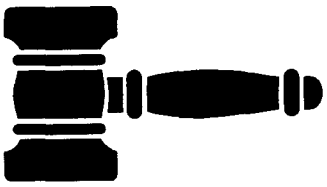
LEHIGH VALLEY
HOSPITAL AND
HEALTH NETWORK

PROGRESS NOTES
Medical Staff

January, 2001 Volume 13, Number 1

In This Issue . . .



From the President

"You cannot live a perfect day without doing something for somebody who cannot possibly repay you."
- John Wooden, UCLA Basketball Coach

What's New and What's Not

On behalf of your medical staff, I would like to offer our best wishes for a healthy and productive New Year to every member of the LVHHN team. As the calendar changes, so do a lot of other things – like your medical staff leadership, for example. We would like to express our sincere thanks to Dr. Bob Murphy as he steps down from the office of past president and his leadership responsibilities. We wish him well in his continuing career development. We also offer a warm welcome to Dr. Alex Rae-Grant as he begins his term as president-elect. This two-year "ramp up" has proven to be extremely useful, and we look forward to working with Alex in this role.

Special Thanks

We really need to express our sincere gratitude to Dr. David Caccese, a leader who has been firm, consistent, and fair as he capably and calmly led our medical staff through difficult manpower and financial challenges and patiently pointed us in the direction of the electronic age for the past two years. He led, and together we reduced LOS and cost per case. We will miss David's monthly "blue notes" in which he taught, cajoled and prodded us, the medical staff members, toward clinical progress, service excellence and financial responsibility. David has been an excellent teacher and role model for me personally as he always gave first priority to the best interests of the medical staff and the institution. He will continue to assist and guide the medical staff for an additional two years in his office of past president.

Direction and Goals for Medical Staff Leadership

As I take the baton from Dr. Caccese, I would like to again express my genuine gratitude to this talented and respected medical staff for allowing me this opportunity to represent you to the LVHHN Board and the organizational leadership – an opportunity that has been stimulating and personally rewarding for me in these past two years.

(Continued on Page 2)

(Continued from Page 1)

After discussion and consideration, your medical staff leadership has decided to focus on the following goals, which represent an appropriate continuum with current initiatives:

1. Respect - We will value the skills and individual contribution of every member of the medical staff and assume positive intent. (API). We respect your time and practice pressures. The medical staff is a type of team and we should behave that way.

2. Communicate - We will actively seek out input and advice from the medical staff by a variety of methods, including individual interviews, visits to Division meetings, regular e-mail messages, point-counter point letters from the staff and informal gatherings.

3. Advise - We will identify and analyze issues that affect us as a medical staff (like the CAT fund, etc.) and offer advice and guidance through these areas of inevitable change.

4. Represent - We will improve the representation of medical staff members with their primary activity at the LVH-M campus with due respect for the traditions and culture of the Bethlehem community as it evolves.

Reciprocal Responsibilities and Goals for Medical Staff

1. Leadership - Recognize that we work and function in a complex community of multiple health care providers and that we have a special responsibility as the clinical team leaders.

2. Attitude - Respect the administration and Board who represent the institution and the community respectively (API). Their goals parallel those of the medical staff, but are not identical.

3. Satisfaction – While there is nothing wrong with fiscally prudent management, recognize the limitations of financial self interest as the sole career goal. There may be a need to modify our goals in the interests of our patients and the community. Ultimately, we joined the ranks of health care providers to heal the sick, and this is where we will derive our true satisfaction.

4. Self-esteem – Appreciate that managed care and health care delivery systems are necessary and will continue to evolve, but physicians and care givers will still provide the actual service. The public knows this. To paraphrase Dr. Guzzo, we will still be here.

On the Radar Screen

Aetna-U.S. Healthcare – As the clock winds down on the March deadline, it appears unlikely that a mutually acceptable resolution will be achieved. The positions of LVH and AUSHC have been well described and will not be reiterated here. Your patients should be appropriately advised.

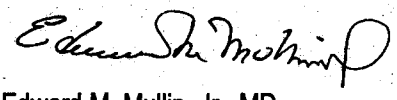
Computer Assisted Physician Order Entry – All the medical staff discussions, as well as my personal reading, indicate that the benefits (immediate and long-term) clearly outweigh the obstacles, and this change appears inevitable. Some managed care systems are discussing "directing" their patients to hospital systems utilizing electronic patient care methods which reduce errors. The health care industry in general has been slow to adopt some of the electronic tracking techniques of industry, but the public will soon demand that we take steps to ensure patient safety. The essential here is a user-friendly system and medical staff members need to test drive it on a small scale before we endorse and sell it to the medical staff at-large. This will be a major project for us as our medical staff leads the way in the Lehigh Valley.

Dr. Don Levick is heading the Coordinating Committee (docs, administration and I/S) as well as the all important design committee. Ultimately this project is about quality of care.

Conflict Management – Change is inevitable – in health care as in life. Change will frequently bring stress, which often leads to conflict. Occasional conflict is not necessarily bad; it depends on how it is managed. We can disagree on issues without insult. This is a page from Terry Capuano's program of developing a "culture of respect". Medical staff leadership will try to assist medical staff members in situations involving conflict management first utilizing the medical staff organizational structure. We will then develop resources (both in-house and outside the institution) for conflict resolution and make them available to the medical staff.

Patient Satisfaction – As the hospital census increases (all over the country), the patient satisfaction scores drop. LVH medical staff members need to appreciate and anticipate this. Satisfaction scores rise when the health care team spends a few moments with the patient and demonstrates to the patient a caring attitude. How? As per the mantra of Dr. Caccese: sit, ask, answer, touch. Easy, really!

WE CAN DO MORE TOGETHER!!!



Edward M. Mullin, Jr., MD
Medical Staff President

Medical Staff Leadership Changes Hands

Effective January 1, 2001, leadership of the Medical Staff changes hands as **Edward M. Mullin, Jr., MD**, begins his term as President, and **Alexander D. Rae-Grant, MD**, begins his term as President-elect.

Please note that all mail to Dr. Mullin, **relating to his position as President of the Medical Staff**, should be sent to Medical Staff Services, Lehigh Valley Hospital, Cedar Crest & I-78, P.O. Box 689, Allentown, PA 18105-1556. Mail relating to patient matters should continue to be sent to Dr. Mullin's patient office at Urologic Associates of Allentown Inc., 1240 S. Cedar Crest Blvd., Suite 310, Allentown, PA 18103-6218.

Mail for Dr. Rae-Grant should continue to be sent to his patient office at Lehigh Neurology, 1210 S. Cedar Crest Blvd., Suite 1800, Allentown, PA 18103-6208.

In addition, mail for **David M. Caccese, MD**, who stepped down as President, should be sent to his patient office at Peters, Caccese, Scott & DuGan, 401 N. 17th Street, Suite 201, Allentown, PA 18104-5085.

If you have any questions regarding this issue, please contact Medical Staff Services at (610) 402-8980.

For the Calendar!

The General Medical Staff meetings for the Year 2001 will be held in the Auditorium of Lehigh Valley Hospital, Cedar Crest & I-78, beginning at 6 p.m., on the following dates:

- March 12
- June 11
- September 10
- December 10

All members of the Medical Staff are encouraged to attend.

Consolidation of Admitting Functions at LVH-Muhlenberg to Bed Management

Effective January 8, 2001, Lehigh Valley Hospital-Muhlenberg **Direct Admission** services will be provided by the Bed Management Department located at Cedar Crest & I-78. Bed Management will also assign beds for the Emergency Department, inter-hospital transfers, and elective admissions. The current Emergency Department admission request will not change except for assignment of the bed by bed management staff. This assignment will be made based on unit specific clinical criteria, physician preference, and other patient specific needs.

Improved Process for Hospital Admissions Directly from Physicians' Offices

Reservations for admissions directly from physicians' offices will now be processed by the Bed Management direct admission service. One phone call to **(610) 402-4508** will be all it takes to admit a patient from the physician's office directly to LVH-Muhlenberg, Cedar Crest & I-78, or 17th & Chew. A specially-trained direct admission clerk will take clinical, demographic, and insurance information on the patient to be directly admitted. (A copy of the Direct Admission Reservation Form is attached on Page 7 to give you an idea of the information that will be requested.) When possible, the bed assignment will be given to the physician's office at the completion of the reservation call. If a bed assignment cannot be made immediately, the office from which the patient will be admitted will be called with the bed assignment by the Bed Management staff within five minutes.

In the event that the patient requires a critical care bed, the direct admission clerk will transfer the call to the **transfer center coordinator**, a specially-trained triage nurse, who will ensure an appropriate and timely bed assignment to a critical care unit. The transfer center nurse is also available to assist you with external hospital transfers to all LVH sites.

If you have any questions about the new consolidation of admitting services, please call Lisa Romano, RN, MSN, Manager of Bed Management, at (610) 402-5150 or pager (610) 830-8455, or Mark Holtz, Vice President of Operations, at (484) 884-4710.

Please note: Next-day/future reservations for admission should continue to be called to Patient Access Services at (484) 884-4545.

Guidelines for Telemetry Monitoring on Medical/Surgical Units

Beginning on Tuesday, January 16, Guidelines for Telemetry Monitoring on Medical/Surgical units will be expanded to all Medical/Surgical units at Cedar Crest & I-78 that receive telemetry patients. The guidelines categorize telemetry patients into three groups based upon the likelihood of identifying a dysrhythmia that will change therapy/outcome as well as upon the relative risk of developing a life threatening dysrhythmia. Patients with Class I indications for telemetry monitoring have a relatively high risk of developing these dysrhythmias. Class II patients have a moderate risk. Class III patients have a very low risk.

Whenever a Med-Surg telemetry bed is requested, Bed Management will elicit the INDICATION for and the CLASS of telemetry required. It is also necessary for the physician to WRITE an order stating the INDICATION for and the CLASS of telemetry monitoring to begin use of the guidelines. The class of telemetry is required information, since it clearly defines the length of time the patient will be monitored. Telemetry is discontinued automatically by the RN as per the guidelines -- Class I (72 hours); Class II (48 hours); Class III (24 hours).

If the physician deems it necessary, telemetry may continue longer than defined in the guidelines. However, a physician's order and documentation of the indication for continued telemetry monitoring is required in this instance.

The Guidelines for Telemetry Monitoring on Medical/Surgical Units are attached for your information. In addition, pocket cards that define the guidelines are available in the Medical Staff Lounge at Cedar Crest & I-78 or contact Mary Jean Potylycki, Director of 4A/4C, at (610) 402-8777.

If you have any questions regarding the guidelines for telemetry monitoring, please contact Bruce Feldman, DO, at (610) 770-2200.

The Annual Meeting of the Greater Lehigh Valley Independent Practice Association is scheduled for Monday, January 22, 2001, at 6 p.m., in the Auditorium of Lehigh Valley Hospital, Cedar Crest & I-78. Agenda items requiring action will be presented to the membership for vote. To receive credit toward the Incentive Plan, please remember to sign in.

News from CAPOE Central

The CAPOE project (Computer Assisted Physician Order Entry) continues to make progress. We have targeted the TTU as the first unit that will use Physician Order Entry, and we have begun discussing the implementation. Both the Trauma and Neurosurgery services have agreed to participate, and I am excited by their enthusiasm. Representatives from both sections will be involved in all steps leading up to implementation. We expect to go live in the TTU with physician order entry sometime in June 2001.

It is clear from experiences at other hospitals that physician input, early in the process, is critical for success. Consequently, we have created a Design Team, comprised of physicians and representatives from ancillary departments. The Design Team will begin meeting after the New Year to provide feedback and suggestions regarding screen design and specific user interface issues. The members of the Team will also act as resources for the rest of the Medical Staff as CAPOE is rolled out in the hospitals. The physician members of the CAPOE Design Team are:

- Don Belmont, MD
- David Caccese, MD
- Dave Carney, MD
- Michael Ehrig, MD
- Larry Glazerman, MD
- Rich MacKenzie, MD
- Rovinder Sandhu, MD
- Brian Stello, MD
- Jeff Faidley, MD, Internal Medicine Resident
- William Bromberg, MD, Chief Surgical Resident

I am very appreciative of everyone's willingness to participate. The effort will certainly pay off in the improvement in the excellent quality of care we provide for our patients. Please contact me if you would like to know more about CAPOE, see a demonstration of the system, or participate with the project.

Don Levick, MD, MBA
Chair, LVPHO I/S Committee
Phone: 484-884-4593

Congratulations!

Wayne E. Dubov, MD, Division of Physical Medicine-Rehabilitation, has recently been certified in the subspecialty of Spinal Cord Injury Medicine by the American Board of Physical Medicine and Rehabilitation.

Brian L. Fellechner, DO, Division of Physical Medicine-Rehabilitation, has recently been certified in the subspecialty of Pain Management by the American Board of Physical Medicine and Rehabilitation.

Papers, Publications and Presentations

Robert O. Atlas, MD, Division of Obstetrics, Section of Maternal-Fetal Medicine, was invited by the Philadelphia Perinatal Society as a panelist on the "Role Perinatal Telemedicine Plays in the Delaware Valley" held at the Society Hill Sheraton, Philadelphia, Pa., on November 15.

Kelly M. Freed, MD, Division of Diagnostic Radiology, presented a talk, "Evaluation of the Pelvic Floor Musculature in Patients With and Without Pelvic Floor Dysfunction with Magnetic Resonance Imaging," at the Radiologic Society of North America in Chicago, Ill., on November 27. Dr. Freed also co-authored a paper, "Radiologic Manifestations of Sclerosing Cholangitis with Emphasis on MR Cholangio Pancreatography," which appeared in ***Radiographics***, 20(4):959-75.

Houshang G. Hamadani, MD, Department of Psychiatry, presented a paper, "The Sociocultural Effects of Current Patterns of Drug Therapy in Psychiatric Practice," at the 2000 Annual Meeting of the Society for the Study of Psychiatry and Culture, held in Chantilly, France.

Gregory R. Harper, MD, PhD, Chief, Division of Hematology-Medical Oncology, was the technical expert in breast cancer while serving on an international evaluation team which visited Ukraine last May to evaluate two United States Agency for International Development (USAID) projects funded to improve breast cancer control in the Ukraine. The report has been recently published and submitted to USAID for both agency and congressional review. The report, ***Ukraine Breast Cancer Support: Participatory Evaluation of USAID Technical Assistance***, was prepared by Barbara Pillsbury, Edward C. Green, Gregory R. Harper, and Viktor Galayda.

Peter A. Keblish, Jr., MD, Division of Orthopedic Surgery, Section of Ortho Trauma, was an invited speaker for a Spanish Orthopedic meeting held in Marrakech from November 29 to December 3. The meeting -- "el Futuro en Movimiento" -- was directed to current issues in TKA. Dr. Keblish presented talks on "Long Term Experience with the LCS knee system," "Lateral Approach in TKA," and "Un-resurfaced Patella Results: A Two Center Study."

Vincent R. Lucente, MD, Acting Chairperson, Department of Obstetrics and Gynecology, and **Craig J. Sobolewski, MD**, Division of Primary Obstetrics and Gynecology, gave a video presentation -- "Laparoscopically Performed Abdominal Sacral Colpopexy" -- at the American Association of Gynecologic Laparoscopists 29th Annual Meeting held in Orlando, Fla. Dr. Lucente performed the Tension Free Vaginal Tape (TVT) procedure at 17th & Chew, which was broadcast to AAGL conference participants.

Nicholas O. Prusack, DDS, Division of Oral and Maxillofacial Surgery, co-authored an article, "Segmental Odontomaxillary Dysplasia," which was published in the October 2000 issue of ***Oral Surgery, Oral Medicine, Oral Pathology***.

Luther V. Rhodes III, MD, Chief, Division of Infectious Diseases, **James Freeman, DO**, Chief Medical Resident, and **Kenneth R. Knecht, DO**, former medical resident, published a clinical and virological article along with CDC collaborators in the December 2000 issue of ***Emerging Infectious Diseases*** (available in the LVH library). The report describes the first two cases of Hantavirus discovered in Pennsylvania and reports on the discovery of a new species of Hantavirus , Monongahela strain.

Peggy E. Showalter, MD, Department of Psychiatry, was a member of the faculty of the 52nd American Psychiatric Association Institute on Psychiatric Services which was held in October. Dr. Showalter presented "Integrating Psychotropics and Psychotherapy for Adults with Severe Developmental Disabilites."

Dean L. Sorrento, DPM, Section of Foot and Ankle Surgery, recently co-authored a book chapter on Tarsal Tunnel Syndrome in McGlamry's ***Comprehensive Textbook of Foot and Ankle Surgery***, 3rd Edition. He also published original research titled, "Incidence of Lateral Talar Dome Lesions in SER IV Ankle Fractures," which was published in the November/December issue of the ***Journal of Foot and Ankle Surgery***.

United Way Goal Reached

Due to the overwhelming generosity and support from physicians and hospital staff, Lehigh Valley Hospital and Health Network reached its United Way Goal this year with a $245,059 Gift of Caring for OUR Community! A big "Thank You" to all members of the Medical Staff who supported this year's campaign.

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 January will include:

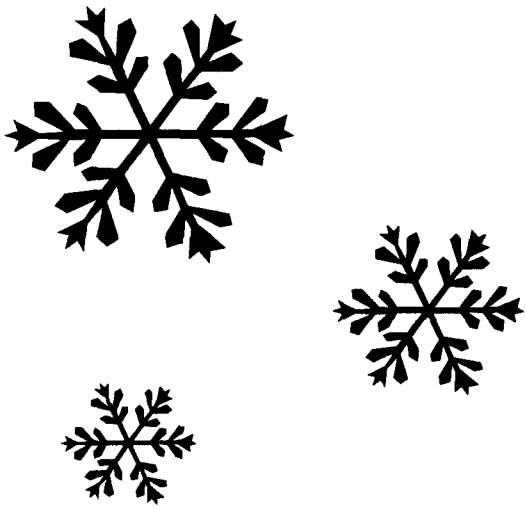
- January 2 - "Office Neurology 101"
- January 9 - "Psoriasis - The Smart Disease"
- January 16 - "Doctors, Drug Companies, Dinners and Dollars: Ethical Implications of a Problematic Relationship"
- January 23 - "The Imaging Evaluation of Pulmonary Embolism"
- January 30 - "Diagnosis and Treatment of Major Pulmonary Emboli"

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

Department of Pediatrics Conference

"Interesting and Puzzling Case Presentations" will be presented on Tuesday, January 23, beginning at 8 a.m., in the hospital's Auditoirum at Cedar Crest & I-78.

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



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

Samuel W. Criswell, MD
(Retiring from office practice)
P.O. Box 3371
Allentown, PA 18106

Garry C. Karounos, MD
2200 Hamilton Street, Suite 103
Allentown, PA 18104-6329
(610) 435-4535
Fax: (610) 435-4599

Jonathan H. Munves, MD
801 Ostrum Street, Suite 102
Bethlehem, PA 18015-1014
(610) 691-6222
Fax: (610) 865-4001

Ralph A. Primelo, MD
1251 S. Cedar Crest Blvd., Suite 202A
Allentown, PA 18103-6214
(610) 402-5766
Fax: (610) 402-5763

Practice Changes

Anthony P. Buonanno, MD
(No longer with Allentown Family Health Specialists)
Joining Lehigh Valley Medical Associates - Effective 1/1/2001
1255 S. Cedar Crest Blvd., Suite 2200
Allentown, PA 18103-6257
(610) 437-9006
Fax: (610) 437-1942

Maria L. Jones, MD
(No longer with Robert M. Taxin, DO)
5731 Ricky Ridge Trail
Orefield, PA 18069-8801

Charles C. Norelli, MD
(No longer with Good Shepherd Physician Group)
Joining Orthopaedic Associates of Allentown - Effective 1/1/2001
1243 S. Cedar Crest Blvd., Suite 2500
Allentown, PA 18103-6268
(610) 433-6045
Fax: (610) 433-3605

LEHIGH VALLEY HOSPITAL – BED MANAGEMENT

DIRECT ADMISSION RESERVATION FORM

Direct admission phone # (610) 402-4508
Bed Management fax # (610) 402-1696

Date: _____ **Time:** _____ **Time Bed Confirmed:** _____

Time Patient Called at Home : _____

Name of Caller : _____ **Call-back #:** _____

Name of Patient: _____

Age/ DOB: _____ **Medical Record #:** _____

DX: _____
Procedure/Date: _____
Inpatient: _____ **Ambulatory:** _____ **Observation:** _____

Type of Bed Requested: M/S M/S telemetry Low-level monitor High-level monitor
(circle type of bed)

_____ **Indication for telemetry**
_____ **Class of telemetry (I,II,III)**
_____ **Ventilator / BiPAP /**
_____ **Swan-Ganz / A-line**
_____ **Dialysis**
_____ **Negative Airflow / Contact Isolation**
_____ **Drips: Nitroglycerine**
Nipride
Dopamine
Dobutrex
Lidocaine
Pronestyl
Other : _____

Referring MD: _____
Admitting MD: _____

Patient Demographic/Insurance information
SS#: _____

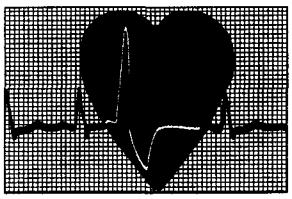
Address: _____

Phone #: _____

Primary Insurance: _____

Secondary Insurance: _____

GUIDELINES FOR TELEMETRY MONITORING ON MEDICAL/SURGICAL UNITS



OVERVIEW

Patients are classified into three groups based upon their relative risk of a life threatening dysrhythmia.

CLASS I - The risk of VF, sustained VT, severe bradycardia (heart rate less than 40 BPM in association with altered consciousness) is significantly increased (>1/100 monitored patients). The likelihood of identifying a significant dysrhythmia that would result in a change in therapy is increased (> 5/100 monitored patients).
MONITORING MUST BE RENEWED EVERY 72 HOURS OR IT WILL BE AUTOMATICALLY DISCONTINUED.

CLASS II - The risk of VF, sustained VT, severe bradycardia, or the likelihood of identifying a dysrhythmia that would result in a change in therapy is low (approximately 5/1,000 monitored patients).
MONITORING WILL BE LIMITED TO 48 HOURS.

CLASS III - The risk of VF, sustained VT, or severe bradycardia, or the likelihood of identifying a significant dysrhythmia that would result in a change in therapy is very low (approximately 5/10,000 monitored patients).
MONITORING WILL BE LIMITED TO 24 HOURS.

CLASS I

MONITORING MUST BE RENEWED EVERY 72 HOURS
OR IT WILL BE AUTOMATICALLY DISCONTINUED

Patients with these clinical criteria should receive rhythm monitoring:

SYNCOPE in patients with: CHF - or respiratory failure; EF Less than 40%; nonsustained ventricular tachycardia; systolic BP less than 90 mmHg; second degree Type II or third degree heart block; bradycardia (heart rate < 45 BPM); tachycardia (heart rate >120 BPM); post VF/VT arrest and resuscitation.

SECOND DEGREE TYPE II OR THIRD DEGREE HEART BLOCK (ASYMPTOMATIC)

ATRIAL FIBRILLATION (NEW ONSET) in patients: receiving rate control treatment; undergoing pharmacologic cardioversion; D.C. electrical cardioversion.

POSTOPERATIVE (NONCARDIAC) SURGERY in Patients with: Angina; ST-T changes; myocardial ischemia on pre-op stress test; systolic BP < 90 mmHg; CHF with respiratory failure (O2 sat <90% on room air or respiratory acidosis); bradycardia (heart rate <45 BPM); tachycardia (heart rate >120 BPM).

POST CARDIAC SURGERY through Day 4.

DEVICE THERAPY: Post permanent pacemaker; Post temporary pacemaker; Post AICD.

POST RADIOFREQUENCY ABLATION

POST VF/VT ARREST RESUSCITATION

INITIATION OF TYPE I/III ANTIARRHYTHMIA AGENTS

DRUG TOXICITY WITH ARRHYTHMIA (e.g. - digitalis toxicity)

RESPIRATORY FAILURE as defined by: hypoxemia - PAO2 < 90% despite FIO2 ≥50%. Hypercapnea - uncompensated respiratory acidosis Ph <7.35 clinical evidence of severe respiratory distress - e.g. respiratory rate >35.

TRAUMA with significant blood loss, hypotension, respiratory failure.

CLASS II

MONITORING WILL BE LIMITED TO 48 HRS

The benefit of monitoring patients with these characteristics was considered controversial.

CHEST PAIN WITH NORMAL EKG

CHF in association with: EF greater than 40%; no respiratory failure; systolic BP >90 mmHg.

SYNCOPE in patients with no structural heart disease (as assessed by exam, ECG and echo.

POSTOPERATIVE (NONCARDIAC) SURGERY in patients with stable cardiac disease (status post CABG, status post PTCA, status post valve replacement with no clinical evidence of heart failure or ischemia).

HYPOTENSION (systolic BP <90mmHg) without associated cardiac disease.

BRADYCARDIA < 45 - (asymptomatic)

TACHYCARDIA > 120 - (asymptomatic)

CARDIAC CONTUSION

RESPIRATORY FAILURE

MAJOR ISCHEMIC OR HEMORRHAGIC STROKES with potential for arrhythmia.

PATIENT WITH STATUS EPILEPTICUS or seizure disorder at risk for sudden death.

CLASS III

The likelihood of identifying a significant dysrhythmia that would result in a change in therapy is very low.

MONITORING WILL BE LIMITED TO 24 HOURS

Patients with these characteristics are at a very low risk for life threatening cardiac dysrhythmias:

TERMINAL ILLNESS: End stage lung disease, heart failure, liver failure, malignancy or CNS disease.

DNR STATUS with specific identification that arrhythmia will not be treated.

ASYMPTOMATIC PVCs

CHRONIC ATRIAL FIBRILLATION with controlled rates.

POSTOPERATIVE (NONCARDIAC) SURGERY in patients with EF greater than 40%; no active ischemia; no signs of congestive heart failure.

POST CORONARY ANGIOGRAPHY in patients with: stable angina; no CHF.

ACUTE MEDICAL ILLNESS with: stable cardiac disease - no ischemia, no CHF.

THE CENTER FOR EDUCATIONAL DEVELOPMENT AND SUPPORT

January 2001

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.

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:

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

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

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

EDUCATION SCHEDULE

January 2001

	1 **Happy Holiday!**	2 **7 am** Surgical GR - CC-Aud **12 Noon** Medical GR CC-Aud	3	4 **12 Noon** Combined TB - JDMCC - CR1 A/B	5 **7 am** GYN TB - CC-CR 1A/B **12 Noon** Breast TB-JDMCC-CR1A/B	6
7	8	9 **7 am** Surgical GR - CC-Aud **8am** Pediatric GR - CC-Aud **12 Noon** Medical GR CC-Aud	10 **12 Noon** Pulmonary TB - JDMCC - CR1 A/B	11 **12 Noon** ENT TB. CR 1A/B	12 **7 am** OBGYN GR - CC-CL Rm 1/2 **12 Noon** Breast TB-JDMCC-CR1	13
14	15 **12 Noon** Colon/Rectal - JDMCC - CR1 A/B	16 **7 am** Surgical GR - CC-Aud **8am** Pediatric GR - CC-Aud **12 Noon** Medical GR CC-Aud	17	18 **12 Noon** Cancer Comm.- JDMCC-CR1 A/B	19 **7 am** OBGYN GR CC-CL RM 1/2 **12 Noon** Breast TB - JDMCC-CR1	20
21	22	23 **7 am** Surgical GR - CC-Aud **8am** Pediatric GR - CC-Aud **12 Noon** Medical GR CC-Aud **12 Noon** Urology TB - JDMCC - CR1 A/B	24	25 **7am** Combined TB -w/ Medical Resident - CC - Aud	26 **7am** OBGYN GR -CC -Cl Rm 1/2 **12 Noon** Breast TB - JDMCC-CR1	27
28	29	30 **7 am** Surgical GR - CC-Aud **8am** Pediatric GR - CC-Aud **12 Noon** Medical GR CC-Aud				

A Targeted, Multidisciplinary Approach to Improving Patient Care

In the fall of 1999, the Institute of Medicine produced a highly publicized report that highlighted potential and actual errors that occurred during medical care. Specifically, the report, *To Err Is Human*, focused on building a safer health system through process and human factors analysis, improving error reporting systems, setting performance standards, and creating "systems of safety" in health care organizations. These systems approaches to patient safety hold the most promise for improving care. While education and non-punitive reporting environments may enhance a culture of safety, systems processes "that make it hard for people to do the wrong thing and easy for people to do the right thing" are the most effective long-term solution.

"EVERY SYSTEM IS PERFECTLY DESIGNED TO ACHIEVE EXACTLY THE RESULTS IT GETS"
...Institute for Healthcare Improvement

In response to the IOM's report, LVHHN has embarked upon a multidisciplinary, systems approach to improving care and reducing medical errors: the Primum Non Nocere projects for 2000-2001. These "First Do No Harm" projects are focused, practical approaches to improving care through:

1) improved communication,
2) process re-design,
3) evidence-based protocol use,
4) reduction of unnecessary procedures, and
5) reduction of preventable adverse events.

Preventable adverse events (PAE) are those injuries that result from a medical error (which by definition, is preventable). PAEs account for two-thirds of medical injuries (1), and cost us $17 Billion annually, approximately 2% of national health expenditures in 1996 (2).

The First Do No Harm projects go further than traditional performance improvement projects in their quest to determine root causes and in their focus on systems re-design to effect solutions. While some of these projects have their roots in departmental performance improvement initiatives or national trend data, these projects place more of an emphasis on preventable adverse events, errors, and near misses. Most of these projects are fast-paced and dynamic, with attempts to bring out rapid, measurable changes in specific clinical areas.

Currently, the PNN Initiative consists of over ten projects. Most of these projects involve one or more clinical departments at LVH-CC, LVH-M, TSU, pharmacy services, risk management, finance, research, management engineering, infection control, and nursing. Several of these projects also provide an opportunity for our residents to complete research projects in an area of their interest, while contributing to improved patient care.

Primum Non Nocere
SOME PROJECT HIGHLIGHTS

1) Reduction of fluid overload in hospitalized patients

This project focuses on reducing the incidence of fluid overload as a complication in patients admitted for AMI, CABG, PTCA, or Valve replacement. Interventions are focused on improved documentation of

admission weights, I/O's, discharge weights, use of preprinted orders for AMI with daily weights and I/O's, use of a fluid overload algorithm, and a heightened awareness of a weight change of >=3lbs per day.

2) Reduction of urinary tract infections

This project focuses on reducing nosocomial UTI's in hospitalized patients with indwelling Foley catheters. The project aims

a) to reduce the number of patients who receive Foley catheters through Foley placement guidelines and a urinary retention protocol that utilizes bladder scanner technology, and
b) to ensure timely Foley discontinuation through preprinted orders.

Residents and attendings will also be given an opportunity to learn how to utilize the bladder scanners, which are located and available for use at all three LVHHN hospital sites.

3) Reduction of medication errors

Medication errors account for 7000 deaths annually, costing over $2 Billion in health care costs (2). As discussed in the last *Progress Notes*, 75% of all medication errors from event reports occur in the ordering and transcribing phase. Computer assisted physician order entry (CAPOE) can help to substantially reduce these errors. The medication errors committee is currently working to provide feedback and recommendations to Information Services on safe medication practices to be integrated into physician order entry.

Additionally, the medication errors project focuses on
a) reducing the number of order sheets in the ER (there will now only be two: the ER physician order sheet, and a standard order sheet),
b) educating on the use and misuse of abbreviations (see the end of this article for some tips), and
c) encouraging the use of preprinted standard order sets.
A subcommittee has also been formed to work on a regional VHA project in association with the Institute of Safe Medication Practices (ISMP), to decrease the number of adverse drug events from patient-controlled analgesia (PCA) and epidural pumps.

4) Reduction of decubitus ulcers

This project focuses on primary and secondary prevention of pressure ulcers using a Braden Scale for assessment of every patient admission. The project works to pro-actively identify patients at risk and to address their risk level with subsequent preventive measures. These patients are not only assessed on admission, but also assessed regularly based on their clinical condition.

5) Reduction of peripheral IV site complications

This project focuses on monitoring and surveillance of IV site complications including phlebitis. The project addresses policies of IV placement, removal, pain at the site, IV meds causing phlebitis, event reporting improvements, and nursing education, to improve our infection and complication reduction goals, and our Press Ganey scores in this arena. For your reference, the list of medications causing phlebitis follows this article.

HOW YOU CAN BE PART OF THE SOLUTION...

While these projects are all coordinated through Care Management, there is always an opportunity to participate in any current project, or to contribute ideas for future projects. Additionally, even if your time is limited to directly participate, your cooperation with preprinted order use, your reporting of preventable adverse events through the Event Report process, your legible orders and printed names or stamps (available through Medical Staff services), and your pro-active identification of patient and employee safety issues, will ensure everyone's success in improving patient care.

Please contact Zubina M. Mawji, MD, MPH with your ideas, suggestions, plans to participate, or questions on specific projects at Care Management: 610-402-5015.

SOME TERMINOLOGY FOR MEDICAL ERRORS

Error: An unintended act, either of omission or commission, or an act that does not achieve its intended outcome.
Adverse event: An injury secondary to medical intervention
Preventable adverse event: An adverse event resulting from an error
Sentinel Event: An unexpected occurrence involving death or serious physical or psychological injury. This may include any event for which a recurrence carries a significant chance of a serious adverse outcome.
Root Cause Analysis: A process for identifying the basic or causal factors that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event.
Near Miss and Close Call: Synonyms used to describe any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome.
Hazardous Condition: Any set of circumstances (exclusive of the disease or condition for which the patient is being treated), which significantly increases the likelihood of a serious adverse outcome.

References:

1. Bates DW, Gawande A. Error in medicine: what have we learned? *Ann Int Med.* 2000; 132(9): 763-67.
2. Kohn LT, Corrigan JM, Donaldson MS, Ed. To Err Is Human. Washington, DC: National Academy Press, 1999.

INTRAVENOUS MEDICATIONS THAT CAUSE PHLEBITIS (from PNN IV complications group)

MEDICATION	TREATMENT
Antibiotics:	
Aztreonam(Azactam)	
Cefazolin (Ancef)	
Ceftriaxone (Rocephin)	
Cefotaxime (Claforan)	
Ciprofloxacin (Cipro)	
Doxycycline (Vibramycin)	
Erythromycin (Erythromycin)	
Nafcillin (Nafcil, Unipen	hyaluronidase (Wydase)**
Piperacillin (Piperacil)	
Vancomycin (Vancocin)	
Antivirals:	
Acyclovir (Zovirax)	
Foscarnet (Foscavir)	
Ganciclovir (Cytovene)	
Chemotherapy:	
Bleomycin (Blenoxane)	
Carboplatin (Paraplatin)	
Carmustine (BiCNU)	
Cisplatin (Platinol)	sodium thiosulfate
Dacarbazine (DTIC)	
Dactinomycin (Cosmegen)	ice + elevate x 48 hours
Daunorubicin (Cerubidine)	
Doxorubicin (Adriamycin)	ice x 24-48 hours
Doxorubicin liposomal (Doxil)	ice
Etoposide (VePesid)	hyaluronidase (Wydase) + heat
Floxuridine (FUDR)	
Fluorouracil (Adrucil)	
Idarubicin (Idamycin)	ice
Ifosfamide (Ifex)	
Mechlorethamine (Mustargen)	sodium thiosulfate
Mitomycin (Mutamycin)	
Mitoxantrone (Novantrone)	
Paclitaxel (Taxol)	hyaluronidase (Wydase) + ice
Streptozocin (Zanosar)	
Teniposide (Vumon)	hyaluronidase (Wydase) + heat
Vinblastine (Velban)	hyaluronidase (Wydase) + heat
Vincristine (Oncovin)	hyaluronidase (Wydase) + heat
Vinorelbine (Navelbine)	hyaluronidase (Wydase) + heat
Other Agents:	
Amiodarone (Cordarone)	
Ammonium Chloride	
Amphotericin (Fungizone)	
Calcium salts	hyaluronidase (Wydase)
Colchicine	
Diazepam (Valium)	
Dobutamine (Dobutrex)	phentolamine (Regitine)
Dopamine (Intropin)	phentolamine (Regitine)
Epinephrine	phentolamine (Regitine)
Lidocaine (Xylocaine)	
Meperidine (Demerol)	
Midazolam (Versed)	
Norepinephrine (Levophed)	phentolamine (Regitine)
Pamidronate (Aredia)	
Phenobarbital	
Parenteral Nutrition	hyaluronidase (Wydase)

Phenytoin (Dilantin)	
Potassium Salts	hyaluronidase (Wydase)
Propofol (Diprivan)	
Sodium bicarbonate	hyaluronidase (Wydase)

Administration of Hyaluronidase into an Extravasation:
1. Pharmacy will dispense a vial containing hyaluronidase-saline solution (15units/ml).
2. Using five tuberculin syringes, withdraw 0.2ml of hyaluronidase-saline solution into each syringe.
3. Cleanse infiltration site and surrounding area with povidone-iodine.
4. Administer hyaluronidase locally by subcutaneous injection using a 25G needle. Dose is 15 units given in five 0.2ml injections into the extravasation site at the outermost edge.

Administration of Phentolamine into an Extravasation:
1. Pharmacy will dispense a vial containing phentolamine-saline solution (10mg/ml).
2. Using five 3cc syringes, draw up 2ml of phentolamine-saline solution into each syringe. Replace the needle with a new 25G needle.
3. Cleanse the site with povidone-iodine.
4. Administer phentolamine locally by subcutaneous injections into the extravasation site at the outermost edge.

References:

1. Applied Therapeutics- The Clinical Use of Drugs. Young LY, Koda-Kimble MA. Applied Therapeutics Inc, Vancouver. Sixth Edition 1995.
2. Meyler's Side Effects of Drugs. Dukes MNG. Elsevier, Amsterdam. Thirteenth Edition 1996.
3. Micromedex-Drug Consults, Micromedex Inc. 2000
4. Solimando DA, Bressler LR, Kintzel PE, Geraci MC. Drug Information Handbook for Oncology. Lexi-Comp's. Cleveland, First Edition 1999
5. Cancer Chemotherapy Guidelines and Recommendations for Practice, Second Edition. Oncology Nursing Press,Inc.Pittsburgh 1999

Abbreviations to avoid for improved patient care (from the PNN Medication errors group)

Instead of...	Use
Qd	daily
Qod	Every other day
Qid	4 times daily
U	units
Amp	Use the correct dose
.1 mg	0.1 mg (use leading zeros)
1.0 mg	1 mg (Don't use trailing zeros!)
Depo	Depo-Provera or DepoMedrol (Drug names should never be abbreviated)

C/mydocuments/prognotes

LEHIGH VALLEY
HOSPITAL AND
HEALTH NETWORK

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

Non-Profit Org.
U.S. Postage
PAID
Allentown, PA
Permit No. 1922

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.