

PERIOPERATIVE BETA-BLOCKERS

By Mark A. Greenberg MD

Strong evidence exists for the use of perioperative beta-blockers to reduce cardiac events and mortality, especially in high-risk patients. Excellent summaries of the literature are as follows:

1. AHRQ, Safety Processes, Chapter 25. Beta-Blockers and Reduction of Perioperative Cardiac Events.
2. NEJM, Vol. 345(23). December 6, 2001. 1677-1682.
3. JAMA, Vol. 287(11). March 20, 2002. 1435-1444.
4. ANN Intern. Med, Vol. 138(6). March 18, 2003, 506-511.

On the basis of the available evidence, the National Quality Forum elevated the use of perioperative beta-blockers to the level of a core safety process. It is almost certain that JCAHO will also adopt this practice as a core safety performance measure in the future. Given the minimal current use of perioperative beta-blockers by LMHS Medical Staff members, a multi-disciplinary group (member names available upon request) was convened to review the data and make recommendations regarding their use and implementation System wide.

The recommendation follows: Pending additional studies, the routine use of perioperative beta-blockers should be limited to patients at moderate and high risk of post-

operative cardiac events who are undergoing high-risk surgical procedures and require at least a two day hospital stay.

High Risk Surgical Procedures:

- Vascular Surgery
- Intra-abdominal Surgery
- Thoracic Surgery

High Risk for Post Operative Cardiac Events:

- Ischemic Heart Disease: History of MI, history of angina and/or use of nitrates; history of positive exercise testing; Q waves on EKG; history of CABG and/or angioplasty with chest pain c/w angina.
- CHF
- Diabetes (IDDM)
- Chronic Renal Insufficiency: Serum creatinine \leq 2.0 mg%, especially if secondary to HTN or diabetes.
- TIA's or history of CVA
- Peripheral Vascular Disease

Moderate Risk for Post-Operative Cardiac Events:

- Two or more:
 - HTN
 - Smoker
 - Diabetes (NIDDM)
 - Cholesterol \leq 240 mg%
- Age > 65 years

continued on page 2

I N • T H I S • I S S U E

- Perioperative Beta-Blockers • Due to... • Continuum of Care for Patients with Hip Fracture
 - Medical Library News • JCAHO National Patient Safety Goals and Abbreviations
 - Recognitions • Web Page for OB Redesign Wave
- Lifeline Helps you Stay Informed of Patient Admissions • Doctors Protect Your Assets
- Clostridium difficile Toxin A & B • Medical Staff Hotline • Continuing Medical Education

continued from page 1

The Cardiology section, Surgery Council, Medicine Council and Anesthesia section have approved the recommendations. As a result, a collaborative effort including LMHS administration, senior nursing, anesthesia and related surgeons was undertaken to produce a comprehensive net of guidelines that have been assembled into a booklet which includes the following:

- Steps for determining at risk patients.
- Patient educational pamphlet on Perioperative Beta-Blockers
- Anesthesia, PACU, and post-operative order sets for the use of Perioperative Beta Blockers.
- Discharge instructions for post-operative beta-blocker patients.

These booklets will be distributed to all of the members of the Departments of Surgery and Medicine. In addition, a member of the Perioperative Beta-Blocker team will conduct education sessions for surgical office staff.

Everyone involved in this initiative has been cognizant of the process issues involved in assessing these patients and providing them with at least a two-week course of beta-

blockers prior to surgery. We are also acutely aware of the difficulties of obtaining pre-operative consultations with cardiologists and primary care physicians during the “peak season”. However, pre-operative risk assessment for the potential of intra-and post-operative acute coronary syndromes is now a standard of care. Those who choose to neglect this facet of care place themselves and LMHS at significant liability risk should an adverse event occur. Throughout the initiative attempts have been made to simplify the process and your constructive suggestions for additional improvement would be welcome.

Finally, the issue of how to handle at risk patients that present for surgery without beta blockade will be handled on a case-by-case basis. Anesthesia will consult with the admitting surgeon and a decision will be made by the physicians involved as to whether or not surgery can proceed without undue risk to the patient.

The anticipated start of the initiative is the second week of January 2004. We look forward to your collaboration in implementing this important safety process.

DUE TO...

“Due to...” Using this simple phrase in medical record entries can directly aid your patient care, data, profile, risk containment and professional reimbursement.

Medical decision-making is the most important and valuable part of the evaluation and management process and is a major part of physician profiling. The more complex the patient, the more work is required for medical decision making. Using the phrase “due to...” is a valuable adjunct in portraying the complexity in your history and physical, progress notes, consults and discharge summaries.

Since many symptoms have a list of possible causes, it is important to write down the

determined cause of the patient’s symptom. It is imperative to link the symptom and the cause. Coders are not permitted to conclude that a symptom is due to a condition you’ve named without your causative statement – that link in the record.

Syncope, for example, is a common symptom that occurs for many reasons.

- syncope due to anemia of renal failure
- syncope due to diabetic autonomic nerve dysfunction
- syncope due to adverse effect of beta-blockers
- syncope due to volume depletion due to dehydration due to GI fluid losses due to gastroenteritis

continued on page 3

continued from page 2

Every time you document the “due to ...,” you are naming the disease in addition to the symptom. It then becomes obvious that it is a disease you are addressing in controlling that symptom. So, rather than dealing with someone who fainted due to nothing, your evaluation and documentation of a link to a

particular condition provides increased specificity and accuracy in indicating what is wrong with your patient.

*Info from Medical Records Briefing,
November 03*

CONTINUUM OF CARE FOR PATIENTS WITH HIP FRACTURE

Hip Fractures are one of the most common, costly, and devastating injuries suffered by Americans. With over 350,000 incidents per year hip fractures account for approximately 30 percent of all fracture related hospitalizations. Nine out of 10 patients with hip fractures are 65 years of age or older. The number of hip fractures is expected to rise dramatically as the population ages.

A National Consensus Conference on Improving the Continuum of Care for Patients with Hip Fracture took place in 2001. Representatives from 11 organizations participated, including the American Academy of Orthopaedic Surgeons, American Academy of Family Physicians, American Academy of Physical Medicine and Rehabilitation, and the American Hospital Association.

The Rehabilitation Hospital has implemented many of the conference recommendations. These include an orthopaedic standard of care based on the attainment of specific functional milestones, standardized communication along the

continuum, systems for rapid access to patient records, nutritional evaluation with osteoporosis education, and falls assessment. The goal is to return patients to their preferred living setting.

The Rehabilitation Hospital has involved other entities along the continuum. The hospital notifies the primary care physician of the hip fracture patient's admission and discharge. Hip protector information is provided through the “Ortho Group” at the hospital. Home Health nurses and Parish Nurses are provided with information packets to review with patients after discharge. Education programs are available for healthcare professionals and the general public.

Additional recommendations include providing appropriate assistive devices after the first fall, encourage immediate post surgery “weight bearing as tolerated” ambulation,

Develop calcium and Vitamin D interventions, consider antiresorptive medication, and encourage the use of hip protectors.

MEDICAL LIBRARY NEWS

MedWeaver, a differential diagnosis program offered by OVID, is available as a free trial to physicians on staff at LMHS until December 15, 2003.

Physicians who already have passwords to OVID will find MedWeaver listed on the OVID menu when they access OVID from their home or office computer. Others are welcome to try it at any of the three LMHS Medical Libraries.

LMHS RESPONDS TO THE JCAHO NATIONAL PATIENT SAFETY GOALS ON USE OF ABBREVIATIONS PROHIBITED IN CLINICAL DOCUMENTATION IN THE MEDICAL RECORD

JCAHO announced in November 2003 that they were expanding the “Do Not Use” list of abbreviations considered to be “dangerous”. The table below lists the abbreviations that are considered inappropriate and are prohibited when documenting clinical orders in the medical record.

LMHS will update the current Unsafe Abbreviation guideline filed in the Physician Order Tab of our medical record. Standing and pre-printed order forms will reflect these changes also.

Unsafe:	Why:	Instead, Use:
Apothecary measures- dram, minim, grains	Dram misread as “3” Minim misread as “ml” Grains misread as “grams”	The “metric system”
μ g	Mistaken for “mg”	“mcg”
q.n.	Misread as “qh” (every hour)	“nightly”
U or u	Mistaken for a zero or “cc”	“Units”
IU	Mistaken for IV (intravenous)	“Units”
X 3 d	Misread as directions to give three times daily or as three doses	Write out “days” or dates the medication should be given, e.g, x 3 days
ss	Mistaken for “55”	Spell out “sliding scale”, “one-half” or “1/2”
q.d. qid qod	The period after the q can be mistaken for the letter “i”. The drug could be given four times daily. The “o” in qod can be mistaken for an “i”.	“daily” or “Q AM” or “Q PM” “four times daily” or “4x daily” “every other day”
MS MSO ₄ MgSO ₄	Confused for one another. Can mean morphine sulfate or magnesium sulfate.	Write “morphine sulfate” or “magnesium sulfate”
T.I.W (for three times a week)	Mistaken for three times a day or twice weekly resulting in an overdose.	Write “3 times weekly” or “three times weekly”

- **Decimal Point Requirements** • No terminal zeroes – **1mg not 1.0 mg** Always use a zero before a decimal point – **0.1 mg not .1mg**
- **Using the FULL drug name is SAFEST** No shortened drug names – e.g. “Nitro”, “Neo”, “Pitt”, “Levo”, “DPH” Avoid acronyms and abbreviations – e.g. Tyl # 3, T#3, PCN
- **INDICATIONS FOR DRUG USE are recommended**
- **Prescriber identified by legible signature, or printed last name, or physician ID/ dictation number.**

If an order is illegible, unclear or ambiguous to the caregiver, you may be contacted for clarification prior to the order being carried out. The safety of our patients is our primary goal and your cooperation in eliminating potential problems through clear, concise, legible orders will assist in meeting the Patient Safety Goals and Initiatives.

RECOGNITIONS

Congratulations to Dr. Al Martinez

Dr. Martinez, a neuropsychologist with Lee Memory Care, has earned the Diplomate status from the American Academy of Clinical Neuropsychology. He is the only neuropsychologist in southwest Florida with this distinction. Dr. Martinez specializes in the diagnosis and treatment of Alzheimer's and other dementias. He also sees patients with Parkinson's, stroke, head injuries and other neurological problems.

The Rehabilitation Hospital of LMHS has been notified that it is awarded a three year accreditation with eight commendations for exemplary conformance to the standards from the Commission on Accreditation of Rehabilitation Facilities (C.A.R.F.). "On balance, the leadership and personnel of The Rehabilitation Hospital show a high level of commitment to maintaining and improving the organization's operations in relation to the CARF standards. The organization's programs benefit the persons served. Both the persons served and other stakeholders express positive attitudes toward the organization."

WEB PAGE FOR OB REDESIGN WAVE

A web page has been established to give you regular updates on the OB Redesign WAVE. To access this information:

- Go to www.leememorial.org
- Click "Health Services"
- Click "Obstetrics" under "Your Health"
- Click "Family Birth Suites" under "Women's Services"
- Click "OB Redesign" in pink navigation bar
- This will link you to an Adobe PDF file. File is password protected. Enter password "obpeds". (Use lower case.)

If you have questions, ideas or feedback, please contact: Sara Dyer, ARNP, OB Redesign Coordinator at 432-3175 or by email at sara.dyer@leememorial.org or Kim Vincent, Director, OB Services-HPMC at 432:3158 or by email at kim.vincent@leememorial.org.

LIFELINE HELPS YOU STAY INFORMED OF PATIENT ADMISSIONS

Lifeline now offers the Lifeline CareAlertsm service which provides physicians, case managers and home health agencies immediate notification via fax of incidents involving their patients. Incidents are created when the patient presses their "alert" button, and the Lifeline agent calls a responder to help them.

The clinician will receive a report with the following information: date/time, summary of

patient situation, what kind of assistance was provided and if the patient was or was not transported to a hospital.

This service can reassure healthcare providers they are kept fully informed of their patients' progress or regress with their plan of care. For more information, or to refer a patient please contact Lifeline at (Fort Myers) 334-5348 or (Cape Coral) 574-0207.

DOCTORS PROTECT YOUR ASSETS!

On December 9th and 12th, the Lee Memorial Health System Foundation is sponsoring seminars to be held at all three hospitals on how physicians can protect their assets from creditor claims. Creditors include tort, malpractice, contract and marital claims.

The seminars are being presented by Joseph Zaks, co-creator of the original intangible tax avoidance trust, who is also a member of the Taxation, Real Property and Probate Sections of the American, Florida and Massachusetts Bar Associations.

The seminars, which will last 1 hour, will be held at the LMH Medical Staff Conference Room on Dec. 9th at 3:00pm, Cape Coral Hospital Life Center on Friday, Dec. 12th at 11:00am and HealthPark Medical Center Meeting Room 1A on Friday, Dec. 12th at 3:00pm.

The seminars are complimentary, however seating is limited, so please RSVP to the Foundation office at 437-1840 by Monday, December 8th. Refreshments will be served.

CLOSTRIDIUM DIFFICILE TOXIN A & B

Toxigenic difficile is a major cause of antibiotic associated diarrhea and colitis and is the causative agent for virtually all cases of pseudomembranous colitis. **Two toxins, toxin A and toxin B, are associated with disease cause by C. difficile.** Effective 12/01/03 C. difficile testing performed by LMHS will include testing for both toxin A and B.

The preferred specimen for laboratory diagnosis is passed liquid or semisolid, unformed fecal specimens. Swabs specimens, because of small volume obtained, are inadequate.

The Society for Healthcare Epidemiology of America (SHEA) says, "test-of cure toxin assays following treatment are not recommended, as they are imperfect predictors of subsequent relapse. SHEA also believes that patients should not be considered therapeutic failures until they have received at least 6 days of treatment. The laboratory will reject repeat test request within 7 days of a previous positive result.

If you have any questions please call the Microbiology Laboratory at 574-0343.

MEDICAL STAFF HOTLINE

*For Medical Staff Issues or Concerns, **Call the Medical staff Hotline at 334-5700.***

CONTINUING MEDICAL EDUCATION – CME

“DVT: PREVENTION & TREATMENT FOR THE MEDICALLY ILL PATIENT”

Franklin Michota, Jr., MD,
The Cleveland Clinic, Ohio
Gulf Harbour Golf & Country Club – The Club House

Tuesday, December 2, 2003

6:30 – 7:00 PM Registration & Dinner

7:00 – 8:00 PM CME lecture

Target audience – Lee Memorial Health System Physicians, Pharmacists
and Nurse Leaders.

RSVP – 574-0397.

STILL NEED TO COMPLETE MANDATORY CME FOR THIS RELICENSURE PERIOD?

The medical library at all three LMHS hospitals offers videos to meet this need. Call 574-0397 with questions regarding CME requirements

The CME Committee values your input. Please email suggestions for CME offerings for 2004 to Joanne.gorgone@leememorial.org

RECEIVE YOUR COPY OF THE MEDICAL STAFF NEWSLETTER VIA EMAIL

Send email address to joanne.gorgone@leememorial.org to receive future copies of the Medical Staff Newsletter via Email.

If you have questions or would like to submit an article to *Medical Staff News*, please contact

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