SVHCD QUALITY COMMITTEE
AGENDA
WEDNESDAY, APRIL 25, 2018
5:00 p.m. Regular Session
(Closed Session will be held upon adjournment
of the Regular Session)

Location: Schantz Conference Room
Sonoma Valley Hospital – 347 Andrieux Street, Sonoma CA 95476

AGENDA ITEM	RECOMMENDATION	
In compliance with the Americans with Disabilities Act, if you require special accommodations to attend a Quality Committee meeting, please contact the Interim District Clerk, Vivian Woodall, at vwoodall@svh.com or 707.935.5005 at least 48 hours prior to the meeting.		
MISSION STATEMENT The mission of the SVHCD is to maintain, improve, and restore the health of everyone in our community.		
1. **CALL TO ORDER/ANNOUNCEMENTS**	*Hirsch*	
2. **PUBLIC COMMENT SECTION** At this time, members of the public may comment on any item not appearing on the agenda. It is recommended that you keep your comments to three minutes or less, Under State Law, matters presented under this item cannot be discussed or acted upon by the Committee at this time For items appearing on the agenda, the public will be invited to make comments at the time the item comes up for Committee consideration.	*Hirsch*	
3. **CONSENT CALENDAR** • Minutes 03.28.18	*Hirsch*	Action
4. **SVH FOUNDATION PRESENTATION**	*Pier*	Inform
5. **POLICIES & PROCEDURES**	*Jones*	Action
6. **QUALITY REPORT**	*Jones*	Inform/Action
7. **UPON ADJOURNMENT OF REGULAR OPEN SESSION**	*Hirsch*	
8. **CLOSED SESSION:** a. Calif. Health & Safety Code § 32155 Medical Staff Credentialing & Peer Review Report b. Calif. Health & Safety Code § 32155 Root Cause Analysis **c.** Calif. Health & Safety Code § 32155 California Dept. of Public Health Deficiencies	*Jones*	Action
9. **REPORT OF CLOSED SESSION**	*Hirsch*	Inform/Action
10. **ADJOURN**	*Hirsch*	

3.

CONSENT

SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
March 28, 2018, 5:00 PM
MINUTES
Schantz Conference Room

Members Present	Members Present cont.	Excused	Public/Staff
Jane Hirsch	Michael Mainardi, MD	Howard Eisenstark, MD	Mark Kobe
Peter Hohorst	Michael Brown, MD	Cathy Webber	Danielle Jones
Carol Snyder		Kelsey Woodward	Chris Kutza
Susan Idell			
Ingrid Sheets			

AGENDA ITEM	DISCUSSION	ACTION
1. **CALL TO ORDER/ANNOUNCEMENTS**	*Hirsch*	
	Meeting called to order at 5:02 pm	
2. **PUBLIC COMMENT**	*Hirsch*	
	None	
3. **CONSENT CALENDAR**	*Hirsch*	Action
• QC Minutes, 02.28.18		**MOTION:** by Mainardi to approve, 2nd by Idell. All in favor.
4. **340B DRUG DISCOUNT PURCHASING PROGRAM**	*Kutza*	Inform
	Hospitals must recertify every year for the 340B program. Only eligible patients receive these drugs.	
	This program resulted in a drug cost reduction of $355,000 in 2017 offset by additional expenses of $45,000 due to the complexity of the program. For ex., Remicaid, which is an outpatient infusion drug for Crohn's disease used to cost over $1 million and the cost is now down to $200,000. Unfortunately, Crofab for rattlesnake bites is not covered.	
5. **MED/SURG PATIENT CARE SERVICES REPORT**	*Kobe*	Inform
	Mr. Kobe gave the Medical/Surgical report. The 20 bed unit is used for a variety of acute patients with	

AGENDA ITEM	DISCUSSION	ACTION
	respiratory, cardiac, gastro, and neuro conditions as well as surgical procedures. Outpatient infusion is also done here (using about four of those beds), often for antibiotic therapy. The unit can accommodate up to 10 cardiac telemetry patients. Inpatients have been averaging around 8-10 per day. He also discussed staffing on the unit and quality metrics. Patient satisfaction/HCAHPS scores are taken from surveys sent to Medical/Surgical patients who are discharged home.	
6. **POLICIES & PROCEDURES**	*Jones*	Action
	Ms. Jones reviewed each of the policies.	**MOTION:** by Mainardi to approve, 2nd by Idell. All in favor.
7. **QUALITY REPORT**	*Jones*	Inform
	Ms. Jones and the Committee discussed the migration from manual quality dashboards to electronic. Committee members wanted to see the dashboard prior to the meeting, thought the screen was very difficult to see, and they also spent a great deal of time getting the dashboard where they wanted it. The electronic version would need to include those changes. It was agreed that both versions would be tried in April.	
8. **UPON ADJOURNMENT OF REGULAR SESSION**	*Hirsch*	
	Regular session adjourned at 6:25 p.m.	
9. **CLOSED SESSION** • Calif. Health & Safety Code § 32155 Medical Staff Credentialing & Peer Review Report	*Jones*	Action
10. **REPORT OF CLOSED SESSION**	*Hirsch*	Inform/Action
		MOTION: by Mainardi to approve credentialing, 2nd by Idell. All in favor.
11. **ADJOURN**	*Hirsch*	
	Meeting adjourned at 6:33 p.m.	

4.

SVH FOUNDATION PRESENTATION
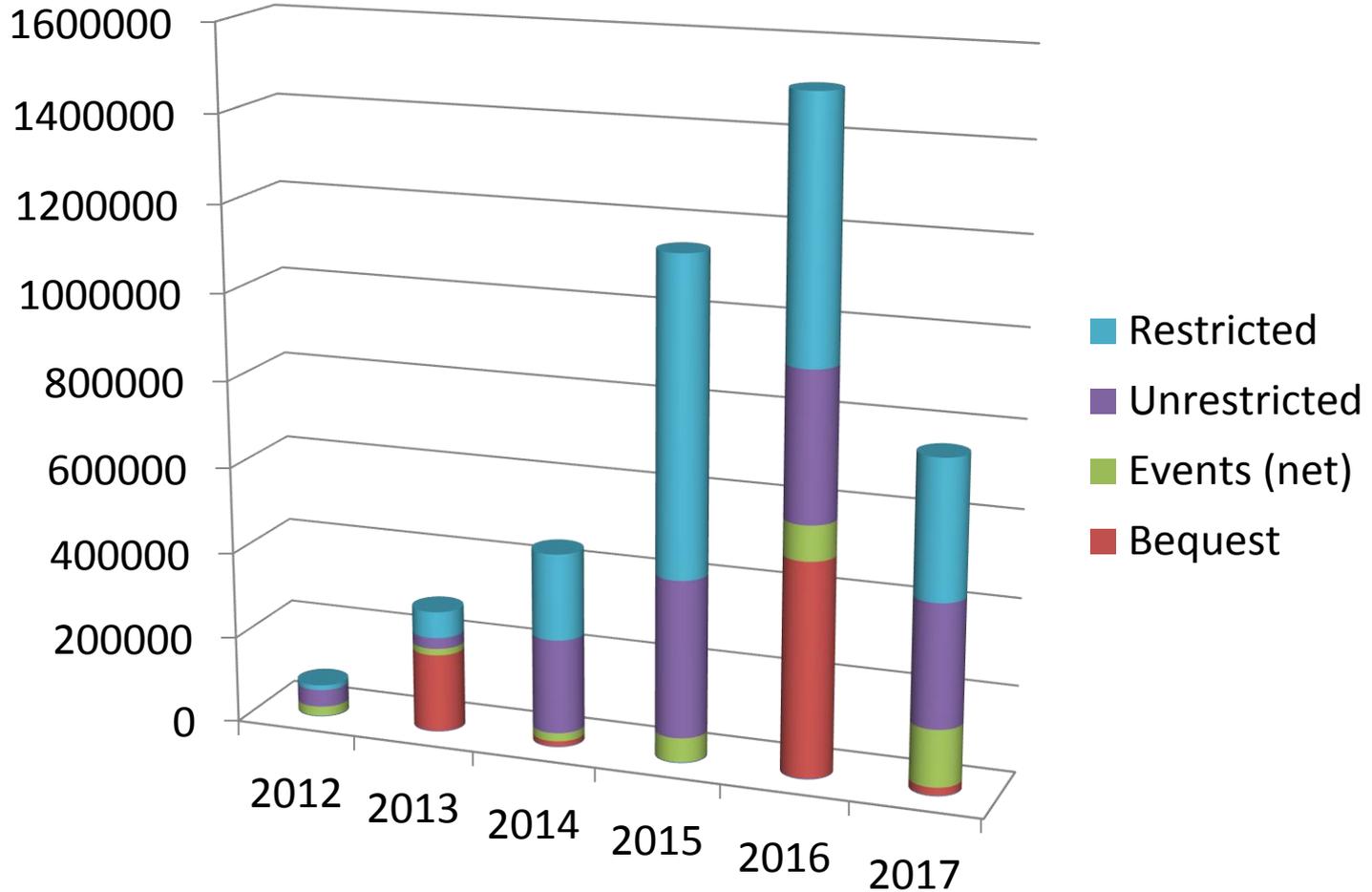
SVHF Progress & Goals

SONOMA VALLEY HOSPITAL
FOUNDATION
Inspiring Support for Sonoma Valley Hospital

SVHF Teamwork

- Board of volunteers

- Staff

- Relationship with SVH

Recent Accomplishments

- **Recently raised funds that have paid for:**
  - ➢ Stryker System in surgery suites
  - ➢ Women's Health equipment—Neoprobe, Hysteroscope
  - ➢ A Woman's Place remodel, equipment, and marketing needs to get started
  - ➢ Preparation and planning costs for the ODC Capital Campaign.
  - ➢ Construction costs for 3D Mammo placement at SVH.
  - ➢ Continued Education for Nurses and SVH staff $31,000 in 2017
  - ➢ Free mammograms for uninsured women
  - ➢ IT System Upgrade
  - ➢ Small Equipment needs ($89k in 2017)
- Collected $1.2M of ER Campaign Pledges in 2017

Foundation Focus

- **ODC Capital Campaign**
- **Major gifts/significant foundations**
- **Stewardship**
- **Legacy Giving**
- **Marketing and Messaging**

Outpatient Diagnostic Center Capital Campaign

- Campaign Timeline
  - Lead Gifts (quiet phase)
  - Internal (Boards and Leadership)
  - Employee Gifts Division
  - Medical Staff Gifts Division
  - Community Campaign

- Progress To Date

QUESTIONS?

5.

POLICIES & PROCEDURES

Review and Approval Requirements

The SVH departmental/organizational policies and/or procedures on the attached list have been reviewed and approved by the following organizational leaders for meeting all of the following criteria. All of these policies and procedures are:

- Consistent with the Mission, Vision and Values of the Sonoma Valley Health Care District
- Consistent with all Board Policy, Hospital Policy and Hospital Procedures
- Meet all applicable law, regulation, and related accreditation standards
- Consistent with prevailing standards of care
- Consistent with evidence-based practice

We recommend their acceptance by the Quality Committee and that the Quality Committee forward them to the Sonoma Valley Health Care District Board with a recommendation to approve.

ORGANIZATIONAL

NEW (Full Policies are attached)**:**

Hospital Evacuation during Disaster EP8610-101

This policy was created in response to the recent fire storm disaster event.   A less formal evacuation policy was embedded in the EOP and was 'pulled' from that document and created as an important stand-alone policy. Evacuation of a facility is a complex process and a complicated decision making process that deserves its own guidelines.

Intravenous Insulin Infusion for Obstetrical Use 6171-193

This policy outlines the process for intravenous insulin for obstetrical use as Diabetic ketoacidosis (DKA) or inability to maintain glycemic control, may have antepartum indications for use of IV insulin infusion. In active labor, insulin infusions are used to maintain euglycemia to prevent neonatal hypoglycemia. It was written to have specific guidelines in place for obstetrical patients during labor, delivery and post-partum phase who have Diabetes Mellitus and Gestational Diabetes Mellitus type I and type II that will require an IV insulin drip.

Precipitous Delivery in A Woman's Place 6171-194

A precipitous delivery occurs when labor progresses rapidly and the infant is born within 3 hours of labor. This policy promotes a safe environment for the mother and infant when a delivery is imminent and the Obstetrician is not available in the hospital for the delivery. It covers the procedure for an ED physician to respond to A Woman's Place to deliver infants in this scenario.

REVISIONS:

Lipid Rescue for Local Anesthetic Toxicity MM8610-104

Upon review, contents of the Lipid Rescue Kit needed to include a filter and primary tubing. The policy has been updated to ensure that all of the main supplies needed during an emergency are present in the kit.

DEPARTMENTAL

Environmental Services Departmental Policies

Change Submission Summary Document is attached

PURPOSE:

To provide safety, guidance and direction to SVH staff and patients in the event of a disaster necessitating evacuation of existing patients.

Evacuation of a healthcare facility may be necessary following an emergency such as a facility fire or damage from a natural disaster such as an earthquake, wildfire or flooding. The decision to evacuate a healthcare facility will be based on the ability of the facility to meet the medical needs of the patients. Immediate threats to life, such as internal fires or unstable structures, will require emergent evacuation, while other situations may allow for a planned and phased evacuation.

POLICY:

An appropriate and available official must retain or be delegated the authority to order partial or full evacuation of the hospital. This authority may generally rest with the CEO, the Administrator On-Call (AOC), and/or the Incident Commander in an activation of the hospital Emergency Operations Plan (EOP). Safe evacuation from the organization's facility includes consideration of care and treatment needs of evacuees, staff responsibilities; transportation identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.

When potential or actual evacuation is first contemplated, the hospital should alert the local emergency medical services agency (LEMSA), Emergency Operations Center (EOC), and/or Medical Health Operational Area Coordinator (MHOAC) in accordance with the protocols established for emergency notification in the area. The LEMSA or EOC may assist the hospital with identifying and coordinating placement and transport of patients and other support while the hospital is preparing and staging for evacuation of patients in accordance with local plans and protocols. See Rainbow guide located in Command Center for contact numbers.

Because attending physicians may not be available for all patients involved in an immediate evacuation, it is anticipated that hospital-based physicians (for example, emergency, hospitalists, medical director) will coordinate with the sending and receiving hospitals. Medical record summaries should accompany each patient and the patients attending physician should be notified of the location of the patient. For SNF patients, send 48 hours of meds with them.

SUBJECT: Hospital Evacuation During Disaster	POLICY: EP8610-101
	PAGE 1
DEPARTMENT: Emergency Operations Plan	EFFECTIVE:
REVISED:	

PROCEDURE:

In most emergencies, a full evacuation of the hospital will not be required. Evacuation is generally considered as a last resort due to the complex needs and unstable nature of many hospital patients. An evacuation should only be ordered when it is absolutely necessary. For example, evacuation would be necessary when there is an imminent or potential unmitigated hazard that threatens patient and staff safety.

Once the decision has been made, the entire hospital shall be notified of the evacuation. Overhead pages, emails, text messages, phone trees, notification of news outlets, and other means of contacting employees and staff can be used.

When an evacuation is to occur, there are several additional key decisions that must be made quickly and communicated both internally to hospital employees and among external partner agencies:

1. Level and Type of Evacuation
2. Evacuation Time Frames (Immediacy of Evacuation)
3. Patient Prioritization During Evacuation
4. Building Evacuation Plans by Floors/Units
5. Assembly Point and Discharge Site Locations
6. Labor Pool Activation
7. Patient Tracking
8. Patient Destination Team Activation

1. **Level and Type of Evacuation**
   The scope of any evacuation can change over time depending on the nature and course of the event. Below is the full list of options for evacuation in order of increasing scope and severity:

   a. Shelter-in-place:
   This level of evacuation requires cessation of all routine activities in preparation for an impending threat, such as a hurricane or out of control fire storm. Specific preparations should be made to mitigate against the anticipated threat. In general during a no-notice event, patients, visitors and staff remain where they are until they receive further instructions. In most cases, the safest place for the patient is in his/her room. Closing doors/windows provides initial protection from fire, smoke, and other hazards. During a shelter-in-place response, preparations should also be taken to enable immediate evacuation of patients should the situation change and evacuation become necessary.

SUBJECT: Hospital Evacuation During Disaster	POLICY: EP8610-101
	PAGE 1
DEPARTMENT: Emergency Operations Plan	EFFECTIVE:
REVISED:	

For an event with notice, such as impending wild fire spread, numerous activities should be undertaken to mitigate risk and prepare to support patient care in a resource-constrained environment. These activities include rapidly discharging patients, increasing on-site staffing levels and securing extra food, linen, and supplies.

b. Horizontal Evacuation:
This level of evacuation involves moving patients who are in immediate danger away from the threat. Patients remain on the same floor of the hospital as the area that they are evacuating. Horizontal evacuation typically involves moving patients to an area of refuge in an adjacent smoke/fire zone or in some cases, at the opposite side of the building. Most evacuations of a single department or patient care unit can be done horizontally, which is the fastest option and has the simplest re-entry process. Evacuation of an entire building may even be accomplished horizontally if a floor of the evacuated building connects to another building such as the West Wing to the New Wing.

c. Vertical Evacuation:
This level of evacuation refers to the complete evacuation of a specific floor in a building. In general, patients and staff evacuate vertically towards ground level whenever possible. Moving patients and staff to lower levels helps to prepare for total or full evacuation of the hospital should the situation worsen. For most localized incidents, vertically evacuated patients and staff are sent to an area of refuge elsewhere in the hospital. During the vertical evacuation of one floor, other floors may be ordered to shelter-in-place or prepare only for their own evacuation.

d. Total or Full Evacuation:
This level of evacuation is used only as a last resort and involves a complete evacuation of the facility. There are many different ways that a total or full evacuation can be planned for and managed.

2. **Evacuation Time Frames (Immediacy of Evacuation)**

The time frame for evacuation may be different depending on the nature of the threat and how much time can be taken to prepare for moving patients. The chart below contains specific orders that may be used:	
Example Evacuation Orders	
Immediate/Emergent:	No time for preparation – evacuate immediately

SONOMA
VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
Healing Here at Home

SUBJECT: Hospital Evacuation During Disaster	POLICY: EP8610-101
	PAGE 1
DEPARTMENT: Emergency Operations Plan	EFFECTIVE:
REVISED:	

Rapid/Urgent:	Limited time for preparation (1-2 hours) – everyone out in 4-6 hours
Gradual/Planned:	Extended time for preparation – phased evacuation to occur over many hours or even days
Prepare Only:	Do not move patients, but begin preparation for evacuation

3. **Patient Prioritization During Evacuation**
   - **Fully ambulatory patients** can be escorted down the stairs by staff members, assuring their footing and balance.
   - **Partially ambulatory and non-ambulatory patients** will be evacuated using the evacuation tools and equipment available in all stairwells (Evacuation chairs, sleds, etc).
   - **Post-partum patients**, if able, should be allowed to carry their **newborns** with them as they evacuate down the stairs. If more than one baby is to be evacuated, the "fire vest" can be used by the nursing staff to assist in the evacuation of the babies if needed.
   - **Laboring mothers** will be evacuated at the discretion of the physician and/or nursing staff.
   - **Patients in the ICU and/or patients on a ventilator** will be evacuated at the discretion of the physician, Chief Medical Officer or Chief Nursing Officer. The appropriate team members (nursing, respiratory therapy, transport) will be gathered to evacuate as necessary.
   - **Patients undergoing surgical procedures and anesthetized patients** will be evacuated at the discretion of the surgeon or physician.

4. **Building Evacuation Plans by Floors/Units**
   In the event of an evacuation, elevators should not be used. Evacuation Plan signs are posted throughout the hospital. Floors/units will evacuate the building as follows:

   - **Skilled Nursing Facility (SNF)** will evacuate via the 3rd Street West Door. If access to that door is blocked, evacuation can occur through the courtyard immediately outside the SNF Activity Room. Patients will be transported along Bettencourt Street to the front of the hospital
   - **Café** personnel will exit the building through the door immediately adjacent to their department and exit to 3rd Street West.
   - **Cardiopulmonary Department, Quality, and Medical Records** will exit to the ED parking lot through the door immediately outside the Cardiopulmonary Department.
   - **Risk Management, Speech Therapy, Administration, Foundation, Engineering and Occupational Health** will evacuate the building through the door to Bettencourt Street immediately outside the Foundation Office.

SUBJECT: Hospital Evacuation During Disaster	POLICY: EP8610-101
	PAGE 1
DEPARTMENT: Emergency Operations Plan	EFFECTIVE:
REVISED:	

- **West Wing** will evacuate using the North and South stairwells. Safest and closest exit stairwell on North or South end of the floor. Med Surg may also go to New Wing and exit if other stairwells are inaccessible.

  - **2 North** will use the North stairwell to 1st Floor and out of the building through Main Lobby or safest exit?
  - **2 South** will use the South stairwell to 1st Floor and out of the building
  - **ICU** (3rd Floor) will use the North stairwell to the lobby and out of the building
  - **Birth Center** (3rd Floor) will use the South stairwell to the lobby and out of the building
  - **Medical Imaging, Admitting, Laboratory, Nursing Administration and Human Resources** will evacuate the building through the lobby and out of the building
  - **Environmental Services, Information Systems and Pharmacy** (Basement level) will use the North stairwell to the first floor to the lobby and out of the building
  - **Materials Management** (Basement level) will use the South stairwell to the first floor to the lobby and out of the building

- Central Core departments (**Emergency Department, PBX)** will use the 4th Street exit or Andrieux Street exit and direct themselves to the front of the hospital.
- **Surgery, Surgical Care Unit, and Central Sterile will use the North stairwell** to Andrieux Street and direct themselves to the front of the hospital.
- In the case of ALL patient evacuation, the front parking lot immediately outside of the hospital lobby will be used for staging the evacuation of patients. The Emergency Department should only be used for staging if the front of the hospital is not accessible. The ED will be tasked with patient care and should not be the first choice for evacuation staging.
- Off Site Departments (**1st St. West, 462 WNS, Hwy 12 – PT/Finance**) Off-site locations may need to close their location in the event of a city-wide emergency or an event impacting their specific location. If it is a fire at their location, Hospital Command Center (HCC) may not be open.
- **Home Care** will evacuate their building if necessary through the front door of the building. The senior most staff member on duty will account for personnel and patients and report to the Hospital Command Center (HCC). The Home Care staff keeps a list of patients needing assistance in evacuation and can present that information to authorities if needed. These patients are not able to evacuate themselves and rely on the Home Care staff for their safety.

SUBJECT: Hospital Evacuation During Disaster	POLICY: EP8610-101
	PAGE 1
DEPARTMENT: Emergency Operations Plan	EFFECTIVE:
REVISED:	

5. **Assembly Point(s) and Discharge Site Locations**
The Incident Command Center shall identify several locations surrounding the hospital that could be used as either an Assembly Point or a Discharge Site.

   a. Assembly Point:
   The place, or set of places, where patient care units gather (outside the main clinical buildings of the hospital) to receive basic care and await transfer, or re-entry back into the hospital. Internal locations should be considered if circumstances outside the hospital prohibit safe transport. ***The Assembly Point(s) should not be a comprehensive field hospital. The Assembly Point(s) should be designed as a holding area with only essential care resources needed to support patient care while patients await transportation assets to leave the hospital grounds.***

   b. Discharge Site:
   The place where patients who are being discharged home wait for family or friends to pick them up. Ideally, the Discharge Site is located at some distance away from the Assembly Point to minimize traffic congestion and competition for roadways. It is important to consider proximity and size when determining suitable Assembly Point and Discharge Sites. An Assembly Point that is close to the hospital can aid in the effort to relocate fragile patients during an evacuation; however, a short distance between the Assembly Point and the hospital may also be of concern for any event involving an explosive device, chemical hazards, or other potentially expansive threat that is acting upon the hospital. Ideally, both the Assembly Point and Discharge Site will permit sheltering indoors. It is also important to remember economies of scale when choosing assembly points and discharge sites. It is much more difficult for clinical support services, including Pharmacy and others, to support patient care in multiple locations. ***Several nearby sites should be identified, in the event of an emergency, these sites should be contacted immediately.***

6. **Labor Pool Activation**
Evacuation is an enormously labor-intensive process. Using the hospital Emergency Operations Plan (EOP), the Labor Pool should be activated immediately to identify and assign staff to support the evacuation. The Labor Pool may need to call in staff from home for any evacuation, but is much more likely to need to do so if an evacuation happens on the evening shift, the night shift, during a weekend or holiday. At a minimum, the Labor Pool should be put on standby if staff may need to be called into the hospital to support operations. Standby lists should include both clinical and general staff.

7. **Patient Tracking**
During an evacuation, a functional internal patient tracking system (even if simple and

paper-based) is crucial to provide clinicians, families, and leaders with situational awareness of the appropriate location and status of all patients throughout the event. A system that reports selected "check-in" and "check-out" data for patients at various touch-points in the process is ideal. Those touch-points include:

Check In Points	Check Out Points
Inpatient Census	Leaving the Patient Care Unit
Arriving at the assembly point	Leaving the assembly point
Arriving at the discharge point	Leaving the discharge point
Arriving at the staging point	Leaving the staging point
Arriving at the receiving facility	

8. **Patient Destination Team Activation**
   The Admitting Department may be tasked with the responsibility for the Patient Tracking function. Their role may include the following responsibilities:
   - Checking-in patients to both the Assembly Point and the Discharge Site
   - Discharging patients from both the Assembly Point and the Discharge Site
   - Updating patient location information in electronic information systems and/or using manual paper logs as backup
   - Providing routine patient tracking reports for the hospital EOC
   - Participating in the Patient Destination process
   - Providing reports with contact information for Social Service staff working in the phone bank
   - Notifying receiving hospitals when patients are en route
   - Contacting receiving facilities to confirm patient arrivals
   - Obtaining location and contact information data from the receiving hospitals for sending to clinicians and patient families

Public Information
Only the Public Information Officer (PIO) can talk to the media. The PIO function will be responsible for communicating information regarding transported patients to family members.

REFERENCE:
CIHQ 42 CFR 482.15 EP # 1-10 July 2017
California Hospital Association Hospital Preparedness Program, www.calhospitalprepare.org

OWNER:
Chief Executive Officer

SUBJECT: Hospital Evacuation During Disaster	POLICY: EP8610-101
	PAGE 1
DEPARTMENT: Emergency Operations Plan	EFFECTIVE:
REVISED:	

AUTHORS/REVIEWERS:
Mark Kobe, Chief Nursing Officer
Kimberly Drummond, Facilities Director

APPROVALS:
Policy & Procedure Team: 4/17/18
Board Quality Committee:
The Board of Directors:

SUBJECT: Intravenous Insulin Infusion for Obstetrical Use	POLICY: 6171-193
	PAGE 1
DEPARTMENT: A Woman's Place	EFFECTIVE:
REVISED:	

PURPOSE:

To outline the process for intravenous insulin for obstetrical use.

POLICY:

It is the policy of Sonoma Valley Hospital that a continuous intravenous regular insulin infusion may be administered by the registered nurse per provider order after the patient's blood glucose, type of insulin, concentration; dosage and route have been verified with another registered nurse.

The pharmacodynamics of IV Regular insulin are as follows (Govoni & Hayes, 1985):
1. Onset of Action: begins in 7 to 10 minutes
2. Peaks: in 25 minutes to 45 minutes
3. Duration: 1 to 2 hours

PROCEDURE:

Critical Point:

1. Diabetic ketoacidosis (DKA) or inability to maintain glycemic control may have antepartum indications to use IV insulin infusion. In active labor, insulin infusions are used to maintain euglycemia to prevent neonatal hypoglycemia.

2. In order to avoid an inadvertent bolus of insulin, consider using a dedicated line for insulin. Only Regular Insulin should be administered intravenously.

3. Other medications should be mixed in a non-glucose containing solution whenever possible.

4. The standard insulin infusion is 100 units Regular Insulin (u100) in 100 mL 0.9% NaCl (concentration 1 unit=1mL) which is prepared by Pharmacy.

5. The regular insulin solution is stable for up to 24 hours at room temperature. The IV insulin bag <u>along with IV tubing</u> must be changed every 24 hours. Record the date and time with your initials on the insulin solution label when a fresh bag of insulin solution is started.

6. Regular insulin may be absorbed by the IV bag and the plastic tubing and filters. To reduce the amount of insulin absorption by the container, **flush 20-30 mL** of the solution through the IV tubing prior to connecting the administration set to the patient each time the tubing is changed.

7. Maintenance IV fluids must be infused using an infusion device to insure accuracy of volume delivered. Consult the order for which type(s) are needed. Label insulin tubing at every injection port with insulin label located in labor rooms and the medication room.

    a. The goal of blood glucose control in labor is to keep BG between 70-110 mg/dL, with or without insulin treatment. NOTE: Hourly BG levels should only be measured with a hospital glucometer. Patient may use her own lancet if desired.

8. For labor or NPO patients, mainline IV solutions of LR and D5LR on infusion pump tubing should be set up. When to infuse each is dependent on provider orders but generally, LR infuses when BG > 130mg/dL and D5LR infuses when BG < 130mg/dL. An order may be obtained to maintain mainline IV solution as either LR/D5LR based on patient condition, not blood sugars. Patients in <u>active labor</u> are usually NPO or taking non-caloric fluids when on an insulin drip.

9. For antepartum or early labor patients that are still eating and on an insulin drip, usual mainline IV fluids is LR at 30 mL/hr and SQ insulin coverage is ordered for meal coverage.

    a. If the patient is eating, SQ insulin coverage should be given for meals in accordance with pre-labor dosing.

Step-By-Step Procedure:

1. Gather equipment:

    a. Infusion pump with at least 2 channels
    b. 3 sets of IV pump tubing
    c. 1 L LR and 1 L D5LR
    d. Standard insulin solution prepared by pharmacy (100 units regular insulin in 100mL NS)
    e. Blood glucose meter & strips
    f. Insulin labels

2. Start mainline IV with 1L LR using a 16 or 18 gauge angiocath at a rate per provider order. Label IV lines with insulin label. Start second peripheral IV line, use appropriate labels on IV lines as they go into the pump and into the IV ports.

SUBJECT: Intravenous Insulin Infusion for Obstetrical Use	POLICY: 6171-193
	PAGE 1
DEPARTMENT: A Woman's Place	EFFECTIVE:
REVISED:	

3. Follow the Intrapartum IV insulin infusion algorithm order in MAR. Suggested IV fluid orders for NPO/active labor patients: If maternal BG is < 130 mg/dl infuse D5LR at 100-125 mL/hr using an infusion pump. If BG is > 130 mg/dl initiate LR at 100-125 mL/hr using an infusion device.

4. Monitor BG levels every 30 minutes x 2 then check BG every hour for the duration of the infusion. Maintain BG levels between 70-110mg/dL for active labor patients or identified goal for others using the insulin infusion algorithm as ordered by the provider.

5. Check infusion site, infusion rate and amount infused every hour. Document infusion rate (dose in units) in the MAR and on the I&O Flowsheet in in the labor and delivery record and in Paragon in the I&O tab

6. Monitor patient for any signs or symptoms of hypoglycemia (i.e., sweating, weakness, hunger, trembling, palpitations, tachycardia, and headache, numbness of tongue or mouth, blurred vision, irritability, hallucinations, confusion). If patient has any of these symptoms, check blood glucose level and notify provider.

7. Treating hypoglycemia for the patient who is NPO or on non-glucose containing fluids:

    a. **BG < 50mg/dl and patient is unconscious:** Stop insulin infusion and notify rapid response team (including the attending Provider) STAT. Give D50 IV 25 mLs IV push. Increase Dextrose infusion to 200 ml/hr until BG > 70mg/dl. Check BG every 15 minutes until BG > 70 X 2. Restart insulin infusion per modified algorithm, which may require modification.
    b. **BG < 50mg/dl and patient is conscious:** Stop insulin infusion and notify MD. Increase Dextrose infusion to 200 ml/hour until BG > 70 mg/dl. Check BG every 15 minutes until BG > 70 X 2. Restart insulin infusion per modified algorithm, which may require modification.
    c. **BG < 70mg/dl but > 50mg/dl (conscious patient):** Stop insulin infusion and Notify MD. Continue D5 ½ NS or D5LR at 125 ml/hour. Check BG every 15 minutes until > 70 X 2. Restart insulin infusion per modified algorithm.

8. **Hyperglycemia**: >190 mg/dL notify MD for modification order. If target BG not achieved within four hours, MD should consider modification of the algorithm.

9. Maintain strict I & O; Urinalysis per provider order to check for ketones. Notify provider if ketones are moderate to large. (Consider checking ketones every eight hours.)

10. Hyperglycemia > 190 mg/dL notify MD for medication order. If target BG not achieved within four hours, MD should consider modification of the algorithm.

11. The insulin infusion is continued while the patient is in labor and/or during cesarean section.

APPENDICES:
Appendix A: IV Insulin Infusion Algorithm

REFERENCES:
UCSF Medical Center Administrative Policy, 6.09.09, Medication Management: Administration of Medication

The Birth Center at UCSF Benioff Children's Hospital Policy BC.09, Diabetes Management in Pregnancy

Inturrisi, M., Lintner, N.C., & Soren, K. (2013). Diabetic ketoacidosis and continuous insulin infusion management in pregnancy. In Troiano, N.H., Harvey, C.J., & Chez, B.F.(Eds.)

High-Risk and Critical Care Obstetrics, 3rd Ed. Philadelphia: AWHONN/Lippincott. Moore, T. R. (2004). Diabetes in pregnancy. In R. K. Creasy, R. Resnick, & J. D. Iams (Eds.). Maternal-Fetal Medicine, 5th Ed. Philadelphia: Saunders.

Palmer, D., & Inturrisi, M. (June 1992). Insulin Infusion Therapy in the Intrapartum Period. Journal of Perinatal & Neonatal Nursing.

OWNER:
A Woman's Place Manager

AUTHORS/REVIEWERS:
Sally Staples, A Woman's Place Manager
Paul Amara, MD, A Woman's Place Medical Director
Rebecca Hengehold, Registered Nurse
Danielle Jones, Director of Quality and Risk Management
Chris Kutza, Director of Pharmacy

APPROVALS:
Obstetrics Task Force: 1/23/18
Surgery Committee: 3/8/18
Medical Executive Committee: 3/15/18
Policy & Procedure Team: 3/20/18

SUBJECT: Intravenous Insulin Infusion for Obstetrical Use	POLICY: 6171-193
	PAGE 1
DEPARTMENT: A Woman's Place	EFFECTIVE:
REVISED:	

Medicine Committee: 4/12/18
Board Quality Committee:
The Board of Directors:

SUBJECT: Intravenous Insulin Infusion for Obstetrical Use	POLICY: 6171-193
	PAGE 1
DEPARTMENT: A Woman's Place	EFFECTIVE:
REVISED:	

Appendix A
IV Insulin Infusion Algorithm

Blood glucose (mg/dl)	Type 1 Insulin (units/hour)	GDM Insulin (units/hour)	Type 2 Insulin (units/hour)
< 70	No insulin	No insulin	No insulin
71-90	0.5	No insulin	No insulin
91-110	1.0	No insulin	1.0
111-130	1.5	1.0	2.0
131-150	2.0	2.0	3.0
151-170	2.5	3.0	4.0
171-190	3.0	4.0	5.0
>190	Call MD, check urine ketones	Call MD, check urine ketones	Call MD, check urine ketones

SUBJECT: Precipitous Delivery in the A Woman's Place	POLICY: 6171-194
	PAGE 1
DEPARTMENT: A Woman's Place	EFFECTIVE:
REVISED:	

PURPOSE:

To promote a safe environment for the mother and infant when a delivery is imminent and the Obstetrician is not available in the hospital for the delivery.

POLICY:

If the Obstetrician is not present for an immediate delivery, the RN will call the Emergency Department Physician to be on standby for the delivery.

PROCEDURE:

1. If a patient appears to be having a precipitous delivery, the RN will stay with the patient and call the Nursing Supervisor or another RN for back-up. The RN will have the Nursing Supervisor or 2nd RN call the Obstetrician to come for the delivery. At this time, the Emergency Department Physician will also be called to be in the room for standby.

2. The RN will encourage the patient to breathe through contractions.

3. If the patient is delivering the infant before the Obstetrician arrives, the Emergency Department Physician will perform the delivery with assistance from the RN.

4. If the Emergency Department Physician is unavailable, the RN will perform the delivery with assistance from the 2nd RN.

5. Call Pediatrician if clinically indicated or per OB RN's clinical judgment.

REFERENCES:
Lippincott Procedures. (2018, February 16). Emergency Delivery.

OWNER:
A Woman's Place Manager

AUTHORS/REVIEWERS:
Sally Staples, A Woman's Place Manager
Paul Amara, MD, A Woman's Place Medical Director
Christina Sullivan, MD, Pediatrician

SUBJECT: Precipitous Delivery in the A Woman's Place	POLICY: 6171-194
	PAGE 1
DEPARTMENT: A Woman's Place	EFFECTIVE:
REVISED:	

Ali Foster, RN

APPROVALS:
Obstetrics Task Force: 2/27/18
Surgery Committee: 3/8/18
Medical Executive Committee: 3/15/18
Policy & Procedure Team: 3/20/18
Medicine Committee: 4/12/18
Board Quality Committee:
The Board of Directors:

Change Submission Summary Document

Title of Document: Updates to Environmental Services Department Policies – Partial
New Policy or Revisions Written By: Kimberly Drummond, Director of Environmental Services

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8440-01: Age-Specific Competencies, Provision for – Change title to AIDET-Patient Relations Protocols
Age-specific competency no longer required. Changed content to reflect Hospital expectations for patient interactions. Very similar content.

8440-16: Cath Lab Cleaning – retire – SVH no longer operates a cath lab

8440-19: Cleaning Supplies and Chemicals – Updated with current chemicals, matrix for uses, dilution color for Ecolab dispensed chemicals and dwell times.

8440-35: Floor Care Procedures – Rewrite and combine several floor cleaning policies. The following policies shall be retired as a result.
8440-10: Bonnet Carpet Cleaning - retire
8440-13: Carpet Care – retire
8440-14: Carpet Cleaning Pro Extraction – retire
8440-15: Carpet Vacuuming – retire
8440-33: Finish Removal – retire
8440-34: Floor Care – retire
8440-95: Wet Floor Safety – retire

8440-36: Gift Shop Cleaning – retire – SVH no longer operates a gift shop

8440-41: Isolation Room Cleaning After Patient Discharge/Transfer
Change title to Patient Room Cleaning – Discharge/Transfer ISOLATION precautions. Changed titles for all patient room cleaning policies to be grouped together in binder for easier retrieval/review. Complete rewrite. Includes room clean pathway and steps. Includes summary of all Isolation precaution details.

8440-59: Patient Bathroom Cleaning – retire. Standards are reflected in each patient room cleaning policy.

8440-61: Patient Room Cleaning-C Difficile Patients
Change title to Patient Room Cleaning – Occupied ISOLATION precautions.   Changed titles for all patient room cleaning policies to be grouped together in binder for easier retrieval/review. This policy now encompasses All precautions. Complete rewrite/format. Includes room clean pathway and steps. Includes summary of all Isolation precaution details.

8440-62: Patient Occupied Room Cleaning
Change title to Patient Room Cleaning-Occupied Room. Rewrite and formatted same as all Patient Room Cleaning policies. This policy is for regular room cleaning.

8440-69: Quality Control Criteria
Change title to Quality Control Criteria and Assessment Standards – Rewrite documenting new assessment standards using disinfection detection marker and black light for Quality assessments and training. Outlines Hospital Clean Standards. Includes Patient Room Cleaning Form that is used during training and assessment with black light. This policy combines 3 policies. The following policies shall be retired as a result:
8440-02: Assessment, Care Unit Environmental
8440-20: Cleanliness, Standards for – retire
8440-68: Q-clean Feedback tool – retire

8440-71: Room Cleaning After Discharge Patient
Change title to Patient Room Cleaning-Discharge/Transfer. Rewrite and formatted same as all Patient Room Cleaning policies. This policy is for regular discharge/transfer room cleaning.

8440-73: Scope of Service EVS Department – Minor update of Department scope and references.

8440-101: Furniture, Fixture, Equipment Specific Cleaning – NEW policy. Specific steps for cleaning all items per policy title. Combines content of individual policies into one comprehensive policy for easier retrieval. The following policies shall be retired as a result:
8440-05: Bed Cleaning – retire
8440-08: Blinds Cleaning – retire
8440-17: Chair and Couch Cleaning – retire
8440-27: Dusting – retire
8440-49: Mirror Cleaning – retire
8440-52: Night Stand Cleaning – retire
8440-58: Over Bed Table Cleaning – retire
8440-64: Pictures and Wallhangings Cleaning – retire
8440-65: Portable Commode Cleaning after Discharge/Transfer - retire
8440-66: Portable Commode Cleaning Occupied Unit – retire
8440-70: Refrigerator Cleaning – retire
8440-75: Shower Cleaning – retire
8440-76: Sink Cleaning – retire
8440-77: Sink (stainless steel) Cleaning – retire
8440-84: Telephone Cleaning – retire
8440-85: Toilet and Hopper Toilet Cleaning – retire
8440-87: Tub Room Cleaning – retire
8440-88: Urinal Cleaning – retire
8440-89: Vent Cleaning – retire
8440-91: Walls, Windows and Ceiling Cleaning – retire
8440-92: Washer and Dryer Cleaning Procedure – retire

8440-94: Water Fountain Cleaning – retire
8440-96: Wheelchair, Gurney and Geri Chair Cleaning – retire
8440-97: Window Cleaning - retire

6.

QUALITY REPORT

To: Sonoma Valley Healthcare District Board Quality Committee
From: Danielle Jones
Date: 4/25/18
Subject: Quality and Resource Management Report

April Priorities:
1. Department QAPI plans & quality monitoring
2. Medication Reconciliation

Department QAPI plans & quality monitoring

In April I have been meeting with department leaders to update the quality assurance performance improvement plans. We reviewed the departments workflow processes based on high risk, high volume, low volume and problem prone areas to establish quality assurance indicators, focused studies and performance improvement projects.

Medication Reconciliation

I have worked with the medication reconciliation team to map the current process for patient flow from emergency department to medical/surgical admission. We identified the following topics as areas of opportunity: Non-hospitalist medication reconciliation education; standardized RN medication history documentation; end dates on medication orders; remote pharmacist roles and responsibilities; hospitalist contract initiatives-admit to floor time; patient interview coordination; source of medication data from patient; supplement and over the counter medication documentation. Chris Kutza, pharmacy director, and I presented this to Medicine Committee in April. The Hospitalists provided their definition of a perfect home medication list. Next steps are to standardize workflow, identify Paragon application enhancements, and then pilot the new program. I also attended a Californian Hospital Patient Safety Organization Safe Table forum related to medication reconciliation and reviewed information about best practices relevant to patient safety and discussed challenges.