Memorandum

To: Mary K. Greene, M.D.
Anne L. Calkins, M.D.
Barbara Wolfson, M.D.
Dawn Light, M.D.
Mark Warren, DO.
Mark J. Halsted, MD

From: Elizabeth H. Ey, M.D.

Date: March 6, 2012

Re: Updates

- **ED issues** -I met with Dr. Krzmarzick today for about an hour. We shared a number of concerns between ED physicians and Radiologists.
  - Number of interruptions to radiologists from ED physicians- Dr. Light shared this concern with me. She mentioned Dr. Chabali calls frequently for advice on how to order studies. Dr. K. agreed to recommend to the ED physicians that they call the techs directly for advice on how to order studies.
  - Significant results - We only have 3 critical results which require a phone call from the radiologist to the referring physician: impending brain herniation, tension pneumothorax, esophageal intubation. One could argue that all of our results (positive and negative) are significant. Dr. K asked if we could call for positive testicular torsion results and asked that the radiologist call for complicated cases, like new diagnosis of bone tumor. I told him that we have a hard time getting to the correct person when we call the ED and end up on hold a lot. He agreed to give us a number for call results (like to a specific nurse). I think we could then add a "call results" note to our study after it is finalized and indicate to the front office staff or Nikki on that note to call the specific "stat results ED line". I would appreciate your thoughts on this.
  - Patients not NPO for stat CT studies with IV contrast. He agreed to look into their process of allowing patients to eat or drink before a decision is made as to whether a CT needs to be done. I reminded him of the department guideline for NPO prior to IV contrast. I would appreciate hearing from each of you as to whether you believe the NPO guideline for IV contrast for ED patients is really necessary. My experience is that the trauma patients rarely experience nausea or vomiting with their CT scans possibly because we use non-ionic contrast. Does anyone feel we could do away with the mandatory 4 hour NPO status for other emergency CT scans requiring IV contrast? If so, which CT scans? Please let me know your opinion.
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- **Oral contrast for MR abdomen/pelvis studies -** Please let me know if you think Volumen is valuable for the abdominal MR studies. I have my doubts as to its usefulness. The patients don't like the taste of it and it can delay scheduling the study.
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- **Incorrect reason for exam in Epic -** Recently, it was brought to my attention that the registrars are not always putting the correct "reason for exam" into Epic. I have asked the managers to have the US and radiography techs put in the correct reason for exam in the tech comments field when they find a discrepancy between the Rx and the reason for exam. CT, NM and MR scan the paperwork at the time of the exam so we can see the correct reason for ourselves on those studies.
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- **Safety rounds –** Joanne Hand has begun attending a hospital-wide safety meeting every week day at 8 pm. Each department will be giving a very brief update on the status of operations and safety in their department. Joanne has created a form for techs, managers and radiologists to use to inform her of issues. (see attached) I have thought of posting one at Nikki's desk for the radiologist to add concerns when they occur. Does this sound like it would work for you? Alternatively, you could e-mail Joanne directly and copy me when you have an issue you believe impacts patient safety.
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- **MVH NICU transport process –** I met for about an hour with the Transport managers, NICU PNP, Joanne, Idamae, Meg from Epic, and radiology PNPs to discuss appropriate care of MR patients brought by the DC transport team for MRI. The goal is to provide local excellent MR services for pediatric inpatients throughout our region. The problem arises from the referring physician not having privileges at DC for ordering sedation medications. The Neonatologists have agreed upon a standard sedation protocol for NICU patients.
  1. Try MRI without sedation first.
  2. If patient needs sedation AND has already begun PO feeds, give chloral hydrate 25-50 mg/kg. May give one additional half dose if needed.
  3. If no PO feeds have been started, IV versed 0.05 mg/kg . May repeat 1 dose.

  To make a long discussion short, we agreed that trying to enter orders in Epic for these patients just doesn't work well. The transport team, NICU nurse, Epic rep, radiology NP, and radiology nurse ultimately agreed that the transport nurse could present the patient's history and condition to the radiologist assigned to MR, make a recommendation for sedation meds to be given based on patient weight and condition, and then hand write sedation orders on paper for the radiologist to co-sign. If you are interested in reading MR studies for patients transported to DC **and** if you are willing to co-sign sedation order for these patients, please send me an e-mail. I will send the list of radiologists who are willing to help to the transport team leaders.

- **Hanging protocols –** If you are having problems with PACS hanging protocols (most recently the limited Brain MR studies), please contact Idamae. She will help you set up and save a hanging protocol for this study.

- **Ketamine sedation for obese patients –** Neither Dr. Kleiner nor Dr. Lacey had concerns for using ketamine sedation in obese adolescents for LP procedures. I would appreciate hearing any opinion from you to trying this sedation as suggested by Dr. Kirkpatrick of anesthesia.

Safety Briefing Report

Date______________________

Yesterday's Issues or concerns:

Today's Issues or concerns:

Safety concerns for tomorrow:

Reported by ____