LEHIGH VALLEY
HOSPITAL AND
HEALTH NETWORK

PROGRESS NOTES

Medical Staff

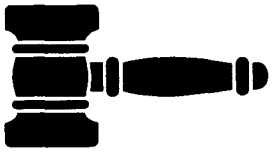
December, 2000 Volume 12, Number 12

In This Issue . . .

GIVE THE GIFT OF LIFE . . .

BLOOD DONOR DRIVE
Tuesday, December 12, 2000
1:30 - 5:30 PM
Lehigh Valley Hospital,
Cedar Crest & I-78
Anderson Wing Lobby
Classroom 1, 2, 3

Please call (610) 402-8899
for an appointment.
Walk-ins will be accepted if
space is available.



From the President

Colleagues:

Over the past several months, I've been discussing some of my concerns about the American pharmaceutical industry with you. I've received a number of comments from Medical Staff colleagues and LVHHN Board members about my remarks. Most of these have been positive and supportive, but some have suggested that I have not been "balanced" in my comments in the ***Medical Staff Progress Notes***, at the Medical Executive Committee, and at the LVHHN Board meetings.

I believe that we in America need a strong, innovative, inventive pharmaceutical industry. Many revolutionary medications have been developed since the introduction of the first antibiotics in the late 1930's. These medications have allowed us to deal with and to treat multiple serious diseases beginning with previously untreatable infectious processes, and then hypertension, coronary artery disease, congestive heart failure, hyperlipidemia, cancer, and AIDS. We now have thrombolytic therapy to reverse the effects of acute coronary occlusion and to provide early treatment for cerebral thrombosis. These are just a few of the many revolutionary contributions from the pharmaceutical industry. These represent remarkable advances and have allowed us to provide care and treat many acute and chronic illnesses that previously resulted in disability and death for millions of Americans. Just think about Lance Armstrong who was diagnosed in 1996 with extensively metastatic choriocarcinoma and, after chemotherapy, has been cured and gone on to win the Tour de France twice. Fifteen years ago, such a recovery would have been unheard of. The new medications developed by the American pharmaceutical industry not only benefit us in the U.S., but also benefit the entire world.

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The development of these revolutionary treatments requires large sums of money to support research and development. Many new compounds that are developed never reach the market because of adverse effects or other problems. The pharmaceutical industry obviously needs to be profitable so those funds can be reinvested in the research and development of new medications and drugs. Profits are needed, expected, and warranted. Obscene profits are not.

With the decrease in N.I.H. support for medical research, the private pharmaceutical industry funds the majority of the medical research that is now done in the United States. Pharmaceutical company donations also provide for funding to support medical education, conferences, and publications. Without pharmaceutical company advertisements, the medical journals we read and depend upon would either be unaffordable or would not be published at all.

At present, my major concern with the pharmaceutical industry is related to the exorbitant costs of the newer medications that we all prescribe for our patients. I believe that one of the major reason for the high costs of many of the newer medications relates to the astronomical marketing budgets that are allocated to promote these medications to the physician community and, more recently, directly to the public. What would happen if the marketing budgets of the pharmaceutical companies were reduced by 50% and this money was used to reduce the cost of the medications that we prescribe for our patients? Would anyone be worse off by not having to listen to television advertisements for Zocor, Pravachol, Vioxx, Arava, or Claritin? What would happen if physicians obtained their drug information from reputable and objective sources such as medical and pharmaceutical textbooks, articles in the medical literature, Micromedex, or ***The Medical Letter***, rather than from pharmaceutical representatives peddling their products?

The fact that we physicians are induced to prescribe medications after receiving a free dinner followed by gift tickets for us and "our guests" to professional sporting events or Broadway theatre presentations says something about our ethics. Obviously, all of the "educational" dinners, "honoraria", free textbooks, pens, flashlights, notepads, etc., etc., have the desired effect, or the drug companies would not continue to do it. The fact that these techniques work says something about us. I believe that what it says is not too good. The process of "training" physicians to accept these marketing gifts begins with medical students and house officers. This is a time when many young physicians are most vulnerable because of their financial situation. Habits we learned then are hard to break. "Why not take the dinner or the money?" "If I don't take it, someone else will be offered the same thing and will be glad to take it."

Do I really think that if pharmaceutical industry marketing budgets were reduced that the cost of the drugs we prescribe for our patients would be reduced? I don't know, but I think it would be worth the effort to find out. If the marketing budgets were reduced dramatically and the cost of medications did not go down, then pharmaceutical industry profit margins would be even more impressive than they are now! This certainly would attract governmental attention.

Imagine how many more people would take the medications we prescribe if they were less expensive. Just suppose that a popular and widely advertised lipid lowering agent cost $.50/tablet instead of $2.00/tablet. I'm sure that the company would sell many more tablets, our patients would be more likely to take them, and the company would make just as much or more money. The next time you are invited to a "dine & dash" at Wegman's, a "case presentation" at Shangy's, or to a dinner at the Glasbern, just take a minute to think about the implications of the offer you're receiving. What is the *quid pro quo* for accepting these offers? I refer you to a recent article in the J.A.M.A. by Dr. Jerome Kassirer entitled *"Financial Indigestion"*.[1]

Prescription drug sales have increased from $42.7 **billion** in 1991 to $111.3 **billion** in 1999! Recently, HMOs have reported an increase in prescription drug costs of 27.8 percent over 1999.[2] For a discussion regarding some of the reasons for these increases and for some defenses of the pharmaceutical industry, please see the following web sites:
http://www.PHRMA.org./publications/publications/value/index.phtml
http://www.epharm5.com/today.asp

E-MAIL - One more time, I'd like to encourage all members of the Medical Staff to read their email regularly or to designate a staff member to be your appointed "surrogate" who can read and print out your email messages for you on a daily basis. If you or your staff need help in assigning a "surrogate," please call Information Services at (610) 402-8303.

Over the past five or more years, many "preprinted order sets" have been developed by groups of physicians and nurses for use in the hospital. It was hoped that the use of these order sets would improve the efficiency of the care that we deliver to our patients. Additionally, these order sets have been

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[1] Kassirer, J.P., J.A.M.A. vol. 284:2156, Nov.1, 2000
[2] http://www.e-dental.com/content/news/ article.asp?DocID={8B3B8FA8-B579-11D4-8

(Continued from Page 2)

developed and modified by physicians based on the most current and accepted "evidence-based" approaches for the care of specific medical and surgical problems. Examples of these order sets are those for CHF, acute MI, community acquired pneumonia, C.O.P.D., G.I. bleeding, total joint replacement, open heart surgery, T.U.R.P., heparin anticoagulation, to name just a few. Many of us feel that the use of these "preprinted orders" would make our daily rounds easier, and would simplify the admission process. I believe that their use would improve the quality of patient care. More frequent use of these order sets would also reduce the number of transcription errors that occur. I would encourage all of you to try to use these preprinted orders, where applicable, for your patients. I think you will find that their use makes your care of hospitalized patients easier and more efficient. If you have trouble finding the "preprinted order sets" you need, either in the Emergency Room or on the medical/surgical floors, please ask the nursing unit directors for assistance.

Sit, Answer and Touch!

Remember, when you are making hospital rounds to sit at your patient's bedside, ask for their questions, answer their questions, and make physical contact with the patient.

Many of us continue to be aggressively involved in the continuing process of implementing a Computer Assisted Physician Order Entry (**C.A.P.O.E.**) system as part of the PHAMIS/IDX patient management system at LVH. Dr. Donald Levick has agreed to serve as the director of this project. Don is now heading a Coordinating Committee composed of physicians, hospital administration, and Information Services management. This group will oversee the project and assure that appropriate resources are dedicated and available to the effort. Don will also be chairing a "Design Committee" composed of a diverse group of staff physicians and nurses. This group will be involved in "tailoring" the CAPOE system so that it will be as "physician friendly" as possible. It is hoped that with input from this group, the process of computer assisted order entry will become as efficient as possible and will accommodate our accustomed practices. Members of this committee will also be involved in visiting their colleagues in their offices to demonstrate the system and to obtain constructive suggestions to improve its operation before the "roll-out" process begins. A preliminary suggestion is that the system would be introduced on a limited basis to one patient care unit at a time. Perhaps this unit would be one that was used by a limited number of physicians and where the patient care orders sets were frequently used.

A number of us have been piloting the use of several different types of "wireless devices". It is hoped that after one of these devices is selected, it will be provided by the hospital to physicians for use on their daily hospital rounds to expedite the computer assisted order entry process for patient care orders. Those of us who are piloting these devices have been surveyed regularly. We are providing feedback to the I/S department regarding our experience. It is expected that implementation of the PHAMIS/IDX 4N Patient Management System with CAPOE will begin during the summer of 2001.

For those of you who are interested in participating in this process, I would encourage you to call Dr. Donald Levick. Medical Staff or other members of the hospital family who are interested in learning more about the computer assisted physician order entry might refer to a *Primer on Physician Order Entry*[3] for an extensive review of the benefits and challenges that such an approach to patient care presents. A group of "Fortune 500" companies has recommended to their members that they should not contract with or recommend hospitals for their employees which have not begun to use computer assisted physician order entry by 2003. This is the "wave of the future. We are positioning the LVH Medical Staff to be at the forefront of this new technology. Hopefully, the use of this type of order entry system will improve the care we deliver to our patients by decreasing the number of errors that are made. It should also improve the efficiency of the care we deliver, especially when it is linked to the use of order sets.

Those of us who have been involved with this concept from the beginning understand that the introduction of this new way of caring for our patients will represent a big change. We recognize that if the new system is to be successful, we will need "buy-in" from the Medical Staff. Without this 'buy-in," the system is bound to fail.

The hospital administration, the I/S department staff, and the physicians involved in this project have pledged to wait to activate the new system until we feel comfortable with **C.A.P.O.E.** and the medical and nursing staffs are trained. There will need to be adequate support from physicians and other members of the hospital family before the Computer Assisted Physician Order Entry part of the new Patient Management System is activated. **"It won't happen until we are ready."**

I mentioned to you last month in the ***Medical Staff Progress Notes*** the importance of printing your name after your signature both for your patient orders and on your progress notes in the in patient medical record. This is a policy that has

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[3] http://www.fcg.com/webfiles/pdfs/CPOE_Report.pdf

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been adopted by the Medical Executive Committee for the Medical Staff of the Lehigh Valley Hospital. Signature stamps with your printed name will be provided free of charge by the hospital for any medical staff physician. You can order one of these stamps by calling Janet Seifert in Physician Relations at (610) 402-8590.

I also would remind you of the importance of signing your telephone and verbal orders before the patient charts leave the medical/surgical units. The Pennsylvania Department of Health requires that these orders be signed within 24 hours of their receipt. Now that the patient charts are scanned into the IMNET system after they leave the floors, it is no longer possible to sign telephone and verbal orders after the patient's discharge.

Printed names after signatures, signing telephone and verbal orders, and preprinted order sets are all issues that will disappear or become more automatic with the introduction of C.A.P.O.E.

Although very little has happened recently with regard to my interest in developing a mechanism to deliver care to the working uninsured of the Lehigh Valley, Ed Mullin and I remain interested in pursuing this project. We are investigating funding mechanisms that would provide for a feasibility study to see if such a program would be worthwhile and beneficial for our community.

PAGING - When paging your physician colleagues, remember to use the blue "***Medical Staff Handbook***" to find the direct pager numbers. You can speed the response time by direct paging. This will reduce the burden on the page operators and, as a result, will decrease the time you have to wait "on hold" to place your page. Pager numbers are also included in the directory, which is available for Palm Pilot owners. See article on Page 6.

This article in ***Medical Staff Progress Notes*** will be my last. My term as President of the Common Medical Staff of LVH and LVH-M will end in December. I've enjoyed writing these monthly articles and hope that some of you have enjoyed reading them. I must thank my editors, Deborah and Janet, who have helped to make these articles appear as acceptable representation of the English language. Thanks also to my partners, Charles Peters, Steven Scott, and Gary DuGan, for their patience and understanding during the past four years when at times my schedule interfered with their office and hospital responsibilities. Thank you to all the members of the Medical Staff and hospital family for their support and encouragement over the past two years. I've enjoyed the opportunity to serve as the President of this great Medical Staff and want to thank the members of our Medical Staff for this honor. As part of TROIKA, I've tried to represent the interests of our staff as I saw fit. Our guiding principle has been and will continue to be to "do the right thing".

I also want to thank Bob Murphy, our past president, and Ed Mullin, our president-elect, for their support, encouragement, advice and wise counsel over the past two years. I'll miss Bob as he steps down from TROIKA, and look forward to working with Ed as he assumes the presidency, and with Alex Rae-Grant, our new president-elect.

Thanks again, it's been a "blast"!

David M. Caccese, MD
Medical Staff President

Neurologist to Serve as President-Elect

Alexander D. Rae-Grant, MD, neurologist, was recently nominated and elected to serve as Medical Staff President-elect for a two-year term beginning January 1, 2001.

Dr. Rae-Grant joined the Medical Staff in 1988, and is Chief of the Division of Neurology. He has served on a number of Medical Staff committees including Medical Executive, Ethics, and the Institutional Review Board. He is also the Medical Director of the Neurodiagnostic Lab.

A graduate of McMaster University Faculty of Medicine, Hamilton, Ontario, Canada, Dr. Rae-Grant completed a two-year Medicine residency at Sunnybrook Hospital, Toronto, Ontario, followed by a Neurology residency at the University of Western Ontario, London, Ontario.

Dr. Rae-Grant is certified by the Royal Canadian Board of Neurology and the American Board of Psychiatry and Neurology in Neurology.

He is a member of Lehigh Neurology, located at 1210 S. Cedar Crest Blvd., Suite 1800, Allentown, Pa.

Dr. Rae-Grant and his wife, Mary Bruce, are the parents of four children -- Michael, Tucker, George, and Sasha.

Reminder - If your license, DEA, or malpractice insurance is expiring soon, please fax updated copies to Medical Staff Services at (610) 402-8926. Also, if you have a new office or home address, phone number, fax number, or pager number, please fax the new information to Medical Staff Services at the number above.

A Note from Don Levick

I ate breakfast at a restaurant the other day with a group of people. The waitress used a wireless hand-held device to place all the orders. She had no trouble keeping up with our individual requests. The order was instantly transmitted to the kitchen, and the food came out correctly prepared and on time. After breakfast, I came to the hospital to make rounds. I spent five minutes trying to decipher an order my associate had written the evening before. I asked nurses and other docs if they could read it. After taking my best guess, I finished rounds and wrote my orders. Ten minutes after leaving the hospital, I was paged while driving to the office. The nurse had trouble understanding my order. After remembering which patient she was referring to, I clarified the order. She was confused because my associate had written a similar order the evening before. I then had to verbally discontinue my order. A few minutes later, while I was in the exam room with the first patient of the morning, I was paged again, this time by the lab. I had ordered a bilirubin on a baby. The lab wasn't sure if I had wanted a total bilirubin, or a newborn bilirubin. While my patient waited in the exam room, I verbally repeated the order I thought I had written earlier that morning. There has to be a better way. I believe that the physician order entry system is a big part of the answer.

We have renamed the physician order entry project. It will be referred to as CAPOE (kay-poe), "Computer Assisted Physician Order Entry," reflecting the use of the technology to facilitate the work of our medical staff. We anticipate that the numerous benefits of the system will indeed expedite and improve the overall care to our patients. CAPOE is an important part of the many "Do No Harm" projects that are occurring throughout the hospital system.

The project team has begun to solicit feedback from physicians and other staff regarding the types of devices will be used as well as the user interface (placement of buttons on the screen, default settings, use of order sets). We are committed to making the process as easy to learn and use as possible. I have had conversations with physicians from several departments regarding where in the hospital to begin using CAPOE. Most have been quite excited and eager to incorporate the system into their workflow process. The Trauma/Neuro Intensive Care Unit has been identified as a potential first site for use of CAPOE. It is expected that the first site would 'go live' in June 2001. We will work closely with the Trauma team in preparation for this exciting time.

If you would like to learn more about CAPOE, or would like a demonstration of the system, please contact me at (484) 884-4593 or pager (610) 402-5100 7481. I welcome the opportunity to show it to you.

Don Levick, MD, MBA

Announcing: Wound Healing Program at LVH-M

On November 1, Lehigh Valley Hospital-Muhlenberg ended its contractual relationship with Curative Health Services, Inc., who provided management services for the Wound Care Center since opening in 1998. This was an administrative decision driven by changes in the Medicare Program. However, outpatient wound care services, formerly provided at the Wound Care Center, will now be provided by the **Wound Healing Program,** located on the fourth floor at Lehigh Valley Hospital-Muhlenberg.

As a hospital-based program, the **Wound Healing Program** will remain under the physician leadership of Robert X. Murphy, Jr., MD, Division of Plastic Surgery/Hand Surgery, Section of Burn, and will continue to be staffed by the same team of physicians and nurses.

The **Wound Healing Program** provides comprehensive wound care for a variety of patients with chronic and non-healing wounds. Plans are underway to expand the current program to include multiple sites and a broader scope of service. Outpatient burn and diabetic foot and wound care are expected to be available at Cedar Crest & I-78 beginning January, 2001.

If you have questions or need more information regarding the **Wound Healing Program**, please contact Ginger Holko, Program Director, Wound Healing Program, at (484) 884-2989, or Deborah Swavely, Administrative Director, Helwig Diabetes Center and the Wound Healing Program, at (610) 402-7312.

For Your Calendar

- A meeting of the **General Medical Staff** will be held on **Monday, December 11**, beginning at 6 p.m., in the Auditorium at Lehigh Valley Hospital, Cedar Crest & I-78. All members of the Medical Staff are encouraged to attend.
- The next **General Membership Meeting of the Greater Lehigh Valley Independent Practice Association** is scheduled for **Monday, December 18**, beginning at 6 p.m., in the Auditorium of Lehigh Valley Hospital, Cedar Crest & I-78. To receive credit for your attendance toward the Incentive Plan, please remember to sign in.

Radiology Compliance Alert

According to Medicare guidelines, referring physicians are required to submit either a narrative description or ICD-9 code(s) when a diagnostic x-ray is ordered. This is to establish medical necessity to the radiologist rendering the service.

A minimum of one, but up to four codes, may be used. *Do not use code diagnoses documentation such as "probable," "suspected," "questionable," or "rule out" as if they are established. Rather, code the condition(s) to the highest degree of certainty for the service provided, including such specifics as signs, symptoms, abnormal test results or other reason(s) for visit.* For example, a patient's chest x-ray can be coded for "cough" or "fever," however, "rule out pneumonia" is not adequate. A patient with an injury to the ankle can be coded as extremity "pain," "swelling," or "injury," however, "rule out fracture" is not satisfactory.

For screening mammography, HCFA has indicated that the appropriate ICD-9 coding is V76.12. If the study is changed to a diagnostic study *on the same day*, a modifier will be used. A second diagnostic code will be added if an abnormality is found and the patient is asked to return for a diagnostic study on another day.

Physicians' practices and hospitals need to work together to provide the medical information necessary for reporting services.

If you have any questions regarding this issue, please contact Christopher L. Brown, MD, Chief, Section, Gastrointestinal & Genitourinary Radiology, at (610) 402-8093.

Radiology Physician Order Form Update

In an effort to reduce the percentage of incorrect orders performed in the Radiology Department, the Radiology Physician Order Form was developed. The form provides specific ordering information for physicians and a simple check-off list for the selection of studies. The form is located in the patient's chart in the physician order section and **is required for all Radiology ordering**.

This is a MANDATORY form and ALL Physicians must comply with its use. Chart audits will be performed on a routine basis to check compliance.

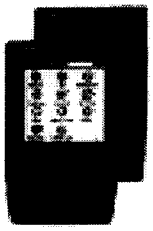
Form Guidelines

- Check off all appropriate boxes (multiple exams may be checked on one sheet for procedures being done at the same time)
- Chief complaint **must** be filled in (no r/o diagnosis will be accepted)
- This is a **single use** form and will remain in the physician order section of the patient's chart for further reference. When ordering future exams, the Administrative Partner/RN will place a new form in the chart.
- Physician signature, date, and time are required on the bottom of the form.
- Chart audits will be performed to assess the usage of the form.
- Physicians should specify on Doctor's Orders Sheet to "see Radiology Order Form" whenever Radiology studies are requested.

The form was implemented hospital wide on October 26, 2000.

If you have any questions regarding the use of the form, please contact Joy Schatz, Radiology Operations Coordinator, at (610) 402-0386, or Cindy Max, Director, Pediatric Unit, at (610) 402-6715.

Palm Pilot Mania



The LVH Medical Staff Directory is now available to individuals with Palm Pilots (Palm III and Palm IV). For more information regarding hotsyncing the directory into your Palm Pilot, contact Beth Martin in Medical Staff Services at (610) 402-8980.

If you do not currently own a Palm Pilot but have been thinking about getting one, a special offer is now available for the Palm IIIc (color) @ $319.00 or the Palm IIIxe @ $239.00. Order forms are available in the Medical Staff Lounge at Cedar Crest & I-78 or in Medical Staff Services. For more information about this offer, please contact Tony Langston at the Preferred Vendor Program at (610) 402-9193.

Revised Restraint and Seclusion Policy

The revised Restraint and Seclusion Policy, which was approved at the November meeting of the Medical Executive Committee, is attached for your information and review.

Good Shepherd Specialty Hospital- Allentown Highlight its Programs

Transitional Rehabilitation Program

Case Presentation: What is the appropriate post-acute placement for the following patient situation?

Mr. G. is a 76-year-old male patient who was admitted to the local hospital with a cough and fever. This patient developed eosinophilic pneumonitis, which resulted in extensive bilateral infiltrates, sepsis and intubation. After several weeks of hospitalization in the critical care unit, his problem list includes 1) Progressive severe respiratory failure, ventilator dependent; 2) Multiple active infections; 3) Vocal cord dysfunction; 4) Severe pharyngeal dysphagia; 5) Hyponatremia; 6) Sinusitis; and 7) Severe neuromuscular weakness, resulting in dependence for all mobility and self-care.

The extent of his multiple infections, current respiratory status, and the need for long-term antibiotics demands continued acute-care hospitalization. Due to the severity of his neuromuscular deficits and speech and swallowing dysfunction, he requires intensive rehabilitation to facilitate return to an independent level. He is unable to tolerate three hours of therapy/day in an acute rehabilitation setting. The Good Shepherd Specialty Hospital- Allentown, licensed as a *long-term acute-care hospital*, offers the appropriate intensity of medical, nursing, and rehabilitative services to meet this patient's needs.

The intensity of rehabilitation services is increased as the patient progresses. With the input of physiatry, experienced staff (nurses, respiratory, physical, occupational and speech therapists, care managers, dietitians, and support personnel) provide aggressive treatment with close monitoring of physiological tolerance in order to maximize the patient's potential. Caregivers provide hands-on education to patient and family to facilitate a smooth transition to home or the next level of care. The interdisciplinary team meets weekly to discuss and revise the patient's needs and goals. Care management coordinates discharge planning with the patient, family, and the interdisciplinary team to ensure that appropriate services and follow-up are established and that all equipment needs are met.

Questions regarding the Transitional Rehabilitation program can be directed to Wayne E. Dubov, MD, Program Medical Director for Transitional Rehabilitation, at pager (610) 402-5100 5182. If you have any questions concerning the Good Shepherd Specialty Hospital–Allentown, please contact either Joseph Pitingolo, Administrator, at (610) 402-8559, or Beverly Snyder, Director of Nursing/Assistant Administrator, at (610) 402-8599.

Identification of the Patient Being Treated With Antithrombotic Therapy

The DO NO Harm Project for anticoagulation errors has instituted, with PIC approval, the application of **Blue Anticoagulation Bands** on all patients receiving the following medications:

> **Medications:** warfarin (Coumadin), unfractionated heparin, low molecular weight heparin (enoxaparin, Lovenox), clopidogrel (Plavix), tPA (tissue plasminogen activator), ticlopidine (Ticlid), Reteplase, Lepirudin, and platelet glycoprotein II/IIIa antagonists (Eptifibate, Abciximab, Tirofibin).

The purpose of this endeavor is to ensure quick identification of those patients receiving anticoagulation therapy. If your patient is receiving any of the above medications and does not have on a blue ID band, please notify the primary care nurse.

Congratulations!

Jane Dorval, MD, Chief, Division of Physical Medicine-Rehabilitation, has recently been elected Chair-elect of CARF -- the Rehabilitation Accreditation Commission.

Indru T. Khubchandani, MD, Division of Colon and Rectal Surgery, was awarded Honorary Professorship of Surgery at the University of Belgrade School of Medicine in Belgrade, Yugoslavia, following an inauguration ceremony on October 26.

Robert E. Wilson, DO, Division of Pain Management, has been awarded Subspecialty Certification in Pain Management by the American Board of Anesthesiology.

Forms Update

The following forms have now been combined -- **Vaginal Hysterectomy with and without repair** has been combined with **GYN Advanced Operative Laparoscopy Orders**. Form numbers to look for are DO 156-1 for pre-op orders, and DO 157-1 and 157-2 for day of procedure and post-op day, respectively. Abdominal Hysterectomy orders will remain DO 118. These forms will be available through the Pic N Pac process.

Coding Tip of the Month

Postpartum Anemia - Postpartum anemia occurs when large amounts of blood are lost during the vaginal delivery or cesarean section with a significant drop of Hgb or Hct. The treatment for this anemia is blood transfusions or iron therapy. Postpartum anemia must be documented by the physician, along with treatment options, in the progress notes for accurate coding. Coding of postpartum anemia, with proper physician documentation, can change the DRG and bring a higher (and more accurate) reimbursement for the hospital.

Papers, Publications and Presentations

While completing the Visiting Clinician Program in Foot & Ankle Surgery at the Mayo Clinic, **George A. Arangio, MD**, Division of Orthopedic Surgery, Section of Ortho Trauma, presented "Medial Displacement Calcaneal Osteotomy Reduces the Excess Forces on the Medial Arch in the Flatfoot" to the Department of Orthopedic Surgery of the Mayo Clinic.

Mark A. Gittleman, MD, Division of General Surgery, was part of the faculty at the Annual Clinical Congress of the American College of Surgeons in Chicago. Dr. Gittleman presented two post-graduate courses: "Image Guided Breast Biopsy," and "Interventional Breast Ultrasound."

Additionally, in November, Dr. Gittleman presented a seminar titled "Breast Imagery and Intervention." He lectured on breast ultrasound, stereotactic biopsy and sentinal node biopsy. This was held for surgeons and radiologists in Philadelphia. He was also a visiting professor at the University of Kansas in Wichita, where he presented "The Surgeon and Breast Ultrasound" at Grand Rounds.

James W. Jaffe, MD, Chief, Section, Cardiovascular-Interventional Radiology, **James A. Newcomb, MD**, Chief, Section of Trauma-Emergency Medicine Radiology, and **Darryn I. Shaff, MD**, Division of Diagnostic Radiology, have had their paper, "Efficacy of Catheter Directed Therapy using Reteplase," accepted for presentation at the National Society of Cardiovascular and Interventional Radiology Meeting in San Antonio, Texas. It will be the lead paper in the Scientific Session on Thrombolysis on March 7, 2001.

Peter A. Keblish, Jr., MD, Division of Orthopedic Surgery, Section of Ortho Trauma, was an invited guest speaker at the 12th Annual Techniques and Science for Successful Joint Arthroplasty in Burlington, Vt. The annual meeting is sponsored by the Thayer School of Biomechanical Engineering of Dartmouth-Hitchcock Medical Center. Dr. Keblish's presentations included "Impaction Autograft Enhancement of Femoral Stem Fixation in Primary Cementless THA," "Mobile Bearing TKA: Rationale and Experiences with the LCS System," and "Revision TKA: A Simplified Approach with Selective Component Replacement." He also chaired a session on "Issues of Surgical Approaches and Technique Aspects of TKA." More than 200 orthopedic surgeons from the United States and Canada attended the conference.

Indru T. Khubchandani, MD, Division of Colon and Rectal Surgery, gave two addresses on Cancer of the Colo-Rectum and Inflammatory Bowel Disease at the Second International Meeting of Coloproctology of Yugoslavia at the First Organization of Society of Coloproctology of Yugoslavia, which Dr. Khubchandani inaugurated. He also showed a video demonstration of surgical technique for hand-sewn anastomosis following colon resection.

Dominic P. Lu, DDS, Division of General Dentistry/Special Care, co-authored two articles and gave a number of presentations recently. The first article, "Acupuncture/acupressure to treat gagging dental patients: a clinical study of anti-gagging effects," was published in the July-August, 2000 issue of the ***Journal of General Dentistry***. The second article, "Shortage of Rural Dental Manpower and Suggestions for Potential Solutions," was published in the July, 2000 issue of the ***National Academies of Practice Forum.*** Dr. Lu gave abstract presentations at Columbia University during the 16th International Symposium on Acupuncture and Electro-Therapeutics held October 27-29. The presentations included "Characteristics of Acupuncture Anesthesia and Advantages of Acupuncture Anesthesia over Local Anesthesia" and "Bi-Digital O-Ring Test for Detecting False Statements in Clinical Practice." In addition, Dr. Lu was involved in a Lecture Series on Sedation and Anxiety Control at St. Joseph Medical Center/Seton Hall University on October 27 and November 3.

Vincent R. Lucente, MD, Acting Chairperson, Department of Obstetrics and Gynecology, participated in a panel discussion on "Paravaginal Repair vs. Anterior Colporrhaphy for Correction of Cystocele" at the American Urogynecologic Society 21st Annual Scientific Meeting held in October.

In addition, Dr. Lucente gave a presentation on "TVT: The USA Experience" at the International Urogynecological Association in Rome, Italy in October. He also presented "Advanced Surgical Techniques in Pelvic Reconstruction" at the American College of Obstetricians and Gynecologists District III 2000 Annual Meeting in October.

(Continued on Page 9)

(Continued from Page 8)

Lester Rosen, MD, Division of Colon and Rectal Surgery, was on a panel at the American College of Surgeons Meeting in Chicago, Ill., on October 26. The panel was titled, "Will Virtual Endoscopy Replace Invasive Procedures?" Dr. Rosen's talk related to the scientific evidence on "Virtual versus Actual Colonoscopy." In addition, Dr. Rosen was an author to the "American Medical Association's Colorectal Cancer, Screening and Surveillance Quality Care Alert," that is to be distributed nationwide with their current recommendations for colorectal screening and surveillance.

Orion A. Rust, MD, Division of Obstetrics, Section of Maternal-Fetal Medicine/Clinical Inpatient Obstetrics, and **Robert O. Atlas, MD**, Division of Obstetrics, Section of Maternal-Fetal Medicine, were two of the co-authors of an article, "A Randomized Trial of Cerclage versus No Cerclage Among Patients with Ultrasonographically Detected Second Trimester Preterm Dilatation of the Internal Os," which was published in the October issue of the ***American Journal of Obstetrics and Gynecology***.

Samina Wahhab, MD, Plastic Surgery resident, was awarded first prize in the resident paper competition for her presentation, "Local Recurrence of Breast Cancer Following Mastectomy," at the Eastern Pennsylvania Chapter Meeting of the American College of Surgeons which was held in Bethlehem, Pa., in October. Co-authors of the paper include **Peter F. Rovito, MD**, Division of General Surgery; **Robert X. Murphy, Jr., MD**, Division of Plastic Surgery/Hand Surgery, Section of Burn; and **Robert B. Kevitch, MD**, Division of Plastic Surgery/Hand Surgery.

Randolph Wojcik, MD, General Surgery resident, was awarded first place for his presentation, "Pre-injury Warfarin Does Not Impact Outcome in Trauma Patients," at the Pennsylvania Committee on Trauma Resident Trauma Paper Competition in Harrisburg, Pa., in November. Dr. Wojcik will present this paper at the regional competition in West Virginia in December. Co-authors of the paper were **Mark D. Cipolle, MD, PhD**, Chief, Section of Trauma Research, **Elizabeth Seislove,RN**, Trauma Development, and **Thomas E. Wasser,PhD**, Department of Health Studies.

Upcoming Seminars, Conferences and Meetings

Medical Grand Rounds

Medical Grand Rounds are held every Tuesday beginning at noon in the Auditorium of Lehigh Valley Hospital, Cedar Crest & I-78, and via videoconference in the First Floor Conference Room at Lehigh Valley Hospital-Muhlenberg, and in the Video Teleconference Room (formerly the Medical Staff Lounge) at 17th & Chew.

Topics to be discussed in December will include:

- December 5 - "A Practical Guide to Safer, More Efficient and Less Costly Medical Care: Infectious Disease"
- December 12 - "Pain Assessment for the Rehab/Cancer Patient"

There will be no Medical Grand Rounds on December 19 or 26, however, they will resume again on Tuesday, January 2, 2001.

For more information, contact Diane Biernacki in the Department of Medicine at (610) 402-5200.

Department of Pediatrics Conference

"Portal Hypertension" will be presented by Carl F. D'Angelo, MD, Chief, Division of Gastroenterology, on Tuesday, December 5, beginning at 8 a.m., in the **John and Dorothy Morgan Cancer Center, Conference Rooms 1A & 1B.**

For more information, please contact Kelli Ripperger in the Department of Pediatrics at (610) 402-2540.

PHYSICIAN DOWNTIME PROCEDURES
402-DOWN (3696)

During an extended network downtime (2 hours or more), please call 402-DOWN and press the appropriate number for the department you are trying to reach:

1 - Admission/Bed Assignment
2 - Pathology, Micro and Clinical Lab Reports
3 - Pharmacy
4 - Radiology
5 - Operating Room Scheduling

Who's New

The Who's New section of ***Medical Staff Progress Notes*** contains an update of new appointments, address changes, resignations, etc. Please remember to update your directory and rolodexes with this information. In addition, the Medical Staff Directory is now available on the e-mail Bulletin Board -- **Directories**. Updates will be made to the Medical Staff Directory at the beginning of each month.

Medical Staff

Changes of Address

Kandula and Pendurthi Surgical Associates
Ravindra R. Kandula, MD
T. Kumar Pendurthi, MD, PhD
2649 Schoenersville Road
Suite 203
Bethlehem, PA 18017-7316

Charles F. Kelley, Jr., MD
Children's HealthCare Center
1517 Pond Road
Allentown, PA 18104-2250
(610) 395-4444
Fax: (610) 366-7886

Lehigh Valley Cardiology Associates
Nadeem V. Ahmad, MD
Kenneth A. Bernhard, MD
Robert H. Biggs, DO
Praveer Jain, MD
John P. Kristofich, MD
John A. Mannisi, MD
George A. Persin, DO
Kenneth P. Skorinko, MD
Deborah W. Sundlof, DO
Anthony M. Urbano, MD
2649 Schoenersville Road
Suite 301
Bethlehem, PA 18017-7317
(610) 866-2233
Fax: (610) 866-7738

Please Note: Robert F. Malacoff, MD, will remain at 800 Ostrum Street, Bethlehem, PA 18015

Toselli & Brusko Surgical Associates
Gregory Brusko, DO
Rovinder S. Sandhu, MD
2649 Schoenersville Road
Suite 202
Bethlehem, PA 18017-7317
(610) 691-8074
Fax: (610) 861-9449

Please Note: Matthew L. Montgomery, MD, and Pat Toselli, DO, will remain at 1575 Pond Road, Suite 201, Allentown, PA 18104

Joseph M. Pascuzzo, DO
VA Outpatient Clinic
3110 Hamilton Blvd.
Allentown, PA 18103-3630
(610) 776-4344
Fax: (610) 776-4314

Practice Change

Douglas P. Harr, MD
(No longer associated with Mishkin, Rappaport, Shore, Urankar)
2305 Mill Hill Road
Quakertown, PA 18951-3904

Fax Number Correction

Easton-Warren Urology
Joseph M. Antario, MD
Scott C. Yeaw, MD
Fax: (610) 258-7193

News from the Pennsylvania Medical Society

(This information is being provided to you by Robert X. Murphy, Jr., MD, OMSS Representative)

State Society Steps Up Offensives:

Seeking CAT Fund Payment Rollback

With only days remaining in the legislative session, Pennsylvania Medical Society leaders are meeting with CAT Fund Administrator John Reed to urge rollback of the 2001 surcharge payment increases. This follows months of tireless efforts by Society leaders to resolve CAT Fund coverage issues.

In October, the State Society President Carol E. Rose, MD wrote to the insurance commissioner strongly protesting the CAT Fund's effect on Pennsylvania's health care system. Dr. Rose advocated the urgent need for action by the governor and the legislature to correct the increasingly hostile practice environment in Pennsylvania, and warned of the urgent need for meaningful lawsuit reform.

Under the 61% surcharge rate set for 2001, increases will range between 7%-56%, depending on specialty, but most physicians will see an increase of about 26%. Add to this the contentious medical malpractice climate in this state, and the statewide physician community is poised to erupt over med mal coverage costs in 2001. The Society is attacking on all fronts to:

* Pursue a comprehensive phase down-The Society's plan would eliminate the Fund but safeguard the financial future of all Pennsylvania physicians in the long term-especially future generations. Opposition to this phase down is intense. Our proposal would increase basic coverage limits for the primary carriers to $800,000. (Read on for more details.)

* Oppose quick-fix proposals-As in any crisis, quick-fixes abound. The Marsh bond proposal is designed to terminate the Fund as of 2002, using bonds to pay off the $2+ billion unfunded liability. Essentially, this proposal would mortgage the future. (See <http://www.pamedsoc.org/page_detail.cfm?id=1054> www.pamedsoc.org/page_detail.cfm?id=1054 for more details.) We also oppose the "opt out" plan designed by the Hospital and Health System Association of Pennsylvania (HAP) because it would lead to abandonment of the Fund by its major contributors, eventual destabilization of the Fund, and higher overall payments for physicians.

Oppose removing gap coverage-Legislative tactics are rife in the last hours of this session to muddy provisions to cover the "gap" in coverage left as the Fund phases down. Negotiations continue on SB 1520, originally intended to provide clarifying language for Section 605 (gap) coverage.

The Society's Phase Down Plan

The CAT Fund is a pay-as-you-go, or "claims paid" system. Conventional insurers collect policy premiums in the year of occurrence; the Fund collects the premium in the year a claim is to be paid. If the Fund were eliminated tomorrow, a substantial number of claims would exist for which there are no reserves. This "unfunded liability" totals roughly $2 billion.

Arguments to eliminate the Fund are based on assumptions in actuarial projections, which vary and are unproven theories. In addition, many who wish to eliminate the Fund believe that the requirement for mandatory insurance would also go away with the Fund. Nothing could be further from the truth. Eliminating mandatory insurance is virtually impossible in the present legislative climate.

The Society proposes a gradual, long-term phase down until the Fund's coverage limit is $400,000. In 1997, the Fund covered $900,000 and primary malpractice insurance covered $300,000. Since then, the Fund has been phased down and currently covers $800,000 with primary insurance covering $400,000. Next year, the phase down would cover $700,000 as primary insurance increases to $500,000.

This gradual phase down allows the health care community to absorb costs. Maintaining the $400,000 level to cover claims filed four years after the occurrence would protect physicians. These claims, known as "605s," are not covered by primary malpractice insurance. Without the Fund's $400,000 coverage, physicians would be left with a "gap" from past years.

We've studied the medical malpractice problems in Pennsylvania for more than 30 years. Our plan can work. But it requires the support of all Pennsylvania physicians-especially of Pennsylvania Medical Society Members.

LAWSUIT ABUSE REFORM IS THE FINAL ANSWER.

The Pennsylvania Medical Society will lead the fight in 2001-Be there!

If you believe, you've got to belong

The Marsh Proposal

The Society opposes the Marsh proposal, one of the plans to eliminate the CAT Fund currently supported by some stakeholders. This proposal would terminate the Fund as of January 1, 2002, and use bonds to pay off the $2+ billion in unfunded liability over time. We oppose it for the following reasons:

1. The costs of borrowing, reinsurance, and transaction fees to Marsh (the actuarial firm) and others make this the most expensive of the numerous proposals to eliminate the Fund.

2. Essentially, this is a plan to mortgage the future. Physicians entering practice on January 1, 2002 would spend the next 30 years (or longer) paying off unfunded liability that they had no part in creating.

3. An 11-member authority would supervise the claims handling and overall management of the Fund run-off. Only one member must be a physician, giving the physician community little voice.

4. This proposal doesn't address the real problem-that once the Fund is eliminated, private insurance costs would increase. The plan promises a cap of the payoff portion, but for only 10 years. The total cost would inevitably be more than physicians pay now.

Coming in 2001:

Lawsuit Abuse Reform Offensive

Your State Society is drawing together resources and expertise to make the fight for tort reform, as well as CAT Fund phase down, a top priority in 2001. Your support is critical to these strategies. We are seeking support for tort reform in these arenas:

* Judicial: Involvement in state judicial races will be vital to addressing the measures enacted by Act 135 which were subsequently emasculated by the courts.

* Legislative: We will continue to seek legislative measures to secure tort reform.

* Public: Public awareness of the effect of Pennsylvania's malicious tort climate is critical to our legislative and judicial efforts. We will invest resources in making sure patients are aware of how this crisis affects the patient-physician relationship.

* Research: Effective communications with legislators and the public depend on solid facts. Our research and analysis of Pennsylvania's medical malpractice experience will be critical in the days ahead.

For more information on the CAT Fund: go to http://www.pamedsoc.org/ www.pamedsoc.org under "advocacy and info/legal" and under Report 18 of the House of Delegates. Call the Legislative Affairs Division at 800-228-7823.

Policy: Administrative
Subject: Restraint and Seclusion

Restraint and Seclusion

I. Policy

In accord with HCFA regulations, it is the policy of Lehigh Valley Health Network Hospitals to use restraint or seclusion when less restrictive interventions have been assessed and determined ineffective. Restraints are utilized in two situations: a) when needed to achieve a clinical outcome for the patient and b) for emergency use in behavior management. The decision to use a restraint is driven by a comprehensive individual assessment, which concludes that for this patient at this time, the use of less intrusive measures poses a greater risk than the risk of using a restraint or seclusion. In all instances, patients' rights, dignity and well being will be supported.

II. Scope

Entities within Lehigh Valley Health Network

III. Definitions

Behavior Management - when a patient's behavior places him/herself in danger of injuring themselves, healthcare workers, property, or the environment.

Physical Restraint - any manual method or physical or mechanical device, material or equipment attached or adjacent (eg. bedrail) to the patients body that he/she cannot easily remove which restricts freedom of movement or normal access to one's body.

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

Types of physical restraints/Securing devices - include, but not limited to, locked limb, locked waist, locked Geri chair bar, cloth limb, mitts, bedrails (when used to keep a patient in bed).

Invasive lines/tubes - includes, but not limited to, peripheral IV lines, central lines, PICC lines, Foley catheters, peg tubes, naso-gastric tubes and endotracheal tubes.

Chemical Restraint - a drug used as a restraint is a medication used to control behavior or restrict the patient's freedom of movement that is not a standard treatment for the patient's medical or psychiatric condition.

Clinical Leadership - an individual who has authority for a department such as Chairman or Vice President of Department/Nursing Leader.

Multiple Episodes - two (2) or more separate episodes within twelve (12) hour or if the patient remains in restraints more than twelve (12) hours.

IV. Procedure

A. Clinical restraint protocol

This protocol describes when clinical restraints can be initiated by a Registered Nurse (RN) following the medical staff approved criteria outlined below. The protocol in acute medical/ surgical care, states that a restraint may be necessary to ensure that (for example) an intravenous or feeding tube will not be removed, or that a patient who is temporarily or permanently incapacitated with a broken hip will not attempt to walk before it is medically appropriate. CLINICAL RESTRAINT MAY BE USED TO LIMIT MOBILITY OR TO TEMPORALLY IMMOBILIZE A PATIENT RELATED TO A PROCEDURE.

A qualified RN may assess a patient and conclude that the criteria in this clinical protocol has been met. If it is the RN's professional judgment that restraints should be utilized, then she/he may do so.

Prior to using any securing device, less restrictive alternatives must have been assessed. Some alternatives that may be considered are: e.g. Patient pulling/grabbing at tubes, intervention may include: securing all tubes, placing tubes under gown or covers, redirect patient, diversion activities or eg. patient climbing out of bed, intervention may include: bed check, personal alarm, observation/sitter/family, reality orientation, 1:1, relaxation activity, quiet time, reduced stimulation etc.

If the nurse determines a securing device is necessary, the nurse will initiate its use and obtain a physician order stating "per clinical protocol". The nurse will reassess the patient every 2 hours according to hospital policy, to determine if the patient still meets the criteria for these restrictions.

The criteria for applying restraints according to clinical protocol that have been approved by the medical staff are:

- Fluctuating or continuous lack of decision-making capacity in which the patient is incapable of understanding the benefits, risks and alternative treatment for which the line/tube was placed. The lack of decision-making capacity may be acute or chronic and is independent of the underlying etiology. Patients with decision-making capacity can refuse restraint.

- The lack of decision-making capacity may be expressed as confusion, delirium, cognitive impairment, marked agitation, or combativeness, which may involve the patient grabbing or pulling or tugging the line/tube.

1. Documentation of the initial assessment and reassessments (Attachment A) will include, at a minimum, the following:
   - behavior/events leading up to the intervention
   - alternatives employed to avoid restraint
   - criteria met to initiate/continue restraint
   - discussion with the patient and/or family, when possible
   - time restraint was initiated/discontinued
   - type/location(s) of restraint applied (protocol excludes locked restraints)

2. Customary patient care (providing comfort measures and observation) under the direction of an RN is addressed every two hours and documented on the Restraint/Seclusion Observation Checklist and will include, when applicable the following:
   - fluid/nutritional needs
   - toileting needs
   - circulation of the restrained limb(s)
   - range of motion and positioning
   - side rails maintained
   - mental status
   - patient location

3. If the reassessment by the RN indicates that the clinical protocol criteria no longer apply, the patient will be removed from restraint. Continuation of restraints in patients no longer meeting the above criteria requires a physician order and adherence to the requirements noted below.

B. Behavior Management

A restraint or seclusion for behavior management is used only as an emergency measure and is reserved for those occasions when a patient's behavior becomes aggressive or violent presenting an immediate, serious danger to his/her safety or that of others. (The use of restraint for a non-violent, non-aggressive patient to address the risk of a fall is addressed in section A.)

Emergent use may be initiated before obtaining a physician's order, based upon the nurses professional assessment. A dated and timed physician order must be obtained for the restraint (Attachment B). The physician must examine the patient within 1 hour and document the behaviors that warrant the use of restraint. If the original order is a verbal order, it must be co-signed within 24 hours. The primary treating

physician must be notified as soon as possible if the restraint has been ordered by another physician.

The nurse may release the patient for a trial period and/or reduce the level of restraint prior to expiration of the 4 hour order if the patient's condition changes. If terminated early, a new order must be obtained prior to reinitiating. If the patient restrained for aggressiveness quickly recovers and is released before the physician arrives to perform the assessment, the physician must still see the patient face to face to perform the assessment within 1 hour after initiation of the intervention. The fact that the patient's behavior warranted the use of restraint or seclusion indicates a serious medical or psychological need for prompt assessment of the incident/ situation leading to the intervention.

Prior to the expiration of the original order, by the physician, the nurse needs to assess the patient and obtain an additional time limited order of, 4 hours for adults, 2 hours if between age 9 - 17 and 1 hour under age 9. The nurse will then need to reassess the patient following the additional time order to determine if restraints are still needed. This may be done up to 6 times within 24 hours.

The patient who is restrained or secluded should be observed every 15 minutes, as a minimum, according to hospital policy. (Attachment A)

Restraint and seclusion may not be used simultaneously unless a staff member continually monitors the patient. Methods of monitoring include 1:1 or concurrent audio and video monitoring. The use of equipment does not eliminate the need for frequent assessment.

Clinical leadership is informed of instances in which individuals experience extended, or multiple episodes of, restraint or seclusion.

Debriefing will take place as soon as possible with patient, staff and family if appropriate, regarding the reason for restraint use/behavior.

C. General Issues

1. Restraint use that is associated with medical, dental, diagnostic or surgical procedures and the related post-procedure care processes when based on standard practice for the procedure which does not require a physician's order. Examples are medical immobilization during surgery, during electroconvulsive therapy, the use of IV arm boards and stretcher side rails.

2. In both instances, A and B, convenience is not an acceptable reason to restrict a patient nor can restraint or seclusion serve as a substitute for adequate staffing to monitor a patient.

3. Prior to initiation of restraint or seclusion, less restrictive alternatives should be considered.

4. A comprehensive assessment of the patient must determine that the risks associated with the use of the restriction are outweighed by the risk of NOT using it.

5. All staff who have direct patient contact must have ongoing education and training in the proper and safe use of seclusion and restraint application as well as techniques and alternative methods for handling aggressive/violent behavior.

6. After restraints are applied, an assessment should ensure that the application was proper and safe.

7. Risks associated with any intervention must be considered in the context of an ongoing loop of assessment, intervention, evaluation, and reintervention.

8. Staff must report to Risk Management any death that occurs while a patient is restrained or in seclusion, or where it is reasonable to assume that a patient's death is a result of either. The Risk Manager will fulfill the organization's responsibility to report such an occurrence to HCFA in compliance with regulation.

9. The use of restrictive devices applied by law enforcement officials, such as handcuffs, are not governed by this policy.

10. A voluntary mechanical support used to achieve proper body position, balance or alignment so as to allow greater freedom of mobility is NOT considered a restraint. (egs. Braces, wheelchairs, sandbags)

11. A positioning or securing device used to maintain position, or temporarily immobilize during a procedure is NOT considered a restraint. (egs. IV armboards, stretcher side rails)

12. Customary patient care, including comfort measures, should be provided to the restricted patient, according to reasonable standards of care. This will include but not be limited to fluid/nutritional needs, toileting, range of motion and position, assessment of circulation of restrained limb, mental status etc.

13. Documentation will include, at a minimum, behavior/events leading up to the intervention, less restrictive alternatives considered/attempted, time of application and termination, type of restriction applied and family notification, when possible. If the patient wants family notified, staff is required to promptly attempt to contact the family.

14. Restraint usage is monitored monthly and reported to the Performance Improvement Council.

V. Attachments

Attachment A – Restraint/Seclusion Observation Checklist
Attachment B – Restraint/Seclusion Doctor's Order Sheet

VI. Distribution

Administrative Manual

VII. Approval

_____	President & CEO	_____
Signature	Title	Date
_____	President of Medical Staff	_____
Signature	Title	Date
_____	Sr.Vice President, Clinical Services	_____
Signature	Title	Date

VIII. Policy Responsibility

Clinical Services

In Coordination with:
Legal Services
Department of Psychiatry

IX. References

Comprehensive Accreditation Manual for Hospitals: The Official Handbook, 2001 standards.
HCFA - Interpretive Guidelines for Hospital, Conditions of Participation for Patient Rights, (HCFA 2000)

X. Disclaimer Statement

This policy and the implementing procedures are intended to provide a description of recommended course of action to comply with statutory or regulatory requirements and/or operational standards. It is recognized that there may be specific circumstances, not contemplated by laws or regulatory requirements that make compliance inappropriate. For advice in these circumstances, consult with the department of Risk Management/Legal Services.

XI. Revision Dates

Origination: February 1990
Review/Revised: October 1990, May 1992, January 1994, November 1994, November 1995, July 1997, June 1998, April 1999, September 2000, October 2000

LEHIGH VALLEY HOSPITAL
ALLENTOWN, PA

LEHIGH VALLEY HOSPITAL - MUHLENBERG
BETHLEHEM, PA

3 1 0

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!

BEHAVIOR MANAGEMENT PATIENT:

☐ adult - restrain for up to 4 (four) hrs

☐ child/adolescent (age 9-17) - restrain for up to 2 (two) hrs

☐ child (under age 9) - restrain for up to 1(one) hr

1. Purpose for restraint(s)/seclusion Date: _____ Time: _____

☐ high risk for self-harm ☐ high risk for causing significant

☐ high risk for harm to others disruption of treatment environment

☐ high risk for flight (attempting to elope) ☐ other _____

2. 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

☐ chemical (physician order to include: medication name, dose, route, frequency)

_____

3. Criteria for discontinuing restraint(s)/seclusion

☐ no aggressive behavior ☐ no risk for causing significant

☐ no aggressive behavior threatened disruption of treatment environment

☐ no suicidal behavior ☐ patient is not destructive of property

☐ no suicidal behavior threatened ☐ other _____

☐ no self-harming behavior _____

☐ no self-harming behavior threatened _____

4. If covering physician is not the attending, then notification to attending is required.

5. At the expiration of the time limited order, a new order is required.

_____ M.D./D.O.

Renewal orders:

Date: _____ Time: _____ _____ M.D./D.O.

Date: _____ Time: _____ _____ M.D./D.O.

Date: _____ Time: _____ _____ M.D./D.O.

Date: _____ Time: _____ _____ M.D./D.O.

Date: _____ Time: _____ _____ M.D./D.O.

LEHIGH VALLEY HOSPITAL
ALLENTOWN, PA

LEHIGH VALLEY HOSPITAL - MUHLENBERG
BETHLEHEM, PA

1 2 2

RESTRAINT / SECLUSION OBSERVATION CHECKLIST

REASON FOR RESTRAINT:

☐ Behavior Management ☐ Clinical Restraints

DATE

**Requires Supportive Documentation*

TIME	0015	0030	0045	0100	0115	0130	0145	0200	0215	0230	0245	0300	0315	0330	0345	0400
PATIENT LOCATION [1]																
PATIENT BEHAVIOR [2]																
TYPE OF RESTRAINT [3]																
INTERVENTION(S) [4]																
COMFORT MEASURES																
VISUAL OBSERVATION [5]																
PATIENT TEACHING REINFORCED																
BEHAVIOR MANAGEMENT PATIENTS: RN TO REASSESS PATIENT AND RENEW ORIGINAL ORDER*																
INITIALS																

TIME	0415	0030	0445	0500	0515	0530	0545	0600	0615	0630	0645	0700	0715	0730	0745	0800
PATIENT LOCATION [1]																
PATIENT BEHAVIOR [2]																
TYPE OF RESTRAINT [3]																
INTERVENTION(S) [4]																
COMFORT MEASURES																
VISUAL OBSERVATION [5]																
PATIENT TEACHING REINFORCED																
BEHAVIOR MANAGEMENT PATIENTS: RN TO REASSESS PATIENT AND RENEW ORIGINAL ORDER*																
INITIALS																

TIME	0815	0830	0845	0900	0915	0930	0945	1000	1015	1030	1045	1100	1115	1130	1145	1200
PATIENT LOCATION [1]																
PATIENT BEHAVIOR [2]																
TYPE OF RESTRAINT [3]																
INTERVENTION(S) [4]																
COMFORT MEASURES																
VISUAL OBSERVATION [5]																
PATIENT TEACHING REINFORCED																
BEHAVIOR MANAGEMENT PATIENTS: RN TO REASSESS PATIENT AND RENEW ORIGINAL ORDER*																
INITIALS																

[1] 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
O = Off Unit

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

[3] TYPE OF RESTRAINT
X4 = 4 pt. locked limbs
X2 = 2 pt. alternate limbs (locked)
CS = Chest Strap
XW = Locked Waist
S = Seclusion
GC/B = Gerichair w/ locked bar
RW = Right Wrist (cloth limb)
LW = Left Wrist (cloth limb)
RA = Right Ankle (cloth limb)
LA = Left Ankle (cloth limb)
M = Mitts
O = 1:1
C = Chemical

[4] INTERVENTION(S)
1. Problem Solving
2. PRN Medication
3. Reality Orientation
4. 1:1 Talk
5. Relaxation Activity
6. Direct Observation - Family/Staff
7. Quiet Time
8. Redirect Patient Focus
9. Leisure Activities
10. Family and/or Significant Other Involved
11. Reduce Stimulation

[5] VISUAL OBSERVATION
OBSERVE WEIGHT SHIFT, RESPIRATIONS AND CIRCULATION TO RESTRAINED EXTREMITY(S). ASSIST AS NEEDED.

RESTRAINT / SECLUSION OBSERVATION CHECKLIST

REASON FOR RESTRAINT:

☐ Behavior Management ☐ Clinical Restraints

**Requires Supportive Documentation*

DATE

TIME	1215	1230	1245	1300	1315	1330	1345	1400	1415	1430	1445	1500	1515	1530	1545	1600
PATIENT LOCATION [1]																
PATIENT BEHAVIOR [2]																
TYPE OF RESTRAINT [3]																
INTERVENTION(S) [4]																
COMFORT MEASURES																
VISUAL OBSERVATION [5]																
PATIENT TEACHING REINFORCED																
BEHAVIOR MANAGEMENT PATIENTS: RN TO REASSESS PATIENT AND RENEW ORIGINAL ORDER*																
INITIALS																

TIME	1615	1630	1645	1700	1715	1730	1745	1800	1815	1830	1845	1900	1915	1930	1945	2000
PATIENT LOCATION [1]																
PATIENT BEHAVIOR [2]																
TYPE OF RESTRAINT [3]																
INTERVENTION(S) [4]																
COMFORT MEASURES																
VISUAL OBSERVATION [5]																
PATIENT TEACHING REINFORCED																
BEHAVIOR MANAGEMENT PATIENTS: RN TO REASSESS PATIENT AND RENEW ORIGINAL ORDER*																
INITIALS																

TIME	2015	2030	2045	2100	2115	2130	2145	2200	2215	2230	2245	2300	2315	2330	2345	2400
PATIENT LOCATION [1]																
PATIENT BEHAVIOR [2]																
TYPE OF RESTRAINT [3]																
INTERVENTION(S) [4]																
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PATIENT TEACHING REINFORCED																
BEHAVIOR MANAGEMENT PATIENTS: RN TO REASSESS PATIENT AND RENEW ORIGINAL ORDER*																
INITIALS																

[1] 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
- O = Off Unit

[2] PATIENT BEHAVIOR
- A = Angry
- AS = Assaultive
- C = Cooperative
- U = Uncooperative
- CB = Combative
- I = Intrusive
- P = Pacing
- Q = Quiet/Subdued
- IC = Incoherent
- R = Restless
- S = Sleeping
- SH = Self Harm
- T = Tearful

[3] TYPE OF RESTRAINT
- X4 = 4 pt. locked limbs
- X2 = 2 pt. alternate limbs (locked)
- CS = Chest Strap
- XW = Locked Waist
- S = Seclusion
- GC/B = Gerichair w/ locked bar
- RW = Right Wrist (cloth limb)
- LW = Left Wrist (cloth limb)
- RA = Right Ankle (cloth limb)
- LA = Left Ankle (cloth limb)
- M = Mitts
- O = 1:1
- C = Chemical

[4] INTERVENTION(S)
1. Problem Solving
2. PRN Medication
3. Reality Orientation
4. 1:1 Talk
5. Relaxation Activity
6. Direct Observation - Family/Staff
7. Quiet Time
8. Redirect Patient Focus
9. Leisure Activities
10. Family and/or Significant Other Involved
11. Reduce Stimulation

[5] VISUAL OBSERVATION
OBSERVE WEIGHT SHIFT, RESPIRATIONS AND CIRCULATION TO RESTRAINED EXTREMITY(S). ASSIST AS NEEDED.

The Center for Educational Development and Support

December, 2000

News from the Library

OVID Training.

The Library has completely converted to OVID's on-line MEDLINE system. This Web-based system is updated daily by Ovid. Call Barbara Iobst in the Health Sciences Library at 610-402-8408 to schedule a one-on-one training session.

New Publications.
CC Library:
"Infectious Diseases of the Fetus and Newborn Infant," 5th edition

17 Street Library:
"Principles and Practice of Emergency Medicine," 4th edition

Muhlenberg Library:
"Trauma," 4th edition.

Computer-Based Training (CBT):

Computer Based Training (CBT) programs are available for LVHHN staff. Topics covered by the CBT programs include:

Access 2.0	Power-Point 4.0
Windows NT 4	Word 97
Excel 97	Access 97
PowerPoint 97	Lotus 1-2-3 Millennium
WordPerfect 8	E-mail GUI

PHAMIS LastWord Inquiry Only commands

CBT programs replace the instructor-led classes previously held at Lehigh Valley Hospital. A proctor will be in the room with the learner while he/she takes the CBT, but the learner will control the pace and objectives of the learning.

Computer Based Training takes place in **Suite 401** of the **John & Dorothy Morgan Cancer Center** (the computer training room) and in the **Muhlenberg Hospital Center computer training room** (off the front lobby). The schedule of upcoming dates is as follows:

CBT sessions for JDMCC, suite 401 are as follows:

December 5 - 8am – Noon
January 9, Noon – 4pm
February 6, 8am – Noon
March 13, 8 am - Noon

Sessions at MHC, I.S. Training room are as follows:

December 19 - Noon - 4pm
January 16, Noon – 4pm
February 13, Noon – 4pm
March 20, Noon – 4pm

Twelve slots are available for each session.

To register, please contact Suzanne Rice via e-mail or at
484-884-2560 with the following:
- date of session
- second date choice
- department
- phone number

You will receive an e-mail confirming your choice within two business days. If you have any questions, please contact Craig Koller at 610-402-1427 or through e-mail.

Any questions, concerns or comments on articles from CEDS, please contact Bonnie Schoeneberger 610-402-1210

December 2000

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
					1 7am GYN Tumor Board-CC-CL1 12noon Breast TB-JDMCC-CR1	2
3	4 12noon Colon/Rectal TB-JDMCC-CR1	5 7am Surgical GR-CC-Aud 8am Pediatric GR- CC-Aud 12 noon Medical GR-CC-Aud	6	7 12noon GI TB-JDMCC-CR1	8 7am OBGYN GR-CC-CL1 12noon Breast TB-JDMCC-CR1	9
10	11	12 7am Surgical GR-CC-Aud 8am Pediatric GR-CC-Aud 12 noon Medical GR-CC-Aud	13 12noon Pulmo TB-JDMCC CR1	14 12noon Combined TB-JDMCC-CR1	15 7am OBGYN GR-CC-CL1 12noon Breast TB-JDMCC-CR1	16
17	18 12noon Colon/Rectal TB-JDMCC-CR1	19 7am Surgical GR-CC-Aud 8am Pediatric GR-CC-Aud 12 noon Medical GR-CC-Aud	20	21 12noon ENT TB-JDMCC-CR1	22 7am OBGYN GR-CC-CL1 12noon Breast TB-JDMCC-CR1	23
24	25 Happy Holiday 	26 7am Surgical GR-CC-Aud 8am Pediatric GR-CC-Aud 12 noon Medical GR-CC-Aud 12noon Urology TB-JDMCC-CR1	27	28 12noon Combined Conf w/Medical Residents - CC - Aud	29 7am OBGYN GR-CC-CL1 12noon Breast TB-JDMCC-CR1	30
31						

LEHIGH VALLEY
HOSPITAL AND
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Medical Staff Progress Notes

Medical Executive Committee

Medical Staff Progress Notes **is published monthly to inform the Medical Staff of Lehigh Valley Hospital 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 (610) 402-8590.