Exhibit NK3.b

PNSO Clinical Practice Committee
Suzanne Fuhrmeister RN-BC, ACNS-BC, Chair
AGENDA- 11/26/2013
Time: 1300-1500 Location: Medical Center Boardroom

Topic **Pre-work (if any)** **Presenter: Time**	**Purpose/Goals**	**Discussion**	**Follow up & responsible person**
Opening Business Pre-work: approval Oct minutes 1300-1305	• *CPC Rounds report* • *Announcements* • *December Practice News focus*	Agenda change: Nancy Eksterowicz coming in January. Agenda adopted as changed. Dec PN coming soon; there will be a streamlined January one too. Recognition for offgoing CPC members who've served their 2 year terms. Suzanne Fuhrmeister taking over as Chair today, transitioning for 2014. Recognition for Sarah Craig's service as 2013 Chair.	
2014 Strategic Planning Suzanne Fuhrmeister, Sarah Craig 1305-1315	• *Continuation of discussion* • *top priorities and theme for 2014* • *Role expectations for CPC*	Our Focus for 2014 will be: Patient Safety and Practice Standardization (key realms for standardization efforts will be medication administration, pain management, HOC, EPIC optimization) • Night Shift Comm working on a literature-based proposal for Sleep Standards – clinical value for uninterrupted sleep e.g. delirium prevention; patient satisfaction (we're the lowest scoring AMC on pt sat w/ noise at night) - will get input/buyin from Night Shift staff, then bring proposal to CPC. Rachel Dentz, Teri Coles, Holly Hintz leading this. How should we grow/mature as committee? We will continue to have lots of subcommittees, but each needs to have clear charter, roles, status reporting and accountability, evaluating for success. We will engage interprofessional partners' help to achieve this – Nursing doesn't operate in isolation. Upcoming workgroups needing attention: - MUSIC – making changes in HOD Outpatient dept's handling of medications; further limitaton of overrides. Nursing reps needed on workgroup for this. - MUSIC – titratable drugs in Acute & Critical Care; order set parameters & methodology will tighten up. Similar to pain meds – need explicit titration orders, to avoid nursing scope of practice problems. We engaged in lots of new communication methods this year: direct email to local leads, rounding, spot-surveys for input. Rounds are great, but really it's YOUR role as a rep to continuously engage colleagues, bring their issues & keep them informed. Strategic Planning 2014. - Overarching: standardization of practice to promote culture of safety; help people with the right mix of standardization and critical thinking (rather than rotely following steps). - IDEAL Handoff of Care implementation/evaluation continues through 2014. - Pain Management, as many QRs pertain to this.	

		- Epic optimization. <u>Recognize staffing challenges:</u> what are creative ways to engage input in these important improvement considerations? - Lack of protected time on the clock for shared governance work - Consider short-term fast turnaround task forces, with some rotating membership around core leaders. Some local committees have had success with this model, and it can engage more RNs in decisionmaking, beyond core annual reps. - Information overload: how to break through saturation; find time to get back to it & absorb the knowledge later if you don't have time right this minute. Because of this, staff find it challenging to keep up with standardization / changes.	
Insulin Administration Independent Double Checks Holly Hintz, Virginia Barton) 1315-1330	*Vote on whether & when to perform insulin verifications*	This is a follow up discussion to previous meetings. A Q17 Glycemic Management group will be forming, overseeign the implementation of this aspect of the org-wide Quality/Safety Plan. This group will take a comprehensive look at many components. The concept of independent doublecheck of insulin as a safety check that we discuss today may be revisited again later by Q17 group as part of the bigger picture. AHSP Recommendations informed our prework (see the MUSIC committee's proposal on Collab). It's AHSP's national standard to recommend an independent doublecheck for insulin (infusion at initiation and bag change). - At UVA, the only insulin doublecheck in place right now is for U500. - Some infusions are done under Dose Rate Verify, but it doesn't have a forced doublecheck screen. - Subcutaneous isn't covered. Pharmacy brought trended data for Insulin Administration QR reported errors for the past 18 months – analyzed to identify trends in error type, several of which could be prevented by independent doublecheck. - Insulin Infusion (vs other delivery routes/types) had the overwhelming majority of reported errors. Level of severity included. Acute Care had the most; roughly double those of Critical Care (curious to see if most errors are in units with lowest staffing); vast majority in Adults; evenly split between Medicine & Surgical. - There also appeared to be a lot of HOC issues pertaining to insulin administration – will be helped by IDEAL implementation too. Laurie Brock also pulled from Epic the drugs for which we do have a forced doublecheck in Epic – many are chemo, but not all. - There are still errors reported for these meds, but nowhere near as many. - The links to protocol documents are already in Epic – but people are picking the wrong population's protocol to read. CPC should consider whether to implement independent doublecheck: for All Insulin? Or Selected types of insulin? (that is, by type, not route) - What's safest for the patient? How to make that feasible for nursing workflow? - 90% of other institutions do it for all insulins – and we used to do it here too (when	

		& why did we stop?). A Forced Doublecheck screen is at the point of administration, with the patient inside the room, when the barcode is scanned. It might help to have a step-by-step training checklist, as part of followup to the recent "Preceptors Reinforce EBP" effort. **PROPOSED**: Leave Insulin Infusions as-is; adopt doublecheck for all other types of injectable insulin. **VOTE Approved**. Discussed timeline – feel some urgency from safety implications: will be included Dec 10th as part of Epic bundle. Special email announcement, as well as Practice News.	
Gum chewing research Beth Quatrara 1330-1340	*Vote on expanding this local pilot, to be adopted as standard practice for Adult Abd. Sgy patients*	Carolin Connelly and Kirsten Davis presented. Colorectal Surgery found literature that supported gum chewing (in lieu of an expensive medication) as a strategy to reduce ileus & LOS because sped time to renormalized bowel function post op. 5Central recently reviewed updated literature again: chewing gum for 30min 3xday decreased length of stay. No real complications or contraindications in literature. 5Central developed a practice reference for nurses and PCAs, including in-clinic awareness pre-surgery as well as on-unit post-op. - The act of chewing triggers peristalsis - without the potential for nausea/vomiting that swallowing actual food post-op might trigger. - Seeing positive results, as expected. - Also, patients actually report improved satisfaction, as it gives them something active to do towards their recovery, especially while they remain NPO. - Recommending sugar-free gum, doesn't matter what type or flavor (have mint or fruit). - Gum is ordered through Nutrition, then stored in a consistent place (suggest it be a monitored location to avoid casual consumption by non-patients). - Note that previously the Gift Shop stopped selling gum because of incorrect disposal/housekeeping concerns. To avoid this, when giving gum to patients, give a med cup as well, for easy/clean disposal. - Dr. Hedrick is supportive of gum-chewing in addition to ERAS as multimodal approach. **PROPOSED:** Adopt a gum-chewing post-op protocol for all Adult Abdominal Surgery patients, with potential expansion to other populatons e.g. GYN Sgy and C-section Delivery. **VOTE Approved**. Practice News in December. Work with Nutrition to supply units. Add to Epic Order Sets in Post-Op Orders? Or could it become a nurse-driven protocol order, similar to the discretionary comfort items?	
Heparin Nomogram update Mary Stack 1340-1350	*update on status of nurse-run heparin nomogram*	Mary Stack, NP in Anticoagulation Clinic, provided an update on Nurse-Driven Heparin Nomogram. Since its launch, she has done chart audits to check for issues that arise. She writes up QRs when she identifies issues during audit. - Getting Epic data is challenging - having different places to document leads to	

		difficult reporting. - The goal for a nurse-driven protocol is faster time to therapeutic levels. In the first quarter post Implementation: of 259 patients, 62% got into therapeutic range within 24hrs, the desired timeframe. - Mary now looking at 3 charts/wk, looking at different nursing-sensitive work facets of the process of the nomogram. o Given these identified trends in work facets, consider doing a systematic process map that identifies which steps incur risks for incorrect action (like the Community Vial group recently did). - Would be useful if a standard Countdown Timer Tool to cue specific-next-step-due could be implemented. Some nurses have found countdown tools online, but it's not consistently used. Pump alarms are one possible solution, but if the primary nurse is distracted elsewhere, someone might reset the alarm without realizing what it meant. All institutions must face this for time-sensitive tasks – how do they solve it? - Mary is doublechecking to see if Nomogram CBL & class was assigned appropriately, as part of followup on QRs. Sue Galloway will consider whether this meets the criteria to add to Mandatories. A task force to further improve the process is forming: Mary Stack with Suzanne Fuhrmeister, Barb Trotter, Laurie Brock, as well as Surabhi Palkimas PharmD for Anticoag.	
Immunizations Martha Holman 1350-1400	*Nurse driven protocol for influenza immunizations*	Amy Mathers & Martha Holman presented on behalf of Q17 Immunization group newly formed. They have nursing reps already from 3rd & 4th floor Medicine, Ortho, Peds, but more volunteers are welcome. They start meeting in December, with a short timeline to delivery (maybe as little as 1 week). The eventual proposed solution is really dependent on Nursing. Most of the background is Flu focused, but would expand to Pneumovax as well. Evidence-based review supporting vaccination safety and effectiveness. - UVA used to do really well with Flu/Pneumovax rates for patients, 90%. - Graph shown for Oct 2013 daily: first 11 days, somewhat low – <u>then Immunization BPA launched and immediate improvement noted</u>. But we're still nowhere near our 90% goal; some are still ignoring the BPA. There are Ordering and Administration aspects to this. CDC supported a Nurse-Driven Protocol for Flu/Pneumovax, way back in 2001. UVA's Patient Care Committee has agreed to adopt it; it's been in place for 4 years in Adult Ambulatory Care, 1 year in Peds Ambulatory Care, now suggest rolling out in Inpatient. - Discuss workflow implications, implementation/education plan. - Meeting with 4C leadership next week to pilot, including an audit tool. - Need admission intake consideration, triggering the order, with actual administration happening closer to discharge (but not waiting till DAY of discharge, which can be a delaying factor or forgotten. Consider alternatives that keep reminding you, but not necessarily At Admission because there are already audited items then that aren't getting done). - Folks may be unfamiliar with finding/adding dates on the Historical Immunization	

		Record (not just the MAR) to get credit for the vaccine. - Q17 process will also work with Ambulatory to ensure appropriate credit given for "vaccine offered but refused" documentation. - It would be helpful for LIP to reinforce the same script/sales pitch as nurses use, to encourage getting the vaccine. - For inpatient rollout, also anticipate ways to overcome LIP reluctance to administer anything that might result in a fever.	
Suspicion of Cardiac Event Suzanne Fuhrmeister 1400-1415	• *Pre-work: guideline for suspicion of cardiac event* • *how does CPC need to be involved in this?*	*Deferred due to time constraints.*	
Hand Off Of Care Update Holly Hintz, Sarah Craig 1415-1435	• *standard of care* • *EPIC tool & written report* • *Preparation for education rollout*	Thanks to all of our subgroup's efforts this year, IDEAL Hand-Off of Care implementation is underway! The first phase of expectations is using IDEAL for Transfer (not yet for shift change; coming a little later in 2014). The CBL will be assigned this week; the Epic tool will be in place by Dec 2, with the expectation that IDEAL be used for Transfer HOC in Inpatient, ED & Procedural areas beginning Jan 6th (ambulatory areas later in the year). If you uncover issues, please email Suzanne Fuhrmeister & Holly Hintz. The sample report provided in prework is intended to show the difference between a succinct "what to watch for/important points" instead of a full scale head-to-toe.	
Care Partners in Isolation rooms Eve Giannetta 1435-1440		There are inconsistent practices in place on different units for Care Partners in Isolation Rooms; even as basic as the definition of "rooming in with patient". See the As-is and Proposed process maps on Collab. **PROPOSED**: Is this doable and is Nursing supportive if this standard is adopted? if partner is spending the night, vs a shorter-term visitor: different expectations for PPE & bathroom usage, where they can go in hospital, etc. A big negotiation will be educating them about the tradeoffs: if you want the privilege of going to the cafeteria, then you need to wear PPE so you don't transfer infectious organizations. **VOTE Approved/supportive** – will go in IPC Manual. Suggest there's signage that visibly provides guidance, especially in common areas.	
Aspiration Signs in patient rooms Scott Croonquist, Dea Mahanes 1440-1445	*Proposal to improve awareness of Aspiration Precautions by reinstating in-room signage*	*Deferred*	
CAUTI update Christie Piedmont 1445-1450		*Deferred*	
Pain policies Nancy Eksterowicz	*review upcoming policy changes & effect on*	*Deferred; presenter unable to attend.* Ketamine protocol updated, education coming.	.

1450-1500	*nursing practice : who needs to use CPOT?*		
Meeting Take Away Points	*Determine the points that members will share with designated staff members.*	• Adopted standard to Implement Doublechecks for Injectable Insulin • Adopted Gum-Chewing Protocol for all Adult Abdominal Surgery patients; • Approved nursing aspects of IPC Manual changes to differentiate PPE & bathroom usage expectations for rooming-in Care Partners vs. casual visitors. • Coming soon: Inpatient nurse-driven protocol to administer Influenza / Pneumococcal Immunizations, to raise rates of eligible patient vaccination Reminder, no meeting in December. See returning members in January!	***All committee members:*** *share these with your Communication Tree designees*

Summarize Outcomes Achieved at this meeting:
Adopted implementing Doublechecks for Injectable Insulin Adopted Gum-Chewing Protocol for all Adult Abdominal Surgery patients; potential for other post-op patients to restore bowel function promptly. Approved nursing aspects of IPC Manual changes to differentiate PPE & bathroom usage expectations for rooming-in Care Partners vs. casual visitors.

Committee Attendance Roster (each month that attendee was present should contain a Checkmark)

Guests: Virginia Barton, Karen Braden, Carolin Connelly, Kristen Davis, Carol Deverell, Jenny Dixon, Eve Giannetta, Martha Holman, Barb Maling, Amy Mathers, Cynthia McCaskill, Beth Quatrara, Cindy Southard

Member Name/ credentials	Department	Jan	Feb	Mar	EBPD	May	Jun	Jul	Aug	Sep	Oct	Nov
Nancy Addison, Children's Procedure Chair	Cn4, PICU	Y	Exc.	Y	Y	Y	Y		Y	Y		
Ken Allmon, Management Committee	Nurse Manager, SSU	Exc.	Y	Y		Y		Y	Y			Y
Laurie Brock, Informatics Chair	Informaticist, Epic	Y	Y	Y		Y	Exc.	Y	Y	Y	Y	Y
Carol Burrage, Psychiatry rep	Cn4, 5 East	Y	Y	Y	Y	Y	Y	Y			Y	Y
Sarah Craig, CPC Chair	APN1-CNS, 4W/TIMU	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Hester Fletcher, Procedure Area rep	NEC2, OR			Y				N.Pierce			exc	
Suzanne Fuhrmeister, CPC Vice-Chair	APN1-CNS, 4C/VIMU	Y	Y	Y		Y	Y	Y	Y		Y	Y
Elizabeth Guydo, ED rep	Cn3, ED	Y			Y	Y	Y	Y	Y		exc	Y
Kimberly Hahn, Women's Place rep	Cn3, 8TWP		Y	Y	Y	y	Y	Exc.	Y			Y
Stephene Hertwig, ICU Procedure Chair	Cn2, MICU	Y	Y	Y			Y	Y	Y	Y	exc	
Holly Hintz, Director, Nursing Governance	Dir., Nsg Governance	Exc.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Tina Knicely, PNSO President	Cn3, SAS	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
Terry Knick, TCH rep	TCH	Exc.	Y		Y	Y	Y					
Michelle Longley, Acute Procedure Chair	APN1-NP, Acute Care	Y		Y	Y	Y	Y	Y	Y	y	Y	Exc.
Cheryl May, Pediatrics rep	7 Acute		Y		Y	y						
Cherie Parks, Ambulatory Practice Chair	RNAC, Heart Center	Y	Y	Y		Y			Y	y	Y	Y
Ellen Smith, Procedure Area Proc Chair	Cn4, Endoscopy	Y	Y	Role change								

Exhibit NK3.b

Member Name/ credentials	Department	Jan	Feb	Mar	EBPD	May	Jun	Jul	Aug	Sep	Oct	Nov
David Strider, Research Util. Chair	UB Wage RN, PICU	K.Fletcher	Exc.		Y							
Cynthia Taylor: Infection Preventionist	Infection Preventionist	Exc.	Y	Y			Y	Y		y		Eve G.
Mary Jane Willis, Per Diem/MET rep	Wage RN, SRO	Y		Y		Y	Exc.	Y	Y		Y	Y
Ad Hoc Members, attend as needed:												
Sue Galloway, Nursing Education rep	New Grad Programs	Y	Y			Y	Y			Y	Y	
Jennifer "JT" Hall, Magnet	Magnet Coordinator	Y	Y		Y	Y	Y		Y		exc	
Jackie Loach, Quality/Pt. Safety/Risk rep	Pt Safety/Clin Mgt Coord											
Cindy Westley, Patient Education rep	Epic				Y							
Richard Schneider, Skin rep	WOC		K.Wilson						Y	Y		Y
Susan Harkness-Shifflett, Night Shift rep	3W			Y			Y	Y	Y	y		