

Surgical Care Improvement Project (SCIP) Rapid-Cycle Intervention Process Physician FAQs



Q: What is CMS' SCIP?

A: The Surgical Care Improvement Project is a set of evidence-based practices that have been shown to improve surgical outcomes. Hospitals publicly report their SCIP-measure outcomes on the CMS *Hospital Compare* Web site.

Q: How are physicians involved?

A: Physicians must address each of the SCIP established standards of care (or a rationale for deviation) in their orders and documentation to reflect that patients received the best care.

Q: What is the purpose of the rapid-cycle intervention, and how does it work?

A: In order to rapidly improve our practice a physician-led team, using the data collected by RNs, rapidly implements process changes and education programs based on findings and refer accountability issues to medical staff leadership.

Q: What happens if physician practice or documentation does not reflect the established standard of care?

A: An RN will contact the physician for an order at the time the deficiency is identified. The RN will document the action on a data-collection tool and send the tool to the SCIP Accountability Team for review and response.

Q: What data are collected on the tool?

A: The data-collection tool is used to concurrently review information in the medical record for each specific standard of practice—including if the standard of practice was ordered and if the associated task was completed on time.

Q: What are the established standards of care for SCIP?

A: SCIP standards of care include the following:

- Appropriate antibiotic (ABX) ordered for cases related to CABG, cardiac, vascular, hip/knee

arthroplasty, hysterectomy, and colon surgeries.

- ABX given within 1 hour prior to surgery
- ABX discontinued within 24 hours of incision (EXCEPTION: 48 hours after cardiac surgery)

- For patients who are already on a beta blocker, a beta blocker must be ordered and received 24 hours prior to surgical incision OR received prior to discharge from PACU. Surgical patients who go directly to a unit from the OR need to receive a beta blocker within 6 hours of admission to the unit.
- Physicians' orders include recommended venous thromboembolism (VTE) prophylaxis, and the patient received VTE prophylaxis within 24 hours prior to anesthesia start time to 24 hours after anesthesia end time.
- For cardiac patients, the glucose level closest to 0600 on Post-Op Day 1 and Post-Op Day 2 should be ≤ 200 mg/dL.
- If a patient has a urinary catheter, the urinary catheter is removed by 2400 on POD 2 (GYN, urological, and perineal surgeries are not included in this measure). If a urinary catheter needs to remain in place longer than POD 2, you must document the reason in the medical record.

Documentation

Q: Where should physicians¹ document contraindications or their rationale for not following a SCIP standard of care?

A: Document the rationale for not following a SCIP standard of care on an order sheet or in the progress notes of the Medical Record.

¹ "Physician documentation" includes documentation by physicians, advanced practice nurses, or physician assistants.



Q: If patients are not already on a beta blocker prior to surgery, do they still require a beta blocker?

A: No, a beta blocker is only required if the patient is already on a beta blocker prior to surgery.

Q: What is the rationale for not giving a beta blocker within 24 hours of surgery or in recovery to patients previously on a beta blocker?

A: Rationales might include:

- Bradycardia with written physician parameters.
- Hypotension with written parameters.
- Other indications as documented by the physician or pharmacist.

Q: What is the rationale for not giving the specified prophylactic antibiotics to a patient population?

A: A rationale for not giving the specified prophylactic antibiotics includes treatment of an infection identified and documented in the medical record prior to surgery.

Q: What are the terms used to describe an infection?

A: Terms used to describe an infection can include abscess, acute abdomen, aspiration pneumonia, bloodstream infection, bone infection, cellulitis, endometritis, fecal contamination, free air in abdomen, gangrene, *H. pylori*, necrosis, necrotic/ischemic/infarcted bowel, osteomyelitis, penetrating abdominal trauma, perforation of bowel, pneumonia or other lung infection, purulence/pus, sepsis, surgical site or wound infection, urinary tract infection (UTI), or other documented infection.

Q: What is the rationale for extending a prophylactic antibiotic beyond 24 hours?

A: A prophylactic antibiotic may be extended beyond 24 hours when the patient has an infection and the antibiotic is no longer being ordered for prophylactic purposes. The physician must document the infection (using the terms above) any time prior to 24 hours after anesthesia end time.

Q: What procedures require pharmacological VTE prophylaxis even if mechanical prophylaxis is ordered?²

A: The following procedures require pharmacological VTE prophylaxis even if mechanical prophylaxis is ordered:

- General surgery
- Elective total hip replacement
- Hip fracture surgery

Q: What are the contradictions or rationales for not using VTE prophylaxis?

A: A physician or pharmacist must document a rationale for not using VTE prophylaxis on an order sheet or in the progress notes. Rationales may include:

- **Pharmacological Contraindications**
 - Active bleeding (gastrointestinal, cerebral, retroperitoneal)
 - Hemorrhage
 - Patient refusal
 - Risk of bleeding
 - Thrombocytopenia
 - Patients on continuous IV heparin therapy within 24 hours before or after surgery
- **Mechanical Contraindications**
 - Bilateral amputee
 - Bilateral lower extremity trauma
 - Patient refusal
 - Patients on continuous IV heparin therapy within 24 hours before or after surgery

Q: What if the patient needs to have a urinary catheter longer than POD 2?

A: If a patient needs to have a urinary catheter longer than POD 2, the physician must place an order to continue the urinary catheter and clearly document the rationale in the medical record.

This material was prepared by Health Services Advisory Group Inc., the Medicare Quality Improvement Organization for Arizona, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication No. AZ-9SOW-6.2.3-032710-01

² Pharmacological prophylaxis is NOT required as long as there is physician or pharmacist documentation of a pharmacological contraindication.