



QUEST FOR ZERO: Excellence in OB

BETA Healthcare Group is focused on improving reliability and reducing risk exposure in obstetrics. As Partners in Patient Safety, BETA provides our members the opportunity for significant reductions in your 2012-2013 contributions. We've restructured our **Quest for Zero** obstetrical safety program and are offering a tiered approach to this award. This new structure is being offered to all BETA members that provide perinatal services and will be "in play" over the course of the next three years (2011-2013).

Menu Selection:

BETA Healthcare Group has various process improvement/risk reduction strategies for you to explore. The menu options allow BETA members to set priorities based on trending and risk related issues specific to your own organization. Members must meet 100% compliance on both elements in Tier 1 in order to qualify for any credits in Tier 2 as Tier 1 elements serve as the foundation for success in Tier 2. Each strategy and associated metrics are described in detail below.

Value of Participation:

Tier 1 is valued at 5% of your primary contribution. There is greater opportunity to gain additional credits by choosing up to two options per year in Tier 2, each worth an additional 2% if all criteria are met. This represents a potential contribution renewal credit of up to 9%!

Get Started:

Please review this Quest for Zero guideline carefully. BETA risk managers are available to provide guidance and/or further information to your staff. Let us know if you plan on participating! We can attend perinatal and staff committee meetings to ensure you have the information needed to achieve success in the coming year. BETA will conclude evaluations of compliance **no later than May 1, 2012** in order to prepare for our July 1 policy renewal period.

We value your enthusiasm and continued interest in BETA Healthcare Group's "Quest for Zero" preventable errors, as we strive for excellence in obstetrical care.

DEMOGRAPHIC

Date of Assessment: _____

Facility Name: _____

BETA Healthcare Group Risk Director: _____

Facility Leadership

Chief Executive Officer: _____

Chief Financial Officer: _____

Chief Nursing Officer: _____

Chair of OB: _____

Nurse Director: _____

Clinical Nurse Specialist: _____

Broker: _____ Date Notified: _____

Collaborative Involvement

BEACON: Y N

CMQCC: Y N

CPQCC: Y N

HASC: Y N

IHI: Y N

March of Dimes: Y N

Other: _____

Licensed Beds

Labor and Delivery: _____

Antepartum: _____

Postpartum: _____

Newborn: _____

NICU: _____

Operating Room Suite: _____

Neonatal/Newborn Service

Level 1: Y N

Level 2a: Y N

Level 2b: Y N

Level 3: Y N

TIER 1

Must complete both criteria in Tier 1 before credit is given to Tier 2 options

STANDARDIZED NOMENCLATURE

National Institute of Child Health and Human Development (NICHD)

REQUIREMENT	FINDINGS	VERIFICATION PROCESS
<p>1. Current NICHD terminology (2008) is reflected throughout clinical practice</p> <ul style="list-style-type: none"> • The term reassuring and non-reassuring is replaced by category • The term hyperstimulation is replaced by tachysystole • The descriptors “fetal distress” and “perinatal asphyxia” have been abandoned • Absent, minimal, moderate or marked are the terms used to describe variability 		
<p>2. All nursing and medical staff policy and procedures reflect the above changes in terminology</p>	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Review of policy & procedure manual
<p>3. All electronic medical record documentation reflects the above changes in terminology</p>	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Review of electronic medical record
<p>4. All paper documentation reflects the above changes in terminology</p>	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Review of 10 randomly selected charts of patients on fetal monitors
<p>5. All narrative documentation by physician and nurses reflect the above changes in terminology</p>	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Same as above
<p>6. OB privileging criteria requires successful completion of an AWHONN or ACOG endorsed class that includes current NICHD nomenclature</p>	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Review of OB Privilege sheet to confirm inclusion of criteria for initial appointment and reappointment. Certificates of completion are required

REQUIREMENT	FINDINGS	VERIFICATION PROCESS
<p>7. The facility has a policy requiring that all providers and labor & delivery nursing staff utilize current NICHD nomenclature for electronic fetal monitor (EFM) interpretation. The policy is approved by the Medical Executive Committee (MEC)</p>	<p><input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met</p>	<p>Policy specific to electronic fetal monitoring</p>

TIER 1

Must complete both criteria in Tier 1 before credit is given to Tier 2 options

ONGOING EDUCATION AND COMPETENCY

REQUIREMENT	FINDINGS	VERIFICATION PROCESS
<p>1. All physicians, residents, CNM's and family practice with OB privileges must complete either the APS Perinatal Safety Curriculum (10 modules) or other coursework (comparable content) endorsed by ACOG or AWHONN within 3 months of credentialing to medical staff</p>	<p><input type="checkbox"/> Met <input type="checkbox"/> Not Met</p>	<p>Review of certificates of completion forms [or completion reports] for 100% of physicians, residents, family practitioners and CNM's to confirm evidence of successful completion</p>
<p>2. All nursing staff must complete either APS Perinatal Safety Curriculum (10 modules) or other comparable coursework (comparable content) endorsed by ACOG or AWHONN within 3 months of hire</p> <p>Comparable Coursework:</p> <ul style="list-style-type: none"> • GE Health Systems • AWHONN Basic Fetal Monitoring • AWHONN Intermediate Fetal Monitoring • AWHONN Advanced Fetal Monitoring • ALSO Course 	<p><input type="checkbox"/> Met <input type="checkbox"/> Not Met</p>	<p>Review staff roster to include dates of hire</p> <p>Review of certificates of completion forms for 100% of nursing staff to confirm evidence of successful completion</p>
<p>3. Coursework must be completed within the last 2 years based on fiscal year July to June</p>	<p><input type="checkbox"/> Met <input type="checkbox"/> Not Met</p>	<p>Verified by documents above</p>

REQUIREMENT	FINDINGS	VERIFICATION PROCESS
4. This requirement is written into privileging criteria for medical staff and allied health	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Review OB privilege sheet to confirm language defines this as a requirement to maintain privileges
5. This requirement is defined as a condition of hire for nursing staff practicing in L&D	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Review job description/HR policy which defines this element as a condition of hire
<ul style="list-style-type: none"> • <i>Once all providers and staff meet Tier 1 successfully, the team will move to the competency maintenance arm of Tier 1</i> • <i>All new hires [providers and staff] must complete the perinatal curriculum within 3 months of hire/credentialing</i> 		
1. Evidence of completion of continuing competency assessment provided through APS subscription for a minimum of 7 months or comparable continuing competency curriculum	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Review certificates of completion [or completion reports] of all providers and staff

TIER 2

100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

MULTIDISCIPLINARY FETAL STRIP REVIEW

REQUIREMENT	FINDINGS	VERIFICATION PROCESS
<p>1. Multidisciplinary fetal strip reviews are attended, at minimum, six times per policy year by all providers and nursing staff who care for laboring mothers</p> <p>Various forums may be utilized to include:</p> <ul style="list-style-type: none"> • Morbidity and Mortality Rounds • Formal strip review via in-service • Immediate post-delivery debrief activity • Change of shift report • Multidisciplinary attended webinar activity 	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Evidence of participation by each clinician is required through sign-in process
<p>2. Must be multidisciplinary attended by <i>at minimum</i>, one physician and one nurse</p>	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Evidence of participation sign-in sheet
<p>3. A sign-in process must exist for ongoing verification and tracking</p>	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Same
<p>4. Multidisciplinary strip review sessions include documentation that identifies EFM strips that are selected for review (by MRN) and may include Category I, II or III tracings</p>	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Description of each strip review must be contained on sign-in sheet (MRN)

TIER 2

100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

SIMULATION AND DRILLS

REQUIREMENT	FINDINGS	VERIFICATION PROCESS
1. In a multidisciplinary fashion, simulation using high or low fidelity simulation (in-situ or offsite) or drills are conducted twice per policy year	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Evidence of participation by a multidisciplinary team (all staff) twice per policy year
2. All team members that must participate are identified prior to establishing the sim/drill scenario. A sign-in process exists to verify each identified team member completed the simulation and/or drills	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Evaluation/planning form which describes identified disciplines
3. Two high-risk, low frequency issues will be pre-selected based on the organization's own trends or national trends For example: <ul style="list-style-type: none"> • Uterine rupture • Prolapsed cord • OB hemorrhage • Uterine emergency (abruption or inversion) • Maternal code • Maternal seizure/stroke • Shoulder dystocia • Analgesia emergency such as high block 	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Evidence of evaluation of high-risk/low frequency events
4. Evidence of a debrief process exists and lessons learned are documented	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Debrief summary of each simulation/drill scenario

TIER 2

100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

CULTURE OF SAFETY

REQUIREMENT	FINDINGS	VERIFICATION PROCESS
<p>1. Unit specific information is gathered through a survey process specifically targeting culture and teamwork behaviors in the perinatal setting</p> <ul style="list-style-type: none"> • Pascal HealthBench will be utilized for this measure as it a comprehensive unit-specific tool that provides information back to the facility • Compliance with the recommendations of Pascal • RMRF may be used to offset the costs of the survey 	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Pascal HealthBench records
<p>2. A baseline survey is obtained by month six of the policy year and goals for improvement are set based on findings</p> <p>A repeat survey is conducted within one year to measure performance</p> <p>A 60% response rate is required for purposes of validity</p>	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Pascal HealthBench records
<p>3. At minimum, four lessons from losses or case study presentations are shared at staff meetings specific to medical error or near miss activity</p> <p>See lessons learned in toolkit</p>	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Evidence of participation by all staff through sign-in sheets
<p>4. Department specific events trends (aka: incident reports/QRR's) are shared at least quarterly at medical staff and nursing staff meetings to discuss trends and develop potential solutions</p>	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Evidence of participation by all staff through sign-in sheets i.e. staff meetings/Committee meeting or Perinatal Safety Committee meeting minutes

REQUIREMENT	FINDINGS	VERIFICATION PROCESS
<p>5. Leadership WalkRounds are implemented by month six of the policy year and are conducted at least monthly. Specific information is obtained, recorded and a feedback mechanism is in place to address the patient safety issues that providers and staff voice as a concern</p> <ul style="list-style-type: none"> • For more information about Leadership WalkRounds, contact Heather Gocke at BETA or access this link to learn more Institute for Healthcare Improvement: Patient Safety Leadership WalkRounds™ 	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	<p>Recorded activity sheet signed by Hospital President, Chief Nurse Executive or CMO</p>

TIER 2

100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

COMMUNICATION

REQUIREMENT	FINDINGS	VERIFICATION PROCESS
<p>1. Utilizing BETA Healthcare Group’s certified trainer or an outside source through Vital Smarts, deliver 2 day Crucial Conversations training to all staff who practice in perinatal services</p> <ul style="list-style-type: none"> • For more information on this content contact Heather Gocke, Director of Risk Management at BETA Healthcare Group at: hgocke@betahg.com 	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Evidence of participation is required
<p>2. A chain of command policy is in place and is unit specific</p>	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Policy review
<p>3. Implement SBAR-R tool in documentation and verbal report</p>	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Evidence through chart review
<p>4. Track and monitor effectiveness of SBAR-R as a performance improvement measure on a monthly basis beginning no later than month six of the policy year</p> <p>This requires observation of compliance with the elements of SBAR</p>	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Documentation of, at minimum, monthly observations starting no later than month six of the policy year

TIER 2

100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

ELECTIVE INDUCTION BUNDLE

Institute for Healthcare Improvement

REQUIREMENT	FINDINGS	VERIFICATION PROCESS
1. Implement bundle requirements and measure for compliance to meet at least 90% compliance with all elements by May 1 of the policy year	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	This measure is adopted as a quality improvement indicator and is monitored through the quality department statistics
2. Elective <i>delivery</i> * does not occur prior to 39 weeks gestation, this is defined in policy and has been taken through the medical staff approval process <ul style="list-style-type: none"> • Delivery is defined as cesarean or vaginal 	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Induction of Labor & Cervical Ripening policy
3. Medical indications for induction/delivery exist, are in accordance with ACOG guidelines and are defined in a medical staff approved policy	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Induction of Labor and Cervical Ripening policy
4. Induction with any agent is not initiated without confirmation of a category I fetal monitor tracing as evidenced through chart review [sample records]	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Review 10 (or 100%) elective inductions that occurred within last six months of policy year
5. Patients are assessed for adequate Bishops Score prior to the start of an elective induction of labor	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Review 10 (or 100%) elective inductions that occurred within last six months of policy year
6. Elective induction of labor does not occur without a Bishops Score of 6 or greater. This score is defined in policy and has been taken through the medical staff approval process	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Review 10 (or 100%) elective inductions that occurred within last six months of policy year

REQUIREMENT	FINDINGS	VERIFICATION PROCESS
<p>7. Tachysystole is defined in policy in accordance with the ACOG definition</p>	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	<p>Review policies:</p> <ul style="list-style-type: none"> • Induction of Labor • Cervical Ripening • Electronic Fetal Monitoring
<p>8. An algorithm is in place to manage tachysystole and this algorithm has been taken through the medical staff approval process</p> <p>See toolkit for example</p>	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	<p>Evidence that algorithm is sent through medical staff approval and is implemented on the unit through observation</p>

TIER 2

100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

VACUUM BUNDLE

Institute for Healthcare Improvement

REQUIREMENT	FINDINGS	VERIFICATION PROCESS
1. Implement bundle requirements and measure for compliance to meet at minimum 90% compliance with all elements by May 1 of policy year	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	This metric is monitored through the Quality Department indicators
2. The Quality Improvement Department reviews 100% of all vacuum deliveries	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Quality data on volume of vacuum extractions Quality data on review of 100% vacuum assisted delivery
3. Alternative labor strategies to include passive descent, rest between pushes or open glottis pushing are established as common practice and education is provided to all clinicians in L&D	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Evidence that second stage of labor management education is provided to staff in L&D or those who manage laboring patients to include CNM's
4. Documentation of informed consent discussion with patient regarding the risks, benefits and alternatives of the application of a vacuum device	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Review 10 (or 100%) vacuum assisted deliveries within last six months of policy year
5. Estimated fetal weight is documented in the chart	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Review 10 (or 100%) vacuum assisted deliveries within last six months of policy year
6. Fetal position and station are documented in the chart	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Review 10 (or 100%) vacuum assisted deliveries within last six months of policy year
7. Policy defines maximum application time and number of pop-offs of vacuum in accordance with manufacturers guidelines and ACOG/AWHONN consensus documents	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Policy on Vacuum Assisted Delivery

REQUIREMENT	FINDINGS	VERIFICATION PROCESS
<p>8. Documentation reflects application time, pressure and popoff's when a vacuum is utilized</p> <p>See sample in toolkit</p>	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p>	<p>Review 10 (or 100%) vacuum assisted deliveries within last six months of policy year</p>
<p>9. A surgical team and resuscitation team are immediately available. Immediately available is defined as "in house". This language is included in policy</p>	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p>	<p>Review policy on Vacuum Assisted Delivery</p>

TIER 2

100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

OBSTETRICAL HEMORRHAGE

California Maternal Quality of Care Collaborative (CMQCC)

REQUIREMENT	FINDINGS	VERIFICATION PROCESS
<p>1. All staff in L&D, antepartum and postpartum must complete the postpartum hemorrhage module offered through Advanced Practice Strategies (APS). This is now provided through the Universal Access subscription</p>	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Evidence of certificates of completion [or completion reports] by all physicians, family practitioners with OB privileges, CNM's and nurses on staff
<p>2. A multidepartmental, multidisciplinary hemorrhage protocol is in place and has gone through the approval process</p> <p>See sample in toolkit</p>	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Review policy/protocol
<p>3. Simulation and/or drills specific to OB hemorrhage occur annually and evidence of participation of all physicians, nurses, family practitioners, CNM's, surgical scrub technicians, lab/blood bank, pharmacy and anesthesia is documented</p>	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Evidence of participation by all involved providers and staff (listed to left) through sign-in process
<p>4. An Emergency OB Hemorrhage Cart is in place in L&D and Postpartum. All staff are oriented to its contents and use. This is documented by inservice attendance</p> <p>See sample in toolkit</p>	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Observation
<p>5. The quality department conducts 100% review of blood utilization</p>	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Review of Quality metrics

TIER 2

100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

SHOULDER DYSTOCIA

REQUIREMENT	FINDINGS	VERIFICATION PROCESS
1. A risk screening mechanism is in place. This can be accomplished through technology (PeriGen) or pre-established clinical findings via a formalized screening tool approved by medical staff	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Dependent on method, review of specific screening tool data (PeriGen) OR Review 10 randomly selected records
2. A second stage of management protocol is approved by medical staff and all staff are oriented to the this protocol	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Review of policy/protocol
3. Documentation reflects compliance with all interventions employed during the course of a suspected shoulder dystocia i.e.: McRoberts, Corkscrew, suprapubic pressure, Zavanelli	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Review 10 (or 100%) shoulder dystocia records
4. Simulation and/or drills specific to shoulder dystocia occur, at minimum, annually and evidence of participation of all physicians, nurses, family practitioners, CNM's, technicians, NICU and anesthesia is documented	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Evidence of participation by all involved providers and staff (listed to left) through sign-in process

TIER 2

100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

NCC CERTIFICATION (RN-C) CREDENTIAL

REQUIREMENT	FINDINGS	VERIFICATION PROCESS
<p>1. All eligible staff* in the departments listed below will sit for the RNC exam by the end of the policy period</p> <p>Exam content areas include:</p> <ul style="list-style-type: none"> • Inpatient Obstetrical Nursing (L&D) • Neonatal Intensive Care Nursing (NICU) • Low Risk Neonatal Nursing (Newborn) • Maternal Newborn Nursing (Postpartum/Antepartum) <p>Those eligible are defined as:</p> <ul style="list-style-type: none"> • Those currently licensed in U.S. • Must have documentation of two years of experience comprised of at least 2000 hours of practice time in one of the exam specialties. Both time and hours must be met • Must be employed in designated exam specialty sometime in the last 24 months which may include direct clinical care, education, administration or research <p>Risk Management Resource Funds (RMRF) may be used to offset the cost of the exam</p>	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
<p>2. Evidence of enrollment and participation in exam is required to meet this goal. Evidence of pass/fail is not required</p>	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	<p>Verify records of NCC that indicate those who sat the exam and those who are eligible</p>

TIER 2

100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

**PERINATAL MEDICATION SAFETY
(SEE ADDENDA)**

REQUIREMENT	FINDINGS	VERIFICATION PROCESS
<p>1. All staff have viewed the ISMP Perinatal Medication Safety DVD</p> <p>This DVD may be obtained from the BETA lending library at www.betahg.com under Member Services</p>	<p><input type="checkbox"/> Met <input type="checkbox"/> Not Met</p>	<p>Staff sign-in sheets that verify all staff have viewed the video</p>
<p>2. Various structure standards for safe use of five common medications administered in the obstetrical and NICU setting are in place and 100% compliance is evident with these standards</p> <p>(See Medication Safety Scorecard requirements in toolkit)</p> <p>Included are the following five medications:</p> <ul style="list-style-type: none"> • Oxytocin • Magnesium Sulfate • Misoprostol/Cytotec • Heparin (in NICU) • Epidural analgesia 	<p><input type="checkbox"/> Met <input type="checkbox"/> Not Met</p>	<p>Compliance with all scorecard structure measures verified through policy, observation or interviews with staff</p>

TIER 2

100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

PERINATAL MEDICATION SAFETY (ADDENDA)

SAFE USE OF CYTOTEC/MISOPROSTOL

REQUIREMENT	FINDINGS	VERIFICATION PROCESS
Postpartum hemorrhage: Dose is limited to 800-1000 mcg/rectally times one and is established in protocol ACOG #76, 2006	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Review policy and procedure • Postpartum hemorrhage
Cervical ripening agent: Dose is limited to 25 mcg/posterior fornix of the vagina every 4 hours to a dose maximum of 200 mcg and is established in protocol ACOG #248, 2000; ACOG 2002; ACOG 2003; ACOG #107, August 2009	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Review policy and procedure • Cervical Ripening • Induction of Labor
Postpartum hemorrhage cart or kits are created and accessible in ADM	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Observation
Cytotec/Misoprostol is contraindicated in VBAC and therefore is not prescribed. This is outlined in policy ACOG #54, 2004; ACOG #342, 2006; ACOG #115, August 2010	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Review policy and procedure • VBAC

REQUIREMENT	FINDINGS	VERIFICATION PROCESS
Policy defines tachysystole in accordance with ACOG/AWHONN and NICHD definition. ACOG#106, July 2009	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Review policy and procedure <ul style="list-style-type: none"> • Electronic Fetal Monitoring
An algorithm is in place that directs the provider/nurse to manage tachysystole. See sample tool	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Confirm algorithm is in place and utilized through interview
Annual multidisciplinary drills are conducted on the unit specific to OB hemorrhage. All providers and staff attend these drills/simulation	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Evidence of attendance in annual drill focused on OB hemorrhage by all providers/staff

SAFE USE/STORAGE OF EPIDURAL ANALGESIA (ADDENDA)

REQUIREMENT	FINDINGS	VERIFICATION PROCESS
Standardized mixture of epidural analgesia is limited to two concentrations only	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Confirmation of structure through interview
Standardized concentrations are premixed and stocked by pharmacy	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Confirmation of structure through interview
Epidural infusions are accessible to, and retrieved only by, anesthesiologists or CRNA (AWHONN 2008 Safe Practice)	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Review policy and procedure
Policy and procedure defines that neuraxial analgesia in obstetrics may be monitored (not managed) by nurses and establishes that nurses may not increase or decrease the rate of infusion or reinitiate an infusion once it has been stopped AWHONN Position Statement 2008	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Review of epidural analgesia policy

SAFE USE/STORAGE OF HEPARIN IN NEONATAL ICU (ADDENDA)

REQUIREMENT	FINDINGS	VERIFICATION PROCESS
Ten thousand (10,000) units/mL will be stored in the IV room only ISMP, 2006	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Pharmacy staff interview
One thousand (1,000) units/mL are removed from NICU ADM's ISMP, 2006	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Pharmacy staff interview
One hundred (100) units/mL doses are physically separated in pharmacy ISMP, 2006	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Pharmacy staff interview
A double check process by pharmacist/pharmacy technician is in place during refill of the ADM and is established in procedure ASHP 2006; ISMP 2006	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Pharmacy staff interview
ADM drawer is labeled with high-risk sticker	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Observation
Premixed flush doses are dispensed by pharmacy. They are not mixed by nurses ASHP 2006; ISMP 2006	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Pharmacy staff interview
Heparin is designated a high-alert medication and a process is in place to manage this high-alert medication to include a double-check. This process is defined in policy TJC, 2007	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	High-alert medication policy

REQUIREMENT	FINDINGS	VERIFICATION PROCESS
Lab values (APTT) are double-checked by two nurses when adjusting IV dose heparin and this is established in policy	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Policy and procedure: Heparin

**SAFE USE/STORAGE OF MAGNESIUM SULFATE
(ADDENDA)**

REQUIREMENT	FINDINGS	VERIFICATION PROCESS
Pharmacy prepares or purchases standardized premixed concentration for loading dose of magnesium sulfate in 50 mL or 100mL volume solution ISMP 1999; ISMP 2005; AWHONN 2008	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Interview with pharmacy staff
Pharmacy prepares or purchases standardized premixed concentration for maintenance dose of magnesium sulfate in 250 mL or 500 mL volume solution ISMP 1999; ISMP 2005; AWHONN 2008	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Interview with pharmacy staff
Magnesium sulfate is designated a high-alert medication and a process is in place to manage this high-alert medication to include a double-check prior to the initiation of a new bag and at dose changes. This process is defined in protocol ISMP 1999; ISMP 2007: TJC 2007	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	High Alert Medication policy
Nurse to patient ratio during load of magnesium sulfate is 1:1 AWHONN 2008	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Policy and procedure of magnesium sulfate administration

SAFE USE/STORAGE OF OXYTOCIN (ADDENDA)

REQUIREMENT	FINDINGS	VERIFICATION PROCESS
Pharmacy prepares or purchases standardized premixed concentration of 30 units oxytocin in 500 mL or 15 units oxytocin in 250 mL of isotonic solution providing for 1:1 dosing AWHONN 2008; ISMP 1999	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Interview with pharmacy staff
Oxytocin infusions are labeled with colored label unique to oxytocin	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Observation
With the goal to reduce variation, one standard protocol exists for administration of low dose oxytocin starting at 1 mu/minute and increasing by 1 mu/min every 30 minutes ACOG #107, August 2009	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Policy and procedure/protocol on Induction of Labor
Policy and procedure defines tachysystole in accordance with ACOG definition ACOG #106, July 2009	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	Policy and procedure on Induction of Labor
Oxytocin is designated a high-alert medication in policy and procedure. This requires a double-check at the initiation of an infusion. ISMP 2007	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	High alert medication policy

NOTES