DOCTORS MEDICAL CENTER

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

Wednesday, February 26, 2014

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
FEBRUARY 26, 2014 – 4:30 P.M.
Doctors Medical Center - Auditorium
2000 Vale Road
San Pablo, CA 94806

5016 Nunn St,
Richmond, CA 94804
1-800-511-1465
1-510-970-5646

Governing Body Members
Eric Zell, Chair
Supervisor John Gioia, 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 MINUTES OF JANUARY 29, 2014** — 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. **QUALITY MANAGEMENT REPORT** — B. Nissila
   a. Presentation
   b. Discussion
   c. Public Comment
   d. ACTION: Acceptance of the February 2014 Quality Management Report

6. **FINANCIALS – JANUARY 2014** — J. Boatman
   a. Presentation
   b. Discussion
   c. Public Comment
   d. *ACTION: Acceptance of the January 2014 Financials*

7. **REVIEW OF ONGOING FINANCIAL CRISIS AND POTENTIAL CLOSURE** — D. Gideon
   a. Discussion
   b. Presentation
   c. Public Comment
   d. *ACTION: For Information Only*

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

9. **MEDICAL EXECUTIVE REPORT** — R. Stern, M.D.
   a. Presentation
   b. Discussion
   c. Public Comment
   d. *ACTION: Approval of the MEC report and the Credentials Committee Report of the Medical Staff*

ADJOURN TO CLOSED SESSION

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

B. Conference with Labor Negotiators (pursuant to Government Code Section 554957.6) Agency negotiators: Bob Redlo, VP of Patient Relations, Labor Relations & Workforce Development, John Hardy, Vice President of Human Resources: California Nurses Association, NUHW, PEU Local One and Local 39.

C. Discussion involving Trade Secrets Pursuant to Health and Safety Code Section 32106. Discussion will concern new programs, services, facilities.

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

DOCTORS MEDICAL CENTER

MINUTES

TAB 3

DOCTORS MEDICAL CENTER

WCCHD DOCTORS MEDICAL CENTER
GOVERNING BODY BOARD OF DIRECTORS

January 29, 2014
Doctors Medical Center - Auditorium
2000 Vale Road
San Pablo, CA 94806

MINUTES

1. CALL TO ORDER

The meeting was called to order at 5:45 P.M.

2. ROLL CALL

Quorum was established and roll was called: 5:46 PM

Present:	Eric Zell, Chair
	Supervisor John Gioia, Vice Chair
	Deborah Campbell
	Nancy Casazza
	Sharon Drager, M.D.
	Wendell Brunner, M.D.
	Richard Stern, M.D.
	Beverly Wallace
	William Walker, M.D
Excused:	Pat Godley
	Irma Anderson

3. APPROVAL OF DECEMBER 18 , 2013 MINUTES

The motion made by Director Nancy Casazza and seconded by Director Beverly Wallace to approve the December 18, 2013 minutes passed unanimously.

4. PUBLIC COMMENTS

No Public Comment

5. QUALITY MANAGEMENT REPORT

Ms. Rebecca Nissila, Director of Quality Management and Medical Staff, presented the Quality Report, and started by providing trends for 2012-2013 in the inpatient core measures, showing that AMI is trending upward and consistently compliant, STEMI program work is a major contributing factor. Heart Failure is also trending upward and moving toward being consistently at 100%. Core Measures for Pneumonia remain inconsistent, with the primary failures being not drawing blood cultures prior to administering antibiotics on ICU patients. Ms. Nissila discussed the performance improvement approach for more consistent and sustained performance for this measure. The SCIP compliance is also inconsistent due to failure to consistently give antibiotics within one hour of surgery start time and discontinuing of antibiotics within 24 hours of surgery end time. She also noted that the Computer Physician Order Entry (CPOE) is not surgeon friendly, resulting in documentation issues. A group of surgeons has been convened to work with IT to overcome barriers to make CPOE more user friendly for post-op orders. The VTE compliance is not consistent and has yet to break 90%, the primary cause is nursing documentation. The unit supervisors will assist in making all documentation compliant with this measure.

Ms. Nissila provided an update on the Stroke program, where issues arise in providing comprehensive discharge instructions. To facilitate nursing's efforts in completion of the discharge plan, IT informatics has created a pick list for instructions specific to the patients other conditions, as well as stroke. The program manager is tracking compliance for the Joint Commission.

A motion was made by Sharon Drager, M.D. and second by Director Deborah Campbell to approve the January 2014 Quality Management Report passed unanimously.

6. STROKE CENTER PRESENTATION

Desmond Carson, M.D., introduced Joan Hernando, Senior Program Director of The American Stroke Association. Ms. Hernando presented DMC with the Silver Stroke Honor Award. DMC achieved the award by meeting 85% or greater of seven compliance measures for stroke, for a period of twelve consecutive months. She thanked Drs. Desmond Carson and Robert Fox and the stroke team for their efforts in excellent patient care. This award will also be presented at the International Stroke Conference in San Diego in early February.

Dr. Carson stated that this award is one more example of the importance of keeping Doctors Medical Center open for this community.

Information Only

7. FINANCIALS- DECEMBER 2013

Mr. James Boatman, CFO, presented and sought acceptance of the December 2013 Financials. Doctors Medical Center had a net loss of $1,259,000 for the month of December. The following are the factors leading to the net income variance for the month:

Net patient revenue was under budget by $1,669,000 for the month. Patient days were 2.4% under budget and discharges under budget by 8.7%. Total outpatient volume was under budget by 11.5% with outpatient surgeries at 20.4% worse than budgeted. Ancillary outpatient visits were 27.3% under budget for December while emergency room visits were 8.7% better than budget.

In December, regular Medicare inpatient discharges were 11.1% under budget and both inpatient and outpatient reimbursements were lower than expected resulting in a $1,186,000 shortfall. Managed Care volume was 14.1% under budget resulting in a shortfall of $709,000 in patient revenue.

Mr. Boatman reported that salaries were under budget by $285,000 due to continued flexing of staff in response to reduced inpatient and outpatient volume. Health benefit costs continue to exceed budget this month by $129,000, which was offset by favorable variances in payroll taxes and other non-productive payroll expenses resulting in a negative variance of $108,000 in benefit expenses. He ending by summarizing the remaining expense variances.

A motion made by William Walker, M.D. and seconded by Director Deborah Campbell to accept the December 2013 Financial report passed unanimously.

8. REVISION TO LOCAL ONE COLLECTIVE BARGAINING CONTRACT

Mr. Bob Redlo, VP of Patient and Labor Relations, presented the proposed changes in contract between Doctors Medical Center and Public Employees Union Local One. The contract modifications will help this hospital save $500k to $600k dollars in the next 18 to 24 months. This is a primary example how concerned the union is with keeping this hospital open. The revision will be a minimum of 18 to maximum of 24 months. The revisions are made in the health benefits and are very similar to the same proposed changes that were approved by the Governing Body Board of Directors last month for all management and non union staff. As has been discussed at multiple meeting of the Governing Body, the costs of health benefits under the DMC self-insured program continues to increase significantly. The modifications also include changes in increase for employee contribution, in eligibility criteria, increased cost sharing by covered individuals, narrowing the network of preferred providers, and enhanced care management. The same two options for Kaiser Permanente health coverage are available for the public employees of Union Local

One as the rest of the employees and management agreed on. The major saving from the changes in the contract comes from the increase of definition in part time employees that changed from 20 hours to 30 hours requirement.

A motion was made by Director Nancy Casazza and seconded by Director Deborah Campbell to approve revision to local one collective bargaining contract passed unanimously.

9. **RESOLUTION: EMPLOYEE RECOGNITION**

Mr. Bob Redlo, VP of Patient Satisfaction, Labor Relations and Workforce Development presented Doctors Medical Center employee of the quarter, and read the following resolution:

WHEREAS, Ms. Lisa Stallworth has demonstrated commitment to the mission, vision and values of Doctors Medical Center and has provided consistent and outstanding customer service as acknowledged by her peers;

WHEREAS, Ms. Stallworth has voluntarily participated in community outreach and educational programs on behalf of Doctors Medical Center, promoting community health education and disease prevention;

WHEREAS, she has contributed to the financial health of Doctors Medical Center through demonstrated cost savings and has contributed to the learning and growth of her department through leadership and exemplification of professional service behaviors;

WHEREAS she has shown commitment to Doctors Medical Center, our patients, and the surrounding community;

NOW, THEREFORE, BE IT RESOLVED that the West Contra Costa Healthcare District Board of Directors Governing Body recognizes and thanks Ms. Lisa Stallworth for her dedication to the community, this hospital and the many patients we serve.

A motion was made by Director Beverly Wallace and seconded by Director Nancy Casazza to adopt Resolution No. 2014-03 passed unanimously.

10. **CEO REPORT**

In the interest of time, Ms. Gideon deferred her report to the February meeting.

11. **MEDICAL EXECUTIVE REPORT**

Dr. Richard Stern presented and sought approval of the Medical Executive Committee and Credentials Committee report. He presented the Emergency Department Surge policy revision for approval. He also presented December 2013 Credential Report and a new Podiatric Core Privileges form for approval.

A motion made by Supervisor John Gioia and seconded by Director Beverly Wallace to approve the MEC report and Credentials Committee report, including the new Podiatric Core Privileges form and Emergency Department Surge Poligy, passed unanimously.

THE MEETING ADJOURNED AT 6:26 PM

DOCTORS
MEDICAL CENTER

QUALITY REPORT

TAB 5

Quality Management Report

Doctor's Medical Center
February 26, 2014

HCAHPS Update
Laboratory 2013
Q4 Restraints
Organ Procurement 2013

Presented by Becky Nissila, R.N. MBA
Director of Quality / Medical Staff Services

HCAHPS (Patient Satisfaction)

- Patient Satisfaction Committee is meeting with focused work groups of multi-disciplinary involvement
  - Staff
  - Physicians
  - Leadership
- Full Report / Update will be presented at the March Board Meeting

Laboratory Quality Summary 2013

- Crossmatch / Transfusion Ratio = 1.4%
  (AABB Goal = < 2%)
  - *Excellent Rate – No action Necessary*
- Patient Safety Audit = 64.8% compliant
  - *ACTION: Initials/Date/Time and Source of specimen – when not present, specimen is sent back to unit for proper labeling.*
- Transfusion Documentation challenge in Transfusion Start and Stop Times (76% compliant)
  - *ACTION: Unit Supervisors are responsible for concurrent auditing of transfusion documentation and holding nurses accountable.*
- TAT for Code Stroke Labs - < 90% meeting Goal TAT
  - *ACTION: Short Term - Stroke tubes id with pink labels, Lab staff remains with specimen until release; Long Term – New analyzer with very short TAT (Analyzer replacement scheduled for 2014)*

Restraints Q4 2013

- Medical Restraints –
  - Challenges in documentation and Order authentication
- Behavioral Restraints –
  - Challenges in documentation of non-physical interventions, physician evaluation w/in 1 hour and re-ordering w/in 4 hours.
- ACTION: Unit Supervisors responsible for concurrent review and assuring documentation, assessments and orders as required.

Organ Procurement 2013

- 100% of DMC deaths were referred to CTDN
- 0 (zero) patients were eligible for ORGAN donation
- 16 patients were eligible for TISSUE donation (4.9% of total deaths) and were successfully harvested
- Conversion Rate = 0% (no eligible organ donors)
- Challenges in timeliness of referral - < 60 min
  - Action: Added to death checklist - Call CTDN < 59 minutes

DOCTORS MEDICAL CENTER

2013 Clinical Laboratory Quality Indicators

INDICATOR	Goal	A	N	Q1 AVG	A	N	Q2 AVG	A	N	Q3 AVG	A	N	Q4 AVG	A	N	2013 AVG	2012 Summary A	2012 Summary N	2012 AVG
1.Blood Bank																			
RBC Wastage	<2.0%	16	804	2.0%	16	764	2.1%	23	776	2.9%	8	769	1.0%	63	3113	2.0%	53	3439	1.5
C / T Ratio	<2.0	534	804	1.5	527	764	1.4	544	776	1.4	551	769	1.4	2156	3113	1.4	3439	2437	1.41
2. False Positive Blood Culture																			
Overall	<3%	48	1916	2.5%	31	1326	2.3%	20	1372	1.5%		1494	0.0%		6108		147	6265	2.3%
3. Patient Safety Audit (Addition of Date/Time/Initial to Collection Tubes)																			
Overall Compliance	>95%	349	491	71.1%	188	312	60.3%	9	10	90%*	156	214	72.9%	702	1027	68.4%	1242	1362	91.2
RN		66	491	65.9%	56	312	62.1%										630	681	92.5
Lab		76	491	84.5%	68	312	78.2%										612	681	89.8
4. Turn-Around-Time (TAT) [AM reported before 8AM, ER reported within 60 of receipt]																			
AM	>80%			83.5%			90.3%			89.3%			78.3%			85.4%			73.3%
ER	>83%	15989	17413	91.8%	15041	15856	94.9%	16554	17272	95.8%	16659	17416	95.7%	64243	67957	94.5%			89.6%
5. Critcal Value RN Notification																			
Called / Total	>98%	5069	5071	99.9%	3773	3774	99.9%	4507	4508	99.9%	4425	4425	100%	17774	17778	99.98%	10989	10992	99.90%
6. Transfusion Documentation Audit																			
Arm Band Present	95%	88	90	98%	88	90	98%	87	90	97%	60	60	100%	323	330	98%			
Consent	95%	88	90	98%	88	90	98%	87	90	97%	60	60	100%	323	330	98%			
RN Cosigner	95%	90	90	100%	88	90	98%	90	90	100%	60	60	100%	328	330	99%			
Start/Stop Time	95%	63	90	70%	73	90	81%	65	90	72%	50	60	83%	251	330	76%			
Quantity Infused	95%	84	90	93%	88	90	98%	88	90	98%	57	60	95%	317	330	96%			
Transfution Reaction	95%	83	90	92%	88	90	98%	89	90	99%	58	60	97%	318	330	96%			
Infused W/In <4Hr	95%	90	90	100%	87	90	97%	90	90	100%	57	60	95%	324	330	98%			
Begun W/In 30 Min.	95%	87	90	97%	90	90	100%	76	76	100%	57	60	95%	310	316	98%			
Vitals	95%	90	90	100%	89	90	99%	87	90	97%	59	60	98%	325	330	98%			
Temperature	95%	90	90	100%	89	90	99%	89	90	99%	60	60	100%	328	330	99%			
7. Code Stroke (% Reported Within 45 Minutes of Order																			
Overall TAT	>90%	76	92	82.6%	64	72	88.9%	60	80	75.4%	86	106	80.8%	286	350	81.7%			
CBC	>90%	28	31	90.3%	24	25	96.0%	26	27	97.9%	32	36	89.1%	111	119	92.9%			
BMP	>90%	22	30	73.3%	15	24	62.5%	12	27	45.0%	24	34	71.6%	73	115	63.9%			
PT/INR	>90%	26	31	83.9%	25	25	100.0%	22	26	88.3%	29	36	81.0%	102	118	86.3%			

KEY LEGEND: N = Total Number of Aduits, A = Number of items meeting audit criteria, TAT reported as percent of total reported within allowed time frame.

=Met Goal =Within 3% of Goal =PI Alert

Reviewed and Approved by

Maureen Fitzgibbons, CLS
Clinical Laboratory Director

EXEC SUMMARY AND ANALYSIS

1.Blood Bank

C/T Ratio remains excellent for facility.

2. False Positive Blood Culture

Q4 data not yet availible.

3. Patient Safety Audit (Addition of Date/Time/Initial to Collection Tubes)

Compiled data indicates that this remains a major issue at this facility. *Sample size for Q3 is relatively small due to time constraints and TJC inspection Prep.

4. Turn-Around-Time (TAT) (Order to Result)

Remain excellent. No action required.

5. Critcal Value RN Notification

Remains excellent. No action required.

6. Transfusion Documentation Audit

Start/Stop Time Documentation continues to be an issue, complete data from Dec-2013 not yet availible.

7. Code Stroke (% Reported Within 45 Minutes of Order

Show progress for most analytes except BMP (Chemistry). Using three-fold approach: 1. Low tech immediate: pink labels for STROKE tubes to help identify them. No other tubes in centrifuge while STROKE tubes Running. Staff must remain with specimen until release. 2. Long-term: Potential replacement of current ABG instruments with analyzers that can release whole blood Chemistries in 1-2 minutes. 3. Long-term: Auto-Verification of normal Chemistry results. Requires validation. Analyzers scheduled for replacement in 2014. Best to validate at that time.

ACTION PLAN

Reviewed and Approved by

Maureen Fitzgibbons, CLS
Clinical Laboratory Director

DOCTORS MEDICAL CENTER

Quality/Patient Safety Metrics

Medical Restraints Audit

Indicator *Highlighted cells do not meet goal	GOAL	Oct 2013	Nov 2013	Dec 2013		Average
Rate REASONS for Medical Restraints use DOCUMENTED	90%	100%	100%	100%		100%
Rate Alternatives to Restraints Documented	90%	(8/9) 89%	(17/10) 89%	(9/12) 75%		(34/40) 85%
Rate SOFT LIMB RESTRAINTS used		100%	(18/19) 95%	(10/12) 83%		(37/40) 93%
Rate Med Restraint ORDER present/current for each episode	90%	(8/9) 89%	(18/19) 95%	(11/12) 92%		(37/40) 93%
Rate MD authenticates Med Restraint TEL Order within 12 hrs	90%	(6/9) 67%	(14/19) 74%	(9/12) 75%		(29/40) 73%
Rate MD authenticates Med Rest renewal order q 24 hours	90%	(5/9) 56%	(14/19) 74%	(10/12) 83%		(29/40) 73%
Rate of Med Restraint INJURY to Staff	0%	0%	0%	0%		0%
Rate of Med Restraint INJURY to Patient	0%	0%	0%	0%		0%
Rate RN documentations showing q2 monitoring Med Restraints	90%	(3/9) 33%	(16/19) 84%	100%		(31/40) 78%
Rate Med Restraint Release Were Trialed during this shift	90%	(7/9) 78%	(15/19) 79%	(9/12) 75%		(31/40) 78%
Total Medical Restraints (DENOMINATOR)		9	19	12		40

ANALYSIS	ACTION(S)	TARGET DATE(S)
Medical restraints utilized for patients with medical devices such as ET Tubes, necessary IV's and other lines, devices necessary for treatment. No injuries occurred to patients or staff due to restraint use. Reasons for restraint use is being documented consistently. However, other required restraint documentation is inconsistent, with gaps by nursing for several hours in some cases. In addition, physician authentication of orders are not being done timely, per policy. Also, order renewal is not consistently timely, per policy.	Unit Supervisors will concurrently audit documentation and hold nurses accountable to required documentation. Physicians will be called to obtain timely authentication.	02/01/2014

DOCTORS MEDICAL CENTER

Quality/Patient Safety Metrics

Behavioral Restraints Audit

Indicator *Highlighted cells do not meet goal	GOAL	Oct 2013	Nov 2013	Dec 2013	Average
Rate Behavioral Restraints DOCUMENTED	90%	100%	100%	100%	100%
Rate Alternative Behavioral Restraints DOCUMENTED	90%	(2/7) 29%	(7/12) 58%	(19/24) 79%	(28/43) 65%
RATE Psych Meds used as alternative to enable DC of Beh Rest		(3/7) 43%	(2/12) 17%	(2/20) 8%	(7/43) 16%
RATE Soft Limb Rest were used		(1/7) 14%	(6/12) 50%	(20/24) 83%	(27/43) 63%
RATE Hard Restraints were used		(6/7) 86%	(6/12) 50%	(4/24) 17%	(16/43) 37%
RATE BEH Restraint ORDER present for each episode	90%	100%	(10/12) 83%	100%	(41/43) 95%
Rate of Beh Restraint INJURY to Staff	0%	0%	(1/12) 8%	0%	(1/43) 2%
Rate of Beh Restraint INJURY to Patient	0%	(1/7) 14%	0%	0%	(1/43) 2%
RATE Beh Rest Release Trialed	90%	(4/7) 57%	(7/12) 58%	100%	(35/43) 81%
RATE LIP evaluation in person was within 1 hour	90%	(6/7) 86%	(6/12) 50%	(2/24) 8%	(14/43) 33%
Rate Behavioral Restraints Order Limited to 4 hours	90%	(6/7) 86%	(6/12) 50%	(4/24) 17%	(16/43) 37%
Rate Behavioral Restraints Reevaluated q4 hours	90%	(6/7) 86%	(6/12) 50%	(4/24) 17%	(16/43) 37%
Rate Beh Rest Monitored face-to-race Observation	90%	100%	100%	100%	100%
Rate Beh Rest Pursuant to Individual Order	90%	100%	100%	100%	100%
Rate EACH Behavioral Rest Episode Documented	90%	100%	100%	(23/24) 96%	(42/43) 98%
Rate Beh Restraint Assessed & Assisted at Initiation of Rest	90%	(6/7) 86%	100%	100%	(42/43) 98%
Rate Beh Rest Assessed & Assisted q15 after initiation	90%	(6/7) 86%	100%	(23/24) 96%	(41/43) 95%
Rate Beh Rest Criteria Met for DC Restraint	90%	(5/7) 71%	100%	100%	(41/43) 95%
Rate Non-Physical Intervention Tried Prior to Restraints	90%	(4/7) 57%	(7/12) 58%	(19/24) 79%	(30/43) 70%
Rate Beh Rest Used Based on Violent/Aggressive Behavior		(6/7) 86%	100%	(12/24) 50%	(30/43) 70%
Rate Beh Order TYPE Based on Pts Assessment	90%	100%	100%	100%	100%
Rate Beh Rest Staff Trained and Competent	100%	(6/7) 86%	100%	100%	(42/43) 98%
RATE Beh Rest EVENT last < 12 hours		(6/7) 86%	(11/12) 92%	(13/24) 54%	(30/43) 70%
Total Medical Restraints (DENOMINATOR)		7	12	24	43

DOCTORS MEDICAL CENTER

ANALYSIS	ACTION(S)	Target Date(s)
Behavioral restraints utilized when all other methods fail to maintain safety to patients and staff in the acute care environment. However, nursing is not consistent in documenting alternatives attempted prior to applying restraints. In October there was an injury to a patient and in November an injury to a staff member. Neither had permanent harm. LIP evaluation within 1 hour of being restrained did not occur consistently. In addition, orders were not given in 4 hour increments, as required and status of need was not documented every 4 hours.	Unit Supervisors will concurrently audit documentation and hold nurses accountable to required documentation. Physicians will be called to obtain timely assessments as required.	02/01/2014

California Transplant Donor Network

CONTACT
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Donation Services Liaison
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kcluff@ctdn.org
http://www.ctdn.org

Hospital Combined Donation & Referral Scorecard

Doctors Medical Center San Pablo Q4 2012

YTD Donation/Referral Counts	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
All Deaths	40	18	33	28	21	18	20	37	27	28	24	31	325
Eligible Deaths	0	0	0	0	0	0	0	0	0	0	0	0	0
Hospital Referrals	40	18	33	28	21	18	20	37	27	28	24	31	325
Missed Referrals	0	0	0	0	0	0	0	0	0	0	0	0	0
Organ/Tissue Referrals	1	0	0	0	0	0	2	0	0	0	0	2	5
Potential Referrals	0	0	0	0	0	0	0	1	0	0	0	0	1
Timely Organ Referrals	0	0	0	0	0	0	1	0	0	0	0	1	2
Organ Donors	0	0	0	0	0	0	0	0	0	0	0	0	0
Eligible Donors	0	0	0	0	0	0	0	0	0	0	0	0	0
Non-Eligible Donors	0	0	0	0	0	0	0	0	0	0	0	0	0
Organs Transplanted	0	0	0	0	0	0	0	0	0	0	0	0	0
Tissue Donors	3	0	1	1	0	2	1	2	0	2	2	2	16

YTD Donation/Referral Rates	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Adjusted Conversion Rate	-	-	-	-	-	-	-	-	-	-	-	-	NaN
Potential Conversion Rate	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Overall Referral Rate	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Timely Organ Referral Rate	0%	-	-	-	-	-	50%	-	-	-	-	50%	40%
Organ Donor FPA Rate	-	-	-	-	-	-	-	-	-	-	-	-	NaN
OTPD	-	-	-	-	-	-	-	-	-	-	-	-	0.00
Death to Tissue Donor Rate	7.5%	0.0%	3.0%	3.6%	0.0%	11.1%	5.0%	5.4%	0.0%	7.1%	8.3%	6.5%	4.9%
Tissue Donor FPA Rate	0%	-	0%	0%	-	0%	0%	0%	-	0%	0%	0%	0%
CTOD Timeliness Rate	74%	61%	73%	75%	50%	89%	69%	73%	70%	79%	67%	86%	73%

See Definitions and Disclosure Notice on Pages 10-12

Organ Referral Details: Q4 2012 (Doctors Medical Center San Pablo)

Detail Data for Report Period Only (Q4 2012)

Referral #	Referral Date	Age / Gender/ Ethnicity	Timely Ref	CTDN Onsite	Hosp Supp	Collab Mention	Eval Prior	CTDN Disc	Plan Disc	Authorization Type	Organ Outcome	Total TX'd
8812384	12/4/2012 12:47:00 PM	53 / M / Caucasian	No	Yes	Yes	Yes	Yes	Yes	Yes	AP Auth	Authorized Not Recovered	-
8835223	12/19/2012 5:17:00 PM	78 / F / African American	Yes							AP Not Asked	Screening Rule Out	-

See Definitions and Disclosure Notice on Pages 10-12

Organ Donor Recovery Details: Q4 2012 (Doctors Medical Center San Pablo)

Detail Data for Report Period Only (Q4 2012)

Organ ID	Recovery Date	Age / Gender/ Ethnicity	Heart	Lungs	Liver	Kidneys	Pancreas	SmB	Total Rec'd	Referral #
No Organ Donors										
Total Organs Recovered									**0**	**Total Organ Donors: 0**

See Definitions and Disclosure Notice on Pages 10-12

Tissue Donor Recovery Details: Q4 2012 (Doctors Medical Center San Pablo)

Detail Data for Report Period Only (Q4 2012)

Tissue ID	Recovery Date	Age / Gender / Ethnicity	Bone	Skin	Cornea	HV	Vein	Referral #
CTDN-2012-1784	10/2/2012 9:20:00 PM	46 / F / Caucasian	X	X	X	X		8718732
CTDN-2012-1947	10/27/2012 12:39:00 PM	48 / F / Caucasian	X	X		X		8753184
CTDN-2012-2010	11/5/2012 1:00:00 PM	65 / F / Caucasian	X	X	X			8767720
CTDN-2012-2016	11/6/2012 12:30:00 AM	49 / F / African American	X	X	X	X		8768615
CTDN-2012-2271	12/14/2012 9:30:00 PM	70 / F / Caucasian	X	X				8826660
CTDN-2012-2322	12/21/2012 10:40:00 PM	30 / M / African American			X			8837715
		Total Tissue Types Recovered	**5**	**5**	**4**	**3**	**0**	**Total Tissue Donors: 6**

See Definitions and Disclosure Notice on Pages 10-12

Definitions & Measurement Goals

Measure	Definition	In Range	Out of Range	Needs Improvement
All Deaths	The total of all hospital referrals plus missed referrals.	N/A		
Eligible Deaths	Deaths that meet all of the following criteria: patient was 70 years old or younger, declared brain dead, and had no CMS contraindications.			
Hospital Referrals	All referrals made to the CTDN referral line by the hospital.			
Missed Referrals	Cardiac deaths identified through death record review that were not referred to CTDN.			
Organ/Tissue Referrals	All referrals made to the CTDN referral line where a patient was evaluated for organ donation.			
Timely Organ Referrals	All referrals made to CTDN within one hour of the patient meeting the clinical cues.			
Organ Donors	The total of all patients that became organ donors.			
Eligible Donors	All organ donors that meet the definition of "eligible".			
Non-Eligible Donors	All organ donors that do not meet the definition of "eligible".			
Organs Transplanted	The total number of organs transplanted from all organ donors.			
Tissue Donors	The total of all patients that became tissue donors.			
Adjusted Conversion Rate	The count of Organ Donors divided by the count of Eligible Deaths plus the count of Non-Eligible Donors (aka Collaborative Conversion Rate).	**≥ 75%**	**70% - 74%**	**< 70%**
Overall Referral Rate	The count of all Hospital Referrals divided by All Deaths.	**100%**	**97%-99%**	**< 97%**
Timely Organ Referral Rate	Count of Timely Referrals (those marked "Yes" in Referral Detail) divided by the count of Referrals (those marked "Yes" and "No" in Referral Detail). Excludes referrals made before death or cases in which the death or referral times are not known.	**≥ 80%**	**75%-79%**	**< 75%**
Organ Donor FPA Rate	The count of all Organ Donors with First Person Authorization (FPA) divided by the count of all Organ Donors.	N/A		
OTPD	Organs Transplanted Per Donor. The count of Organs Transplanted divided by the number of Organ Donors.	**≥ 3.75**	**3.00 - 3.74**	**< 3.00**
Death to Tissue Donor Rate	Nationally recognized metric where the count of Tissue Donors is divided by the count of all Deaths.	N/A		
Tissue Donor FPA Rate	The count of all Tissue Donors with First Person Authorization (FPA) divided by the count of all Tissue Donors.			
CTOD Timeliness Rate	The count of all TE and RO referrals made within 60 minutes of cardiac time of death divided by all TE and RO referrals with a cardiac time of death noted.	**≥ 85%**	**80%-84%**	**< 80%**
Potential Conversion Rate	A measure that relates the number of total donors to the number of potential deaths.	**≥ 40%**	**39%-35%**	**< 35%**

DOCTORS
MEDICAL CENTER

FINANCIALS
January 2014

TAB 6

DOCTORS MEDICAL CENTER

Board Presentation

January 2014

Financial Report

Financial Report Key Points

- Net loss was $2.5M in January, $188K under budget
- Net patient revenue was $194K under budget
- Operating expenses were in line with budget

Statement of Activity - Summary

For the Period Ending

January 31, 2014

(Thousands)

Month to Date				Year to Date		
Actual	Budget	Var		Actual	Budget	Var
9,952	10,169	(217)	**Net Operating Revenues $**	9,952	10,169	(217)
13,167	13,182	15	**Total Operating Expenses $**	13,167	13,182	15
(3,215)	(3,013)	(202)	**Income/(Loss) from Operations $**	(3,215)	(3,013)	(202)
709	696	13	**Income from Other Sources $**	709	696	13
(2,506)	(2,318)	(188)	**Net Income / (Loss) $**	(2,506)	(2,318)	(188)
2,459	2,145	314	**Patient Days**	2,459	2,145	314
519	479	40	**Discharges**	519	479	40
6,403	6,573	(170)	**Outpatient Visits**	6,403	6,573	(170)
539	592	52	**Worked FTE's**	539	592	52
1.54	1.55	(0.01)	**Medicare CMI**	1.54	1.55	(0.01)

Budget Variances – Net Revenue

- Medicare $(236) K
- Managed Care $(104) K
- Medi-Cal $ 129 K

Budget Variances - Expenses

- **Salaries** ($127K) - Higher labor costs due to overtime.
- **Professional Fees** $92K - Lower physician and consulting fees.
- **Supplies** $116K - Underutilization of pacemakers offset by higher pharmaceutical and implants costs.
- **Purchased Services** ($228K) - Higher collection costs offset by higher A/R cash collections.

Cash Position
January 31, 2014

(Thousands)

	January 31, 2014	December 31, 2013
Unrestricted Cash	$3,529	$9,609
Restricted Cash	$6,420	$4,723
Total Cash	$9,949	$14,332
Days Unrestricted Cash	8	25
Days Restricted	17	14
Total Days of Cash	25	39

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

Accounts Receivable

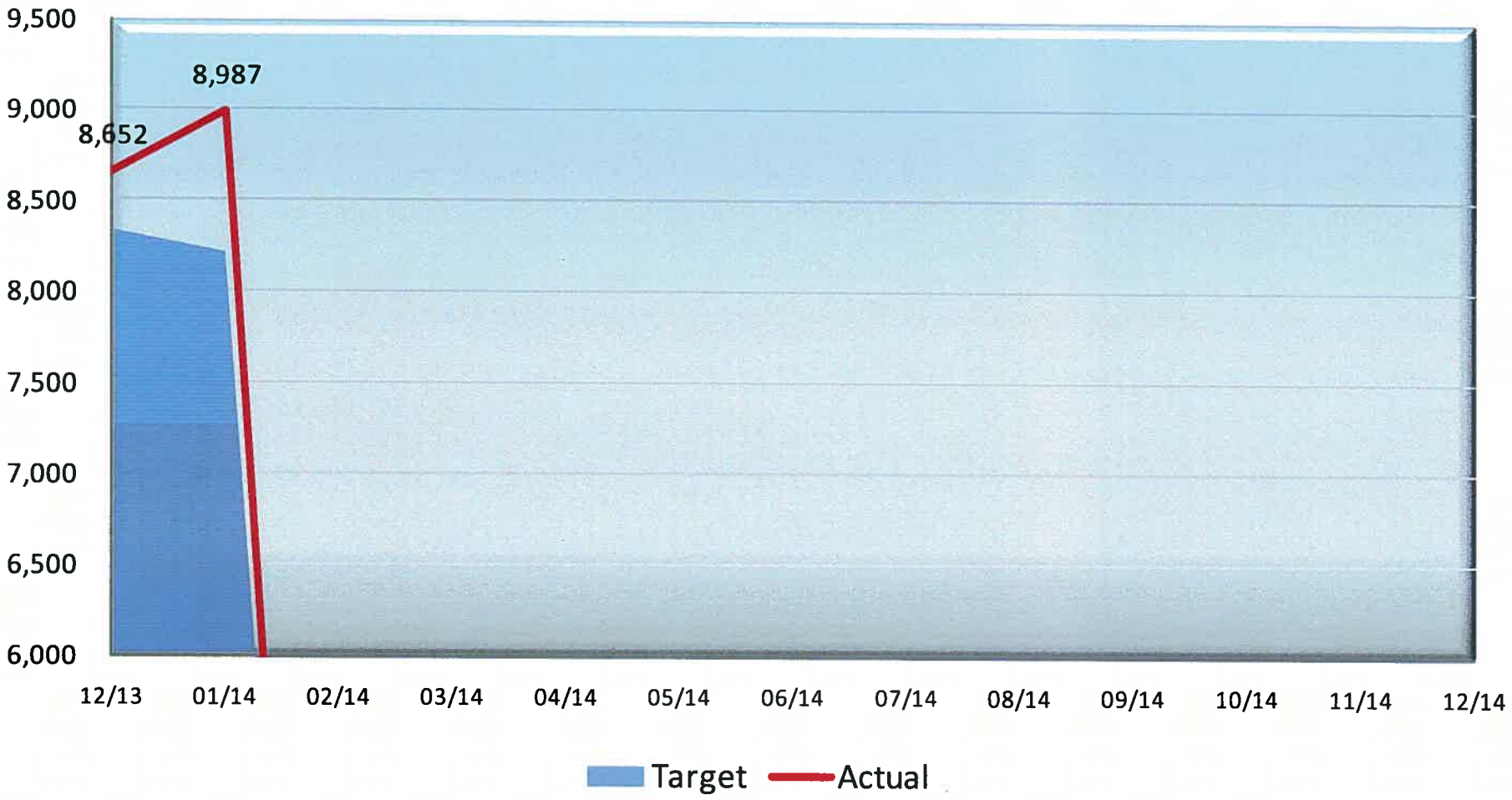
January 31, 2014

(Thousands)

	January 31, 2014	December 31, 2013
Net Patient Accounts Receivable	$21,611	$20,457
Net Days in Accounts Receivable	73.9	72.8

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

Cash Collection



WEST CONTRA COSTA HEALTHCARE DISTRICT
DOCTORS MEDICAL CENTER
INCOME STATEMENT
January 31, 2014
(Amounts in Thousands)

CURRENT PERIOD ACTUAL	CURRENT PERIOD BUDGET	CURRENT PERIOD VAR	CURRENT PERIOD VAR %	PRIOR YEAR ACTUAL		CURRENT YTD ACTUAL	CURRENT YTD BUDGET	CURRENT YTD VAR	CURRENT YTD VAR %	PRIOR YEAR ACTUAL
					OPERATING REVENUE					
9,884	t0,078	(194)	-1.9%	10,916	Net Patient Service Revenue	9,884	10,078	(194)	-1.9%	10,916
68	91	(23)	-25.5%	102	Other Revenue	68	91	(23)	-25.5%	102
9,952	10,169	(217)	-2.1%	11,018	**Total Operating Revenue**	9,952	10,169	(217)	-2.1%	t t,018
					OPERATING EXPENSES					
5,311	5,184	(127)	-2.4%	5,124	Salaries & Wages	5,311	5,184	(127)	-2.4%	5,124
3,478	3,553	75	2.1%	3,203	Employee Benefits	3,478	3,553	75	2.1%	3,203
860	952	92	9.6%	1,107	Professional Fees	860	952	92	9.6%	1,107
1,388	1,504	116	7.7%	1,424	Supplies	1,388	1,504	116	7.7%	1,424
1,188	960	(228)	-23.8%	1,021	Purchased Services	1,188	960	(228)	-23.8%	1,021
243	261	18	7.0%	322	Rentals & Leases	243	261	18	7.0%	322
413	413	0	0.1%	417	Depreciation & Amortization	413	413	0	0.1%	417
286	354	68	19.2%	338	Other Operating Expenses	286	354	68	19.2%	338
13,167	13,182	15	0.1%	12,956	**Total Operating Expenses**	13,167	13,182	15	0.1%	12,956
(3,215)	(3,013)	(202)	6.7%	(1,938)	**Operating Profit / Loss**	(3,215)	(3,013)	(202)	6.7%	(1,938)
					NON-OPERATING REVENUES (EXPENSES)					
-	-	-	0.0%	-	Other Non-Operating Revenue	-	-	-	0.0%	-
1,143	1,138	5	-0.4%	1,123	District Tax Revenue	1,143	1,138	5	-0.4%	1,123
8	11	(3)	-29.0%	47	Investment Income	8	11	(3)	-29.0%	47
(442)	(453)	11	0.0%	(404)	Less: Interest Expense	(442)	(453)	11	-2.5%	(404)
709	696	13	1.9%	766	**Total Net Non-Operating**	709	696	13	1.9%	766
(2,506)	(2,318)	(188)	8.1%	(1,172)	**Income Profit (Loss)**	(2,506)	(2,318)	(188)	8%	(1,172)
					Profitability Ratios:					
-32.3%	-29.6%	-2.7%		-17.6%	Operating Margin %	-32.3%	-29.6%	-2.7%		-17.6%
-25.2%	-22.8%	-2.4%		-10.6%	Profit Margin %	-25.2%	-22.8%	-2.4%		-10.6%

WEST CONTRA COSTA HEALTHCARE DISTRICT
DOCTORS MEDICAL CENTER
INCOME STATEMENT
January 31, 2014
(Amounts in Thousands)

CURRENT PERIOD				PRIOR YEAR		CURRENT YTD				PRIOR YEAR
ACTUAL	BUDGET	VAR	VAR %	ACTUAL		ACTUAL	BUDGET	VAR	VAR %	ACTUAL
2,292	2,611	318	12.2%	2,268	SWB / APD	2,292	2,611	318	12.2%	2,268
66.8%	66.3%	-0.5%		64.3%	SWB / Total Operating Expenses	66.8%	66.3%	-0.5%		64.3%
3,434	3,939	504	12.8%	3,529	Total Operating Expenses / APD	3,434	3,939	504	12.8%	3,529
34,863	36,281	(1,418)	-3.9%	40,570	I/P Gross Charges	34,863	36,281	(1,418)	-3.9%	40,570
19,492	20,328	(836)	-4.1%	19,688	O/P Gross Charges	19,492	20,328	(836)	-4.1%	19,688
54,355	**56,609**	**(2,254)**	**-4.0%**	**60,258**	**Total Gross Charges**	**54,355**	**56,609**	**(2,254)**	**-4.0%**	**60,258**
					Payor Mix (IP and OP)					
49%	54%	-5%		57%	Medicare %	49%	54%	-5%		57%
25%	22%	3%		20%	Medi-Cal %	25%	22%	3%		20%
11%	11%	0%		11%	Managed Care	11%	11%	0%		11%
4%	4%	0%		2%	Other Government %	4%	4%	0%		2%
11%	10%	1%		10%	Self Pay %	11%	10%	1%		10%
					STATISTICS					
529	479	50	10.4%	580	Admissions	529	479	50	10.4%	580
519	479	40	8.4%	571	Discharges	519	479	40	8.4%	571
2,459	2,145	314	14.6%	2,472	Patient Days	2,459	2,145	314	14.6%	2,472
79.3	69.2	10.1	14.6%	79.7	Average Daily Census (ADC)	79.3	69.2	10.1	14.6%	79.7
4.74	4.48	0.26	5.8%	4.33	Average Length of Stay (LOS)- Accrual Based	4.74	4.48	0.26	5.8%	4.33
31	31			31	Days in Month	31	31			31
809	747	62	8.3%	848	Adjusted Discharges (AD)	809	747	62	8.3%	848
3,834	3,347	487	14.6%	3,672	Adjusted Patient Days (APD)	3,834	3,347	487	14.6%	3,672
124	108	16	14.6%	118	Adjusted ADC (AADC)	124	108	16	14.6%	118
88	77	11	14.3%	72	Inpatient Surgeries	88	77	11	14.3%	72
74	73	1	1.4%	105	Outpatient Surgeries	74	73	1	1.4%	105
162	**150**	12	8.0%	**177**	**Total Surgeries**	**162**	**150**	12	8.0%	**177**

WEST CONTRA COSTA HEALTHCARE DISTRICT
DOCTORS MEDICAL CENTER
INCOME STATEMENT
January 31, 2014
(Amounts in Thousands)

CURRENT PERIOD				PRIOR YEAR		CURRENT YTD				PRIOR YEAR
ACTUAL	BUDGET	VAR	VAR %	ACTUAL		ACTUAL	BUDGET	VAR	VAR %	ACTUAL
3,523	3,531	(8)	-0.2%	3,582	ED Outpatient Visits	3,523	3,531	(8)	-0.2%	3,582
2,806	2,969	(163)	-5.5%	3,010	Ancillary Outpatient Visits	2,806	2,969	(163)	-5.5%	3,010
74	73	1	1.4%	105	Outpatient Surgeries	74	73	1	1.4%	105
6,403	**6,573**	(170)	-2.6%	**6,697**	**Total Outpatient Visits**	**6,403**	**6,573**	(170)	-2.6%	**6,697**
472	429	43	10.1%	556	Emergency Room Admits	472	429	43	10.1%	556
13.4%	12.1%			15.5%	% of Total E/R Visits	13.4%	12.1%			15.5%
89.2%	89.5%			95.9%	% of Acute Admissions	89.2%	89.5%			95.9%
539	592	52	8.9%	592	Worked FTE	539	592	52	8.9%	592
699	703	4	0.5%	721	Paid FTE	699	703	4	0.5%	721
4.36	5.48	1.12	20.4%	5.00	Worked FTE / AADC	4.36	5.48	1.12	20.4%	5.00
5.65	6.51	0.86	13.2%	6.09	Paid FTE / AADC	5.65	6.51	0.86	13.2%	6.09
2,578	3,011	(433)	-14.4%	2,973	Net Patient Revenue / APD	2,578	3,011	(433)	-14.4%	2,973
14,178	16,914	(2,737)	-16.2%	16,412	I/P Charges / Patient Days	14,178	16,914	(2,737)	-16.2%	16,412
3,044	3,093	(48)	-1.6%	2,940	O/P Charges / Visit	3,044	3,093	(48)	-1.6%	2,940
1,385	1,549	164	10.6%	1,396	Salary Expense / APD	1,385	1,549	164	10.6%	1,396
5.20	4.90	(0.30)	-6.2%	4.77	Medicare LOS - Discharged Based	5.20	4.90	(0.30)	-6.2%	4.77
1.54	1.55	(0.01)	-0.4%	1.60	Medicare CMI	1.54	1.55	(0.01)	-0.4%	1.60
3.37	3.16	0.21	6.6%	2.99	Medicare CMI Adjusted LOS	3.37	3.16	0.21	6.6%	2.99
4.74	4.49	(0.25)	-5.5%	4.33	Total LOS - Discharged Based	4.74	4.49	(0.25)	-5.5%	4.33
1.58	1.51	0.07	4.6%	1.55	Total CMI	1.58	1.51	0.07	4.6%	1.55
3.00	2.97	0.03	0.9%	2.80	Total CMI Adjusted LOS	3.00	2.97	0.03	0.9%	2.80

WEST CONTRA COSTA HEALTHCARE DISTRICT
DOCTORS MEDICAL CENTER
BALANCE SHEET
January 31, 2014
(Amounts in Thousands)

	Current Month	Dec. 31, 2013
ASSETS		
Cash	3,529	9,609
Net Patient Accounts Receivable	21,611	20,457
Other Receivables	1,142	508
Inventory	1,637	1,647
Current Assets With Limited Use	6,420	4,723
Prepaid Expenses and Deposits	1,286	1,262
TOTAL CURRENT ASSETS	**35,624**	**38,206**
Assets With Limited Use	**642**	**642**
Property Plant & Equipment		
Land	12,120	12,120
Bldg/Leasehold Improvements	29,717	29,433
Capital Leases	10,926	10,926
Equipment	45,402	45,321
CIP	643	876
Total Property, Plant & Equipment	98,808	98,676
Accumulated Depreciation	-59,026	-58,618
Net Property, Plant & Equipment	**39,782**	**40,058**
Intangible Assets	**1,387**	**1,392**
Total Assets	**77,435**	**80,298**
Current Ratio (CA/CL)	***0.92***	***0.99***
Net Working Capital (CA-CL)	***(3,037)***	***(492)***
Long Term Debt Ratio (LTD/TA)	***0.77***	***0.75***
Long Term Debt to Capital (LTD/(LTD+TE)	***2.00***	***1.84***
Financial Leverage (TA/TE)	***-2.6***	***-2.9***
Quick Ratio	**0.65**	**0.78**
Unrestricted Cash Days	**8**	**25**
Restricted Cash Days	**17**	**14**
Net A/R Days	**73.9**	**72.8**

		Current Month	Dec. 31, 2013
	LIABILITIES		
96	Current Maturities of Debt Borrowings	1,323	1,320
97	Accounts Payable and Accrued Expenses	13,553	14,052
98	Accrued Payroll and Related Liabilities	17,850	17,501
99	Deferred District Tax Revenue	2,891	2,891
100	Estimated Third Party Payor Settlements	3,044	2,934
101	**Total Current Liabilities**	**38,661**	**38,698**
	Other Liabilities		
102	Other Deferred Liabilities	8,871	9,112
	Long Term Debt		
103	Notes Payable - Secured	60,316	60,319
104	Capital Leases	890	920
105	Less Current Portion LTD	-1,323	-1,320
106	**Total Long Term Debt**	**59,883**	**59,919**
107	**Total Liabilities**	**107,415**	**107,729**
	EQUITY		
108	Retained Earnings	-27,474	-8,053
109	Year to Date Profit / (Loss)	-2,506	-19,378
110	**Total Equity**	**-29,980**	**-27,431**
111	**Total Liabilities & Equity**	**77,435**	**80,298**

DOCTORS MEDICAL CENTER

January 2014 Executive Report

Doctors Medical Center had a net loss of $2,506,000 for the month of January. As a result, net income was $188,000 worse than budget. The following are the factors leading to the net income variance for the month:

Net Patient Revenue Factors	Positive / (Negative)
Medicare	($236)
Managed Care	($104)
Medi-Cal	$129

Net patient revenue was under budget by $194,000 for January particularly due to lower inpatient and outpatient reimbursements. While total gross revenue targets were 4% below expectations, patient days and discharges exceeded budget by 14.6% and 8.4%, respectively. Total outpatient volume was under budget by 2.6% with ancillary visits at 5.5% worse than budgeted.

In January, Medicare Care outpatient volume was 17.4% worse than budgeted resulting in a $236,000 shortfall in patient revenue. Managed Care inpatient volume was 7.3% under budget resulting in a shortfall of $104,000 in patient revenue. The Medi-Cal inpatient volume was 8.8% over budget resulting in a $129,000 positive variance to budget.

Salaries exceeded budget by $127,000 in January as we incurred higher levels of overtime to staff for the increase in volume.

Professional Fees were $92,000 under budget as a result of reduced physician fees and consulting costs.

Supplies were favorable by $116,000 in January due to lower pacemaker utilization offset by higher pharmaceutical costs and implants usage. Inpatient surgeries were 14.3% higher than budget.

Purchased services exceeded budget by $228,000 primarily due to additional bad debt collection costs which are offset by increased cash collections on claims greater than 150 days old.

DOCTORS MEDICAL CENTER

MEDICAL EXECUTIVE REPORT

TAB 9

MEDICAL EXECUTIVE COMMITTEE
REPORT TO THE BOARD

MEC DATE: February 10, 2014 **BOARD DATE:** February 26, 2014

TOPIC	Comment (S)
Kathy White, Interim COO provided the following report: • Lytton Casino has agreed to lease Parking Lot C over the course of 20 years for $5 M. Administration is working through the details of how this will be implemented to include the location of parking for patients and employees who now park there. The Cancer and Out patients will either be able to park in the remaining parking lot or DMC will provide a valet service. Dawn Gideon, Interim CEO is currently working with attorneys in finalizing contract agreement. Updates will be given as the plan evolves. Concerns should be directed to any member of the executive team. • Mail in parcel tax vote is scheduled for May 6th.	No action required by the Board
Richard Stern, Chief of Staff: • None Presented	No action required by the Board
Policy, Procedures, Forms: A. Pharmacy & Therapeutic Committee Report • Accucheck Inform II • Arzerra -Ofatumumab Order Set • Warfarin Order Form • Ado-Trastuzumab Formulary Addition Request B. Other • Approval of New Committee Chairs 2014	Approval Approval
Credentials Committee • Credentials Report: January 2014	Approval

APPROVAL ROUTING SHEET FOR POLICIES AND PROCEDURES

DOCTORS MEDICAL CENTER

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

†**TITLE:** Accucheck Inform II	†**CHECK ONE:** ☒ New ☐ Reviewed ☐ Revised : ☐ Major ☐ Minor
† ☐ **Administrative** ☐ **Clinical** ☒ **Department** Laboratory	
†**SUBMITTED BY:** David Enfield, M.D.	
†**NEW POLICY - REASON FOR SUBMISSION:** ☐ Change in Law ☐ New Regulation: CMS CDPH TJC Other Change in instrument	
†**REVIEWED OR REVISED - SUMMARY OF POLICY / PROCEDURE CHANGES:** .Updated policy and procedure to reflect updated instrumentation for checking blood sugar.	

	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	1/16/2014	1/16/2014
☐ 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)**†		
☐ **Executive Leadership**		
☒ **Medical Executive Committee (MEC)** (as applicable)	2/10/2014	2/10/2014
☒ **Board of Trustees** *(automatic from MEC)* *(as applicable)*	2/26/2014	

DOCTORS MEDICAL CENTER

Manual: DEPARTMENTAL	Sub Folder: CLINICAL LABORATORY/ POINT OF CARE
Title: Glucose Monitoring Using the Accuchek Inform II	Reviewed: Revised:
Effective Date:	Page 1 of 11

I. PURPOSE:

The ACCU-CHEK Inform II system is used by trained Nursing staff (RN or LVN) to quantitatively measure glucose in fresh venous, arterial and capillary (fingerstick and neonatal heelstick) whole blood. The system is used as an aid in monitoring the effectiveness of glucose control.

II. POLICY:

The system may be used on multiple patients when compliant with the cleaning and disinfecting recommendations of the FDA, CDC, and CMS found in the following documents:

A. *Use of Fingerstick Devices on More Than One Person Poses Risk for Transmitting Bloodborne Pathogens: Initial Communication* [1]

B. *CDC Clinical Reminder: Use of Fingerstick Devices on More than One Person Poses Risk for Transmitting Bloodborne Pathogens*[2]

The ACCU-CHEK Inform II system is used within its limitations as described by the manufacturer's most current literature on interference and limitations.

Reagents are not used past their expiration date.

Proper blood sample collection is an essential and integral part of bedside glucose testing. All staff members who perform testing on the ACCU-CHEK Inform II system must be fully trained to collect samples according to established sample collection policies and procedures. Only a currently certified operator may perform testing on the ACCU-CHEK Inform II system. Operators must successfully complete the in-servicing program per hospital policy. Operators may perform tests only after entering their own ID and must under no circumstances provide their ID to enable another operator to perform testing. *Reference Hospital Policy*

III. PRINCIPLE:

A. The ACCU-CHEK Inform II system quantitatively measures glucose in whole blood. The enzyme on the test strip, mutant variant of quinoprotein glucose dehydrogenase from Acinetobacter calcoaceticus, recombinant in E. coli, converts the glucose in the blood sample to gluconolactone. This reaction creates a harmless electrical DC current that the meter interprets

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[1] FDA Public Health Notification: Use of Fingerstick Devices on More than One Person Poses Risk for Transmitting Bloodborne Pathogens: Initial Communication, (2010).
http://www.fda.gov/ MedicalDevices/Safety/AlertsandNotices/ucm224025.htm, accessed 03/02/12.

[2] CDC Clinical Reminder: Use of Fingerstick Devices on More than One Person Poses Risk for Transmitting Bloodborne Pathogens, (2010). http://www.cdc.gov/injectionsafety/Fingerstick-DevicesBGM.html , accessed 03/0212.

for a glucose result. The sample and environmental conditions are also evaluated using a small AC signal.

B. The system is calibrated with venous blood containing various glucose concentrations and is calibrated to deliver plasma-like results. The reference values are obtained using a validated test method. This test method is referenced to the hexokinase method and is traceable to an NIST standard.

IV. LIMITATIONS:

A. The ACCU-CHEK Inform II test strips are for testing fresh capillary, venous, arterial, or neonatal whole blood. Cord blood samples cannot be used.
B. Hematocrit should be between 10–65 %.
C. Lipemic samples (triglycerides) in excess of 1800 mg/dL may produce elevated results.
D. Blood concentrations of galactose >15 mg/dL will cause overestimation of blood glucose results.
E. Intravenous administration of ascorbic acid which results in blood concentrations of ascorbic acid >3 mg/dL will cause overestimation of blood glucose results.
F. If peripheral circulation is impaired, collection of capillary blood from the approved sample sites is not advised as the results might not be a true reflection of the physiological blood glucose level. This may apply in the following circumstances: severe dehydration as a result of diabetic ketoacidosis or due to hyperglycemic hyperosmolar non-ketotic syndrome, hypotension, shock, decompensated heart failure NYHA Class IV, or peripheral arterial occlusive disease.
G. This system has been tested at altitudes up to 10,000 feet.
H. The performance of this system has not been evaluated in the critically ill.

V. PROCEDURE:

A. ACCEPTABLE SAMPLES:

1. The following fresh whole blood sample types may be used:
   a. Venous whole blood
   b. Arterial whole blood
   c. Capillary (non-neonate fingerstick and neonate heelstick) whole blood

2. The following anticoagulants are acceptable **(do not use any other anticoagulants for meter testing):**
   a. Lithium or Sodium Heparin; EDTA
   b. EDTA

B. SUPPLIES:

1. ACCU-CHEK Inform II system strips are dispensed by the Purchasing Department to the Pharmacy. QC reagents on nursing units are stored in PAR Cart, and replenished by the Central Supply. Test strips are stocked by Pharmacy in the automated dispensing machine (Omnicell).
2. ACCU-CHEK Inform II test strips expire on the date printed on the test strip vial label. ACCU-CHEK Inform II control and linearity solutions expire on the date printed on the vial label, or 3 months from opening, whichever comes first. Whenever an operator opens a vial of controls or linearity solution, he/she must handwrite the expiration date

on the vial. That date will be either 3 months from opening or the date printed on the vial label, whichever comes first.

3. Lancets are ordered through and supplied by Purchasing.
4. Batteries are rechargeable. Only compatible batteries may be used on Accuchek Inform II. Please contact the Laboratory if the battery appears to be malfunctioning.

Performing ACCU-CHEK Inform II Quality Control

Quality control testing is performed as a primary means of ensuring on-going proper performance of the ACCU-CHEK Inform II system. The section below describes the steps taken to perform quality control testing on the ACCU-CHEK Inform II system. Low and high quality control testing is performed on the following occasions:

A. One time(s) per 24 hour period of patient testing
B. When a new test strip vial is opened and placed into service.
C. *If the meter has been dropped or replaced.*
D. *If questionable results are obtained during testing.*
E. Acceptable quality control results are defined as results that are within *3 Standard Deviations (3SD) range as provided by manufacturer (per strip lot).*
F. Entering new control lots into the ACCU-CHEK Inform II system.

Quality control testing results must be acceptable prior to performing patient testing, according to the *Interpretation of Results* section of the procedure below.

A. SAMPLES: ACCU-CHEK Inform II low and high glucose controls are used for quality control testing

B. MATERIALS: Gather the following supplies in preparation for quality control testing:

1. ACCU-CHEK Inform II meter – fully charged and coded to the test strip lot you intend to use.
2. ACCU-CHEK Inform II Control Level 1 (Low) and Control Level 2 (High), the lot and range information will be available in meter.
3. ACCU-CHEK Inform II test strip vial (in date)

4. **NOTE about reagents:** Reagents are not to be used past their expiration date.
   a. **ACCU-CHEK Inform II strips expire on the date printed on the strip vial label.**
   b. **ACCU-CHEK Inform II Control expire on the date printed on the vial label, or 3 months from opening,** whichever comes first. Whenever an operator opens a vial of controls, he/she must handwrite the expiration date and his/her on the vial. That date will be either 3 months from opening or the date printed on the vial label, whichever comes first.

C. QC METER OPERATION:

1. Turn on the ACCU-CHEK Inform II meter.
2. Enter or your operator ID by means of *scanning employee badge barcode.* **NOTE:** If the operator ID you enter is not accepted, attempt to re-enter it. If it is still rejected, contact your supervisor or Point of Care Coordinator. **DO NOT** attempt to perform tests under another operator's ID.
3. From the *Main Menu*, touch *Control Test.*
4. Select the level of control that you wish to test *via barcode on the control bottle.*
5. Confirm that the meter is coded (calibrated) to the same test strip code that is printed on the test strip vial by *barcode scanning and/or screen confirmation.* Contact your supervisor or Point-of-Care Coordinator if you are unable to confirm the correct test strip code.
6. The meter will display a picture of a test strip with a downward flashing arrow on the meter indicating that you are ready to insert a test strip into the meter. Remove a test strip from the vial and immediately recap the vial. Insert the test strip into the meter in the direction of the arrows and with the "ACCU-CHEK" lettering facing upward. The meter will display a flashing drop above the test strip icon when the test strip is properly inserted indicating that you are ready to apply control solution.
7. Apply control solution to the front edge of the test strip. The solution will fill the yellow sample chamber by capillary action. Do not apply sample to the top of the test strip. Once sufficient sample has been detected, the measurement begins. An hourglass icon indicates that the measurement is in progress. You will get an error message if the sample is insufficient. If this occurs, you will need to repeat the test.
8. The measurement is complete when the result is displayed on the meter screen. See the "Interpretation of Results" and "Troubleshooting" sections below for guidance on what to do if your result is "Fail" or shows an "out of range" message associated with the result.
9. Remove the test strip and dispose of it in a regular garbage receptacle.
10. Touch the comment button () to enter an appropriate comment(s) as required in the "General Policies" section of this document.
11. Touch the  button to confirm the result and send the result from the meter wirelessly or place the meter in the base unit to send the result and record the result into the electronic data management system. The base unit also charges the meter.

D. INTERPRETATION OF QUALITY CONTROL RESULTS

1. Results are displayed on the screen as a Pass or Fail. Any result that shows an "out of range" message or "Fail" is an indication that the system may not be performing correctly for patient testing.

2. **Patient testing may not be performed if quality control testing results are not within acceptable limits** and the meter will not display the patient testing option if scheduled quality control results exceed acceptable limits.

3. **Troubleshooting out-of-range quality control results:** Quality control results must be within 3SD as stated by strip manufacturer. Take the following actions if your results are not within established limits:

a. Add a comment(s) to the out-of-range result indicating that the test will be repeated.
b. Repeat the test **one** time using the same test strip vial, control solution(s) and meter.
c. If the result is in range, you may proceed to patient testing.
d. If the repeat test using the same test strip vial is still out of range, repeat the test using a different test strip vial. If the result is within range, you may proceed with patient testing **using the new test strip vial.** Discard the vial that failed quality control testing.
e. If the repeat test using the different test strip vial remains out of range, repeat the test using a new vial of control solution. If the result is within range, you may proceed with patient testing. Discard the control vial that failed quality control testing.
f. If the repeat test using the new control vial remains out of range, remove the meter and all of the test strips and controls you used from service and deliver them to the Laboratory for further investigation.

Performing ACCU-CHEK Inform II Patient Testing

Patient testing with the ACCU-CHEK Inform II system quantitatively measures glucose in fresh venous, arterial, neonatal heelstick and capillary whole blood from the finger and is used as an aid in monitoring the effectiveness of glucose control. The procedure below describes the steps taken to perform patient testing on the ACCU-CHEK Inform II system. General patient testing is as follows:

A. MATERIALS:

Gather the following supplies in preparation for patient testing:

1. ACCU-CHEK Inform II meter – fully charged and coded to the test strip lot you intend to use.
2. ACCU-CHEK Inform II test strip vial. Note about reagents: Reagents are not to be used past their expiration date. ACCU-CHEK Inform II strips expire on the date printed on the strip vial label.
3. Supplies for collecting a blood sample as required by established phlebotomy procedures, such as cotton balls, alcohol preps, approved auto-disabling single-use lancing device.
4. Gloves
5. Biohazard and sharps container
6. Transfer pipette or syringe as needed if testing a venous, arterial or line draw sample.

B. ACCEPTABLE SPECIMENS:

1. The following fresh whole blood sample types may be used:
   a. Venous whole blood
   b. Arterial whole blood
   c. Capillary (non-neonate fingerstick and neonate heelstick) whole blood

2. The following anticoagulants are acceptable (do not use any other anticoagulants for meter testing):

a. Lithium or Sodium Heparin
b. EDTA

SPECIMEN NOTE:

1. **Fingerstick or neonate heelstick samples**: Test immediately as the sample is collected.
2. **Venous, arterial or line draw samples:** Test as soon as possible and no later than 30 minutes following collection. Be sure they are well mixed and that line draw samples have been thoroughly cleared of line fluids. Do not allow bubbles to enter the test strip-sampling chamber.

C. PERFORMING THE TEST (FINGERSTICK AND METER OPERATION)

1. Assemble the materials and meter you will need to collect a blood sample (gloves, skin preparation pad, auto-disabling single-use lancet device, gauze or cotton ball).
2. Perform hand hygiene and don gloves and any other personal protective equipment as required by infection control and isolation policies and procedures.
3. Turn on the meter.
4. From the *Main Menu*, touch *Patient Test*.
5. Enter your operator ID by means of *scanning employee badge barcode.* **NOTE:** If the operator ID you enter is not accepted, attempt to re-enter it. If it is still rejected, contact your supervisor or Point of Care Coordinator. **DO NOT** attempt to perform tests under another operator's ID.
6. Patient identifiers are entered into the ACCU-CHEK Inform II system when prompted by the meter.
7. Patient identification numbers are entered into the ACCU-CHEK Inform II system by means of barcode scanning of patient armband.
8. Confirm that the meter is coded (calibrated) to the same test strip code that is printed on the test strip vial by barcode scanning and/or screen confirmation. Contact your supervisor or Point-of-Care Coordinator if you are unable to confirm the correct test strip code.
9. You will now see a picture of a test strip with a downward flashing arrow on the screen indicating that you are ready to insert a test strip into the meter.
10. Remove a test strip from the vial and immediately recap the vial. Insert the test strip into the meter in the direction of the arrows and with the "ACCU-CHEK" lettering facing upward. The meter will display a flashing drop above the test strip icon when the test strip is properly inserted indicating that you are ready to apply a blood sample.
11. Assess the patient for compromised peripheral blood flow. Fingertips should be warm and pinkish when the hand is gently massaged from the palm outward to the fingertips. Fingertips should not appear pale, bluish or mottled. Patients with compromised peripheral blood flow are not good candidates for fingerstick testing.
12. Select the finger site for puncture. It is preferred to select the side of a middle or ring finger that has not been punctured recently. Avoid centers of fingers index finger and thumb.

    NOTE: If unable to obtain capillary sample, draw patient peripherally and blood can be applied to test strip carefully as described below.

13. Enhance blood flow to the selected puncture site by means of:
    a. Warming the intended puncture site

b. Instructing the patient to flex and move the arm, wrist, hand and fingers while you are assembling your supplies and preparing the system for testing
c. Positioning the intended puncture site below heart level
d. Gently massaging in an outward (distal) direction from the palm and the base of the finger to the fingertip. Do not squeeze finger.

14. Cleanse the puncture site by means of alcohol prep. Allow the site to air dry completely before puncturing.
15. Advise the patient of imminent puncture.
16. Perform capillary puncture as follows:
    a. Twist off the protective cap of the lancet and discard
    b. Hold the lancet tip against the puncture site
    c. Press the trigger button
    d. Withdraw the lancet from the site
17. Hold the puncture site downward and gently apply intermittent proximal to distal pressure along the finger toward the puncture site to express a blood drop. Do not apply strong repetitive pressure at the fingertip as it may cause hemolysis or contamination of the sample with tissue fluid and may lead to questionable results. Do not "milk" the finger.
18. The first drop often contains as much as 50% tissue fluid and leads to an inaccurate result. Therefore, it is **important to wipe off the first drop** and proceed with testing on the next drop. This is advantageous because it ensures that the cleansing agent is dry, it stimulates blood flow and clears interstitial fluid from the sample[3, 4]
19. Apply a well-formed drop to the ACCU-CHEK Inform II test strip. The sample will fill the yellow sample chamber by capillary action. Do not apply sample to the top of the test strip.
20. Once sufficient sample has been detected, the measurement begins. An hourglass icon indicates that the measurement is in progress.
21. After the sample has been obtained, apply gentle pressure to the puncture with a clean gauze square or cotton ball site for several minutes. If the patient is conscious and capable, enlist the patient's assistance with applying pressure.
22. The measurement is complete when the result is displayed on the screen. Depending upon how high or low the result is, it may appear in a numeric or non-numeric format. See *Interpretation of Results* section below for interpretation of each result format.
23. Remove the test strip and dispose of it in a regular trash receptacle.
24. Touch  to enter up to three appropriate comment(s) as required in the "General Policies" section of this manual.
25. Touch the  button to confirm the result and place the meter in the base unit to send the result and record the result into the electronic data management system. The base unit also charges the meter.
26. Document the result in the patient chart.
27. Check the site to ensure that it is no longer bleeding before leaving the patient bedside.
28. Follow up on any results that exceed critical or reportable limits according to Hospital Hypo/Hyperglycemic Protocol.
29. Clean and disinfect as necessary following your hospital's policy.
30. Discard all sample collection and testing materials in the appropriate waste stream.
31. Wash hands before leaving the patient room.

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[3] CLSI Document H4-A5: Procedures and Devices for the Collection of Diagnostic Blood Specimens by Skin Puncture – Approved Standard; Fifth Edition; 2004; Page 11

[4] CLSI Document POCT12-A3: Point-of-Care Blood Glucose Testing in Acute and Chronic Care Facilities; Approved Guideline – Third Edition; 2013; Section 10.2.3; Page 15.

32. Clean and disinfect according to section below on care and maintenance.

NOTE: Follow all facility safety and infection control policies when collecting blood samples when collecting blood samples, especially patients in isolation.

E. INTERPRETATION OF PATIENT RESULTS

1. Results will be displayed numerically. **It is the nurse's responsibility to recognize critical levels and take appropriate action. It is also the nurse's responsibility to recognize blood glucose levels that would invoke the hypoglycemic or hyperglycemic protocols.**
2. **Critical limits** for patient testing are:
   a. **Low: Less than 45 mg/dL (45mg/dL is not interpreted as Critical)**
   b. **High: Greater than 400 mg/dL (400 mg/dL is not interpreted as Critical)**
   c. **Reportable limits** for patient testing are **10 mg/DL to 600mg/dL**. Results that exceed the reportable limits of the system will be displayed as RR HI/RR LO or HI/LO, the measurement range default.
3. Patient test results that **exceed critical limits or reportable limits** must be followed-up by following Hyper/Hypoglycemic protocols, and by calling the appropriate physician and documenting in the medical record.
4. **Comments:** Appropriate comment(s) are required to be attached to the following result(s):
   a. Control results that are out of range
   b. Patient results that exceed critical limits
   c. Patient results that exceed reportable limits
   d. Repeated test results
   e. *Any test that an operator intends to repeat (questionable results, known procedural errors, etc.)*

   Optional comments may be attached as deemed appropriate by the operator.

F. PATIENT TESTING PROCEDURE NOTES

Good sample quality is essential for reliable results. The following tips will help you to optimize the quality of a fingerstick capillary sample:

1. Assess the patient for signs of reduced peripheral circulation such as cold hands, pale, mottled or bluish nailbeds and administration of vasopressor medications. If peripheral circulation is impaired, collection of capillary blood from approved sites is not advised, as the results might not be a true reflection of the physiologic blood glucose level. This may apply in the following circumstances: severe dehydration as a result of diabetic ketoacidosis, or due to hyperglycemic hyperosmolar non-ketotic syndrome, hypotension, shock, decompensated heart failure NYHA class IV, or peripheral arterial occlusive disease.
2. Always take basic steps to stimulate blood flow to the intended puncture site. Even if the patient's peripheral circulation is not impaired this will help you to procure a sufficient and free flowing sample, especially in patients who are sedentary. Common methods for stimulating blood flow include:
   a. Warming the site

b. Positioning the hand below the heart
c. Gently massaging the hand by stroking from the palm outward to the fingertip
d. Asking the patient to move and flex his/her arm, wrist, hand and fingers while you are gathering supplies and preparing the system for testing

3. Be sure to allow the cleansing agent to completely dry before puncturing the intended site.
4. Be sure to wipe away the first drop of blood before obtaining test sample.
5. Do not attempt to express blood from a previous puncture site even if it still appears to be bleeding because it is likely that the clotting process has begun and may alter the sample matrix. A fresh puncture should be made for every test.
6. Do not place the meter on bedding after applying blood to the test strip. This can cause the blood to be wicked out of the test strip by the bedding.
7. Recap the test strip vial immediately after you remove the test strip you plan to use. Never use test strips found loose outside the vial. Discard any vial of strips that you find uncapped.

VI. TRANSFERING RESULTS:

A. Wired Data Transfer: Results are transferred into the Laboratory Information System (HLAB) by placing the meter into a base unit that is connected to the hospital network. When properly docked the meter will automatically transfer test results. The following series of screen displays will appear to confirm that data transfer is occurring:

1. "Connecting," (meter is establishing connection)
2. "Transferring," (meter is transferring information)
3. "Idle" (meter has finished communications and is ready to use.)

The meter can be removed and used at any time during the transfer of information. Any information not completed will be transferred the next time the meter is docked. When properly docked the meter will communicate every 10 minutes even if the meter is off. This connection gives the meter the most up to date settings and ADT information when available. This transfer can occur also when a wireless meter is docked in a connected base unit.

VII. CARE AND MAINTENANCE

A. Hospital-approved bactericidal wipes are used for cleaning and disinfecting the ACCU-CHEK Inform II meters and system components.
B. Meters are cleaned and disinfected before and after each use.
C. Base Unit cleaning and disinfecting - Base units are cleaned and disinfected weekly.
D. Accessory box cleaning and disinfecting - Accessory boxes are cleaned and disinfected weekly.
E. Cleaning and disinfecting are companion procedures that are generally performed together at the same time.
   1. Cleaning removes visible soil and organic material.
   2. Disinfecting destroys most recognized pathogenic microorganisms but not necessarily all microbial forms (e.g., bacterial spores).

NOTE: The FDA recommends that Point of Care testing devices, such as blood glucose meters, should be used only on one patient and not shared. If dedicating blood glucose meters to a single patient is not possible, the meters must be properly cleaned and disinfected after every use

following the guidelines given in this manual.

F. **General Cleaning and Disinfecting Procedural Considerations:**

1. **Dos:**

a. **Follow all facility safety and infection control policies when handling, cleaning and disinfecting ACCU-CHEK Inform II meters.**
b. If you notice any signs of deterioration after cleaning and disinfecting a meter system, contact ACCU-CHEK Customer Care at 1-800-440-3638 for assistance.
c. Obtain and dispose of acceptable cleaning and disinfection products per facility guidelines.

2. **Don'ts**

a. **Do Not** clean or disinfect the meter while performing any type of test.
b. **Do Not** allow pooling of liquid on the touchscreen.
c. **Do Not** spray anything onto the meter or base unit.
d. **Do Not** immerse the meter or base unit in liquid.
e. **Do Not** get liquid into the strip port! If liquid does get into the test strip port, immediately dry the components with a dry cloth or gauze pad. If solution is allowed to collect in any meter opening, severe damage to the system can occur. If you suspect that moisture may have entered the strip, perform glucose control testing.
f. **Do Not** wipe the electrical connectors on the back of the base unit.
g. **Do Not** use any cleaning and disinfecting product other than that which is recommended by the manufacturer, identified in this procedure and provided through normal procurement policies and procedures.

VIII. RELATED DOCUMENTS:

Accuchek Inform II Quick Reference Guide for Healthcare Professionals.

Hypoglycemic Protocol (DMC Protocol)
Point of Care Testing Policy – Glucose using the Accuchek Inform II – Nursing Procedure

IX. REFERENCES:

Manufacturer provided: "Sample Template for: Comprehensive Policies, Processes and Procedures Manual For Use With the ACCU-CHEK® Inform II Glucose Monitoring System", © 2012-2013, Roche Diagnostics.

APPROVAL ROUTING SHEET FOR POLICIES AND PROCEDURES

DOCTORS MEDICAL CENTER

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

†**TITLE:** Arzerra -Ofatumumab Order Set	†**CHECK ONE:** ☐ New ☐ Reviewed ☒ Revised : ☐ Major ☐ Minor
† ☐ **Administrative** ☐ **Clinical** ☒ **Department** Pharmacy	
†**SUBMITTED BY:** Therese Helser, Pharmacy Director	
†**NEW POLICY - REASON FOR SUBMISSION:** ☐ Change in Law ☐ New Regulation: CMS CDPH TJC Other	
†**REVIEWED OR REVISED - SUMMARY OF POLICY / PROCEDURE CHANGES:** New order set reflects new addition to formulary (chemotherapy) used for leukemia. .	

	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	1/16/2014	1/16/2014
☐ 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)**†		
☐ **Executive Leadership**		
☒ **Medical Executive Committee (MEC)** (as applicable)	2/10/2014	2/10/2014
☒ **Board of Trustees** *(automatic from MEC)* *(as applicable)*	2/26/2014	

DOCTORS MEDICAL CENTER San Pablo, CA

PHYSICIAN ORDERS

Patient Sticker Here

ARZERRA *(Ofatumumab)* 1/14

Height: _____ **Weight:** _____ **Allergies/Reactions:** _____

ARZERRA (Ofatumumab)

☐ *For* _____ *doses*

Diagnosis _____

LAB requirements:

- *Hold drug for: WBC less than 2,000 or* _____ *ANC less than 1,500 or* _____ *Platelets less than 100,000 or* _____
  - ☐ *Serum Creatinine greater than 1.5 mg/dl or* _____ ☐ *AST/ALT 1-3 x upper limit of Normal (ULN)* _____
  - ☐ *Total Bilirubin greater than 1.5 mg/dl or* _____

1. Admit to Infusion Center for chemotherapy.
2. Prior to infusion, confirm patient has no active infection, including localized infections. If signs & symptoms of infection are present, hold infusion and inform physician.
3. VS: on admission and before discharge Diet: ☐Regular ☐_____; Activity: ☐ Up ad lib ☐ _____
4. Begin IV of 250 ml 0.9% NaCL at a TKO rate
5. **Premedications give ONE HOUR prior to each drug infusion: HOLD for any sign of infection, notify MD:**
   Corticosteroid pre medication:
   - Do not reduce corticosteroid dose for doses 1, 2, and 9,
   - Corticosteroids dose may be reduced as follows for doses 3 through 8 and 10 through 12:
     - Doses 3 through 8: ***gradually reduce*** with successive infusions if a grade 3 or greater reaction ***did not*** occur with previous doses
     - Doses 10 through 12: ***administer full or half*** corticosteroid if a grade 3 or greater infusion reaction ***did not*** occur with dose 9.

☐	Dexamethasone (DECADRON): ☐10mg ☐20mg ☐PO ☐IVP (Over 4-5 minutes)	☐	Diphenhydramine (BENADRYL): ☐ 25 mg ☐ 50mg ☐ PO ☐IVP Infuse over 2 minutes ☐ May also give every 8 hours for rash or itching.
☐	Acetaminophen (TYLENOL) PO ☐ 650 mg ☐ 500 mg (2 tab) ☐ May also give every 4 hours as needed for temp greater than 100°F or mild discomfort	☐	**Ondansetron:** ☐16 IVPB (over 15 minutes) (ZOFRAN) ☐8 mg ☐ IVPB ☐PO ☐SL ☐4 mg IVP (Over 2 minutes)

6. **Infuse:(ok to round the dose down to the nearest 10%)**

A. ARZERRA (Ofatumumab)

DOSE ONE (1): 300 mg in 1000 ml 0.9 % Na Cl ***use an inline filter (supplied)***

- Initiate infusion at a rate of 3.6 mg/hr (12 mL /hour) may increase infusion every 30 minutes if tolerated by following table below.

Table 1. Infusion Rates for ARZERRA

Interval after start of the infusion (min)	DOSE 1 (mL/hour)	DOSE 2 (mL/hour)	DOSE 3-12 (mL/hour)
0-30	12	12	25
31-60	25	25	50
61-90	50	50	100
91-120	100	100	200
GREATER THAN 120	200	200	400

a. Dose 1 = 300 mg (0.3 mg/mL).
b. Doses 2 and 3-12 = 2,000 mg (2 mg/mL).

One week later: Date:_____

DOSE TWO (2) THROUGH EIGHT (8) once a week for 7 doses : 2,000 mg in 1000 ml 0.9 % Na Cl use an inline filter (supplied)

- DOSE 2: Initiate infusion at a rate of 24 mg/hour (12 mL/hour) may increase infusion every 30 minutes if tolerated by following table above.
- DOSES 3-12: Initiate infusion at a rate of 50 mg/hour (25 mL/hour) may increase infusion every 30 minutes if tolerated by following table above

Start week 9: Date_____

DOSES NINE (9)THROUGH TWELVE (12) every 4 weeks for 4 doses: 2,000 mg in 1000 ml 0.9 % Na Cl use an inline filter (supplied)

- Continue infusion at a rate of 50 mg/hour (25 mL/hour) may increase infusion every 30 minutes if tolerated by following table above.
- Miscellaneous information:
  - For all infusions: Watch for infusion reaction and follow hypersensitivity reaction protocol as needed.
  - Grade 4 reactions do not resume infusion
  - Grade 1, 2, 3 infusions: if the reaction resolves after following the protocol and following modifications according to initial grade of the infusion reaction:
    - Grade 1 or 2: infuse at one half of the previous infusion rate
    - Grade 3: infuse at 12 mL/hour
  - After resuming, the infusion rate may be increased according to the above table based on the patient's tolerance.
  - DO NOT MIX with or infuse with other medications
  - Flush the IV with NS before and after each dose

B. Other:

7. **Discharge Meds and instructions:** Nursing to call patient's pharmacy

☐	**Inform patient that taking Actemra may lower resistance to infections and to contact physician when symptoms of an infection appear (cough, fever, skin lesion, redness, drainage, etc)**	☐	Acetaminophen (TYLENOL) PO☐ 650 mg ☐ 500 mg (2 tab) ☐ May also give every 4 hrs as needed for temp greater than 100°F or mild discomfort
☐	Prochlorperazine (COMPAZINE) 10 mg tab PO Q 6hours PRN nausea and vomiting	☐	Diphenhydramine (BENADRYL): PO ☐ 25 mg ☐ 50mg Give every 8 hours for rash or itching.
☐	Dexamethasone 4 mg tablets 2 tablets twice a day X3 days	☐	Ondansetron (ZOFRAN) 8mg Sig: 3 tabs PO daily x 3 days start in Am day after chemo

The necessity and appropriateness of the proposed procedure, as well as alternative treatment techniques, have been discussed with the patient prior to scheduling the procedure. I have explained to the patient the nature and purpose of the procedure described above and the risks involved in the performance of the procedure. No guarantee has been or can be made regarding the cosmetic or functional result of the procedure.

Physician signature: _____ Date and Time: _____

Nurse Noted: _____,RN Date and Time: _____

DOCTORS MEDICAL CENTER San Pablo, CA **PHYSICIAN ORDERS** **ARZERRA** *(Ofatumumab)* *01/14*	Patient Sticker Here

INSTRUCTIONS FOR SERIOUS HYPERSENSITIVITY REACTIONS:
(Hypotension, hives, dyspnea, chest pain, flushing)

1. Stop the infusion. Infuse Normal Saline at 125ml per hour

2. Call physician STAT

3. If no pre-medications were given administer:
   - Diphenhydramine 50mg IVP
   - Methylprednisolone (SOLUMEDROL) 125mg IVP

   If pre-medications were given administer:
   - Diphenhydramine 25mg IVP
   - Methylprednisolone (SOLUMEDROL) 80mg IVP

4. Place on O2: Start O2 at 2L and titrate to keep O2 sat equal to or above 90%.

5. Have Respiratory Therapy phone number ready.

6. Have Epinephrine 1:10,000 (1mg/10ml) prefilled syringe on hand to give per physician order.
   If patient remains symptomatic after above treatments initiated give:

   ❑ Epinephrine 0.5mg (5ml) of 1:10,000 prefilled syringe IVP. Inform the physician.

7. If the patient has been receiving beta blockers (e.g. atenolol or propanolol) inform the physician.
   If patient is still symptomatic after receiving epinephrine:

   ❑ Give glucagon 1mg IVP X1
   - Check blood sugar by Accucheck. Call physician if BS is above 200 or below 80
   - Repeat Accucheck in 15 minutes x2

8. Vital signs Q 5-15 minutes as dictated by patient's condition

Physician Signature: _____ Date and Time: _____
❑ Read back Verified: _____, RN Date and Time: _____
Nurse Noted:_____ Date and Time: _____

APPROVAL ROUTING SHEET FOR POLICIES AND PROCEDURES

DOCTORS MEDICAL CENTER

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

†**TITLE:** Warfarin (Coumadin) Order Form	†**CHECK ONE:** ☐ New ☐ Reviewed ☒ Revised : ☐ Major ☐ Minor
† ☐ **Administrative** ☐ **Clinical** ☒ **Department** Pharmacy	
†**SUBMITTED BY:** Therese Helser, Pharmacy Director	
†**NEW POLICY - REASON FOR SUBMISSION:** ☐ Change in Law ☐ New Regulation: CMS CDPH TJC Other	
†**REVIEWED OR REVISED - SUMMARY OF POLICY / PROCEDURE CHANGES:** Updated order set to reflect use of KCENTRA (antidote) for reversing bleeding due to warfarin (Coumadin).	

	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	1/16/2014	1/16/2014
☐ 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)**†		
☐ **Executive Leadership**		
☒ **Medical Executive Committee (MEC)** (as applicable)	2/10/2014	2/10/2014
☒ **Board of Trustees** *(automatic from MEC)* *(as applicable)*	2/26/2014	

Doctors Medical Center San Pablo
2000 Vale Road, San Pablo, CA 94806

PHYSICIAN ORDERS

Warfarin (Coumadin) Order Form **11/2013** **Patient Name:**

- **ALL ADMISSION *INITIATION* AND *CONTINUATION* OF WARFARIN THERAPY MUST BE ORDERED ON THIS FORM UNLESS IT IS PART OF OTHER PRE-PRINTED PROTOCOLS.**
- **LABS:**
  1. **INR daily during titration. INR MWF after INR goal achieved and maintained X2 days**
  2. **Hemoglobin, and Platelets every 3 days while on warfarin.**
- **NURSING MONITORING:**
  1. **Monitor signs and symptoms of bleeding and Monitor signs of skin necrosis**
  2. **Monitor elevated INR beyond target.**
- **PATIENT EDUCATION:**
  1. Give patient warfarin educational material and document electronically.
  2. Discuss food/drug interactions and document (Dietary)
- **Recommended INR goal based on indication below:**

1. INDICATION and GOAL INR*: MD MUST CHECK INDICATION FOR USE & FILL OUT HOLD PARAMETERS

INDICATION (check)	INR GOAL (Recommended based on DMC LAB)	Hold for INR above (MD/DO MUST FILL OUT)
☐ Prophylaxis of venous thrombosis (orthopedic surgery)	1.5 to 2.2	
☐ Prophylaxis of venous thrombosis (other than high risk surgery)	2 to 3	
☐ Treatment of Deep vein thrombosis/Pulmonary embolism	2 to 3	
☐ Cancer (hypercoagulable)	2 to3	
☐ Acute myocardial infarction (to prevent systemic embolism)	2 to 3	
☐ Acute myocardial infarction (to prevent recurrent MI)	2.5 to 3.5	
☐ Atrial fibrillation	2 to 3	
☐ Tissue heart valves	2 to 3	
☐ Bileaflet mechanical valve in aortic position	2 to 3	
☐ Valvular heart disease	2 to 3	
☐ Mechanical/Bioprosthetic valve	2.5 to 3.5	
☐ Antiphospholipid Antibodies/Lupus Anticoagulant	2.5 to 3.5	

2. PATIENTS ON WARFARIN PRIOR TO ADMISSION:

- ☐ **Continue on admission: Dose=_____mg, Daily at 1800 or_____ Hold for INR _____**
- ☐ **On hold for elevated INR**
- ☐ **On hold for surgery. (Bridging with UFH/LMWH/Fondaparinux may be necessary)**

3. ☐ **WARFARIN INITIATION,** patient starting on warfarin as inpatient. (Bridging with UFH/LMWH/Fondaparinux may be necessary)

4. **RECOMMENDED DOSING FOR INITIATION OF *WARFARIN* *Patients with lower or higher INR goal ranges than 2-3 will need alternative dosing adjustments than those specified in chart below. The chart does not replace clinical judgment and is to be used only as a guideline.**

Day	INR	Warfarin Dose (Check one to initiate)	
1	Obtain baseline	☐ 2.5 mg (if elderly, malnourished, liver disease, high bleeding risk, CHF exacerbation, or interacting drugs)	☐ 5 mg
2		SAME AS DAY 1 DOSE. (If INR above 3 check with MD)	SAME AS DAY 1 DOSE (If INR above 3 check with MD)
3	Less than 1.5	5 mg or_____mg	7.5 mg or_____mg
	1.5 to 1.9	2.5 mg or_____mg	5 mg or_____mg
	2 to 3	2.5 mg or_____mg	5 mg or_____mg
	Above 3	Omit dose or_____mg	Omit dose or_____mg
4	Less than 1.5	10 mg or_____mg	10 mg or_____mg
	1.5 to 1.9	5 mg or_____mg	7.5 mg or_____mg
	2 to 3	2.5 mg or_____mg	5 mg or_____mg
	Above 3	Omit dose or_____mg	Omit dose or_____mg
5	Less than 1.5	10 mg or_____mg	10 mg or_____mg
	1.5 to 1.9	7.5mg or_____mg	10 mg or_____mg
	2-3	2.5 mg or_____mg	5 mg or_____mg
	Above 3	Omit dose or_____mg	Omit dose or_____mg
6	Less than 1.5	7.5 mg or_____mg	12.5 mg or_____mg
	1.5 to 1.9	5 mg or_____mg	10 mg or_____mg
	2 to 3	2.5 mg or_____mg	5 mg or_____mg
	Above 3	Omit dose or_____mg	Omit dose or_____mg

5. ***AFTER DAY 6* ADJUST WARFARIN DOSE:** If not at INR goal of 2-3 by day 6 adjust weekly warfarin dose by 10 to 20% .

Print_____ **Signature**_____MD/DO **Date/Time**_____

Warfarin Reversal Guidelines for elevated INR

Condition	Intervention
INR more than therapeutic goal range but less than 5 and no significant bleeding	• Lower dose or omit dose • Monitor more frequently • Resume at lower dose when INR therapeutic (may resume at same dose if INR minimally above therapeutic range)
INR greater than or equal to 5 but less than 9 and no significant bleeding	• Hold warfarin for 1 or 2 doses, • Monitor INR more frequently • Resume at an appropriately adjusted dose when INR is in therapeutic range. • Alternatively, hold dose and give vitamin K oral 1-2.5mg (if patient has mechanical valve, check with cardiologist prior to administration). • Repeat vitamin K oral 1-2.5mg if INR still elevated.
INR greater than or equal to 9 and no significant bleeding	• Hold warfarin therapy • Give vitamin K oral 2.5 to 5mg (if patient has mechanical valve, check with cardiologist prior to administration). • Monitor INR more closely • Use additional vitamin K if needed. • Resume warfarin at appropriate dose when INR is therapeutic
Serious bleeding at any elevation of INR	• Hold warfarin therapy • Give vitamin K 10mg by slow IVPB infusion over 30minutes I(if patient has mechanical valve, check with cardiologist prior to administration) • Supplemented with FFP urgency of the situation **OR** • **4 factor Prothrombin Complex Concentrate (Kcentra)- refer to cpoe order form OR** • **If patient has history of HIT (heparin induced thrombocytopenia) 3 factor Prothrombin Complex Concentrate (Profilnine)- 30 units/kg, slow iv infusion (pharmacy to round to nearest vial size).** • Vitamin K IVPB can be repeated every 12 hours
Life threatening bleeding	• Hold warfarin therapy • **4 factor Prothrombin Complex Concentrate (Kcentra)- refer to cpoe order form OR** • ~~Give 2 units of FFP (each unit has 200ml),~~ • If patient has history of HIT (heparin induced thrombocytopenia) 3 factor Prothrombin Complex Concentrate (Profilnine)- 30 units/kg, slow iv infusion (pharmacy to round to nearest vial size). • Vitamin K 10mg by IVPB over 30mins. • Repeat Vitamin K if necessary depending on INR

1. Administration of vitamin K in patients with mild to moderately elevated INRs without major bleeding, give vitamin K orally rather than IV
2. If parenteral vitamin is required, IV only. Do not order IM or S.C.
3. If continuing warfarin therapy is indicated after high doses of vitamin K1, then heparin or low-molecular-weight heparin can be given until the effects of vitamin K1 have been reversed, and the patient becomes responsive to warfarin therapy.
It should be noted that INR greater than 4.5 are less reliable than values in or near the therapeutic range. Thus, these guidelines represent an approximate guide for high INRs.

APPROVAL ROUTING SHEET FOR POLICIES AND PROCEDURES

DOCTORS MEDICAL CENTER

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

†**TITLE:** Ado-Trastuzumab Formulary Addition	†**CHECK ONE:** ☐ New ☐ Reviewed ☒ Revised : ☐ Major ☐ Minor
† ☐ **Administrative** ☐ **Clinical** ☒ **Department** Pharmacy	
†**SUBMITTED BY:** Therese Helser, Pharmacy Director	
†**NEW POLICY - REASON FOR SUBMISSION:** ☐ Change in Law ☐ New Regulation: CMS CDPH TJC Other	
†**REVIEWED OR REVISED - SUMMARY OF POLICY / PROCEDURE CHANGES:** .New order set reflects new addition to formulary (Chemotherapy) for Breast Cancer.	

	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	1/16/2014	1/16/2014
☐ 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)**†		
☐ **Executive Leadership**		
☒ **Medical Executive Committee (MEC)** (as applicable)	2/10/2014	2/10/2014
☒ **Board of Trustees** *(automatic from MEC)* *(as applicable)*	2/26/2014	

I. A.H.F.S.: HER2-targeted Antibody-drug complex

II. GENERIC NAME: Ado-Trastuzumab

III. BRAND NAME: Kadcyla™

IV. USE/INDICATION (FDA APPROVED): *Kadcyla™* is an antibody drug conjugate which is indicated as a single agent for the treatment of patients with human epidermal growth factor 2 (HER2)-positive metastatic breast cancer in adults with progression following treatment with trastuzumab and a taxane. Patients should have either received prior therapy for metastatic disease or developed disease recurrence during or within six months of completing adjuvant therapy.

V. EFFICACY: In the EMILIA trial, progressive free survival was increased by a median of 3.2 months with ado-trastuzumab compared with lapatinib plus capecitabine (HR 0.65, 95%CI 0.55 to 0.77, p<0.001) and overall survival was increased by a median of 5.8 months with ado-trastuzumab compared with lapatinib plus capecitabine (HR 0.68, 95% CI 0.55 to 0.85, p<0.001).

VI. PHARMACOLOGY/KINETIC PROPERTIES: This drug is a anti-HER2 IgG1 antibody, drug conjugate which incorporates the HER2 targeted actions of trastuzumab, and the microtubule inhibitor, DM1. It selectively targets HER2 expressing cancer cells and delivers the DM1 cytotoxin directly inside them, causing cell death. This drug demonstrates linear kinetics following IV administration. The DM1 component is highly protein bound and is metabolized by CYP3A4. The median half-life following IV infusion is ~4 days. Peak plasma concentrations occur around the end of the infusion (30-90 minutes). The volume of distribution of the ado-trastuzumab conjugate is 3.13 L.

VII. DOSING/ADMINISTRATION: The recommended dose is 3.6 mg/kg (not to exceed) given IV only every 21 days. Administer first dose over 90 minutes and monitor closely for infusion-related reactions and extravasation. If the first dose is well tolerated, infuse subsequent doses over 30 minutes. Modify doses for elevated serum transaminases, hyperbilirubinemia, left ventricular dysfunction, and thrombocytopenia. If a dose reduction is necessary, do not re-escalate dose. Do not substitute for or with trastuzumab.

VIII. LOOK-ALIKE/SOUND ALIKE: Trastuzumab and Ado-trastuzumab. Products are NOT interchangeable.

IX. ADVERSE EFECTS: The most frequent side effects reported include nausea (40%), fatigue (36%), musculoskeletal pain (36%), thrombocytopenia (31%), elevated liver enzymes (29%), headache (28%), constipation (26%). Currently no contraindications. Serious adverse effects/toxicities include possible liver failure, reduction of left ventricular ejection fraction (cardiotoxicity), pulmonary toxicity, thrombocytopenia, neurotoxicity, infusion reactions, immunogenicity, extravasation, embryo-fetal birth defects, and death.

X. COST: $3328.28 for 100mg. $5323.25 for 160mg.

XI. RECOMMENDATION: Add to DMC formulary as a monotherapy treatment option for treating HER2-positive metastatic breast cancer in adults who previously received trastuzumab and a taxane either separately or in combination.

References: Kadcyla Package Insert by Genentech, Novation Drug Monograph July 2013

Prepared by: Danessa Lerias, PharmD student December 2013 Reviewed: Sandeep Kaur, Pharm.D. Dec 2013

DOCTORS MEDICAL CENTER
2000 Vale Road
San Pablo, CA 94806

MD ORDERS

Patient Sticker Here

Height:_____ **Weight:** _____ **BSA**_____ **Allergies/Reactions** _____

(Any change in the order requires new orders to be written)

Ado-Trastuzumab Emtansine (KADCYLA)

☐ **Muga scan at baseline and every 3 months. HOLD if LVEF greater than10 % point decline from baseline.**

PATIENT IS ON A CLINICAL TRIAL ☐ YES ☐ NO **Informed consent signed** ☐ YES ☐ NO

Cycle #_____ ☐**every 3 weeks** **for** _____**Cycles**

Diagnosis _____

Hold chemotherapy for:
☐***WBC less than 2,000 or*** _____ ☐***ANC less than 1,500 or*** _____ ☐***Platelets less than 100,000 or*** _____
☐***Se Creatinine greater than 1.5 mg/dl or*** _____ ☐***Total Bilirubin greater than 1.5 mg/dl if greater than 10x ULN DC permanently***
☐***AST/ALT greater than 5 to less than 20 x ULN.....if greater than 20x ULN DC permanently***
☐***Permanently discontinue KADCYLA treatment in pts with serum transaminases greater than 3 x ULN and concomitant total bilirubin > 2 x ULN.***

1. Admit to Infusion Center for chemotherapy
2. **VS** on admission and per protocol for KADCYLA infusion **Diet:** ☐Regular ☐_____ **Activity:** ☐ Up ad lib ☐_____
3. Begin IV of 250ml 0.9% NaCl at TKO
4. **Premedications 30 minutes prior to chemotherapy:**

☐	Lorazepam ☐1mg ☐2 mg ☐0.5mg ☐ x1 only ☐ Q4 hours PRN nausea or anxiety ☐PO ☐ SL ☐IVP Infuse at max rate of 2mg / minute	☐	Ondansetron ☐ 16 mg IVPB over 15 minutes ☐ 8 mg or ☐____mg ☐PO ☐ SL ☐4 mg IVP Infuse over 2 minutes
		☐	Acetaminophen 650 mg PO
☐	Famotidine 20 mg IVP dilute to total volume of 5-10ml and infuse over 2 minutes	☐	Prochlorperazine ☐ 10mg ☐ 25mg ☐ PO ☐Supp ☐IVP Infuse over 2 minutes
☐	Dexamethasone ☐10mg ☐20mg ☐PO ☐ IVP Infuse over 4-5 minutes	☐	Diphenhydramine ☐ 25 mg ☐ 50mg ☐ PO ☐IVP Infuse over 2 minutes
☐	Aprepitant (EMEND) ☐ 150 mg IVPB over 30 minutes	☐	

6. Chemotherapy give in the order written: (ok to round to the nearest 10%)

a. KADCYLA 3.6 mg/kg or_____**mg/kg via infusion in 250 ml 0.9% NaCl =** _____

- **Use an inline (0.22 micron)** ☐ **1st infusion: over 90 minutes plus 90 minutes observation time**
  ☐ Subsequent infusions: over 30 minutes plus 30 minutes observation time
- **Do not mix KADCYLA, or administer as an infusion, with other medicinal products.**
- **Do not administer I.V. push or bolus**
- **Do not use Dextrose (5%) solution (incompatible)**
- **Follow Hypersensitivity Protocol:**

b. ☐**Other**: _____

7. Discharge Meds: Nursing to call patient's pharmacy:

☐	Ondansetron 8 mg tabs, 3 tabs PO daily x 3 days	☐	Prochlorperazine 10 mg tab PO Q6h PRN nausea and vomiting #30
☐	Dexamethasone 4 mg tab, 2 tabs PO BID x 3 days	☐	

The necessity and appropriateness of the proposed procedure, as well as alternative treatment techniques, have been discussed with the patient prior to scheduling the procedure. I have explained to the patient the nature and purpose of the procedure described above and the risks involved in the performance of the procedure. No guarantee has been or can be made regarding the cosmetic or functional result of the procedure.

Physician: _____/_____ Date/Time:_____
Print Signature

Nurse : _____/_____ Date/Time:_____
Print Signature

DOCTORS MEDICAL CENTER 2000 Vale Road San Pablo, CA 94806 **MD ORDERS**	Patient Sticker Here Page 2 of 2
Height:_____ **Weight:** _____ **BSA**_____	**Allergies/Reactions** _____

INSTRUCTIONS FOR SERIOUS HYPERSENSITIVITY REACTIONS:
(Hypotension, hives, dyspnea, chest pain, flushing)

1. Stop the infusion. Infuse Normal Saline at 125ml per hour.
2. Call MD stat.
3. If no pre-medications were given administer:
   - Diphenhydramine 50mg IVP.
   - Solumedrol 80mg IVP.

   If pre-medications were given administer:
   - Diphenhydramine 25mg IVP.
   - Solumedrol 80mg IVP.
4. Place on O2:
   - If no Hx of COPD/Emphysema place on O2 at 15 L/min per non-rebreather mask.
   - If patient has a Hx of COPD/Emphysema place on O2 at 2L/min nasal cannula.
5. Have Respiratory Therapy phone number ready.
6. Have Epinephrine 1:10,000 (1mg/10ml) prefilled syringe on hand to give per MD order.

☐ If patient remains symptomatic after above treatment is initiated give:
   - Epinephrine 0.5mg (5ml) of 1:10,000 prefilled syringe IVP. Inform the MD.

7. If the patient has been receiving beta blockers (such as atenolol or propanolol) inform the MD.

☐ If patient is still symptomatic after receiving epinephrine:
   - Give glucagon 1 mg IVP X1.
   - Check blood sugar by accucheck. Call MD if BS is above 200 or below 80.
   - Repeat accucheck in 15 minutes x2.

8. Vital signs Q 5-15 minutes as dictated by patient's condition.

Physician: _____ / _____ Date/Time:_____
Print Signature

Nurse : _____ / _____ Date/Time:_____
Print Signature

MEDICAL STAFF COMMITTEES CHAIR 2014

BYLAWS COMMITTEE

Ellen Morrissey, MD	Chair	

CANCER COMMITTEE

Stuart Gourlay, MD	Chair /Cancer Liaison Physician	

CREDENTIALS & PRIVILEGES COMMITTEE & INTERDISCIPLINARY PRACTICE COMMITTEE

Lorna Cogen, MD	Chair	

INFECTION CONTROL

Khosrow Afsari, MD	Chair	

INSTITUTIONAL REVIEW BOARD (IRB)

David Irwin, MD	Chair	

INVASIVE LAB COMMITTEE

Stephen Arnold, MD	Chair	

MEDICAL EDUCATION & LIBRARY COMMITTEE

Khosrow Afsari, MD	Co-Chair (Medicine)	
Stuart Gourlay, MD	Co-Chair (Surgery)	

MEDICAL ETHICS COMMITTEE

Abid Majid, MD	Chair	

MEDICAL EXECUTIVE COMMITTEE

Richard Stern, MD	Chief of Staff	

MEDICAL PEER REVIEW COMMITTEE

Denise Ricker, MD	Chair	

MEDICAL STAFF LEADERSHIP/PERFORMANCE IMPROVEMENT/PATIENT SAFETY COMMITTEE

Richard Sankary MD	Co-Chair	
Sharon B. Drager MD	Co-Chair	

PHARMACY AND THERAPEUTICS COMMITTEE

Abid Majid, MD	Chair	

MED ERROR PREVENTION (Sub-committee of P/T)

Therese Helser, RPh	Chair	

PHYSICIAN WELL BEING COMMITTEE

Khosrow Afsari, MD	Chair	

RADIATION SAFETY COMMITTEE

Christopher Lee, MD	Chair	

RESPIRATORY / CRITICAL CARE / ED COMMITTEE

Abid Majid, MD	Co-Chair	
Muhammad Raees, MD	Co-Chair	

STANDARDS OF CONDUCT COMMITTEE

Richard Stern, MD	Chief of Staff	

SURGICAL PEER REVIEW COMMITTEE

Collin Mbanugo, MD	Chair	

UTILIZATION MANAGEMENT COMMITTEE

Stephen Arnold, MD	Chair	

DEPARTMENT OF MEDICINE

Muhammad Raees, MD	Department of Medicine Chair	

DEPARTMENT OF SURGERY

Collin Mbanugo, MD	Department of Surgery Chair	

MEDICAL STAFF COMMITTEE RECOMMENDATIONS	DATE
CREDENTIALS COMMITTEE	January 23, 2014
MEDICAL EXECUTIVE COMMITTEE	February 10, 2014
BOARD OF DIRECTORS APPROVAL	February 26, 2014

DOCTORS MEDICAL CENTER
CREDENTIALS REPORT
JANUARY 2014

INITIAL APPOINTMENTS

The following practitioners have applied for membership and/or clinical privileges at DOCTORS MEDICAL CENTER. This summary includes factors that determine status of membership, licensure, professional liability insurance, required certifications (if applicable), etc. Factors that determine current competence include medical/professional education, training (internship/residencies/fellowship) and experience, board certification (if applicable), current and previous hospital and other institutional affiliations, physical and mental health status, peer references, and past or pending professional disciplinary action.

NAME	DEPARTMENT/SPECIALTY	CATEGORY	APPOINTMENT TERM	RECOMMENDATION
Narsinh, Kiran, MD	Med./Family Practice/Gastroenterology	Provisional	02/26/2014 – 02/25/2016	Approval
Golino, Hilarie, PA	Med./Family Practice/ER-Physician Assistant	Allied Health	02/26/2014 – 02/25/2016	Approval

REAPPOINTMENTS

The following practitioners have applied for reappointment to the Medical Staff. This summary includes factors that determine membership; licensure, DEA, professional liability insurance, required certifications (if applicable), etc. Qualitative/quantitative factor, developed through on-going professional performance evaluation, include peer review, quality performance, clinical activity, privileges, competence, technical skills, behavior, health, medical records, blood review, medication usage, litigation history, utilization and continuity of care. ***Membership requirements are met, unless specified below.***

NAME	DEPARTMENT/SPECIALTY	CATEGORY	REAPPOINTMENT TERM	RECOMMENDATION
Fox, Robert, MD	Medicine & Family Practice/Neurology	Active	03/23/14 – 02/28/16	Approval
Bordow, Richard, MD	Medicine & Family Practice/Pulmonary Med	Active	03/23/14 – 02/28/16	Approval
Wu, Roland, MD	Medicine & Family Practice/Cardiology	Courtesy	03/23/14 – 02/28/16	Approval
Turman, Steven, MD	Medicine & Family Practice/Med. Hematology	Courtesy	03/23/14 – 02/28/16	Approval
Drager, Sharon, MD	Surgery/Vascular Surgery	Active	03/23/14 – 02/28/16	Approval