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

Wednesday, October 26, 2011
4:30 PM
Doctors Medical Center - Auditorium
2000 Vale Road
San Pablo, CA

WEST CONTRA COSTA HEALTHCARE DISTRICT
DOCTORS MEDICAL CENTER

GOVERNING BODY
BOARD OF DIRECTORS

WCCHD DOCTORS MEDICAL CENTER
GOVERNING BODY BOARD OF DIRECTORS
OCTOBER 26, 2011, 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 — E. Zell

2. ROLL CALL

3. APPROVAL OF SEPTEMBER 28, 2011 MINUTES — E. Zell

4. PUBLIC COMMENTS — E. Zell
   [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. FINANCIALS – SEPTEMBER 2011 — J. Boatman
   a. Presentation
   b. Discussion
   c. Public Comment
   d. *ACTION: Acceptance of the September 2011 Financials.*

6. QUALITY REPORT — J. Maxworthy
   a. Presentation
   b. Discussion
   c. Public Comment
   d. *ACTION: For information only.*

7. CEO REPORT — D. Gideon
   a. Presentation
   b. Discussion
   c. Public Comment
   d. *ACTION: For information only.*

8. MEDICAL EXECUTIVE REPORT — S. Drager, M.D.
   a. Presentation
   b. Discussion
   c. Public Comment
   d. *ACTION:*
      - *Acceptance of Medical Staff Report*
      - *Approval of Appointments, Reappointments and Changes of Staff Status, and Policies and Procedures*

ADJOURN TO CLOSED SESSION

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

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

DOCTORS
MEDICAL CENTER

MINUTES

September 28, 2011

TAB 3

WEST CONTRA COSTA HEALTHCARE DISTRICT
DOCTORS MEDICAL CENTER GOVERNING BODY

Minutes

September 28, 2011 – 4:30 pm
Doctors Medical Center - Auditorium
2000 Vale Road, San Pablo, CA 94806

1. **Call to Order**

   The meeting was called to order at 4:30 p.m.

2. **Roll Call**

   Quorum was established and roll was called:

   Voting Members: *Supervisor John Gioia*
   Eric Zell
   Irma Anderson
   Deborah Campbell
   Wendel Brunner, M.D.
   Nancy Casazza
   Sharon Drager, M.D.
   Richard Stern, M.D.
   William Walker, M.D.
   Beverly Wallace

   Excused Absence: *Pat Godley*

3. **Approval of Minutes of August 24, 2011**

   The motion made by Director Casazza and seconded by Director Anderson to approve the minutes of August 24, 2011 passed unanimously.

4. **Public Comments**

   Fr. James Patrick Vaughn was a stroke patient at DMC. He gave recognition to the ER staff for the professionalism and excellent care.

5. **Fire Alarm System Upgrade**

William Appling, Director of Plant Operations presented an overview of the Fire Alarm System Upgrade and sought approval of the expenditure. The upgrade will allow DMC to meet the California Fire Code (CFC) (4603.6.3, 4603.6.3.1) for existing Group 1-2 occupancies, as mandated by the Contra Costa Fire District.

William Appling also provided a hand out which listed a summary of events, report requirements, actions taken and plans for the upgrade (*see attachment*).

Supervisor Gioia suggested that the Board should not enter into the contract until after the parcel tax issue is resolved.

The motion made by Director Zell and seconded by Director Wallace to direct and authorize William Appling, Director of Plant Operations to develop a bid process, and to return to the Board for final approval passed unanimously.

6. **Financials – August 2011**

Jim Boatman, CFO reported August 2011 was a net loss of $539,000 less than budgeted. Net loss to date is $10M. Accounts receivable days dropped to 60.2 days and below the California Benchmark; Operating cash in August was $6.7M or 28 days.

The motion made by Director Anderson and seconded by Director Wallace to accept and approve the financial statements for August 2011 passed unanimously.

7. **Quality Report**

Juli Maxworthy, VP Quality, presented the following highlights and informational items:

- Clinical Lab Survey (Joint Commission) was conducted September 14 – 16: received one finding that require 45 days to submit plan of correction and 6 findings that require 60 days to submit plan of correction.
- Stroke Accreditation Survey is scheduled on September 29. A 1 day survey; Tiffany Littlefoot, Stroke Coordinator will be leading the surveyors throughout the organization.
- Patient First Forum; the speaker on 9/22 was an employee and patient; who is a stroke survivor. The patient had a positive experience, very impressed with the outpouring concern with his care.

The motion made by Director Anderson and seconded by Director Casazza to accept the Quality presentation passed unanimously.

8. **Medical Executive Report**

Dr. Drager sought approval of the new Stroke Program Plan Policy. Establishes stroke program to deliver evidence-based care to patients with acute stroke and ensure compliance with The Joint Commission standards for a certified primary stroke center.

Dr. Drager also sought approval of the August 2011 Credentials Report.

The motion made by Director Zell and seconded by Director Anderson to approve the Medical Staff Report/Policy and Credentials Report for August 2011 passed unanimously.

The meeting went into closed session at 5:30 p.m. Supervisor John Gioia announced that there would be no reportable actions taken in closed session.

Fire Alarm System Upgrade
September 28, 2011

Summary of Events

- February, 2011: Routine Annual Fire Marshal Inspection
- New interpretation that constituted 7th floor CDCR inpatient a "change in use" from a Group 1-2 (hospital) to Group 1-3 (Place of Detention)
- August, 2011, Meeting was held with all parties to attempt to rectify without large investment
- Sept 9, 2011 Received Fire Marshall's Report and Requirements

September 9, 2011 Report/Requirements:

Group 1-3 (place of detention) requires:

A. An automatic sprinkler system.
B. Occupancies shall be equipped with a manual and automatic fire alarm system installed for alerting staff.

Group 1-2 (hospitals) requires:

C. An automatic fire alarm system which responds to the products of combustion other than heat. (More devices)

Note: This impacts our current facility, not just the 7th floor and CDCR

Action Taken as of Sept 23, 2011

A. Moved CDCR patients to former Burn unit thereby complying with A above.

Remaining requirements to B & C above:

Within 90 days of Sept 9, 2011, DMC shall have a signed contract with a licensed fire alarm contractor with all work to be completed no later than Sept 9, 2012.

In addition a fire watch program shall be submitted for review, approval and be operational by Sept 23, 2011. *(In place)*
The fire watch program shall be maintained until the upgraded fire alarm system is installed and successfully accepted.

Our plan:

- ✓ In order to meet the timelines set forth by the Fire Marshal's office, we will contract with an experienced vendor to design the new system.
- ✓ This process should start within the next two weeks.
- ✓ By contracting for the design phase we will accomplish the following:

  1. Ensure that the recommended solution is correct and final
  2. Ensure that all OSHPD issues are identified and accounted for
  3. During the design, multiple bids can be obtained for equipment and installation. This will allow DMC an accurate project cost and construction timeline

Once this process of developing the project and defining the scope is complete, a recommendation will be presented to the board no later than November 2012.

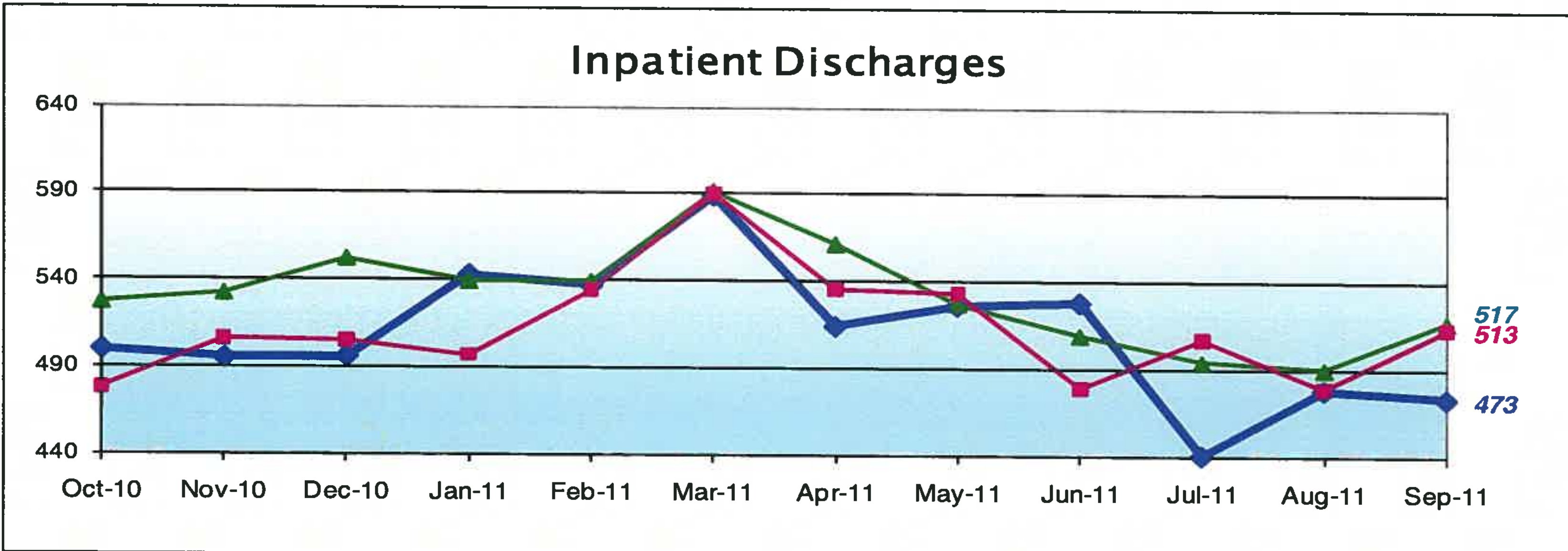
SEPTEMBER 2011 FINANCIAL REPORT

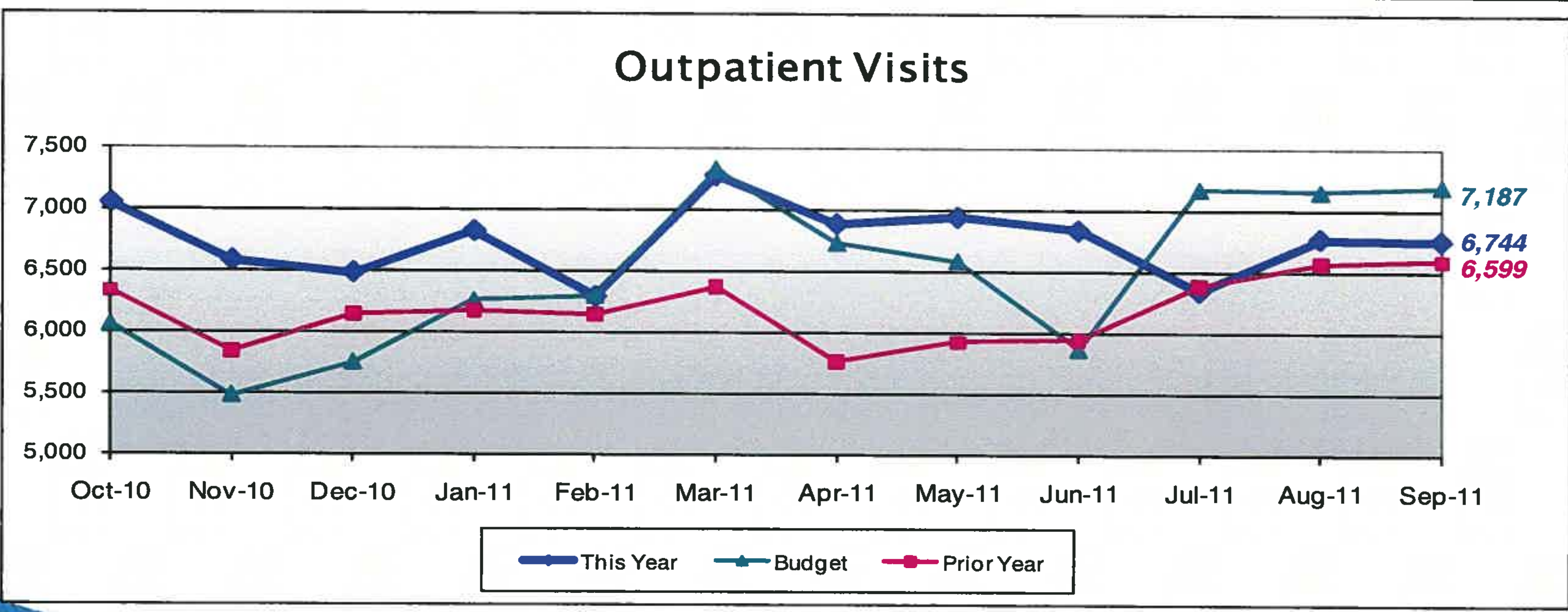
TAB 5

Board Presentation

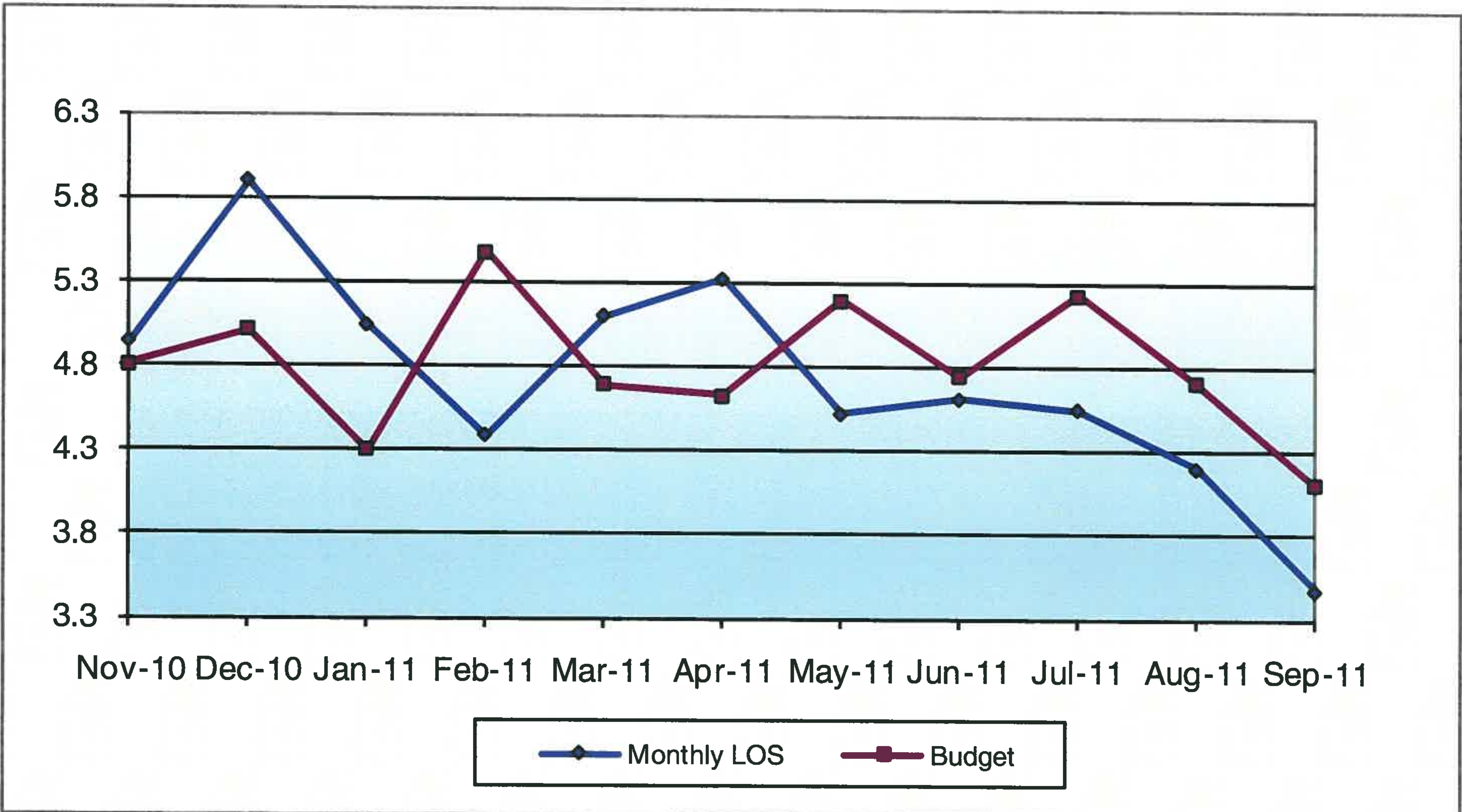
September 2011 Financial Report

Patient Volumes





Monthly Length of Stay
Discharged Patients



Statement of Activity - Summary

For the Period Ending

September 30, 2011

(Thousands)

Month to Date				Year to Date		
Actual	Budget	Var		Actual	Budget	Var
8,383	11,547	(3,164)	**Net Operating Revenues $**	90,917	102,039	(11,122)
11,205	11,639	434	**Total Operating Expenses $**	112,619	109,354	(3,265)
(2,822)	(92)	(2,730)	**Income/(Loss) from Operations $**	(21,702)	(7,315)	(14,387)
1,862	666	1,196	**Income from Other Sources $**	10,465	5,949	4,516
(960)	574	(1,534)	**Net Income / (Loss) $**	(11,237)	(1,365)	(9,872)
(11.5%)	5.0%	(16.4%)	**Net Income Percentage**	(12.4%)	(1.3%)	(11.0%)

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

Budget Variances – Net Revenue

- Medi-Cal/Medi-Cal HMO – ($251K).
- HMO/PPO/Commercial – ($1,952M).
- Medicare / Medicare HMO– ($618K).

Budget Variances – Expenses

- Salaries & Benefits $693K – Salaries under budget due to low contract labor, flexing and hospital reorganization.
- Professional Fees ($51K) –Higher legal costs related to labor negotiations.
- Supplies $274K – Flexed supply cost, reduction in implants and surgery supplies.
- Purchased Services ($132K) – Renal Dialysis, Lab Referrals, Repairs, and Payroll Audit were over budget.
- Restructuring Costs– ($333K)

Cash Position

September 30, 2011

(Thousands)

	September 30, 2011	December 31, 2010
Unrestricted Cash	$2,369	$5,229
Restricted Cash	$3,258	$4,006
Total Cash	$5,627	$9,235
Days Unrestricted Cash	6	12
Days Restricted	10	11
Total Days of Cash	17	23

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

Accounts Receivable

September 30, 2011

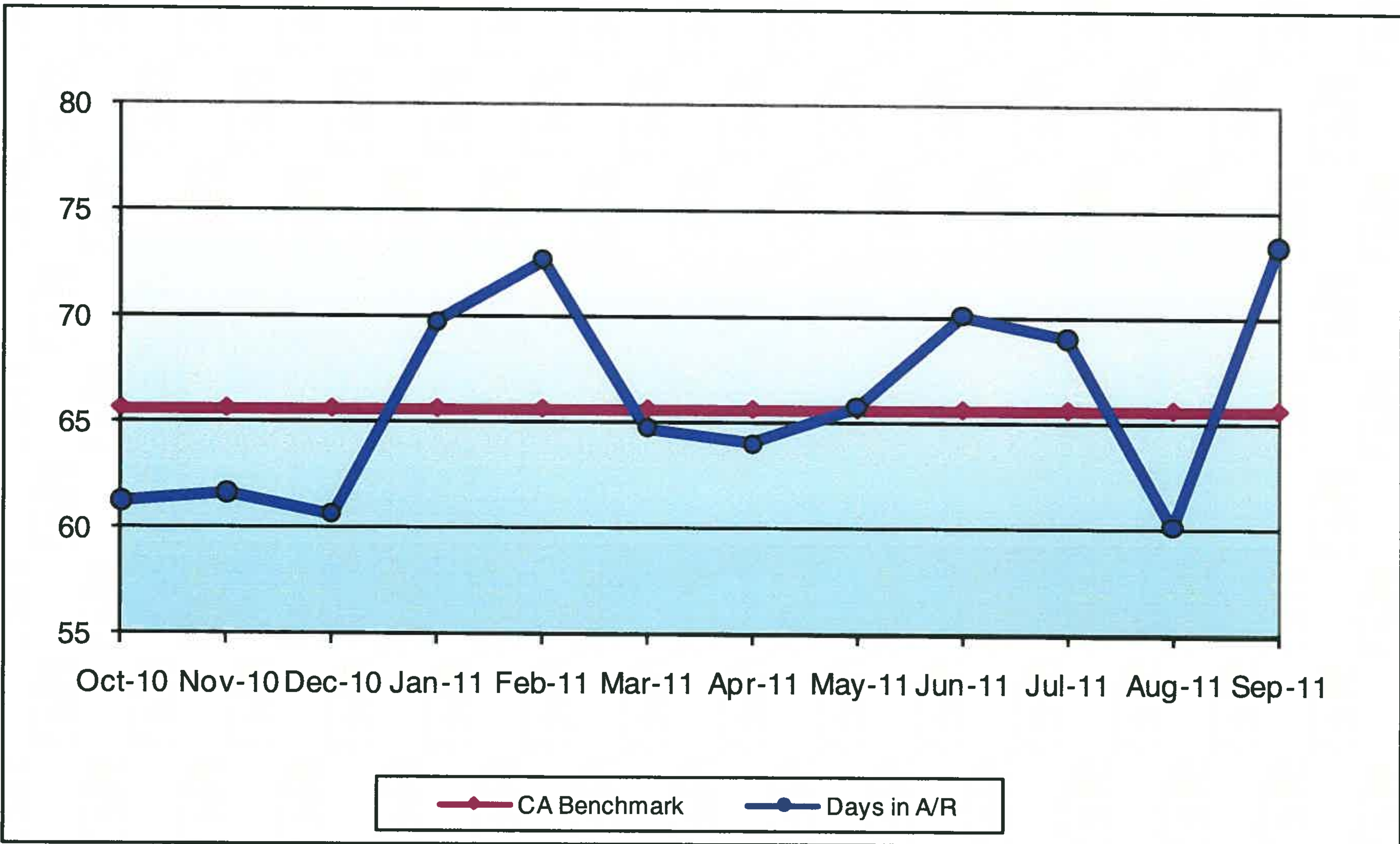
(Thousands)

	September 30, 2011	December 31, 2010
Net Patient Accounts Receivable	$18,173	$20,433
Net Days in Accounts Receivable	62.5	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



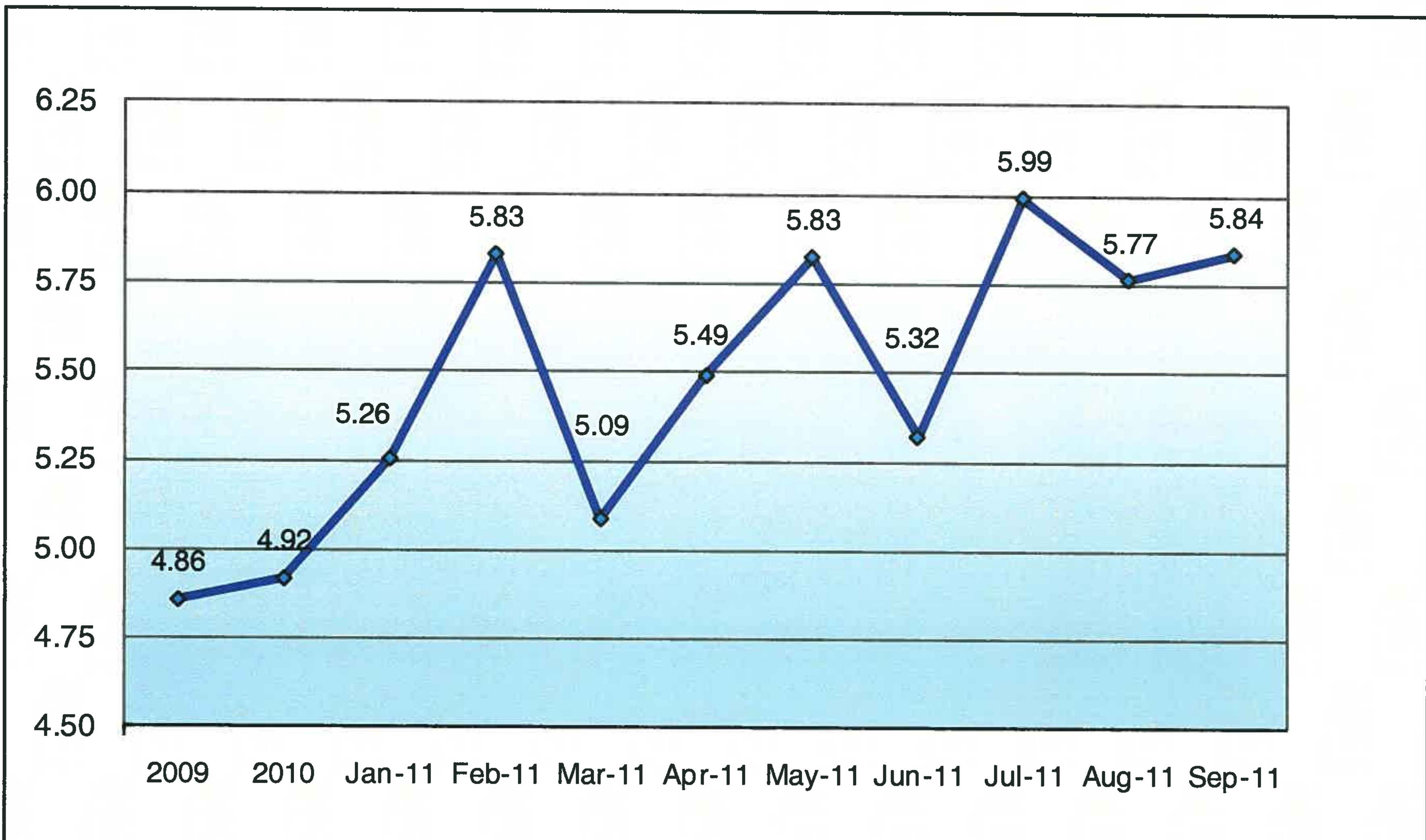
Outpatient Center Statement of Activity

For the Period Ending

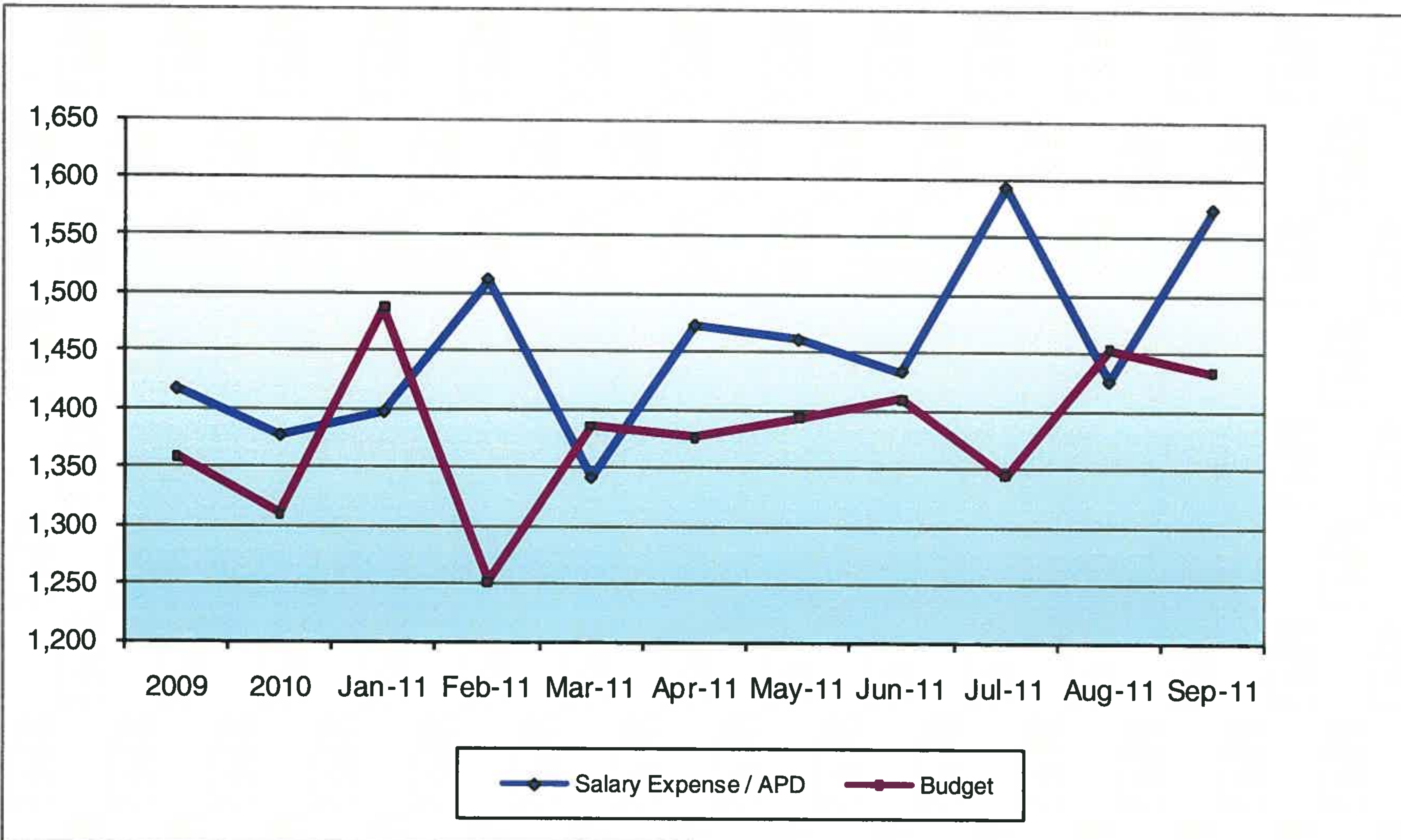
September 30, 2011

Month to Date				Year to Date		
Actual	Budget	Var		Actual	Budget	Var
173,009	202,500	(29,491)	**Net Operating Revenues $**	1,533,616	1,764,611	(230,995)
196,892	247,321	50,429	**Total Operating Expenses $**	1,804,287	2,239,979	435,692
(23,883)	(44,821)	20,938	**Income/(Loss) from Operations $**	(270,671)	(475,368)	204,697
(5,148)	(5,148)	-	**Income from Other Sources $**	(53,500)	(53,500)	-
(29,031)	(49,969)	20,938	**Net Income / (Loss) $**	(324,171)	(528,868)	204,697
(16.8%)	(24.7%)	7.9%	**Net Income Percentage**	(21.1%)	(30.0%)	8.8%

Worked FTE / AADC



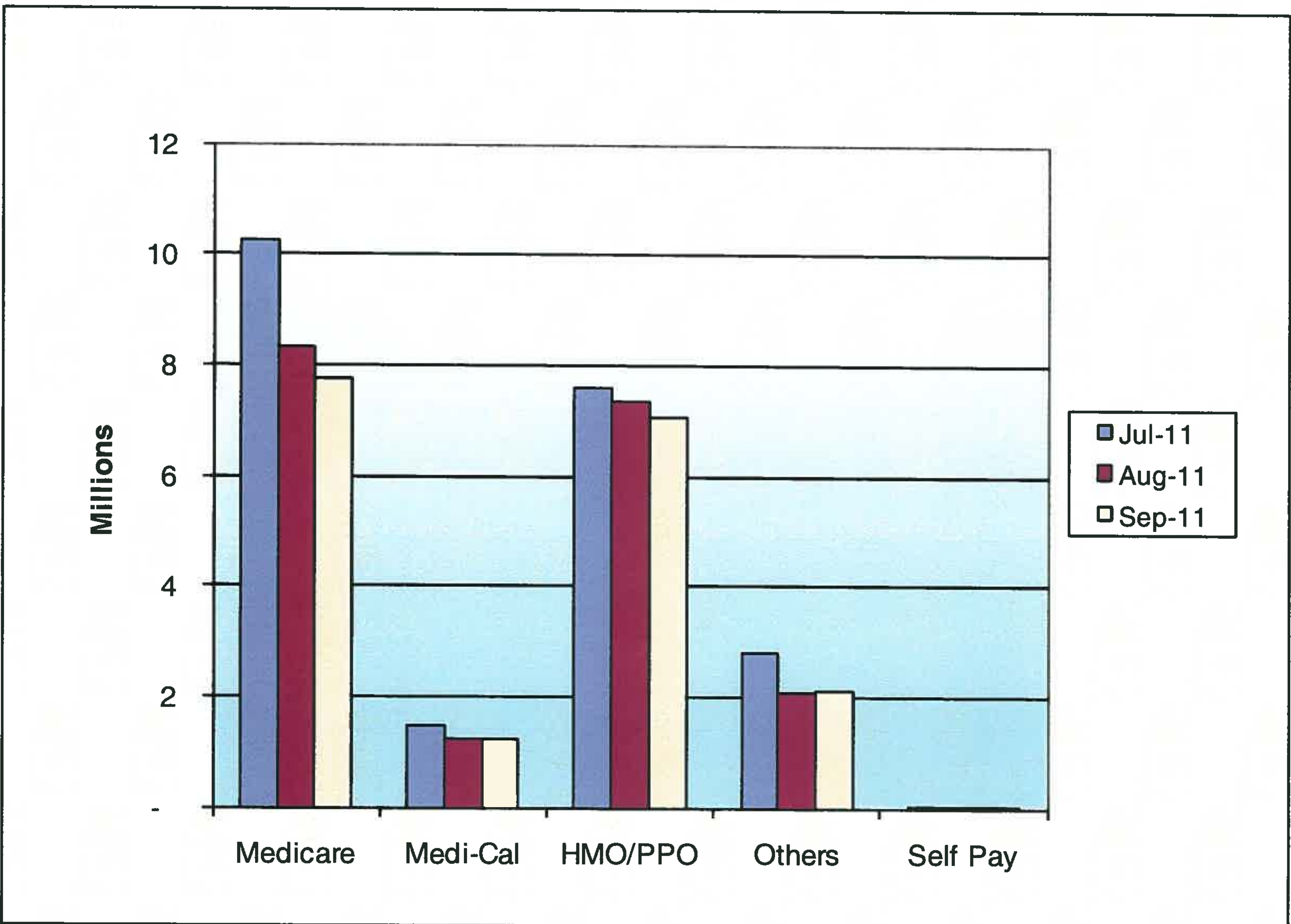
Salary Expense / APD



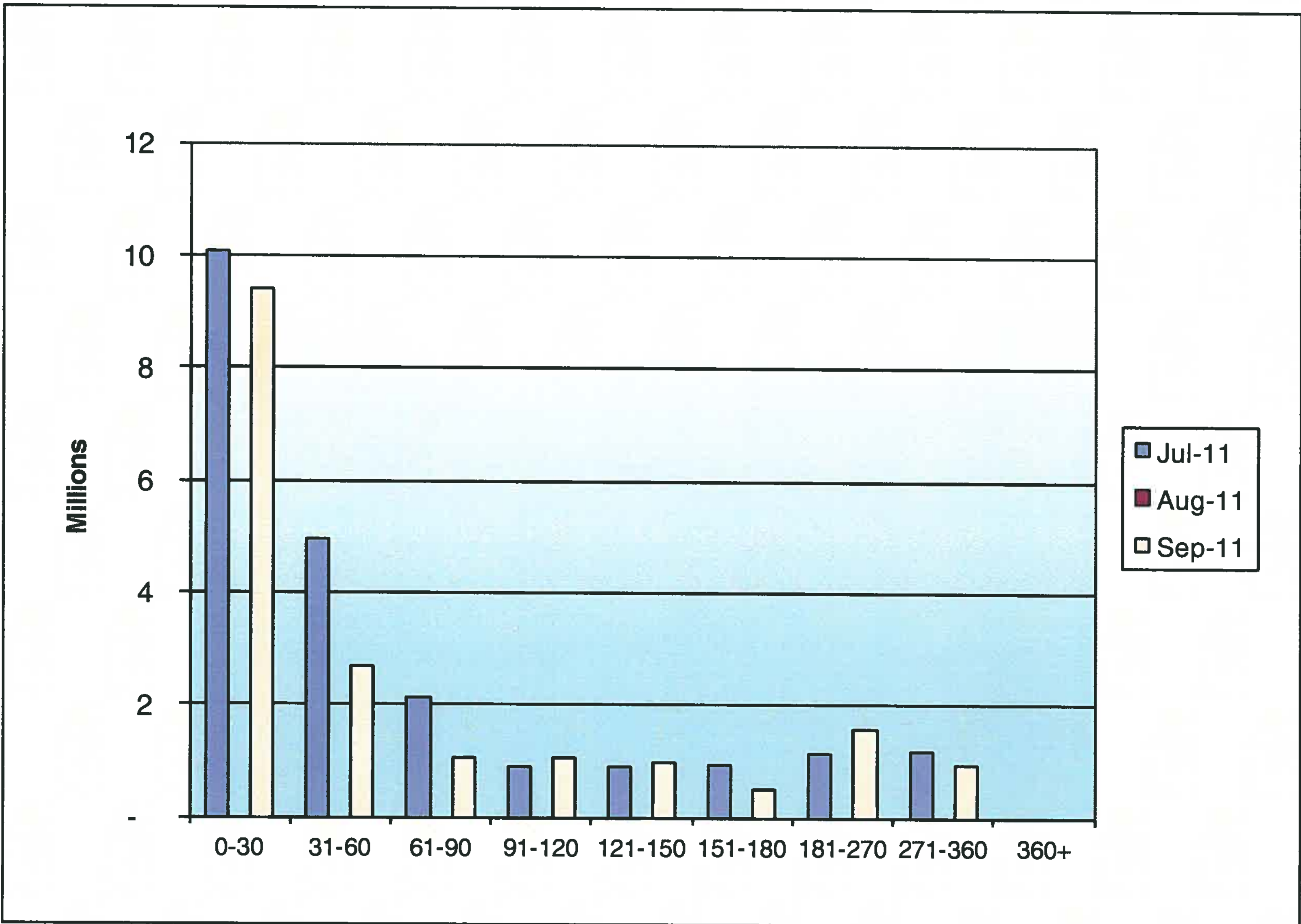
Financial Report Key Points

- Net Loss was $960K in September. Net Loss to date is $11M.
- Payroll and Supply expenses under budget for the 2nd straight month.
- Operating Cash in September was $2.4M or 6 Days.

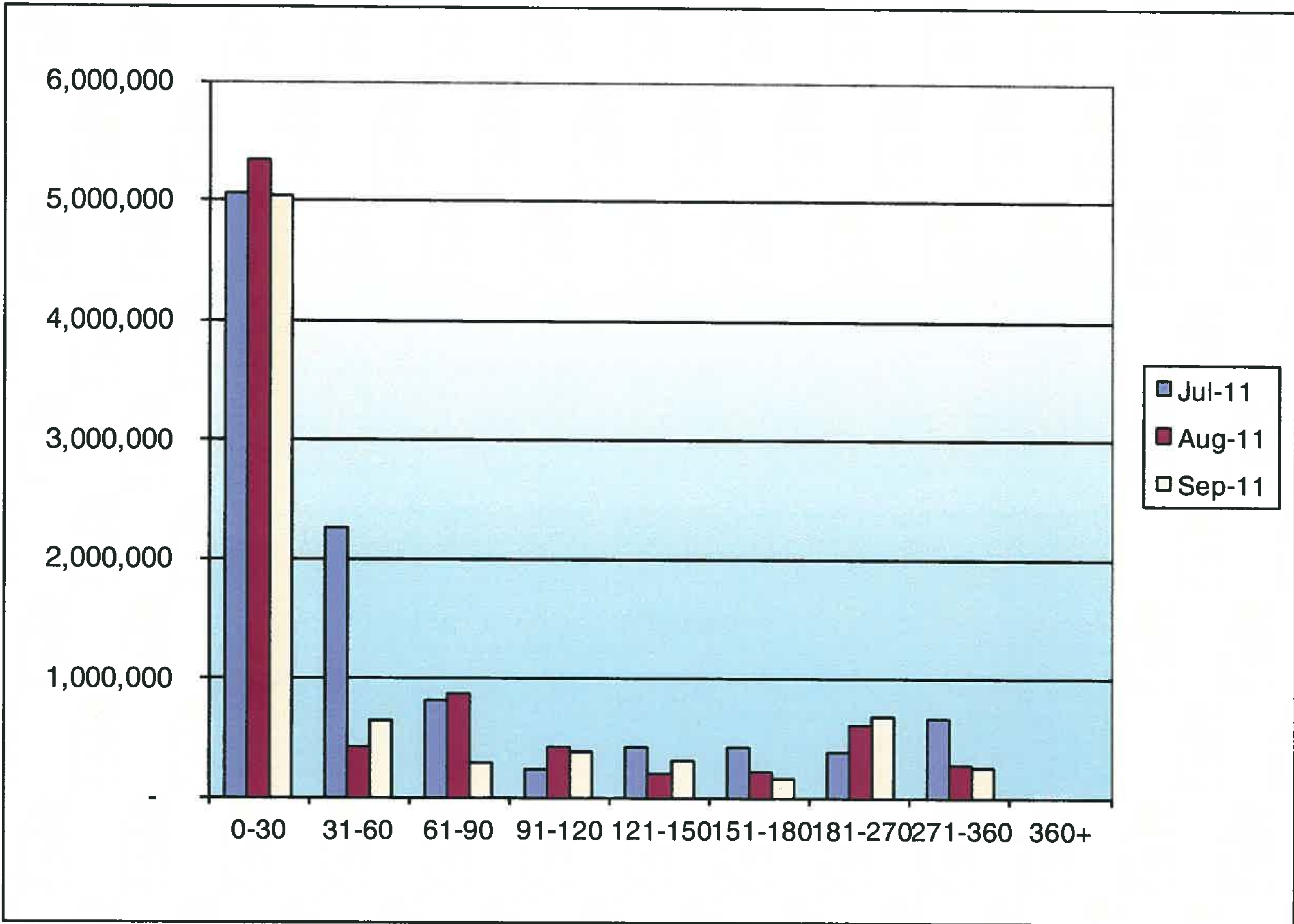
Net A/R by Payor



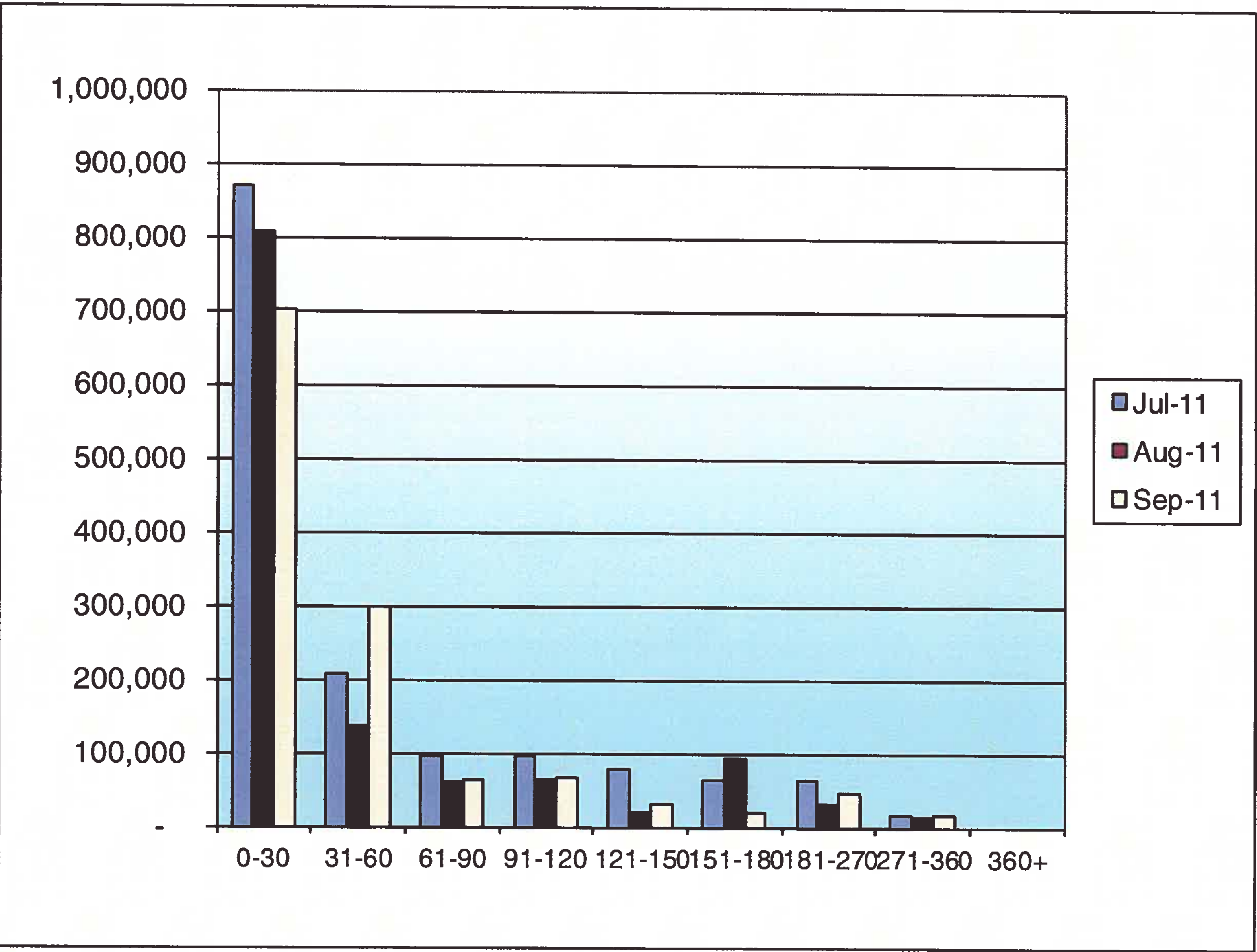
Aged Total Net Accounts Receivable



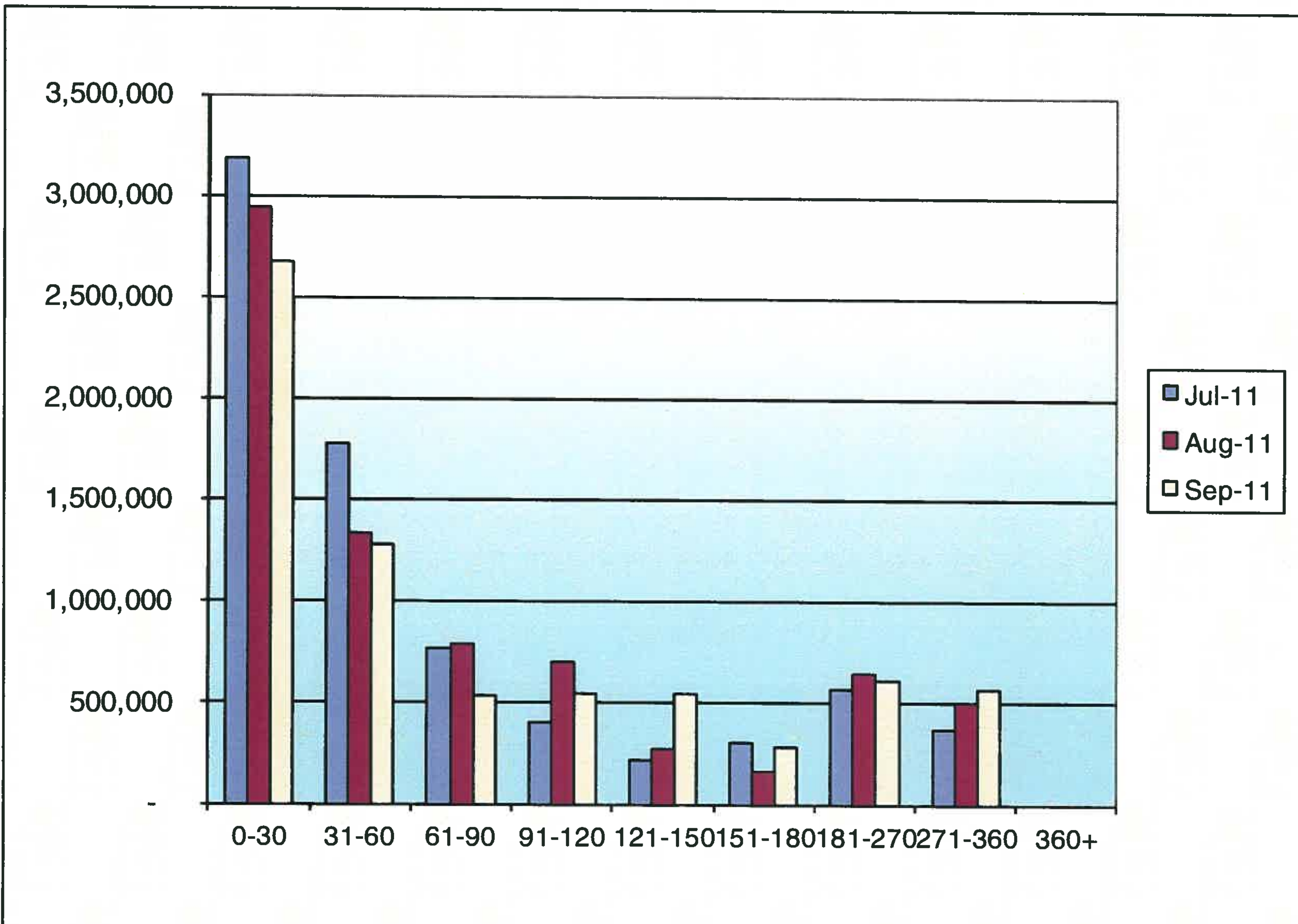
Net Medicare Receivables



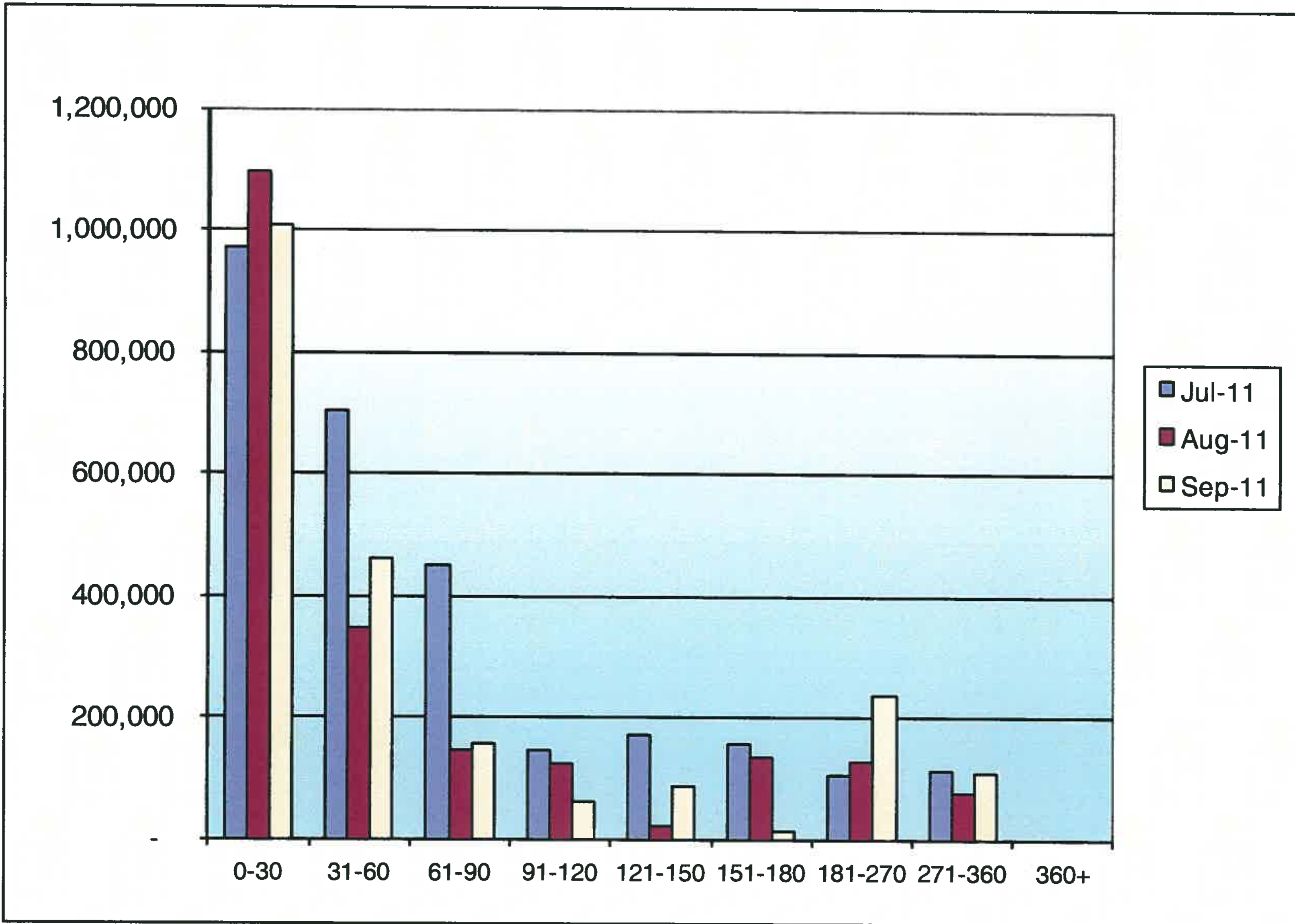
Net Medi-Cal Receivables



Net HMO / PPO Receivables



Net Other Payors Receivables



September 2011 Executive Report

Doctors Medical Center had a Net Loss of $960,000 in the month of September. As a result, net income was under budget by $1,534,000. The following are the other factors leading to the Net Income variance:

Net Patient Revenue Factors	Over / (Under)
HMO/PPO/ Commercial Volume	($1,952,000)
Medi-Cal/ Medi-Cal HMO	($251,000)
Medicare / Medicare HMO	($618,000)
Expenses	
Salaries & Benefits	$693,000
Professional Fees	($51,000)
Supplies	$274,000
Purchased Services	($132,000)
Restructuring Costs	($333,000)

Net patient revenue was under budget by $3,163,000. Gross charges were under budget in September 20.5%. Patient days were 22.8% under budget and discharges were 7.4% 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 $1,952,000 variance from budget. Our volumes in Medicare and Medi-Cal were also under budget resulting in missing the net revenue target.

Salaries and Benefits combined were under budget $693,000 while patient days were 22.8% under budget. Worked FTE's were under budget 16.3% as a reflection of the volume reduction. The normal flexing of staff for the volume decrease would have been $255,000 but we exceeded that amount by $336,000.

Professional Fees were over budget in July $51,000. Legal costs were over budget $51,000 due to the cost of labor negotiations.

Supplies were under budget $274,000. Our supplies should have been reduced by $203,000 based on our volume. We were able to flex supplies another $71,000 with most of this reduction in implant and pacemaker costs.

Purchased Services were over budget $132,000. Repairs and Maintenance for the facility was over budget by $35,000 in September. We also received a bill for an unbudgeted payroll audit that was completed for $33,000. Purchased services for lab test referrals and renal dialysis were over by $13,000 and $41,000 respectively.

Restructuring Costs in the month were $333,000. 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
September 30, 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	8,293	11,456	(3,163)	-27.6%	10,399	Net Patient Service Revenue	89,975	101,185	(11,210)	-11.1%	95,205
2	90	91	(1)	-0.6%	81	Other Revenue	942	853	89	10.4%	859
3	8,383	11,547	(3,164)	-27.4%	10,480	**Total Operating Revenue**	90,917	102,039	(11,122)	-10.9%	96,064
						OPERATING EXPENSES					
4	4,419	5,010	591	11.8%	5,153	Salaries & Wages	47,104	48,020	916	1.9%	47,498
5	2,474	2,576	102	4.0%	2,373	Employee Benefits	25,738	23,469	(2,269)	-9.7%	22,906
6	872	821	(51)	-6.2%	902	Professional Fees	7,659	7,391	(268)	-3.6%	7,552
7	1,393	1,667	274	16.5%	1,849	Supplies	14,999	15,821	822	5.2%	15,830
8	804	672	(132)	-19.7%	968	Purchased Services	7,525	6,687	(838)	-12.5%	6,967
9	218	219	1	0.4%	152	Rentals & Leases	2,238	1,919	(319)	-16.6%	1,364
10	350	350	0	0.0%	302	Depreciation & Amortization	3,118	3,137	19	0.6%	2,659
11	333	-	(333)		314	Restructuring Costs	1,209	-	(1,209)		-
11	342	323	(19)	-5.8%	314	Other Operating Expenses	3,029	2,909	(120)	-4.1%	3,028
12	11,205	11,639	434	3.7%	12,327	**Total Operating Expenses**	112,619	109,354	(3,265)	-3.0%	107,804
13	(2,822)	(92)	(2,730)	2973.6%	(1,847)	**Operating Profit / Loss**	(21,702)	(7,315)	(14,387)	196.7%	(11,740)
						NON-OPERATING REVENUES (EXPENSES)					
14	1,300	-	1,300	0.0%	(3,583)	Other Non-Operating Revenue	5,185	-	5,185	0.0%	9,059
15	708	754	(46)	6.1%	755	District Tax Revenue	6,415	6,787	(372)	5.5%	6,958
16	3	6	(3)	-48.8%	6	Investment Income	37	76	(39)	-51.4%	77
17	(149)	(94)	(55)	0.0%	(111)	Less: Interest Expense	(1,172)	(913)	(259)	28.3%	(1,046)
18	1,862	666	1,196	179.6%	(2,933)	**Total Net Non-Operating**	10,465	5,949	4,516	75.9%	15,048
19	(960)	574	(1,534)	-267.2%	(4,780)	**Income Profit (Loss)**	(11,237)	(1,385)	(9,872)	723.0%	3,308
						Profitability Ratios:					
20	-33.7%	-0.8%	86.3%		-17.6%	Operating Margin %	-23.9%	-7.2%	129.4%		-12.2%
21	-11.5%	5.0%	-16.4%		-45.6%	Profit Margin %	-12.4%	-1.3%	-11.0%		3.4%

WEST CONTRA COSTA HEALTHCARE DISTRICT
DOCTORS MEDICAL CENTER
INCOME STATEMENT
September 30, 2011
(Amounts in Thousands)

22	2,456	2,171	(285)	-13.1%	1,948	SWB / APD	2,257	2,067	(190)	-9.2%	1,947
23	61.5%	65.2%			61.1%	SWB / Total Operating Expenses	64.7%	65.4%			65.3%
24	3,992	3,331	(661)	-19.8%	3,190	Total Operating Expenses / APD	3,490	3,161	(328)	-10.4%	2,982
25	28,290	37,014	(8,724)	-23.6%	42,961	I/P Gross Charges	352,248	377,715	(25,467)	-6.7%	354,723
26	20,188	23,962	(3,774)	-15.8%	20,472	O/P Gross Charges	178,728	195,161	(16,433)	-8.4%	170,403
27	**48,478**	**60,976**	**(12,498)**	**-20.5%**	**63,433**	**Total Gross Charges**	**530,976**	**572,876**	**(41,900)**	**-7.3%**	**525,126**
						Payor Mix (IP and OP)					
28	38%	36%	2%		39%	Medicare %	40%	37%	3%		38%
29	10%	17%	-7%		16%	Medi-Cal %	14%	17%	-3%		17%
30	15%	15%	0%		14%	Managed Care HMO / PPO %	11%	14%	-3%		14%
31	11%	10%	1%		10%	Medicare HMO %	9%	10%	-1%		9%
32	11%	7%	4%		6%	Medi-Cal HMO %	11%	7%	4%		7%
33	0%	0%	0%		1%	Commercial %	0%	0%	0%		0%
34	2%	1%	1%		2%	Worker's Comp %	1%	1%	0%		2%
35	4%	3%	1%		2%	Other Government %	3%	3%	0%		3%
36	9%	10%	-1%		10%	Self Pay /Charity %	10%	10%	0%		10%
						STATISTICS					
37	479	517	(38)	-7.4%	518	Admissions	4,613	4,767	(154)	-3.2%	4,674
38	473	517	(44)	-8.5%	513	Discharges	4,628	4,767	(139)	-2.9%	4,667
39	1,638	2,121	(483)	-22.8%	2,617	Patient Days	21,408	22,806	(1,398)	-6.1%	24,423
40	54.6	70.7	(16.1)	-22.8%	87.2	Average Daily Census (ADC)	78.4	83.5	(5.1)	-6.1%	89.5
41	3.46	4.10	0.64	15.6%	5.10	Average Length of Stay (LOS)	4.63	4.78	0.16	3.3%	5.23
42	30	30			30	Days in Month	273	273			273
43	811	852	(41)	-4.8%	757	Adjusted Discharges (AD)	6,976	7,230	(254)	-3.5%	6,909
44	2,807	3,494	(687)	-19.7%	3,864	Adjusted Patient Days (APD)	32,270	34,590	(2,319)	-6.7%	36,155
45	94	116	(23)	-19.7%	129	Adjusted ADC (AADC)	118	127	(8)	-6.7%	132
46	67	94	(27)	-28.7%	78	Inpatient Surgeries	817	788	29	3.7%	784
47	113	116	(3)	-2.6%	107	Outpatient Surgeries	902	870	32	3.7%	849
48	**180**	**210**	**(30)**	-14.3%	**185**	**Total Surgeries**	**1,719**	**1,658**	61	3.7%	**1,633**

WEST CONTRA COSTA HEALTHCARE DISTRICT
DOCTORS MEDICAL CENTER
INCOME STATEMENT
September 30, 2011
(Amounts in Thousands)

49	2,933	3,453	(520)	-15.1%	2,860	ED Outpatient Visits	26,609	29,748	(3,139)	-10.6%	25,905
50	3,698	3,618	80	2.2%	3,618	Ancillary Outpatient Visits	33,325	29,905	3,420	11.4%	29,043
51	113	116	(3)	-2.6%	107	Outpatient Surgeries	902	870	32	3.7%	849
52	**6,744**	**7,187**	(443)	-6.2%	**6,585**	**Total Outpatient Visits**	**60,836**	**60,523**	313	0.5%	**55,797**
53	453	404	49	12.1%	433	Emergency Room Admits	4,059	3,783	276	7.3%	4,001
54	15.4%	11.7%			15.1%	% of Total E/R Visits	15.3%	12.7%			15.4%
55	94.6%	78.1%			83.6%	% of Acute Admissions	88.0%	79.4%			85.6%
56	546	653	106	16.3%	651	Worked FTE	659	660	1	0.2%	623
57	678	766	87	11.4%	763	Paid FTE	772	768	(5)	-0.6%	722
58	5.84	5.60	(0.24)	-4.2%	5.05	Worked FTE / AADC	5.58	4.83	(0.75)	-15.4%	4.70
59	7.25	6.58	(0.68)	-10.3%	5.92	Paid FTE / AADC	6.53	5.62	(0.91)	-16.2%	5.45
60	2,955	3,279	(324)	-9.9%	2,691	Net Patient Revenue / APD	2,788	2,925	(137)	-4.7%	2,633
61	17,271	17,451	(180)	-1.0%	16,416	I/P Charges / Patient Days	16,454	16,562	(108)	-0.7%	14,524
62	2,993	3,334	(341)	-10.2%	3,109	O/P Charges / Visit	2,938	3,225	(287)	-8.9%	3,054
63	1,574	1,434	(140)	-9.8%	1,334	Salary Expense / APD	1,460	1,388	(71)	-5.1%	1,314
64	3.8	4.6	0.81	17.6%	4.6	Medicare LOS	5.1	5.0	(0.19)	-3.7%	5.3
65	1.43	1.51	0.08	5.5%	1.48	Medicare CMI	1.57	1.56	(0.01)	-0.5%	1.54
66	2.67	3.06	0.39	12.7%	3.12	Medicare CMI Adjusted LOS	3.28	3.18	(0.10)	-3.2%	3.44
67	3.5	4.1	0.63	15.4%	5.5	Total LOS	4.6	4.8	0.21	4.4%	5.27
68	1.438	1.520	0.08	5.4%	1.555	Total CMI	1.495	1.517	0.02	1.4%	1.479
69	2.41	2.70	0.29	10.6%	3.50	Total CMI Adjusted LOS	3.06	3.16	0.10	3.0%	3.56

DOCTORS
MEDICAL CENTER

QUALITY REPORT

TAB 6

West Contra Costa County Health District Board Meeting

October 26, 2011

JULI MAXWORTHY, VP, QUALITY/RISK MANAGEMENT

SURVEY UPDATE

SURVEY UPDATE

- Stroke Certification
  - Joint Commission approved plans and we are certified as of September 30th
- Lab Recertification
  - Action plans to be submitted beginning of November to the Joint Commission
- MERP Survey
  - Received notification from California Department of Public Health of necessary follow-up and will submit by October 26th

CORE MEASURES

Quality/Patient Safety Metrics

Congestive Heart Failure (CHF)

Issue of patient receiving both of the last pages of their educational documents instead of it being included in their medical record. Improvements to process have already shown improvement in compliance.

Acute Myocardial Infarction (AMI)

- All AMI elements for 2Q 2011 are in the green (above 90%), no exceptions.

Congestive Heart Failure (CHF)

Measure	4Q 2010	1Q 2011	2Q 2011	Goal	Measure	4Q 2010	1Q 2011	2Q 2011	Goal
All Discharge Instructions	(49/66) 74.2%	(56/64) 87.5%	(53/63) 84.2%	90%-100%	Symptoms worsening instructions at discharge	95.4%	100%	100%	90%-100%
Activity instructions at discharge	93.9%	98.4%	100%	90%-100%	Weight monitoring instructions at discharge	(58/66) 87.8%	95.3%	93.6%	90%-100%
Diet instructions at discharge	95.4%	100.0%	100%	90%-100%	Evaluation of Left Ventricular Systolic (LVS) Function	100%	100%	100%	90%-100%
Follow-up instructions at discharge	90.9%	98.4%	100%	90%-100%	Medications: ACEI or ARB for LVSD[1]	96.9%	28/33 84.8%	24/27 88.8%	90%-100%
Medications instructions at discharge	95.4%	95.3%	90.4%	90%-100%	Adult smoking advice/ counseling	100%	100%	100%	90%-100%

Acute Myocardial Infarction (AMI)

Measure	4Q 2010	1Q 2011	2Q 2011	Goal	Measure	4Q 2010	1Q 2011	2Q 2011	Goal
Medication: Aspirin at arrival	96.9%	96.2%	100%	90%-100%	Percutaneous Cardiac Intervention (PCI) w/in 90 min of arrival	90.9%	(7/8) 87.5%	100%	90%-100%
Medication: Aspirin at discharge	98.3%	97.8%	100%	90%-100%					
Medication: ACEI/ARB for LVSD[1]	100%	100%	100%	90%-100%	Statin Prescribed at Discharge	94.6%	100%	100%	90%-100%
Smoking advice/ counseling	100.0%	100%	100%	90%-100%					
Medication: Beta blocker at discharge	96.2%	93.2%	97.3%	90%-100%					

[1]Left Ventricular Systolic Dysfunction (LVSD)

Quality/Patient Safety Metrics

Surgical Care Improvement Project (SCIP)

Ongoing education continues with staff

Surgical Care Improvement Project (SCIP)

	4Q 2010	1Q 2011	2Q 2011	Goal		4Q 2010	1Q 2011	2Q 2011	Goal
Antibiotics within 1 hour	94.6%	91.6%	96.6%	90%-100%	Periop Temp Mgt	100%	100%	100%	90%-100%
Antibiotics Selection	97.2%	100.0%	100.0%	90%-100%	Beta Blocker Perioperative	100%	100%	100%	90%-100%
Antibiotics discontinued within 24 hours	(27/36) 75%	95.6%	96.5%	90%-100%	VTE Prophylaxis Ordered	92.8%	91.2%	9[illegible].3%	90%-100%
Hair Removal	100%	100%	100%	90%-100%	VTE Prophylaxis Timely	90.4%	93.9%	(41/46) 89.13%	90%-100%
Urinary Catheter Removed Post-Op Day 1 & Day 2	94.4%	90.0%	94.7%	90%-100%					

Pneumonia (PN)

- The forms have been updated to show Pneumonia antibiotic recommendations for ICU and non-ICU patients.

- Antibiotic MONOtherapy for patients admitted to the ICU is a fallout. The recommended PNA antibiotic selection is listed on the back of the core measure alert form.
- Currently, due to a low numerator or denominator ratio (5/6), antibiotic selection for ICU patients is at 83.3%.

	4Q 2010	1Q11	2Q 2011	Goal		4Q 2010	1Q 2011	2Q 2011	Goal
Pneumococcal vaccination	(27/31) 87.1%	100%	100%	90%-100%	Antibiotic selection for ICU/non-ICU patients	100%	100%	91.6%	90%-100%
Blood Culture within 24 hrs of arrival-ICU	100%	100%	13/15 86.6%	90%-100%	Antibiotic selection for ICU patients	100%	100%	(5/6) 83.3%	90%-100%
Blood Culture in ED prior to initial Antibiotic	96.9%	93.9%	95.6%	90%-100%	Antibiotic selection for Non-ICU patients	100%	100%	94.4%	90%-100%
Adult smoking advice/ counseling	100%	100%	100%	90%-100%	Influenza vaccination	97.2%	92.1%	N/A	90%-100%
Antibiotics within 6 hours of arrival	100%	97.1%	95.6%	90%-100%					

APPROPRIATE CARE MEASURES (ACM)

- Starting **January 1, 2012**, the Joint Commission will be expecting hospitals to achieve a composite score for the ACM of at least 85%.
- The ACM will be based on the 27-indicators (7 AMI, 4 HF, 6 PNE and 10 SCIP indicators). All patients eligible for care in at least one of the 27 indicators are counted in the denominator. The patients receiving all the care they are eligible for are counted in the numerator.
- An example is below:

Topic	# Patients	# Patients meeting ACM criteria	ACM
AMI	**5**	**2**	**40%**
HF	**10**	**5**	**50%**
PNE	**10**	**8**	**80%**
SCIP	**5**	**5**	**100%**
Total	**30**	**20**	**67%**

FALLS

Quality/Patient Safety Metrics

Patient Safety: Falls								
Indicator	*January 2011*	*February 2011*	*March 2011*	*April 2011*	*May 2011*	*June 2011*	*CALNOC Benchmark*	*Total*
Total Falls (Inpatient and Outpatient)	6	19	17	16	17	13	N/A	88
Total Falls With Injury (Inpatient and Outpatient)	0	0	2	0	0	0	N/A	2
% Falls with Injury	0%	0%	12%	0%	0%	0%	N/A	2%
Rate: Falls (Per 1,000 Patient Days)	1.531	5.282	3.712	4.088	4.442	3.551	2.94	3.738
Rate: Falls with Injury (Per 1,000 Patient Days)	0	0	0.464	0	0	0	0.1	0.133

PATIENT SATISFACTION

Patient Satisfaction (HCAHPS)

INDICATOR	Threshold	Target	Goal	3rd Qtr 2010	4th Qtr 2010	1st Qtr 2011	2nd Qtr 2011	1st to 2nd Qtr 2011
Patient Satisfaction -Top Box Scores(HCAHPS)	US Average	CA Average	DMC	Top Box	Top Box	Top Box	Top Box	%Change
Number of Surveys Returned	CMS Required Minimum= 300+ Annually			281	276	314	279	N/A
Mean Score (Related to Press Ganey Supplemental Questions)	Unavailable	Unavailable	80%	78%	80%	77%	**76%**	↓ 1%
Patients who gave DMC a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest).	67%	63%	63%	48%	48%	48%	**44%**	↓ 4%
Patients who reported YES, they would definitely recommend the hospital.	69%	67%	67%	51%	50%	45%	**49%**	↑ 5%
Patients who reported that their nurses "Always" communicated well.	76%	71%	71%	60%	65%	64%	**60%**	↓ 4%
Patients who reported that their doctors "Always" communicated well.	80%	76%	76%	71%	77%	70%	**71%**	↑ 1%
Patients who reported that they "Always" received help as soon as they wanted.	64%	57%	57%	41%	49%	44%	**44%**	–
Patients who reported that their pain was "Always" well controlled.	69%	66%	66%	56%	66%	59%	**56%**	↓ 3%
Patients who reported that staff "Always" explained about medicines before giving it to them.	61%	56%	56%	49%	48%	51%	**46%**	↓ 5%
Patients who reported that the area around their room was "Always" quiet at night.	58%	48%	48%	36%	46%	38%	**38%**	–
Patients who reported that their room and bathroom were "Always" clean.	71%	68%	68%	67%	70%	61%	**59%**	↓ 2%
Patients who reported that YES, they were given information about what to do during their recovery at home.	81%	79%	79%	75%	70%	74%	**71%**	↓ 3%

Action Plans

AIDET: Implement house-wide to improve communication between caregivers and patients.
HCAHPS: Training to new Managers to closely monitor and track unit scores and patient comments. Weekly reports being distributed and discussed with charge nurses and frontline staff.
Patients receiving new Patient Guides to provide information on completing surveys and reminding them of ways to ensure they receive optimal care.
Dawn Gideon speaking about scores at Town Hall and Unit Meetings

Definitions

Top Box- HCAHPS response rates of patients who provided the highest score in each domain or stand alone question. Example: Definitely Yes, Always and 9-10
Mean Score- An average of all Press Ganey Supplemental question responses based on a 0-100 scoring system. Example: Very Poor=0, Poor=25, Fair=50, Good=75, Very Good=100

PRESSURE ULCERS

Quality/Patient Safety Metrics

Patient Safety: Pressure Ulcers							
Indicator	*Apr-Jun 2010*	*Jul-Sep 2010*	*Oct-Dec 2010*	*Jan-March 2011*	*Apr-June 2011*	*Beacon 10/28/10 Benchmark*	*Total*
Total HAPU Reportable Events: Stage III, IV, and Unstageable	0	0	1	0	0	N/A	1
Patient Skin/ Wound Integrity Events (All reported events)	79	56	42	57	33	N/A	267
Hospital Acquired Pressure Ulcer (HAPU) Rate: Adjusted Patient Days	0	0.262	0.185	0.169	0.268	Beacon Collaborative Benchmark 0.2	0.175

DOCTORS
MEDICAL CENTER

MEDICAL EXECUTIVE REPORT

TAB 8

DOCTORS
MEDICAL CENTER

MEDICAL EXECUTIVE COMMITTEE
REPORT TO THE BOARD OF DIRECTORS
<u>OCTOBER 2011</u>

ITEM	ACTION
A. CHIEF OF STAFF REPORT	Informational
B. POLICIES, PROCEDURES & FORMS REPORT October 2011	Approval
C. CREDENTIALS REPORT – September 2011	Approval

DOCTORS
MEDICAL CENTER

MEC APPROVAL DATE: 10/17/11

BOARD OF DIRECTORS APPROVAL DATE: 10/26/11

POLICY, PROCEDURE AND FORMS REPORT

October 2011

IN ACCORDANCE WITH MEDICAL STAFF BYLAWS, REGULATORY AND ACCREDITATION STANDARDS, THE POLICIES, PROCEDURES AND FORMS LISTED BELOW HAVE BEEN DEVELOPED AND/OR REVISED BY APPROPRIATE HOSPITAL AND/OR MEDICAL STAFF COMMITTEES AND HAVE BEEN APPROVED BY THE MEDICAL EXECUTIVE COMMITTEE.

**NOTE: COPIES OF ALL POLICIES LISTED IN SECTION A AND SECTION B 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 MEDICAL STAFF OFFICE AND ADMINISTRATION.*

POLICY/PROCEDURE/FORMS	TYPE	REASON FOR REVIEW
A. Revised With Major/Substantive Changes 1. Patient Controlled Analgesia (PCA) Policy and Flowsheet	IV Medication Policy & Procedure	Revised to reflect current practice, including the guidelines for the set up and use of patient controlled analgesia, and ensure compliance with Joint Commission Standards.

DOCTORS MEDICAL CENTER

Manual: IV/MEDICATION	Sub Folder:
Title: PATIENT CONTROLLED ANALGESIA	Reviewed: 08/2002 Revised: 07/00, 08/05, 06/10
Effective Date: 7/98	Page 1 of 14

PURPOSE:

To outline nursing management responsibilities and a guideline for the set up and use of patients receiving patient controlled analgesia. The Patient Controlled Analgesia Protocol (PCA) is a multidisciplinary approach toward providing controlled analgesia via an infusion pump in a safe and effective manner. The major objective of PCA is to suppress pain and minimize narcotic dosage requirements and side effects such as respiratory depression, sedation and decreased cough reflex. The PCA pump is designed to administer narcotic analgesics intravenously in a continuous flow mode (basal infusion), patient request mode, or a combination of the two. In addition, the nurse has the ability to bolus the patient as needed when ordered by the physician.

POLICY:

1.0 Patient Controlled Analgesia (PCA) is started and discontinued according to physician's orders using the PCA order form.

2.0 In order for a patient to effectively and safely use a PCA pump, the patient must be able to understand the relationship between pain, pushing the PCA button and pain relief. The patient and family members will be educated about the PCA pump and how it works prior to its initiation.

2.1 Teach patients and family members about the proper uses of PCA and the dangers of others pressing the button for the patient. Provide literature and teach patient about PCA when patient is started on PCA. Literature can be obtained via Krames on Demand. Provide written instructions and educate family members NOT to administer PCA doses. The use of the PCA will enable the patient to participate in their pain management plan of care.

2.2 All teaching will be documented on the Interdisciplinary Plan of Care (IPOC).

3.0 The patient must also be able to physically self-administer a PCA dose using the available equipment. The PCA button (delivery pendant) is to be pushed by the patient only.

3.0 All PCA pumps will be initiated by an RN when orders have been written.

3.1 Some patients may not be appropriate candidates to receive PCA. The following criteria should be considered as exclusion criteria for PCA:

a. Age – infants and young children
b. Mental State – patients that are confused agitated and restless

c. Level of consciousness, psychological stability or intellectual capacity

3.2 When assessing a patient for Patient Controlled Analgesia, identify risk factors such as:
a. Age
b. Weight
c. Pre-existing conditions including allergies, renal function, and current medication use that may suggest increased monitoring.

4.0 Obtain orders for medication on pre-printed PCA Order Sheet.

5.0 PCA can be ordered by an anesthesiologist, surgeon or primary physician. However, use of PCA devices must be approved by the surgeon and/or physician.

6.0 Every 24 hours the PCA pump usage should be evaluated by the managing physician to determine if the patient will benefit from continued therapy.
Only RNs who have been in-serviced with PCA may initiate and change rates on PCA infusion pumps.

7.0 Two RNs will verify the correct settings and both must sign the PCA flow sheet when:
a. Initially programming and setting up the PCA device,
b. At shift change,
c. When changing dosing parameters, drug, or giving a bolus
d. When discontinuing PCA and wasting syringe contents.

8.0 The RN may adjust dose as needed within ordered parameters, utilizing patient assessment.

8.1 Carefully monitor patients. Even at therapeutic doses, opiates can suppress respiration, heart rate and blood pressure, so the need for monitoring and observation is critical. Patient will be monitored every 2 hrs X 4, then every 4 hrs until PCA is discontinued after PCA has been initiated and will be documented on the PCA Flow sheet form. Oximetry monitoring may be appropriate in some cases.

8.2 After adjusting a dose setting or giving a bolus, the patient must be reassessed in 30 minutes.

9.0 Data may be collected by trained nursing personnel including RN, LVN, Interim Permitee or Student Nurse. Data consists of pump settings, VS, level of sedation, side effects, and pain level as determined by the patient.

10.0 Nursing assistants may assist in collecting pain control data in addition to the above listed nursing personnel.

11.0 Warning labels on all PCA machines stating: "Patient Only".

DEFINITION/OVERVIEW: (If Needed)

1.0 **Opiate Tolerant** – "Patients who are considered opioid-tolerant are those who have been taking, for a week or longer, at least 60 mg of morphine daily, or at least 30 mg or oral oxycodone daily, or at least 8 mg or oral HYDROmorphone daily, or an equianalgesic dose of another opioid." *(Food and Drug Administration)*

2.0 **Opioid Naïve** – Patients who do not meet the definition of opioid tolerant, who have not had narcotic doses at least as much as those listed above for a week or more, are considered to be opioid naïve.

3.0 **Loading dose (initial bolus)** - Initial dose given to patient as ordered by physician. All bolus doses must be administered by RNs and BP, R, pain level, and LOC monitored closely.

4.0 **Lockout interval** - period during which the PCA cannot be activated and no analgesic can be delivered by patient. NOTE: A bolus dose can be given during lockout interval if ordered and needed.

5.0 **Bolus dose** - an additional dose given to a patient on a PRN basis - ordered by physician. All bolus doses must be administered by RN and BP, R, LOC, and pain level monitored closely.

6.0 **4° Cumulative Limit** - The maximum amount of narcotic patient can receive in 4 hours (use only when further restriction is required).

7.0 **Upper soft limits (USL)** of medication doses will be indicated on the screen by a constant upward arrow above the dose.

8.0 **Upper hard limits (UHL)** of medication doses are not allowed and must be changed before proceeding with the dosage set up.

9.0 **Hard upper limit 4 hour** maximum doses are built into the library of the medications and cannot be altered.

10.0 **Patient pain assessment** (on flow sheet) using Wong Baker pain scale of 0 - 10
0 = comfortable, 5 = moderate, 10=unbearable.
Important: patient assesses his or her own pain: nurse documents.

PROCEDURE:

III. EQUIPMENT

- *Hospira* LIFECARE PCA® infuser
- PCA order set completed by the physician
- PCA continuous set with injector

- PCA extension tubing
- Pre-filled analgesic syringe (30 ml) (from automated medication dispensing system)
- Primary IV pump
- Primary IV pump tubing
- Maintenance IV fluids
- PCA pump key from the floor/unit automated medication dispensing system
- PCA Record
- PCA teaching materials.

* Naloxone (narcan) = 0.4 mg/ml minimum 3 vials - must be available in automated medication dispensing system (Omni cell) and not attached to the bedside.

PROCEDURE	PERTINENT DATA
1. Obtain completed PCA Order Set from physician. Orders must specify drug, drug concentration, mode of delivery, dose, lockout interval, 4 – hour cumulative limit, and all other appropriate information for the PCA therapy.	PCA order set **must** be used and scanned to pharmacy. Orders and parameters written on a blank physician order sheet are discouraged. Bypassing this safety measure can be harmful to the patient.
Obtain order regarding the intravenous solution which is to be used in conjunction as a "KVO" IV line when no primary IV is in place.	If not ordered elsewhere, start: D5W at TKO (15 ml) per PCA orders.
2. Obtain equipment needed, medication and new PCA Record. Assure the PCA Brochure is on the pump and the PCA delivery pendant is labeled "Stop! Button for patient use only!".	Notify Central Distribution (UHS) to replace any missing brochure or label.
3. Continuous pulse oximetry is required if patient is 65 years or older, morbid obesity with BMI or greater than or equal to 35, has history of asthma, COPD, history of obstructive sleep apnea, history of snoring, history of excessive daytime sedation, history of hypertension or is prescribed continuous infusion with PCA therapy.	
4. Confirm allergies.	Document allergies on PCA record.
5. Transcribe the PCA settings onto a blank PCA Record from the physician's PCA order set.	The current PCA Record is to be filed as the first page in the Scheduled Medication section of the MAR binders. File the completed PCA record as the first page in the Medication Administration Record (MAR) section of the chart.
6. Inspect the PCA syringe for cracks. Assemble the syringe to the PCA injector.	If the vial is cracked, discard the vial in the blue stericycle container with a witness and document the waste in the OmniCell. Morphine and Meperidine syringes need to be assembled with the PCA injector. Fentanyl and hydromorphone will come with the injector already assembled by pharmacy.

7. Unlock the PCA pump, open the door, and secure the equipment to the IV pole just below the primary pump (for initial set up).	When the PCA door is locked the pole clamp is also locked to prevent theft. It is not necessary to manually "Power On" the machine. The PCA pumps for patients with existing IV fluids are secured to the IV pole at the bedside when the set up is completed.
8. Squeeze the cradle release mechanism together at the top of the holder and move to the uppermost position.	Always confirm the bar code reader window is clean before inserting the syringe. To clean the window wipe with a dry, soft, clean cloth or alcohol swab.
9. Insert the bottom of the syringe into the middle black bracket of the cradle. Ensure the bar code label faces the bar code reader on the right side.	Positioning the syringe into the upper clip first can crack or chip the syringe.
10. Gently press the upper end of the syringe into the upper black bracket of the cradle.	
11. Squeeze the cradle release mechanism together and move down until the injector snaps into the bottom bracket.	Inserting and loading a vial will automatically "Power On" the PCA equipment. The bar code reader will read the bar code at this time.
12. The infuser will complete a *"Self Test".* The next screen will indicate the test is complete. The screen will also show *System Settings* and *Continue.*	If the bar code is not read the system will not continue. Slowly rotate the vial and position the bar code on the right until it can be read. *System Settings* will change the volume of the alarm, contrast of the screen, and time/date of the equipment.
13. The next screen confirms the medication and previous settings are cleared.	The system will retain the previous syringe information and history if the machine has been turned off for less than four hours.
If the system has retained the history it will indicate *New Patient.* Select *Yes* or *No.*	*Yes* > New Patient or changing type of medication for the same patient, i.e. Morphine to Fentanyl (all history and settings will clear). *No* > Changing syringe but not the medication.
14. Next screen is to confirm the medication and concentration. If correct enter *Confirm.*	Remove the vial if the medication and concentration is not correct as displayed on the screen.

15. Select *Continue*. The screens will display a series of questions.	Read closely and choose the correct response. At any time you may return to the previous screen by selecting *Previous*.
If the machine has been off for more than four hours. *New Patient* appears. Select *Yes* or *No*.	*No*> the history and medication settings are retained. *Yes*> the history and medication settings are cleared.
16. Select Clinical Care Area (CCA).	**Again** select and confirm the correct medication and concentration.
17. Attach the syringe to the long end of the PCA tubing. Prime the short end of the PCA tubing with the ordered IV fluids (for initial set up) or Normal Saline (for setting up to a patient with existing IV fluids or when changing the tubing).	The syringe and tubing set must **NOT** be connected to the patient when priming with the pain medication or setting up the machine settings.
18. Late and Time tubing change on label and affix to tubing	Tubing change is done every 72 hours.
19. *Purge?* Select *Yes* or *No*.	Select *Yes*> CAUTION: Disconnect the PCA set from the patient before starting purge cycle. Press and hold purge key. Stop purging after flow is seen at the end of the PCA set. Purging through the PCA enables the machine to subtract the amount from the syringe used to prime the tubing.
20. *Set Loading Dose?* Select *No* unless there is a second RN available to verify that the pump has been programmed correctly. If a second RN will be available to confirm the final settings, select *Yes,* program the loading dose and choose *Deliver Later* to finish programming the PCA machine.	**A loading dose cannot be administered until the pump settings are verified by a second RN.** Bypassing this safety measure can be harmful to the patient.
21. *Select Delivery Mode?*	
PCA Only	Administers the dose only at patient request.
PCA + Cont.	Delivers a continuous rate and allows patient to receive doses when requested.

Continuous

Delivers a preset continuous rate.

22. Program the PCA dose.

Enter the amounts using the key pad on the front of the machine and press *Enter* after each selection.

23 Program the lockout interval.

This is the amount of time the pump is "locked out" between patient doses. NOTE: Administering a loading dose or bolus will put the patient in lockout.

24. Program continuous rate if ordered.

25. Program the four hour dose limit if ordered.

This limits the total dose that can be delivered in a four hour period. The machine will ask you to *Confirm No Dose Limit* if this option is not selected and an amount entered.

26. Confirm all settings comparing them to the PCA record with a second RN. Close and lock the door of the PCA pump.

The second RN must verify against the PCA physician orders:

- Correct medication
- Correct concentration of medication
- Correct dose
- Correct lockout interval
- Correct rate (if continuous)
- Correct four hour limit
- Any changes made to settings

NOTE: The second RN must verify the settings at this point in order to infuse the loading dose on the next screen.

27. If the second RN is not available, select *Confirm. Cancel* the loading dose, close and lock the PCA door.

The second RN must then confirm the settings by pressing *History* on the front of the machine. Press *Exit* once the settings are verified to exit the next machine history screens.

It is not necessary to open the PCA door to verify the settings using *History*.

Pressing *Silence* before *History* will silence the alarm while confirming the settings in this manner.

28. Compare patient's ID bracelet to

Ask patient to state their name and date of

physician's order set and PCA Record.

birth (if able) and use 2 patient identifiers.

29. Attach distal end of primed PCA set to the patient IV access device and establish flow of primary IV fluids.

Primary IV fluids must run at least TKO rate (20 ml) to carry the medication through the tubing.

30. Give the PCA button to the patient and press *Start/Pause* to begin continuous infusion if ordered.

The PCA button is not given to the patient, if loading dose infused, or continuous rate started until the settings have been verified by a second RN.

31. Explain use of the pump to the patient. Provide patient and/or family with PCA education material.

The patient must be able to understand and comply with instructions and be physically able to administer the PCA dose.

32. Explain to patient, family and other visitors that the pump is to be **used by the patient ONLY**. Document this instruction on the PCA Record and IPOC teaching section.

Pump use by patient's family or other visitors can be very harmful to the patient. A sedated patient will not push the PCA button. Bypassing this safety measure causes over sedation and is potentially dangerous to the patient.

33. Verify the warning tag (**Stop! Button for patient use only**.) is attached to the PCA pendant – show this to the patient, family and other visitors.

Notify Central Distribution (UHS) if label is missing.

34. The patient's RN will verify PCA settings on transfer, at beginning and end of each shift. Compare pump settings with the most current order information on the PCA Record and PCA Physician order and verify the pump is programmed correctly.

Verification of settings on transfer and each shift is charted on the PCA Record and does not require a witness. However, at the beginning and end of each shift, it is required to have an RN witness to verify settings, credit, and dose history. Press the *History* button at any time to verify settings. The settings will appear in the display. Press *Exit* to return to the previous display. (The PCA settings on the PCA Record are verified with the physician's order by the initiating RN at the time of transcription to the PCA Record.)

35. Record pain scale, descriptors, Level of Consciousness, Saturation, BP, P, and respiratory rate with the initiation of pump or with any setting changes. Check every two hours X 4, then every four hours thereafter and record. This information is documented on the flow sheet.

Refer to Pain Management Guideline
LOC will be evaluated with the following scale:

- A - Alert
- D – Drowsey
- CF – Confused
- S – Stuporous

CM - Comatose
If respiratory rate is ≤ 8, administer Narcan per orders and place on oxygen STAT. Notify physician.

36. Perform pain assessment using 0-10 pain scale.

Refer to Pain Management Guideline
Notify physician for inadequate pain control.

37. If adverse signs occur (as below), press *STOP* and call physician:
   a. Over sedation (e.g., changes in LOC)
   b. Respiratory rate less than (8) per minute or as ordered.
   c. Significant nausea or vomiting
   d. Allergic reaction
   e. Decrease in BP
   f. Confusion

38. Assess patient's pain level; if patient is comfortable and is not using PCA frequently (0-2 doses every two (2) hours X one shift), confers with physician about increasing lockout interval, or decreasing basal or PCA dose.

39. Assess bowel function and document on the Graphic Flow Sheet daily and notify physician if no BM X two (2) days.

40. Assess if patient is in pain, and if not receiving his maximum hourly dose:
   a. Check pump for proper operation and settings
   b. Re-instruct patient in how to operate pump.

Assess for continued complaint of pain. If patient is in pain and is using his maximum hourly dose X 2 hours, confer with physician about decreasing lockout interval, or increasing basal or PCA dose.

41. Begin a new PCA Flow Sheet and PCA Physician Order any time new medication or settings are entered in the infuser.

Follow the preceding steps when changing type and/or concentration of medication.

42. "PCA" is recorded on the pain intervention section of the Nursing Flow Sheet to indicate

PCA
as the type of intervention.

43. Document any bolus doses on the PCA Flow Sheet and also as an intervention on the Nursing Flow Sheet.

Additional pain medications or sedatives ordered by the service managing the pump or the Department of Anesthesia – Pain Management Services are charted on the Scheduled (one time only doses) or PRN MAR.

44. Initiate Pain Nursing Diagnosis and Care Plan on IPOC.

Update the Pain Care Plan at least daily on the IPOC.

45. Change tubing at least every 96 hours with a syringe change.

Do not interrupt syringe infusion to change tubing. If tubing is due to expire, change it earlier if necessary to avoid interruption of syringe infusion.

46. *Total Delivered* is **only** cleared when the syringe is changed. However, the 8 hour total and usage is recorded on the record every 8 hours at the end of the shift.

47. Making changes after the initial set up of the PCA equipment:
Anytime the PCA door is unlocked and/or opened, the PCA will pause and the medication cannot be dispensed.

The screen will display several options:
Loading Dose – Select to set up and give a loading dose or bolus.
Change RX - Select to change the PCA mode or dose.
Clear Shift – Select *Yes* > when changing the syringe but not changing the medication.
Change CCA – Select when changing **type** of medication.
The next screen will warn you that *Changing CCA will clear the RX settings.* Continue or return to previous screen.

Read closely and choose the correct response.

When you select and enter the dose, the next screen will ask you to verify the dose. NOTE: The start button will infuse the dose with the door open.

Changes must be verified by a second RN.

Read closely and choose the correct response. The system will confirm clearing the history. Continue to set up the PCA dose from the new PCA order set for the new medication. A second RN must verify the new medication and settings.

48. Use AC power when the equipment is being used and during storage to ensure a fully charged battery.

Internal battery use for emergency backup and temporary portable operation is approximately 2.5 hours.
The intermittent "Low Battery" warning alarm will sound when the battery is low (approximately 30 minutes before power is drained). If the equipment is not connected to an AC outlet and the battery drains, the pump will turn off. The continuous "Dead Battery" alarm will sound.
The history and information will be stored **IF** the lithium battery still has power. If the lithium battery is drained all information will be lost.

NOTE: The wireless antenna on the top of the machine will drain the battery when unplugged from AC power whether the pump is in use or not.

PROTOCOL

Patients going to surgery who have a PCA pump must have the PCA pump disconnected prior to leaving the floor. The opioid will be wasted with a witness 2nd RN in OmniCell when the syringe is removed from the pump. Document this action on the PCA record. Document the type of opioid and time discontinued on the pre-op checklist in the medication section.

Changes made to any PCA settings must be verified by a second RN. The nurse verifying the new settings must time and sign in the appropriate space on the PCA record.

REFERENCES

PI Data from SLH Medication Error Team Jan 2001 - June 2002

PATIENT SAFETY-L Digest 2Oct 2002 to 7Oct 2002 (#2002-218)

Area standards from local facilities

Institute for Safe Medication Practices, "Smart" infusion pumps join CPOE and bar coding as important ways to prevent medication errors; February 7, 2002 issue

JCAHO Sentinel Event Alert Issue 33

McCaffery and Pasero, Pain Clinical Manual, Mosby 1999.

Hospira LIFECARE PCA®, System Operating Manual, 430-04685-004 (Rev. 01/06)

Institute for Safe Medication Practices, (7/2003). *Pain control in hospitals using patient-controlled analgesia must be made safer.* Preventing medication errors.

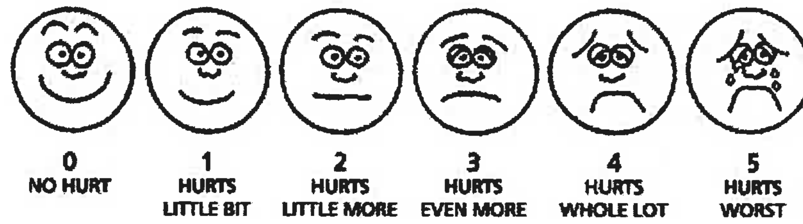
Institute for Safe Medication Practices, (7/2003). *How to prevent errors - Safety issues with patients controlled analgesia.* Medication safety alert.

Joint Commission International Center for Patient Safety, (12/2004). *Patient controlled analgesia by proxy.* Sentinel Event Alert, Issue 33.

Responsible for review/updating (Title/Dept)	Vice President – Nursing	Nursing

APPENDIX A:

Wong-Baker FACES Pain Rating Scale



DOCTORS
MEDICAL CENTER

MEDICAL EXECUTIVE COMMITTEE
CREDENTIALS REPORT TO THE BOARD

SEPTEMBER 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 (07/28/11) and the Medical Executive Committee (08/08/11).

CREDENTIALS REPORT TO THE BOARD JULY 2011	
INITIAL APPOINTMENTS	
NAME	***DEPARTMENT/SPECIALTY***
REAPPOINTMENTS	
Batts, Richard, MD	Medicine & Family Practice/Internal Medicine
Connolly, Edward, MD	Medicine & Family Practice/Pediatrics
Cooper, Joanna, MD	Medicine & Family Practice/Neurology
Escalada, Maria, MD	Medicine & Family Practice/Pediatrics
Hill, David, MD	Medicine & Family Practice/Cardiology
Jones, Sharon J., MD	Medicine & Family Practice/Internal Medicine
Katler, Ernest I., MD	Medicine & Family Practice/Rheumatology
Naughton, James, MD	Medicine & Family Practice/Internal Medicine
Raees, Muhammed, MD	Medicine & Family Practice/Pulmonary Medicine
Gadwood, Gary, MD	Surgery/General Surgery
Khan, Junaid H., MD	Surgery/Cardiothoracic
Delaney, Leslie, MD	Surgery/Pain Management
RESIGNATIONS	
Kohli, Reebu, MD	Medicine & Family Practice/Nephrology
McCabe, James M., MD	Medicine & Family Practice/Internal Medicine