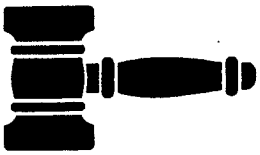
LEHIGH VALLEY HOSPITAL

Medical Staff Progress Notes

AUGUST

1997
Volume 9
Number 8

In This Issue . . .



From the President

When there is an open mind, there will always be a frontier.

Charles F. Kettering

These are the lazy, hazy, crazy days of summer, so I promise to keep this brief.

Things have been relatively quiet on the Medical Staff front these last few weeks. While the Medical Executive Committee has several works in progress, only one topic reached its conclusion at our last meeting -- "Consultation Guidelines." As a tertiary care center, we, as a staff, generate a significant number of consultations each day. Many physicians have noticed, however, that a sense of collegiality and decorum is often missing. A consult which is called to an office or an answering service and reads "patient known to you" can often leave a potential consultant guessing about the urgency of the consultation and the role she/he, as a consultant, is being asked to play.

As a result of discussions generated by the Medical Executive Committee's own David Caccese and John VanBrakle, the attached "Consultation Guidelines" document was generated. The basic theme is that we should reintroduce the personal touch, if it is lacking, between primary caregiver and consultant. I'd ask that you keep an open mind and read it through. If it makes sense, let's try to instill these principles as part of our Medical Staff culture.

Enjoy the rest of the summer!

Robert X. Murphy, Jr., MD
President, Medical Staff

Medical Staff Trivia

Of the 820 members of the Medical Staff, 37 of them are Juniors!

Radiology Update

Prostascint Studies

The New Technology Committee approved the use of Prostascint studies at Lehigh Valley Hospital as of June 10. Studies have begun on patients who fall within the guidelines for the use of Prostascint. Currently, LVH is the only facility in the area able to perform Prostascint studies; and we will actually serve to certify other physicians to do these procedures. As there is a very large backlog of patients who need to have these studies performed, your patience is appreciated as we try to get to all of them.

If you have questions regarding Prostascint studies, please contact Paul S. Sirotta, MD, in Nuclear Medicine at 402-8383.

17th & Chew Renovations

The final renovation plans for the Radiology Department at 17th & Chew have been approved. This plan will relocate Ultrasound from the first floor to the ground floor and will consolidate the entire Radiology Department on one floor. Construction is scheduled to begin in September or October and will take approximately three to four months to complete.

Report Turnaround Time

In an effort to improve report turnaround time, the Radiology Department requests your assistance. When you sign out films from Radiology, please try to return them within 48 hours. Through the use of electronic tracking with the new radiology system, the process of releasing films to physicians will improve dramatically.

New Radiology System

The Radiology Department is on track to implement the new Radiology Information System on August 26. With this new system, the process of listening to dictation reports will be streamlined. You will no longer need to look up the accession number in the Phamis system to listen to the dictated report on the Lanier dictation system. You will simply enter the patient's medical record number to access the patient's report.

Last year, a survey regarding incorporation of technology into medical education was distributed as part of the hospital's Strategi Plan for Medical Education. As a follow-up, a residency education survey is included with this issue of ***Medical Staff Progress Notes*** which focuses on the use of technology in resident learning. This survey is intended to give post-graduate faculty an opportunity to voice their opinions on the use of technology here at Lehigh Valley Hospital.

As new technologies such as Virtual Reality and Interactive Multimedia continue to develop, we need to assess our educational techniques and learning tools. Your answers and comments will help the Center for Educational Development and Support to fine tune our services in order to provide you with the best support possible.

Please complete and return the survey by August 22 to Dean Shaffer, Center for Educational Development and Support, John and Dorothy Morgan Cancer Center, Suite 407.

Policy Change... Administrative Policy AD1601.00 - Restraint and Seclusion

In July of 1996, the Joint Commission on Accreditation for Healthcare Organizations released a set of standards that addressed the use of restraint and seclusion in JCAHO accredited organizations. **The JCAHO's goal for the revision is to assure that the patient's need for the restraint is assessed and that alternatives are attempted before restraints are utilized. The standards are very specific and are responsible for more Type 1 recommendations than any other standard.** The following changes have been made in order to assure our compliance with the above mentioned standards and will be implemented on August 1, 1997:

The Administrative Policy (attached) has been revised to reflect the new standards. The modifications include the following:

- Restraints may be used without a physician's order when they are considered part of "standard care" or when the protocol is initiated. Standard care is defined as: use of restraints during transport via wheelchair, stretcher, etc.; during medical, diagnostic, surgical procedures or tests; as adaptive support; or as protective devices. The Protocol Guiding the Use of Immobilization Devices for the Sedated/Anesthetized, Brain Injured/Cognitively Impaired Patient allows for restraints (soft) to be utilized when the less restrictive interventions are ineffective and the patient is in imminent danger to self or others.
- Customary patient care and regular hourly observation is performed and documented in the patient's medical record.
- When restraints are used for reasons other than those noted above, the following must occur: if restraints are applied emergently, the physician is to be notified immediately and a verbal order received within one hour (verbal orders must be dated and timed when written and co-signed by the physician within 24 hours); a Doctors Order Sheet has been developed in order to assure that all components of the order are present; the order for restraint is time-limited and cannot exceed 24 hours; **in order to continue the use of restraint beyond the 24 hour time limit, a face-to-face assessment must be completed by the physician and a new order written**; the patient is to be observed every 15 minutes and the results of the observation is documented on the Restraint and Seclusion Flowsheet; customary patient care will be provided as per the policy.
- Additional requirements for patients with primary behavioral health needs (patients admitted to the Psychiatric Unit or the Emergency Department) include the physician order be time-limited for no more than 4 hours for adults, 2 hours for children and adolescents (ages 9-17) and 1 hour

Continued on Page 4

(Continued from Page 3)

for children under age 9; the physician order may specify that the RN may continue the original order for up to 24 hours after a reassessment is completed by the RN and documented in the patient's medical record.

- PRN orders are not acceptable

In addition to the policy, attached you will find a copy of the Doctor's Order Sheet, the Restraint/Observation Checklist, and a copy of the Restraint Alternatives Decision Tree that has been incorporated into the Patient Care Services ***Patient Seclusion/ Restraint Policy***.

Additional information for completion of the Doctor's Order Sheet:

- the order must be dated and timed to be initiated (only way to track the length of time the order is in effect)
- the restraint device must be indicated with a check
- the purpose for the restraint/seclusion must be checked (may indicated more than one reason)
- the criteria for discontinuing restraint/seclusion must be checked
- a definitive period of time must be specified (cannot exceed 24 hours)
- psychiatry/behavioral health patients only (patients admitted to the psychiatric unit or emergency department) must have the appropriate time frame checked (if the RN is to continue the original order for additional periods of time that must be noted)
- the order sheet must be signed

For additional information or for clarification, please contact Beverly Snyder in Risk Management at 402-5218, or Karen Peterson, Patient Care Specialist, Department of Psychiatry, at 402-2813.

As we continue to prepare for our JCAHO survey . . .

Standard TX.4 requires that *"each patient's nutrition care is planned."*

All patients, regardless of their nutritional status or need, receive a prescription or order for food or other nutrients. The food or other nutrient ordered can range from nothing by mouth (NPO orders), to regular diets, to parenteral or enteral tube nutrition.

Standard TX.4.2 states that *"authorized individuals prescribe or order food and nutrition products in a timely manner."*

Food and nutrition products are administered only when prescribed or ordered by medical staff, authorized housestaff, or other individuals with appropriate clinical privileges. Verbal prescriptions/orders are authenticated within the timeframe specified in the medical staff bylaws and such orders for food are documented in the patient's medical record before any food or other nutrient is administered to the patient.

Remember to: ***WRITE A DIET ORDER FOR EVERY PATIENT***

The above standards will be surveyed during the visits to patient care areas (open medical record review) and also during the closed medical record review. The surveyors will look for a diet order on ***every*** patient's medical record.

New Surgical Procedure Benefits Patients, Hospital

Two LVH colon and rectal surgeons -- **Robert D. Riether, MD**, and **John J. Stasik, MD** -- have introduced a new surgical procedure to the Lehigh Valley that will benefit the patient and the health care system with fewer complications, shorter hospital stays and lower costs.

Transanal Endoscopic Microsurgery (TEM) is emerging internationally as a minimally invasive means of resecting certain rectal tumors. Drs. Riether and Stasik introduced the procedure in May at LVH after completing an intensive training course in Tubingen, Germany. As such, LVH joins less than 10 institutions in the United States that have successfully performed TEM.

Developed in Germany, TEM uses either a 12 cm or 20 cm operating rectoscope and specialized instrumentation to remove adenomas that are small, large, or even circumferential, as well as selected carcinomas up to 24 cm. Most significantly, TEM is an alternative to an open transsacral or transabdominal approach for lesions in the mid and upper rectum.

Traditionally, patients diagnosed with early malignant rectal tumors or benign distal colonic polyps greater than 2 cm have been treated with a transanal or transabdominal resection; the minimal stay for such major abdominal surgery is usually seven to 10 days. If the lesion was in the distal third of the rectum and not more than 9 cm, colon-rectal surgeons have attempted a transanal resection (e.g. Kraske's, York-Mason's, or Bacon pull-through procedure). Although less invasive than the abdominal approach, a transanal excision may require a prolonged intraoperative resection and as many as three to four inpatient days.

Experience with TEM at LVH and in Germany, Italy and Japan -- where it already is being used as a standard treatment -- shows the following benefits for patients who are candidates for this procedure:

- No abdominal incision or colostomy.
- Dramatically less pain and minimal risk of post-op infection.
- Discharge from hospital within one to two days.
- Return to normal activity expeditiously.
- Reduced intraoperative surgical and anesthesia time.
- Lower hospital costs and improved outcomes.

A team consisting of a primary physician, gastroenterologist and/or colon-rectal surgeon will evaluate potential patients and provide follow-up care. If you feel you have a patient who could benefit from TEM or would like more information about the procedure, please call the Lehigh Valley Hospital Physician-to-Physician Hotline at 1-800-LVH-2040. We look forward to collaborating with you in the care of your patients.

Use of New Patient Transfer Form Begins August 1

Important changes have been made to the Patient Transfer Form. Input from physicians, patient care services staff, clinical resource management staff, ancillary departments and receiving facilities personnel served as a foundation for these changes. This form replaces both the med/surg and critical care transfer forms (#NSG-61-1 and NSG-61-2).

The revisions are as follows:

1. There is now a place where the physician can check to indicate authorization for transfer to an SNF or other acute care facility.

- Previously, the physician's signature authorized only a transfer to an SNF even though the form was also used to transfer to acute care facilities.

2. The Surgical Procedure Section will now be completed by the Clinical Resource Manager.

- Information is easily retrieved from the Operative Report.

- Physician time needed to fill out form will be decreased.

3. Physicians will need to complete all sections in the **PHYSICIAN SECTION**. (Only the attending or his physician designee may sign the orders.)

- This section represents the doctor's orders that are to be followed for the patient until the receiving facility's physician writes new orders. In the case of an SNF, physician orders are a requirement of the written contract between the hospital and the SNF.

- The doctor **CANNOT** give a verbal order to a nurse because all verbal orders have to be signed within 24 hours -- which would be impossible in most cases.

Exceptions:

- The nurse caring for the patient will note when the last dose was given on any medication that the patient was on in the hospital. This is to be done for all the medications listed by the physician in the Medication Section.

- The nurse will fill in PT/INR and Coumadin dose given on the day of discharge. This information was requested by the SNF's.

4. Page 2, completed by the patient's nurse and other caregivers, has been expanded so that the receiving facility will have comprehensive, easily retrievable information needed to care for the patient on arrival.

- Receiving facilities were often unsure of where to locate information about the patient on the chart copy accompanying the patient.

5. The Patient Care Services staff will no longer be permitted to release a patient from the unit unless the Patient Transfer Form is completed and signed by the physician.

- The SNF's have said that they will not accept a patient unless the patient is accompanied by a completed Patient Transfer Form, signed by a physician.

If you have any questions regarding this form, please contact Carol Balcavage, Coordinator, Enterostor Therapy, at 402-8633.

Pocono Medical Center Joins PennCARE

Pocono Medical Center, East Stroudsburg, and members of the affiliated physicians' organization, have joined the PennCARE integrated health care delivery system, a network of hospitals, physicians and other providers offering a full range of prevention and treatment services to communities throughout eastern Pennsylvania.

The addition of Pocono Medical Center and the physicians' organization to PennCARE brings the number of hospitals to 10, with combined medical staffs of 2,327 physicians. More than 1.87 million residents live in the counties now served by PennCARE providers, an area measuring 5,475 square miles.

Pocono Medical Center is a 192-bed acute care hospital with an active and provisional medical staff that numbers 120 -- 25 primary care physicians and 95 specialists, all board certified or board eligible. The system serves residents in Monroe, southern Pike, and northern Northampton counties. The hospital provides specialized care in cardiology, obstetrics, general surgery, pulmonary medicine, gastroenterology, behavior health, and orthopedics, and features a new 23-bed skilled nursing facility.

"Pocono Medical Center and its medical staff share a commitment to their community that is common to all in the PennCARE network," said Elliot J. Sussman, MD, chairman of the board and president of PennCARE. "The decision by the hospital and the physician organization to become partners with nine other local health systems measurably strengthens the network. More importantly, it expands the scope of services available to local residents and increases local health care providers' options for participation in integrated systems."

PCC Update: Phone Calls to RNs

Is the phone line busy when you try to reach the RN cell phone? Do you get upset because of the frequency of this occurrence?

A recent two-day study of incoming calls to RNs on 7A revealed an alarming trend -- one-quarter to one-half of the calls in an eight-hour period were unnecessary to be made to the RN and could have been handled by someone else. The average number of calls to the RN was 35 calls during the shift.

To address this growing dilemma, a team comprised of clinical, administrative, and support members met, discussed, and developed a "Telecommunications Communication Plan." It is designed to direct only critical calls to the RN, and involve the technical, support, and administrative partner in calls that are more appropriate to their roles. The plan will be introduced on the PCC units in August.

The plan is intended to free up RN phones so they only field calls from physicians, patient families, and emergent patient care issues. It is anticipated that you will find the phone lines to the RNs less busy thereby improving the care of the patient and our customer service.

News from the Library

OVID Training

To schedule a one-on-one OVID (MEDLINE) training session, call Barbara Iobst in the Health Sciences Library at 402-8408.

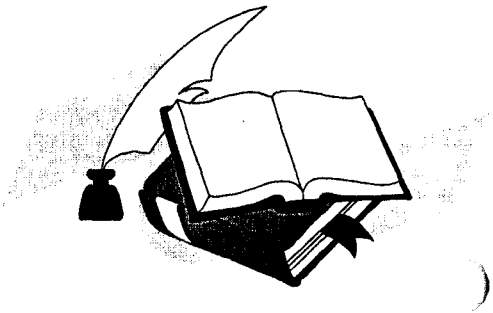
New Books

The 1997 edition of the **Report of the Committee on Infectious Diseases,** also known as the "Red Book," is now available in the Reference Section of the Cedar Crest & I-78 and 17th & Chew libraries.

Light Reading

If you would like a break from "heavy" reading, the following titles, authored by Stephen Covey, may be borrowed from the Cedar Crest & I-78 Health Sciences Library:

- **Daily Reflections for Highly Effective People**
- **First Things First: To Live, to Love, to Learn, to Leave a Legacy** (book and audio book)
- **The Seven Habits of Highly Effective People: Restoring the Character Ethic**
- **The Seven Habits of Highly Effective Families** (audio book)



Congratulations!

Michael J. Marcinczyk, MD, one of this year's graduating Chief Surgical Residents, won the Bosanac Research and Publication Award for his paper, "Asymptomatic Carotid Endarterectomy: Patient and Surgeon Selection," which was published in the journal, ***Stroke.*** His paper also received the Stahler-Rex Surgical Research Paper Award. Co-authors of the paper include **Gary G. Nicholas, MD**, Chief, Division of Vascular Surgery, and Program Director of the General Surgery Residency; **James F. Reed III, PhD**, Director of Research; **and Susan A. Nastasee**, Surgical Editor, Department of Surgery.

Charles C. Worrilow, MD, Department of Emergency Medicine, recently received notification that he successfully completed the certification examination and has become certified as a Diplomate of the American Board of Emergency Medicine.

In an effort to assess computer system strengths, weaknesses, and opportunities for improvement, please take a few moments to complete the attached Information Management Survey and return to Nancy O'Connor, Information Services, 2024 Lehigh Street, Allentown, PA 18103, by August 22.

Papers, Publications and Presentations

The paper, "Arterial Embolization is a Rapid and Effective Technique for Controlling Pelvic Fracture Hemorrhage," has been accepted for publication in the September 1997 issue of the ***Journal of Trauma***. The study's authors include **Stafano F. Agolini, MD**, Chief Surgical Resident; **Kamalesh T. Shah, MD**, Division of General Surgery/Trauma-Surgical Critical Care; **James W. Jaffe, MD**, and **James A. Newcomb, MD**, Division of Diagnostic Radiology; **Michael Rhodes, MD**, Chief of Surgery at the Medical Center of Delaware; and **James F. Reed III, PhD**, Director of Research.

George A. Arangio, MD, Division of Orthopedic Surgery, was the primary author of a research paper published in ***Clinical Biomechanics***. The title of the study was "Biomechanical Study of Stress in the Fifth Metatarsal." In addition, he was also the primary author of a research paper published in ***Clinical Orthopaedics and Related Research***. The title of the study was "Effect of Cutting the Plantar Fascia on the Mechanical Properties of the Foot."

Brian L. Fellechner, DO, Division of Physical Medicine/Rehabilitation, presented "Treatment of Chronic Pain with Sphenopalatine Ganglion Block: A Review of a Decade of Clinical Experience" at the American Osteopathic College of Rehabilitation Medicine/Greater Philadelphia Pain Society combined annual meeting held in Philadelphia.

Stephen K. Klasko, MD, Chairperson, Department of Obstetrics and Gynecology, was featured in both ***OB-GYN News*** (May 1, 1997) and the Obstetrician & Gynecologist Edition of the ***Medical Tribune*** (April 3, 1997) for his innovative new programs included in the residency program. These include training in time management, patient interaction skills, community outreach, and the business aspects of practice. Dr. Klasko described the program at the recent joint annual meeting of the Council on Resident Education in Obstetrics and Gynecology (CREOG) and the Association of Professors of Gynecology and Obstetrics (APGO) in New Orleans, La. In addition, Dr. Klasko's article, "Educating Residents to Thrive and Prosper in the Twenty-First Century or Tales from the Dark Side: Applying Business Modules for the Benefit of Patients and Providers," was featured as part of the Annual Meeting Highlights in Volume XXV, No. 1 of ***The APGO Reporter***.

Orion A. Rust, MD, Chief, Section of Clinical Obstetrics, co-authored a number of papers which were recently published. "The Origin of Endothelin-1 in Patients With Severe Preeclampsia," and "A Randomized Trial of Two Vacuum Extraction Techniques," were both published in the May, 1997 issue of ***Obstetrics & Gynecology***. "Twins and Preterm Labor" was published in the April, 1997 issue of ***The Journal of Reproductive Medicine***.

Patrice M. Weiss, MD, Division of Primary Obstetrics and Gynecology, was the keynote speaker at Women's Health 1997, a program sponsored by Geisinger Wyoming Valley on April 16 at East Mountain Inn in Wilkes-Barre, Pa. Dr. Weiss presented "Health Issues Facing Today's Women." In addition, Dr. Weiss was a guest speaker at the May 1 meeting of Executive Women International. Her topic for the meeting was "Seasons of a Woman's Life."

Upcoming Seminars, Conferences and Meetings

Psychiatry Grand Rounds

The Department of Psychiatry is pleased to announce that Dr. Paul Keck of the University of Cincinnati will present "Medical Management of Bipolar Disorder" on Thursday, August 28, from noon to 1 p.m., in the hospital Auditorium at 17th & Chew.

For your convenience, a light luncheon will be served between 11:45 a.m. and noon.

For more information, contact Bruce Curry in the Department of Psychiatry at 402-2810.

Who's New

The Who's New section of ***Medical Staff Progress Notes*** contains an update of new appointments, address changes, status changes, etc. Please remember to update your directory and rolodexes with this information.

Medical Staff

Appointments

Anjam N. Bhatti, MD
(solo)
1726 Sequoia Court
Allentown, PA 18104
(610) 530-0087
Department of Medicine
Division of General Internal Medicine
Provisional Active

Jeaninne M. Einfalt, DO
Coopersburg Medical Associates
629 W. State Street
Coopersburg, PA 18036-1955
(610) 282-4646
FAX: (610) 282-2513
Department of Medicine
Division of General Internal Medicine
Provisional Active

Douglas G. Field, MD
Milton S. Hershey Medical Center
Department of Pediatrics
500 University Drive
P.O. Box 850
Hershey, PA 17033-2391
(717) 531-5901
Department of Pediatrics
Division of Gastroenterology
Provisional Associate

Debra L. Kruse, MD
ABC Pediatrics
Allentown Medical Center
401 N. 17th Street
Suite 203
Allentown, PA 18104-6805
(610) 821-8033
FAX: (610) 821-8931
Department of Pediatrics
Division of General Pediatrics
Provisional Active

(Continued on Page 11)

(Continued from Page 10)

Howard E. Kulin, MD
Milton S. Hershey Medical Center
Department of Pediatrics
500 University Drive
P.O. Box 850
Hershey, PA 17033-2391
(717) 531-5901
Department of Pediatrics
Division of Endocrinology
Provisional Associate

Brent M. Nickischer, DO
Macungie Medical Group
3261 Route 100
Box 487
Macungie, PA 18062-9389
(610) 966-4646
FAX: (610) 965-6201
Department of Medicine
Division of General Internal Medicine
Provisional Active

Sharon J. Schubach, MD
Medical Imaging of LV, PC
Lehigh Valley Hospital
Cedar Crest & I-78
P.O. Box 689
Allentown, PA 18105-1556
(610) 402-8088
FAX: (610) 402-1023
Department of Radiology/Diagnostic
Medical Imaging
Division of Diagnostic Radiology
Provisional Active

Leave of Absence

Larry B. Feldman, MD
Department of Medicine
Division of General Internal Medicine
(From 8/1/97 to 7/31/99)

Paul Guillard, MD
Department of Medicine
Division of General Internal Medicine
(From 6/1/97 to 5/31/99)

Ajay M. Parikh, MD
Department of Medicine
Division of General Internal Medicine
(From 4/14/97 to 4/13/98)

Status Change

Lisa H. Medina, MD
Department of Family Practice
From Active to Affiliate

Edward A. Schwartz, DPM
Department of Surgery
Division of Orthopedic Surgery
Section of Foot and Ankle Surgery
From Provisional Active to
Provisional Affiliate

Address Change

Thomas A. Ward, MD
1251 S. Cedar Crest Blvd.
Suite 309C
Allentown, PA 18103-6205

Resignation

Natalie A. Yurick, MD
Department of Medicine
Division of General Internal Medicine

Practice Name Change

Candio, Kovacs & Lakata, PC
Joseph A. Candio, MD
Robert J. Kovacs, MD
Thomas J. Lakata, DO
Larry B. Feldman, MD (LOA)
Paul Guillard, MD (LOA)

Primary Care Associates in the Lehigh Valley, PC
David Stein, DO
Shawn Ruth, DO

(Continued on Page 12)

(Continued from Page 11)

New Practice Affiliation and Address Change

Judith N. Barrett, MD has joined the practice of
Primary Care Associates in the Lehigh Valley, PC (David Stein, DO)
Her office will be located at
1028 N. 19th Street
Allentown, PA 18104-3762
(610) 437-1288

Allied Health Professionals

Appointments

Lori G. Butz, RN
Physician Extender
Professional
RN
(Comprehensive Pain Management - Dr. Y. Khan)

Martha H. DelManzo, CRNP
Physician Extender
Professional
CRNP
(John J. Cassel, MD, PC)

Greta Flederbach, PA
Physician Extender
Physician Assistant
(Coordinated Health Systems - Dr. M. Busch)

Anthony Lewandowski, CRNA
Physician Extender
Professional
CRNA
(Allentown Anesthesia Associates - Dr. Maffeo)

Effective July 21, the members of Lehigh Valley Family Health Center (William L. Miller, MD, Elizabeth L. Stanton, MD, Brian Stello, MD, and Headley S. White, Jr., MD) and Southside Family Medicine (Neal J. Berkowitz, MD, Louis E. Spikol, MD, and Mark Wendling, MD) have combined inpatient services at Lehigh Valley Hospital known as **Family Practice Service**. The goal of this service is to create a more efficient and coordinated approach to the delivery of primary care and to enhance teaching of Family Practice residents and students. Both groups will continue to maintain separate outpatient offices and practices.

If you have any questions, please contact Dr. Stello at 402-3500.

GUIDELINES FOR CONSULTATIONS

Physicians are professionals, and as professionals, expect and deserve a certain amount of respect from their physician colleagues. We have had some discussions about the process of requesting and performing consultations at this hospital, and how this process might be improved.

The following suggestions are offered as "guidelines" both for physicians requesting consultations, and for physicians performing consultations. Much of what follows has been previously suggested by Dr. John VanBrakle and is not original with me. Also, much of what follows is simply a reflection of the type of professional behavior which I believe all of us learned at one time, but are now often too busy to follow. In addition, I believe that if the "guidelines" were followed we would significantly improve professional and patient communication, improve the quality of patient care, and reduce the cost of the care which we deliver to our patients.

Remember, the request for a consultation from the attending physician to another physician or health care professional is a request for an opinion regarding a specific issue related to the patient's diagnosis or care.

- The consultation request should address a specific question or a specific need. e.g. "Please help diagnose my patient's problem", "Please recommend the best treatment for my patient's condition", "Please evaluate my patient medically before a planned operation", or "Please see my patient for possible abdominal aortic aneurysm repair", etc.

- A personal call to the consultant from the attending physician stating the reason for the consultation request, what is expected from the consultant, and whether orders should be written by the consultant is appropriate, encouraged, and a simple professional courtesy. The attending/referring physician may know or have information about the patient which is not available in the medical record which would be helpful for the consultant to know.

- It should be clear in the consultation request whether the attending physician is requesting the consultant's advice, opinion, or direct involvement in the patient's care.

- "Courtesy Consultations" are appropriate and should be placed to physicians who have been closely involved with the patient's care, but whose opinion is not necessarily needed or required by the attending physician. An example would be a "courtesy consultation" to the patient's family physician by the attending surgeon who is preparing the patient for an uncomplicated mastectomy. A patient charge should not be generated for a "courtesy consultation".

- "Teaching Consultations" are also appropriate for the benefit of residents in training and medical students when an interesting or unusual patient problem becomes apparent to the attending physician, but the services of another physician are not necessarily required. Patients should be informed that their problem is unusual or interesting and asked if it would be acceptable to have another physician and some resident physicians stop by to review the patient's record and briefly interview and examine the patient. A patient charge should not be generated for a "teaching consultation". This type of consultation is in the best interest of the goals of a teaching institution, its medical staff, resident physicians, and students.

- It should be made clear at the time of the request for the consultation whether the attending physician wants the consultant to discuss his/her findings and recommendations with the patient and the patient's family or whether the recommendations should be discussed with the attending physician either solely or primarily.

- The consultant should always introduce him/herself to the patient and his family if they are present. He/she should inform the patient and family that he has come to see the patient at the request of the attending physician and should mention the referring physician by name. He/she should specify why he was asked to see the patient by the referring physician. It is also helpful to ask the name of the patient's primary care physician. After the evaluation the consultant should tell the patient that he will discuss his findings and recommendations with the patient's attending physician and that together they will develop a plan for the patient's future care.

- It is useful for the consultant to provide his professional card or to provide his name in writing to the patient and his/her family.

- After the consultation is performed, a personal call from the consultant to the attending physician detailing the findings, recommendations, and suggestions regarding the further involvement of the consultant in the patient's care is appropriate as a professional courtesy and in the interests of the highest quality patient care. The initial question asked by the attending physician should be answered by the consultant at this time.

- At this point, it should be clarified as to whether the attending physician wants to write all of the orders in the patient's chart or whether the consultant has the authority to write orders for diagnostic tests and treatments.

- The consultant should not write an order for another consultant to see the patient without discussing this with the attending physician. The consultant should not order an invasive diagnostic or therapeutic procedure for a patient without first discussing this with the attending physician. Do not write an order unless specifically cleared

by the attending physician. You are offering an opinion which the attending physician may or may not choose to follow.

- As a consultant, discuss the need for post discharge follow up of the patient with the attending physician.

- If the consultation request is for "patient management" and the consultant feels that the extent of his/her involvement would be best served by a transfer from the referring physician to the consultant's service, this should be discussed with the attending physician after the patient is seen and evaluated.

- The consultation report should be completed before the consultant leaves the patient care unit. This note should answer the question which was originally addressed in the consultation. The note may be brief, but should be followed by a longer more detailed note, preferably one which is dictated and transcribed so that it will become a *legible* part of the patient's permanent medical record. References can be provided if useful, but not simply to "show off".

- It is useful to have a copy of the detailed consultation report mailed to the attending physician as well as to the patient's primary care physician.

- As a consultant, never criticize the previous or present treatment to the patient or his/her family.

- As a consultant, if you have strong objections to the patient's present diagnosis or treatment, do not start an argument in the medical record. Discuss you opinions with the referring physician directly.

- As an immediate response it is acceptable to say "I don't know, but I will find out" or "I need a little time to think and/or talk this over with someone else". This is preferable to guessing. If you really don't know - look it up!

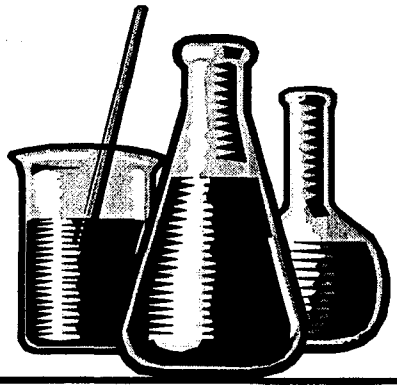
Hopefully by following the above simple guidelines we will improve communication between physicians and between physicians and patients. This improvement in communication will lead to better professional relationships between physicians and health care providers and may significantly reduce the risk of medical malpractice. I believe that if these guidelines are followed we also may see a significant reduction in the duplication of studies and in the cost of care which we deliver to our patients.

David M. Caccese, M.D.

July 1, 1997
consult.wpd

HEALTH NETWORK LABORATORIES

A Service of LEHIGH VALLEY HOSPITAL



Cardiac Troponin I

Cardiac Troponin I is both a sensitive and specific marker for the detection of myocardial injury. As a component in our 3-specimen serial MI profile it challenges CKMB as the optimal marker for acute myocardial infarction. Once it turns positive (within 3-4 hours of an infarction) it remains elevated for several days. Troponin I has been so clinically diagnostic as a cardiac marker that CKMB (the current gold standard test) is being dropped by many laboratories as a routine cardiac marker test, especially in today's climate of decreasing hospitalization costs. More about this to follow at a later time.

However, the laboratory has received several reports by physicians of decidedly false positive Troponin I values. Indeed this was correct. We identified the problem as being due to the presence of microclots in the heparinized plasma specimens interfering with the measurement and resulting in sporadically elevated values. At the same time, a paper in Clinical Chemistry 43, No. 5, p. 860 (1997) reported the same observation and came to the same conclusion. We hope that the use of heparinized plasma specimens centrifuged at room temperature for a minimum of 10 minutes followed by visual inspection of the sample for microclots will avoid false positive Troponin I results. If microclots are still visually observed, the specimen will be recentrifuged for an additional 10 minutes and reinspected. This protocol should solve the problem.

Finally, as a quality assurance check , Total CK, CKMB and Troponin I will all be reported at the same time. The CKMB determination requires a serum specimen which would often not clot because the patient was receiving heparin. We are adding thrombin to these CKMB specimens to promote clotting resulting in more rapid testing.

We expect that this new protocol for handling MI profile specimens will eliminate false positive results and improve general turnaround-time. If you feel that any results are still questionable, please notify the laboratory ASAP so that we can pull the specimen and investigate the problem.

John J. Shane, MD
Chairperson, Department of Pathology
Health Network Laboratories

Gerald E. Clement, Ph.D.
DABFT, DABCC, DABCT
Technical Director,
Health Network Laboratories

1243 South Cedar Crest Boulevard
Allentown, Pennsylvania 18103-6296

LEHIGH VALLEY
HOSPITAL

July 14, 1997

Dear Medical Staff Member:

LVH currently spends more than $50 million annually on supplies. This figure includes specialty products (e.g., pacemakers, ortho implants), common medical/surgical products (e.g., IV tubings, disposable packs and gowns), imaging and laboratory supplies, and pharmaceuticals. Market data available from sources such as Mecon and ECRI (a non-profit organization that assists hospitals with supply and equipment spending) suggest that organizationally we can maintain or improve the quality of care while reducing the amount we spend on supply acquisition and handling by 20%, or more than $10 million per year.

Our purpose in writing is to communicate the strategies and goals we are pursuing to achieve responsible savings in the area of supplies acquisition, including an overview of the process we will follow to get there. Most importantly, we need your understanding, commitment and help in making informed decisions that ensure appropriate care and savings too. Our individual project plans will become more focused in the coming weeks, positioning us to interface with you both individually and collectively. We wish to engage your assistance as appropriate and to provide opportunities for addressing any questions or concerns you might have.

We also need your help in the near term with regard to new product requests. We ask that new product requests be made only if you deem them to be essential for patient care. As you read on, the basis of asking your cooperation on this matter should become clear. If you do have an essential request, please follow the current process in your area.

To pursue supply cost savings, LVH has initiated a program called Procurement FOCUS 1998. This is a comprehensive effort designed to assure that quality and clinical need criteria are met while we responsibly reduce supply costs on a "total-in" basis. The "total-in" approach is an indication that we are not looking solely at the acquisition cost, but also the variety of products and suppliers we use (standardization) and the rate of usage (utilization) in rendering care, plus the logistics activities (ordering, invoicing, handling, inventorying), as important components of overall cost.

Market research, including some focused benchmarking, indicates that 75% of our available savings will come from standardization/utilization improvements in concert with clinical path development efforts; 15% of savings will come from better pricing available through increased volume commitments to selected suppliers; and, 10% of savings will result from improved logistics, including the implementation of processes that rely heavily on electronic data interchange (EDI) to process transactions which for the most part are manual in nature today.

We presently have several specialty product standardization initiatives underway. For example, we have been working with the orthopedics division for nearly a year, and have standardized from seven suppliers to three for implants. With more work to be done, we have saved nearly $600,000 from this effort through a combination of volume commitments and price concessions. In cardiology, we have a multi-disciplinary team consisting of physician leaders, administrators, and supplier services personnel looking at pacemakers and implantable defibrillators. The goal of this group is to standardize to the fewest possible suppliers while assuring that the products provide the necessary features and functions. We expect the chosen suppliers, in exchange for a volume commitment from us, will offer substantial pricing concessions.

In the common med/surg product area, LVH has chosen seven manufacturing partners. The names of these companies and the categories for which they have been selected are reflected on the attachment. These companies were chosen as a result of a thorough review against very specific criteria including:

- -- nationally recognized organizations with major market share
- -- willingness to commit to a long term relationship
- -- clinical resources to support product standardization/utilization efforts with medical staff
- -- high quality products at competitive prices
- -- demonstrated capability to implement electronic commerce
- -- focus on continuous improvement and innovative supply management programs
- -- willingness to go at risk with LVH for achievement of savings

Our goal is to move as much product as is acceptable clinically to these organizations. In exchange, the companies will commit to the best pricing available and to facilitating informed standardization/utilization efforts. As the conversion initiatives are more specifically defined, we will solicit the involvement and opinions of physician leaders We will attempt to assure that we are drawing the right people into our efforts at the right level to make the right decisions.

Success with Procurement FOCUS 1998 is expected to benefit all who are associated with LVH by assuring continued access to needed supplies in a more cost effective and efficient manner. Organizationally, it will aid us in being more cost competitive in the ever changing environment of managed care. We look forward to your participation.

Sincerely,

Robert X. Murphy, Jr., MD	Louis L. Liebhaber	Stuart S. Paxton
President - Medical Staff	Chief Operating Officer	Vice President - Operations

Common Medical/Surgical Supply Manufacturing Partners

- B|BRAUN (spinals, epidurals, vascular access, needless technology)
- BARD (urologicals, wound suction, vascular access)
- BECTON DICKINSON (needles, syringes, IV catheters, vacutainers)
- KENDALL (wound care, vascular therapy, respiratory, incontinent care)
- Kimberly-Clark Corporation (packs, paper gowns)
- MALLINCKRODT (contrast media, airway management, anesthesia products)
- McGaw, Inc. (IV solutions, sets, pumps, needless technology)

THERAPEUTICS AT A GLANCE

The following actions were taken at the May - July -1997 Therapeutics Committee Meeting Maria Barr, Pharm.D., BCPS, Rebecca Hockman, Pharm.D., Howard Cook, R.Ph, BCNSP, FASHP

THERAPEUTIC COMMITTEE CHARTER UPDATE

The Therapeutics Committee, formerly Pharmacy and Therapeutics Committee, reviewed and approved a new charter. The charter reflects the new committee name, Therapeutics Committee, and the committee responsibilities and goals which will affect the Lehigh Valley Health Network.

The responsibilities include:

1. The development or approval of policies and procedures relating to medication use and therapeutics.
2. Hospital Formulary Management.
3. Review of all significant adverse drug reactions.
4. The monitoring and evaluation of drug usage for the purpose of identifying opportunities to improve use, prevent problems, and provide safe and effective therapy at the lowest reasonable cost (pharmacoeconomics).
5. The review and evaluation of all significant medication errors.
6. Participation, as appropriate, required in the quality assessment and credentialing process.
7. The preparation and submission of written reports of the committee's findings, conclusions, recommendations, and actions to the Medical Staff through Medical Executive Committees as well as directly to the Medical Staff and others via the Therapeutics Committee Newsletter.

The Goals of the Therapeutics Committee are:

1. Creation and ongoing maintenance of, through multidisciplinary participation, a disease-management based Formulary assuring optimal patient outcomes.
2. Seek opportunities to continuously improve the medication use process within the Lehigh Valley Health Network, assuring optimal patient outcomes.

For more information on the Therapeutics Committee, please contact Fred Pane, Director of Pharmacy at Ext. 8882.

NEW FORMULARY REQUEST PROCESS APPROVED

The Therapeutics Committee approved a new process, to have a medication (therapy) reviewed, in order to be added to the Lehigh Valley Hospital Formulary. A formulary request form, will no longer be used. A request to have therapy evaluated for formulary consideration, can be made by contacting the Clinical Pharmacy Office at Ext. 8884.

Formulary drugs are therapeutic or diagnostic agents recommended as essential, for the best possible patient care (outcomes) and whose place in therapy is established with a minimum of duplication by other agents in the Formulary.

Drugs to be added to the Formulary, will be evaluated by:

- unique place in therapy
- advantages/disadvantages compared to formulary agent
- therapeutic impact
- therapy acquisition price
- potential therapy deletions or alternatives
- alteration of resource utilization
- effect on patient outcome and expected length of stay (LOS)
- laboratory costs/testing
- inpatient and outpatient use

If you have any questions related to this new process, please contact the Clinical Pharmacy Office at Ext. 8884.

ADVERSE DRUG REACTION REPORTING AND DOCUMENTATION

A Therapeutics Subcommittee met to discuss and evaluate the Adverse Drug Reaction (ADR) reporting system at LVH. Issues presented for discussion were:

1) Current JCAHO recommendations for ADR reporting
2) The effectiveness of the current ADR reporting system at LVH
3) Effective utilization of ADR information
4) Methods of follow-up and ADR reporting to the physician and patient
5) Documentation of ADR's in the patient chart and in Phamis

Following a lengthy discussion, the subcommittee made the following recommendations:

1) Investigate the creation, within the Phamis system, of a single, uniform ADR/Allergy screen which is accessible to any caregiver in the network
2) Define and clarify current reaction classifications on the ADR Documentation Form to assure clear, accurate ADR reporting
3) Create a card/letter notification system for the patient and physician addressing suspected/confirmed Adverse Drug Reactions. This system must be uniform throughout the network.

The above recommendations were accepted by the full Therapeutics Committee.

EPIDURAL CLONIDINE FOR CHRONIC SEVERE PAIN

Epidural Clonidine, available under the trade name Duraclon^{R}, has been approved for use at LVH. It is indicated for continuous epidural administration as an adjunctive therapy with intraspinal opiates for the treatment of severe pain in cancer patients that is not adequately relieved by opioid analgesics alone. It is more likely to be effective in patients with neuropathic pain than somatic or visceral pain.

Hypotension is the most common adverse effect, which increases in frequency when clonidine is administered with narcotic analgesics. The drug readily partitions into plasma via epidural veins and therefore exerts systemic effects. Tricyclic antidepressants may antagonize the hypotensive effects of clonidine - beta blockers may increase the risk of rapid rise in blood pressure if epidural clonidine is abruptly discontinued.

The drug is given as a continuous epidural infusion beginning at 30mcg/hr. The dose can be titrated based on clinical response. Infusion rates above 40mcg/hr should be used with caution. The drug may be used alone or combined with morphine or bupivacaine. Standard concentrations for inpatient and implantable pumps are available in the revised Hospital Formulary appendix.

A NEW AGENT FOR USE IN ALZHEIMER'S DISEASE

Donepezil hydrochloride (Aricept^{R}, Eisai Inc and Pfizer Inc), a newly approved agent for the LVH Formulary, is FDA indicated for the treatment of mild to moderate dementia of Alzheimer's type.

Donepezil differs structurally from tacrine hydrochloride (Cognex^{R}), but possesses the same mechanism of action - acting centrally to reversibly inhibit acetylcholinesterase. In the mild to moderate stages of Alzheimer's, research demonstrates that cognitive dysfunction is associated with reduced cortical acetylcholine levels. The inhibition of acetylcholinesterase may increase cholinergic levels resulting in enhanced cognitive function. Unfortunately, these agents do not alter the progression of the disease.

The pharmacokinetics of donepezil are characterized by rapid GI absorption, high plasma protein binding (96%), hepatic metabolism with urinary excretion of intact drug

at 57%, and an extensive elimination half-life of 70 hours. The hepatic metabolism occurs through the cytochrome p450 system at the isoenzymes CYP2D6 and CYP3A4. To date, pharmacokinetic studies performed with theophylline, cimetidine, warfarin and digoxin reveal no significant interactions. High plasma protein binding and CYP450 metabolism may lend caution for many potential drug interactions.

Clinical efficacy with dozepezil has been shown only in placebo controlled trials of 12-24 weeks duration. A variety of assessment scales were used in these trials. These scales encompass neurophysiological test scoring; subjective assessments by health care practitioners, patients, and families; and evaluations of behavior and abilities to perform activities of daily living. Benefits were statistically significant, but minimal in clinical improvement.

The most common adverse effects include nausea, diarrhea, vomiting, insomnia, muscle cramps, fatigue, and anorexia. Adverse effects are seemingly dose related.

The initial starting dose is 5mg by mouth once daily. The extensive half-life translates to approximately 15 days to attain steady state. A four to six week titration period is recommended before escalating to the maximum daily dose of 10mg/day. LVH cost/day of therapy is approximately $3.20 compared to $4.28 for tacrine.

Therapeutic advantages of donepezil versus tacrine include once daily dosing, and the lack of abnormalities in liver function tests. No manufacturer requirements exist for hepatic enzyme monitoring, as do with tacrine. Disadvantages surround the lack of comparative data with tacrine, and short duration of controlled clinical trials.

The Therapeutics Committee at LVH voted to add donepezil to the formulary, while simultaneously deleting tacrine.

VALPROIC ACID - NO LONGER JUST PO

Valproic Acid Sodium Injection (Depacon[R], Abbott Labs) - The LVH Therapeutic Committee voted to extend the formulary to include Valproic Acid Sodium Injection. The approved indication for valproic acid IV is when oral administration is temporarily not feasible.

The pharmacologic, pharmacokinetic, adverse effect, and drug interaction profiles are the same as those with PO therapy. These include the manufacturer boxed warning for contraindication in patients with liver dysfunction. Most common adverse effects include dizziness, headache, nausea, injection site pain and injection site reaction. As with PO therapy, there is no reliable association between plasma drug levels and clinical efficacy, but the therapeutic range is considered to be 50-100mg/ml.

The conversion from PO to IV therapy is simple and convenient. When switching from PO to IV use the same total daily dose IV as used PO, and administer with the same frequency as PO. Valproate sodium is to be mixed with D5W, Normal Saline or Lactated Ringers and infused over **60 minutes** (maximum rate of 20mg/min). Clinical data is not available for treatment beyond 14 days in duration. In comparison with oral therapy, the LVH cost for 500mg of valproate sodium IV is $7.20, versus $1.06 for valproic acid (Depakene[R]) or $1.03 for Divalproex (Depakote[R]).

IV HEPARIN THERAPY: APPROPRIATE DOSING

Though not widely utilized throughout the institution a weight-based preprinted physician's order sheet is available for use at LVH. A Therapeutics Subcommittee met to discuss proper utilization of the order sheet, dosing for obese or morbidly obese patients and appropriate monitoring of IV heparin therapy.

In reviewing variation in IV heparin dosing, a retrospective analysis of patients with the primary

diagnosis of pulmonary embolism was conducted. Though a small sample size, the time to reach a therapeutic aPTT with a weight based-heparin dosing vs other dosing methods revealed an average of 8.2 hours compared to 59.4 hours, clearly supporting the use of the weight based method for heparin. The committee felt strongly that weight-based heparin protocol and utilization of the order sheet should be routinely used for suspected or documented PE or DVT.

To properly communicate and promote the utilization of the weight-based heparin order sheet, the subcommittee will develop a pocket card would assist with heparin dosing as well as assure residents are reeducated. A possible joint grand rounds with surgery and medicine may assist with education of the staff. (The pocket cards are presently being developed).

With such variability in weights of patients, much confusion has arisen with what weight to use for dosing in the obese or morbidly obese patients with regard to heparin. Though sparse literature support, the subcommittee concluded TOTAL BODY WEIGHT rather than an adjusted body weight should be used. It was concluded the benefit of attaining a therapeutic aPTT sooner rather than later outweighed the risk. The clarification of using TOTAL BODY WEIGHT will appear on the next revision of the preprinted heparin order sheet. Of note, the subcommittee agreed the comparison of using total body weight vs an adjusted body weight and the time to attain a therapeutic aPTT and outcome would be an excellent research project.

The final topic of appropriate heparin monitoring regarding correlation of therapeutic aPTT with heparin levels is still being discussed. The subcommittee recommended an adjustment to the heparin order sheet with regard to heparin levels. The statement, "If heparin dose > 1500 units/hr, order heparin level □ yes □ no" will be changed to "If heparin dose > 20 units/kg/hr, without attaining a therapeutic aPTT, obtain heparin level □ yes □ no." This would provide consistency with the weight-based order sheet.

Stay tuned for further information regarding appropriate heparin dosing!

pt\797.hi

LEHIGH VALLEY HOSPITAL

Residency Education Survey

Center for Educational Development and Support

Previous surveys covered a general overview of information technology in medical education. In an effort to gain insight into more specific needs or desires for implementing technology into residency education, we ask that you take the time to complete this assessment.

1. What technologies have you implemented or would you implement into your teaching if they were easily accessible within the LVHHN system?

MODALITY	IMPLEMENTATION		
	CURRENTLY USING	INTERESTED IN USING	COMMENTS
Computer-based education			
Interactive multimedia			
Drills and practice			
Expert systems (Iliad, QMR)			
Tutorials			
Simulations			
Virtual reality			
Internet/intranet education			
Case-based learning			
Databases/references			
Chat groups			
Listservs			
Virtual Library			
Electronic resources			
Medline			
Micromedex			
Teleconferencing			
Telemedicine			

2. What specific programs or software would you like to implement as part of your teaching?

3. If programs are not commercially available, would you be willing to create your own multimedia programs with the help of the Instructional Design group or by using a non-programmer authoring package?

4. Have you seen, or are you aware of specific programs or technologies that are presently in use at other institutions which you would like to emulate? If yes, please specify.

5. Would you be more inclined to implement technology-based training (i.e., virtual reality, interactive multimedia) if any or all of the below-listed items were in place at LVH? (check any that would be applicable)

☐ Computer lab with equipment support available (learning resource center)
☐ Access to programs at workstations throughout LVHHN
☐ Access to programs through the Internet/intranet
☐ Access to programs from remote locations
☐ An automatic computer training management system (keeps track of student progress and performance while using computer-based training)
☐ Medical informatics program (to help physicians become comfortable with technology)
☐ CD-ROM drives on computers allowing for use of interactive multimedia training
☐ Assistance with evaluation and recommendations for software

6. In what areas do you see a need for additional educational support or training regarding residency education?

7. Are there specific courses or programs you would like to see offered as part of the residency curricula here at LVH? (e.g., courses on HMOs, business practices, ethics, bedside manner, etc.)

8. Comments or suggestions (Feel free to use additional paper for your answers) :

Name (optional, but appreciated) _____ Phone _____

Please return surveys to Dean Shaffer, Instructional Design Group, Center for Educational Development and Support, Suite 407, JDMCC. If you would like to discuss any of these issues, please contact Dean Shaffer, (610) 402-0055.

resquest.ppt 07/97

INFORMATION MANAGEMENT SURVEY

Information Services is conducting this survey to assess computer system strengths, weaknesses and opportunities for improvement and to comply with JCAHO Information Management requirements. Your input is very important to the success of this project. Please send the completed survey to: Nancy O'Connor, Information Services, 2024LS by **August 22, 1997**. Thank you for your help.

Please circle one: Attending MD Resident Practice Manager Other

Please circle the most appropriate answer.
1-poor/none, 2-fair, 3-good, 4-very good, 5-excellent/to a very great extent, NA-not applicable

1. Rate the I/S staff based on the following criteria:

helpfulness	1	2	3	4	5	NA
friendliness	1	2	3	4	5	NA
politeness	1	2	3	4	5	NA
overall knowledge of application or work process	1	2	3	4	5	NA
providing alternative solutions to work problems	1	2	3	4	5	NA

2. Rate the knowledge the I/S staff has concerning:

your office and its work processes	1	2	3	4	5	NA
PHAMIS	1	2	3	4	5	NA
Email	1	2	3	4	5	NA
Departmental systems (please specify)						
_____	1	2	3	4	5	NA
_____	1	2	3	4	5	NA
_____	1	2	3	4	5	NA

3. Do you know who to call in Information Services when you have a problem during the following times:

0700-1700	YES	NO
1700-0700	YES	NO
weekends, holidays	YES	NO

4. Rate how quickly Information Services solves the questions you call about. (circle one)

within minutes same day next day takes quite awhile never NA

5. Do you usually get transferred to someone else or is your call handled by the person who answers it? (circle one)

handled by person answering transferred NA

6. When you call I/S Customer Service, how long are you on hold before someone helps you? (circle one)

more than a minute less than a minute a few seconds not put on hold

7. Rate the I/S Customer Service Automated Call Distribution (ACD) message/call handling.

	1	2	3	4	5	NA

8. Are the choices clear to determine what ACD line to select? YES NO

9. How well are PC software products supported? (e.g., WordPerfect, Word, Lotus, Excel)?

questions answered expediently and thoroughly	1	2	3	4	5	NA
there is an understanding of the priority of the problem	1	2	3	4	5	NA

10. Rate how well major system downtimes are handled. 1 2 3 4 5 NA

11. Rate I/S related training based on the following criteria:

completeness of training: covers all aspects of systems you use	1	2	3	4	5	NA
relativity of training: covers how you'll use system on daily basis	1	2	3	4	5	NA
teaching materials effective, available	1	2	3	4	5	NA
classes available when needed	1	2	3	4	5	NA

12. Which methods of training work best for you and your staff? (Check all that apply.)

- ☐ classroom with hands-on practice - Internal (on campus)
- ☐ classroom with hands-on training - External (training centers, technical schools, etc.)
- ☐ large group overview with no hands-on practice
- ☐ self paced computer based training (CBT)
- ☐ self paced video based training
- ☐ _____

13. Rate how well Information Services institutes changes you have requested based on the following criteria:

the duration of the project was timely considering its scope	1	2	3	4	5	NA
the change is made according to what has been requested	1	2	3	4	5	NA
how the changes are communicated to you during the process	1	2	3	4	5	NA

14. Rate how well I/S is able to allocate staff to support projects affecting your office.

flexible, able to accommodate priorities	1	2	3	4	5	NA
staff is knowledgeable, well suited to the assignment	1	2	3	4	5	NA
communication of how staff is allocated to departments	1	2	3	4	5	NA

15. Do you understand the I/S project request process? YES NO

16. Rate your level of satisfaction that the current computer applications are meeting your needs today.

1 2 3 4 5 NA

17. Rate the timeliness of the information you need from:

PHAMIS	1	2	3	4	5	NA
Email	1	2	3	4	5	NA
departmental system (_____)	1	2	3	4	5	NA

18. Rate your level of confidence that the data and information is correct from:

PHAMIS	1	2	3	4	5	NA
Email	1	2	3	4	5	NA
departmental system (_____)	1	2	3	4	5	NA

19. Rate how well the reports from your system give you the information required to:

plan, manage, reprioritize functions.	1	2	3	4	5	NA
perform your daily duties	1	2	3	4	5	NA
report data to upper management	1	2	3	4	5	NA

20 Rate the logon/signon process based on the following criteria:

easy	1	2	3	4	5	NA
quick	1	2	3	4	5	NA
secure	1	2	3	4	5	NA

21 Do you have access to the data and information you need to do your job well. YES NO

22 Are you getting too much information? YES NO

23 Please estimate PHAMIS' overall impact *to your job*. (Check all that apply.)

- ☐ has helped in my day to day job functions
- ☐ has added extra work to my day to day job functions
- ☐ has not affected my day to day job functions
- ☐ other (please explain)

24 Please estimate Email's overall impact *to your job*. (Check all that apply.)

- ☐ has helped in my day to day job functions
- ☐ has added extra work to my day to day job functions
- ☐ has not affected my day to day job functions
- ☐ other (please explain)

25. Describe your future needs for information. List the top five (5), high priority requirements.

26. How can I/S be of greater assistance to you?

I. POLICY

The facility complies with the Pennsylvania Bill of Rights, and the Standards of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

It is the practice of the facility to use restraint and seclusion in clinically appropriate and justified situations when other less restrictive, or non-restrictive interventions are not sufficient or not available. Patients' rights, dignity, and well-being are supported and maintained. Restraint and/or seclusion is never used in a manner which causes undue physical discomfort, harm or pain to the patient or as a form of punishment, discipline or for the convenience of staff.

Restraint or seclusion may be used in response to an emergent and/or dangerous behavior or addictive disorder (as described in Section IV, C) as an adjunct to planned care, a component of an approved protocol, or, in some cases, as part of standard practice. Standard care (as described in Section IV, A) does not require a physician's written order, nor does use of restraint as part of an approved protocol that has clear criteria for use in assessing a patient's need for restraint.

Emergent use of restraint and/or seclusion may be initiated before obtaining a physician's order when the assessing RN or other trained authorized member of the health care team determines the need for immediate intervention to prevent the patient from harming self, others, property, or treatment environment. The health care team works together in the emergency application of restraint. When it is determined that help must be obtained, the team continues to work with the patient to use the least restrictive method possible, until the decision is agreed upon to restrain the patient.

Assessment of patient need and a time-limited physician's written order are required for use of restraint or seclusion in behavioral health areas (as described in Section IV, D)and when a patient's assessed need requires the use of restraint outside a defined, approved protocol. A verbal order must be obtained within one (1) hour. In Behavioral Health, time-limited orders are restricted to: 4 hours for adults, 2 hours for children and adolescents (ages 9-17), and 1 hour for children under age 9. An RN may reassess the patient and make the decision to continue the original order for additional periods not to exceed 24 hours if specified in the original order.

The individual applying the restraint is responsible for the correct, safe application of the restraint device.

II. SCOPE

Personnel trained in the proper use of restraint and seclusion.

III. DEFINITIONS

Personnel - includes, but is not limited to, all employees, medical staff, allied health professional staff, students, volunteers, and others engaged in any activities at the hospital, excluding patients and visitors (JCAHO).

Physical restraint - voluntary or involuntary use of any method physically restricting a person's freedom of movement, physical activity, or normal access to his or her body, as either part of an approved protocol or use of individual orders.

Seclusion - involuntary confinement of a person alone in a room where the person is physically prevented from leaving.

Types of restraints - locked limb, locked waist, locked Geri chair bar, cloth limb, mitts, bedrails (when used to keep a patient in bed).

Types of immobilization devices - cloth limb or extremity holders/immobilizers, mitts, soft belts, siderails as used per protocol guidelines (Attachment A).

Service specific forms - documentation form that may include but not limited to Critical Care Flowsheet, Restraint and Seclusion Flowsheet.

IV. PROCEDURE

A. Standard Care

Action	Responsibility
1. Use of restraint devices on patients without a physician's order is acceptable under these standard conditions: • during transportation via wheelchair, stretcher, or any transportation vehicle. • during medical, diagnostic, surgical procedures or tests. • as adaptive support to achieve maximum normative bodily functioning or to posturally support the patient (i.e., orthopedic appliances, braces, wheelchairs, Geri chairs). • as protective devices intended to compensate for a specific physical deficit or prevent safety events not related to cognitive dysfunction (i.e., to prevent a cognitively intact patient from falling out of a chair due to a physical inability to support his or her own body).	Personnel

IV. **PROCEDURE (Continued)**

A. Standard Care

Action	Responsibility
• forensic/correction restrictions used for security purposes (Refer to Emergency Preparedness Policy EP2004.00).	
2. Assess patient to determine need for standard restraint device(s).	Personnel
3. Perform customary patient care and regular hourly observation of patient.	Personnel
4. Document use of standard restraint device(s) on service specific forms (as indicated).	Personnel
5. Reassess patient to assure the standard restraint device(s) continues to meet patient need.	Personnel

B. Sedated/anesthetized, Brain injured/cognitively impaired patients:

1. Apply appropriate soft immobilization device when less restrictive interventions are ineffective and patient is in imminent danger to self or others. Less restrictive interventions may include: • verbal interventions • decrease of environmental stimuli • family/significant other supervision	Personnel
2. Initiate Sedated/Anesthetized, Brain injured/ cognitively impaired Patient Protocol.	Physician RN
3. Document use of protocol on Restraint/ Observation Checklist or service specific form, as appropriate.	Personnel
4. Perform customary patient care and regular hourly observation of patient.	Personnel
5. Reassess patient to assure the soft restraint continues to meet patient need.	Personnel
6. Remove soft immobilization device when the patient demonstrates a reduction of behaviors that led to restraint use.	Personnel

IV. **PROCEDURE (Continued)**

C. Emergency application of restraint and/or seclusion:

	Action	Responsibility
1.	Notify physician immediately (verbal order must be obtained within 1 hour when emergency application of restraint or seclusion is necessary; the order is time limited and not to exceed 24 hours).	RN
2.	Co-sign and date verbal order within 24 hours, if applicable.	Physician
3.	Remain with a violent patient until the devices are correctly applied, and procedures for appropriate observation and care of the patient are initiated.	Personnel
4.	Protect the patient's dignity, modesty, and well-being.	Personnel
5.	Document the following: • events leading up to the intervention. • prior use of alternative measures. • patient's response to alternative measures. • time restraint/seclusion was initiated. • time restraint/seclusion was terminated.	Personnel
6.	Observe the patient every 15 minutes.	Personnel
7.	Offer the following: • use of the bathroom, bedpan or urinal as appropriate for the patients condition • provide for meals and fluids at least every 4 hours • Provide regular hygiene and skin care • check color, motion, and sensation of the restrained extremity perform range of motion, as needed	Personnel
8.	Document on the Restraint and Seclusion Flow Sheet.	Personnel
9.	Discuss the use or possible use of restraint and seclusion with the patient and/or family whenever possible.	Personnel
10.	Write a new order every 24 hours following a face-to-face assessment.	Physician
11.	Document the use of restraint and/or seclusion (including justification) in the progress notes.	Physician

IV. **PROCEDURE (Continued)**

D. **Additional requirements for psychiatry/behavioral health patients:**

	Action	Responsibility
1.	Write time-limited order for no more than: 4 hours for adults 2 hours for children and adolescents (ages 9 to 17) 1 hour for children under age 9 (Order may specify that RN may continue original order for up to 24 hours).	Physician
2.	Reassess the patient and make the decision to continue the original order for additional periods not to exceed 24 hours if specified in the original physician order.	RN/Physician
3.	Observe the patient every 15 minutes	Personnel
4.	Offer the following: • use of the bathroom, bedpan or urinal as appropriate for the patients condition • provide for meals and fluids at least every 4 hours • provide regular hygiene and skin care check color, motion, and sensation of the restrained extremity	
5.	Release restraint or seclusion before the time limit based upon monitoring and reassessment.	Personnel
6.	Reapply the original order if release time is less than one (1) hour and the same behavior is evident.	Personnel
7.	Document reduction or early termination of restraint/seclusion on the Restraint Observation Checklist (Nsg. 37).	Personnel
8.	Document the use of restraint and/or seclusion in the Patient Treatment Plan.	Personnel

V. **ATTACHMENTS**

Protocol Guiding the Use of Protect/Immobilization Devices for the Sedated/Anesthetized, Brain Injured/Cognitively Impaired Patient

VI. **DISTRIBUTION**

VII. **APPROVAL**

_____	President & CEO	_____
Signature	Title	Date
_____	President of Medical Staff	_____
Signature	Title	Date
_____	Vice-President of Nursing	_____
Signature	Title	Date

VIII. **POLICY RESPONSIBILITY:**
Patient Care Services

IN COORDINATION WITH:
Legal Services
Department of Psychiatry

IX. **REFERENCES**

Comprehensive Accreditation Manual for Hospitals: The Official Handbook, 1997 standards.

X. **REVISION**

Hospital reserves the right unilaterally to revise, modify, review, rescind or alter the terms and conditions of this policy within the constraints of the law, by giving reasonable notice.

XI. **OTHERS**

N/A

XII. **DATES**

Origination: _____ Last Review: _____ Next Review: _____

Protocol Guiding the Use of Immobilization Devices for the Sedated/Anesthetized, Brain Injured/Cognitively Impaired Patient

Purpose:

The purpose of this protocol is to assist in the identification of patients at risk for injury and the interventions to be utilized prior to the use of protective and immobilization devices.

Protocol:

1. The following are observations/behaviors which may place the patient at risk for injury:

- Improper body alignment
- Pulling at IV's, tubes
- Impaired judgment which compromises or exacerbates condition
- Unable to remember instructions
- Harming self or others
- Restless agitation
- Confusion with:
  - sensory impairment
  - unsteady gait
- Recent fall/risk for fall
- Low level of consciousness (can be aroused, but unable to maintain wakefulness)

2. The following are interventions to be utilized when appropriate to the patient situation in an attempt to maintain patient safety and freedom of movement and prior to the use of protective/ immobilization device:

- Glasses/hearing aide
- Frequently used items placed close to patient
- Orient to unit
- Brighter/softer light
- Toileting
- Fluids/nourishment
- Up to chair
- Lounge chair
- Medication
- Family tapes/pictures
- Family education
- Bed check
- Chair check
- Family/sitter present
- Increased observation level
- Move patient to room close to nurses' station
- Diversional activity

3. If in spite of attempting the appropriate foregoing interventions, the patient's at risk status/behavior persists, an RN may decide to apply an immobilization device (i.e., soft limb holders). The device chosen will permit the greatest freedom of movement consistent with patient safety.

   Devices are applied according to manufacturer's instructions and hospital policy.

   Document protocol use on restraint/observation checklist or service specific form, as appropriate.

LEHIGH VALLEY HOSPITAL

DOCTOR'S ORDER SHEET

DRUG INTOLERANCES: REACTIONS:

DRUG ALLERGIES: REACTIONS:

☐ NONE KNOWN

DATE & TIME ORDER WRITTEN	UNIT CLERK INITIALS & TIME	NURSE SIGNATURE AND TIME	HT / WT	DOCTOR'S ORDERS — WRITE WITH BLACK BALL POINT PEN ONLY

RESTRAINT/SECLUSION ORDERS

Date and time must be provided for order to be initiated!

1. Restrain patient with:

☐ 4 point locked limb ☐ locked waist ☐ wrist (cloth limb)
☐ 2 point locked limb ☐ geri-chair w/ locked bar ☐ ankle (cloth limb)
☐ chest strap (Psych/ED only) ☐ mitts ☐ seclusion

2. Purpose for restraint(s)/seclusion

☐ high risk for self-harm
☐ high risk for harm to others
☐ high potential for removing tubes equipment, lines, etc
☐ high risk for causing significant disruption of treatment environment
☐ other_____

3. Criteria for discontinuing restraint(s)/seclusion

☐ no aggressive behavior
☐ no aggressive behavior threatened
☐ no suicidal behavior
☐ no suicidal behavior threatened
☐ no self-harming behavior
☐ no self-harming behavior threatened
☐ no risk for causing significant disruption of treatment environment
☐ patient is not destructive of property
☐ no potential for removing tubes, equipment, lines, etc.
☐ other_____

4. Patient to be restrained/secluded for up to _____ hours (not to exceed 24 hours)

5. *PSYCHIATRY/BEHAVIORAL HEALTH PATIENT:*

☐ adult-restrain for up to 4 (four) hrs
☐ child/adolescent-restrain for up to 2 (two) hrs
☐ child (under age 9)-restrain for up to 1(one) hr
☐ RN will reassess patient and may continue original order for additional periods up to ___ hours (not to exceed 24 hrs)

*RN Signature	Time	Continue Yes	Continue No	*RN Signature	Time	Continue Yes	Continue No
		☐	☐			☐	☐
		☐	☐			☐	☐
		☐	☐			☐	☐
		☐	☐			☐	☐
		☐	☐			☐	☐
		☐	☐			☐	☐

*Supportive documentation required in Progress Note

M.D./D.O.

"... dispense the generic or chemical equivalent unless specified as brand necessary by the physician."

LEHIGH VALLEY HOSPITAL

RESTRAINT/OBSERVATION CHECKLIST

1. LEVEL OF PRECAUTION:

DATE

☐ 1 : 1 ☐ q 15 min. ☐ q 1 hr

2. REASON:

☐ New Admission ☐ Behavior ☐ Elopement ☐ Close Observation ☐ Suicide Precaution ☐ Restraints

☐ Seclusion ☐ Visual Observation ☐ Sedated/Anesthetized, Brain Injured/Cognitively Impaired Protocol

TIME	0015	0030	0045	0100	0115	0130	0145	0200	0215	0230	0245	0300	0315	0330	0345	04
INITIALS																
PATIENT LOCATION																
PATIENT BEHAVIOR																
TYPE OF RESTRAINT																
SIDE RAILS UP																
OFFER TOILET q 2 hr																
OFFER FLUIDS q 1 hr																
CIRCULATION CHECKS																
ROM q 2 hr																
SEE PROGRESS NOTE																

TIME	0415	0430	0445	0500	0515	0530	0545	0600	0615	0630	0645	0700	0715	0730	0745	0
INITIALS																
PATIENT LOCATION																
PATIENT BEHAVIOR																
TYPE OF RESTRAINT																
SIDE RAILS UP																
OFFER TOILET q 2 hr																
OFFER FLUIDS q 1 hr																
CIRCULATION CHECKS																
ROM q 2 hr																
SEE PROGRESS NOTE																

TIME	0815	0830	0845	0900	0915	0930	0945	1000	1015	1030	1045	1100	1115	1130	1145	1
INITIALS																
PATIENT LOCATION																
PATIENT BEHAVIOR																
TYPE OF RESTRAINT																
SIDE RAILS UP																
OFFER TOILET q 2 hr																
OFFER FLUIDS q 1 hr																
CIRCULATION CHECKS																
ROM q 2 hr																
SEE PROGRESS NOTE																

PATIENT LOCATION

BR = Bathroom
CR = Consultation Room
DR = Dining Room
LR = Laundry Room
PR = Patient Room
QR = Quiet Room
RR = Recreation Room
SR = Smoke Room
H = Hallway
B = Bed
C = Chair
L = Litter
W = Wheelchair
GC = Gerichair
O = Off Unit

PATIENT BEHAVIOR

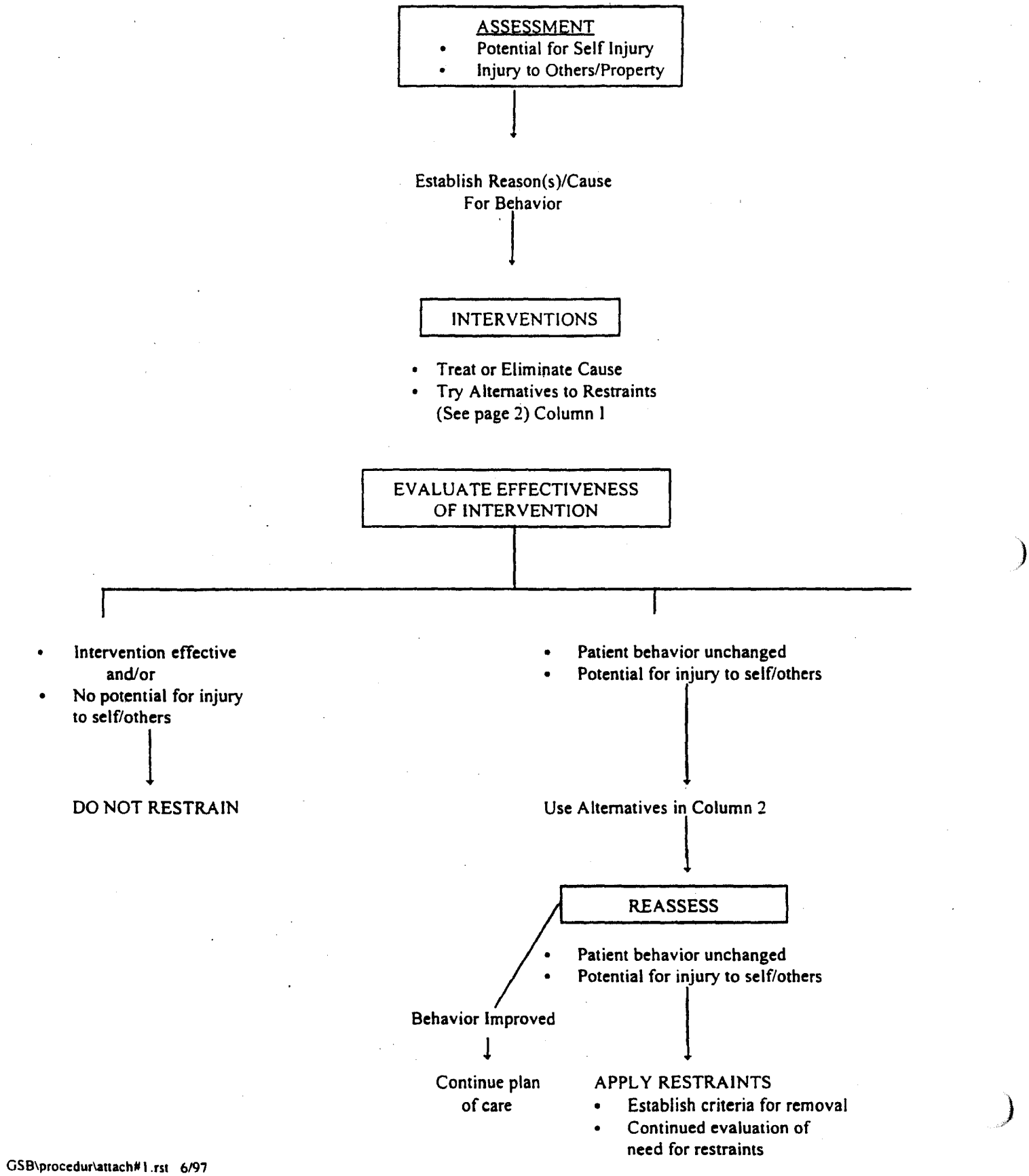
A = Angry
AS = Assaultive
C = Cooperative
U = Uncooperative
CB = Combative
I = Intrusive
P = Pacing
Q = Quiet/Subdued
R = Restless
S = Sleeping
SH = Self Harm
T = Tearful

TYPE OF RESTRAINT

X4 = 4 pt. locked limbs
X2 = 2 pt. alternate limbs (locked)
CS = Chest Strap
LW = Locked Waist
S = Seclusion
GC/B = Gerichair w/ locked bar
W = Wrist (cloth limb)
A = Ankle (cloth limb)
M = Mitts

ATTACHMENT C

RESTRAINT ALTERNATIVES DECISION TREE



COLUMN I	COLUMN II
Least Restrictive	
Changing or eliminating bothersome treatments • Initiate oral (as opposed to IV or NG) feedings. • Remove catheters and drains as soon as possible.	• Continue verbal interventions • 1:1 nursing observation • Medication • Remove patient to an area of decreased stimulation
Modifying the environment • Increase or decrease the amount of light in the room, depending on glare and the patient's preference or needs. • Position the bedside commode so that the patient can use it easily. • Arrange for patient to be near the nursing station, unless the stimulation triggers agitation or worsens confusion. • Place the mattress on the floor, so the patient can move about freely in bed without falling. • Leave the bedrails down if the patient tends to climb over them, or use half rails to prevent rolling out of bed. • Reduce environmental noise. • Keep the call button accessible. • Use special furniture accordingly (a lower bed, a reclining chair).	• Show of force • Escort patient to room • Behavioral contract • Special programming (Psych only) • Time out • Give direction versus offering choices.
Offering diversionary and physical activities • Use TV, radio, or music for diversion (depending on the patient's cognitive capacity and individual preferences). • Enlist the aid of a recreational therapist. • Provide exercise and ambulation whenever possible. • Initiate training in activities of daily living. • Use physical and occupational therapists to help the patient increase his strength and endurance and feel a sense of accomplishment.	

LEHIGH VALLEY
HOSPITAL

Cedar Crest & I-78
P.O. Box 689
Allentown, PA 18105-1556

Medical Staff
Progress Notes

Robert X. Murphy, Jr., M.D.
President, Medical Staff
David M. Caccese, M.D.
President-elect, Medical Staff
John E. Castaldo, M.D.
Past President, Medical Staff
John W. Hart
Vice President
Rita M. Mest
Director, Medical Staff Services

Janet M. Seifert
Physician Relations
Managing Editor

Medical Staff Progress Notes **is published monthly to inform the Lehigh Valley Hospital Medical Staff and employees of important issues concerning the Medical Staff. Articles should be submitted to Janet M. Seifert, Physician Relations, Lehigh Valley Hospital, Cedar Crest & I-78, P.O. Box 689, Allentown, PA 18105-1556, by the 15th of each month. If you have any questions about the newsletter, please call Mrs. Seifert at 402-8590.**
Lehigh Valley Hospital is an equal opportunity employer.
M/F/H/V