

NPIC/QAS H1N1 Survey Results

In October, 2009 NPIC/QAS sent a survey to member and contract hospitals to determine the impact of H1N1 on their practice at this point in time. As of 11/16/09, 17 hospitals/regional perinatal centers responded to this survey; results are summarized below (for the time period 1/1/09 – 9/30/09).

Hospital/Perinatal Center Descriptive Data

<i>Average number of deliveries</i>	4,474
<i>Range</i>	1,000 – 14,000
<i>Hospital Levels</i>	4 for Level II 5 for Level III 8 for Regional Perinatal Center

Survey Responses by American Hospital Association Region:

- 6% are from Region 1 (CT, ME, MA, NH, RI, VT)
- 24% are from Region 2 (NJ, NY, PA)
- 29% are from Region 3 (DE, KY, MD, NC, VA, WV)
- 12% are from Region 4 (AL, FL, GA, MS, SC, TN)
- 24% are from Region 5 (IL, MI, IN, OH, WI)
- 6% are from Region 7 (AR, LA, OK, TX)

Data Concerning Suspected/Confirmed H1N1 Admissions

<i>For hospitals reporting admissions:</i>	<i>average</i>	<i>range</i>
Hospital pregnancy admissions for suspected H1N1 (n=13; 3 said “0”)	11.64	1-50
Hospital pregnancy admissions for confirmed H1N1 (n=9; 5 said “0”)	4.80	1-15
Number of hospitalized days for mothers with suspected H1N1	7.27	0-30
Number of hospitalized days for mothers with confirmed H1N1	12.70	0-52

Deaths

- One hospital with 50 admissions for suspected H1N1 reported 2 maternal deaths with H1N1; no other hospitals reported a maternal death.
- None of the hospitals reported neonatal deaths related to maternal H1N1/preterm birth.
- None of the hospitals reported fetal deaths related to H1N1.
- One hospital reported a single neonatal admission for confirmed H1N1 and another hospital reported one neonatal admission for suspected, confirmed and a neonatal death with H1N1.

Changes Related to H1N1

- 94% reported changing visitation policies (limiting visitation of family, friends; etc.)
- 80% reported a loss of staff time due to H1N1 and
- 44% reported an increase in staffing patterns (needing additional staff due to H1N1 or due to staff being out (e.g., RNs out between 4-19 days)
- 38% reported a negative impact on patient satisfaction
- 25% reported a decrease in overall services sought by patients (patients are choosing not to come to clinics, classes, etc.)
- 13% reported closing of outpatient or other services (such as clinics, childbirth classes)

Notes:

- Developed temporary triage area outside of L&D for pregnant suspected H1N1 patients which has increased staffing patterns.
- Community educational activities, especially those involving children, moved to off-site classrooms to keep exposure down in main hospital setting.
- Minimal H1N1 vaccination of staff occurring due to shortage of supply.
- Increased number of maternal triage visits for flu symptoms.
- Possible increase in staffing if an H1N1 pregnant patient goes to ICU. A fetal monitor-trained L&D nurse needs to be available.
- No site reported closing their facility to maternal and/or neonatal transports due to H1N1 virus.

Responses to Greatest Challenge(s)

- Changing the triage process to accommodate these patients in the ER if the reason for admission is not OB related. Providers are used to all patients greater than 23 weeks being seen in L&D even if the visit is non OB related.
- Pregnant patients do not always have influenza-like symptoms. The ones transferred to ICU had shortness of breath or "work of breathing" and several had bilateral lower lobe pneumonia.
- Contiguous environment of department (L&D, postpartum and special care nursery all together) is challenging for potentially infected patients; therefore treated both patients in ICU isolation room; remote fetal monitoring and remote staffing most challenging; deciding how to triage potential H1N1 patients either in ED or in OB; created a OB Triage to do so.
- Isolation and acuity x 14 days- plan of care for fetus with potential maternal demise. How to isolate suspected H1N1 patients from the rest of the population.
- Keeping up with the changing CDC requirements regarding isolation, negative pressure rooms, and visitation.
- Appropriate assignments related to nursing staff and mixing well patients with sick patients.
- Managing the contacts including who her family interacted with before diagnosis.
- Visitor anger concerning limitation of age and number of visitors.
- Isolation

Responses to Lessons Learned

- Pregnant patients can decompensate very quickly from moderately ill to severely compromised. Need a lower RN/patient ratio on non-ICU floors to allow for closer monitoring.
- Quick evaluation and decision making for admission is important.
- Getting testing to confirm suspected cases. One spike of fever could be a reason to do testing.
- Fetal strips on women with the flu can appear compromised but may not necessarily indicate the need for delivery; worth taking a look at and giving some practice recommendations for this population.
- Have a multidisciplinary plan in place.
- How to care for siblings and potentially exposed employees i.e., transport, or triage, wherever they present.
- Prepare to care for prenatal patients on floors other than maternity

For questions or comments about these data, contact Donna Caldwell, Ph.D., Vice President or Julie Shocksnyder, Associate Vice President, at the National Perinatal Information Center/ Quality Analytic Services, (401) 274-0650 or dcaldwell@npic.org/jshocksnyder@npic.org.