June 19 2019 Regular Meeting

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DRAFT AGENDA

NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS REGULAR MEETING

June 19, 2019 at 5:30 p.m.

2957 Birch Street, Bishop, CA

1. Call to Order (at 5:30 pm).
2. Introduction, Southern Mono Healthcare District Chief Executive Officer (*information item*).
3. At this time persons in the audience may speak on any items not on the agenda on any matter within the jurisdiction of the District Board (*Members of the audience will have an opportunity to address the Board on every item on the agenda. Speakers are limited to a maximum of three minutes each).*
4. Strategic Plan update, Quality and Performance Committee report (*information item*).
5. Chief of Staff Report; Allison Robinson MD:
   A. Medical Staff Officers and Service Chiefs for 2019/2020 (*action items*):
      1. *Chief of Staff – William Timbers, MD*
      2. *Immediate Past Chief of Staff – Allison Robinson, MD*
      3. *Chief of Emergency Room Service – Sierra Bourne, MD*
      4. *Chief of Medicine – Nickoline Hathaway, MD*
      5. *Chief of Obstetrics – Martha Kim, MD*
      6. *Chief of Pediatrics – Charlotte Helvie, MD*
      7. *Chief of Radiology – Edmund Pillsbury, MD*
      8. *Chief of Surgery – Robbin Cromer-Tyler, MD*
      9. *Member-at-Large – Stacey Brown, MD*
   B. Policy and Procedure approvals (*action items*):
      1. *Patient Safety Attendant or 1:1 Staffing Guidelines*
      2. *High Alert Medications: Preparation, Dispensing, Storage*
      3. *Newborn Blood Glucose Monitoring*
      4. *Neonatal Death, Fetal Demise & Spontaneous Abortion Procedure*
      5. *Nursing Management of Preeclampsia*
      6. *Pediatric Standards of Care and Routines*
      7. *Removal of Placenta from Hospital per Patient's Request*
      8. *Infection Prevention Plan*

9. Vendor Credentialing

10. Aerosolized Transmissible Disease Exposure Plan/Respiratory Protection Program

11. Healthcare Worker Health Screening and Maintenance Requirements

12. Skilled Nursing Facilities

13. Standards of Care ICU

14. Definition and Limitations of Direct Access Physical Therapy Care

15. Standards of Care in the Outpatient Infusion Unit

C. Perinatal Critical Indicators 2019 - update (*action item*).

D. Core Privilege form update (*action item*):

1. Family Medicine

E. Medical Staff Appointments (*action items*):

1. Samantha Jeppsen, MD (*emergency medicine*) – Provisional Active Staff
2. Carly Harvey, MD (*radiology*) – Provisional Consulting Staff

F. Temporary Privileges for 60 days (*action item*):

1. Ruhong Ma, DO (*internal medicine*) – Locums/Temporary Staff

G. Extension of privileges for an additional 60 days (action items):

1. Kristina Jong, MD (*radiology, breast imaging*) – effective 6/7/19
2. Michael Rhodes, MD (*internal medicine/hospitalist*) – effective 6/24/19
3. Joseph BenPerlas, MD (*internal medicine/hospitalist*) – effective 5/23/19

H. Additional Privileges (action item):

1. Uttama Sharma, MD (*family medicine*) – chemotherapy in consultation with oncologist

I. Resignation (*action item*):

1. Sun Kim, MD (*urology*) – effective 5/2/19

6. New Business

A. Operating Budget 60-day extension of 2018/2019 budget (*action item*).

B. District Board Resolution 19-04, *Appropriations Limit for 2019/2020* (*action item*).

C. District Board Resolution 19-05, *Funding of NIHD 401(a) Pension Plan* (*action item*).

D. RQI Master Services Agreement (*action item*).

E. Employee Engagement Survey results (*information item*).

F. Pharmacy update (*information item*).

G. Determination of date for Board Self-Assessment review (*information ite*m).

H. Ad Hoc Committee report and appointment of Board member for District Zone 1 (*action item*).

7. Old Business
   A. Athena update (*information item*).
   B. Phase III budget management (*information item*).

Consent Agenda (action items)

8. Approval of minutes of the May 15 2019 regular meeting
9. Approval of minutes of the May 28 2019 special meeting
10. Policy and Procedure annual approvals

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11. Reports from Board members (*information items*).
12. Adjournment to closed session to/for:
    A. Discuss trade secrets, new programs and services (estimated public session date for discussion yet to be determined) (*Health and Safety Code Section 32106*).
    B. Conference with Labor Negotiators; Agency Designated Representative: Irma Moisa; Employee Organization: AFSCME Council 57 (*pursuant to Government Code Section 54957.6*).
    C. Conduct Public employee performance evaluation, Chief Executive Officer (*pursuant to Government Code Section 54957*).
13. Return to open session and report of any action taken in closed session.
14. Adjournment.

In compliance with the Americans with Disabilities Act, if you require special accommodations to participate in a District Board meeting, please contact administration at (760) 873-2838 at least 48 hours prior to the meeting.

Stacey Brown

Robin Christensen

Scott Hooker

Jeff Kneip

Jannalyn Lawrence

Richard Miears

Justin Nott

Wendy Runley

Lynda Vance

Quality Improvement Operational Team

NIHD Health Care Worker Vaccination Rate 2018-2019 Influenza Season

Personnel Type	Declinations	Contraindicated	Vaccinated Else-ware	Vaccinate Here	Working	Percent Vaccinate
Employee	10	1	14	481	536	99%
Licensed Independent Practitioner	2	0	25	46	73	97%
Adults students trainees and volunteers	2	0	10	32	44	95%
All health Care Workers	14	1	49	559	623	98%

Sepsis Definition

Sepsis is the body's overwhelming and life-threatening response to infection that can lead to tissue damage, organ failure, and death. In other words, it's the body's overactive and toxic response to an infection

Retrieved from Sepsis Alliance. (2019). https://www.sepsis.org/sepsis/definition/

Who is at Risk for Sepsis?

Anyone can get an infection and any infection can lead to sepsis. Certain people are at higher risk:

- Adults 65 or older
- People with chronic medical conditions such as diabetes, lung disease, cancer, and kidney disease
- People with weekend immune systems
- Children younger than one
- Implanted medical device or recent surgical procedure

Common infections that can lead to sepsis

- Urinary tract infection
- Pneumonia
- Flu
- MRSA

Team Goal

- Raise community awareness on “early warning signs” of sepsis
- Improve patient outcomes by:
- Decrease patients presenting to hospital in “severe sepsis’ or “septic shock”
- Decrease inpatient mortality
- Decrease hospital length of stay

Community Awareness

- Education material distributed (English and Spanish)
- Posters around NIHD on campus
- Vons Shopping cart insert
- Newspaper article & radio announcements
- Public education
  - Bishop Care Center, Sterling Heights, Senior Center
- Dr. Brown to focus on sepsis with “ Healthy Lifestyle Talk”

TIME

Combination of these symptoms

Temperature

Higher or lower than normal

Infection

May have signs and symptoms of an infection

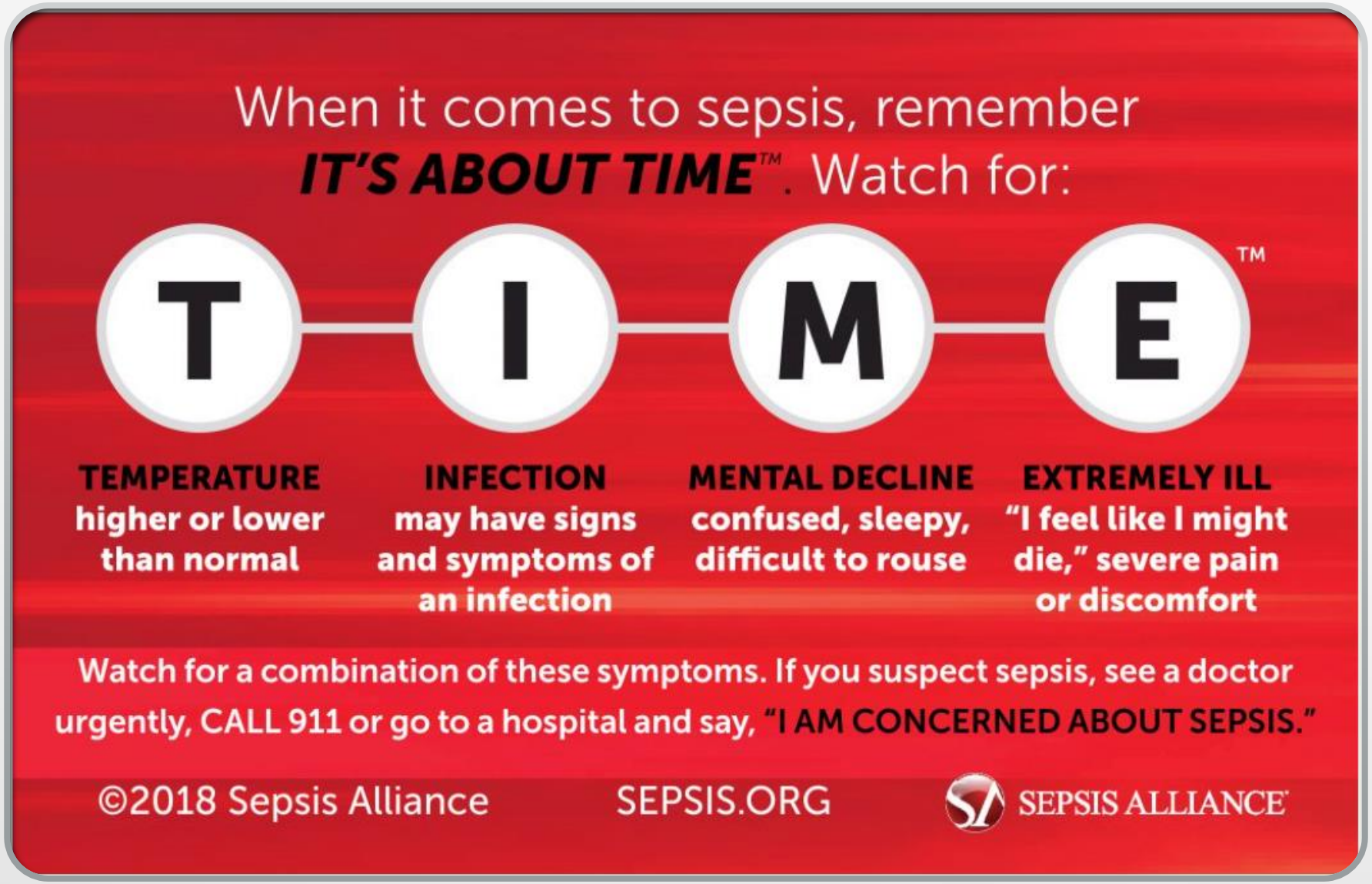
Mental Decline

Confused, sleepy, difficult to rouse

Extremely ill:

“ I feel like I might die”

Severe pain or discomfort



Example of public education material/card

Next Quarter Goals & Metric

Review last 10 adult patients charts that presented in severe sepsis or septic shock to obtain baseline

Review number of adult patients diagnosed with sepsis before and after community education campaign

Follow CMS Inpatient Quality Reporting (IQR) reporting algorithm* (see next slide)

Numerator: # of adult patients who meet IQR criteria (best practice)

Denominator: # of adult patients with diagnosis of Severe Sepsis and/or Septic Shock

*** Only validated for patients 18 years or older**

Hour-1 Bundle

Initial Resuscitation for Sepsis and Septic Shock

Surviving Sepsis Campaign

MEDICAL EMERGENCY

Initiate bundle upon recognition of sepsis/septic shock.

May not complete all bundle elements within one hour of recognition.

1 Measure lactate level.

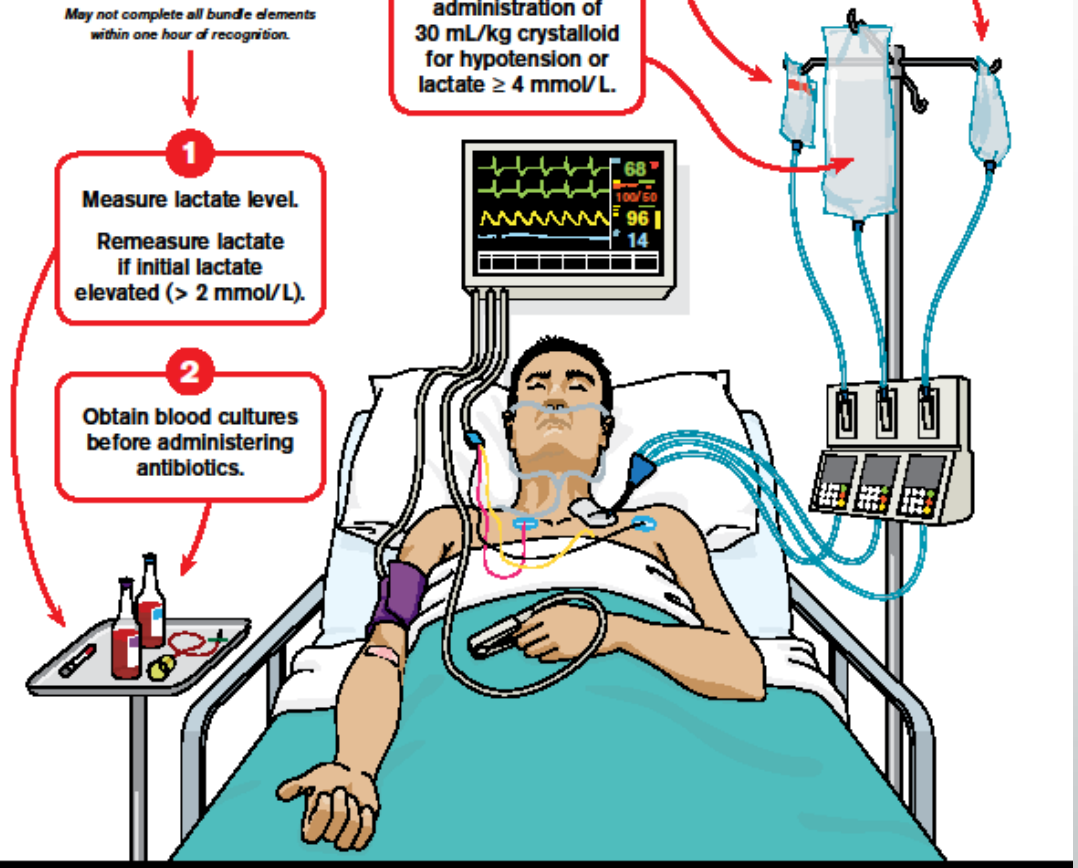
Remeasure lactate if initial lactate elevated (> 2 mmol/L).

2 Obtain blood cultures before administering antibiotics.

3 Administer broad-spectrum antibiotics.

4 Begin rapid administration of 30 mL/kg crystalloid for hypotension or lactate ≥ 4 mmol/L.

5 Apply vasopressors if hypotensive during or after fluid resuscitation to maintain a mean arterial pressure ≥ 65 mm Hg.



Bundle: SurvivingSepsis.org/Bundle **Complete Guidelines:** SurvivingSepsis.org/Guidelines

Society of Critical Care Medicine

References

Centers for Disease Control and Prevention. (2018). What is sepsis?. Downloaded 6/11/19 from https://www.cdc.gov/sepsis/what-is-sepsis.html

Sepsis Alliance. (2019). Suspect Sepsis. Save Lives. Downloaded 6/11/19 from https://www.sepsis.org/

Surviving Sepsis Campaign. Downloaded 6/11/19 from https://www.survivingsepsis.org

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Patient Safety Attendant or 1:1 Staffing Guidelines*	
Scope: Nursing Services	Manual: CPM - Patient Safety (PS)
Source: Chief Nursing Officer	Effective Date: 4/1/16

PURPOSE:
The purpose of a Patient Safety Attendant (SA) is to help keep the patient oriented to place and/or help assure the patient's safety by one-to-one observation.

POLICY:
1. A Medical Staff Practitioner may write an order for a patient safety attendant however a nurse may also initiate the use of a SA through assessment and by collaboration with other team members. Patient safety attendant criteria include:
    a. Suicide precaution (All patients on suicide precautions will have a safety attendant until a physician has cleared the patient from such precautions.)
    b. Protecting patients from harm when they are at high risk for falls
    c. Patient disorientation/non cooperative
2. With the exception of a patient placed on suicide precautions (one-to-one observation), the patient's family may serve as a patient safety attendant.
3. Patient safety attendant may be from different levels of care providers, including LVN, CNA, Clerk, Security, Environmental Services, etc.
4. Performance standards of a patient safety attendant (what the patient safety attendant may do for and with the patient) will be based on the patient safety attendant's job description.

PROCEDURE:
1. When a patient safety attendant is deemed necessary for the safety of the patient, the RN or designee will notify the House Supervisor (HS) for coverage. The HS will find staffing coverage.
    a. Patient Safety Attendants are usually not provided in ICU or when staffing meets 1-2 patient ratio
2. If a patient's family member chooses to sit with the patient, instructions will be given that the family member is to:
    a. Call for assistance as needed using the call bell
    b. Not to leave the patient unattended
3. A guest tray may be ordered for the family member who is sitting with the patient.
4. All patient care is under the direction of the RN assigned to the patient. The RN will:
    a. Give direction to the SA based on the SA's job description performance standards
    b. Check on the SA when completing hourly rounding every hour from 0800-2200 and every two hours from2200-0800
5. The patient SA will be located in the room with the patient. The patient SA will:
    a. Not leave the room (i.e. breaks and meals unless relieved by another person)
    b. Notify the RN of any assistance needed or concerns
    c. Document utilizing the 'close observation' form every 15 minutes for patients requiring SA (see attached document)
    d. Follow the 'Safety Attendant Guidelines' (see attached document)
6. The patient need for a patient safety attendant should be re-assessed on an ongoing basis but not less that every 24 hours.
    a. Patient Safety Attendant continuation will be reviewed at the daily interdisciplinary team meeting.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Patient Safety Attendant or 1:1 Staffing Guidelines*	
Scope: Nursing Services	Manual: CPM - Patient Safety (PS)
Source: Chief Nursing Officer	Effective Date: 4/1/16

REFERENCES:

1. McFarlane-Kolb, H. (2004) Falls Risk assessment, Multitargeted Interventions and Impact on Hospital Falls. International Journal of Nursing Practice 10: 199-206
2. NCPS Falls Toolkit; 2004 National Center for Patient Safety.http://www.patientsafety.gov/SafetyTopics/fallstoolkit/notebook/completebooklet.pdf.
3. Care of the Psychiatric Patient in the Emergency Department, ACEP Emergency Medicine Practice Committee (2014)
4. Sentinel Event Alert: New Alert Focuses on Suicidal Ideation, The Joint Commission Perspectives, (2016)

CROSS REFERENCE P&P:

1. Management of the Behavioral Health Patient (5150 and non-5150)
2. Fall prevention and management

Approval	**Date**
CCOC	5/14/19
MEC	6/10/19
Board of Directors	
Last Board of Director review	4/18/18

Developed: 12/92
Reviewed: 10/97, 3/06, 5/09, 5/11, 9/12, 4/18ta
Revised: 1/16, 4/19ta

Replaces 1:1 Staffing (Sitter)

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: High Alert Medications: Preparation, Dispensing, Storage*	
Scope: Pharmacy, Nursing Services	Manual: CPM - Medication (MED), Pharmacy
Source: Pharmacy Director	Effective Date: 9/15/17

PURPOSE:
To ensure that the preparation, dispensing, and storage of high alert medications occurs safely

POLICY:

1. High Alert medications are cancer chemotherapy drugs, monoclonal antibody drugs, concentrated electrolytes solutions, insulin, heparin, PCA narcotics, neuromuscular blocking agents and any medications designated as High Alert by the Pharmacy and Therapeutics Committee.

2. High Alert medications will not be dispensed or prepared for dispensing without a Provider order.

3. Prior to preparation or dispensing, the pharmacist will check the diagnosis, indications, contraindications, precautions, adverse effects, dose, route of administration in an FDA sanctioned publication (e.g.: the package insert), or in a industry-recognized compendium such as the American Hospital Formulary Service, Facts and Comparisons Chemotherapy Manual, or in a peer-reviewed article in a recognized medical journal. This step may be skipped if the pharmacist is sufficiently familiar with the drug to judge the safety and appropriateness of the order.

4. The drug will only be prepared and dispensed if the pharmacist is satisfied of the safety and appropriateness of the drug and dose.

5. For cancer chemotherapy orders and for orders written on a Chemotherapy Orders sheet, the pharmacy Chemotherapy Policy and Procedure will be followed.

6. Prior to the final mixing of non-chemotherapy High Alert medication, the prepared dose of the medication will be double checked by another pharmacist, a pharmacy technician, or a registered nurse.

Department specific actions for High Alert Medications:

Class of Medication	**Pharmacy**	**Nursing**
Chemotherapy	Segregated in pharmacy Double check	Double check
Monoclonal Antibody	Segregated in Pharmacy Double check	Double check
Concentrated Electrolyte Sol.	Alert Note in Pharmacy Double check	
Insulin	Double check	Double check
Heparin	Pre-mix sol (excludes Heparin Flush for line integrity)	Double check
PCA Narcotics	Double check	Double check Alert packaging
Neuro-Muscular Blocking Agent	Alert Note in Pharmacy	Alert packaging
Oxytocin	Double check	Double check Alert packaging

Title: High Alert Medications: Preparation, Dispensing, Storage*	
Scope: Pharmacy, Nursing Services	Manual: CPM - Medication (MED), Pharmacy
Source: Pharmacy Director	Effective Date: 9/15/17

OB Premixed Epidural	Mixed by Pharmacist Only	Lock Box in Refrigerator Alert packaging Double check
Thrombolytics (Alteplase, TNKase)	Double check	Double check

Double check means that medication and dose are independently checked by 2 licensed practitioners.

Approval	**Date**
CCOC	11/19/18
Pharmacy and Therapeutics Committee	2/21/19
Medical Executive Committee	6/10/19
Board of Directors	
Last Board of Director Review	7/19/17

Revised: 2/04, 12/09, 11/18jk
Reviewed: 10/05, 9/10, 9/11, 9/12, 11/13, 4/14, 3/15/17
Supersedes:
Index Listing

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

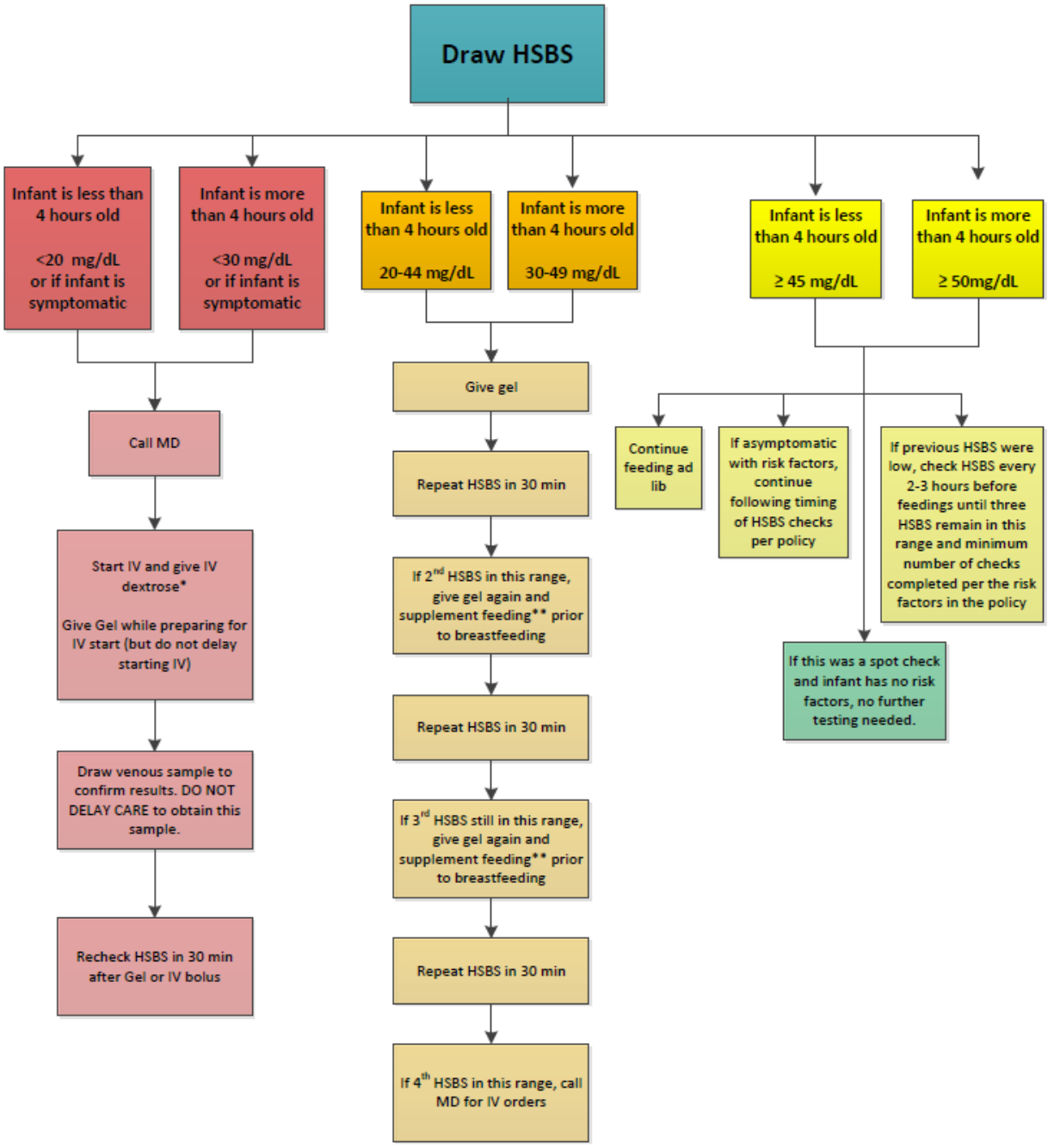
Title: Newborn Blood Glucose Monitoring	
Scope: Perinatal	Manual: Perinatal
Source: Manager of Perinatal Department	Effective Date:

PURPOSE:
Blood glucose monitoring is done to ensure stable blood glucose levels in neonates at risk.

POLICY:
1. All newborns will be assessed for the need to monitor blood glucose levels.
2. Only infants with risk factors for hypoglycemia (asymptomatic) or clinical signs consistent with hypoglycemia (symptomatic) will undergo routine glucose screening.
3. All testing will be done by heelstick blood sugar (HSBS) unless otherwise indicated.

PROCEDURE:
1. Assess all newborns for hypoglycemia risk factors (see below)
2. **INITIAL** feed: All infants should be fed within the first hour of life and prior to the first blood glucose check, unless unstable.
3. Screen all at risk infants within 2 hours of birth. See below for risk factors
4. Screen all symptomatic newborns immediately.
    - Symptoms include irritability, exaggerated Moro reflex, high pitched cry, decreased suck, temperature instability, jitteriness, tachypnea, apnea, lethargy, decreased tone, or seizures.
5. Screen all asymptomatic newborns with risk factors at the times described below:
    - Screen for **24 hours** (Check blood glucose at 1 hour of age, and then at approximately 4, 7,13 and 19 hours of age. Check blood glucose prior to feeds whenever possible. Further screening needed if any of the last three blood glucose results are <45. Recheck blood glucose immediately if infant becomes symptomatic.
        - PRETERM (less than 37 weeks gestation)
        - SGA *(UpToDate chart attached)*
        - Trisomy 21
        - Endocrine/metabolism disorders, or midline defect or microphallus
        - Maternal intrapartum dextrose infusion or maternal hypoglycemia
    - Screen for **12 hours** Check blood glucose at 1 hour of age then approximately 4 and 7 hours of age. Check blood glucose prior to feeds whenever possible. Further screening needed if any blood glucose results are <45. and Recheck blood glucose immediately if infant becomes symptomatic.
        - LGA ≥4000 grams
        - Infant of diabetic mother (IDM)
        - Postdates (>42 weeks gestation)
        - Discordant twin (weight is 10% less than twin)
        - Perinatal stress (arterial cord pH <7, 5 minute Apgar score <7)
        - Suspected sepsis, maternal infection or maternal fever > 38.3˚C
        - Prolonged respiratory distress for greater than30 minutes (Respiratory rate >60 rpm or infant requiring oxygen)
        - Infants requiring continuous IV fluids at greater than 5mL/hr
        - Maternal treatment with terbutaline, propranolol, or labetalol within 48 hours prior to delivery
        - Congenital cardiac malformations

- Hyperviscosity/polycythemia (Hct >65%)



Orders required for the following:

*IV Dextrose: D10W 2ml/kg over 1-2 minutes then continuous D10W at 80ml/kg/day.
**Gel: Dextrose gel 40%. Rub into dry buccal surface. Breast feed immediately after giving gel whenever possible.
***Supplemental feeding: Give at least 8 ml (and up to 30ml if tolerated) of expressed breast milk or formula.

Title: Newborn Blood Glucose Monitoring	
Scope: Perinatal	Manual: Perinatal
Source: Manager of Perinatal Department	Effective Date:

SGA Chart (per *UpToDate*)

Gestation	Male	Female
36	≤2407	≤ 2300
37	≤ 2596	≤ 2484
38	≤ 2769	≤ 2657
39	≤ 2908	≤ 2796
40	≤ 2986	≤ 2872
41	≤ 3007	≤ 2891
42	≤ 2998	≤ 2884

REFERENCES:

1. *Overview of the routine management of the healthy newborn infant*, UpToDate
2. *Management and outcome of neonatal hypoglycemia*, UpToDate
3. *AWHONN Templates for Protocols and Procedures for Maternity Services*, 2nd edition, Patti Besuner, RN, MN, CNS Washington, DC 2010 P123-124

CROSS REFERENCE P&P:

1. Admission, Care, Discharge and Transfer of the Newborn

Approval	**Date**
CCOC	7/16/18
PeriPeds	5/14/19
Medical Executive Committee	6/10/19
Board of Directors	
Last Board of Directors Review	

Developed: 4/1/2018
Reviewed: 3/2019AF
Revised: : 3/2019AF
Supersedes: Newborn Blood Glucose Monitoring
Index Listings:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: /FPOBUBM %FBUI 'FUBM %FNJTF 4QPOUBOFPVT "CPSU.	
Scope: Perinatal	Manual: Perinatal
Source: Perinatal Nurse Manager	Effective Date:

PURPOSE: To provide guidelines for nursing personnel in the care of neonatal death, fetal demise or spontaneous abortion.
To provide emotional support to the parents/family experiencing a fetal/neonatal death.

POLICY:

1. Every neonatal death and/or fetal demise (stillborn) shall be processed in a legal manner.
2. Every effort shall be made to facilitate this process in a caring, sensitive manner.
3. The attending physician will determine the gestational age of the infant/fetus.
4. "Products of conception" that meet the "Live Birth" definition must have a birth certificate.
5. The fetus born at less than 20 weeks gestation will be sent to Pathology as a tissue specimen.
6. A physician will be called to examine any "Live Birth" under 20 week's gestation.
7. Infant/fetal death following a "Live Birth" requires disposition of the remains by a mortician and issuance of a death certificate.
8. Social Service will be notified of any fetal/neonatal death.
9. The family is responsible for making funeral arrangements.
10. All neonatal/fetal deaths that qualify as a coroner's case will be reported as required.
11. Neonatal resuscitation procedures will be followed for any "Live Birth" unless/until "No Code" order given/written by physician. A medical record number will be issued for any fetus born live. If a fetus is stillborn, no medical record number will be issued.
12. It is the responsibility of the physician to obtain consent from the family for an autopsy.
13. For any of the below status, please hang the butterfly picture on the outside of mom's room so to alert staff (including EVS, dietary, lab, etc.) that this mom is experiencing a loss.

DEFINITIONS:

Birth is defined as the complete expulsion or extraction from its mother the product of conception (irrespective) of the duration of, or viability of the pregnancy

Adherence to the following definitions is required:

Live birth: means the complete expulsion or extraction from its mother of a product of conception which breathes, has a heartbeat, pulsating umbilical cord or definite movement of voluntary muscles before or after cutting of umbilical cord or placental separation.

Fetal death/stillborn: means death prior to birth, as defined as the complete expulsion or extraction of a product of conception which does not breathe, have beating heart, pulsating umbilical cord or definite movement of voluntary muscles, at any time. (Before or after the umbilical cord is cut or placenta separates).

Abortus: A fetus or embryo expelled from the uterus before the 20th week of gestation and showing no signs of life.

Neonatal death: Death of an infant that was born live. (called a neonate from birth through the first 27 days).

Title: /FPOBUBM %FBUI 'FUBM %FNJTF 4QPOUBOFPVT "CPSU…	
Scope: Perinatal	Manual: Perinatal
Source: Perinatal Nurse Manager	Effective Date:

PROCEDURE:

A. Neonatal Death: Care at delivery of "Live Birth" of a non-viable fetus, due to immaturity or anomalies incompatible with life.
   1. Dry infant with blankets.
   2. If physician not present, cut and clamp the cord.
   3. Assess Apgar score.
   4. Assign medical record number.
   5. Follow neonatal resuscitation procedures unless/until order by physician for "no code" is given or until physician has pronounced infant death.
   6. After no code order given or infant pronounced dead by physician:
      a. wrap infant in dry blanket, use stockinet cap to cover cranial deformities, if appropriate
      b. allow parents to hold infant for as long as desired
      c. Assist the family in Spiritual, Cultural, or Family traditions
      d. place completed baby identification bands on infant
      e. weigh and measure infant
      f.. if infant still has any signs of life, keep infant warm and provide comfort care as ordered.
      g. note Apgars per protocol, and note the time of birth and death in the newborn and mothers charts (any live birth requires an infant chart to be generated)

B. Memory Box Preparation
   a. take Digital picture of infant, label it with mother's name, date and time of birth, and offer to parents with other mementos (lock of hair, footprints etc.) in memory box describing the memory box and its contents and its present location (follow instructions on memory box)—camera and other necessary equipment for compiling mementos for the family are in the "grief" bag located in the utility room. Label a zip lock bag (with the addressograph card stamped on the label) and place it in the Memory box containing their mementos. If the parents are not interested in the memory box at the time of discharge, the box can be stored in OB Nurse Managers office or after 1 year to be stored in Medical Records. Place a patient belonging envelope in the Medical Record.
   b. Offer these to the family--if they do not wish to have these at this time, leave memento's in a zip-lock bag in chart so the parents may have them available at a later date.

C. Care at delivery of "Fetal Death"/Stillborn
   1. Dry infant with blankets
   2. If the physician is not present, clamp and cut the cord
   3. Follow procedures outlined in 5a-5g above
   4. All chart entries are made on the mothers chart--no separate infant chart is generated if the infant is stillborn

D. Care and disposition of remains of "Fetal Death" under 20 weeks (does not include "Live Birth" under 20 weeks with subsequent death)
   1. Weigh and measure fetus, record on delivery record

2. Place fetus and placenta in specimen bucket with formalin (various sizes of specimen containers are located in the cabinet with the "grief bag") unless for genetic studies then place in normal saline
3. Label side of bucket with patient identification sticker. Complete pathology request form (include all relevant information on pathology requisition, i.e. gravida/para, date and time of delivery, gestational age, etc)
4. Take fetus to pathology, place in the Lab refrigerator on A Floor if after hours, or give to supervisor to take to pathology refrigerator after hours.
5. Parents have the right to take the fetus and placenta with them if they so desire.

E. Care and disposition of remains of "Fetal Death" 20 weeks and over or live birth with subsequent death

1. Weigh and measure fetus, record on delivery record.
2. Wrap the body in blue underpad. Place identa-band on arm or leg of body. For fetus too small or macerated to put arm or leg bands on, place the band across the body inside the underpad. Wrap the baby in a clean blanket and pin the second identa-band to outside of blanket.
3. Send placenta to pathology in the usual manner:
    a) if no genetic work-up required, then placenta is placed in formalin and sent to pathology
    b) if genetic work-up is required, then placenta is placed in normal saline and sent to pathology
4. Notify the supervisor that the baby is ready to be sent to the mortuary (all paperwork must be filled out and given to the mortuary at the time they arrive to take the body); all babies 20 weeks and over are sent to the mortuary regardless of whether an autopsy is to be done or not

F. Genetic Workup

1. If genetic workup is requested, provider will obtain 1x1 segment of placenta and place in normal saline. Collection of specimen can be performed by an RN. Provider order is required.

G. Checklist:

ALL INFANTS

_____ Spiritual, Cultural or Family traditions included in patient wishes
_____ Weight and length of infant documented
_____ Momentos given to family: complete and follow directions in memory box
_____ "No Code" order by MD when appropriate
_____ Social Services contacted
_____ Copy of face sheet to mortuary with fetus if indicated
_____ Autopsy consent signed if indicated
_____ Release of body consent signed by mortician if indicated
_____ Birth certificate information completed and signed by parent if live birth occurred
_____ High risk referral sent to Health Department

Title: / F P O B U B M % F B U I ' F U B M % F N J T F 4 Q P O U B O F P V T " C P S U J	
Scope: Perinatal	Manual: Perinatal
Source: Perinatal Nurse Manager	Effective Date:

Less Than 20 Weeks

___ MD statement of gestational age
___ Contact mortuary for any fetus ≥ 20 weeks
___ Contacted MD if gestational age not documented

___ Place in formalin and send to pathology,
or if genetic work-up is ordered, then specimens sent in normal saline

Greater Than 20 Weeks

__ Notify MD that death certificate is required

___ Paperwork completed and ready for mortician

__ L&D record completed and signed

Genetic Workup
_____ Pathology slips completed and attached
_____Placenta 1x1 sample placed in Normal Saline
_____20 weeks of less: fetus and placenta in normal saline, then refrigerated
_____Provider order for workup

CROSS REFERENCE P&P:

1. Pathology Department Policy "Handling of Pregnancy Loss Specimens for Cytogenetic Analysis Only" for additional information for specimens to be sent for genetic work-up)

Committee Approval	**Date**
CCOC	
Perinatal/Pediatrics Committee	3/5/19
Medical Executive Committee	6/10/19
Board of Directors	
Last Board of Directors Review	2/15/17

Developed:
Reviewed: 01/01, 03/04 JK, 9/09jk, 9/12jk
Revised: **3/98**
Supersedes:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Nursing Management of Preeclampsia	
Scope:	Manual Perinatal
Source: OB Nurse Manager	Effective Date: 11/97

PURPOSE:

To outline the nursing management of inpatients who have preeclampsia including special considerations management of patients on magnesium sulfate, patients on antihypertensive medications and manageme eclampsia.

BACKGROUND:

Preeclampsia is a hypertensive disorder of pregnancy characterized by vasospasm and endothelial damage, which may impact the cardiovascular, renal, hematological, neurologic, and hepatic systems as well as the uteroplacental unit. It is of unknown etiology. Preeclampsia is characterized by new onset of hypertension proteinuria after 20 weeks' gestation in a previously normotensive woman.

Diagnostic Criteria for Preeclampsia

- Hypertension: Systolic blood pressure ≥140 mmHg or diastolic blood pressure ≥90 mmHg on at least two occasions at least four hours apart.
- Proteinuria: ≥0.3 g of protein in a 24-hour urine specimen or protein/creatinine ratio ≥0.3 in a random urine specimen or dipstick ≥2+ if a quantitative measurement is unavailable.

Diagnostic Criteria for Preeclampsia with Severe Features

- Systolic blood pressure ≥160 mmHg or diastolic blood pressure ≥110 mmHg and proteinuria (with or without signs and symptoms of significant end-organ dysfunction).
- Systolic blood pressure ≥140 mmHg or diastolic blood pressure ≥90 mmHg (with or without proteinuria) and one or more of the following signs and symptoms of significant end-organ dysfunction
    - New-onset cerebral or visual disturbance, such as:
        - Photopsia (flashes of light) and/or scotomata (dark areas or gaps in the visual field).
        - Severe headache (ie, incapacitating, "the worst headache I've ever had") or headache th persists and progresses despite analgesic therapy.
        - Altered mental status.
    - Severe, persistent right upper quadrant or epigastric pain unresponsive to medication and not accounted for by an alternative diagnosis or serum transaminase concentration ≥2 times upper limit of normal for a specific laboratory, or both.
    - <100,000 platelets/microL.
    - Progressive renal insufficiency (serum creatinine >1.1 mg/dL [97.3 micromol/L]; some guidelines also include doubling of serum creatinine concentration in the absence of other renal disease).
    - Pulmonary edema.

REPORTABLE CONDITIONS:

Notify provider for:

1. Repeated blood pressure greater than 160 systolic OR greater than 110 diastolic (taken at least 15 minutes apart).

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2. New or worsening complaint of any of the following:
    a. Headache
    b. Visual changes
    c. Right Upper Quadrant (RUQ) or epigastric pain
3. Abnormal lab values

PROCEDURE:

ADMISSION:

1. Assess for absence or presence of:
    a. Headache
    b. Visual changes
    c. Right upper quadrant or epigastric pain
    d. Nausea/vomiting
    e. General malaise
2. Assess upper or lower deep tendon reflexes.
3. Auscultate for lung sounds, noting any presence of rales, rhonchi, wheezing, etc.
4. Assess for generalized edema and significant, rapid weight gain.
5. Assess blood pressure using an appropriately sized blood pressure cuff with patient sitting or in t upright position with the patient's arm at the level of the heart. Do not reposition the patient to her le side and retake blood pressure. It will give a false lower reading.
6. Apply external fetal monitor (if viable fetus).
7. Prepare to obtain IV access as ordered by provider.
8. Prepare to administer medications to lower blood pressure and prevent seizure activity.
9. Maintain activity as ordered by provider. If on bedrest, maintain lying position as much as possible, avoiding supine position, and change position every two hours or more often as needed.
10. Provide emotional support and opportunity for patient family to verbalize questions, concerns and/ fears.
11. Assess maternal vital signs including: blood pressure as described above, respiratory rate, heart r temperature, and oxygen saturation as ordered by provider.
12. Prepare to assess lab values as ordered.
13. Ensure oxygen and suction equipment are present and functioning.
14. Implement measures to decrease stress level, such as provision of a quiet environment and low lightin
15. Monitor temperature per department protocol.
16. Assess intake and output every 1 hour.

ANTEPARTUM ONGOING ASSESSMENT:

Goals of patient management are: