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

SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
REGULAR MEETING AGENDA
Wednesday, October 24, 2012
5:00 p.m. Open Session
(Closed Session will be held upon adjournment of the Open Session)

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

AGENDA ITEM	RECOMMENDATION	
MISSION STATEMENT *The mission of the SVHCD is to maintain, improve, and restore the health of everyone in our community.*		
1. CALL TO ORDER	Carruth	
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. At all times please use the microphone.*	Carruth	
3. CONSENT CALENDAR: A. Prior Meeting Minutes – September 26, 2012 B. Tracking Report for Uncorrected Items	Carruth/Lovejoy	Inform/Action
4. PHYLLIS CARTER REQUEST	Carter	Inform
5. BOARD SOLICITING COMMITTEE MEMBERS	Carruth	Inform
6. QUALITY TRAINING FOR THE BOARD AND COMMITTEE	Carruth	Inform
7. QUALITY COMMITTEE CHARTER REVIEW AND ANNUAL REPORT TO THE BOARD	Carruth	Inform/Action
8. QUALITY REPORT	Lovejoy	Inform
9. POLICIES & PROCEDURES: A. Adult Hypoglycemia	Lovejoy	Inform/Action
10. DASHBOARD	Lovejoy	Inform
11. NOVEMBER AND DECEMBER MEETING DATES	Carruth	Inform/Action
12. CLOSING COMMENTS	Carruth	Inform
13. ADJOURN		
14. UPON ADJOURNMENT OF THE REGULAR OPEN SESSION	Carruth	Inform
15. CLOSED SESSION: A. Calif. Health & Safety Code § 32155 – Medical Staff Credentialing & Peer Review Report	Smith/Amara	Inform/Action
16. REPORT OF CLOSED SESSION	Carruth	Inform

3.A.

MINUTES
9.26.12

SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
REGULAR MEETING MINUTES
Wednesday, September 26, 2012
Schantz Conference Room

Committee Members Present	Committee Members Absent	Community Members Present	Administrative Staff Present
Kevin Carruth, Chair Dr. Jerome Smith Joel Hoffman Jane Hirsch	Dr. Paul Amara Sharon Nevins Bob Burkhart	Dr. Howard Eisenstark	Dr. Robert Cohen, Chief Medical Officer Leslie Lovejoy, Chief Quality & Nursing Officer Mark Kobe, Director of Nursing

AGENDA ITEM	DISCUSSION	CONCLUSIONS/ ACTION	FOLLOW-UP/ RESPONSIBLE PARTY
MISSION AND VISION STATEMENTS	*The mission of the SVHCD is to maintain, improve, and restore the health of everyone in our community.* *The vision of the SVHCD is that:* *SVH will be a nationally recognized, compassionate place of healing and known for excellence in clinical quality. We serve as the guide and indispensable link for our community's health care journey.*		
1. CALL TO ORDER	5:07 p.m.		
2. PUBLIC COMMENT SECTION ON CLOSED SESSION	There was no public comment.		
4. REPORT OF CLOSED SESSION		**MOTION:** by Hirsch, seconded, to forward the Credentialing Report to the Board and carried. All in favor; none opposed	
5. PUBLIC COMMENT *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.*	There was no public comment.		

AGENDA ITEM	DISCUSSION	CONCLUSIONS/ ACTION	FOLLOW-UP/ RESPONSIBLE PARTY
At all times please use the microphone.			
6. CONSENT CALENDAR: A. Prior Meeting Minutes 8.22.12 B. Tracking Report for Uncorrected Items		**MOTION:** by Hirsch; seconded, to approve Item A on the Consent Calendar and carried. All in favor; none opposed. **MOTION:** by Carruth; seconded, to approve the Tracking Report and carried. All in favor; none opposed	
7. QUALITY REPORT	*Leslie Lovejoy*		
	Ms. Lovejoy reported priorities for September were heavily regulatory. The Studer Group encourages the Leadership team and front line staff to inquire into patient satisfaction results so they can explain them to their peers. The Measurement Team had been trained and oriented on the survey. The Medicare Breakeven team has been reformed. The California Department of Public Health had asked SVH to provide three plans of corrections for some HIPAA violations and had been accepted. The California Department of Public Health Pharmacy surveyor also visited the Hospital regarding Medication Error Reduction Plan (MERP). Random validation surveys were done and passed on SVH's evidence of standards compliance and measures of success from The Joint Commission. The central sterile construction is almost complete, as well as the kitchen drain pipe. Final permit from OSHPD had been received for the Occupational Health and Human Resources move. She further explained the Press Ganey patient satisfaction survey summary report and the Value Based Purchasing score regarding quality and satisfaction on SVH's performance. The "Pardon Our Noise" initiative was also discussed, due to the construction taking place at the Hospital. Mr. Carruth recommended the reports that were presented this year to be discussed at next month's meeting to present at the December Board meeting.		
8. REDUCING WASTE THROUGH UTILIZATION AND RESOURCE MANAGEMENT	*Leslie Lovejoy*		
	Ms. Lovejoy explained managing utilization, resource management, and waste management on how to achieve quality care at low cost. The three components, which are inter-related: 1) Managing Utilization: Making sure		

AGENDA ITEM	DISCUSSION	CONCLUSIONS/ ACTION	FOLLOW-UP/ RESPONSIBLE PARTY
	the patient obtains the right level of care at the right time and location, which results in high quality care. The strategies that were used are: case management transformation initiative, implementing a pilot ED case management program focusing on the returns of the patient, readmissions, those who have no insurance and complex cases that may need some community case management. Readmissions and palliative care program were also used as part of the strategies; 2) Managing Resources: Continuous performance improvement identifies what waste there is in the organization, and move to reduce it. Managed cost by using operational benchmarks. Creating strategic affiliations with Marin General and Palm Drive. Contracting with medical groups that bring managing costs to the table and strategic planning to manage the overall costs to providing high quality care. Using data in an effective way for identifying overuse of some tests, developing physician group dashboard indicators, and holding leaders accountable. Medicare breakeven project identified initial goals. Using MRI testing in the inpatient setting, implementing best practice guidelines to reduce the need for in use blood transfusions for outpatient surgery, identify and reduce the number of repetitive and potential wasteful lab testing, and PICC line process, pre-operating testing, printing lab results, throughput from ED to acute, and use of supplies. Comparing practice patterns by physician by DRG to identify opportunities for education and standardization; and 3) Managed Costs: Reducing patient chargeables and supply costs in surgery, changed from single supply items to packs for the majority of their cases, and adding prices to their preference cards. The Materials Management department also reduced contractual costs, renegotiate contracts, review supply costs, and partnering with Marin General Hospital. Lastly, keeping the revenue SVH generates.		
9. ELECTRONIC HEALTH RECORD UPDATE AND MEANINGFUL USE	*Dr. Robert Cohen*		
	Dr. Cohen briefly summarized the term "meaningful use", which was to alter the quality of medical care and have cost benefits. EHR was to provide increased quality and availability of data reporting of certain diseases to governmental agencies where the government and have come up with sets of standards so that hospitals were able to meet their 90-day attestation period in order to be reimbursed a portion of their cost for purchasing EHR. Unifying single database that encompasses all of the areas in the Hospital, which are pharmacy, lab, operating room, and emergency department into one unified database. EHR went live on May 2012 shortly thereafter started the attestation period. Total cost of EHR program was $6,000,000 plus. Stage 2 had been finalized, which would require additional modules. All progress		

AGENDA ITEM	DISCUSSION	CONCLUSIONS/ ACTION	FOLLOW-UP/ RESPONSIBLE PARTY
	notes to be either typed or voice recognition. There are a number of Stage 2 requirements that would go through the same process while in the 90-day attestation period. Many of the same elements that are in Stage 1 would be in Stage 2.		
10. POLICIES & PROCEDURES:	*Leslie Lovejoy*		
A. Infant Security (Revisited)		**MOTION:** by Hirsch; second by Hoffman to approve the Infant Security policy and be brought to the Board. All in favor; none opposed.	
	Ms. Lovejoy reported on the wording changes that were made.		
B. Humidity and Temperature Monitoring		**MOTION:** by Hirsch; seconded, to approve the Humidity and Temperature Monitoring policy and be brought to the Board. All in favor; none opposed.	
	Ms. Lovejoy reported this policy met Centers for Medicare and Medicaid Services, State, and The Joint Commission requirements for measuring humidity.		
C. Ice Machine Maintenance		**MOTION:** by Carruth; seconded, to approve with the amendment for the ice machine maintenance policy and be brought to the Board. All in favor; none opposed.	
	Ms. Lovejoy briefly explained the ice machine maintenance policy.		
11. CLOSING COMMENTS	*Kevin Carruth*		
	Mr. Carruth announced that Dr. Eisenstark, who had been regularly attending the meetings, was unable to attend for this meeting and the ad for Board Committee vacancies would be advertised soon.		
12. ADJOURN	6:35 p.m.		

3.B.

TRACKING REPORT

Quality Committee					
Outstanding Items Log					
Item # & Topic	**Discussion**	**Follow-up**	**Date Due**	**Date Completed**	**Update/Comments**
082511-2 Central Sterile	A TJC citing regarding the potential for cross contamination of instruments. Requires physical plant structural changes in OR.	Monthly report on progress in Quality Report until completed.	9/22/11		OSHPD Permitted
072512-1 Occupational Health & HR	CDPH returned a directed plan of action	Monthly report on progress in Quality	8/22/12		At OSHPD
072512-2 Dishwasher Drain	Drain pipes for diswasher in Nutritional Services	Monthly report on progress in Quality Report until completed.	8/22/12		Beginning the OSHPD process
072512-3	Skilled Nursing Broken Water Pipe	Monthly report on progress in Quality Report until completed.	9/15/12		OSHPD permit and in process

4.

PHYLLIS CARTER REQUEST

10/11/12 RM received (LL).
At read letter to Board

Phyllis Carter, 454 Rosalie Drive, Sonoma August 4, 2012

I am a 10 year breast cancer survivor. Although I will use myself as an example, this is not about me. I am here in the hopes of preventing women in the future from enduring the pain and concerns that I have due to silicone implants.

For the past couple of months your CEO, Ms. Mather, and I have had some correspondence. Obviously if I had had a satisfactory response I wouldn't be here. I would be happy to share all of these letters with you at a future time.

The last letter I received from Ms. Mather was probably one of the better CYA pieces I have read. As a med mal attorney friend said, it's BS but that's probably the response he would have recommended had he been your general counsel.

I believe my doctors to be some of the best. Likewise, with the one exception of a traveler nurse ten years ago, I have had the best of care. Your nurses and technicians are professional, competent, courteous and caring.

The silicone breast implants I received were not acceptable and I will tell you why. They were not cohesive and, as a result, I have suffered the consequences. Cohesive implants present far less risk of implant shell failure. And even in the event of failure, the cohesive gel filler maintains its shape.

This summer, I needed to have my remaining implant removed. During the procedure, it was discovered that the implant had ruptured and that silicone gel had leaked into my body. My doctor believes she was able to get all the silicone out, but we don't know that for sure.

I have been told that one side effect of silicone infiltration is the swelling and pain of the joints, much like rheumatoid arthritis. Another consequence, and more troublesome to me, is the compromising of the immune system. I will forever need to be watchful.

One medical practitioner told me that she thought the FDA said all silicone implants had to be cohesive. Obviously, that is not the case. I know so much more now than I did eight years ago. I was not fully informed and was not given options.

Breast implants do not last forever. You want the best for your clients but you compromise women with inferior products when you provide non-cohesive implants. You now know that not all silicone implants are cohesive. In order not to jeopardize any more women who choose to use silicone implants, whether for augmentation or reconstruction, it is necessary for you to mandate that physicians and staff use cohesive implants at Sonoma Valley Hospital.

I am a former member of this board, and have always been watchful of what is best for the hospital **and** its patients. I hope you have learned from my experience and will move forward to make sure this never happens to another patient here.

5.

BOARD SOLICITING COMMITTEE MEMBERS

FOR IMMEDIATE RELEASE

Date: October 1, 2012

Subject: SVHCD Board Committees Seek New Members

Contact: Vivian Woodall 707.935.5005

Sonoma Valley Health Care District Board Committees Seek New Members

The Board of Directors for the Sonoma Valley Health Care District announced it is seeking new members for the following Board Committees: Citizens Bond Oversight Committee, Finance Committee, and Quality Committee. Peter Hohorst, Board Chair, said that "we want residents from all corners of our District--which runs from Sears Point up the Sonoma Valley through Glen Ellen--to be involved with the hospital. We all know that the Sonoma Valley Hospital is our only hospital and it is critical to every one of us, our families and our friends, as well as Sonoma's many visitors. Everything about the hospital continues to improve. The quality of patient care and the patient experience have improved dramatically, construction is now underway for our bond funded Emergency Room and surgical suites, our financial bottom line is stronger, and we are engaged in a successful fundraising campaign. To ensure we continue on this successful path, we are reaching out for people who will bring their special talents, energy and time to help the hospital. Having the active involvement of District residents is one more way we ensure that Sonoma Valley Hospital remains viable and provides the best possible care every day."

The Citizens Bond Oversight Committee (CBOC) is looking for one voting member and three non-voting alternates. The CBOC functions as the District's steward of the 2008 Bond measure assuring citizens that the funds are spent for the purposes intended. Citizens with an interest in the financial health of the hospital, including those who have experience with government bonds, as well as those who want to ensure the hospital continues to use the bonds as approved by the voters, are encouraged to apply. Meetings are scheduled quarterly on the third Thursday of the month at 5 PM—the first meeting for new members will be on January 17, 2013. It is anticipated that the CBOC's work will be completed by June 2014.

The Finance Committee is in need of two voting members. The Finance Committee assists the Board in all aspects of its oversight of the District's financial affairs. Residents with an interest in sharing their expertise in fields such as health care finance, business, banking, commercial real estate, real estate development, and accounting, as well as those who have a special interest in the financial affairs of the hospital, are encouraged to apply. Meetings are scheduled on the fourth Tuesday of the month at 5 PM.

The Quality Committee is looking for one voting member and three non-voting alternates. The Quality Committee serves as the steward for overall quality improvement. Not only can persons who have a background in medicine and health care bring beneficial expertise, but those who have experience and knowledge about quality control, quality assurance and customer service in other fields can be equally valuable, including but not limited to airline pilots, lawyers, insurance professionals, manufacturing experts, and specialized academics. Those who have an interest in ensuring we provide high quality medical care and exceptional patient experiences are encouraged to apply. Meetings are scheduled on the fourth Wednesday of the month at 5 PM.

All of these committees meet at Sonoma Valley Hospital. Non-voting alternates are strongly encouraged and expected to attend and actively participate in all their committee's meetings. As voting member vacancies occur, the future voting committee members will come from the ranks of the non-voting alternates.

Interested persons who live within the District may obtain an application at the Hospital's Administration Office, 347 Andrieux Street, Sonoma, California 95476, weekdays from 8 AM to noon and 1 PM to 4:30 PM, or e-mail Gina Studebaker at gstudebaker@svh.com.

Completed applications with resumes/CV may be delivered to the hospital in person during normal business hours or mailed to the address listed above. All applications should be received no later than the close of business (4:30 p.m.) on Thursday, October 17th.

A Special Board meeting will be held the evening of Wednesday, November 7th, to interview all the applicants and select the new committee members and alternates.

7.

QUALITY COMMITTEE CHARTER REVIEW

The Mission of the SVHCD is to maintain, improve and restore the health of everyone in our community.

POLICY # 1

POLICY TITLE

Quality Committee Charter

PURPOSE

Consistent with the Mission of the District the Board, with the assistance of its Quality Committee (QC), serves as the steward for overall quality improvement for the District. The QC shall constitute a committee of the District Board of Directors. The Board shall refer all matters brought to it by any party regarding the quality of patient care, patient safety, and patient satisfaction to the QC for review, assessment and recommended Board action. The QC makes recommendations and reports to the Board. It has no authority to make decisions or take actions on behalf of the District unless the Board specifically delegates such authority, as the Board has for Physician Credentialing (see below).~~.~~

The QC shall assist the Board in its responsibility to ensure that the Hospital provides high-quality patient care, patient safety, and patient satisfaction. To this end the QC shall:

1. formulate policy to convey Board expectations and directives for Board action;
2. make recommendations to the Board among alternative courses of action, including but not limited to physician credentialing and oversight activities;
3. provide oversight, monitoring and assessment of key organizational processes, outcomes, and external reports.

SCOPE AND APPLICABILITY

This is a SVCHD Board Policy and it specifically applies to the Board, the Quality Committee, the Audit Committee, the Medical Staff, and the CEO of SVH.

RESPONSIBILITY

Physician Credentialing

1. The QC shall ensure that recommendations from the Medical Executive Committee and Medical Staff are in accordance with the standards and requirements of the Medical Staff

Bylaws, Rules and Regulations with regard to: completed applications for initial medical staff and allied health staff appointment; initial staff category assignment, initial department/divisional affiliation; membership prerogatives and initial clinical privileges; completed applications for reappointment of medical staff, staff category; clinical privileges; establishment of categories of allied health professionals permitted to practice at the hospital; the appointment and reappointment of allied health professionals; and privileges granted to allied health professionals.

2. The QC shall, in closed session on a case by case basis, fully, rigorously, and carefully review the recommendations of the Medical Staff regarding the appointment, reappointment, and privilege delineation of physicians and submit recommendations to the Board for review and action.

3. Initial Credentials and Privileges
   - The MEC recommends a new applicant for credentialing and privileges effective the first of the next month.
   - The QC votes to recommend to the Board that they grant privileges and credentials to the professional, pending Board approval at the next Regular Board Meeting.

4. Reappointments
   - The credentials and privileges of the professional in question are in effect at the time the QC meets to consider their approval,
   - That professional's credentials and privileges will expire before the next Regular Board meeting, and
   - The QC votes to recommend to the Board that they grant privileges and credentials to the professional, pending Board approval at the next Regular Board Meeting.

5. When the QC does not meet or for some other reason is unable to act as authorized above:
   - The two Board Members on the QC may act to temporarily grant credentials and privileges, pending Board approval at the next Regular Board Meeting, or
   - If one or both of these QC Board members are not available Board Chair may select temporary Board replacement(s) to meet and act to grant credentials and privileges, pending Board approval at the next Regular Board Meeting.

~~2.~~

Develop Policies

1. The QC shall submit recommendations for action to the Board on draft policies developed by the QC and those developed by the Hospital regarding quality patient care, patient safety, and patient satisfaction.

Oversight

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Annual Quality Improvement Plan

1. The QC shall review and analyze findings and recommendations from the CEO resulting from the Hospital's prior year Annual Quality Improvement Plan, including but not limited to a comparison of the plan to actual accomplishments, administrative review and evaluation activities conducted, findings and actions taken, system or process failures and actions taken to improve safety, both proactively and in response to actual occurrences.

2. The QC shall review the Hospital's Annual Quality Improvement Plan for continuously improving quality, patient safety, and patient satisfaction and submit the analysis with recommendations establishing priorities to the board for discussion and action. The Hospital's plans should include, but not be limited to, assessing the effectiveness and results of the quality review using metrics and benchmarks, utilization review, performance improvement, implementing and improving electronic medical/health records, professional education, risk management programs, and patient care related activities and policies of the Hospital and/or Medical Staff, as applicable.

Medical Staff Bylaws

1. The QC shall assure that the Medical Staff's Bylaws are reviewed and approved by the Board and are consistent with the District and Hospital Mission, Vision and Values, Board policy, and accreditation standard, prevailing standards of care, and evidence-based practices.

2. The QC shall review the Medical Staff's fulfillment of its responsibilities in accordance with the Medical Staff Bylaws, applicable law and regulation, and accreditation standards and make recommendations to the Board.

Quantitative Quality Measures

1. The QC shall assess and recommend quantitative measures to be used by our Board in assessing the quality of the Medical Staff's and Hospital's services and submit them to the Board for deliberation and action. The recommendations shall include descriptions that show how the organization measures and reports the improvement of patient care as well as management accountability.

2. The QC shall review all reports by and Hospital responses to accreditation organizations, e.g., Fire Marshals, Environmental Health, State Department of Health Services (DHS), and other external organizations conducting management, programmatic, physical plant audits/assessments/reviews that are directly or indirectly related to the quality of health care delivery in the Hospital (quality patient care, patient safety, and patient satisfaction). Track all uncompleted/open items until remedied/closed by the Hospital, and make recommendations and report to the Board for its action as appropriate. This includes the final OSHPD report on a construction project prior to licensing by DHS, but it does not include on-going OSHPD reviews/inspections/reports while a project is in design or construction. This does not include routine financial audits, unless the audit identifies quality patient care, patient safety, and/or patient satisfaction issues, in which case the Audit Committee shall refer the audit to the QC for its review and recommendations to the

Board.

3. The QC shall ensure there is an effective, supportive and confidential process for anyone (the Medical Staff, other health care professionals; Hospital administration; leaders and staff; patients and their families and friends; and the public) to bring issues to the QC directly or via the Hospital—as a group, personally or anonymously--in order to promote the reporting of quality and patient safety problems and medical errors, and to protect those who ask questions and report problems.

4. The QC shall review and assess the process for identifying, reporting, and analyzing "adverse patient events" and medical errors. The QC shall develop a process for the QC to address these quality deficiencies, in the most transparent manner possible, without unnecessarily increasing the District's liability exposure.

5. The QC shall review the assessment of patient needs/satisfaction, and submit this assessment with recommendations to the Board for review and possible action. This may include but is not limited to CMS Value Based Purchasing information; Press Ganey surveys; reports and comparisons to other hospitals, state and national standards; and patient and/or family complements and complaints.

6. The QC shall review and assess the system for resolving interpersonal conflicts among individuals working within the Hospital environment that could adversely affect quality of care, patient safety or patient satisfaction and make recommendations to the Board.

Hospital Policies

1. The QC shall assure that the Hospital's administrative policies and procedures are reviewed and approved by the appropriate Hospital leaders and that the policies and procedures are submitted to the Board for its action are consistent with the District and Hospital Mission, Vision and Values; Board policy; and accreditation standards.

2. The AC shall assure that the Hospital's policies and procedures relative to quality, patient safety, and patient satisfaction are reviewed and approved by the appropriate Hospital leaders and the policies and procedures submitted to the Board for its action are consistent with the District and Hospital Mission, Vision and Values, Board policy, and accreditation standards, prevailing standards of care, and evidence-based practices.

Other

1. Perform other duties related to high-quality patient care, patient safety, and patient satisfaction as assigned by the Board.

Annual QC Work Plan

The QC shall develop an Annual QC Work Plan comprised of the required annual activities and additional activities selected by the QC. The Annual QC Work Plan shall be reviewed and acted on by the Board after considering the CEO's work plan to support the QC.

Required Annual Calendar Activities

For Calendar Year 2012

1. The QC shall submit the CY 2012 Work Plan to the CEO no later than the first week in January.

2. The QC shall submit its Work Plan and the CEO's Work Plan to the QC Board for its review and action no later than the February Board meeting.

3. The QC shall review the adequacy of financial and human resources currently allocated for maintaining high-quality care, patient safety, and patient satisfaction in April, in advance of the annual budget process and provide an assessment to the Board and CEO with recommendations for action.

4. The QC shall review and assess all Board policies regarding quality, including the QC Charter, and makes recommendations to the Board for action in December.

For Subsequent Calendar Years

1. The QC shall review the adequacy of financial and human resources currently allocated for maintaining high-quality care, patient safety, and patient satisfaction in April, in advance of the annual budget process and provide an assessment to the Board and CEO with recommendations for action.

2. The QC and CEO Work Plans shall be submitted to the Board for its review and action no later than December.

3. The QC shall report on the status of its prior year's work plan accomplishments by December.

4. The QC reviews and assesses all Board policies regarding quality specifically including the QC Charter, and makes recommendations to the Board for action in December.

QC Membership and Staff

The QC shall have 7 voting members and three non-voting public member alternates appointed pursuant to Board policy. Pursuant to Health and Safety Code Section 32155, based on the need for Medical Staff quality assessments, Physician Credentialing and Privileges are discussed and action is taken in Closed Session without the QC public members and alternates. Hospital employees who staff the QC are not voting members of the QC. QC membership is:

- Two Board members one of whom shall be the QC chair, the other the vice-chair. Substitutions may be made by the Board chair for Board QC members at any QC meeting--for one or both Board members.

- Two designated positions from the Medical Staff leadership, i.e., the President and the President-Elect. Substitutions may be made by the President for one Medical Staff member at any QC meeting.

- Three members of the public. In addition, substitutions may be made at all QC meetings from three prioritized non-voting members of the public as alternate public members. Alternates shall attend closed session QC meetings and vote as QC members when substituting for a voting public member. Alternates may attend QC meetings as non-voting alternates and fully participate in the open meeting discussions.

Staff to the QC include the Hospital's Chief Medical Officer (CMO), Chief Nursing Officer (CNO), and the Director of Quality and Resource Management who shall be the lead staff in support of the QC Chair for meetings, documents, and activities. Staff is expected to attend the QC meetings. The CEO may attend all QC and subcommittee meetings and shall be a resource at the QC meetings upon request of the QC Chair.

Frequency of QC Meetings

The QC shall meet monthly, unless there is a need for additional meetings.

Public Participation

All QC meetings shall be announced and conducted pursuant to the Brown Act. Physician Credentialing and Privileges are discussed and action is taken in QC Closed Session without the QC public members and alternates, or the general public.

The general public, patients and their families and friends, Medical Staff, and Hospital staff are always welcome to attend and provide input. Other Board members may attend but may not comment as it may be a Brown Act violation.

Narrowly focused and short term ad hoc subcommittees may meet to address specific issues that will be brought to the QC for review and referral to the Board for its deliberation and action. Subcommittee meetings are not subject to the Brown Act.

FREQUENCY OF REVIEW/REVISION

This shall occur annually or more often if required. If revisions are needed they will be taken to the Board for action.

POLICY HISTORY

December 1, 2011--Board Policy regarding the QC was first adopted.

March 1, 2012—Charter amended.

July 5, 2012—Charter amended.

--END--

8.

QUALITY REPORT

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

T0: Sonoma Valley Hospital Care District Board Quality Committee
FROM: Leslie Lovejoy, Director, Quality and Resource Management
DATE: 10/24/2012
SUBJECT: Quality Report

October Priorities:

1) Statewide Disaster Drill
2) Delivery System Reform Incentive Pool (DSRIP) Plan
3) ED Case Management pilot
4) Leadership Culture of Safety Training
5) Joint Commission Complaint

1. The hospital participated in the Statewide Disaster Drill on Thursday, October 18th. Called "The Great Shake Out III", the focus was on a major earthquake. The focus was on testing redundant communication systems, conducting information exchange with the Health Department, participation in public information/warning messaging; and coordinating medical surges of patients. We also were able to test putting up the triage tent and the hand held radios. Mark Kobe is our Emergency Management Director.

2. The Delivery System Reform Incentive Pool program is a state run, federally funded incentive program for those insured by Medi-Cal or the uninsured. It is part of the Affordable Care Act. The goal of the program is to support and reward hospitals for improvements in healthcare delivery systems that support the simultaneous pursuit of improving the experience of care, improving population health, and reducing the per capita costs of health care. Each district hospital submits a plan to CMS and when approved, the plan is monitored by CDPH who authorizes release of funds depending on progress in meeting project goals. The first plan is due on October 26th and the second, sometime in November. Projects are monitored over three years and must be interrelated. I will bring the full plan to the November meeting.

3. We have hired a new Case Manager that is currently working for our Home Care Agency to head this pilot project. We are in the education of ED staff and physicians' stage and the initial exploration of what the role will entail. The new case manager, Carrie De Fere, has both case management and emergency department experience and a great deal of program development and management practical experience as well.

4. The leadership team, as part of the leadership Development Institute, received 1.5 hours of training in the hospital's culture of safety program. This was developed and presented in response to the responses to the AHRQ Culture of Safety Survey that I reported on early this year. It also aligns with one of the strategic initiatives from our three –year strategic plan. This training builds on what was already in place and moves us into the direction of developing what is called a "Just Culture". We will roll it out to staff in the remaining months and then use the AHRQ survey to test success. I have attached the power point with notes for you to look through. We are also rolling out a team approach to patient complaints based on the book entitled: "Sorry Works". Dr. Cohen is leading that project.

5. We received notice from the Joint Commission of a complaint that was sent to them regarding the lack of response of one department to the ICU. I have attached the complaint and our response which will be filed on Thursday the 18th. They will then notify us if they accept our investigation and action plan. This relates directly to our culture of safety training above.

Topic for Discussion: Suggestions for Dashboard for 2013 reporting

Next Month: Annual Contracts Evaluation Report
Evaluation of Quality Committee Work Plan

The Joint Commission Connect™

Organization response to a complaint

Incident Number: 170563
Incident Date: 09/14/2012
Programs: HAP

Complaint Summary

Pt. was in ICU bed 2 Male. Respiratory therapist repeatly ignored calls to attend to this patient from ICU RN's. Patient was passed onto incoming therapist and left without responding to several pages. Pt. almost coded Co2 110. Pt had to be intubated and placed on vent. Manager of respiraratory Kathy Cole was informed of situation and failed to take any type of diciplinary action and acted like it was not their fault. Respiratory therapy failed to take any responcability or corrective measures. The only actions that were taken is that the oncoming theraoist was removed from schedule due to retaliation because the the therapist responcable was written up.

Comments and Analysis

Upon receipt of this complaint, the Chief Nursing Officer conducted a full and exhaustive investigation and analysis to determine the root issues that resulted in the complaint. The Respiratory Therapy Manager and her senior leader and the Director of the ICU interviewed all staff involved to obtain a picture of the event. It was of utmost importance to determine if patient safety was placed at risk and whether the care provided met nursing and respiratory standards of practice as well as hospital policies and procedures. A Chronology of events was completed based on medical record documentation from nursing, respiratory therapy and medical staff. While the patient received safe and effective care and recovered without incident, there were a number of issues raised that the hospital has and will continue to address.

Conclusions

Opportunities for Improvement: 1. Hand-off communication between the ICU nurses at change of shift. 2. Lack of documentation by the ICU RN that a change in condition had occurred and any actions taken. The hospital is four months into an electronic medical record. Nursing is still learning where and how to document in the electronic world. 3. Failure to communicate a sense of urgency or to ask about urgency on the part of both Nursing and Respiratory Therapy. The nurse did not tell the therapist of the change in condition nor did the therapist ask if there was one. The respiratory therapist continued change of shift report with the oncoming therapist after the second page because of the lack of communication. At the third page the respiratory therapist was on their way to the ICU. There was an assumption, by the Respiratory Therapy Manager, that ICU will call for a Rapid Response Team overhead as a way of alerting respiratory therapy that a patient was in distress. 4. Failure to activate the chain of command on a timely basis. 5. Lack of proximity to the ICU during change of shift reporting in Respiratory Therapy & potential pager malfunction. The department is at the opposite end of the building from the patient care areas & pagers sometimes fail. With regards to the issue of "retaliation", The Manager of the Respiratory Therapy Department reported that the Respiratory Therapist in question was on her 90-day probationary period as a new employee. The employees was, prior to this incident, on a performance improvement action plan as she was not meeting departmental expectations and behaviors required. The action plan issues did not relate to the event but the manager took her off the schedule in preparation for termination right after the event. The employee appeared to have made an assumption and reported it to the ICU nurses as retaliation when it was serendipity.

Follow-Up Actions

1. Culture of Safety training for leaders and employees. a. Leaders will receive further training, October 25th, in behavioral expectations and performance tools to improve our culture's efforts to provide safe patient care. Chain of Command, SBAR and other IHI tools will be implemented. All employees will be trained by Dec 31, 2012. b. Review incident and provide Immediate education to ICU nurses regarding effective communication using SBAR and the Chain of Command. Respiratory Therapist Manager to provide education to her employees in staff meeting regarding effective communication. Education and coaching completed in both Departments effective 10/19/2012 2. Reeducated ICU RN's to documentation in the electronic health record. Coaching and reeducation completed on 10/19/12. 3. Move to cell phones rather than pagers for Respiratory Therapists. Expected completion date is November 30, 2012.

Date Printed: Wednesday, October 17, 2012

Creating a Culture of Safety

TODAYS OBJECTIVES:

- Share with you what it means to create a Culture of Safety;
- Give you an understanding of why humans experience errors; and
- Introduce you to the Behavioral-Based Expectations (BBE) and related error prevention tools that we use to create a safe culture.

WHAT IF……

- We could significantly reduce our errors?
- We could leave work feeling absolutely confident that we delivered the best care possible?
- We felt empowered to fix a problem related to safety?
- There were more ‘tools and less rules’ – fewer policies to fumble through?
- We came to work knowing exactly what is expected of us?

LET'S NOT LEARN PATIENT SAFETY BY ACCIDENT….

- Feb 22, 2001 18 month old Josie King died of a third world disease – dehydration--- in the best hospital in the world. Peter J. Pronomost, MD
- December 1994 Betsy Lehman, "Boston Globe Reporter Dies After Receiving An Accidental Four-Fold Overdose of Chemotherapy"
- Feb 1995 Willie King 51 year old Florida resident went to the hospital for amputation of his right leg. The wrong leg was removed.

  Instead of being able to walk with a prosthetic leg, he left in a wheelchair.

SAFETY-ALREADY A STRONG FOCUS

- SVH already has a strong commitment to safe, quality, and compassionate care by staff, leadership and the medical staff.
- We already track national patient safety goals and other key indicators of safety.
- We conduct root cause analyses when things go wrong to understand what factors contribute to errors and to prevent them in the future.
- We are implementing new technology to help “hard wire” error prevention into our processes.

WHY CULTURE IS IMPORTANT

- Culture: the shared values and beliefs of individuals in a group or organization.

Culture = Shared Values & Beliefs

Shared Values & Beliefs ⇒ Behaviors

Our Behaviors ⇒ Outcomes

CREATING A CULTURE OF SAFETY

- A Culture of Safety……

Promotes behaviors throughout the organization which result in safe, reliable, and productive performance.

WHAT'S IN IT FOR ME?

- I care about the safety of our patients.
- I care about the safety of myself and my coworkers.
- I care about the reputation of our hospital as a place to receive safe, quality care.
- I care about my reputation as an individual who behaves and acts in a responsible, accountable way.
- It makes my job easier.

HUMAN ERROR 101

Understanding WHY we make errors
and HOW to prevent errors.

FROM A PRIORITY TO A CORE VALUE

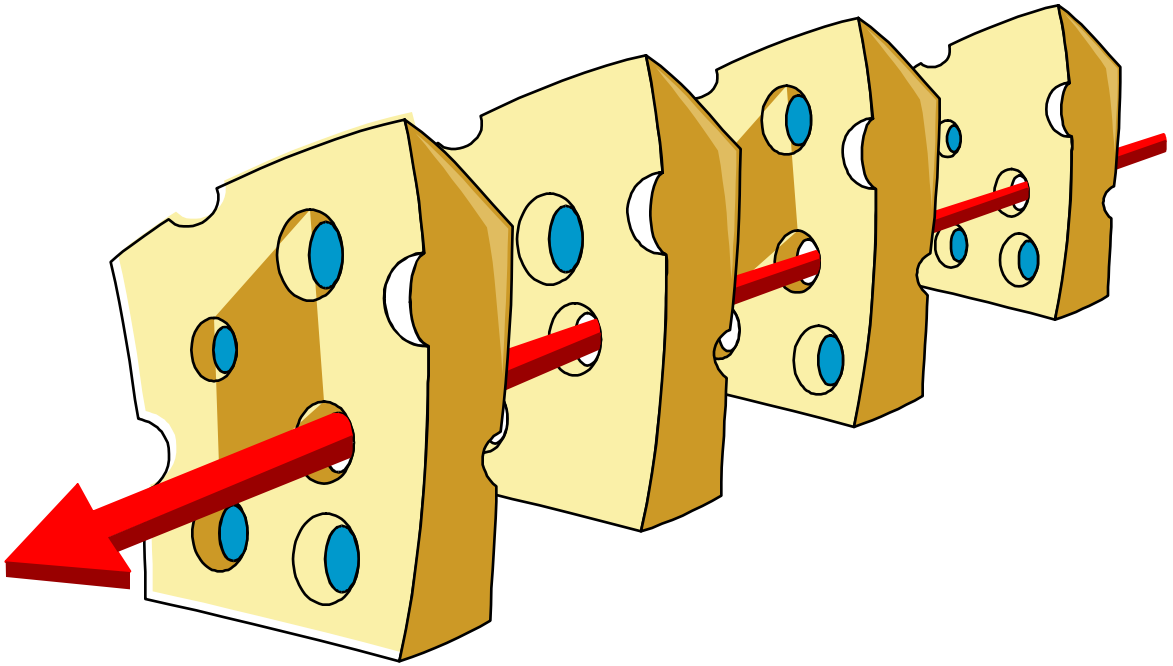
- Patient Safety should not be a priority.
- Why not? Because priorities shift. It can go up and down on a list.
- At SVH Safety is a core value. It is the basis of all that we do, the goals we set and the strategic direction we take.

SIX CIRCLES OF PERFORMANCE EXCELLENCE

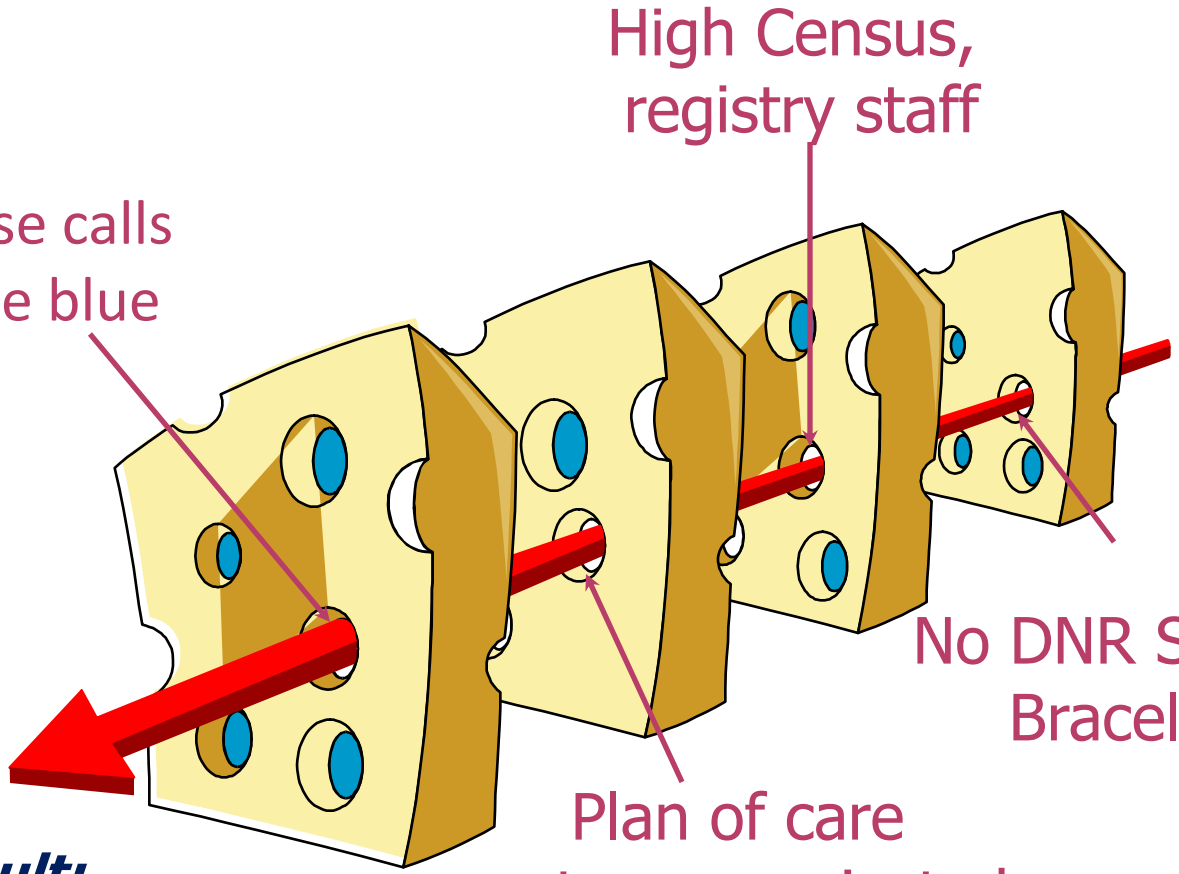
Safety = No Harm

Our Challenge: Figure out a way to achieve excellence in each circle at the same time, all the time!!

WHY DO EVENTS HAPPEN?



THE "SWISS CHEESE MODEL" OF MAJOR ACCIDENTS & ERRORS



End Result:

Patient Mistakenly Resuscitated

James Reason, *Human Error*

THREE WAYS HUMANS PERFORM

Courtney McMahon

THREE WAYS HUMANS PERFORM

- Skill-Based Performance

  a.k.a. Autopilot

- Rule-Based Performance

  a.k.a. If-Then Response

- Knowledge-Based Performance

  a.k.a. Figuring-It-out Mode

SKILLS BASED PERFORMANCE

- Autopilot Mode
- Doing tasks so familiar and routine that we don't even have to think about them while doing them.
- Error Types
  - Slips: without intending to, we do the wrong thing
  - Lapses: without intending to, we forget to do what we meant to do
- Error Rate: 3 out of every 1,000 acts
- Prevention Strategy:

Stop and think before acting

RULE-BASED PERFORMANCE

- If-Then Response Mode

  We choose how to respond to a situation using a rule we were taught or learned by experience.

  For example: easy math problems (2+2=4)

  Following detour signs when driving

  Adjusting speed to the speed limit

What are some examples from your work area?

RULES-BASED PERFORMANCE

- Error Types

  Use the wrong rule: we were taught or learned the wrong response for a situation.

  Misapply a rule: we knew the right response but chose the wrong response

  Choose not to follow the rule: usually because we think not using the rule seems like a better thing to do at the time.

- Error Rate: about 1 out every 100 choices
- Error Prevention Strategy: **Think a second time before choosing.**

KNOWLEDGE-BASED PERFORMANCE

- Figuring-it-Out Mode

  We are problem-solving in a new, unfamiliar situation. We don't have the skills or know the rules or no rules exist for the situation.

- Examples:

  Getting lost in an unfamiliar part of town

  Fixing the shuttle Discovery while in orbit

KNOWLEDGE-BASED PERFORMANCE

- Error Type:

  Arrive at the wrong solution to the problem: we didn't seek an expert source to find out the rule for the situation…or an expert source didn't exist for the situation.

- Error Rate: about 30 out of every 100 choices.
- Error Prevention Strategy: STOP and find an expert source.

3-STEP PLAN FOR CREATING A CULTURE OF SAFETY

- Establish Expectations

  Establish behavior-based expectations consistent with our mission, goals and leadership standards for event-free performance.

- Educate-Develop Knowledge & Skills

  Educate individuals at all levels of the organization on behavior-based expectations and error prevention techniques.

- Manage Accountability for Results

  Establish an accountability system to convert behaviors to work habits.

WHAT IS ACCOUNTABILITY?

- Accountability is….
  - Something everyone has;
  - Something you want to strive to build and enhance;
  - About being responsible for your actions, conduct and work; and
  - Intrinsic motivation to meet performance standards.

- **Accountability is not about punishing people!!**

VERTICAL ALIGNMENT
BACKBONE OF A STRONG CULTURE

Safest Hospital

Zero events of unintended harm

Communications required by processes & protocols

Communicate Clearly

Repeated backs
Clarifying Questions
Phonetic & numeric clarifications
SBAR
Good Catch

MAKING IT STICK

- Stages of an effective error prevention program:
  - *Awareness:* understanding what creates errors
  - *Skill Acquisition:* learning the tools
  - *Habit Formation:* practice makes habits
  - *Performance:* practices are hard wired

- Outcome Measure: Increased reporting of good catches & reduction in errors by 80% within 2 years.

BEHAVIOR-BASED EXPECTATIONS (BBE) TOOLBOX

Chris Kutza

BEHAVIOR-BASED EXPECTATIONS (BBE) TOOLBOX FOR ALL EMPLOYEES

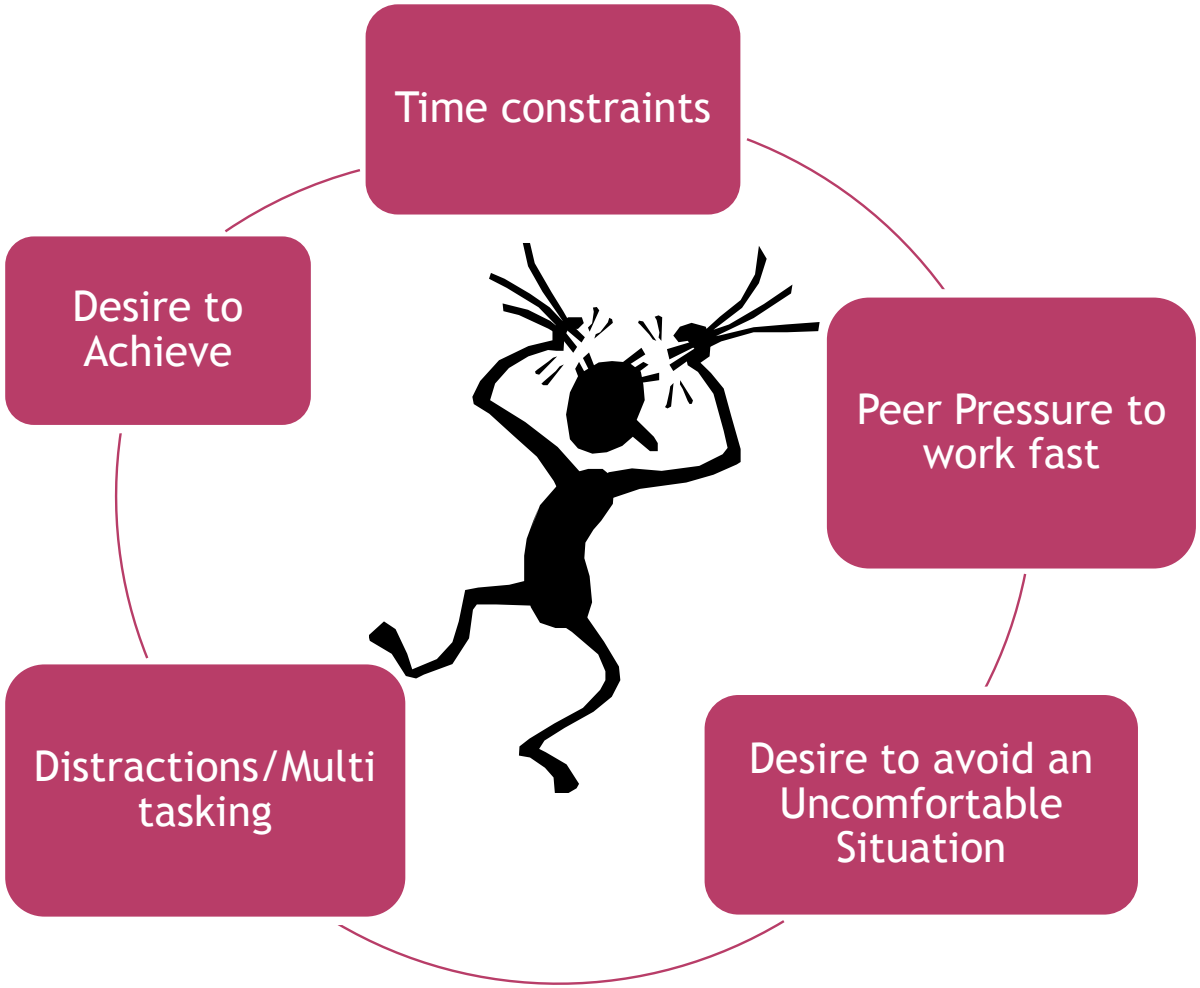
Behavior Expectation	Error Prevention Techniques
We Commit to Safety *We act so that safety comes first*	1. Pay Attention to Detail (STAR) 2. Speak Up and Listen (ARCC) 3. Never Leave Your Wingman
Communicate Clearly *We communicate so that information is complete, correct and understood*	1. Repeat/Read Backs 2. Clarifying Questions 3. Phonetic & Numeric Clarifications 4. SBAR 5. Effective Handoffs using 5P's
Think Critically *We use a questioning attitude to perceive correctly and ensure our actions are the best*	1. Qualify, Validate & Verify 2. Intelligent Compliance with P&P 3. Good Catch

PAY ATTENTION TO DETAIL

- Why should we do this?
  - To avoid unintended ***slips*** or ***lapses***
  - To reduce the chance that we'll make an error when we are under time pressure or stress.

PAY ATTENTION TO DETAIL

- What causes skill based errors?
  - Time pressure and work stress!
- Factors:



PAY ATTENTION TO DETAIL
SELF CHECKING USING STAR

Stop:	*Pause for 1-2 seconds to focus on what you are going to do.*
Think:	*Think about what you are about to do—is it the right thing?*
Act:	*Concentrate and perform the task.*
Review:	*Check to see if the task was done right.*

The most important step is …

It gives your brain a chance to catch-up with what your hands are getting ready to do.


EVERYONE NEEDS A
WINGMAN

NEVER LEAVE YOUR WINGMAN

- Helping others and expecting that others will help us.
- Why should we do this?
  - To ensure that conditions in the work environment are noted by other team members;
  - To ensure that team members benefit from our experience;
  - To provide independent checks when team members are readily available; and
  - To ensure that team members comply with policy, procedure, professional standards, and expectations.

NEVER LEAVE YOUR WINGMAN: PEER CHECKING

- Take advantage of working together
  - Identify slips and lapses
  - Point our unusual situations or hazards
- Check others when working together
  - Verify the correctness of acts
  - Impromptu consultations

Key to Successful Peer Checking

*Be willing to check others **AND** be willing to have others check us*

NEVER LEAVE YOUR WINGMAN: PEER COACHING

- Encourage: positively reinforce safe and productive behaviors
- Discourage: negatively reinforce unsafe and unproductive behaviors

- Habits for Peer Coaching:
  - *Balance positive and negative feedback (5:1)*
  - *Use the lightest touch possible to obtain the desired results*
  - *Talk with supervisor for difficult cases*

SPEAK UP AND LISTEN USING ARCC

- To ensure that we protect without offending or to help us assert against perceived authority. Use the lightest touch possible…

Ask a question (Inquire)

Make a Request (Advocate)

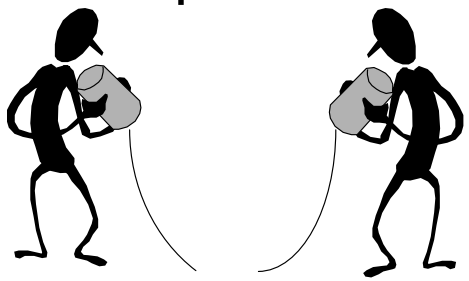
Voice a Concern (Assert)

If not, then use….

Chain of Command

COMMUNICATE CLEARLY

- Why should we do this?
  - To ensure that we hear things correctly and that we understand things correctly;
  - To prevent/avoid wrong assumptions and misunderstandings that could cause us to make wrong decisions; and
  - When you need to communicate about a problem or issue that needs clarification.



- When should we do this?

Whenever we communicate information—either in person or over the phone—that could affect the care and safety of a patient or employee.

REPEAT/READ BACK COMMUNICATION TECHNIQUE

- Repeat Back steps:
  - **Sender initiates** communication using Receiver's name. Sender provides an order, request, information to Receiver in a clear & concise format.
  - **Receiver acknowledges** receipt by a repeat-back of the order, request or information.
  - **Sender acknowledges** the accuracy of the repeat-back– **"That's Correct"**. If not correct, repeats the communication

- Read Back: all telephone orders & telephone reporting of critical values. Receiver writes it down and reads it back.

CLARIFYING QUESTIONS

- Ask 1-2 clarifying questions
  - When in ***high risk*** situations;
  - When information is ***incomplete***; and
  - When information is ***ambiguous***

- **Why?** *To reduce the probability of making a wrong assumption. Asking clarifying questions reduces the risk by 2 ½ times!!*

- **How?** *Phrase your clarifying question in a positive way and in a manner that will get an answer that improves your understanding of the information.*

PHONETIC & NUMERIC CLARIFICATIONS

- For sound alike words: say the letter followed by a word that begins with the letter.

  Example: A Alpha C Charlie Y Yellow
  R Romeo O Olive W Winner

- For sound alike numbers: say the number and then speak each digit of the number.

  Example: 15.. That's one-five
  50.. That's five-zero

SBAR BRIEFING FORMAT

- When you need to communicate about a problem or issue that needs resolution.
- Situation
  - Who you are calling about, the immediate problem, current vital signs, your concerns
- Background
  - Review the pertinent information: procedures, mental status, skin condition, oxygenation
- Assessment
  - Your view of the problem and the urgency of action
- Recommendation
  - Your suggestion to or request of the physician

EFFECTIVE HANDOFFS

- TICKET TO RIDE Ensure that complete & accurate information is communicated when responsibility transfers from one person to another.

Sticker/Name:

Room #:_____

RN Name:_____

Ticket to Ride

RN extension:_____

S

Transport to:_____ Reason/procedure:_____

☐ ID Band

B

Diagnosis:_____

Code Status: ☐ Full code ☐ No Code/DNR ☐ Limited Code:_____

Orientation: ☐ Oriented/follows instructions ☐ Confused/unable to follow instructions

Fall risk: ☐ Yes ☐ No Restraints: ☐ Yes ☐ No

Ability to stand: ☐ Independently ☐ With assistance ☐ Unable to stand

Isolation: ☐ None ☐ Contact ☐ Airborne ☐ Droplet ☐ Neutropenic

Allergies: ☐ Yes (List below) ☐ No

Communication: ☐ English ☐ Other Language:_____ ☐ Hard of hearing ☐ Visual Impairment

Other:

A

Oxygen:_____

IV/Tubes/drains: ☐ IV ☐ Foley (bag emptied) ☐ NG ☐ Other:_____

Recent medications/narcotics:_____ Time:_____

Other:

R

Post Procedure:

For questions, call _____ at extension_____

NOTES:

THINK CRITICALLY

- Why do we want this behavior?
  - To ensure that work activities are stopped when uncertain/unsafe conditions are identified.
  - To minimize the chance of a high-risk situation causing an error
  - To ensure consistent performance results

- Three techniques:
  - Qualify, Validate and Verify
  - Intelligent Compliance with Expectations
  - Good Catch program

QUALIFY & VALIDATE

- Qualify: consider the source
  - Is the source relevant?
  - Is the source accurate?

- Validate: think a second time
  - Does this condition or information make sense to me? Is it right based on what I know?
  - Is this what I expected?
  - Does this information “fit-in” with my past experience or other information I may have at this time?

Get in the habit of asking these questions all the time…. It takes only seconds

VERIFY

- Checking the accuracy of information with an independent, reliable source such as:
  - Monitors and indicators
  - lab values and physical data
  - Documentation
  - Another reliable individual
- Use Verify in these instances:
  - High risk situations
  - When your plan changes
  - When you note inconsistency from your validation effort

INTELLIGENT COMPLIANCE WITH EXPECTATIONS

- Know, comply, and use policies, procedures & job aids.
- Stop when unsure and check with expert source.

- *Do not proceed in the face of uncertainty if there is a question, if the situation does not match your experience, training or expectations and/or if the activity can't be performed as specified.*

GOOD CATCH PROGRAM

Cindi Newman and Lorna Gantenbein

GOOD CATCH PROGRAM

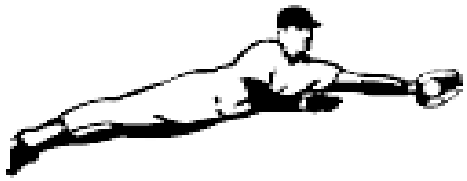
- What is a Good Catch?
- A Good Catch (akin to “Near Miss”) is the recognition of an event that could have been harmful but was prevented.
- What’s the importance?

  Near misses occur at a much higher rate than actual errors in patient care. Studies show that reporting near misses can prevent more serious errors.
- At SVH, we do not want to “name and blame”. We want to look for ways to identify and improve to create a culture of Safety and Quality that we can be proud of.

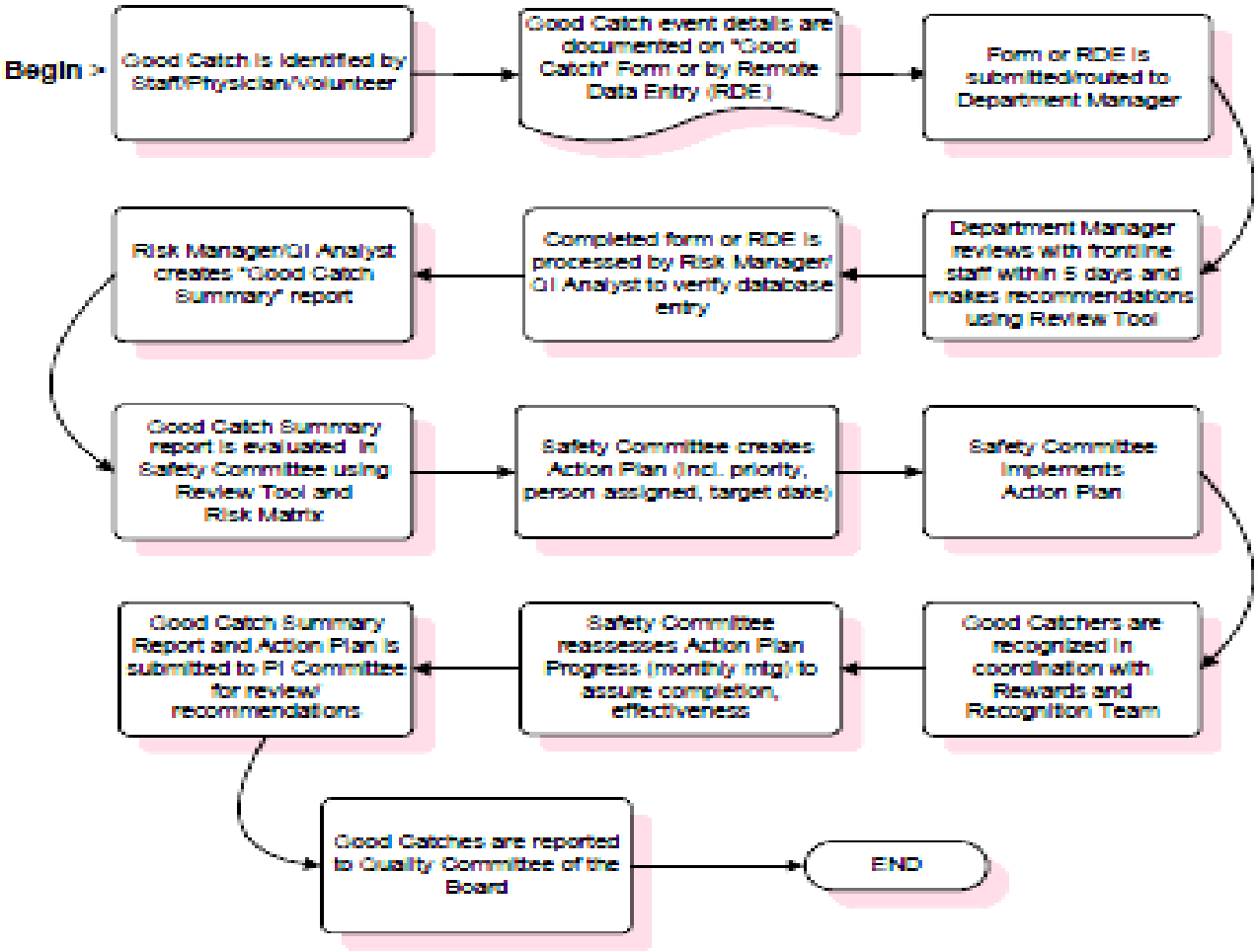
ESSENTIALS OF GOOD CATCH PROGRAM

- Change to positive, proactive terminology and mindset.
- Non-punitive reporting (can be anonymous)
- Encourage team-based, friendly competition
- End of shift safety reporting/rounding
- Leaders acknowledge top performers/good catchers—coordinate with R & R Team.
- Multidisciplinary work-group (front-line staff, Safety Committee) using consistent tools
- Increased reporting; decreased errors/harm.

SONOMA VALLEY HOSPITAL



GOOD CATCH PROCESS



GOOD CATCH TOOLS

TOOLS ARE IN “GOOD CATCH HANDBOOK” LOCATED IN YOUR CULTURE OF SAFETY BINDER.

- REPORT FORM OR REMOTE DATA ENTRY (RDE)
- REVIEW FORM
- RISK ASSESSMENT MATRIX
- POLICY AND PROCEDURE

RDE FACILITATES GOOD CATCH

Remote Data Entry (RDE) is:

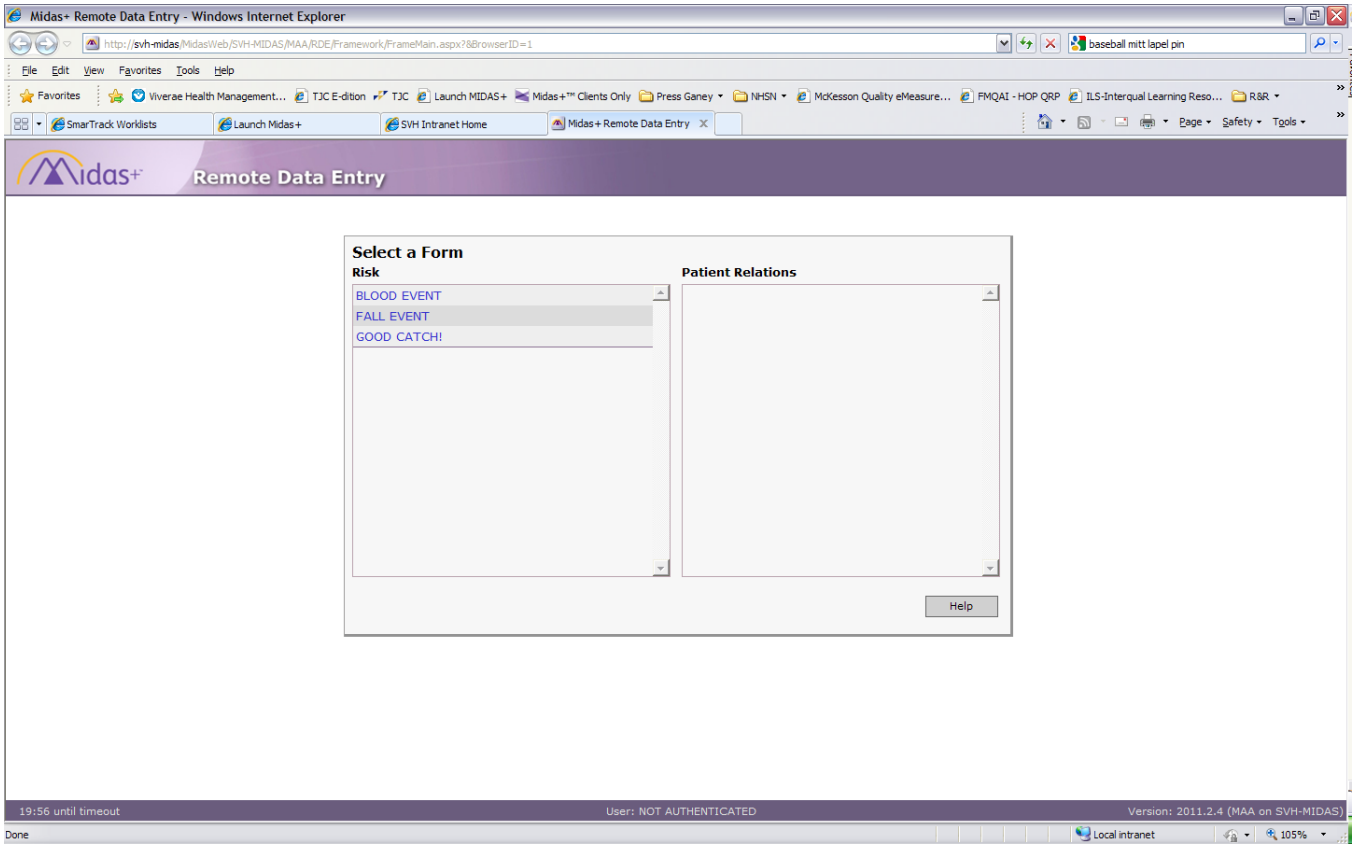
- Anonymous (if wished)
- Available on the intranet
- SIMPLE
- Is directly linked/integrated with existing Event Reporting database
- Data is trendable/reportable

RDE WILL REPLACE NOTIFICATION FORMS

Link on intranet home page

RDE SIMPLE INTERFACE

All events have specialized links



SUMMARY AND TAKE-AWAYS

- Tools
- Tip Sheet (rounding on staff every month)
- Packet

- Something to think about before the next Leadership meeting:
- How do we roll this out to the entire staff

9.A.

ADULT HYPOGLYCEMIA POLICY

SUBJECT: Adult Hypoglycemia Policy	POLICY #
	PAGE 1 OF 3
DEPARTMENT: Organizational	EFFECTIVE: 5/17/2012
APPROVED BY: Medical Director	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 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 (blood glucose level below 50mg/dl or is symptomatic with a blood glucose of 70mg/dl or below) must be initiated even if the patient is not symptomatic.

Procedure:

1. Perform a finger stick blood glucose test
2. If blood glucose level is below 50mg/dl, or if patient is symptomatic with a blood glucose less than or equal to 70mg/dl, notify attending physician if immediately available and if patient condition allows.
   (a) If unable to obtain physician's orders immediately, implement the most appropriate intervention based upon an assessment of the patient's clinical status.
3. If the patient is conscious and able to swallow, give one of the following:
   (a) Oral glucose gel (1 tube= 15gm glucose)
   (b) 4 ounces of fruit juice or cola
   (c) 1 packet honey
4. Repeat finger stick 15 minutes after giving fast acting carbohydrate. (Repeat steps 1&3 until the blood glucose rises above 70mg/dl.).
5. Follow with nourishment based on the following
   (a) If next meal is within 1 hour, request an early tray, have the patient eat as soon as possible

If next meal is more than 1 hour away, give patient one of the following snacks:

1 package graham crackers and 8 oz low fat or nonfat milk.
2 packages graham crackers and 8 oz low fat or nonfat milk
2 packages cheese and crackers.
2 packages peanut butter and crackers.
½ sandwich on whole wheat bread and 8 oz low fat or nonfat milk.
1 whole sandwich on whole wheat bread

- If IV access is available, administer 50% Dextrose, 25 gm slow IV push.
- If IV access is not available or can not be quickly obtained, administer Glucagon 1 mg IM. Position patient side lying.
- Notify the attending physician, or, if unavailable, the ED physician and obtain orders for further medical management.
- Repeat finger stick 10 minutes after injection of Glucagon or Dextrose.
    - Follow Physician orders
    - If patient regains ability to swallow and is not NPO:
      If blood sugar is below 80 mg/L, offer one of the following fast-acting carbohydrates (Each one contains 10-24gms of Carbohydrate):
      Oral glucose gel (1 tube)
      4oz fruit juice or cola
      1 packet of honey

- Repeat blood glucose test 15 minutes after giving fast-acting carbohydrate. Repeat steps 1 & 3 and until blood glucose rises above 80mg/dL.
- If patient is NPO or unable to swallow, start D5W at 100ml/hr.
- If IV unavailable notify attending physician immediately.
- Follow with nourishment based on the following:
    - If next meal is to be within one hour, request an early tray. Have patient eat as soon as possible.
    - If next meal is more than one hour away, give patient one of the following snacks.
      1 package of graham crackers and 8oz of low fat or nonfat milk.
      2 packages of cheese and crackers.
      2 packages of peanut butter and crackers.
      ½ sandwich and 8oz of low fat or nonfat milk.
      1 whole sandwich.

6. Hold all insulin and all oral diabetic medications until ordered by MD to restart medications.
7. Check blood glucose Q4 hrs x 24 hrs.

SUBJECT: Adult Hypoglycemia Policy	POLICY #
	PAGE 3 OF 3
DEPARTMENT: Organizational	EFFECTIVE: 5/17/2012
APPROVED BY: Medical Director	REVISED:

Reference:

1.Workgroup on Hypoglycemia, American Diabetes Association. Defining and reporting hypoglycemia in diabetes: a report from the American Diabetes Association Workgroup on Hypoglycemia. Diabetes Care 2005; 28:1245.