DOCTORS
MEDICAL CENTER

# West Contra Costa Healthcare District
# Doctors Medical Center
# Governing Body
# Board of Directors

Wednesday, January 25, 2012
4:30 PM
Doctors Medical Center - Auditorium
2000 Vale Road
San Pablo, CA

DOCTORS MEDICAL CENTER

**WEST CONTRA COSTA HEALTHCARE DISTRICT**
**DOCTORS MEDICAL CENTER**

**GOVERNING BODY**
**BOARD OF DIRECTORS**

**WCCHD DOCTORS MEDICAL CENTER**
**GOVERNING BODY BOARD OF DIRECTORS**
**JANUARY 25, 2012 - 4:30 P.M.**
**Doctors Medical Center - Auditorium**
**2000 Vale Road**
**San Pablo, CA 94806**

**Board of Directors**
*Supervisor John Gioia, Chair*
*Eric Zell, Vice Chair*
*Irma Anderson*
*Wendel Brunner, M.D.*
*Deborah Campbell*
*Nancy Casazza*
*Sharon Drager, M.D.*
*Pat Godley*
*Richard Stern, M.D.*
*William Walker, M.D.*
*Beverly Wallace*

## AGENDA

1. **CALL TO ORDER** — J. Gioia

2. **ROLL CALL**

3. **APPROVAL OF DECEMBER 14, 2011 MINUTES** — J. Gioia

4. **PUBLIC COMMENTS** — J. Gioia
   *[At this time persons in the audience may speak on any items not on the agenda and any other matter within the jurisdiction of the of the Governing Body]*

5. **FIRE ALARM SYSTEM UPDATE** — W. Appling
   a. Presentation
   b. Discussion
   c. Public Comment
   d. *ACTION: For Information Only.*

6. **FINANCIALS –DECEMBER 2011** — J. Boatman
   a. Presentation
   b. Discussion
   c. Public Comment
   d. *ACTION: Acceptance of the December 2011 Financials.*

7. **POLICIES** — J. Maxworthy
   a. Presentation
   b. Discussion
   c. Public Comment
   d. *ACTION: Approval of the Following New Policies:*
      *- Plant Operations: Medical Equipment Management Program Policy*
      *- Communications/Telecom: Electronic Communication and Personal Devices*

8. **QUALITY REPORT** — J. Maxworthy
   a. Presentation
   b. Discussion
   c. Public Comment
   d. *ACTION: For Information Only.*

9. **CEO UPDATE** — D. Gideon
   a. Presentation
   b. Discussion
   c. Public Comment
   d. *ACTION: For Information Only.*

10. **EMERGENCY DEPARTMENT YEAR IN REVIEW PERFORMANCE SNAPSHOT PRESENTATION** — S. Thomas, M.D.
    a. Presentation
    b. Discussion
    c. Public Comment
    d. *ACTION: For Information Only.*

11. **MEDICAL EXECUTIVE REPORT** — L. Hodgson, M.D.
    a. Presentation
    b. Discussion
    c. Public Comment
    e. *ACTION:*
       *- Acceptance of Medical Staff Report*
       *- Approval of Appointments, Reappointments and Changes of Staff Status and Procedures*

**ADJOURN TO CLOSED SESSION**

A. Reports of Medical Staff Audit and Quality Assurance Pursuant to Health and Safety Code Sec. 32155.

B. Conference with Labor Negotiators (pursuant to Government Code Section 554957.6) Agency negotiators: John Hardy, Vice President of Human Resources: California Nurse Association.

ANNOUNCEMENT OF REPORTABLE ACTION(S) TAKEN IN CLOSED SESSION, IF ANY.

DOCTORS
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# MINUTES

## December 14, 2011

TAB 3

## 5. PARCEL TAX REVENUE: COLLECTION and DISTRIBTUION REPORT

Ms. Gideon, Interim President and CEO provided brief information on the Measure D; Parcel Tax Revenue Collection and Distribution report. Under the disclosure agreements of the 2004 financing, DMC is obligated to report how much revenue is collected taxes and how it's been paid out on an annual basis.

*A motion made by Supervisor John Gioia and seconded by Director Godley to accept the report passed unanimously.*

## 6. FINANCIALS – NOVEMBER 2011

On behalf of Mr. Jim Boatman, CFO, Ms. Gideon presented and sought approval of the November 2011 financials.

Ms. Gideon reported outpatient and inpatient volume decreased significantly. LOS picked up in September and increased in October and November at 4.5.

Ms. Gideon also reported a net loss was $2.8M in November. Net loss to date is $16M. Payroll and supply expenses were under budget again, consistent with volume. Worked FTE's were 11.6% below budget, significantly below volume. Operating cash in November was $4.4M or 12 days.

*A motion was made by Director Zell and seconded by Directly Godley to approve the November 2011 Financials passed unanimously.*

## 7. QUALITY REPORT

Juli Maxworthy, DNP, VP Quality & Risk Management reported the following core measures:

- Congestive Heart Failure (CHF), Surgical Care Improvement Project (SCIP) and Pneumonia (PN) elements are all currently in the green (above 90%).
- Acute Myocardial Infarction (AMI):
  - Most AMI elements for 3Q 2011 are in the green above 90%, except Fibrinolysis treatment within 30 min. of arrival and PCI within 90 min. of arrival.
  - Fibrinolysis within 30 min of arrival – only one out of two cases for Q3 2011 fell out of the 30 min. requirement (low n/d ratio). Case has been reviewed by cardiology group.
- The goals for the core measures are to move the goal to 95% next year.

Other data included:

- Inpatient and Outpatient Falls reported a decrease in 3rd quarter.
- Patient Satisfaction is improving in almost all areas.

- Clinical Laboratory Performance Improvement Key Indicators are green in all areas.
- Employee health had an exposure in August with appropriate follow up.
- Quality Updates:
  - Radiology, all indicators are within desired results.
  - Pharmacy & MERP monitoring improved, decreased percentage of overrides and medication passes.
  - Patient Satisfaction Summit to be held at the end of January to focus on areas to improve in 2012.

## 8. CEO UPDATE

Ms. Gideon announced updates for Medical Staff Officers effective January 1, 2012. They are as follows:

- Chief of Staff – Laurel Hodgson, M.D.
- Chief of Staff Elect - Ernest I. Katler, M.D.
- Immediate Past Chief – Sharon B. Drager, M.D.
- Secretary/Treasurer – Richard S. Stern, M.D.

- **Paragon System:** The electronic medical records implementation is progressing well. The committee is evaluating options for efficiency in providing and developing greater connectivity with the County and others who are upgrading systems. We continue to work with the Paragon implementation while that initiative is still underway. The time line for the physician order entry is April 23, 2012.

- **Contra Costa Local Agency Formation Commission (LAFCO):** Director Zell and Ms. Gideon met with LAFCO and presented the status of the District and the hospital to the organization. The hospital is due for the 5 year LAFCO Municipal Service Review in the fourth quarter of 2012.

- **Facility:** Anticipating some esthetic facility upgrades to be completed early 2012. Carpeting, paint, stair strips, and furniture were purchased two years ago which remains in storage. Carpets will be installed from ED through the physician entrance. Replacing furniture in ED waiting room and several other public areas. Labor and OT have been budgeted.

- **COP**: Institutional investor call was conducted. We can now begin to roll out the official statement and anticipating completing a pricing call within the next 24 hours. The interest rate will be determined and hoping to complete the sale within the next week. Closing is scheduled for December 29, 2011.

- **Strategic Planning Initiative:** An RFP has been sent to a number of planning firms to bid as DMC's advisor in the strategic planning initiative process. Ms Gideon provided an overview of the RFP, which outlined the objectives, process and proposal requirements.

## 9. MEDICAL EXECUTIVE REPORT

Dr. Drager sought approval of the November Credentials Report. There were no policies.

*The motion made by Director Godley and seconded by Dr. Walker to approve the Medical Staff and Credentials report for November 2011 passed unanimously.*

The meeting adjourned at 4:00 P.M.

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# FINANCIAL REPORT
## DECEMBER 2011

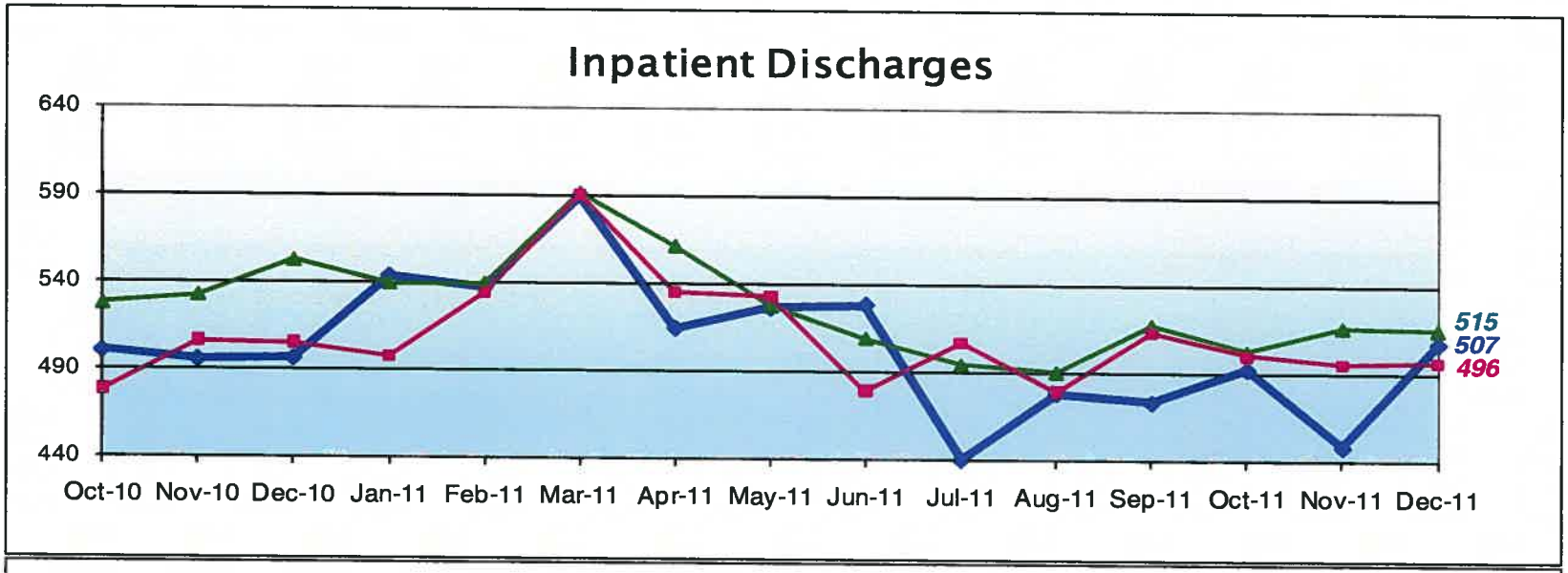
TAB 6

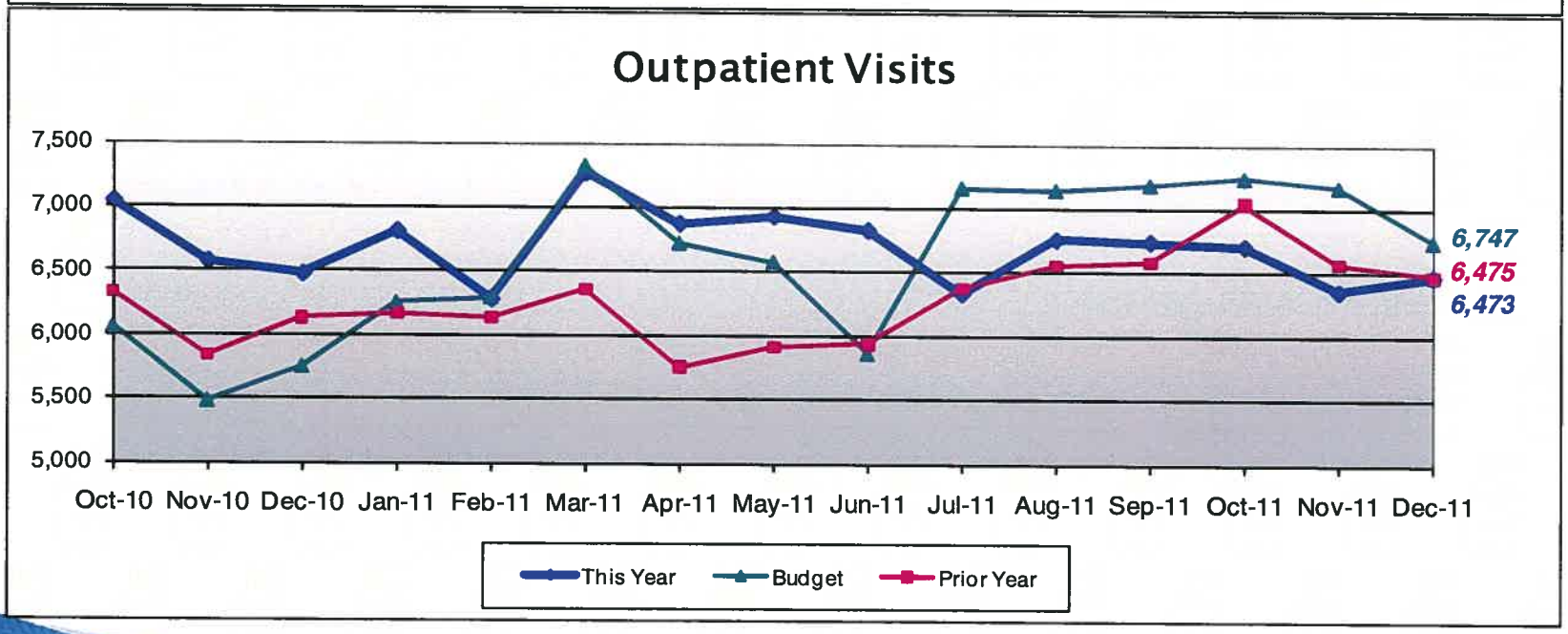
DOCTORS MEDICAL CENTER

# Board Presentation

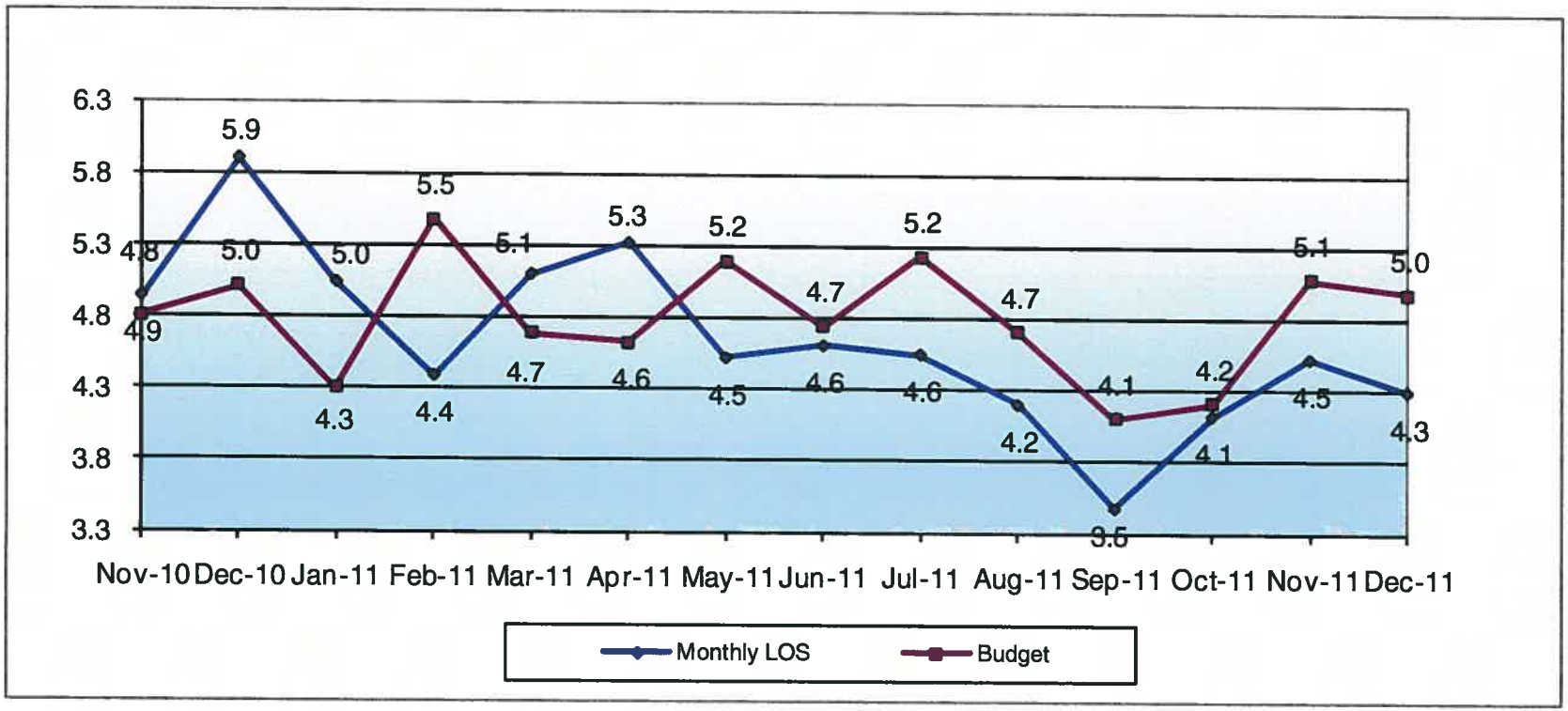
# December 2011 Financial Report

# Patient Volumes



# Monthly Length of Stay
## Discharged Patients



# Statement of Activity - Summary

For the Period Ending

December 31, 2011

*(Thousands)*

| Month to Date | | | | Year to Date | | |
|---|---|---|---|---|---|---|
| Actual | Budget | Var | | Actual | Budget | Var |
| 9,454 | 11,255 | (1,801) | **Net Operating Revenues $** | 116,645 | 136,734 | (20,089) |
| 12,487 | 11,903 | (584) | **Total Operating Expenses $** | 147,672 | 144,703 | (2,969) |
| (3,033) | (648) | (2,385) | **Income/(Loss) from Operations $** | (31,027) | (7,969) | (23,058) |
| 980 | 681 | 299 | **Income from Other Sources $** | 12,889 | 7,969 | 4,920 |
| (2,053) | 33 | (2,086) | **Net Income / (Loss) $** | (18,138) | 0 | (18,138) |
| (21.7%) | 0.3% | (22.0%) | **Net Income Percentage** | (15.5%) | 0.0% | (15.5%) |

| | |
|---|---|
| California Benchmark Avg | 2.1% |
| Top 25% | 7.1% |
| Top 10% | 11.5% |

# Budget Variances – Net Revenue

- Medi-Cal/Medi-Cal HMO - ($75K).
- HMO/PPO/Commercial - ($1,945K).
- Medicare / Medicare HMO- ($530K).
- AB 915 Funds - $946K.

# Budget Variances - Expenses

- **Salaries & Benefits** ($39K) - Salaries under budget due to low contract labor, flexing and hospital reorganization. Benefit cost in excess of $400K.
- **Supplies** $332K - Flexed supply costs, reduction in implants, pacemakers, and pharmaceuticals.
- **Purchased Services** ($764K) - Unbudgeted fire sprinkler review, higher security, excess repair cost, McKesson software costs.
- **Rentals Expenses** ($71K )- Destroyed records $40K.
- **Restructuring Costs** ($77K)

# Cash Position
## December 31, 2011

*(Thousands)*

| | December 31, 2011 | December 31, 2010 |
|---|---|---|
| Unrestricted Cash | $13,972 | $5,229 |
| Restricted Cash | $29,847 | $4,006 |
| Total Cash | $43,819 | $9,235 |
| Days Unrestricted Cash | 35 | 12 |
| Days Restricted | 76 | 11 |
| Total Days of Cash | 110 | 23 |

| | |
|---|---|
| California Benchmark Average | 34 |
| Top 25% | 82 |
| Top 10% | 183 |

# Accounts Receivable

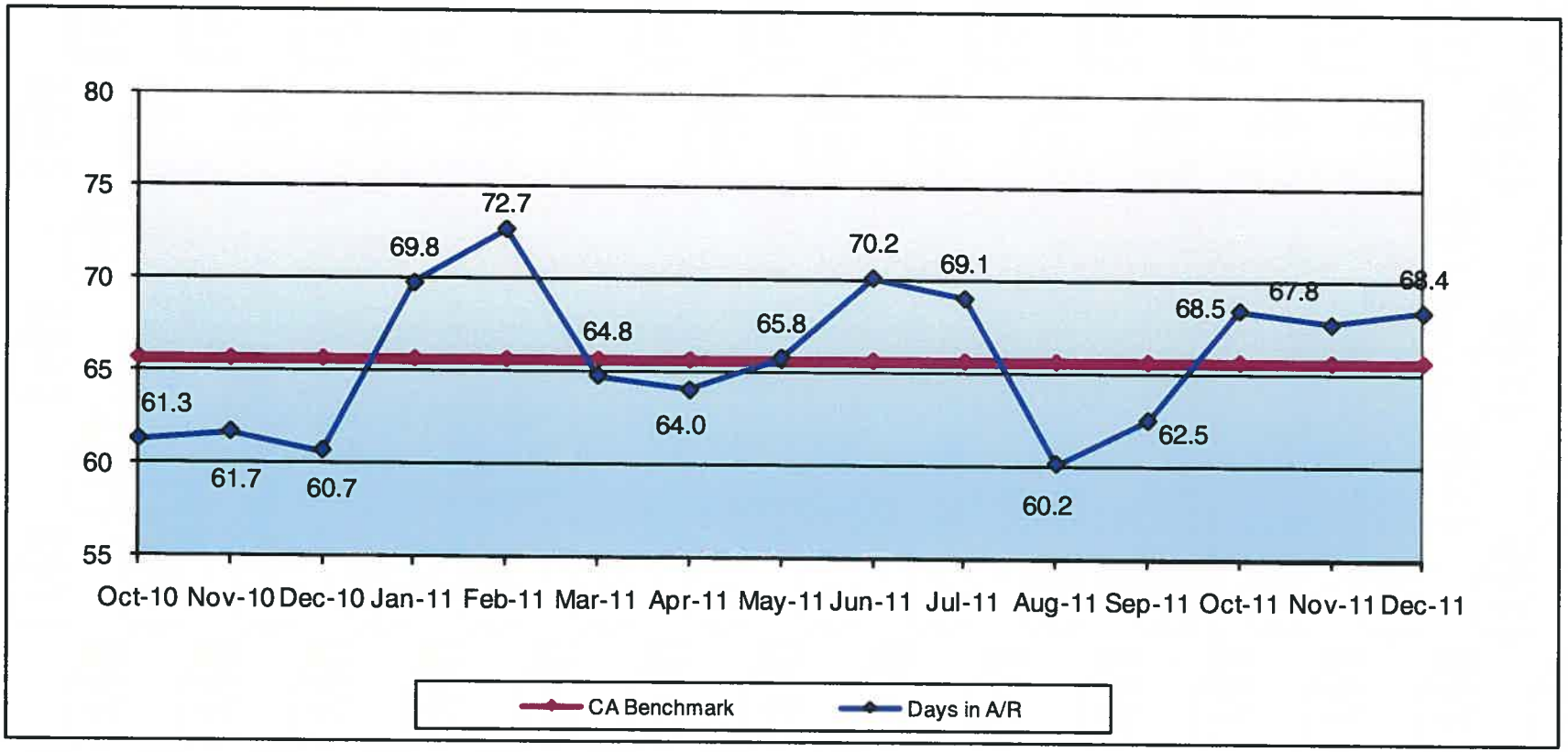
## December 31, 2011

*(Thousands)*

| | December 31, 2011 | December 31, 2010 |
|---|---|---|
| Net Patient Accounts Receivable | $18,951 | $20,433 |
| Net Days in Accounts Receivable | 68.4 | 60.7 |

| | |
|---|---|
| California Benchmark Average | 65.7 days |
| Top 25% | 45.2 days |
| Top 10% | 35.5 days |

# Accounts Receivable
## Net Days in A/R



# Financial Report Key Points

- Net Loss was $2.0M in December. Net Loss to date is $18M.
- Payroll and Supply Expenses under budget again.
- Worked FTE's were 7.7% below budget.
- $40M Bond indenture sold by year end. Operating Cash in December was $14M days. Restricted cash balance of $30M is related to the new bond indenture.

DOCTORS MEDICAL CENTER

# December 2011 Executive Report

Doctors Medical Center had a Net Loss of $2,053,000 in the month of December. As a result, net income was under budget by $2,086,000. The following are the other factors leading to the Net Income variance:

| **Net Patient Revenue Factors** | **Over / (Under)** |
|---|---|
| HMO/PPO/ Commercial Volume | ($1,945,000) |
| Medi-Cal/ Medi-Cal HMO | ($75,000) |
| Medicare / Medicare HMO | ($530,000) |
| AB 915 Funds | $946,000 |
| | |
| **Expenses** | |
| Salaries & Benefits | ($39,000) |
| Supplies | $332,000 |
| Purchased Services | ($764,000) |
| Rentals | ($71,000) |
| Restructuring Costs | ($77,000) |

Net patient revenue was under budget by $1,805,000. Gross charges were under budget in December 13.3%. Patient days were 15.1% under budget and discharges were 1.6% under budget. The large revenue variance is created by the decrease in HMO/PPO business including rate increases put into the budget that have not occurred. That business group by itself accounted for a $1,945,000 variance from budget. Our volumes in Medicare and Medi-Cal were also under budget. We received AB915 funds in December for a $946,000 positive variance. The AB915 funds were spread out over the year in the budget.

Salaries and Benefits combined were under budget $39,000 while patient days were 15.1% under budget. Worked FTE's were under budget 7.7% as a reflection of the staffing reduction. The normal flexing of staff for the volume decrease would have been $78,000 but we exceeded that amount by $295,000. Benefits were over budget in December as large invoices for medical services to our employees came through in December in excess of $400,000

Supplies were under budget $332,000. Our supplies should have been reduced by $41,000 based on our volume. We were able to flex supplies another $291,000 with most of this reduction in implant, pharmaceuticals and pacemaker costs.

Purchased services was over budget $764,000 in December. The largest overage was in fees to McKesson. We have been working with McKesson to finance the cost of the Paragon project through MedOne and have been reliant on their classification of their invoices for capitalizing the costs of the upgrade. In reviewing the invoice classified as "Paragon upgrade" we found $685,000 that was maintenance fees for both the old Horizon system and the new Paragon system. Cost for repairs for equipment and elevators exceeded budget by $60,000 and Security continues to run over budget by $25,000.

Rentals were over budget $71,000. We incurred a once time cost to destroy old records in storage costing $40,000. This onetime cost will end up saving us money over the coming years. The balance of the overage is for the financing cost of equipment that were not budgeted to be financed.

Restructuring Costs in the month were $77,000. These costs are one time unbudgeted costs we are incurring due to the financial restructuring of the hospital.

**WEST CONTRA COSTA HEALTHCARE DISTRICT**
**DOCTORS MEDICAL CENTER**
**INCOME STATEMENT**
**December 31, 2011**
(Amounts in Thousands)

| | CURRENT PERIOD | | | | PRIOR YEAR | | CURRENT YTD | | | | PRIOR YEAR |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | ACTUAL | BUDGET | VAR | VAR % | ACTUAL | | ACTUAL | BUDGET | VAR | VAR % | ACTUAL |
| | | | | | | **OPERATING REVENUE** | | | | | |
| 1 | 9,363 | 11,168 | (1,805) | -16.2% | 11,642 | Net Patient Service Revenue | 115,455 | 135,617 | (20,162) | -14.9% | 130,654 |
| 2 | 91 | 87 | 4 | 4.6% | 126 | Other Revenue | 1,190 | 1,117 | 73 | 6.6% | 1,164 |
| 3 | 9,454 | 11,255 | (1,801) | -16.0% | 11,768 | **Total Operating Revenue** | 116,645 | 136,734 | (20,089) | -14.7% | 131,818 |
| | | | | | | **OPERATING EXPENSES** | | | | | |
| 4 | 4,949 | 5,322 | 373 | 7.0% | 6,290 | Salaries & Wages | 61,474 | 63,875 | 2,401 | 3.8% | 64,689 |
| 5 | 3,026 | 2,615 | (412) | -15.8% | 2,704 | Employee Benefits | 33,887 | 30,953 | (2,934) | -9.5% | 30,839 |
| 6 | 810 | 821 | 11 | 1.4% | 769 | Professional Fees | 9,826 | 9,855 | 29 | 0.3% | 10,021 |
| 7 | 1,250 | 1,582 | 332 | 21.0% | 1,660 | Supplies | 18,775 | 20,677 | 1,902 | 9.2% | 20,928 |
| 8 | 1,436 | 672 | (764) | -113.8% | 1,296 | Purchased Services | 10,594 | 8,702 | (1,893) | -21.8% | 10,166 |
| 9 | 290 | 219 | (71) | -32.5% | 174 | Rentals & Leases | 3,027 | 2,576 | (451) | -17.5% | 2,192 |
| 10 | 350 | 350 | (0) | 0.0% | 321 | Depreciation & Amortization | 4,164 | 4,187 | 23 | 0.6% | 3,593 |
| 11 | 77 | - | (77) | | 316 | Restructuring Costs | 2,018 | - | (2,018) | | - |
| 11 | 299 | 323 | 24 | 7.5% | 316 | Other Operating Expenses | 3,906 | 3,879 | (27) | -0.7% | 4,345 |
| 12 | 12,487 | 11,903 | (584) | -4.9% | 13,846 | **Total Operating Expenses** | 147,672 | 144,703 | (2,969) | -2.1% | 146,773 |
| 13 | (3,033) | (648) | (2,385) | 367.8% | (2,078) | **Operating Profit / Loss** | (31,027) | (7,969) | (23,058) | 289.4% | (14,955) |
| | | | | | | **NON-OPERATING REVENUES (EXPENSES)** | | | | | |
| 14 | 547 | - | 547 | 0.0% | 417 | Other Non-Operating Revenue | 5,990 | - | 5,990 | 0.0% | 10,310 |
| 15 | 671 | 754 | (83) | 11.0% | 22 | District Tax Revenue | 8,502 | 9,048 | (546) | 6.0% | 8,490 |
| 16 | 14 | 9 | 5 | 55.6% | 6 | Investment Income | 54 | 103 | (49) | -47.7% | 94 |
| 17 | (252) | (82) | (170) | 0.0% | (109) | Less: Interest Expense | (1,657) | (1,183) | (474) | 40.1% | (1,394) |
| 18 | 980 | 681 | 299 | 43.9% | 336 | **Total Net Non-Operating** | 12,889 | 7,969 | 4,920 | 61.7% | 17,500 |
| 19 | (2,053) | 33 | (2,086) | -6344.0% | (1,742) | **Income Profit (Loss)** | (18,138) | 0 | (18,138) | -7729252% | 2,545 |
| | | | | | | **Profitability Ratios:** | | | | | |
| 20 | -32.1% | -5.8% | 132.4% | | -17.7% | Operating Margin % | -26.6% | -5.8% | 114.8% | | -11.3% |
| 21 | -21.7% | 0.3% | -22.0% | | -14.8% | Profit Margin % | -15.5% | 0.0% | -15.5% | | 1.9% |

**WEST CONTRA COSTA HEALTHCARE DISTRICT**
**DOCTORS MEDICAL CENTER**
**INCOME STATEMENT**
**December 31, 2011**
(Amounts in Thousands)

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 22 | 2,350 | 2,054 | (296) | -14.4% | 2,454 | SWB / APD | 2,263 | 2,071 | (193) | -9.3% | 2,033 |
| 23 | 63.9% | 66.7% | | | 65.0% | SWB / Total Operating Expenses | 64.6% | 65.5% | | | 65.1% |
| 24 | 3,679 | 3,080 | (599) | -19.5% | 3,778 | Total Operating Expenses / APD | 3,505 | 3,160 | (345) | -10.9% | 3,124 |
| 25 | 34,957 | 41,698 | (6,741) | -16.2% | 41,026 | I/P Gross Charges | 453,774 | 500,708 | (46,934) | -9.4% | 475,430 |
| 26 | 19,517 | 21,126 | (1,609) | -7.6% | 20,730 | O/P Gross Charges | 237,690 | 260,948 | (23,258) | -8.9% | 232,517 |
| 27 | **54,474** | **62,823** | **(8,349)** | **-13.3%** | **61,756** | **Total Gross Charges** | **691,464** | **761,656** | **(70,192)** | **-9.2%** | **707,947** |
| | | | | | | **Payor Mix (IP and OP)** | | | | | |
| 28 | 39% | 37% | 2% | | 37% | Medicare % | 40% | 37% | 2% | | 38% |
| 29 | 10% | 17% | -7% | | 19% | Medi-Cal % | 13% | 17% | -4% | | 17% |
| 30 | 13% | 14% | -1% | | 11% | Managed Care HMO / PPO % | 12% | 14% | -2% | | 14% |
| 31 | 11% | 10% | 1% | | 10% | Medicare HMO % | 10% | 10% | 0% | | 9% |
| 32 | 13% | 7% | 6% | | 7% | Medi-Cal HMO % | 11% | 7% | 4% | | 7% |
| 33 | 0% | 0% | 0% | | 0% | Commercial % | 0% | 0% | 0% | | 0% |
| 34 | 1% | 1% | 0% | | 1% | Worker's Comp % | 1% | 1% | 0% | | 2% |
| 35 | 2% | 3% | -1% | | 4% | Other Government % | 3% | 3% | 0% | | 3% |
| 36 | 11% | 10% | 1% | | 11% | Self Pay /Charity % | 10% | 10% | 0% | | 10% |
| | | | | | | **STATISTICS** | | | | | |
| 37 | 501 | 515 | (14) | -2.7% | 485 | Admissions | 6,081 | 6,300 | (219) | -3.5% | 6,155 |
| 38 | 507 | 515 | (8) | -1.6% | 496 | Discharges | 6,075 | 6,300 | (225) | -3.6% | 6,158 |
| 39 | 2,178 | 2,565 | (387) | -15.1% | 2,435 | Patient Days | 27,650 | 30,106 | (2,456) | -8.2% | 31,552 |
| 40 | 70.3 | 82.7 | (12.5) | -15.1% | 78.5 | Average Daily Census (ADC) | 75.8 | 82.5 | (6.7) | -8.2% | 86.4 |
| 41 | 4.30 | 4.98 | 0.68 | 13.7% | 4.91 | Average Length of Stay (LOS) | 4.55 | 4.78 | 0.23 | 4.8% | 5.12 |
| 42 | 31 | 31 | | | 31 | Days in Month | 365 | 365 | | | 365 |
| 43 | 790 | 776 | 14 | 1.8% | 747 | Adjusted Discharges (AD) | 9,257 | 9,583 | (326) | -3.4% | 9,170 |
| 44 | 3,394 | 3,865 | (471) | -12.2% | 3,665 | Adjusted Patient Days (APD) | 42,133 | 45,796 | (3,663) | -8.0% | 46,983 |
| 45 | 109 | 125 | (15) | -12.2% | 118 | Adjusted ADC (AADC) | 115 | 125 | (10) | -8.0% | 129 |
| 46 | 82 | 85 | (3) | -3.5% | 73 | Inpatient Surgeries | 1,059 | 1,044 | 15 | 1.4% | 1,044 |
| 47 | 114 | 94 | 20 | 21.3% | 104 | Outpatient Surgeries | 1,224 | 1,172 | 52 | 4.4% | 1,172 |
| 48 | **196** | **179** | 17 | 9.5% | **177** | **Total Surgeries** | **2,283** | **2,216** | 67 | 3.0% | **2,216** |

**WEST CONTRA COSTA HEALTHCARE DISTRICT**
**DOCTORS MEDICAL CENTER**
**INCOME STATEMENT**
**December 31, 2011**
(Amounts in Thousands)

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 49 | 2,915 | 3,275 | (360) | -11.0% | 2,993 | ED Outpatient Visits | 35,381 | 39,875 | (4,494) | -11.3% | 34,941 |
| 50 | 3,444 | 3,378 | 66 | 2.0% | 3,378 | Ancillary Outpatient Visits | 43,769 | 40,634 | 3,135 | 7.7% | 39,772 |
| 51 | 114 | 94 | 20 | 21.3% | 104 | Outpatient Surgeries | 1,224 | 1,172 | 52 | 4.4% | 1,172 |
| 52 | **6,473** | **6,747** | (274) | -4.1% | **6,475** | **Total Outpatient Visits** | **80,374** | **81,681** | (1,307) | -1.6% | **75,885** |
| 53 | 449 | 430 | 19 | 4.4% | 425 | Emergency Room Admits | 5,444 | 5,006 | 438 | 8.7% | 5,269 |
| 54 | 15.4% | 13.1% | | | 14.2% | % of Total E/R Visits | 15.4% | 12.6% | | | 15.1% |
| 55 | 89.6% | 83.5% | | | 87.6% | % of Acute Admissions | 89.5% | 79.5% | | | 85.6% |
| 56 | 610 | 661 | 51 | 7.7% | 674 | Worked FTE | 643 | 667 | 24 | 3.7% | 633 |
| 57 | 701 | 781 | 80 | 10.2% | 803 | Paid FTE | 750 | 778 | 27 | 3.5% | 735 |
| 58 | 5.57 | 5.30 | (0.27) | -5.1% | 5.70 | Worked FTE / AADC | 5.57 | 5.32 | (0.25) | -4.7% | 4.92 |
| 59 | 6.41 | 6.26 | (0.14) | -2.2% | 6.79 | Paid FTE / AADC | 6.50 | 6.20 | (0.30) | -4.9% | 5.71 |
| 60 | 2,759 | 2,890 | (131) | -4.5% | 3,176 | Net Patient Revenue / APD | 2,740 | 2,961 | (221) | -7.5% | 2,781 |
| 61 | 16,050 | 16,256 | (206) | -1.3% | 16,848 | I/P Charges / Patient Days | 16,411 | 16,631 | (220) | -1.3% | 15,068 |
| 62 | 3,015 | 3,131 | (116) | -3.7% | 3,202 | O/P Charges / Visit | 2,957 | 3,195 | (237) | -7.4% | 3,064 |
| 63 | 1,458 | 1,377 | (81) | -5.9% | 1,716 | Salary Expense / APD | 1,459 | 1,395 | (64) | -4.6% | 1,377 |
| 64 | 4.5 | 4.5 | (0.01) | -0.3% | 5.4 | Medicare LOS | 5.0 | 5.0 | (0.05) | -0.9% | 5.4 |
| 65 | 1.48 | 1.51 | 0.03 | 2.1% | 1.66 | Medicare CMI | 1.53 | 1.55 | 0.02 | 1.4% | 1.57 |
| 66 | 3.06 | 2.99 | (0.07) | -2.4% | 3.24 | Medicare CMI Adjusted LOS | 3.27 | 3.20 | (0.07) | -2.3% | 3.44 |
| 67 | 4.3 | 5.0 | 0.68 | 13.7% | 5.9 | Total LOS | 4.5 | 4.8 | 0.27 | 5.6% | 5.26 |
| 68 | 1.410 | 1.520 | 0.11 | 7.2% | 1.562 | Total CMI | 1.462 | 1.517 | 0.06 | 3.7% | 1.497 |
| 69 | 3.05 | 3.28 | 0.23 | 7.0% | 3.78 | Total CMI Adjusted LOS | 3.09 | 3.15 | 0.06 | 2.0% | 3.51 |

DOCTORS MEDICAL CENTER

# POLICIES

TAB 7

DOCTORS MEDICAL CENTER

# POLICY, PROCEDURE, AND FORMS REPORT

## January 2012

**In accordance with regulatory and accreditation standards, the policies, procedures and forms listed below have been developed and/or revised by the appropriate committees. Please note that copies of all policies listed in Section A (New) and Section B (Revised with Major/Substantive Changes)below are attached to this report, those policies/documents listed in Section C (Revised with Minor/Non-Substantive Changes), will be available for review in the Quality Department.**

| POLICY/PROCEDURE/FORMS | TYPE | REASON FOR REVIEW |
|---|---|---|
| **A. New**<br>**1.Telecommunications**<br>• Electronic Communications and Employee Owned Devices | Communications house-wide policy | New policy |
| **2. Clinical Engineering**<br>**a.** Policies:<br>• Medical Equipment Management Plan-2011<br>• Medical Equipment Management Program<br>• Medical Equipment Maintenance Priorities<br>• Notification of Delays in Maintenance Equipment<br>• Preventive Maintenance<br>• Clinical Engineering Rounds<br>• Work Order System<br>• Electrical Safety Testing<br>• Electromagnetic Interference<br>• Initial Inspections<br>• Test Equipment Calibration<br>• Hazard Recalls<br>• SMDA Reporting<br>• Repair or Replace Determination<br>• Outside Service Control<br>• Infection Control Guidelines for Clinical Engineering<br>b. Form:<br>• Non Hospital-Owned Equipment & Non Hospital Owned Medical Release Form | Clinical Engineering policies and a form | New policies and one form |

# APPROVAL ROUTING SHEET FOR POLICIES AND PROCEDURES

DOCTORS MEDICAL CENTER

**All items marked with † must be completed, and or required routing**

| | |
|---|---|
| **†TITLE: Electronic Communication and Personal Devices** | **†CHECK ONE:** ☒ **New** ☐ **Reviewed** ☐ **Revised :** ☐ **Major** ☐ **Minor** |
| † ☒ **Administrative** ☐ **Clinical** ☒ **Department** Communications/Telecom | |
| **†SUBMITTED BY:** John Bliss | |
| **†NEW POLICY - REASON FOR SUBMISSION:** ☐ Change in Law ☐ New Regulation: CMS CDPH TJC (Other) | |
| **†REVIEWED OR REVISED - SUMMARY OF POLICY / PROCEDURE CHANGES:** | |

| | MEETING DATE | APPROVAL |
|---|---|---|
| ☒ **Manager or Department Director†** | 10/10/12 | 10/10/12 |
| ☐ **Medical Staff Department(s):** | | |
| ☐ Cancer Committee ☐ CV Surgery Committee | | |
| ☐ Infection Control Committee ☐ IDP Committee | | |
| ☐ Medical Ethics Committee ☐ Patient Safety Committee | | |
| ☐ Radiation Safety Committee ☐ P&T Committee | | |
| ☐ Respiratory/Critical Care/ED Committee | | |
| ☐ Quality Improvement Team: ☐ EM Committee | | |
| ☐ EOC/Safety Committee ☐ Other: | | |
| ☐ **Nursing Department:** ☐ Nursing Practice: | | |
| ☐ **Forms Committee** (as applicable) | | |
| ☒ **Administrative Policy Review Committee (APRC)†** | 12/28/11 | 12/28/11 |
| ☒ **Executive Leadership via Email** | 1/13/12 | 1/13/12 |
| ☐ **Medical Executive Committee (MEC)** (as applicable) | | |
| ☐ **Board of Trustees** *(automatic from MEC)* *(as applicable)* | | |

**DOCTORS MEDICAL CENTER**

| Manual: COMMUNICATIONS/TELECOM | Sub Folder: COMMUNICATIONS |
|---|---|
| Title: Electronic Communications and Employee Owned Devices | Reviewed:<br>Revised: |
| Effective Date: | Page 1 of 2 |

**PURPOSE:**

**1.0 PURPOSE**

To set forth Doctors Medical Center policy concerning use of electronic communications and any employee owned electronic device as defined in this section. This policy shall apply to all Doctors Medical Center employees, volunteers, and physicians. For the purposes of this policy, any employee owned electronic device shall be defined as any employee owned electronic device capable playing movies, transmitting or receiving voice, text or data messages, including but not limited to CD players, computers, cellular telephones, pagers, personal digital assistants (PDA's), Bluetooth, or other wireless units. Doctors Medical Center reserves the right to modify this policy at any time.

**POLICY:**

**2.0 GENERAL USE**

Employees should restrict the use of those devices defined in section 1.0 of this policy to non-work time and in non-work areas. Such devices should remain off at all other times unless otherwise expressly authorized by a Supervisor, Manager, Director or Administrator to conduct Hospital business. The personal use of electronic devices when on break or meal periods is limited to designated break/lunch rooms and the exterior of the Medical Center only and shall not interfere with access to the facility or care of patients and visitors.

**2.1 MEDICAL CENTER ELETRONIC EQUIPMENT**

Medical Center issued required electronic handheld devices will be exempt from this section, but should at all times be used in a manner consistent with their intent and not for personal business.

**2.3 PERSONAL PHONE CALLS**

All personal phone calls should be restricted to non-work time only (breaks, meals, before/after an employee's shift). Employees should notify their external contacts / family members that emergency phone calls are to be directed to the Medical Center switchboard for proper routing. At no time should personal phone calls take place in patient care areas without the approval and discretion of the Department Supervisor. While it is understood that there may be occasions to use Medical Center telephones for phone calls, such use will be limited so as to keep lines open to the unit or department, and shall in no way interfere with the provision of patient care or interaction with visitors.

### 2.4 LOSS, THEFT, DAMAGE

The Medical Center shall not be held liable for loss, theft, or damage to any of the devices defined in section 1.0 if this policy.

**PROCEDURES:**

### 3.0 ENFORCEMENT

Violations of this policy may result in disciplinary action, up to and including termination of employment.

| | | |
|---|---|---|
| **Responsible for review/updating (Title/Dept)** | Director of Communications<br>Title | Telecommunications<br>Dept |

# APPROVAL ROUTING SHEET FOR POLICIES AND PROCEDURES

DOCTORS MEDICAL CENTER

All items marked with † must be completed, and or required routing

| †TITLE: Medical Equipment Management Program | †CHECK ONE: ☒ New ☐ Reviewed ☐ Revised : ☐ Major ☐ Minor |
|---|---|
| † ☐ Administrative ☐ Clinical ☒ Department Plant Operations | |
| †SUBMITTED BY: William Appling | |
| †NEW POLICY - REASON FOR SUBMISSION: ☐ Change in Law ☐ New Regulation: CMS CDPH TJC (Other) | |

†REVIEWED OR REVISED - SUMMARY OF POLICY / PROCEDURE CHANGES:

1. Medical Equipment Management Plan-2011
2. Medical Equipment Management Program
3. Medical Equipment Maintenance Priorities
4. Notification of Delays in Maintenance Equipment
5. Preventive Maintenance
6. Clinical Engineering Rounds
7. Work Order System
8. Electrical Safety Testing
9. Electromagnetic Interference
10. Initial Inspections
11. Test Equipment Calibration
12. Hazard Recalls
13. SMDA Reporting
14. Repair or Replace Determination
15. Outside Service Control
16. Infection Control Guidelines for Clinical Engineering
17. Non Hospital-Owned Equipment & Non Hospital Owned Medical Release Form

| | MEETING DATE | APPROVAL |
|---|---|---|
| ☐ **Manager or Department Director**† | | |
| ☐ **Medical Staff Department(s):** | | |
| ☐ Cancer Committee ☐ CV Surgery Committee | | |
| ☐ Infection Control Committee ☐ IDP Committee | | |
| ☐ Medical Ethics Committee ☐ Patient Safety Committee | | |
| ☐ Radiation Safety Committee ☐ P&T Committee | | |
| ☐ Respiratory/Critical Care/ED Committee | | |
| ☐ Quality Improvement Team: ☐ EM Committee | | |
| ☒ EOC/Safety Committee ☐ Other: | 8/17/2011 | WDA |
| ☒ **Nursing Department: Nursing Leadership** ☐ Nursing Practice: | 10/27/2011 | Committee |
| ☐ **Forms Committee** (as applicable) | | |
| ☒ **Administrative Policy Review Committee (APRC)**† | 10/5/2011 | Committee |
| ☐ **Executive Leadership** | | |
| ☐ **Medical Executive Committee (MEC)** *(as applicable)* | | |
| ☐ **Board of Trustees** *(automatic from MEC) (as applicable)* | | |

| Manual: ENVIRONMENT OF CARE | Sub Folder: Medical Equipment |
|---|---|
| Title: Medical Equipment Management Plan 2011 | Reviewed:<br>Revised: |
| Effective Date: | Page 1 of 7 |

## I. SCOPE

The Medical Equipment Management Program is designed to ensure proper selection of the appropriate medical equipment to support a safe patient care and treatment environment. The Program will ensure effective preparation of staff responsible for the use, maintenance, and repair of the equipment, and manage risks associated with the use of medical equipment technology. Finally, the Program is designed to ensure continual availability of safe, effective equipment through a program of planned maintenance, timely repair, ongoing education and training, and evaluation of all events that could have an adverse impact on the safety of patients or staff as applied to the building and services provided at Doctors Medical Center.

The program is applied to the hospital and the Cancer Center, Sleep Disorders Center, and the Outpatient Clinic.

## II. FUNDAMENTALS

A. The sophistication and complexity of medical equipment continues to expand. Selecting new medical equipment technology requires research and a team approach.
B. Patient care providers need information to develop an understanding of medical equipment limitations, safe operating conditions, safe work practices, and emergency clinical interventions during failures.
C. Medical equipment may injure patients or adversely affect care decisions if not properly maintained.

## III. OBJECTIVES

The Objectives for the Medical Equipment Program are developed from information gathered during risk assessment activities, annual evaluation of the previous year's program, performance measures, and environmental tours. The objectives for this plan are:

- Reevaluate levels of maintenance schedules for medical equipment.
- To increase training, both formal and informal for resident technicians.
- Implement handheld devices to reduce the use of paper.

## IV. ORGANIZATION & RESPONSIBILITY

A. The Board of Directors receives regular reports through the Environment of Care (EC) Committee regarding activities of the Medical Equipment Program. The Board of Directors reviews the reports and, as appropriate, communicates concerns about identified issues, and regulatory compliance. The Board of Directors provides support to facilitate ongoing activities of the Medical Equipment Program.

B. The COO receives regular reports of the current status of the Medical Equipment Program through the EC Committee. The COO reviews the reports and, as necessary, communicates concerns about key issues and regulatory compliance to the medical staff, nursing, Clinical Engineering, and other appropriate staff.

C. The Director of Plant Operations insures that the Medical Equipment Program is implemented in all key clinical areas. Program manages a variety of activities, including tracking of rental or leased equipment, warranty repairs, and contract services. The Program also assists in the management of the activities of specialty contractors providing services to other departments, such as radiology, laboratory, respiratory care, and surgery and anesthesia.

D. The Assistant Chief, Clinical Engineering, under the supervision of the Chief Engineer implements the in-house medical equipment maintenance program and tracks maintenance provided by original equipment manufacturers, and other contractors who provide maintenance and repair services for specific items of equipment.

E. Department heads orient new staff to their department and, as appropriate, specific uses of medical equipment. When requested, the Assistant Chief, Clinical Engineering provides assistance.

F. Individual staff members are responsible for learning and following job and task specific procedures for safe medical equipment operation.

## V. PROCESSES FOR MANAGING MEDICAL EQUIPMENT RISKS EC.02.04.01

**Management Plan- EC.01.01.01 EP7**

The organization develops and maintains the Medical Equipment Management Plan to effectively manage the medical equipment risks of the staff, visitors, and patients at Doctors Medical Center.

**Selection & Acquisition- EC.02.04.01 EP1**

The Director, Materials Management has overall responsibility for coordinating the medical equipment selection and acquisition process. Department heads and others, as appropriate, collaborate to select and acquire medical equipment. Department heads develop recommendations related to equipment to purchase. The organizations also subscribes to ECRI research agency specializing in medical equipment. When appropriate, The Assistant Chief, Clinical Engineering coordinate vendor negotiations, and ensure medical equipment considered for purchase meets appropriate standards of performance and safety.

The Chief Engineer works with design professionals and medical staff to identify needs for space and support of new equipment. They also manage the commissioning of new equipment. The commissioning process includes assembly, installation, and testing of new equipment prior to initial usage. The documentation of the tests is maintained by the Plant Operations.

The managers of clinical departments where new equipment is installed collaborate with Materials Management and equipment suppliers to ensure appropriate education and training are provided to all initial users of the equipment and a program for training additional future users is developed.

Capital equipment requests for medical equipment are included as part of the annual budget process. The CEO and Board of Directors have final approval over all new medical equipment

purchases. The Plant Operations department maintains documentation related to the Medical Equipment.

**Criteria & Inventory- EC.02.04.01 EP2**

Doctors Medical Center maintains either a written inventory of all medical equipment or an inventory of selected medical equipment categorized by physical risk associated with use and equipment incident history. This includes all life support equipment. The Assistant Chief, Clinical Engineer evaluates new types of equipment before initial use to determine whether to include this equipment in the inventory.

Written criteria are used to identify risks associated with medical equipment. The risks include, equipment function, physical risks associated with use, and equipment incident history as it relates to patient safety. The risks identified are used to assist in determining the strategies for maintenance, testing, and inspection of medical equipment. In addition, the identified risks are used to guide the development of training and education programs for staff that use or maintain equipment.

Equipment requiring a program of planned maintenance is listed as part of a maintenance inventory. The list includes equipment maintained by in-house staff as well as equipment maintained by vendors.

**Maintaining, Inspecting, and Testing Activities- EC.02.04.01 EP3**

The Director of Plant Operations, with the support of the Clinical Engineering department identifies in writing the activities used for maintaining, inspecting, and testing all of the medical equipment in the inventory used for the diagnosis, care, treatment, and monitoring of patients thus assuring safety and maximum useful life. The determination of the appropriate activity is made as part of the initial evaluation of equipment.

Potential activities may be selected to ensure reliable performance including:

- Predictive maintenance based on manufacturer's recommendations
- Reliability-centered maintenance based on equipment history
- Interval-based inspections based on specified intervals between tests, inspections, or maintenance activity
- Corrective maintenance based on a request for service or failure of the equipment to pass internal self-tests (Such equipment is subject to an initial test on receipt, and asset management)

**Maintaining, Inspecting, and Testing Frequencies- EC.02.04.01 EP4**

The Director of Plant Operations, with the support of the Clinical Engineering department identifies in writing the frequencies for inspecting, testing, and maintaining medical equipment on the inventory. The frequency of planned maintenance is determined based on criteria including manufacturer recommendations, risk levels, and current hospital experience. The frequency of maintenance is determined at the time of initial evaluation of the medical equipment based on the following:

- Interval testing

- Run-time based inspections
- Corrective maintenance
- Metered maintenance based on hours of use, or other time of use processes (This strategy uses on-board clocks or event recorders to trigger specific tests, inspections or service)
- Other strategies, based on the use of the equipment may include inspection immediate prior to each use, for equipment used infrequently, borrowed or rented from vendors or others

A work order is used to manage the work for each planned maintenance event. Work orders are issued for maintenance performed by in-house staff and by contractors. The Assistant Chief, Clinical Engineering or designee manages the work order generation and completion process.

Clinical Engineering Technicians perform assigned work orders and return completed work orders to managers. Work done by outside contractors is tracked to ensure the work is completed in accordance with the terms of a contract.

Doctors Medical Center has partnered with Universal Hospital Services (UHS) in an asset management agreement program; UHS currently manages BBraun Infusomat Space pumps, Hospira Lifecare PCA machines, Gaymar SPR Plus III (a low air loss mattress systems). UHS also maintains the critical care ventilation units, these items include: Nellcor - Puritan Bennett model 840 Ventilation System, Philips - Respironics model BiPap Vision Ventilatory Support System as well as Philips - Respironics V60 NIV Ventilation Systems. Any inspection information as well as preventative maintenance documentation is being managed by Universal Hospital Services (UHS), an on-site partner of the hospital.

Central Sterile or Sterile Processing documents performance testing or biological cultures on all sterilizers used. This information is reported at their respective Quality Improvement Committee or Infection Control meetings. Engineering and Plant Operations provides maintenance support on sterilizers at Doctors Medical Center. Clinical Engineering provides maintenance support on sterilizers at Doctors Medical Center.

In addition, Davita manages the performance testing and maintenance of the dialysis water processing system. Davita currently manages the Fresenius and MarCor Millineum dialysis systems. Chemical testing of dialysis RO product water is performed at least annually and biological testing of the RO system is completed monthly. Each machine has biological testing performed on a scheduled basis. Results are reported to the applicable Quality Improvement, Infection Control or Safety / Environment of Care Committee.

**Safe Medical Devices Act- EC.02.04.01 EP5**

The Risk Manager is responsible for monitoring and reporting all incidents in which medical equipment is suspected in or attributed to the death, serious injury, or serious illness of any individual, as required by the Safe Medical Devices Act of 1990. The Risk Manager collects information about potentially reportable events through the incident reporting and investigation process. The Risk Manager and appropriate clinical staff conduct investigations of medical equipment incidents to determine if the incident is reportable under criteria established by the Food and Drug Administration.

The Risk Manager uses the Sentinel Event Process to investigate and document reportable incidents. The Risk Manager prepares quarterly reports for the Safety Committee on those incidents determined to be reportable. The Risk Manager is also responsible for completing all reports and handling other communications with medical equipment manufacturers and the FDA required by the Safe Medical Devices Act.

Appropriate changes in processes and training are made through the performance improvement process. The changes are communicated to all appropriate staff.

**Emergency Procedures- EC.02.04.01 EP6**

The Assistant Chief, Clinical Engineering, or designee assists in the development of written procedures that are followed when medical equipment fails. These procedures include emergency clinical interventions and the location and use of backup medical equipment. The head of each department that uses life support or other life-critical medical equipment develops and trains staff about the specific emergency procedures to be used in the event of failure or malfunction of equipment whose failure could cause death or irreversible harm to the patient dependent on such equipment.

These emergency response procedures provide clear, specific instructions for staff responding to an emergency and provide information about notifying appropriate administrative staff of the emergency, actions required to protect patients from harm, contacts for spare equipment or repair services, and contacts to obtain additional staff to manage the emergency.

Each department head maintains copies of applicable emergency procedures in accessible locations in their departments. Departmental staff receives orientation and ongoing education and training about the emergency procedures.

Each department head reviews the department specific medical equipment emergency procedures annually.

**Testing medical equipment prior to initial use- EC.02.04.03 EP1**

The Clinical Engineering department will insure that a test is performed on all medical equipment on the inventory before initial usage. Clinical Engineering is notified by Materials Management or user departments when equipment is received into the hospital. The Plant Operations department performs, operational, and functional checks and inspections, including testing of clinical alarms and an electrical safety inspection (where applicable) in accordance with all applicable policies and procedures before initial use. The inventory includes, equipment owned by the Doctors Medical Center, leased, and rented from vendors, with the exception of the infusion pumps and ventilators. These inspection, testing and maintenance documents are maintained in the Plant Operations department for review. The Chief Engineer, with the support of the Assistant Chief, Clinical Engineering manages the program of planned inspection and maintenance.

**Testing of Life Support Equipment- EC.02.04.03 EP2**

The Assistant Chief, Clinical Engineering ensures that scheduled testing of all life support equipment is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the EC Committee each quarter. Information included on the work order includes at a minimum: the asset ID (CE# or serial number), a description of problem, the department, and the technician performing the work, a description of the repair or maintenance action, and the time spent on the action. If the quarterly rate of completion falls below 100%, the Assistant Chief, Clinical Engineering will present an analysis to determine the cause of the problem and make recommendations for addressing it. These

inspection, testing, and maintenance documents are maintained in Plant Operations department for review.

**Testing of Non-Life support Medical Equipment- EC.02.04.03 EP3**

The Assistant Chief, Clinical Engineering ensures that scheduled testing of all non-life support equipment is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the Environment of Care Committee each quarter. Information included on the work order includes at a minimum: the asset ID (CE# or serial number), a description of problem, the department, and the technician performing the work, a description of the repair or maintenance action, and the time spent on the action. If the quarterly rate of completion falls below 90%, the Assistant Chief, Clinical Engineering will conduct an analysis to determine the cause of the problem and make recommendations for addressing it. Inspection, testing and maintenance documents are maintained by the Plant Operations department for review.

**Testing of Sterilizers- EC.02.04.03 EP4**

Central Sterile is responsible for testing and maintaining of all types of sterilizers used in Doctors Medical Center. Records of load testing and regular maintenance are maintained by Central Sterile. Any improper results are documented as patient safety incidents and reported to the Infection Control for evaluation and action. Documentation of the testing and maintenance activities are maintaining in the Central Sterile Department for review.

**Testing of Dialysis Equipment- EC.02.04.03 EP5**

Davita manages the performance testing and maintenance of the dialysis water processing system. The program of maintenance includes, regular cleaning and disinfection of all dialysis equipment, and testing for compliance with biological and chemical standards for the dialysis water supply. Corrective action will be taken for any value outside of AAHI limits. Davita currently manages the Fresenius and MarCor Millineum dialysis systems. Chemical testing of dialysis RO product water is performed at least annually and biological testing of the RO system is completed monthly.Results are reported to the applicable Quality Improvement, Infection Control or Safety / Environment of Care Committee. Documentation of the testing and maintenance activities is maintained in the Dialysis Department for review.

**Annual Testing and Calibration of Nuclear medicine equipment- EC.02.04.03 EP5**

Qualified staff coordinates the inspection, testing and calibration of nuclear medicine equipment. Clinical Engineering is responsible for coordinating inspection, testing and calibration of Nuclear Medicine Cameras. Ancillary and test equipment is the responsibility of the facilities Nuclear Medicine Department.

## VI. PERFORMANCE ACTIVITIES

The performance measurement process is one part of the evaluation of the effectiveness of the Medical Equipment Program. Performance measures have been established to measure at least one important aspect of the Medical Equipment Program.

The performance measure for the Medical Equipment Program is:

- 95% of PM's are completed within 30 days of PM generation date. This information will be reported to the EOC Committee on a quarterly basis.

**Evaluating the Management Plan- EC.04.01.01 EP15**

On an annual basis, Plant Operations Director evaluates the scope, objectives, performance, and effectiveness of the Plan to manage the medical equipment risks to the staff, visitors, and patients at Doctors Medical Center.

**REFERENCES:**

**NFPA 99, 1996 Edition**
**CMS CoP §482.41(c)(2)**

| | |
|---|---|
| **Responsible for review/updating (Title/Dept)** | Title: Director, Plant Operations Dept: Plant Operations |

**DOCTORS MEDICAL CENTER**

| **Manual: ENVIRONMENT OF CARE** | **Sub Folder: Medical Equipment** |
|---|---|
| **Title: Medical Equipment Management Program** | **Reviewed:**<br>**Revised:** |
| **Effective Date:** | **Page 1 of 3** |

## PURPOSE:

To define the types of equipment supported by the Clinical Engineering department. To establish responsibilities for equipment maintenance and support.

## PURPOSE:

To provide a quality oriented clinical equipment service management program which meets operational, financial and regulatory requirements.

## PROCEDURE:

Clinical Engineering shall:

A. Repair, maintain, or manage the maintenance of diagnostic, therapeutic, and monitoring equipment used to treat Doctors Medical Center patients.

B. Test and ensure the operating safety of clinical equipment utilized at Doctors Medical Center according to requirements set forth by TJC, OSHA, NFPA, Title 22, and other appropriate regulatory agencies.

C. Maintain a facility "Equipment Inventory List" for the devices specified above.

D. Perform and document all required safety, corrective and preventive maintenance actions for the devices specified above. Clinical alarms will be tested for functionality and audibility during the PM inspection.

E. Affect immediate and timely repair of all clinical equipment found to be malfunctioning and/or operating outside the required safety standards.

F. Maintain a paperless "Historical Data File" for each listed device to include all repair and maintenance actions performed.

G. Provide documentation, upon request, to each using area detailing all work accomplished and the equipment status.

H. Inspect all Clinical Equipment prior to its initial use and at intervals to be identified utilizing a "Risk Based" evaluation system.

I. Provide a quality assurance program to validate the performance of the Clinical Engineering program.

J. Continually review, monitor and when appropriate, address any and all pertinent regulatory changes, including but not limited to:

1. FDA (Safe Medical Devices Act)
2. TJC
3. NFPA
4. OSHA
5. Other Regulatory Agencies

***RISK FACTOR CRITERIA FOR INCLUSION IN THE EQUIPMENT MANAGEMENT PROGRAM***

The following criteria will be used to determine if a piece of equipment will be included in Equipment Management Program. The three factors that will be measured to determine inclusion into the Equipment Management Program are: Equipment Function, Clinical Application, Maintenance Requirements, and Environmental Use Area.

1. *Equipment Function:* This is best defined as the role the equipment may play in patient care and Hospital/Departmental support. The area which particular pieces of equipment serve shall be considered when evaluating equipment function using the table below.

**EQUIPMENT FUNCTION TABLE**

| | |
|---|---|
| Therapeutic-Life Support | 10 |
| Therapeutic-Surgical or Intensive Care | 9 |
| Therapeutic-Patient or Treatment | 8 |
| Diagnostic-Surgical or Intensive Care | 7 |
| Diagnostic-Other Physiological Monitoring | 6 |
| Analytical-Lab Analyzing | 5 |
| Analytical-Lab Accessories | 4 |
| Analytical-Computer Related | 3 |
| Miscellaneous-Patient Related | 2 |
| Miscellaneous-Non-Patient Related | 1 |

2. *Clinical Application:* Considers the question of the possible consequences to patients and staff in the event of equipment failure, which could result in death, injury, and misdiagnosis, disruption of services or loss of critical materials using the table below.

**CLINICAL APPLICATION TABLE**

| | |
|---|---|
| Potential Patient Death | 5 |
| Potential Patient Injury | 4 |
| Equipment Damage | 3 |
| Inappropriate Therapy of Mis-Diagnosis | 2 |
| No Significant Identified Risk | 1 |

3. *Maintenance Requirement:* The number of corrective work requests that have occurred with the specific device in the last 12 month period. This number may range from 1 to 5, based upon the table below:

**MAINTENANCE REQUIREMENT TABLE**

| Corrective Factor | Number of Corrective Actions (12 Month Period) |
|---|---|
| 1 | 0-1 Actions Annually (No PM Required) |
| 2 | 2-3 Actions Annually (Annual PM Required) |
| 3 | 4-5 Actions Annually (Semi-Annual PM Required) |
| 4 | 6-7 Actions Annually (Quarterly PM Required) |
| 5 | 8 Actions and above (Monthly PM Required) |

4. *Incident History:* Considers the number of documented incidences, such as abuse or hazard recalls that could potentially have an impact on the performance of the medical device using the table below:

**INCIDENT HISTORY TABLE**

| | |
|---|---|
| Less than 3 Months | 5 |
| Every 6 Months | 4 |
| Every Year | 3 |
| Every 3 Years | 2 |
| Every 5 Years | 1 |

5. *Environmental Use Area:* Considers the question of the possible consequences of the potential impact that the physical environment could have on the performance of the medical device using the table below:

**ENVIRONMENTAL USE AREA TABLE**

| | |
|---|---|
| Anesthetized Locations | 5 |
| Critical Care Areas | 4 |
| Wet Locations | 3 |
| General Care Areas | 2 |
| Non- Patient Care Areas | 1 |

The environmental use area is added to the incident history factor, maintenance requirement factor, the clinical application factor, and the equipment function factor to determine the total risk level factor. The risk level factor total is used as a part of the system to assign devices into risk levels of 1-5. The tier system provides an ongoing process for evaluating the level of preventive maintenance support and inclusion into the program.

**RISK LEVEL TABLE**

| Risk Assessment Total | Risk Level |
|---|---|
| 0-5.99 | 5 |
| 6-11.99 | 4 |
| 12-14.99 | 3 |
| 15-17.99 | 2 |
| 18 or Greater | 1 |

When a device is first added to the equipment database, a default maintenance requirement factor of 1 is automatically assigned. As corrective work requests are attached to the asset throughout the life of the asset, the maintenance requirement factor from 1 to 5 may be adjusted to the equipment function and clinical application values to complete the risk level total described as above. As this total risk level increases, the threshold from one tier to another may occur.

4. The Clinical Engineering department will ensure the following:

A. All clinical equipment is evaluated for inclusion in the program.

B. Include in the program, any equipment that exceeds a total risk assessment score of 6.

C. All clinical equipment risk factors are consistently applied throughout the database.

D. Maintain a database of equipment to be included in the program.

**REFERENCES:**

**NFPA 99, 1996 Edition**
**CMS CoP §482.41(c)(2)**

| | |
|---|---|
| **Responsible for review/updating (Title/Dept)** | Title Director, Plant Operations Dept Plant Operations |

**DOCTORS MEDICAL CENTER**

| Manual: ENVIRONMENT OF CARE | Sub Folder: Medical Equipment |
|---|---|
| Title: Medical Equipment Maintenance Priorities | Reviewed:<br>Revised: |
| Effective Date: | Page 1 of 2 |

**POLICY:**

It is the responsibility of the appropriate Clinical Engineering Technician to prioritize all scheduled and unscheduled work requests. Requests should be prioritized as urgent, preventive, routine, or deferred.

**PURPOSE:**

To prioritize Preventive and Corrective Maintenance Actions.:

**PROCEDURE:**

1. Life Support Preventive Maintenance Actions will have a higher priority than Corrective Maintenance with the exception of emergency Corrective Maintenance Work Orders.
2. To facilitate the efficient allocation of CE and Hospital resources the following priority system has been established for corrective work orders:

| | |
|---|---|
| **EMERGENCY** | These are corrective actions of such a nature that failure to take immediate action or actions as soon as possible will jeopardize the operation of the Hospital with respect to its primary function and service. |
| **ROUTINE** | These are corrective actions which should be performed at the first opportunity but their nature such that the primary function of the Hospital is not significantly affected. |
| **DEFERRED** | These are projects or corrective action that will in no way affect the primary function and service of the hospital. |

For all service requests or technical assistance the user should contact Clinical Engineering, by telephone, extension 5520.

Work Orders are entered in the computer for record keeping and work scheduling. The appropriate Clinical Engineering operational manager will normally determine the priority assigned to the requests. Input from the users is encouraged.

3. All repair actions involving clinical equipment will be documented on a Work Order with any corresponding attachments.
4. The Clinical Engineering request procedure by telephone or on-line request should be as follows:

   A. Identify the malfunctioning equipment by equipment name, model, the manufacturer,

CE number, if available, and its physical location in the Hospital.

B. Explain the problem or malfunction as clearly as possible.

Reports detailing labor man-hours and material costs will be made available to Nurse Managers upon request. An itemized report of all corrective and preventive maintenance actions by CE number will also be made available upon request.

**REFERENCES:**

**NFPA 99, 1996 Edition**
**CMS CoP §482.41(c)(2)**

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|---|---|
| **Responsible for review/updating (Title/Dept)** | Title Director, Plant operations Dept Plant operations |

**DOCTORS MEDICAL CENTER**

| Manual: ENVIRONMENT OF CARE | Sub Folder: Medical Equipment |
|---|---|
| Title: Notification of Delays in Maintenance Equipment | Reviewed:<br>Revised: |
| Effective Date: | Page 1 of 1 |

**POLICY:**

During normal working hours, Clinical Engineering will respond to all requests for service within 20 minutes.

Ten (10) business days has been identified, by Clinical Engineering management, as the maximum allowable repair time for all equipment (see Policy CE-007). In the event that a work order cannot be completed in the requested time or within ten days the Clinical Engineering technician will notify the request originator or department Manager and inform them of the reasons that the equipment repair will be delayed and provide them with an estimated time of repair.

**PURPOSE:**

To establish the standard for maximum response time and repair turn-around time from the Clinical Engineering department on all requests for service.

To set the procedure for reporting to the appropriate department Manager any unavoidable delays in excess of ten days for completing a work order.

**PROCEDURE:**

1. All requests for service should be responded to within 20 minutes during normal working hours.
2. During the course of performing maintenance on clinical equipment, there will be times when the unavailability of spare parts, technical documentation or work hour limitations will make it impossible to facilitate a repair within ten days. In the event that a work order cannot be completed in the requested time or within ten days the Clinical Engineering technician will notify the request originator or department Manager and inform them of the reasons that the equipment repair will be delayed and provide them with an estimated time of repair.
3. It is understood that there are occasions when a faster repair time is deemed necessary. (i.e. specialized or one of a kind items) These will be handled on a case by case basis with the agreement of the Clinical Engineering department and the Manager of the responsible department.

**REFERENCES:**

**NFPA 99, 1996 Edition**
**CMS CoP §482.41(c)(2)**

| Responsible for review/updating (Title/Dept) | Title Director, Plant Operations | Dept Plant Operations |
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**DOCTORS MEDICAL CENTER**

| Manual: ENVIRONMENT OF CARE | Sub Folder: Medical Equipment |
|---|---|
| Title: Medical Equipment Preventive Maintenance | Reviewed:<br>Revised: |
| Effective Date: | Page 1 of 3 |

**POLICY:**

Maintain a comprehensive Periodic Maintenance Program that will include a testing and maintenance program for all equipment included in the program.

Clinical Engineering and EOC/ Safety Committee determine the interval of periodic maintenance inspections by using Risk assessment, Data Driven (Corrective Maintenance) Information, Industry Standards, Manufacturer Recommendations, and Facility experience.

Periodic Maintenance documentation is stored in the Computerized Maintenance Management System (CMMS) database. Periodic Maintenance includes Preventive Maintenance Inspections and Electrical Safety Inspections.

Equipment will be included in this program if it meets one or more of the following criteria:

1. The equipment is essential for life support.

2. The equipment requires testing due to regulatory/mandatory regulations.

3 The equipment requires a more intensive maintenance schedule, by reason of its complexity or extended use schedule.

4. The incident of failure history indicates that the equipment is in need of an intensified schedule of preventive maintenance.

5. The equipment is supplied by or maintained by outside vendor.

6. The equipment is under lease and the periodic maintenance schedule is part of said lease. (Some Rental/Leased PM's are by agreement the rental/lease company's responsibility. Reports are provided to us as to the PM task, schedule and completion of these PM's).

7 The equipment is under warranty covering service parts only. (Required periodic maintenance will be completed by the Clinical Engineering Department)

8. If maintenance history is tracked. (Some equipment maintained under contract and/or history is not tracked may not be included in the PM Program).

**PROCEDURE:**

1. During the middle of the month prior to PM due date, PM's are automatically generated by the Computerized Maintenance Management System (CMMS). This allows prior review of due equipment to ensure necessary PM parts are ordered and available. This schedule will cover all equipment to receive a periodic maintenance inspection. The work schedule will be broken down to assign units or devices to specific biomedical technicians. Work orders will be generated and distributed to the assigned technician.

2. Maintenance is performed in accordance with the established periodic maintenance procedure. These procedures are based on manufacture protocols and/ or facility experience. The assigned engineer or technician shall document the maintenance, including any pertinent observations on the work order. The equipment under test receives a PM sticker. When maintenance and documentation is completed the work order is subsequently updated in the CMMS.

3. If scheduled work cannot be completed or performed (i.e., parts are needed, equipment is in use), the reason is documented in a work order. Steps will be taken to insure that the necessary parts, etc. are ordered to complete the work order.

4. If scheduled maintenance is being handled by an outside vendor, the Clinical Engineering Department will notify the vendor and schedule the PM service. When maintenance and documentation is completed the work order is subsequently updated in the CMMS.

5. Life Support Equipment- This classification of equipment requires a 100% PM completion percentage. However, there are times when removing a piece of equipment from a patient only for PM completion purposes may compromise patient safety. When equipment is in use and cannot be removed, Clinical Engineering will work closely with the user department to ensure that the equipment is inspected once it is removed from the patient.

6. Non Life Support Equipment- This classification of equipment requires a 95% or greater completion percentage.

7. PM work orders which cannot be completed during PM can be completed as "Could Not Locate" only after the following three steps have been followed and documented in order. 1) the technician has made a concerted effort to locate the equipment during the month due 2) the assistance of the equipment owner department has been requested and received. The technician will obtain the help of clinical department supervision/ staff for difficult to locate equipment 3) and if approved by a Clinical Engineering Operations Manager after another concerted effort was made to locate the equipment. PM's should be completed no earlier than 20 days prior to the scheduled completion date, and no later than 40 days after the scheduled completion date.

8. If a piece of equipment cannot be located for two (2) consecutive PM cycles it will be removed from service and deactivated in the CMMS.

9. Management rounding may be used as a means of ensuring technician competency and that correct PM procedures and actions are taken.

10. PM completion percentage is reported to the relevant EOC/ Safety Committee on at least a quarterly basis.

Longer or shorter periodic maintenance intervals are adopted after documented justification based on previous safety testing records.

**REFERENCES:**
**NFPA 99, 1996 Edition**
**CMS CoP §482.41(c)(2)**

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| **Responsible for review/updating (Title/Dept)** | Title Director, Plant Operations Dept Plant Operations |

**DOCTORS MEDICAL CENTER**

| Manual: ENVIRONMENT OF CARE | Sub Folder: Medical Equipment |
|---|---|
| Title: Clinical Engineering Rounds | Reviewed:<br>Revised: |
| Effective Date: | Page 1of 1 |

**PURPOSE:**

To proactively seek out areas of concern with customers, including:

- equipment issues
- checking for out of date stickers
- identifying/confirming departmental inventories
- customer satisfaction issues
- special departmental concerns

To market the presence, and skills of the Clinical Engineering personnel. These skills include availability of in-service education, consultative services, and technical expertise.

To establish uniform procedures for performing rounds to major departments, and to identify documentation required in support of rounds.

**POLICY:**

Staff from Clinical Engineering, will visit all major equipment owning/user departments as assigned. This visit will include a visual inspection of equipment as well as contact with key department personnel. The rounds are documented in the Work Order Database.

**PROCEDURE:**

Personnel from Clinical Engineering will participate in the rounds procedure. Rounds will be conducted as part of the monthly round work order.

The purpose of the Clinical Rounds is to:

1. Discuss the status of equipment items in Clinical Engineering for repair.
2. Observe potential equipment hazards. ( ie: liquids on electrical equipment, etc.) and correct any identified hazards .
3. Verify critical battery operated equipment is plugged in.
4. Observe operation of equipment to ensure proper usage. Schedule in-service if improper usage is observed.
5. Provide greater visibility of Clinical Engineering to equipment operators thereby developing trusting relationships.
6. Checking for out of date/ missing stickers and identifying/confirming departmental inventories.

The technician performing the rounds is responsible for documenting the rounds procedure to include time spent, and topics or issues discussed. The technician is also responsible for communicating to the operational manager, any topics or issues of concern discussed each day during the rounds.
Rounding will be a topic of discussion at each employee's annual evaluation and will be a component in overall scoring.

**REFERENCES:**

**NFPA 99, 1996 Edition; CMS CoP §482.41(c)(2)**

| Responsible for review/updating (Title/Dept) | Title Director, Plant Operations Dept Plant Operations |
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**DOCTORS MEDICAL CENTER**

| Manual: ENVIRONMENT OF CARE | Sub Folder: Medical Equipment |
|---|---|
| Title: Work Order System | Reviewed:<br>Revised: |
| Effective Date: | Page 1of 2 |

**POLICY:**

The Clinical Engineering department has adopted a standard work order system for all departments requesting maintenance on clinical equipment. When a malfunction occurs with a piece of clinical equipment that is encompassed within the program of the Clinical Engineering department, the using department shall notify Clinical Engineering during rounds, by telephone, by on-line web request or by bringing the device to the Clinical Engineering office. Upon receipt of the request, a work order will be initiated in the Work Order Management Database, including assignment of the work order to a technician for completion. The ultimate priority classification (emergency, routine, or deferred) will be determined by a Clinical Engineering manager, based on the needs of all departments.

**PURPOSE:**

To provide guidelines for the receipt and processing of Clinical Engineering service requests.

**PROCEDURE:**

Any unscheduled work will be documented on an electronic work order.

The clinical equipment Work Order will be assigned a priority of maintenance as defined below and detailed in Policy CEM-003:

| | |
|---|---|
| **EMERGENCY** | Valid emergency repair requests |
| **ROUTINE** | Completed at first opportunity |
| **DEFERRED** | Completed as opportunity permits |

Urgent requests for technical assistance should be requested by telephone. When Clinical Engineering personnel are contacted with an "Emergency" request, the following information will be provided:

1. Department calling.
2. Name of person to contact in that department.
3. Reason for urgent call.

Priority assigned to the requests will normally be determined by the appropriate Clinical Engineering operational manager. Input from the users is encouraged.

The following information should be provided on the Work Request, by the person originating the request for service, or by the CE technician:

1. C.E. Number
2. Cost Center
3. Equipment Description
4. Telephone Number
5. Name of Contact
6 Location of Equipment
7. Description of the problem

Upon completion of the work, the technician will complete the electronic work order by noon the following day. All pertinent information relating to the service request will be gathered by the technician for data entry and the work order will be completed in accordance with Policy CE-003.

All work orders are dated and logged for record keeping. The ultimate priority will be assigned by a Clinical Engineering manager in accordance with the needs of all departments.

In the event that a work order cannot be completed in the requested time or within ten business days (as specified in Policy CE-004), the Clinical Engineering technician will notify the request originator or department Manager and inform them of the reasons that the equipment repair will be delayed and provide them with an estimated time of repair. It is the responsibility of each Clinical Engineering technician to follow-up on such situations as needed and personally contact the request originator or department Manager if necessary.

**REFERENCES:**

**NFPA 99, 1996 Edition**
**CMS CoP §482.41(c)(2)**

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|---|---|
| **Responsible for review/updating (Title/Dept)** | Title Director, Plant Operations Dept Plant Operations |

**DOCTORS MEDICAL CENTER**

| Manual: ENVIRONMENT OF CARE | Sub Folder: Medical Equipment |
|---|---|
| Title: Electrical Safety Testing | Reviewed:<br>Revised: |
| Effective Date: | Page 1 of 2 |

**POLICY:**

The Clinical Engineering department performs electrical safety testing, on all electrically powered diagnostic and therapeutic clinical equipment, under the responsibility of Clinical Engineering as identified by Doctors Medical Center.

**PURPOSE:**

To ensure all electrically powered clinical equipment is electrically safe for patients, visitors and staff.

**PROCEDURE:**

A. Clinical Engineering is responsible for the performance and documentation of scheduled Electrical Safety Inspections (ESI) on all clinical equipment.

B. ESI's will be conducted in accordance with all established standards and guidelines. Measurable parameters will be evaluated with a calibrated electrical safety analyzer.

C. The results of all ESI's will be recorded and will remain on file in the Clinical Engineering department database.

D. All electrically powered clinical equipment will be evaluated as part of the Incoming Inspection of clinical equipment and periodically thereafter.

E. Electrical diagnostic and therapeutic equipment excluded from the PM will receive at least a 5 year ESI.

F. Rental, loaner, leased units, trial units, and any physician owned equipment will be tested prior to its use.

G. Equipment not meeting current standards will be withheld from service until corrected.

Clinical Laboratories – Clinical Engineering follows the electrical safety guidelines as set forth by the College of American Pathologists in the COMMISSION ON LABORATORY ACCREDITATION Laboratory Accreditation Program LABORATORY GENERAL CHECKLIST - 9/27/2007

1. Electrical safety testing will be performed when placed into service.
2. Electrical safety testing will be performed when equipment is moved *and* a safety problem is noted (i.e. power cord is damaged, cord frayed, etc.).
3. Electrical safety testing will be performed when equipment is repaired.

**Scheduled Electrical Safety Inspections**

1. The areas of inspection are divided into segments and each segment is scheduled for an ESI.
2. The appropriate CE operational manager will assign the ESI to the CE Technician that has responsibility for the area. The Technician will perform an ESI on the electrically powered clinical equipment which is not in the preventive maintenance program.
3. The Technician will perform and document the ESI.
4. Any equipment not meeting the ESI standard will be removed from service and a corrective

maintenance work order will be opened against that piece of equipment. The unit will not be returned to service until the discrepancy is corrected.

5. The Technician will document all time for the ESI inspections against the work order number.

The results of all inspections performed on electrical and electronic systems and equipment, including any action taken or recommended, will be made available upon request to the appropriate Nurse Manager or Department Manager.

**REFERENCES:**

**NFPA 99, 1996 Edition**
**CMS CoP §482.41(c)(2)**

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|---|---|---|
| **Responsible for review/updating (Title/Dept)** | Title Director, Plant Operations | Dept Plant Operations |

**DOCTORS MEDICAL CENTER**

| Manual: ENVIRONMENT OF CARE | Sub Folder: Medical Equipment |
|---|---|
| Title: Electromagnetic Interference | Reviewed:<br>Revised: |
| Effective Date: | Page 1 of 2 |

**POLICY:**

Doctors Medical Center (DMC) recognizes that the proliferation of electronic devices in use within the hospital environment poses a potential electromagnetic interference (EMI) risk to medical equipment. Cellular/cordless telephones, wireless computers & handheld computers (Palm Pilot, Pocket PC, etc.) and the two-way radios often employed by health system personnel are all recognized as potential sources of EMI.

DMC will minimize the risk associated with this phenomenon by limiting the use of EMI generating devices in Patient Dependant Equipment (PDE) locations such as FICU, MICU, Telemetry Unit (4th floor), Emergency Department, Operating Room, and Cath Lab, monitoring locations in outpatient facilities, etc. A PDE location is defined as an area which has equipment attached to patients who, if the equipment malfunctions, could cause or contribute to the serious illness, injury, or death of the patient.

**PURPOSE:**

This policy shall define:

Potential EMI generating devices
Restricted areas for use of EMI generating devices
Procedures for emergency use of two-way radios in restricted areas

**PROCEDURE:**

*The following devices are considered to be restricted for use in PDE locations:*

Two-way radios - General Mobile Radio Services (GMRS)*
Ham (CB) radios

*GMRS radios operate at between 1 and 5 watts and require a FCC license.

*The following devices should be used with caution in PDE location:*

- Cellular/Cordless Telephones
- Computers with a wireless network or a wireless modem Wireless handheld computers (Palm Pilot, Pocket PC, etc.) Two-way pagers
- Wireless LAN phones
- Two way radios – Family Radio Service (FRS)** Any device known to emit electromagnetic energy

**FRS radios operate at a maximum of 0.5 watts (500 milliwatt) and do not require a FCC license.

*Although these devices are not specifically prohibited in PDE locations, they should only be used when essential and preferably in areas away from life support medical equipment. DMC staff should ensure that EMI generating devices are not within three (3) feet of critical medical devices.*

***Restricted Areas***

Two-way radios (GMRS) and ham radios are restricted from use in all PDE locations:

*Procedures for Emergency Use of Two-Way Radios in Restricted Areas*

Although there are certain potential risks associated with using two-way radios in Patient Dependant Equipment locations, there are clearly unacceptable risks in prohibiting the use of these devices by Public Safety, hospital safety/security officers, EMS personnel, and Life Flight personnel. This policy is not intended to prohibit the use of two-way radios in PDE locations, but rather to restrict their use to emergency situations.

Whenever a Public Safety, Hospital safety/security officer, EMS personnel or a Life Flight employee is in a PDE location and an emergency occurs which requires the use of a two-way radio, they should make their best effort to adhere to the following guidelines which are listed in order of preferred compliance:

- Immediately leave the PDE location to use the two-way radio

*(Interference created by transmitting from RF devices is minimized as the distance between the RF device and the affected equipment is increased.)*

- If circumstances dictate the emergent use of a two-way radio in a PDE location, transmitting near any energized medical device should be avoided at all times.
- If output levels are adjustable, use the lowest setting possible this still facilitates acceptable communications.

**If any equipment in the vicinity of the radio user should malfunction while the radio is in use, use of the radio is to be terminated immediately! Any further use should be conducted from a non-PDE location.**

*Review*

The Center for Devices and Radiological Health (CDRH), a division of the FDA, in cooperation with the Association for the Advancement of Medical Instrumentation (AAMI) has also developed guidance standards for medical device manufacturers seeking pre-market approval.

Clinical Engineering will continue to review technical publications and standards for trends and updates relating to this issue and communicate noteworthy advances to the EOC Committee. Clinical staff may contact Clinical Engineering (phone 5023) if they suspect that the function of a medical device has been affected by an EMI generating device. Clinical Engineering will follow up on any incident and report to Risk Management.

*Exceptions*

Very low power mini-cell systems or Family Radio Service two way radios may be used throughout the hospital in order to facilitate the emergent nature of the healthcare business. The devices have a very small operating range, emit less power than handheld cell phones and are much less likely to cause interference with medical devices.

NOTE: Air waves are unprotected and conversations may be intercepted by other telephones. Refrain from the disclosure of protected health information during cellular phone conversations to prevent the breach of a patient's right to confidentiality.

**REFERENCES:**
**NFPA 99, 1996 Edition; CMS CoP §482.41(c)(2); CDRH; AAMI**

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|---|---|---|
| **Responsible for review/updating (Title/Dept)** | Title Director, Plant Operations | Dept Plant Operations |

**DOCTORS MEDICAL CENTER**

| Manual: ENVIRONMENT OF CARE | Sub Folder: Medical Equipment |
|---|---|
| Title: Initial Inspections | Reviewed:<br>Revised: |
| Effective Date: | Page 1 of 2 |

**PURPOSE:**

To assure that all clinical equipment is inspected prior to its initial use and identified for inclusion/ exclusion in the equipment management program.

**POLICY:**

All Clinical (*Diagnostic and/or Therapeutic)* Equipment coming into Doctors Medical Center that is included in the Medical Equipment Management program is tested before initial use and appropriately inventoried. These tests, evaluations, and inventories are documented.

All clinical equipment, regardless of ownership, falling under the responsibility of Clinical Engineering is covered by this policy. The following categories of equipment provide examples of equipment covered under this policy:

- Rental/Leased Equipment
- Physician-Owned Equipment
- Donated/Loaned Equipment
- Hospital-Owned Equipment

Equipment purchased, leased, on-loan, here for trial evaluation, or equipment donated, must pass the incoming inspection before it will be allowed into the Hospital.

**PROCEDURES (Hospital Owned Equipment)**

A. When notified that new clinical equipment is received in the hospital, Clinical Engineering will initiate a work order.

B. The Clinical Engineering Department will ensure that the new equipment is inspected for:

1. Presence of all accessories required for proper operation.
2. Presence of Operators Manuals and Technical Service Manuals, and Schematics.
3. Proper operation of the equipment as specified in the performance specifications in the manufacturer's service literature.
4. Clinical alarm functionality and audibility.
5. Passage of electrical safety requirements as specified by NFPA, and other applicable agencies.
6. Inclusion into, or exclusion from, the Equipment Management Program.

C. If equipment passes all required inspections the Technician will affix a Clinical Equipment Maintenance inspection sticker in a visible location on the device.

The Clinical Engineering Technician who performs the inspection is responsible for ensuring the completion of the initial inspection documentation. If the Technician determines that an in-service education would be beneficial, the technician will make a recommendation to the Education Department or the department Manager. Should a manufacturer in-service be required, the Technician will assist in coordinating this effort with the Education Department.

D. Testing of devices brought in for demonstration or trial evaluation:

Doctors Medical Center is responsible for the safety of all patients, staff, and visitors: When notified that clinical equipment is coming into the Health System for loan, evaluation, or demonstration, Clinical Engineering will evaluate the equipment to ensure that it is safe.

1. All electrical equipment which passes the Clinical Engineering safety inspection will have a Clinical Equipment Maintenance sticker affixed in a visible location, indicating that it has been inspected, and is safe for use in the Hospital. (Certain battery-operated devices may be excluded from the PM program, and will not have a sticker affixed. Device included in the program, but that do not require regular preventive maintenance will also receive a "PM Exempt" sticker)
2. For easy of use and quick identification, the Clinical Equipment Maintenance stickers are color-coded and numbered to correlate with the month that the PM is due. (See attached illustration)
3. Any equipment that fails the Clinical Engineering safety inspection will be returned to its originating source with a description of the failure. This unit will be prohibited from being used in the facility until it has been repaired and satisfactorily passes the Clinical Engineering safety inspection.

E. Equipment on loan or trial to the facility.

Loaned or trialed equipment is tested prior to its use in the Health System, unless an emergency dictates otherwise. In this instance, the user should ensure with reasonable certainty that the equipment is in safe working condition before operating. If the equipment is to remain in the Health System subsequent to its emergency use, it must be safety tested by the Clinical Engineering Department.

F. Equipment intended for use in a clinical laboratory application.

Equipment intended for use in a clinical laboratory application, for the analysis of body fluids, cells or tissues, must be approved by the office of the Director, Clinical Laboratories, Department of Pathology, and safety tested as required by CAP prior to being placed into service.

G. Non Hospital Owned medical equipment.

Follow DMC Inspection of Patient Care Equipment Procedure or Non Hospital Owned Medical Equipment Policy.

**REFERENCES:**

**NFPA 99, 1996 Edition**
**CMS CoP §482.41(c)(2)**

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|---|---|
| **Responsible for review/updating (Title/Dept)** | Title Director, Plant Operations Dept Plant Operations |

**DOCTORS MEDICAL CENTER**

| Manual: ENVIRONMENT OF CARE | Sub Folder: Medical Equipment |
|---|---|
| Title: Medical Equipment Management Program | Reviewed:<br>Revised: |
| Effective Date: | Page 1 of 1 |

**POLICY:**

All test and measuring equipment utilized in the Clinical Engineering department will be calibrated at least annually.

**PURPOSE:**

To ensure all test devices, utilized in the maintenance of the clinical equipment, perform in accordance with the manufacturer's specifications.

**PROCEDURE:**

- An inventory of all test equipment utilized to maintain the clinical equipment will be kept in the electronic database. This inventory should list all pertinent information (manufacturer, model & serial numbers, etc.) as well as current calibration dates.
- Inventory will be certified by either the original manufacturer or a company to be NIST traceable.
- Calibration certificates for each piece of test equipment shall be filed in the Clinical Engineering Department.
- The calibration certificates will be made available for any inspection agency representatives as well as hospital personnel during normal working hours.

**REFERENCES:**

**NFPA 99, 1996 Edition**
**CMS CoP §482.41(c)(2)**

| Responsible for review/updating (Title/Dept) | Title Director, Plant Operations | Dept Plant Operations |
|---|---|---|

**DOCTORS MEDICAL CENTER**

| Manual: ENVIRONMENT OF CARE | Sub Folder: Medical Equipment |
|---|---|
| Title: Hazard Recalls | Reviewed:<br>Revised: |
| Effective Date: | Page 1 of 1 |

**POLICY:**

The Clinical Engineering Department shall follow the prescribed course of action (if any) for recalls, take such action, and document actions taken.

**PURPOSE:**

To ensure that clinical equipment in the environment of care is safe and poses no threat to the patients or staff, and to ensure that necessary actions are taken to correct any equipment hazard or recall event.

**PROCEDURE:**

A. Materials Management receives all hazard recall and alerts. When notice of an equipment hazard or recall is received by Clinical Engineering, the Assistant Chief, Clinical Engineering or designee will ensure that the equipment inventory database is reviewed to determine if any Hospital equipment is affected.

B. If there is equipment in the inventory which has been identified in the alert or recall, the Clinical Engineering department will:

- Notify the Department Manager of the alert or recall.
- Locate the equipment.
- Take the recommended steps described in the alert.
- Make an appropriate entry in the alerts database
- Document the actions in the work order system, or log the report in a database named Hazard Alerts/Recalls for those items which do not have a CE Number.
- Notify the department manager of the action taken.

**REFERENCES:**

**NFPA 99, 1996 Edition**
**CMS CoP §482.41(c)(2)**

| Responsible for review/updating (Title/Dept) | Title Director, Plant Operations | Dept Plant Operations |
|---|---|---|

**DOCTORS MEDICAL CENTER**

| Manual: ENVIRONMENT OF CARE | Sub Folder: Medical Equipment |
|---|---|
| Title: SMDA Reporting | Reviewed:<br>Revised: |
| Effective Date: | Page 1 of 1 |

**POLICY:**

The Clinical Engineering Department is a supporting entity for Doctors Medical Center's device incidents as part of the e-QRR-Electronic Incident Reporting. When equipment related failures occur, Clinical Engineering will receive the initial e-QRR report, provide instruction to the reporting personnel, provide consultation to Risk Management, and when appropriate as a matter of quality assurance, investigate device incidents on behalf of Risk Management/Counsel's Office. Risk Management is the designated reporting official in the Hospital to report incidents to equipment manufacturers and to the FDA.

**PURPOSE:**

To comply with the DMC e-QRR protocol, which Clinical Engineering will follow as it responds to the e-QRR report. This procedure will provide guidelines for completion of required documentation, necessary notification, and procedures to follow for equipment investigations.

**PROCEDURE:**

Clinical Engineering shall follow all Doctors Medical Center e-QRR procedures as outlined in the Occurrence Reports Procedure.

**DEFINITIONS:**

**Medical Device**:

Anything that is used in treatment or diagnosis that is not a medication. The FDA defines a medical device as an instrument, apparatus or other article that is used to prevent, diagnose, mitigate or treat a disease or to affect the structure or function of the body, with the exception of drugs. Example of medical devices are: x-ray machine, suture material, defibrillator, vascular graft, syringe, surgical laser, heating pad, bone screw, gauze pad, patient restraint, wheelchairs, infusion pump, etc.

**Serious Illness and Serious Injury:**

An injury or illness that (1) is life threatening, (2) results in permanent impairment of a body function or permanent damage to a body structure, or (3) necessitates medical or surgical intervention to preclude permanent impairment of a body function or permanent damage to a body structure.

**REFERENCES:**

**NFPA 99, 1996 Edition**
**CMS CoP §482.41(c)(2)**

| Responsible for review/updating (Title/Dept) | Title Director, Plant Operations | Dept Plant Operations |
|---|---|---|

**DOCTORS MEDICAL CENTER**

| Manual: ENVIRONMENT OF CARE | Sub Folder: Medical Equipment |
|---|---|
| Title: Repair or Replace Determination | Reviewed:<br>Revised: |
| Effective Date: | Page 1 of 1 |

**POLICY:**

It is the joint responsibility of the Clinical Engineering department and the equipment owning department to review the cost/benefit of repairing versus replacement of clinical equipment that has suffered a major breakdown and has met one or more of the following conditions:

- Demonstrated an increasing failure incidence and cost of repair.
- Can not be repaired due to lack of parts availability.

**PURPOSE:**

To provide a systematic approach to repair/replacement decisions for clinical equipment that has suffered a major breakdown.

**PROCEDURES:**

Prior to repairing a medical device found to require extensive maintenance, the Clinical Engineering department will conduct research using the following guidelines:

1. Estimated cost of repair versus cost of replacement.
2. Availability of repair parts.
3. Estimated down time due to repair.
4. Total repair costs based on equipment corrective maintenance history record.
5. Age of equipment in question.
6. Frequency of equipment failures.

Once this information is compiled the Director of Plant Operations or his designee will contact the manager of the department owning the equipment to provide him/her with the information. They should then discuss the following criteria:

1. Urgency of having the equipment back in service.
2. Immediate and long range impact on patient care.
3. Technology level of current item versus new one.
4. Existing budget restrictions and strategic plans.
5. Current remaining book value of equipment in question may also become a factor in the decision.
6. Any relative patient care issues like current standards of care, safety issues, etc.

In the absence of good data or lack of research time due to the urgency of the situation, the following criteria can be used. As a general guideline, the decision to recommend repair or replacement can be based on the following formula:

1. Are the cumulative costs of all repairs, plus the loss of revenue from not having the equipment in service during the repair process greater than 70% of the cost of new equipment?

If the answer is **YES** then replace the equipment.
If the answer is **NO** then repair, or

2. Are the cumulative costs of all repairs greater than 50% of the cost of new equipment?
If the answer is **YES** then replace the equipment.
If the answer is **NO** then repair.

Any recommendation to replace will be justified, in writing to the equipment user. It will be the user's responsibility to communicate the replacement need to Plant Operations.
The authority to repair or replace rests with Administration.

**REFERENCES:**

**NFPA 99, 1996 Edition**
**CMS CoP §482.41(c)(2)**

| | | |
|---|---|---|
| **Responsible for review/updating (Title/Dept)** | Title Director, Plant Operations | Dept Plant Operations |

**DOCTORS MEDICAL CENTER**

| Manual: ENVIRONMENT OF CARE | Sub Folder: Medical Equipment |
|---|---|
| Title: Outside Service Control<br>CEM 015 | Reviewed:<br>Revised: |
| Effective Date: | Page 1 of 1 |

**POLICY:**

It shall be the responsibility of the Clinical Engineering department to contact and monitor all outside contractors, providing service to the healthcare system, whenever the request is the responsibility of the Clinical Engineering department.

It is understood that calls not generated by and not the responsibility of the Clinical Engineering department do not fall under this policy.

**PURPOSE:**

To centralize, monitor and control all requests for services by outside contracts that originate from the Clinical Engineering department.

**PROCEDURE:**

1. All outside service personnel, contacted by the Clinical Engineering department, will check in and out through the Clinical Engineering Department during normal business hours, Monday through Friday. These visits will be documented in the work order system.

   All visits after normal working hours will be of emergency repair nature and will have been initiated by the Clinical Engineering Department. In these cases, the outside service personnel will check in with the appropriate department manager. A legible file copy of the vendor service report is to be left with the department Manger. This copy should be forwarded to the Clinical Engineering department through Inter-Office mail or other means by the department manager.

2. During normal working hours, a legible vendor service report is required to be left at the Clinical Engineering department when the service contractor is leaving after completion of his/her work.
3. The Clinical Engineering Department will perform a quality inspection of outside contractor's work and convey the results to the Department manager.
4. No payments for services will be approved unless the above steps are followed.

**REFERENCES:**

**NFPA 99, 1996 Edition**
**CMS CoP §482.41(c)(2)**

| Responsible for review/updating (Title/Dept) | Title Director, Plant Operations | Dept Plant Operations |
|---|---|---|

**DOCTORS MEDICAL CENTER**

| Manual: ENVIRONMENT OF CARE | Sub Folder: Medical Equipment |
|---|---|
| Title: Infection Control Guidelines for Clinical Engineering | Reviewed:<br>Revised: |
| Effective Date: | Page 1of 2 |

**POLICY:**

All Clinical Engineering employees will be aware of current Doctors Medical Center policies regarding Infection Control. Employees will not knowingly expose themselves or others to any types of Infectious Waste.

**PURPOSE:**

To provide all employees with a safe, clean working environment to protect Clinical Engineering technicians from contaminated equipment.

**PROCEDURE:**

*General Precautions:*

1. Visibly contaminated equipment will not be accepted for repair until adequately cleaned by the appropriate department. Appropriate PPE is worn to handle equipment.
2. All Clinical Engineering technicians will observe all isolation guidelines as well as the dress and scrub procedures for the area in which they are working. Clinical Engineering technicians should not enter "Isolation Rooms" or "Restricted Areas" without first obtaining permission and instructions, if necessary, from the appropriate charge nurse.
3. All Clinical Engineering employees will attend annual infection control education and updates. These events will be properly documented in the employees personal training record kept on file in the Clinical Engineering department.
4. Hand washing is required whenever:
    A. Hands become contaminated with blood or body fluids.
    B. Protective gloves are removed.
    C. Between patient contacts.
    D. Eating, drinking, applying cosmetics, and handling contact lenses are prohibited in areas where there is a risk of occupational exposure to blood or body fluids.

*Personal Protective Equipment (PPE):*

1. Disposable gloves are available, within the Clinical Engineering department, for all workers at risk of exposure for use at their discretion or as required.
2. Eye protection and/or facemask will be worn whenever handling equipment that puts the employee at risk of occupational exposure to blood or body fluids through splashing.
3. Personal Protective Equipment, (i.e. gowns, gloves, masks and goggles) will be supplied whenever needed by the using department.
4. Contaminated supplies, (i.e. gowns, gloves, masks and absorbent towels) are to be placed in sturdy, plastic bags and tightly closed for transport in accordance to Doctors Medical Center's policy on Infectious Waste.

*Equipment Precautions*

1. All equipment containing filters, which are serviced by Clinical Engineering, will have the filters cleaned or replaced according to manufacturer recommendations.
2. Gloves will be worn during non-HEPA filter changes. These filters will be placed in normal waste.
3. Any equipment containing a HEPA filter requires that gloves, particulate respirator, gown, and protective eyewear are worn. These filters will be placed in a red bag and disposed of as infectious waste.
4. All filters from the Clinical Laboratory, that are changed, should be considered contaminated and disposed of as infectious waste. Appropriate PPE will be worn.
5. All equipment that needs to be opened and vacuumed or blown clean will be done away from patient care or employee work area whenever possible. Equipment that can be carried or rolled easily will be removed to the Clinical Engineering shop for cleaning. Clinical Engineering personnel will wear masks to eliminate the risk of breathing the dust from the machine.
6. All equipment that cannot be moved from the employee work area will be vacuumed, so as not to contaminate the work environment.

**REFERENCES:**

**NFPA 99, 1996 Edition**
**CMS CoP §482.41(c)(2)**

| | | |
|---|---|---|
| **Responsible for review/updating (Title/Dept)** | Title Director, Plant Operations | Dept Plant Operations |

**DOCTORS MEDICAL CENTER**

| Manual: ENVIRONMENT OF CARE | Sub Folder: Medical Equipment |
|---|---|
| Title: Non Hospital-Owned Equipment | Reviewed:<br>Revised: |
| Effective Date: | Page 1of 2 |

**Policy:**

Use of patient owned medical equipment is discouraged. Patients can be permitted to use patient owned medical equipment if all needed parts, accessories, and/or attachments are brought by the patient/family and the patient/guardian signs the Non-Hospital Owned Medical Equipment Release Form and:

1. A suitable Hospital-owned or rented equivalent is not available, or
2. Removing the patient owned equipment is deemed clinically detrimental to the patient's care. Decision as to clinical detriment is the responsibility of the patient's clinical provider(s).
3. The patient's physician writes an order stating whether to continue patient owned equipment or to use hospital owned equipment
4. Provider will clean the device with a hospital approved disinfecting agent prior to the equipment being placed on the patient.
5. If the device delivers medication, the provider will consult with the Pharmacy for review.

**Definitions:**

*Non Hospital owned medical equipment:*

Medical equipment brought to the hospital by a patient, whether owned or leased or rented, previously in use by the patient outside of Doctors Medical Center.

*Implanted Devices:*

This policy does not apply to procedurally implanted devices such as implanted defibrillators or implanted pacemakers.

*Durable Medical Equipment:*

This policy does not apply to durable medical equipment such as wheelchairs or crutches.

*Provider:*

The patient's nurse or respiratory therapist.

*Life Support Medical Equipment:*

Only Hospital-owned life support medical equipment or such equipment that is patient owned and was obtained from an approved vendor can be used in the Hospital.

Approval of a vendor means that the vendor has stated that the vendor meets criteria established by Doctors Medical Center for a safe and effective corrective and preventative maintenance program. Such approval does not indicate endorsement of or recommendation for a vendor or for a vendor's equipment, nor does it indicate whether the actual maintenance has been completed. Completion and maintenance of the corrective and preventative maintenance program is the responsibility of the patient in collaboration with the company.

Life Support Medical Equipment Types (as listed in the medical equipment inventory):

- Ventilators
- Defibrillators
- Pacemakers
- Circulatory Assist Devices
- Anesthesia Machines

The provider will be responsible for performing a visual check of the device for visible signs of breakage prior to the device being used on the patient. This will consist of a visual check of the electrical cord, housing, and patient cables to assess for obvious breakage.

If the device does not pass this visual check, it will not be placed in service.

- The provider who performed the visual check will document the reason for the equipment check failure.
- The patient's physician will be contacted for an order for use of hospital owned equipment.

**REFERENCES:**

**NFPA 99, 1996 Edition**
**CMS CoP §482.41(c)(2)**

| | |
|---|---|
| **Responsible for review/updating (Title/Dept)** | Title Director, Plant Operations Dept Plant Operations |

# NON-HOSPITAL OWNED MEDICAL EQUIPMENT RELEASE FORM

**DATE:**

**MANUFACTURER:**

**DEVICE TYPE:**

**MODEL NUMBER:**

**SERIAL NUMBER:**

I have chosen to use medical equipment that is not owned by Doctors Medical Center (DMC).

I understand that DMC will not verify that the equipment is functioning to manufacturer specifications. These specifications may include, but are not limited to general safety, alarm functions (settings, actuation, volume, etc.), flow accuracy, pressure accuracy, etc.

I/the Patient/ Legal Guardian am fully responsible for the operation and maintenance of the equipment while in the hospital and I have contact information for maintenance/ support of my equipment, as follows:

Telephone Number for Maintenance/Repair:

Company and Representative Name (Print legibly):

I have received training previously in the proper operation and maintenance of this device. I have requested that I be permitted to use this non-DMC device while an inpatient in Doctors Medical Center. I agree to take full responsibility for this device, including proper use. I understand that I am to report to my nurse any malfunction of the device, and that I am responsible for asking for a DMC owned replacement if needed, which might not be of the same type, model, or therapeutic settings due to device design. In return for being permitted to use the non-DMC device, I agree that DMC, West Contra Costa Healthcare District, and all officers, employees, students, and staff shall not be responsible or liable for any known or unknown injury or event resulting from my use of this device.

Patient Name (Print) Date

Patient Signature Nursing or Respiratory Therapy Signature

Parent or Guardian Signature
(If minor patient or under guardianship)

Comments:

**Please place form in patient's medical record.**

DOCTORS
MEDICAL CENTER

# QUALITY REPORT

TAB 8

# Quality Report

Juli Maxworthy, DNP
Vice President, Quality/Risk

# 2012 National Patient Safety Goals

# 2012 JC National Patient Safety Goals

## Identify Patients Correctly

- Use at least two ways to identify patients. For example, use the patient's name and date of birth. This is done to make sure that each patient gets the correct medicine and treatment.
- Make sure that the correct patient gets the correct blood when they get a blood transfusion.

## Improve Staff Communication

- Get important test results to the right staff person on time.

## Use Medicines Safely

- Before a procedure, label medicines that are not labeled. For example, medicines in syringes, cups and basins. Do this in the area where medicines and supplies are set up.
- Take extra care with patients who take medicines to thin their blood.
- Record and pass along correct information about a patient's medicines. Find out what medicines the patient is taking. Compare those medicines to new medicines given to the patient. Make sure the patient knows which medicines to take when they are at home. Tell the patient it is important to bring their up-to-date list of medicines every time they visit a doctor.

# 2012 JC National Patient Safety Goals

## Prevent Infection

- Use the hand cleaning guidelines from the Centers for Disease Control and Prevention or the World Health Organization. Set goals for improving hand cleaning. Use the goals to improve hand cleaning.
- Use proven guidelines to prevent infections that are difficult to treat.
- Use proven guidelines to prevent infection of the blood from central lines.
- Use proven guidelines to prevent infection after surgery.
- Use proven guidelines to prevent infections of the urinary tract that are caused by catheters.

## Identify Patient Safety Risks

- Find out which patients are most likely to try to commit suicide.

## Prevent Mistakes in Surgery

- Make sure that the correct surgery is done on the correct patient and at the correct place on the patient's body.
- Mark the correct place on the patient's body where the surgery is to be done.
- Pause before the surgery to make sure that a mistake is not being made.

# Miscellaneous

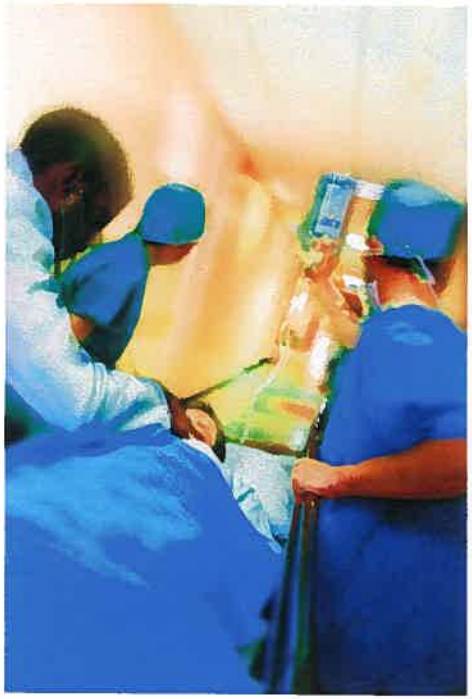
- **Security Report-3rd quarter 2011**
  - Increase in finding doors left unlocked
    - Staff have been re-educated on ensuring their workspace is secure
  - Decrease in combative patients requiring security assistance and having to provide standby assistance with aggressive patients and trespassing on the property

- **Use of Black Lights for ensuring proper cleaning of Operating Room Suites**
  - Environmental Services utilizing black lights to validate compliance
- **Patient Satisfaction Summit**
  - January 24th

DOCTORS
MEDICAL CENTER

# EMERGENCY DEPT. YEAR IN REVIEW PRESENTATION

TAB 10



# CEP America

EMERGENCY PHYSICIAN PARTNERS

# Doctors Medical Center San Pablo

## ED Performance Snapshot

Seth Thomas, MD
ED Medical Director

January 25, 2012

CEP America

# Presentation Overview

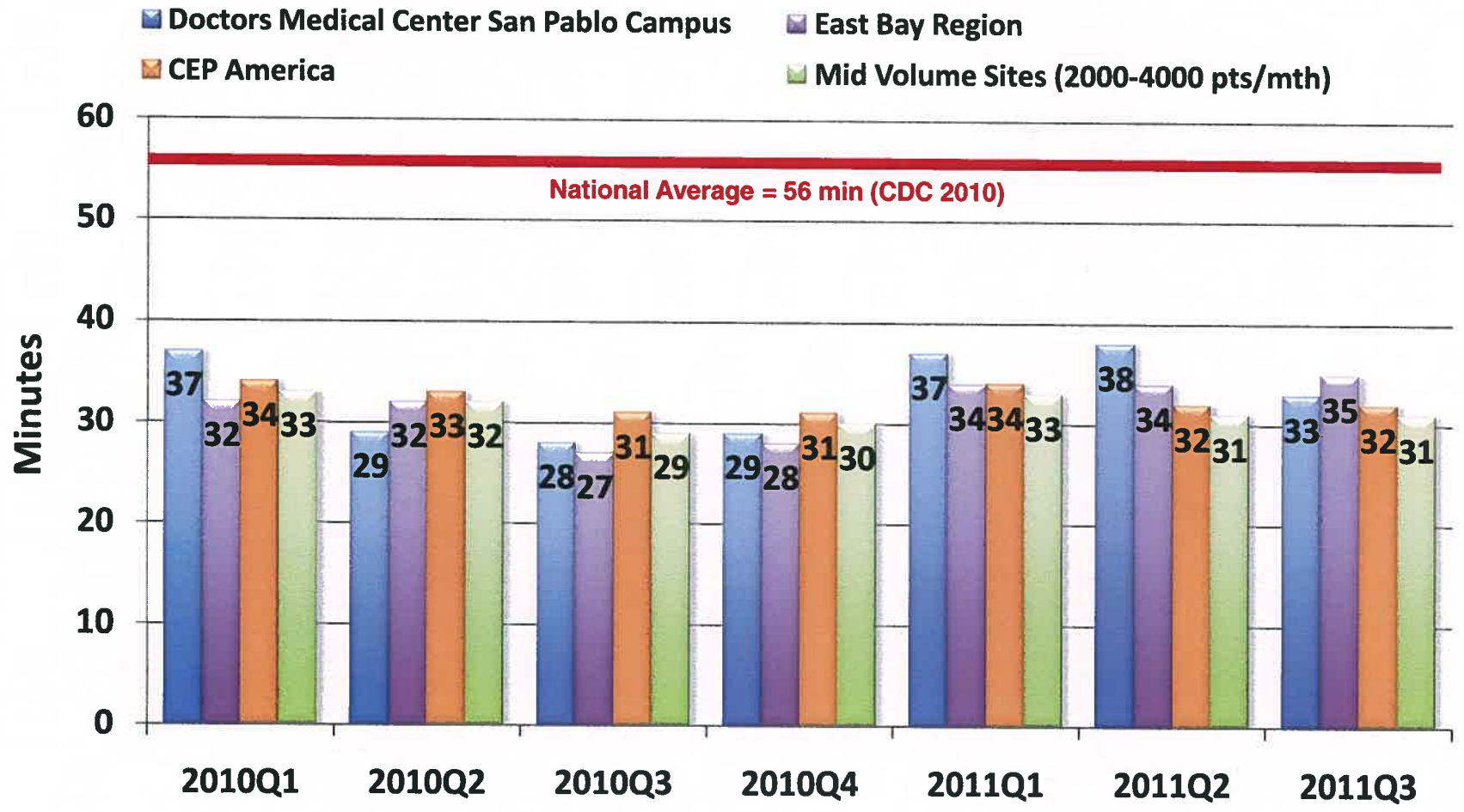
- Introduction
- History
- ED Performance
- Achievements
- Partnering for the Future

CEP America

# History

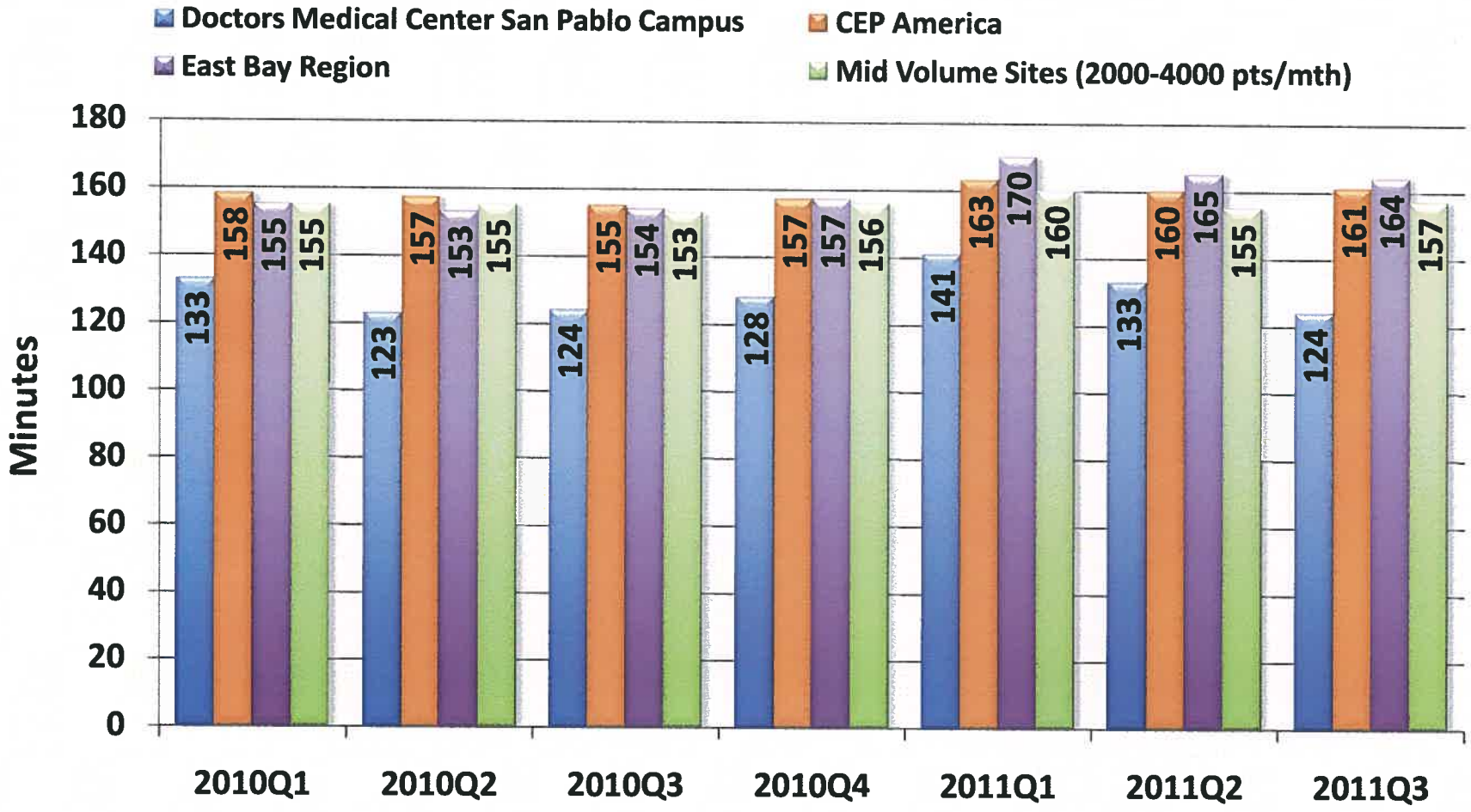

CEP America

# Time to Provider by Quarter



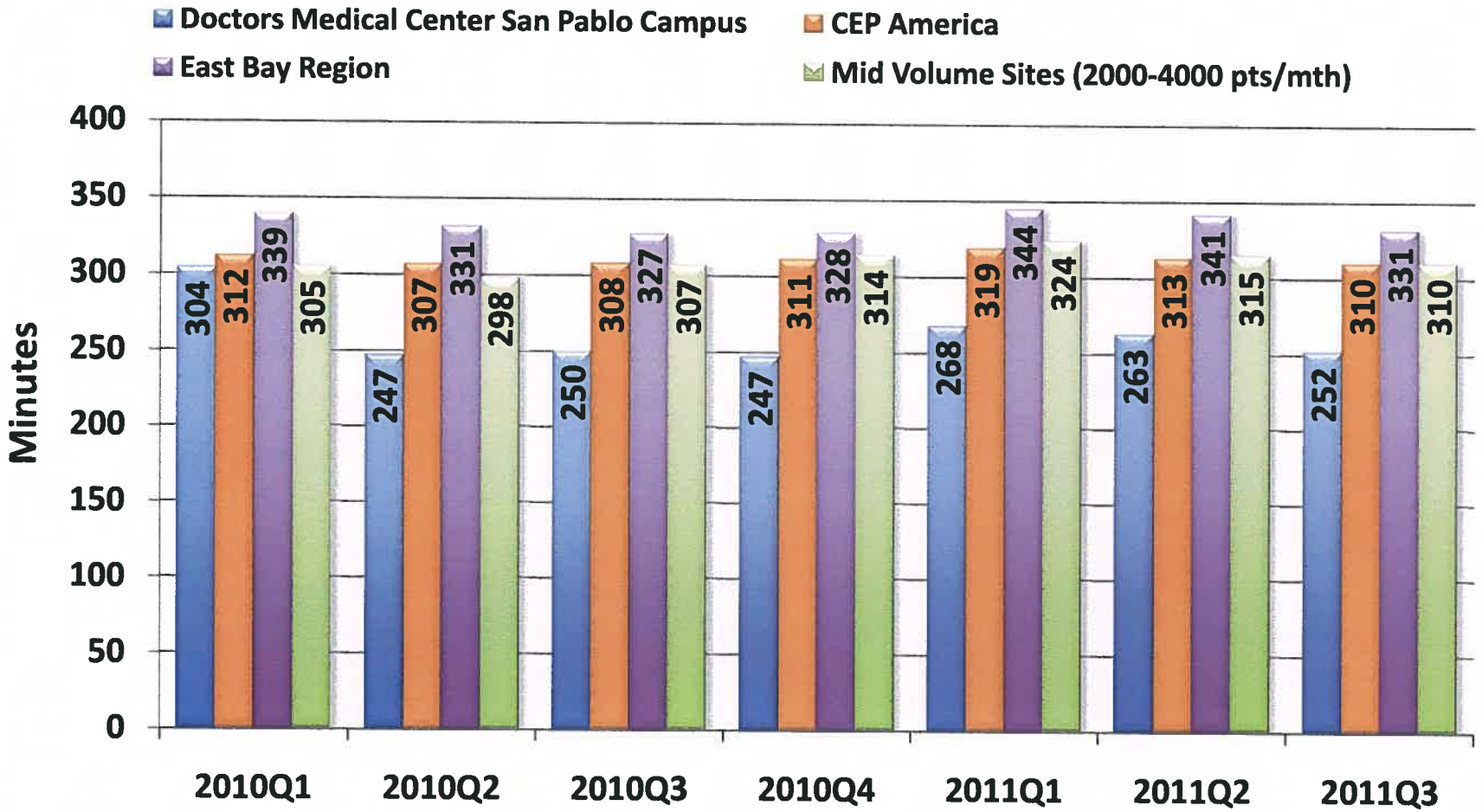

CEP America

# TAT Discharged Patients by Quarter



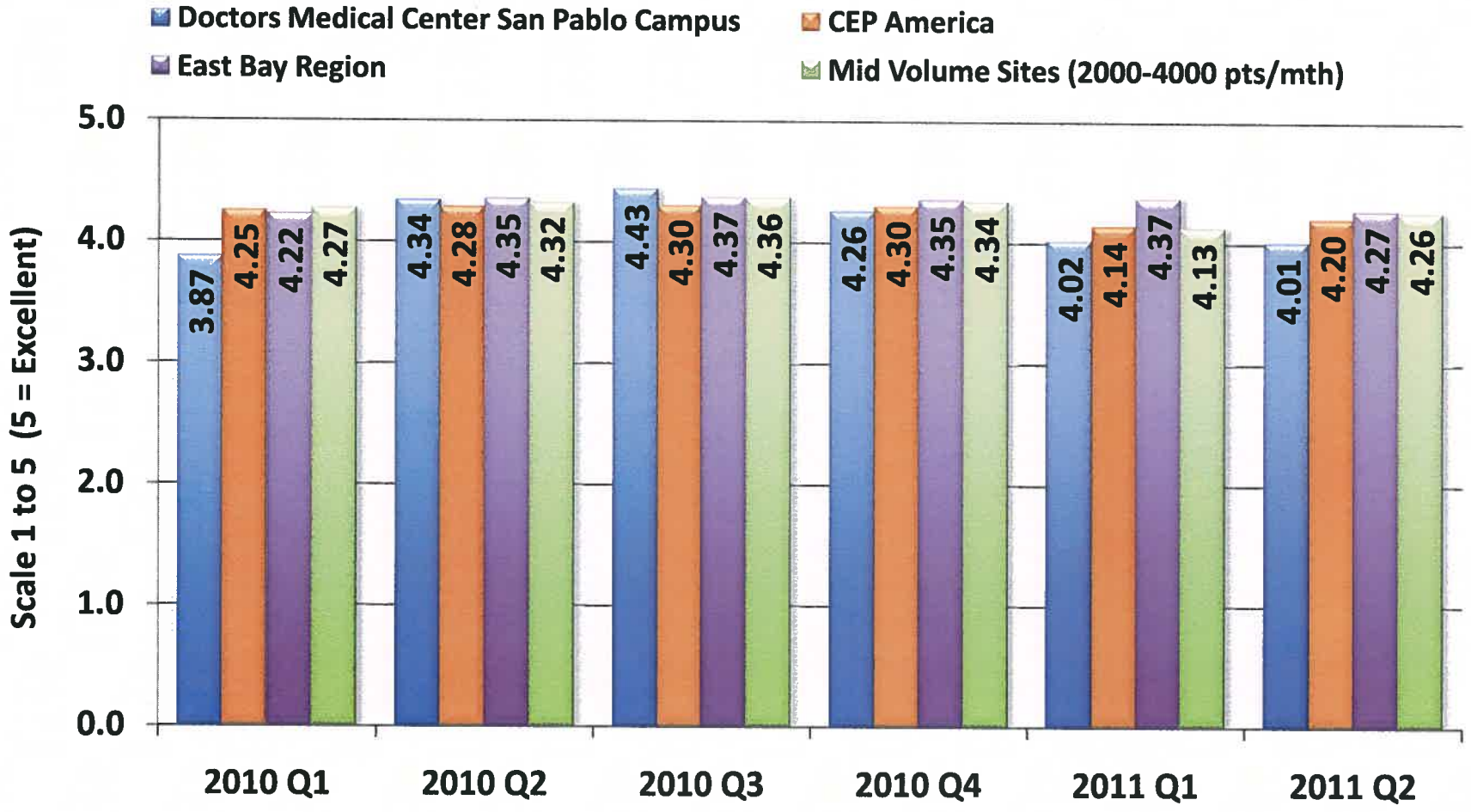

CEP America

# TAT Admitted Patients by Quarter




CEP America

# Patient Satisfaction by Quarter

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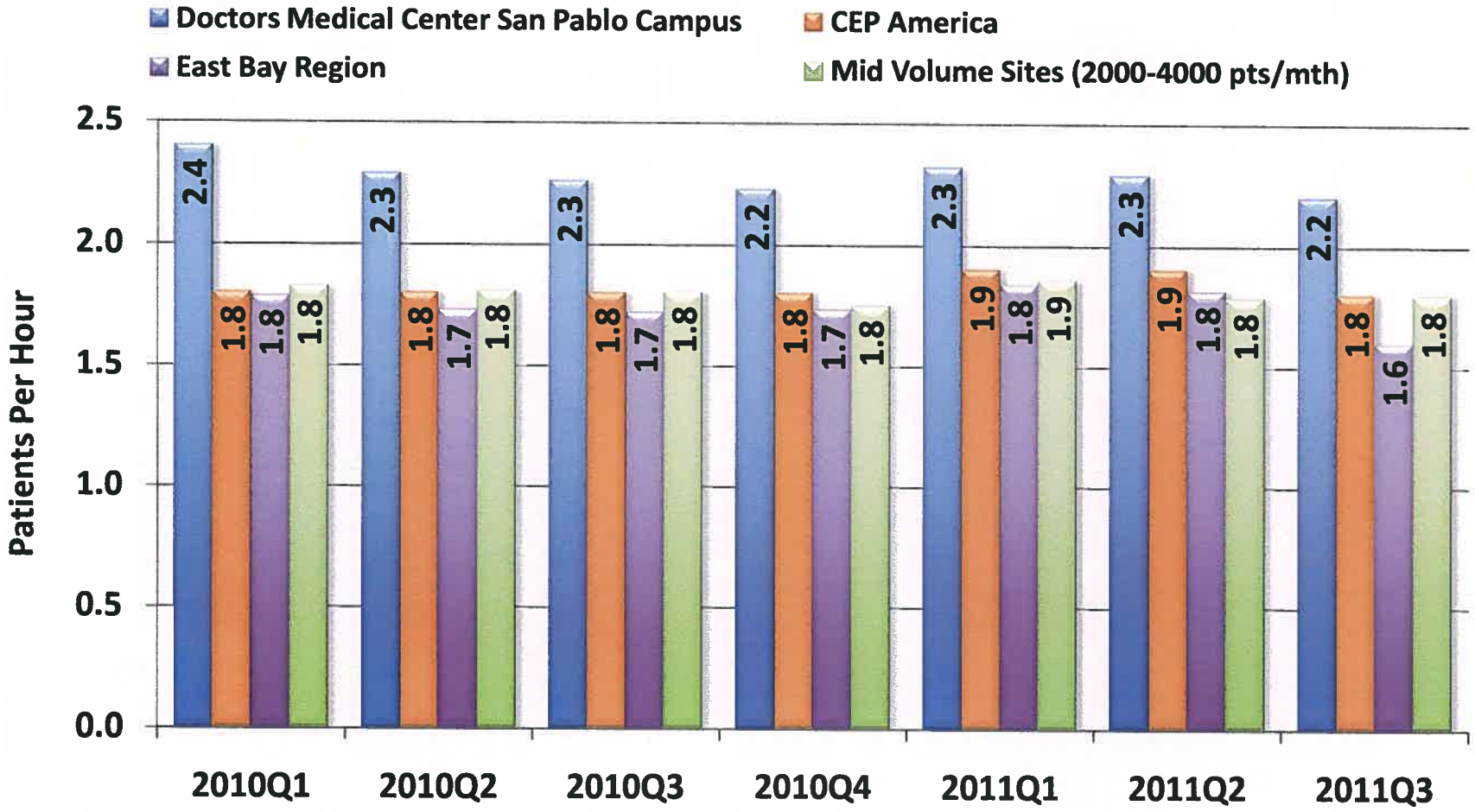
# Productivity by Quarter

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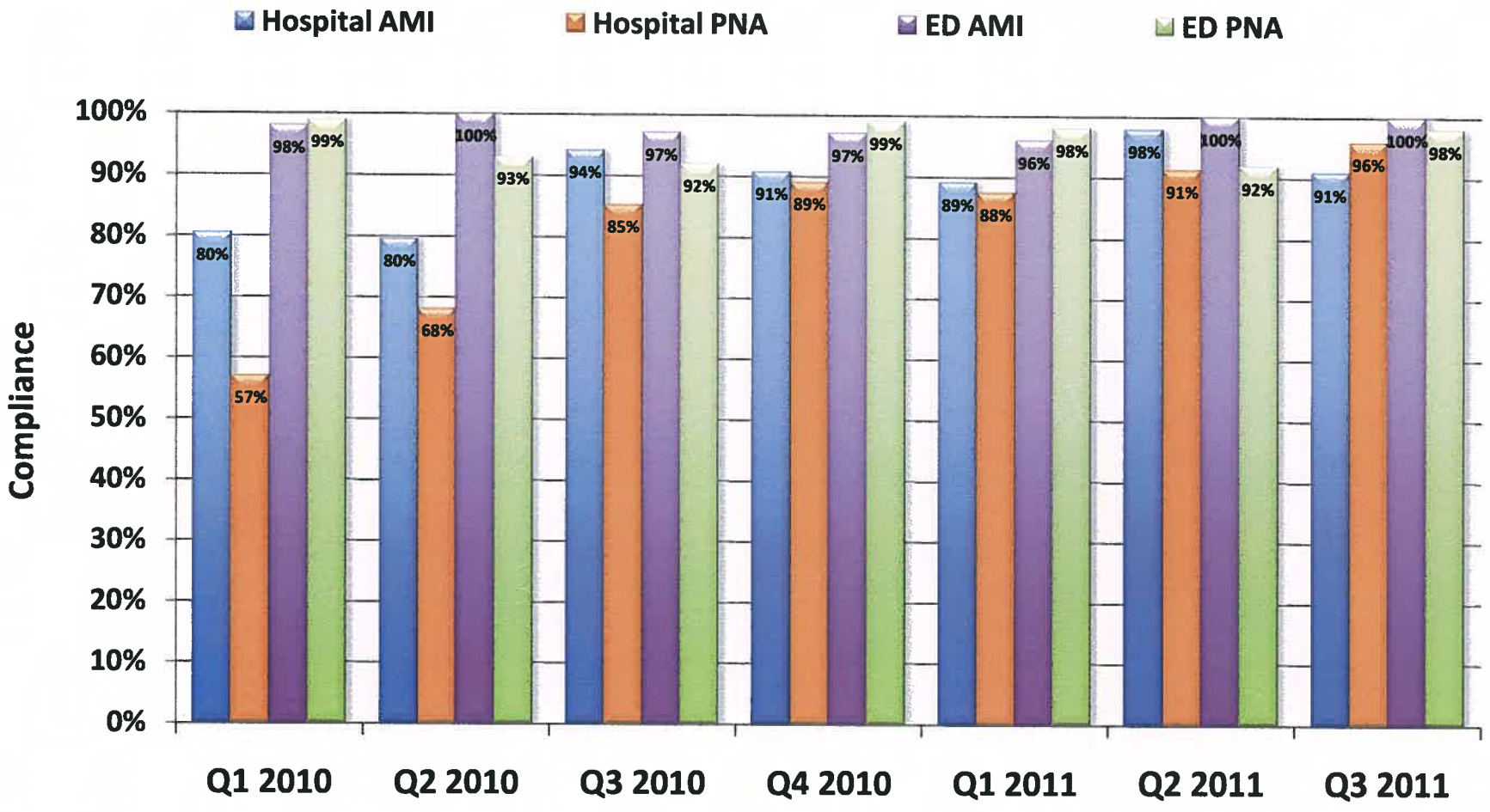
# Core Measures by Quarter

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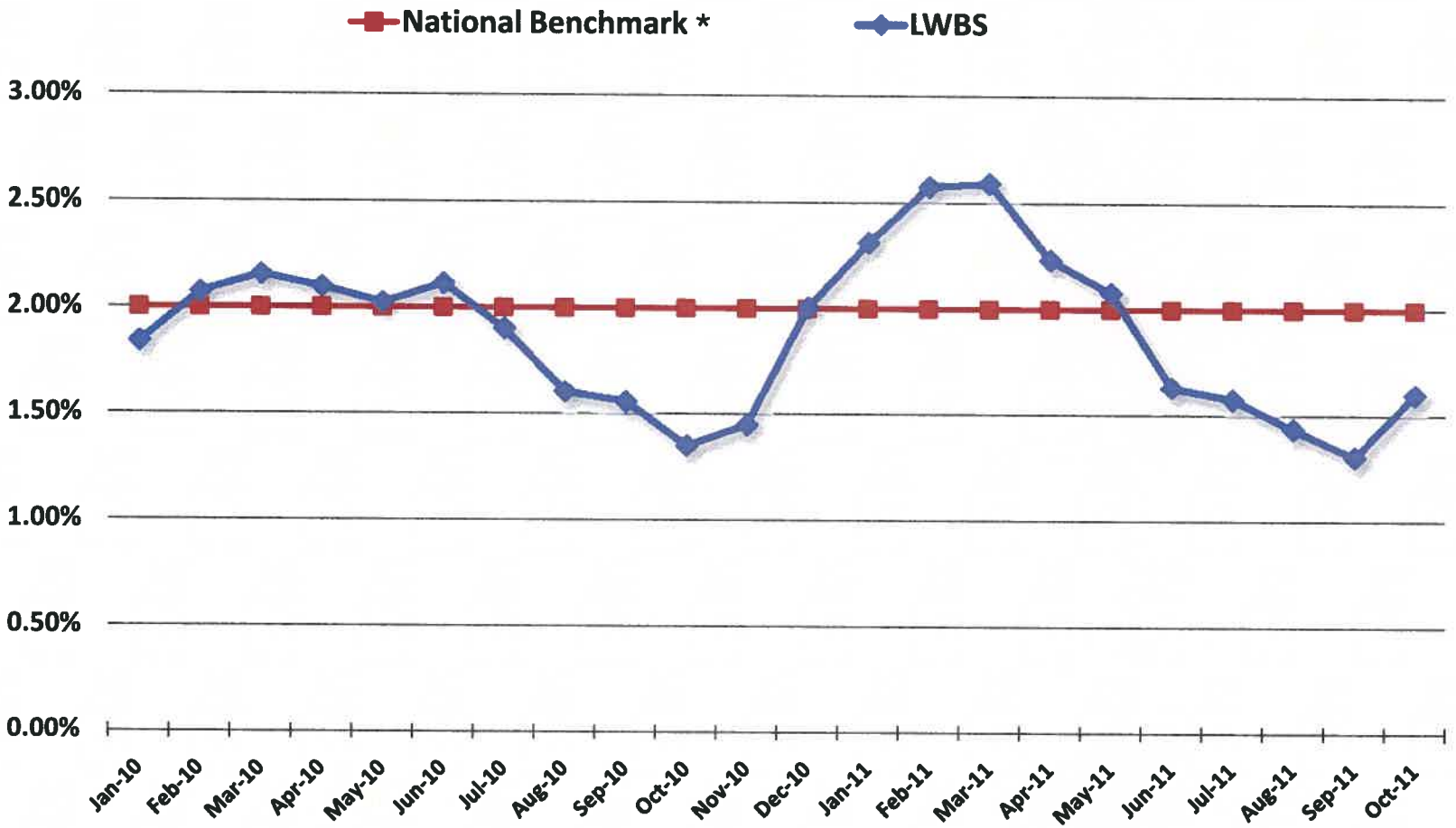
# Left Without Being Seen




*2008 National Healthcare Quality Report

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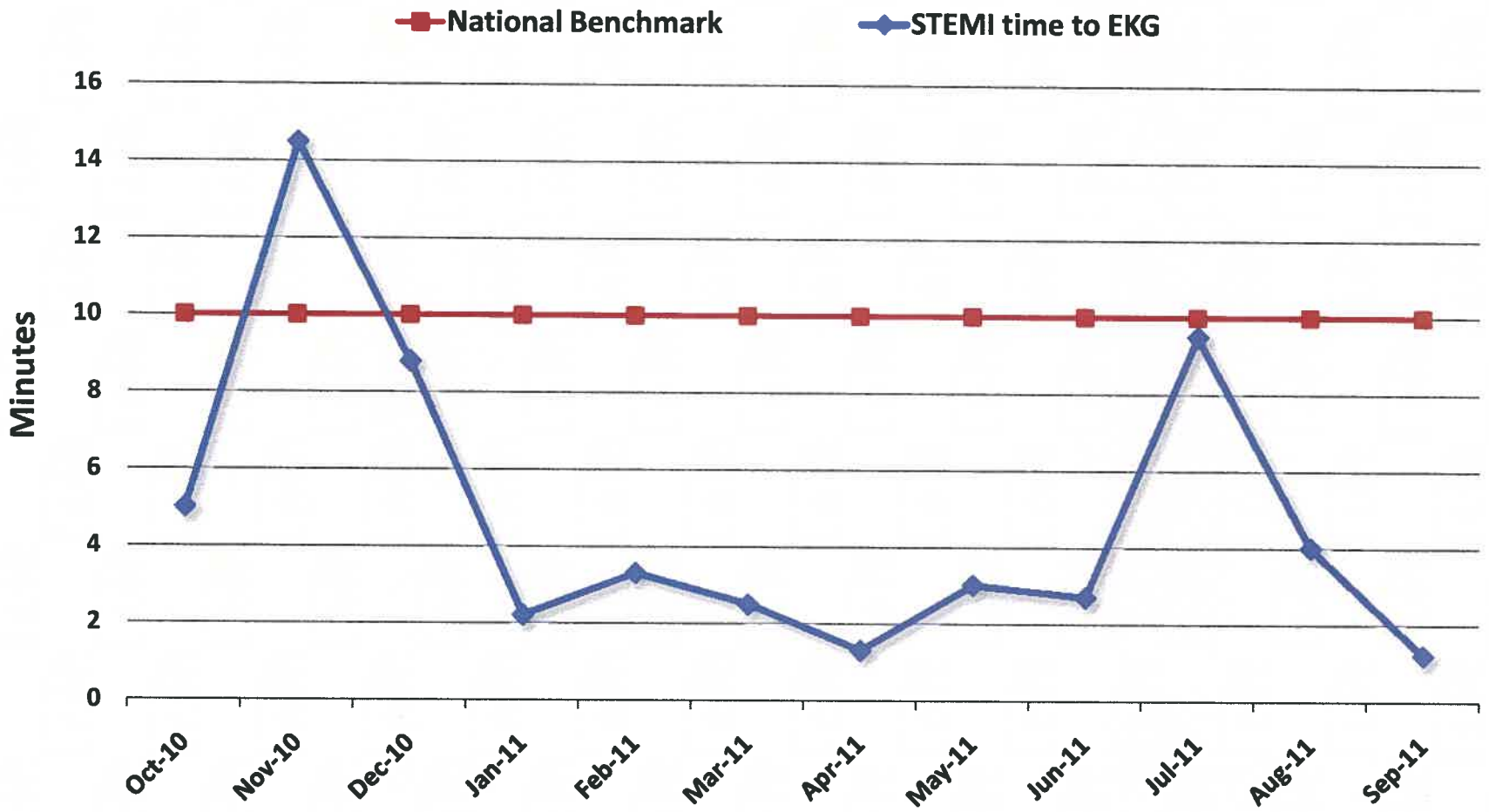
# STEMI – Time to EKG

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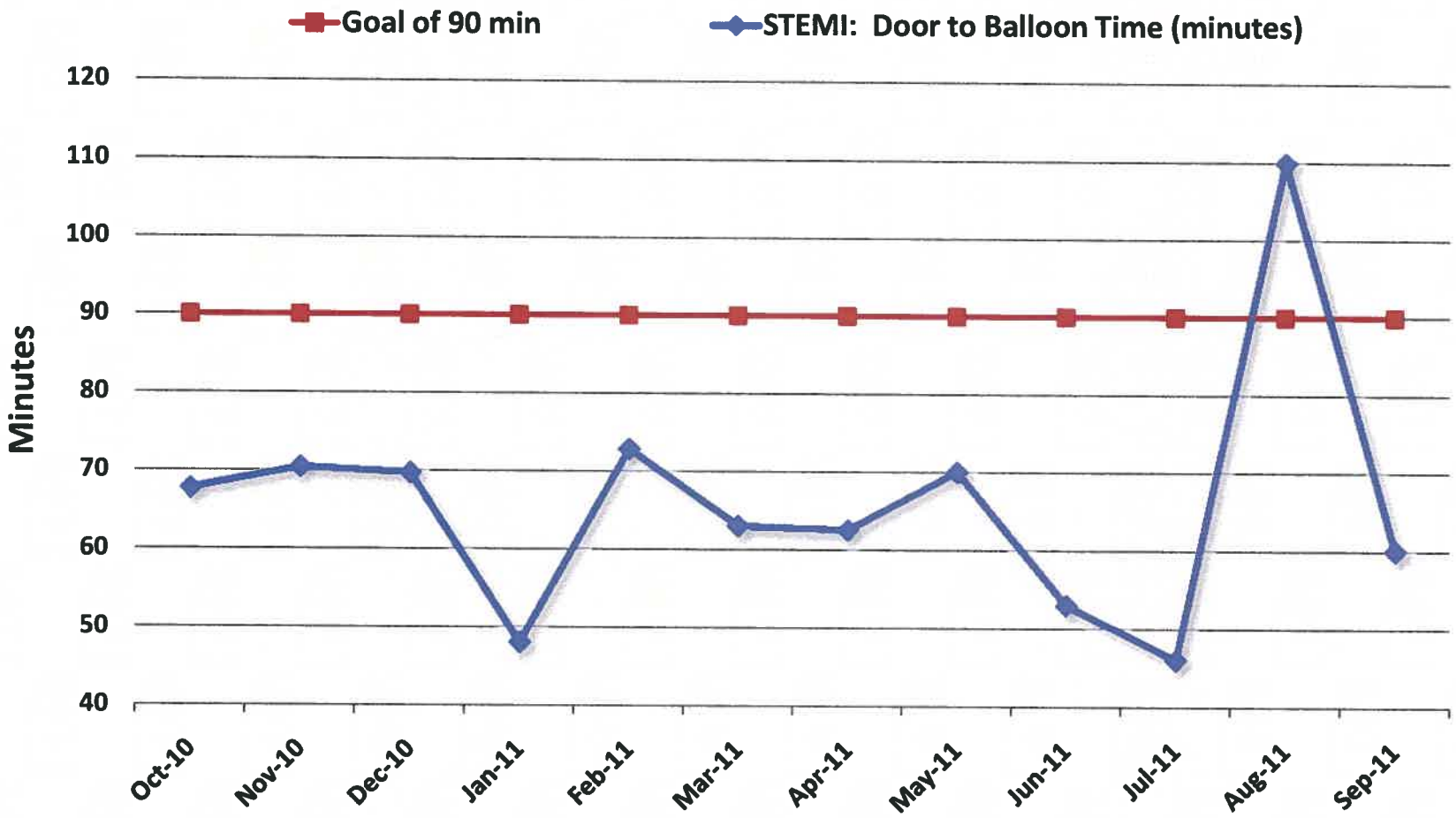
# STEMI – Door to Balloon Time

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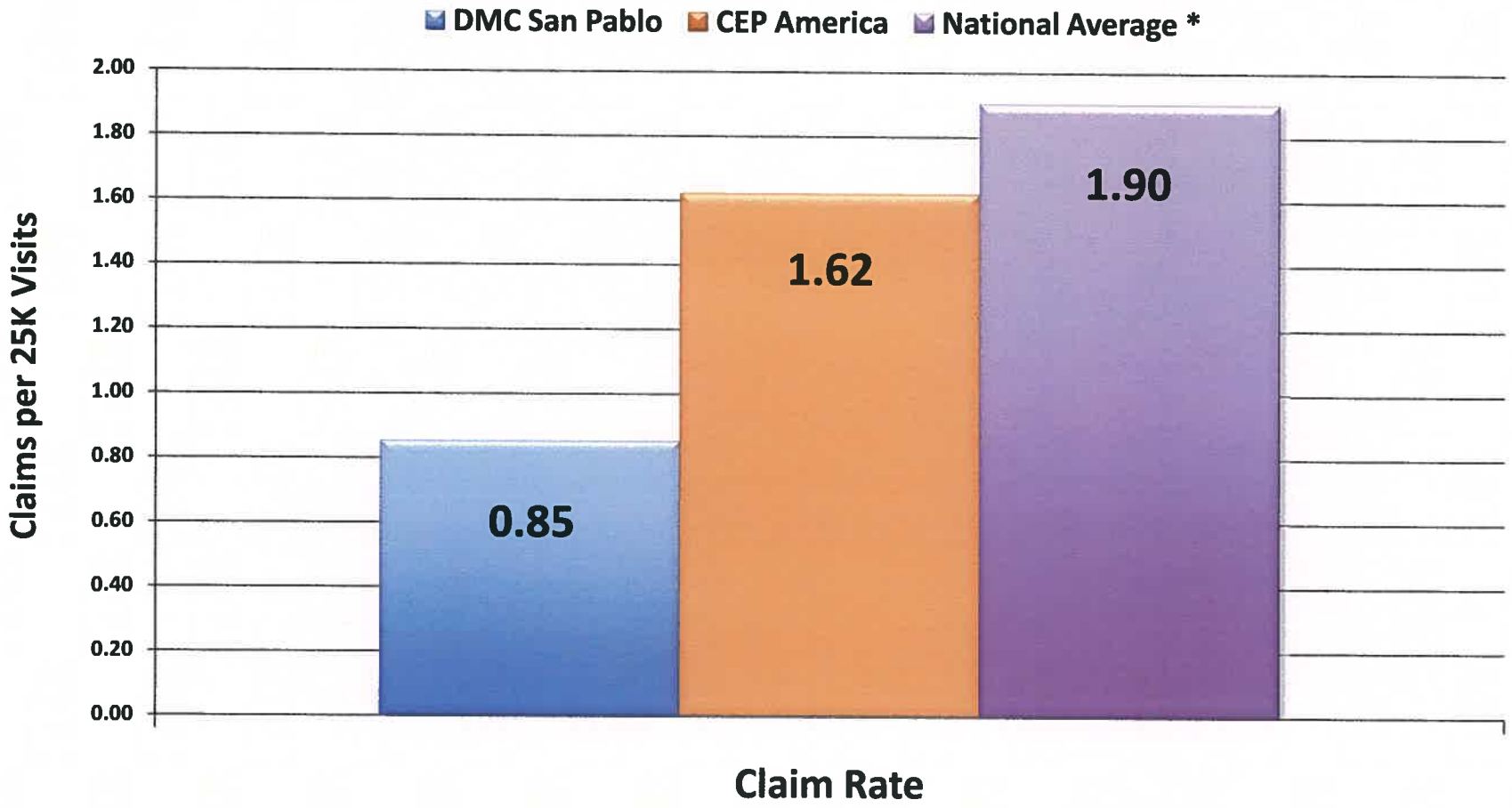
# Risk Profile




*2010 American Medical Association

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# Achievements

- ✓ Stroke Program Certification
- ✓ STEMI Program Certification
- ✓ Flat Rate Program Development
- ✓ Galen Hospitalist Partnership
- ✓ Patient Callback Program
- ✓ Scribe Program
- ✓ Administrative Staff Development
- ✓ E-Doc Award
- ✓ Community Outreach
- ✓ **Measure J and SB 644 Support**

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# Partnering for the Future

1. Provide Value to DMC
2. Maintain ED Performance
   - Core Measures/Utilization
   - Improve Throughput Metrics (TTP, TAT) - PIT
   - Maximize Collections
   - Provide Exceptional Leadership
     - Quality Initiatives (Core Measures)
     - Patient Satisfaction Initiative
     - Recruitment of Superior Clinicians (leading by example)

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# Thank You

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# Questions?

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DOCTORS
MEDICAL CENTER

# MEDICAL EXECUTIVE REPORT

TAB 11

DOCTORS
MEDICAL CENTER

# MEDICAL EXECUTIVE COMMITTEE
# REPORT TO THE BOARD OF DIRECTORS
# JANUARY 2012

| ITEM | ACTION |
|---|---|
| **A. CHIEF OF STAFF REPORT** | Informational |
| **B. CREDENTIALS REPORT – December 2011** | Approval |

DOCTORS MEDICAL CENTER

# MEDICAL EXECUTIVE COMMITTEE
# CREDENTIALS REPORT TO THE BOARD

## DECEMBER 2011

*The following practitioners' applications for appointment and/or reappointment have been reviewed by the appropriate committees of the Medical Staff and have been deemed as complete and are recommended for approval by the Credentials Committee (12/15/11) and the Medical Executive Committee (01/09/12).*

| CREDENTIALS REPORT TO THE BOARD DECEMBER2011 | |
|---|---|
| | |
| ***INITIAL APPOINTMENTS*** | |
| ***NAME*** | ***DEPARTMENT/SPECIALTY*** |
| Chiu, Elaine, MD | Med/Family Practice/Emergency Med |
| | |
| ***REAPPOINTMENTS*** | |
| ***NAME*** | ***DEPARTMENT/SPECIALTY*** |
| | |
| Cianci, Paul MD | Medicine/Family Practice/Hyperbaric Medicine |
| Doud, Robert MD | Medicine/Family Practice/Nephrology |
| Drager, Sharon MD | Surgery/Vascular Surgery |
| Fink, Richard MD | Surgery/Neurosurgery |
| Strykers, Peter H. MD | Family Practice/Honorary Retired |
| | |