FROM: ID FACULTY

TO: STUDENTS, RESIDENTS & FELLOWS ON INFECTIOUS DISEASES ROTATION

DATE: FEBRUARY 2012

Adult Infectious Diseases Consultation Service
At Memorial Hermann Hospital
and Lyndon B. Johnson General Hospital

CONTENTS:
1. Clinical Service
2. Teaching Program
3. Medical & Legal Issues
4. Antibiotic Approval Program

1. Clinical Service – MHH and LBJ

1.1. Hours
Please arrive at the hospital by 8 a.m. to start seeing patients. Unless there is an urgent consult in the morning, the “old” patients should be finished by 10:30 a.m. and you should be ready to round with the micro lab at 11:00 a.m.

All the members of the Infectious Diseases team, including residents, students, the fellow on call, and the attending round at MHH on Saturday mornings. The fellow on call will cover the two hospitals for the remainder of the weekend. Residents are responsible for Saturday consults until noon.

On the initial consult note, as well as on all progress notes, please indicate in the top right corner of your note what antibiotics the patient is on, and what day of therapy it is and expected duration, if known. Example: Clindamycin Day 5, Cipro Day 3, AmBisome Day 12.

You are expected to personally review all pertinent x-rays, microbiology and pathology on all of your patients.

You are expected to see consultations the same day as they are called in. However, when many consults have been requested on a given day, consults called in after 4 p.m. may be seen the following morning, if the patient is stable and the consulting service concurs.

1.2. General Operating Procedures
- Master on-call beeper for MHH service. Proper routing of calls through the page operator is sometimes difficult. Changes in schedule and other confusion can make it hard to find the right person. In an effort to resolve this, we have a master beeper for consults. This beeper number for MHH service is 713-605-8989, Ext. 24639. The page operator will use this as the number to call for anyone who calls and asks: “Who is on call?” or “How do I get a consult?” Of course, the caller might seek one of us by name, but to resolve the general issue of who’s up, this beeper is the answer. This beeper will be carried continuously by the fellow. If the handoff of the beeper fails to occur when a fellow is not on for a weekend, the fellow who actually has the beeper is still...
responsible for answering it, taking down the information and relaying messages to the actual on-call fellow.

- **Master Beeper for LBJ service.** The LBJ antibiotic approval beeper (281-952-3509) should be used for all infectious diseases consults at LBJ, regardless of who is on call.

- **The approach to handling the initial call for a consult.** If you receive a call for a consult, please take a complete message. This is true whether or not you are actually on call and whether or not you are carrying the “on-call” beeper. Please don’t make the caller go around in circles trying to find the real consultant. Just take the call, take the message including caller’s name and beeper number and discuss the case as if you were going to do the consult. Then, if you are not going to be the one doing the consult, be sure that the caller knows this and then pass the message to the person actually doing the consultation.

- **Notes in EMR.** The EMR is a great way to store the results of our consultations. Please be sure that an attending reviews your note before it is finalized. A note should be in the EMR within 24h of requested consultation.

- **Sending a copy of your consultation to the primary physician.** At the close of a consultation, it is often appropriate to write or dictate a summary letter to the primary physician. The need for this varies with the nature of the interaction, so there are few hard rules here. This note can be done in EMR, and should generally be done by the attending. This note should be in the form of a letter. A good start is: “Dear Dr. Jones: Thank you for the recent opportunity to participate in the care of Ms. Rhonda Smith during her stay at Memorial Hermann Hospital. For your records and mine, let me briefly summarize the features of her hospital course that are relevant to the consultation we provided.” You would then summarize the case, and conclude with the final plans relevant to the patient’s future care. If not written directly by the attending, the attending should see and review this letter before it is finalized. If ID will follow the patient in clinic, dictate a brief ID summary including diagnosis, relevant organisms and their susceptibilities, and the overall plan for antibiotics and their duration.

### 1.3. Structure of the Team Obligations and Responsibilities

New consults should be seen on a priority basis either jointly or students first followed by the resident. The resident should communicate with the fellow as soon as a new consult is received and then after seeing the patient in order for the fellow to examine, assess, and discuss the case prior to rounds. A full history (including review of old records) and physical examination should be documented on the chart by either the student (reviewed and amended by the resident) or by the resident. For billing purposes, initial work-ups must contain Review of Systems (ROS) with at least 10 separate categories. This document should reflect the pertinent findings and a preliminary assessment of the patient’s problems. Recommendations should be discussed with the fellow or staff first. This note should be countersigned by the fellow or attending.

The fellow or resident should assign patients to the students at his/her discretion based on the teaching value of each case. An average student/patient load should be 1:4-5. The resident should assume a supervisory role for the smooth operation of the service. This includes the gathering of pending data and execution of staff suggestions. Questions, problems, or comments should be referred to the fellow or attending. The students should serve as the principal reporter of information as it pertains to the patient and the patient’s problems. The resident will assume more of these responsibilities if the student displays a lack of interest or motivation.
Both students and residents are expected to personally examine their patients on a daily basis and to follow-up the pertinent studies (e.g. radiological and microbiological data). The infectious disease service should be the first to know infectious disease information about our patients. It is not acceptable to have the ward team or their attending inform us about positive cultures or susceptibility patterns of isolated bacterial pathogens. Discussion of patient progress and optimal management strategies prior to daily rounds should take place. With demonstrated interest and commitment to quality medical care, the house staff (and rarely students) will be given more independence in the consultation management of the patients. The fellow should know all patients, but need not write a note except at LBJ or if the attending so indicates. Ordinarily the fellow should know before rounds what the attending knows after rounds.

1.4. Contacting the Consulting attending after the patient is seen
Usually we will write the antibiotic orders for patients on the orthopedic service. If there are questions about this, the attending in orthopedics will need to be contacted for clarification. When we do write orders, the house staff involved should be informed verbally of our order. Be sure and sign any verbal orders; otherwise the consulting attending has to go by record and sign later. We do not write discharge orders. If a consulting team wishes ID to manage home antibiotics, clear this with your attending.

1.5. Switching Coverage for Residents and Fellows
It is understandable that a switch in coverage is needed on occasion. Residents should get the approval of the ID Attending. Fellows must get approval from the Chief ID fellow and Dr. Ericsson, the Program Director. The Hermann Hospital page operator should be notified.

2. Teaching Program
The resident should take an active role in student teaching. Both residents and students are expected to consult the pertinent literature and should strive to read at least one article per patient. They should feel free to ask the fellow or attending their advice as to what direction to take in their literature search. In the case of interesting or complex patients it is advised to have a particularly instructive and useful article placed on the chart for general educational value.

Conferences
- **Monday Adult ID Clinical Conference**
  This conference is held each Monday at 1:00 p.m. in Room MSB B.625 and is an excellent teaching experience for students and house staff. It will depend on careful selection of cases and outside preparation of material and educational information. The conference will be geared to the student and resident level. In general, the fellow presents and discusses the case. While the format is subject to change, it is ideal to focus discussion on a controversial issue relating to the case presentation.
- **Wednesday Citywide Conference**
  This meeting is held each Wednesday at 12:00 noon at the Baylor College DeBakey Bldg, 1st floor conference room. Infectious Diseases physicians from across the medical center and the city participate in this Journal Club and all members of the ID team are encouraged to attend.
- **Wednesday Resident/Student Lecture/Case Vignettes Discussion**
  This meeting is held every Wednesday at 1:00 p.m. in MSE R.233. The Hermann Hospital attending physician will give lectures and lead case discussion.
- **Thursday Core Curriculum Lecture**
  Covering topics to meet core curriculum requirements of the ACGME, this weekly meeting is held on Thursdays at 1:00 pm. Locations vary. ID faculty and guest speakers provide information on a broad range of subjects.
Friday ID Journal Club
The UT Houston Medical School Infectious Diseases Journal Club is held Fridays at noon in MSE R.233. Fellows select articles from one or more ID related journals to present and discuss. Occasionally, faculty present their research at this time.

3. Medical-Legal Issues about Our Notes

Risk management issues are, sadly, a very important part of our working environment. Our surgical colleagues are especially sensitive to this issue. The content of the medical record is critical, and we must be attentive to its proper use. The primary purpose of the medical record is to allow health care professionals to record important data and communicate with each other about the patient’s condition, so they may work as a team to provide quality care. With increasing litigation and ever-changing rules regulating reimbursement to third party payors, the medical record has assumed an expanded role. The following text has been extracted from the UT System’s Risk Management Course available at: http://www.utsystem.edu/hcqrm/rmtextquizinfo.htm. The principal focus of the selected text is to explain what constitutes good documentation practice.

3.1. Progress notes
Progress notes and nurses’ notes serve as the day-to-day account of the patient’s condition and treatment. They tell the story of the patient’s hospitalization. All progress notes should be characterized as follows:

Timed and Dated – The actual time and date of the note should always be included on both the note and any orders. Times such as “morning” or “AM rounds” are not acceptable. Having a record of when you were (or were not!) at the bedside can at times be critical.

Specific – Avoid general phrases like “doing well” or “condition unchanged.” Instead, document the specific impression and the basis for that impression, such as “neurological status improving – neuro signs normal.” The note should describe the specific condition and relevant clinical observations.

Objective – Avoid judgmental labels like “uncooperative” or “non-compliant.” Instead, describe the behavior (e.g. “patient refuses to remain on bed rest”).

Avoid terms that imply that someone was at fault (e.g. “mishap,” “inadvertent,” “unfortunate” or “iatrogenic”). Avoid phrases and statements that imply a newborn’s injury was related to the labor and delivery process (e.g. “difficult delivery,” “difficult forceps application,” “compromised infant,” “marked delay in delivery,” “required greater force than usual,” or “birth asphyxia,” etc.) Focus on documenting objective finding.

Include number of days on antibiotic therapy.

Complete and displaying a thought process – All progress notes should include the diagnosis or problem being addressed, results of physical examination, impressions and plans for further treatment. Avoid notes such as “Okay today,” or “No change.” If controversial or unusual treatments are prescribed, the rationale should be well documented. The progress notes should justify all treatment orders.
The medical record should include documentation of the following:

1. Patient’s account of symptoms on admission, using quotes whenever possible to describe pain and other symptoms;
2. Patient’s baseline weight (daily weight of all pediatric patients);
3. Patient’s baseline temperature, blood pressure, pulse and respiration rate;
4. Temperatures of febrile patients after being given antipyretics;
5. Content of all communications with the patient and/or patient’s family members (including telephone conversations, e-mails, and written correspondence), especially all informed consent discussions and discussions involving patient teaching;
6. Discharge instructions as well as the patient’s level of understanding;
7. Patient’s condition upon discharge;
8. Name of party accompanying patient as discharge; and

Telling a story – By reading the progress notes, a subsequently treating health care professional should be able to discern the sequence of events in the patient’s care and the progress made by the patient. To help maintain continuity, read the last one or two progress notes before making a new entry. This practice will help keep the story cohesive and avoid gaps in the sequence of events.

3.2. Complications
Complications are significant events during a patient’s hospitalization and, therefore, they must be documented. Absence of such documentation can lead to allegations of “cover up.” It is important to document the complication completely and objectively without judgments about whether anyone is to blame. Avoid words that imply fault, such as “inadvertently,” “mishap,” “iatrogenic,” “unfortunately,” or “accidentally.” When a complication occurs, it should be treated like any other physical problem and documented as such in the medical record until it is resolved.

3.3. Disagreements
Disagreements can and do occur among members of the health care team. For example, a consultant’s recommendations may be at odds with the plans of the primary physician. Most disagreements can be resolved with discussion and do not need to be documented. Occasionally, however, the disagreement affects the patient’s care and must be documented. This situation creates a problem only when the documentation in the medical record reflects animosity and hostility among team members rather than a common concern for the patient.

Disagreements must be documented discretely using the following guidelines:

- Objectively state the substance of the disagreement.
- Example: “Dr. Doe’s recommendation for Gentamicin noted; however, because of the patient’s past history of sensitivity to the drug, will not order it at this time. Will follow patient with blood cultures.”
- Do not write any negative statements about the abilities or competence of the other party.
- Include the alternative plan to be followed and the reasons for it, as in the above example.

3.4. The main thing is to focus on the facts and nothing but the facts.
You can show the logic for what you are going to do for the patient, but don’t speculate on causality. Be sure to follow-up on any conditional diagnoses. If you write down a long list of “rule out x,” “rule out y,” etc., be sure to later write down “x ruled out,” “y ruled out.” Here are some specific things not to do….

- A patient is admitted with fever and a murmur. Antibiotics are started, but blood cultures are not sent. We are called on day 5 for discharge planning. This is clearly dumb, but don’t write “due to the lack of blood cultures, I have no idea what to do.” Rather, just discretely order some blood
cultures and then write, “blood cultures data not available. Will treat with vancomycin for now, as that will cover the most common pathogens.” Analysis: Don’t use the chart as a way to critique care rendered. This form of instruction is best done verbally. You can and should, however, show the logic relevant to the treatment plan.

- A diabetic patient undergoes CABG and then develops sternal osteomyelitis. When you see the patient, you note that this 500 pound patient has had continuously poor glucose control during the peri-operative period and received only 500 mg vancomycin as operative prophylaxis. Do not write: “Diagnosis: sternal osteomyelitis following CABG, with contributory factors of poor glycemic control and inadequate prophylaxis. Needs antibiotics and better blood sugar control.” Instead write, “Diagnosis: Sternal osteomyelitis. Plan: 1. Antibiotics 2. Blood sugar control.” Analysis: Even simple comments can contain an implied criticism. Stick to the facts and the plan. Unless it is relevant to your treatment plan, do not speculate on causality.

- Blood is ordered for a patient. It arrives on the unit, and is hung. The patient become febrile and hypotensive during the transfusion. This resolves when the transfusion stops. The charge nurse calls and tells you this, concluding with “the agency nurse hung the wrong unit. She’s been a problem before.” Do not write: “the patient had a hypotensive transfusion reaction that was terminated when we realized that the wrong bag of blood was hanging.” Write instead, “The patient developed fever and hypotension during the transfusion. This abated when the transfusion was stopped. All supplies were returned to the blood bank for testing.” Analysis: Don’t speculate on causation, particularly when you think something may have gone wrong. You might be wrong, the charge nurse might be wrong. When you really think an incident has occurred, get risk management involved before you start complaining or critiquing in the chart.

4. Antibiotic Approval Program

At LBJ Hospital, we make use of an antibiotic approval program. Contrary to popular belief, the purpose of this program is not to ensure use of the cheapest antibiotic! Rather, the goals are:

- Ensure use of appropriate antibiotics given our current pattern(s) of antimicrobial resistance.
- Ensure proper choice of therapeutic routes. For example, the fluoroquinolones have the same PK by mouth and by vein. Oral therapy is much less costly, and should be used in patients with a functioning gut.
- There are times when virtually identical drugs are available at widely discrepant prices. If the drugs are equivalent, there is little reason not to use the lower-priced version.

If a restricted antibiotic is ordered at LBJ, the antibiotic approval beeper carried by the ID fellow should be paged: 281-952-3509. If the ID service wishes to use a restricted antimicrobial, the ID attending will need to call in the approval. The consult beeper (281-952-3509) should also be used for all LBJ infectious diseases consults, regardless of who is on call. The on-call ID fellow’s beeper number is to be used ONLY for back-up. Use of a single beeper at ALL times avoids confusion.

The next page outlines the antibiotic approval program, including a list of restricted antibiotics.