SVHCD QUALITY COMMITTEE

AGENDA

WEDNESDAY, JUNE 26, 2024

5:00 pm Regular Session

Held in Person:

SVH Administrative Conference Room

To Participate Via Zoom Videoconferencing
use the link below:
https://sonomavalleyhospital-org.zoom.us/j/97100197319

Meeting ID: 971 0019 7319

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AGENDA ITEM	RECOMMENDATION	
In compliance with the Americans with Disabilities Act, if you require special accommodations to attend a District meeting, please contact the Board Clerk, Whitney Reese, at wreese@sonomavalleyhospital.org, 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	*Kornblatt Idell*	
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.*	*Kornblatt Idell*	
3. CONSENT CALENDAR • Minutes 05.22.24	*Kornblatt Idell*	Action
4. LAB QA/PI	*Alfred Lugo* *Nicolaos Hadjiyianni*	Inform
5. QUALITY INDICATOR PERFORMANCE & PLAN	*Cooper*	Inform
6. POLICIES AND PROCEDURES	*Cooper*	Inform
7. CLOSED SESSION: a. Calif. Health & Safety Code §32155: Medical Staff Credentialing & Peer Review Report	*Kornblatt Idell*	Action
8. ADJOURN	*Kornblatt Idell*	

SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
Wednesday, May 22, 2024, 5:00 PM
MINUTES

Members Present – In Person	Excused	Public/Staff – Via Zoom
Susan Kornblatt Idell Kathy Beebe, RN PhD Carl Speizer, MD Carol Snyder Howard Eisenstark, MD Michael Mainardi, MD		Denise Kalos, via zoom Kylie Cooper, RN BSN CPHQ MBA, Director of Quality and Risk Mgmt. Jessica Winkler, DNP, RN, NEA-BC, CCRN-K, CNO Chris Kutza, PharmD Paul Amara, MD, FACOG, via zoom Whitney Reese, Board Clerk

AGENDA ITEM	DISCUSSION	ACTION
1. CALL TO ORDER/ANNOUNCEMENTS	*Susan Kornblatt Idell*	
	Meeting called to order at 5:01pm.	
2. PUBLIC COMMENT SECTION	*Susan Kornblatt Idell*	
	No public comments	
3. CONSENT CALENDAR Minutes 04.24.24	*Susan Kornblatt Idell*	ACTION
	Motion to approve Eisenstark, 2nd by Mainardi	
4. PHARMACY QA/PI	*Chris Kutza, PharmD*	INFORM

	Kutza presented various quality measures for monitoring pharmacy performance in the following categories: • Adverse Drug Events • Antimicrobial Stewardship • Controlled Substances • Pyxis Utilization • IV Room • Pharmacy Services High-risk medication errors were zero. The use of smart pumps and handling hard alerts were highlighted, showing improvements following staff education. Antimicrobial spend is tracked for cost and days of therapy, which is averaging about $6/day. Controlled substance audits, metrics for after-hours pharmacy performance, and Pyxis overrides are monitored. Interventions with prescribers are handled through direct communication or escalated to an infectious diseases physician if needed. Changes made according to USP 797 were implemented.	*Chris Kutza presented to the committee*
5. PATIENT CARE SERVICES DASHBOARD 1ST QTR	*Jessica Winkler*	INFORM
	Winkler provided an update on Patient Care Services for Q1 2024. RN turnover included losing three RNs and one unit assistant for various reasons. Patient satisfaction scores were near the target, with all over goal of 4.75 except the ER, close at 4.6. No patients were turned away due to staffing shortages in Q1 2024. Staffing remains a challenge, especially finding experienced nurses, but new graduate preceptorships are helping. The hospital's turnover rate is lower than the national average, and efforts to hire quality staff are ongoing despite difficulties. Clinical programs with local colleges provide a pipeline for new nurses.	*Jessica Winkler provided an update on Patient Care Services for Q1 2024*
6. QUALITY INDICATOR PERFORMANCE & PLAN	*Kylie Cooper*	INFORM
	Cooper presented data for April 2024. Strong performance with no patient safety indicator events or hospital-acquired infections. Two patient deaths occurred, neither raising	*Kylie Cooper presented the Quality department's April 2024 data*

	concerns. No patient safety indicator events, nor sentinel events. There were minor drug administration errors but no patient harm. Improvements in patient falls (zero incidents) and length of stay. Satisfaction scores were high across various departments. HCAHPS Q1 2024 scores were presented by Winkler.	
7. POLICIES AND PROCEDURES	*Kylie Cooper*	INFORM
	Quality Committee reviewed and discussed policy changes for approval to the Board of Directors and the following new policies: • NEW_ Fire Safety - MRI 7630.24-147 • NEW_ MRI Safety and Pregnancy	*Quality Committee recommends for approval to Board of Directors, with edits*
8. CLOSED SESSION: a. Calif. Health & Safety Code §32155: Medical Staff Credentialing & Peer Review Report	*Susan Kornblatt Idell*	ACTION
	Motion to recommend to Board of Directors for approval Eisenstark, 2nd by Speizer	
9. ADJOURN	*Susan Kornblatt Idell*	
	Meeting adjourned at 6:49pm	

Laboratory Report

Current Review YTD

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Laboratory Staff

- Laboratory Director, Frederick Kretzschmar, MD
- Lab Manager, Nicolaos Hadjiyianni
- Technical Supervisor, Al Lugo
- Clinical Lab Scientists (3 FT, 3 PT, 8 PD)
- Microbiologists (1 PT)
- Clinical Laboratory Assistants (2 FT, 5 PD)

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Scope of Services

- Phlebotomy/Specimen Collection
- Clinical Laboratory testing
  - Chemistry/Toxicology/Special Chemistry
  - Hematology
  - Immunology/Immunohematology/Serology
  - Urinalysis
  - Microbiology/Molecular Diagnostics
- Blood Transfusion service
- Multi-departmental POC Coordination
- Collection service for Quest and PathGroup

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Accomplishments

- New Technical Supervisor
- Implementation of Quarterly Meetings with ER Medical Director

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Upcoming Projects

- Analyzer Implementation
  - Hematology
  - Chemistry
  - Molecular Diagnostics
- Core Lab Concept Redesign?
- CLIA Inspection

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Challenges

- Staffing
  - Comparable compensation
  - Location
- Aging Equipment
  - Core Lab instrumentation upgraded 2017
- Space Utilization
  - Poor ergonomic design
  - Lack of Storage
- Increased Testing
- Lack of Microbiology-trained CLS

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Volumes

FY 2022	FY 2023	FY 2024 Annualized
161,924	127, 823	125,858

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LAB QAPI
June '23 – May '24

Blood Cultures -Total Contamination Rate (M) 66% 25% 9% History	Breaches Alarm	4.1% 8/195	Deteriorated	May 2024	3.0%	4.0%	n/a	2.2%
Lab | API Manual Test Entry Error (M) 75% 9% 16% History	Breaches Alarm	3.6% 3/84	Deteriorated	May 2024	0.0%	1.0%	n/a	0.2%
Lab | Blood Admin Audit (Q) 66% 23% 11% History	Target Met	100.0% 1/1	No Change	Q1-2024	100.0%	99.0%	n/a	80.0%
Lab | Critical Values Communication per protocol (M) 100% History	Breaches Alarm	92.9% 105/113	Deteriorated	May 2024	100.0%	99.0%	n/a	91.3%
Lab | Manual Test Entry (Q) 100% History	Target Met	100.0% 573/573	No Change	Q4-2022	100.0%	95.0%	n/a	100.0%
Lab | Transfusion Effectiveness (M) 83% 17% History	Target Met	100.0% 3/3	No Change	May 2024	100.0%	99.0%	n/a	97.0%
Lab | Transfusion Reaction (M) 83% 17% History	Target Met	0.0% 0/15	No Change	May 2024	0.0%	1.0%	n/a	0.8%

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Quality Indicator Performance & Plan

Board Quality Presentation June 2024

Data For May 2024

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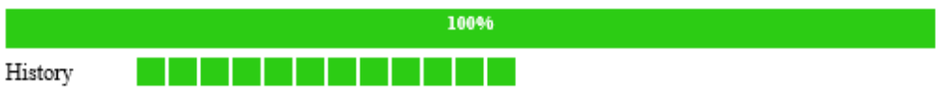
Mortality

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
Acute Care Mortality Rate (M)								
	Target Met	0.0% 0/60	Improved	May 2024	15.3%	n/a	n/a	3.2%
COPD Mortality Rate |M|								
	Target Met	0.0% 0/5	Improved	May 2024	8.5%	n/a	n/a	6.1%
Congestive Heart Failure Mortality Rate |M|								
	Target Met	0.0% 0/5	No Change	May 2024	11.5%	n/a	n/a	0.0%
Pneumonia Mortality Rate |M|								
	Target Met	0.0% 0/2	No Change	May 2024	15.6%	n/a	n/a	3.1%
Ischemic Stroke Mortality Rate |M|								
	Target Met	0.0% 0/4	No Change	May 2024	13.8%	n/a	n/a	0.0%
Hemorrhagic Stroke - Mortality Rate (M)								
	Target Met	0.0% 0/1	No Change	Apr 2024	0.0%	1.0%	n/a	12.5%

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
Sepsis, Severe - Mortality Rate (M)								
	Target Met	0.0% 0/3	No Change	Apr 2024	25.0%	n/a	n/a	9.8%
Septic Shock - Mortality Rate (M)								
	Target Met	0.0% 0/1	No Change	Apr 2024	25.0%	n/a	n/a	25.0%

AHRQ Patient Safety Indicators

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
PSI 90 (v2023-1) Midas Patient Safety Indicators Composite, ACA (M)								
75% 25% History	Target Met	0.00 0/0.01	No Change	May 2024	0.00	n/a	n/a	3.93
PSI 90 (v2023-1) Patient Safety Indicators Composite, ACA - Numerator Volume (M)								
75% 25% History	Target Met	0	No Change	May 2024	0	n/a	n/a	0

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Adverse Events Reporting

Indicator	Performance	Most Recent	Trend	Period				
Adverse Event | SE (M) volume								
100% History	Target Met	0	No Change	May 2024	0	1	n/a	0

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Blood Products

Lab | Transfusion Effectiveness (M)								
75% 25%	Breaches Alarm	0.0% 0/3	Deteriorated	May 2024	100.0%	99.0%	n/a	92.4%
History								
Lab | Transfusion Reaction (M)								
83% 17%	Target Met	0.0% 0/15	No Change	May 2024	0.0%	1.0%	n/a	0.8%
History								

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Significant Medication Errors and Adverse Drug Reactions

- No Adverse Drug Reactions

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
Rx-ADEs-High Risk Med Errors Per 10,000 Doses (M)								
100% History	Target Met	0.00 0/62537	— No Change	May 2024	1.13	2.00	n/a	0.07
Rx-Administration Errors Per 10,000 Doses Dispensed								
83% 17% History	Target Met	0.32 2/62537	Improved	May 2024	1.00	3.00	n/a	0.50

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Patient Falls

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕̄
RM ACUTE FALL- All (M) per 1000 patient days								
66% 17% 17%	Breaches Alarm	10.15 2/197	Deteriorated	May 2024	3.75	4.00	n/a	2.05
History								
RM ACUTE FALL- WITH INJURY (M) per 1000 patient days								
91% 9%	Target Met	0.00 0/197	No Change	May 2024	3.75	4.00	n/a	0.34
History								

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Readmissions

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
30-DV Inpatients - % Readmit to Acute Care within 30 Days (M)								
100% / History	Target Met	8.77% 5/57	Deteriorated	May 2024	15.30%	15.50%	n/a	5.83%
COPD, CMS Readm - % Readmit within 30 Days, ACA (M)								
66% / 17% / 17% / History	Target Met	0.0% 0/5	No Change	May 2024	19.5%	20.0%	n/a	8.0%
HF, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)								
66% / 34% / History	Target Met	0.0% 0/4	Improved	May 2024	21.6%	22.0%	n/a	11.1%
Hip/Knee, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)								
66% / 34% / History	Target Met	0.0% 0/1		May 2024	4.0%	5.0%	n/a	0.0%
PNA, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)								
91% / 9% / History	Target Met	0.0% 0/2	Improved	May 2024	16.6%	17.0%	n/a	3.3%
Sepsis, Severe - % Readmit within 30 Days (M)								
83% / 17% / History	Target Undefined	n/a		May 2024	12.0%	13.0%	n/a	0.0%
Septic Shock - % Readmit within 30 Days (M)								
100% / History	Target Met	0.0% 0/1	Improved	Apr 2024	13.3%	14.0%	n/a	0.1%

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Blood Culture Contamination

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
Blood Cultures -Contamination Rate |LAB| (M)								
History 	Target Met	1.1% 1/88	Deteriorated	May 2024	3.0%	4.0%	n/a	1.4%
Blood Cultures -Total Contamination Rate (M)								
History 	Breaches Alarm	4.1% 8/195	Deteriorated	May 2024	3.0%	4.0%	n/a	2.2%
Blood Cultures -Contamination Rate |RN| (M)								
History 	Breaches Alarm	6.5% 7/107	Deteriorated	May 2024	3.0%	3.1%	n/a	3.0%

Month	RN-Contaminated Culture Reports (num)	Blood Cultures Drawn by RN (den)	Percent
May 2024	7	107	6.5%
Apr 2024	1	105	1.0%
Mar 2024	5	113	4.4%
Feb 2024	5	86	5.8%
Jan 2024	1	93	1.1%
Dec 2023	3	112	2.7%
Nov 2023	2	134	1.5%
Oct 2023	3	122	2.5%
Sep 2023	1	97	1.0%
Aug 2023	5	94	5.3%
Jul 2023	2	89	2.2%
Jun 2023	3	98	3.1%

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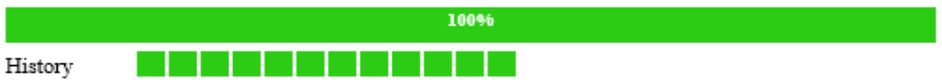
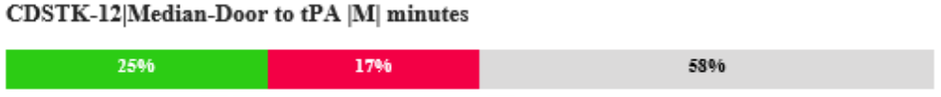
CIHQ Stroke Certification Measures

Indicator	Performance	Most Recent	Trend	Period				
CDSTK-03|Median- Code Stroke Called |M| elapsed time (mins)								
	Target Met	9	Deteriorated	May 2024	10	11	n/a	4
CDSTK-04|Median- Door to Phys Eval |M| minutes								
	Target Met	1	No Change	May 2024	10	11	n/a	1
CDSTK-05|Median- Door to CT Scanner |M|elapsed time (minutes)								
	Target Met	12	Deteriorated	May 2024	25	26	n/a	10
CDSTK-06|Median- Neuro Consult Contacted |M| minutes								
	Target Met	28	Deteriorated	May 2024	30	31	n/a	24
CDSTK-07|Median- CT Read by Radiology |M| minutes								
	Target Met	42	Deteriorated	May 2024	45	46	n/a	26
CDSTK-08|Median- Lab Results Posted |M| minutes								
	Target Met	39	Deteriorated	May 2024	45	46	n/a	26
CDSTK-10|Median- Door to EKG Complete |M| minutes								
	Target Met	27	Deteriorated	May 2024	60	61	n/a	33
CDSTK-11|Median-Door to tPA Decision |M| minutes								
	Target Met	55	Deteriorated	May 2024	60	61	n/a	36
CDSTK-12|Median-Door to tPA |M| minutes								
	Breaches Alarm	72		May 2024	60	61	n/a	59

Utilization Management

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
MS-DRG Case Mix Index (CMI) |M|								
41% 59% History	Breaches Alarm	1.34	Deteriorated	May 2024	1.55	1.40	n/a	1.38
MS-DRG Case Mix Index (CMI) MEDICARE |M|								
33% 8% 59% History	Breaches Alarm	1.31	Deteriorated	May 2024	1.55	1.40	n/a	1.42
1 Day Stay Rate Medi-Cal |M|								
100% History	Target Met	0.00% 0/7	No Change	May 2024	2.61%	5.00%	n/a	0.00%
1 Day Stay Rate-Medicare |M|								
100% History	Target Met	0.00% 0/42	No Change	May 2024	8.10%	10.00%	n/a	0.00%
Acute Care Risk-adjusted Average Length of Stay, O/E Ratio |M|								
91% 9% History	Target Met	0.92 218/236.07	Improved	May 2024	0.99	1.00	n/a	0.93
Inpatients Risk-adjusted Average Length of Stay, O/E Ratio |M|								
91% 9% History	Target Met	0.92 219/239.19	Improved	May 2024	0.99	1.00	n/a	0.90
Medicare Risk-adjusted Average Length of Stay, O/E Ratio |M|								
91% 9% History	Target Met	0.84 100/119.42	Deteriorated	May 2024	0.99	1.00	n/a	0.88
Acute Care - Geometric Mean Length of Stay |M|								
50% 50% History	Breaches Alarm	3.49 41.8949/12	Deteriorated	May 2024	2.75	3.23	n/a	3.46

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Core Measures

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
Core OP29/ASC9 - Colonoscopy:F/U for Avg Risk Pts (M)								
100% History	Target Met	100.0% 17/17	No Change	May 2024	88.0%	50.0%	n/a	100.0%

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
Core OP 18b Median Time ED Arrival to ED Departure - Reporting Measure (M)								
16% 9% 75% History	Breaches Alarm	164.00	Deteriorated	May 2024	132.00	140.00	n/a	154.00

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
Core OP 22 ED LWBS Emergency Dept Left Without Being Seen (M)								
100% History	Target Met	0.7% 6/883	Deteriorated	May 2024	2.0%	2.5%	n/a	0.5%

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
Core OP-23 - Head CT/MRI Results for STK Pts w/in 45 Min of Arrival (M)								
50% 17% 33% History	Target Met	100.0% 2/2		May 2024	72.0%	70.0%	n/a	81.2%

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Core Measures Sepsis

Indicator	Performance	Most Recent	Trend	Period				
SEP-1 Early Management Bundle, Severe Sepsis/Septic Shock (M)								
	Target Met	100.0% 1/1	Improved	May 2024	81.0%	80.0%	n/a	75.0%
SEPa - Severe Sepsis 3 Hour Bundle (M)								
	Target Met	100.0% 1/1	Improved	May 2024	94.0%	90.0%	n/a	85.0%
SEPb - Severe Sepsis 6 Hour Bundle (M)								
	Target Met	100.0% 1/1	No Change	May 2024	100.0%	90.0%	n/a	95.5%

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Infection Prevention

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
IC-Surveillance| HAI-C.DIFF Inpatient infections per 10k pt days |M|	Target Met	0	No Change	May 2024	1	1	n/a	0
IC-Surveillance| HAI-CAUTI Inpatient infections per 10k patient days |M|	Target Met	0	No Change	May 2024	1	1	n/a	0
IC-Surveillance| HAI-CLABSI Inpatient infections per 10k patient days |M|	Target Met	0	No Change	May 2024	1	1	n/a	0
IC-Surveillance| HAI-MRSA Inpatient infections per 10k patient days |M|	Target Met	0	No Change	May 2024	1	1	n/a	0
IC-Surveillance| HAI-SSI infections per 10k pt days |M|	Target Met	0	No Change	May 2024	1	1	n/a	0
QA-02 | Hand Hygiene Practices Monitored |M|	Target Met	96% (48/50)	Improved	May 2024	90%	85%	n/a	89%

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CIHQ Corrective Action Plan Monthly Compliance Condition Level Findings

QS-10 | Documentation: Continuous Observation of High Risk Pts |M|

Breaches Alarm	62% 5/8	Deteriorated	May 2024	100%	95%	n/a	65%

DATE	1:1 Observation for High Risk Patie		Percent
May 2024	5	8	62%
Apr 2024	4	5	80%
Mar 2024	8	9	89%
Feb 2024	9	11	82%
Jan 2024	6	6	100%
Dec 2023	5	8	62%
Nov 2023	4	4	100%
Oct 2023	3	6	50%
Sep 2023	2	6	33%
Aug 2023	2	4	50%
Jul 2023	1	5	20%
Jun 2023	2	6	33%

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Patient Satisfaction

HCAHPS reported Quarterly

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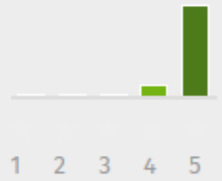
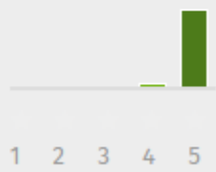
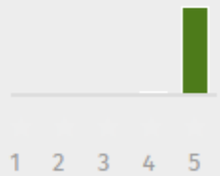
Rate My Hospital
Scale 1-5
May Data

	Question Responses	Average Score	Score breakdown
Sonoma Valley Hospital / Emergency Department	107	4.611 95% CI: 4.555—4.667	

	Question Responses	Average Score	Score breakdown
Sonoma Valley Hospital / Inpatient Care	8	4.839 95% CI: Not enough samples	

	Question Responses	Average Score	Score breakdown
Sonoma Valley Hospital / Outpatient Surgery	46	4.925 95% CI: 4.898—4.952	

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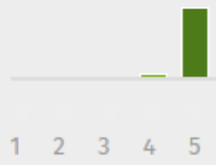
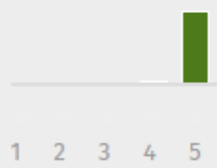
Rate My Hospital
Scale 1-5
May Data

	Question Responses	Average Score	Score breakdown
Sonoma Valley Hospital / Medical Imaging	206	4.877 95% CI: 4.850—4.903	

	Question Responses	Average Score	Score breakdown
Sonoma Valley Hospital / Hand and Physical Therapy	147	4.906 95% CI: 4.879—4.933	

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
HEALING HERE AT HOME

Document Tasks By Committee

Listing of currently pending and/or upcoming document tasks grouped by committee.

Sonoma Valley Hospital

Run by: Reese, Whitney (wreese)
Run date: 06/21/2024 4:44 PM

Report Parameters

Filtered by: Document Set: - All Available Document Sets -
Committee: 07 BOD-Quality (P&P Review)
Include Current Tasks: Yes
Include Upcoming Tasks: No

Grouped by: Committee

Sorted by: Document Title

Report Statistics

Total Documents: 17

Committee: **07 BOD-Quality (P&P Review)**

Committee Members: **Finn, Stacey (sfinn), Newman, Cindi (cnewman), Reese, Whitney (wreese)**

Current Approval Tasks (due now)

Document	Task/Status	Pending Since	Days Pending
Approved Panel List *Clinical Lab Dept*	**Pending Approval**	6/20/2024	1

Summary Of Changes: **Added ER-ONLY test notation which are critical values that will pertain only to ER patients**

Edited table to fit necessary addition to list

Added critical values for Calcium and Vancomycin

Moderators: **Newman, Cindi (cnewman)**
Lead Authors: **Ramos, Karen (kramos), Lugo, Al (alugo)**
Approvers: **Kuwahara, Dawn (dkuwahara) -> 01 P&P Committee - (Committee) -> 02 MS-Medicine Department - (Committee) -> 03 MS-Surgery Department - (Committee) -> 04 MS-Performance Improvement/Pharmacy & Therapeutics Committee - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Document	Task/Status	Pending Since	Days Pending
Critical Value Reporting 7500-12 *Clinical Lab Dept*	**Pending Approval**	6/20/2024	1

Summary Of Changes: **Under Sonoma Valley Hospital Critical Value - specified the policy where the list of critical value Policy #7500-04 is located**

Under Emergency Department - Included a comment of newly marked ER-ONLY test in the approved panel list for critical calls

Referenced CIHQ in References

Moderators: **Newman, Cindi (cnewman)**
Lead Authors: **Ramos, Karen (kramos), Lugo, Al (alugo)**
Approvers: **Kuwahara, Dawn (dkuwahara) -> 01 P&P Committee - (Committee) -> 02 MS-Medicine Department - (Committee) -> 03 MS-Surgery Department - (Committee) -> 04 MS-Performance Improvement/Pharmacy & Therapeutics Committee - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Document	Task/Status	Pending Since	Days Pending
Discharge Medication Charity Program *Discharge Planning (DP)*	**Pending Approval**	6/20/2024	1

Summary Of Changes: **Policy reviewed.**

Changes- Prescriptions must be sent electronically/transmitted to Pharmacy (no longer by phone or fax)

Moderators: **Newman, Cindi (cnewman)**
Lead Authors: **Cooper, Kylie (kcooper)**
ExpertReviewers: **Kutza, Chris (ckutza)**
Approvers: **Winkler, Jessica (jwinkler) -> 01 P&P Committee - (Committee) -> 04 MS-Performance Improvement/Pharmacy & Therapeutics Committee - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Enoxaparin Dosing Protocol | **Pending Approval** | 6/20/2024 | 1

Medication Management Policies (MM)

Summary Of Changes: **Changes made to simplify the protocol and have it match current dosing guidelines. Changed name to make it specific to enoxaparin dosing. Dose rounding protocol included.**

Moderators: **Kutza, Chris (ckutza), Newman, Cindi (cnewman)**
Lead Authors: **Kutza, Chris (ckutza)**
Approvers: **01 P&P Committee -> 04 MS-Performance Improvement/Pharmacy & Therapeutics Committee - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Fluid Restriction Allowance 8340-155 | **Pending Approval** | 5/23/2024 | 29

Food & Nutrition Services Dept Policies

Summary Of Changes: **Reviewed, no changes**

Moderators: **Newman, Cindi (cnewman)**
Lead Authors: **Finn, Bridget (bfinn)**
Approvers: **Winkler, Jessica (jwinkler) -> 01 P&P Committee - (Committee) -> 02 MS-Medicine Department - (Committee) -> 04 MS-Performance Improvement/Pharmacy & Therapeutics Committee - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

NEW: Hazardous Drug Handling-USP 800 | **Pending Approval** | 6/20/2024 | 1

Medication Management Policies (MM)

Summary Of Changes: **New policy spelling out how SVH complies with USP 800 standard regarding hazardous drugs as defined by NIOSH.**

Moderators: **Kutza, Chris (ckutza), Newman, Cindi (cnewman)**
Lead Authors: **Kutza, Chris (ckutza)**
Approvers: **01 P&P Committee -> 04 MS-Performance Improvement/Pharmacy & Therapeutics Committee - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

NEW: Health Equity-Screening for Social Drivers of Health (SDOH) | **Pending Approval** | 6/20/2024 | 1

Governance and Leadership Policies

Summary Of Changes: **New Policy to address the 2023 IPPS Final Rule, CMS mandated that hospitals reporting to the Inpatient Quality Reporting (IQR) program submit two brand new measures:
SDOH-1, Screening for Social Drivers of Health and
SDOH-2, Screen Positive Rate for Social Drivers of Health.**

Moderators: **Newman, Cindi (cnewman)**
Lead Authors: **Cooper, Kylie (kcooper)**
ExpertReviewers: **Kidd, Sabrina (skidd), Taylor, Jane (jtaylor)**
Approvers: **Winkler, Jessica (jwinkler) -> 01 P&P Committee - (Committee) -> 02 MS-Medicine Department - (Committee) -> 03 MS-Surgery Department - (Committee) -> 04 MS-Performance Improvement/Pharmacy & Therapeutics Committee - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

NEW:: Hypoglycemia Protocols	**Pending Approval**	6/20/2024	1
Patient Care Policy			

Summary Of Changes:	**NEW policy/procedure to replace obsolete version since implementing a new EHR.**
Moderators:	**Newman, Cindi (cnewman)**
Lead Authors:	**Taylor, Jane (jtaylor)**
ExpertReviewers:	**00 Clinical P&P multidisciplinary review, Kutza, Chris (ckutza), Medical Director-Patient Care Services**
Approvers:	**00 Clinical P&P multidisciplinary review -> Winkler, Jessica (jwinkler) -> 02 MS-Medicine Department - (Committee) -> 03 MS-Surgery Department - (Committee) -> 04 MS-Performance Improvement/Pharmacy & Therapeutics Committee - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Non-Obstetric Elective Surgery During Pregnancy	**Pending Approval**	6/20/2024	1
Patient Care Policy			

Summary Of Changes:	**Updated reference and authors, added the words "as available"' to the purpose section discussing getting pediatrician opinion prior to proceeding with surgery.** **changed bullet point number one to reflect we will not do elective and non-urgent patients at all vs specifying certain weeks of gestation parameters.** **changed to elective- and non-urgent surgery should be postponed until after delivery.** **Some grammatical changes** **KGC- Removed following lines that refer to other facilities, they would have their own policies.** **- A pregnant woman should never be denied indicated surgery, regardless of trimester.** **• If fetal monitoring is to be used, surgery should be done at an institution with neonatal and pediatric services and an obstetric care provider with cesarean delivery privileges should be readily available.** **• When non-obstetric surgery is planned, the primary obstetric care provider should be notified. If that health care provider is not at the institution where surgery is to be performed, another obstetric care provider with privileges at that institution should be involved.**
Moderators:	**Newman, Cindi (cnewman)**
Lead Authors:	**Cornell, Kelli (kcornell)**
ExpertReviewers:	**00 Clinical P&P multidisciplinary review, Medical Director-Patient Care Services**
Approvers:	**Winkler, Jessica (jwinkler) -> 01 P&P Committee - (Committee) -> 02 MS-Medicine Department - (Committee) -> 03 MS-Surgery Department - (Committee) -> 04 MS-Performance Improvement/Pharmacy & Therapeutics Committee - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Parenteral Nutrition Protocol	**Pending Approval**	6/20/2024	1
Medication Management Policies (MM)			

Summary Of Changes:	**Simplified policy to remove the actual procedures and guidelines and make them an attachment. Updated policy to reflect how Epic handles TPN orders. Updated guidelines and references to make them match current practice. Added dosing table specific to Clinimix premix bags that are formulary choices.**
Moderators:	**Kutza, Chris (ckutza), Newman, Cindi (cnewman)**
Lead Authors:	**Kutza, Chris (ckutza)**
ExpertReviewers:	**Tremain, Alesha (atremain)**
Approvers:	**01 P&P Committee -> 04 MS-Performance Improvement/Pharmacy & Therapeutics Committee - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Pharmacist Review of Medication Orders	**Pending Approval**	6/20/2024	1
Medication Management Policies (MM)			

Summary Of Changes:	**Updated how auto-processing of Computer Physician Order Entry (CPOE) orders is handled, defining the two patient care areas where this is approved to occur.**
Moderators:	**Kutza, Chris (ckutza), Newman, Cindi (cnewman)**
Lead Authors:	**Kutza, Chris (ckutza)**
Approvers:	**01 P&P Committee -> 04 MS-Performance Improvement/Pharmacy & Therapeutics Committee - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Reporting Controlled Substance Theft or Loss — **Pending Approval** — 6/20/2024 — 1

Medication Management Policies (MM)

Summary Of Changes:	**Updated DEA reference links to current versions and updated date accessed. Removed reference to paper form 106 and changed to electronic reporting.**
Moderators:	**Kutza, Chris (ckutza), Newman, Cindi (cnewman)**
Lead Authors:	**Kutza, Chris (ckutza)**
Approvers:	**01 P&P Committee -> 04 MS-Performance Improvement/Pharmacy & Therapeutics Committee - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Sterile Compounding Procedures 8390-03 — **Pending Approval** — 6/20/2024 — 1

Pharmacy Dept\Compounding Related

Summary Of Changes:	**Previously submitted. Updated procedures to match updated standards with USP 797**
Moderators:	**Kutza, Chris (ckutza), Newman, Cindi (cnewman)**
Lead Authors:	**Kutza, Chris (ckutza)**
Approvers:	**01 P&P Committee -> 04 MS-Performance Improvement/Pharmacy & Therapeutics Committee - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Unapproved Abbreviations — **Pending Approval** — 6/20/2024 — 1

Medication Management Policies (MM)

Summary Of Changes:	**Updated last accessed date on Institute for Safe Medication Practices (ISMP) reference.** **Added unapproved abbreviation list to attachments**
Moderators:	**Kutza, Chris (ckutza), Newman, Cindi (cnewman)**
Lead Authors:	**Kutza, Chris (ckutza)**
Approvers:	**01 P&P Committee -> 04 MS-Performance Improvement/Pharmacy & Therapeutics Committee - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Vancomycin Protocol — **Pending Approval** — 6/20/2024 — 1

Medication Management Policies (MM)

Summary Of Changes:	**Updated attachment (only) to current version with maximum loading dose of 2.5gm**
Moderators:	**Kutza, Chris (ckutza), Newman, Cindi (cnewman)**
Lead Authors:	**Kutza, Chris (ckutza)**
Approvers:	**01 P&P Committee -> 04 MS-Performance Improvement/Pharmacy & Therapeutics Committee - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Verbal and Telephone Orders — **Pending Approval** — 6/20/2024 — 1

Medical Staff Dept

Summary Of Changes:	**Reviewed. Removed references to Paragon and replaced with "Electronic Health Record"** **Changed Telephone order Definition from a" verbal request via telephone for care activities from a provider who is not physically present within the Hospital:, to ": A verbal request via telephone for care activities from a provider who is not physically present within the care area"** **Changed all verbal orders written on paper record must be signed with 48 hrs.**

Removed reference to Skill Nursing Facility.
Added lab orders to types of verbal/telephone orders pharmacists can receive.

Moderators:	**Newman, Cindi (cnewman)**
Lead Authors:	**Kutza, Chris (ckutza), Finn, Stacey (sfinn), Cooper, Kylie (kcooper)**
ExpertReviewers:	**Cooper, Kylie (kcooper), Kutza, Chris (ckutza)**
Approvers:	**Kidd, Sabrina (skidd) -> 01 P&P Committee - (Committee) -> 04 MS-Performance Improvement/Pharmacy & Therapeutics Committee - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Warfarin Protocol **Pending Approval** 6/20/2024 1

Medication Management Policies (MM)

Summary Of Changes:	**Corrected typos, defined (International Normalized Ratio (INR), clarified that indication and INR range are to be part of the initial protocol order, deleted processes and references related to Paragon, removed section on RN duties as not necessary due to it reiterating practices that are not unique to warfarin and standard of care, removed appendices and made them attachments, clarified order of operations in procedure to be more clear. Updated protocol to newer version that incorporates rate of change of INR into dosing and version that allows for management of patient's home regimen.**
Moderators:	**Kutza, Chris (ckutza), Newman, Cindi (cnewman)**
Lead Authors:	**Kutza, Chris (ckutza)**
Approvers:	**01 P&P Committee -> 04 MS-Performance Improvement/Pharmacy & Therapeutics Committee - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

SUBJECT: Hazardous Drug Handling-USP 800	POLICY #MM8610-2404
	PAGE 1 OF 5
DEPARTMENT: Organizational	EFFECTIVE:
REVISED:	

PURPOSE:
To define procedures that promote patient safety, worker safety, and environmental protection when handling hazardous drugs (HDs).

DEFINITIONS
Hazardous Drug (HD)[1]: A drug approved for human use by the Food and Drug Administration's (FDA) Center for Drug Evaluation and Research (CDER) that is not otherwise regulated by the U.S. Nuclear Regulatory Commission that:

- Is accompanied by prescribing information in the "package insert" that includes a manufacturer's special handling information (MSHI), *OR*
- Is determined to be a carcinogenic hazard, developmental hazard, reproductive hazard, genotoxic hazard, or other health hazard by exhibiting one or more of the following toxicity criteria in humans, animal models, or in vitro systems:
  - Carcinogenicity
  - Developmental toxicity (including teratogenicity)
  - Reproductive toxicity
  - Genotoxicity
  - Organ toxicity at low doses
  - Structure and toxicity profile that mimics existing drugs determined hazardous by exhibiting any one of the previous five toxicity types

NIOSH: National Institute for Occupational Safety and Health

- NIOSH Group 1 Drugs: Antineoplastic drugs that meet one or more of the NIOSH criteria for an HD
- NIOSH Group 2 Drugs: Non-antineoplastic drugs that meet one or more of the NIOSH criteria for an HD
- NIOSH Group 3 Drugs: Non-antineoplastic drugs that primarily have reproductive adverse effects

Active Pharmaceutical Ingredients (API): the active components in a pharmaceutical drug that produce the required effect on the body to treat a condition. APIs are produced by processing chemical compounds.

POLICY:

[1] NIOSH [2023]. Procedures for developing the NIOSH list of hazardous drugs in healthcare settings. By Whittaker C, Ovesen JL, MacKenzie BA, Hartley T, Berry KA, Piacentino J. Cincinnati, OH: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Institute for Occupational Safety and Health, DHHS (NIOSH) Publication No. 2023-129, https://doi.org/10.26616/NIOSHPUB2023129

- The facility identifies in writing its hazardous drugs.
- The risks associated with handling hazardous drugs are communicated to staff involved.
- The facility designates qualified and trained individual(s) to oversee compliance with hazardous drug handling standards and other applicable laws and regulations.
- Hazardous drugs will be handled according to standards described in US Pharmacopeia General Chapter <800> Hazardous Drugs-Handling in Healthcare Settings (USP 800)
- Sonoma Valley Hospital does not compound APIs or drugs defined by NIOSH as Group 1 drugs.

PROCEDURE:

List of Hazardous Drugs (HD)

- Hazardous drugs are identified based on the *NIOSH List of Antineoplastic and Other Hazardous Drugs in Healthcare Settings.*
- The facility maintains a list of the hazardous drugs handled in the facility.
- The facility list of hazardous drugs identifies the HDs based on defined NIOSH group/table.
- The facility hazardous drug list is reviewed and updated at least annually and as necessary as new drugs with hazard potential are brought into the facility.
- New agents or dosage forms used in the facility are reviewed, as part of formulary criteria, for inclusion on the facility HD list.
    - New agents and dosage forms on the *NIOSH List of Antineoplastic and Other Hazardous Drugs in Healthcare Settings* are added to the facility's HD list as applicable.
    - Agents and dosage forms that entered the market after the most recent version of the NIOSH list and investigational drugs are evaluated using:
        - Criteria provided in the NIOSH list, and
        - Product package inserts (PI) are reviewed for reproductive or developmental toxicity (Section 8 of PI), carcinogenicity, genotoxicity, teratogenicity (Section 13 of PI), and treated as hazardous or nonhazardous depending on the information provided.
        - Safe-handling warnings (Section 16 of PI) are reviewed and incorporated, as applicable.

Assessment of Risk

- The facility performs an assessment of risk for eligible hazardous drugs to determine alternate containment strategies, workplace practices and required/recommended personal protective equipment (PPE).
- The assessment of risk considers at minimum:
  - Type of HD based on NIOSH group/table
  - Dosage form
  - Risk of exposure
  - Packaging
  - Manipulation
- The alternate containment strategies/workplace practices determined by the assessment of risk are documented.
- The assessment of risk is reviewed at least annually, and the review is documented.

HDs ***Not* Eligible for Assessment of Risk (Must follow all USP 800 requirements)**

- HD active pharmaceutical ingredients (API)
- HD antineoplastics requiring manipulation.

HDs Eligible for Assessment of Risk

- Final dose forms of compounded HDs and commercially manufactured HDs, including antineoplastics that do *not* require manipulation other than counting or repacking (unless required by the manufacturer).
- Dosage forms of all other HDs that may require manipulation.

Hazardous Drug Containment

- An assessment of risk is performed for HDs to define containment strategies and workplace practices.

Responsibilities of Personnel Handling Hazardous Drugs-Designated Person(s)

- The designated person is responsible for:
  - Developing and implementing appropriate procedures
  - Overseeing compliance
  - Ensuring competency of personnel
  - Ensuring environmental control of the storage and compounding areas

  - Overseeing facility monitoring
  - Maintenance of testing and sampling reports, including acting on results
- The individual(s) identified as the designated person(s) is documented.

Personnel Handling HDs
Personnel who handle HDs are responsible for understanding the fundamental practices and precautions and for continually evaluating these procedures and the quality of final HDs to prevent harm to patients, minimize exposure to personnel, and minimize contamination of the work and patient-care environment.

Storage Area Requirements

- Non-antineoplastic, reproductive risk only and final dosage forms of antineoplastic HDs may be stored with other inventory.
- Drug packages, bins, shelves, and storage areas bear distinctive labels identifying those drugs requiring special handling precautions.

Personal Protective Equipment (PPE)

- PPE is worn when handling HDs as defined in the facility assessment of risk.

Receiving

- A spill kit is readily available.
- During the receiving process, each shipping container is inspected for damage or breakage.

Disposal

- Disposal of HD waste, including, but not limited to, unused HDs and trace contaminated PPE and other materials, comply with all applicable federal, state, and local regulations and facility Pharmaceutical Waste Management Plan.

Administration

- Precautions regarding administration of HDs are defined in the facility assessment of risk.

REFERENCES:

- Centers for Medicare and Medicaid Services (CMS) §482.25(a), §482.25(b)
- National Institute for Occupational Safety and Health (NIOSH) List of Antineoplastic and Other Hazardous Drugs in Healthcare Settings Accessed March 2024

SUBJECT: Hazardous Drug Handling-USP 800	POLICY #MM8610-2404
	PAGE 5 OF 5
DEPARTMENT: Organizational	EFFECTIVE:
REVISED:	

- NIOSH Procedures for Developing the NIOSH List of Hazardous Drugs in Healthcare Settings Accessed March 2024
- NIOSH Managing Hazardous Drug Exposures: Information for Healthcare Settings Accessed March 2024
- CDC Managing Hazardous Drug Exposures: Information for Healthcare Settings Accessed March 2024
- USP General Chapter <800> Hazardous Drugs-Handling in Health Care Settings
- Pharmaceutical Waste Management Policy MM8610-155

ATTACHMENTS:

- Hazardous Drug Assessment-USP 800
- USP 800 Designated Person

OWNER:
Director of Pharmacy

AUTHORS/REVIEWERS:
Director of Pharmacy
Board Quality Committee

COMMITTEE APPROVALS:
Policy & Procedure Team:
Performance Improvement/
Pharmacy & Therapeutics Committee:
Medical Executive Committee:
The Board of Directors:

SUBJECT: Health Equity-Screening for Social Drivers of Health (**SDOH**)	POLICY: GL8610-2401
	Page 1 of 4
DEPARTMENT: Organizational	EFFECTIVE:
REVISED:	

NEW POLICY

In the 2023 IPPS Final Rule, CMS mandated that hospitals reporting to the Inpatient Quality Reporting (IQR) program submit two brand new measures:

SDOH-1, ***Screening for Social Drivers of Health*** and

SDOH-2, ***Screen Positive Rate for Social Drivers of Health.***

WHY:

Social risk factors can negatively impact a person's health, including worse outcomes and more time spent in hospitals for longer periods of time. Unfortunately, social risk factors disproportionately impact underserved communities.

These new measures establish a screening for social risk factors and provide a rate of your inpatient population who were identified as having one or more of these social risk factors.

The primary goal from CMS is to get all hospitals systematically collecting patient-level social risk factor data to create "meaningful collaboration between healthcare providers and community-based organizations." Once a patient is identified as having a social risk factor, clinicians can link with community-based organizations to provide a patient with the other resources that are necessary to establish whole person care.

CMS is testing to see if systematically finding and dealing with the health-related social needs of patients has any effect on their total health care costs and makes their health outcomes better.

Their (CMS) second goal is to eventually use the data gathered in these measures to stratify patient risk and hospital performance rates.

They (CMS) also hope these measures will help clinician burnout by systematically acknowledging patients' social needs that contribute to adverse health outcomes, which could enhance patient-centered treatment and make discharge planning easier on clinicians.

SUBJECT: Health Equity-Screening for Social Drivers of Health (**SDOH**)	POLICY: GL8610-2401
	Page 2 of 4
DEPARTMENT: Organizational	EFFECTIVE:
REVISED:	

PURPOSE:
Establish organization wide screening policy for social risk factors and provide a rate of inpatient population who were identified as having one or more of these social risk factors.

POLICY:
Sonoma Valley Hospital recognizes that social risk factors can negatively impact a person's health, including worse outcomes and more time spent in hospitals for longer periods of time. Unfortunately, social risk factors disproportionately impact underserved communities. We will collect, monitor, analyze and improve care, where identified, to ensure our underserved patients will be referred to community resources for support whenever possible.

PROCEDURE:
All patients admitted to our hospital who are 18 years or older will be screened for the five domains of Social Determinants/Drivers of Health (**SDOH**). There are two measures: **SDOH-1**, ***Screening for Social Drivers of Health*** and **SDOH-2**, ***Screen Positive Rate for Social Drivers of Health.*** These are both process measures and have specific patient populations.

In essence, the first measure wants to know how many patients were screened and the second wants to know of the screened patients, how many were positive. CMS uses the acronym HRSN to define the five specific social needs to screen for. **HRSN** means health-related social needs and includes food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety. Any of these HRSNs leads to negative health outcomes.

Patients over the age of 18 will be assessed upon admission by Nursing,
During the inpatient admission process, the nurse should complete Social Determinants of Health (SDOH) screenings as part of the admission navigator in Epic. This information is then visible to Case Management and helps to identify areas of concern and improve understanding of patient needs.

SDOH-1 POPULATIONS

In Layman's Terms: Of all the patients admitted to the hospital, how many did you screen for SDOH?

Denominator: All patients admitted to the hospital who are 18 years or older.

Exclusions: Patients who opt-out of screening and/or patients who are unable to complete the screening during their stay and have no legal guardian or caregiver who can do so on their behalf.

Numerator: The number of patients who were screened for the five domains of SDOH (listed below).

SDOH-2 -POPULATIONS

In Layman's Terms: Of all the patients admitted to the hospital who received a SDOH screening, how many were identified as having one or more social risk factor?

Denominator: All patients admitted to the hospital who are 18 years or older and are screened for the five domains of SDOH.

Exclusions: Patients who opt-out of screening and/or patients who are unable to complete the screening during their stay and have no legal guardian or caregiver who can do so on their behalf.

Numerator: The number of patients who screened positive for any of the five domains of SDOH.

The results of the SDOH-2 measure will be calculated as five separate rates – one for each of the five domains.

The 5 Domains of SDOH Screening

1. **Food Insecurity**
   Food insecurity is defined as limited or uncertain access to adequate quality and quantity of food at the household level.
2. **Housing Instability**
   Housing instability encompasses multiple conditions ranging from the inability to pay rent or mortgage, frequent changes in residence including temporary stays with friends and relatives, living in crowded conditions, and actual lack of sheltered housing in which an individual does not have a personal residence.
3. **Transportation Needs**
   Unmet transportation needs include limitations that impede transportation to destinations required for all aspects of daily living.

4. **Utility Difficulties**
   Inconsistent availability of electricity, water, oil, and gas services is directly associated with housing instability and food insecurity.
5. **Interpersonal Safety**
   Assessment for this domain includes screening for exposure to intimate partner violence, child abuse, and elder abuse.

REFERENCES:
CMS IQR FY24
CMS Roadmap for Healthcare Equity

OWNER:
Chief Nursing Officer

AUTHORS/REVIEWERS:
Chief Medical Officer
Director of Quality & Risk Management, Case Management
Director of Patient Care Services
Board Quality Committee

APPROVALS:
Policy & Procedure Team:
Medicine Committee:
Surgery Committee:
Performance Improvement/
Pharmacy & Therapeutics Committee
Medical Executive Committee:
The Board of Directors:

SUBJECT: Hypoglycemia Protocols	POLICY: PC 8610-108.2
	Page 1 of 7
DEPARTMENT: Organizational	EFFECTIVE:
REVISED:	

NEW POLICY
New policy needed to reflect different EHR and appropriate protocol process.

OWNER: Chief Nursing Officer

AUTHORS/REVIEWERS:
Director of Patient Care Services
Director of Pharmacy
Chief Nursing Officer
Board Quality Committee

SUBJECT: Hypoglycemia Protocols	POLICY: PC 8610-108.2
	Page 2 of 7
DEPARTMENT: Organizational	EFFECTIVE:
REVISED:	

PURPOSE:

To provide guidelines for the appropriate evaluation and treatment for the patient who presents with blood glucose level below 50mg/dL or is symptomatic with a blood glucose (BG) level of 70mg/dl or below. Signs and symptoms of hypoglycemia include:

a) Cold sweats, clammy skin, lightheadedness, irritability
b) Pounding heart rate, shaking, blurred vision
c) Verbalization of need for food or sugar
d) Alteration of mental status

POLICY:

Treatment for hypoglycemia (i.e. blood glucose level below 50mg/dL) must be initiated even if the patient is not symptomatic, and is initiated if patient is symptomatic with a blood glucose of 70mg/dL or below.

PROCEDURE:

HYPOGLYCEMIA MANAGEMENT PROTOCOL FOR ADULT PATIENTS

1. Hypoglycemia is defined as:

- a blood glucose value less than 70 mg/dL in adults

Acute effects of hypoglycemia range from asymptomatic to severe. Signs and symptoms include but are not limited to clammy skin, hunger, restless sleep, fatigue, headache, confusion, visual changes, dizziness, fast heart rate, and irritability

2. If patient hypoglycemic or displays signs or symptoms of this condition, initiate treatment as follows and notify provider:

a. IF ABLE TO TAKE PO

i. Give 15 gm glucose gel, 4 oz. juice, 4 oz. non-diet soda, or 8 oz. milk {per local protocol).

ii. *History of Bariatric surgery: Give 15 gm glucose gel. If not available, treat with D50W IV as per 2.b. below. Do not delay treatment if gel is not available.

b. IF UNABLE TO TAKE PO
   i. IV access:
      1. Blood glucose 50-69 mg/dL, administer 12.5 gm (25ml) D50W (dextrose 50%) IV over 2 minutes
      2. Blood glucose less than 50 mg/dL, administer 25 gm (50ml) D50W (dextrose 50%) IV over 2 minutes
   ii. No IV access: Administer Glucagon 1 mg IM (place order if not available on MAR).

3. IN ALL CASES

a. Check blood glucose every 15-30 minutes until greater than 100 mg/dL, then recheck in one hour or sooner as clinically indicated.
b. If patient has persistent or recurrent hypoglycemia, treat as above and notify provider.
c. If unable to maintain blood glucose greater than 70 mg/dl after two rounds of treatment, start dextrose infusion {D10W) at 50ml/hr.
d. Recheck blood glucose 30 min after starting D10W then at least hourly and PRN until it is discontinued.
e. Call provider to discuss parameters for D10W discontinuation.

4. When patient is no longer hypoglycemic

a. Resume ROUTINE blood glucose monitoring once blood glucose levels are greater than 100 mg/dl on 2 or more consecutive checks.
b. If patient tolerating PO, give a carbohydrate and protein meal or snack
c. *History of Bariatric Surgery, give:
   i. Post Op day of surgery: Protein Packet (6 gm) mixed in 4 oz. clear liquids or milk, to drink as tolerated over a few hours.
   ii. Day after surgery and up to 2 weeks postop: Protein Packet (6 gm) mixed in in 4 oz. clear liquid, milk/ full liquids to drink as tolerated over a few hours.
   iii. Greater than 2 weeks postop, carbohydrate/protein meal or snack as you would to other patients.

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HYPOGLYCEMIA MANAGEMENT PROTOCOL FOR PATIENTS RECEIVING TUBE FEEDING (TF)

If TF stopped unexpectedly, check BG every 2 hours x 3 and monitor the patient for signs and symptoms of hypoglycemia.

FOR BG< 100 mg/dL:

- Begin D10W at 50ml/hr unless patient has fluid overload, renal failure or hyponatremia (call provider). Recheck Blood Glucose in 1 hour.
- Titrate D10W per D10W order on MAR until q2h BG checks remain greater than or equal to 100 mg/dl with no intervention (rate= 0 ml/hr) x 2 hours.
- DC IV Dextrose 10% when q2h BG is stable with no intervention x 2 hours.

FOR BG < 70 mg/ dL:

- Give 12.5 gm(25 ml) DSOW (dextrose 50%) IV over 2 minutes (place order if not available on MAR)
- If no IV access order and administer Glucagon 1 mg SQ. (place order if not available on MAR)
- Recheck BG in 15 minutes.
  - If still hypoglycemic, repeat above glucose treatment and recheck BG every 15 minutes until not hypoglycemic.
  - If BG still hypoglycemic after three doses, call physician
- Once no longer hypoglycemic, check blood glucose:
  - every 15 minutes x 2
  - then every 30 minutes x 2
  - then in 4 hours

If hypoglycemia recurs within 6 hours treat the low BG as above AND call provider for orders to prevent further hypoglycemia. 4

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HYPOGLYCEMIA MANAGEMENT PROTOCOL FOR PEDIATRIC PATIENTS

Check blood glucose for signs and symptoms of hypoglycemia. If not otherwise ordered, initiate hypoglycemic protocol for:

PEDIATRIC HYPOGLYCEMIA: BG 0-69 mg/dL

IF ALERT & ORIENTED:

- For 6 years and older: Give 4 oz. non-diet soda, 4oz juice, 0.5 gm/kg (max 15 gm) glucose gel - per local protocol.
- For 5 years and younger: Give 80 ml juice, 80 ml non-diet soda, or 0.5 gm/kg (max 10 gm) glucose gel - per local protocol.

IF UNABLE TO TAKE PO:

- (NPO,unable to swallow, poorly responsive, unresponsive, poor PO tolerance)
- Administer D10W (dextrose 10%) 4 ml/kg (max 50ml) IV bolus over 2 minutes, or
- If no IV access, administer Glucagon 0.03 mg/kg (max 1mg) **IM.** (Place order if not available on MAR)

IN ALL CASES:

- Recheck BG in 15 minutes.
- If BG< 70 mg/d, repeat above glucose treatment and recheck BG every 15 minutes until BG 70mg/
- If BG still< 70mg/dL after 3 doses, call physician
- Once BG 70, give meal or snack if tolerating PO (1/2 sandwich, 8 oz. milk or yogurt)

ONCE BG70mL/dL, CHECK BLOOD GLUCOSE:

- If NO insulin last 2 hours, check BG:
  - every 15 minutes x 2
  - then every 30 minutes x 1

- If had insulin last 2 hours, check BG:
  - every 15 minutes x 2
  - then every 30 minutes x 2

Notify physician of the episode of hypoglycemia before next dose of insulin given.

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HYPOGLYCEMIA MANAGEMENT PROTOCOL FOR ADULT PATIENTS RECEIVING INSULIN INFUSION

HYPOGLYCEMIA PROTOCOL:

If blood glucose < 80 mg/dL, see attached protocol. Recheck blood glucose in 15 minutes and repeat as necessary.

NOTIFY PROVIDER:

1. Blood glucose< 80 mg/dl for two consecutive measurements.
2. Hypoglycemia reoccurs at the 30-minute blood glucose re-check or within 6 hours, treat the hypoglycemia and notify provider for orders to prevent further hypoglycemia.

HYPOGLYCEMIA MANAGEMENT PROTOCOL FOR DKA PATIENTS

HYPOGLYCEMIA PROTOCOL:

1. Stop insulin infusion and administer dextrose 50% based on blood glucose level:
   a. Blood glucose 70-79 mg/dl, administer 5gm (10ml) D50W (dextrose 50%) IV over 2 minutes
   b. Blood glucose 60-69 mg/dl, administer 7.5gm (15ml) D50W (dextrose 50%) IV over 2 minutes
   c. Blood glucose 50-59 mg/dl, administer 10gm (20ml) D50W (dextrose 50%) IV over 2 minutes
   d. Blood glucose 30-49 mg/dl, administer 12.5gm (25ml) D50W (dextrose 50%) IV over 2 minutes
   e. Blood glucose less than 30 mg/dl, administer 15gm (30ml) D50W (dextrose 50%) IV over 2 minutes.
2. Recheck blood glucose in 15 minutes.
3. If blood glucose remains below 80 mg/dL, then readminister dextrose 50% based on blood glucose level and repeat blood glucose checks every 15 minutes until blood glucose is equal to or greater than 80 mg/dL
4. When blood glucose is equal to or greater than 80 mg/dL, then resume insulin infusion rate 1 column to the left of the last column used and resume every 1-hour

blood glucose checks.

5. Notify provider if blood glucose is less than 80 mg/dlon2 consecutive measurements.

REFERENCES:
Providence St Joseph Health
Epic Hypoglycemia Protocols

OWNER:
Chief Nursing Officer

AUTHORS/REVIEWERS:
Director of Patient Care Services
Director of Pharmacy
Chief Nursing Officer
Board Quality Committee

APPROVALS:
Policy & Procedure Team:
Medicine Committee:
Surgery Committee:
Performance Improvement/
Pharmacy & Therapeutics Committee
Medical Executive Committee:
The Board of Directors: