued improvement over the last 2 quarters.
        2. 63% of charts had all required fields completed within 36 hours. Up from 33% last quarter.
        3. Improvement seen in staff documentation of last dose. Documented in 93% of charts which is a huge improvement from 46% in Q1.
        4. MD rationale for medication discrepancies was fully completed in 66% of the charts which is an improvement from Q1 at 24%.
            a. MD rationale for medication discrepancies is an area that requires continued focus for improvement.
        5. Action Item: Scott Berry to identify the performance goal ranges for the Medication Reconciliation Report. Possibly part of SV Indicator Dashboard.

8. Areas of Improvement Identified – See Action Items for more information
    a. Peer Review

9. Adjourn Time
    a. 3:40 pm

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Attendee	License	Job Title	Agency/Department
☒ Alex Olivera		Administrative Analyst	QI
☐ Amy Cone		QI Program Manager	QI
☒ Amy Giacomini	RN	Psychiatric Nurse	QI
☐ Annie Monroe	RN	Psychiatric Nurse	QI
☐ Ashlyn Taylor	RD	Registered Dietitian	SV
☒ Christine Skotzko*	MD	Medical Director	SV
☒ Cyanne Brocious*	RN	Director of Nursing	SV
☒ Edward Dudome		Administrative Analyst	QI
☒ Gina Turner		Medical Office Assistant	QI
☐ Jenn Katz		Administrative Analyst	SV
☒ Jessica Duke	LMFT	SV Hospital Administrator	SV
☐ Jimmy Cookman		Compliance and QA Administrator	QMS
☐ Kathryn Maguire	RN	Psychiatric Nurse	QI
☒ Kelsey Landis	RN	Psychiatric Nurse	QI
☐ Lily Pressnall	ASW	BH Clinician	QI/HCCF
☐ Mariette Franklin	RN	Psychiatric Nurse	QI
☒ Pamela Prindle	RN	Infection Control Nurse	SV
☒ Paul Bugnacki*	LCSW	Deputy Director	BH Admin
☒ Robert Lopez		Administrative Analyst	QMS
☒ Scott B. Irvin*		Medical Records Manager	Medical Records
☒ Scott Berry		Administrative Analyst	QI
☒ Stefan Sayles-Croy		Administrative Analyst	BH Admin
☒ Teresa Domingo-Chase		Executive Secretary	Medical Staff
☐ Teri Vodden	LCSW	Senior Program Manager	Adult OP
☒ Tobias Griggs*	LCSW	Supervising M H Clinician	SV
☒ Tyler Gibson	RN	Assistant Director of Nursing	SV
☒ Wendy Choate	BASW	Administrative Secretary	SV

*Denotes Committee Member

Minutes by:	Gina Turner
Signature and Date of QIC or designee:	
Distribution date:	