



DEPARTMENT OF THE NAVY

NAVAL MEDICAL CENTER
620 JOHN PAUL JONES CIRCLE
PORTSMOUTH, VIRGINIA 23708-2197

IN REPLY REFER TO:

NAVMEDCENPTSVAINST 6010.23
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02 APR 2010

NAVMEDCENPTSVA INSTRUCTION 6010.23

Subj: MEDICAL STAFF POLICY AND PROCEDURES

- Ref:
- (a) BUMEDINST 6010.17B, Naval Medical Staff Bylaws
 - (b) Comprehensive Accreditation Manual for Hospitals, Joint Commission
 - (c) BUMEDINST 6320.67A, Adverse Privileging Actions, Peer Review Panel Procedures, and Healthcare Provider Reporting
 - (d) BUMEDINST 6320.66E, Credentials Review and Privileging Program
 - (e) NAVMEDCENPTSVAINST 6320.7G, Credentials Review and Privileging Program
 - (f) NAVMEDCENPTSVAINST 5450.1H, Organization of Naval Medical Center, Portsmouth, Virginia
 - (g) DOD 6025.13R, Military Health System (MHS) Clinical Quality Assurance (CQA) Program Regulation
 - (h) NAVMEDCENPTSVAINST 6000.7B, Sentinel Event Policy
 - (i) NAVMEDCENPTSVAINST 6710.21, Administration of Sedation and Anesthesia by Non-anesthesiologists and Non-certified Registered Nurse Anesthetists
 - (j) NAVMEDCENPTSVAINST 6320.65B, Operative and Other Procedures
 - (k) NAVMEDCENPTSVAINST 6320.28D, Consent to Medical Treatment
 - (l) NAVMEDCENPTSVAINST 5420.11, Medical Management Program
 - (m) NAVMEDCENPTSVAINST 6320.61G, Patient Restraint, Seclusion, and Supportive Devices
 - (n) NAVMEDCENPTSVAINST 6470.3B, Conduct of Fluoroscopy
 - (o) NAVMEDCENPTSVAINST 5212.4C, Inpatient Record Manual
 - (p) NAVMEDCENPTSVAINST 6550.5B, Utilization Guidelines for Physician Assistants
 - (q) NAVMEDCENPTSVAINST 6320.77A, Medication Reconciliation Policy
 - (r) OPNAVINST 11320.27, Navy Installation Emergency Medical Services (EMS) Program
 - (s) NAVMEDCENPTSVAINST 5212.5A, Name Stamps and Signatures Used by Healthcare Providers

"FIRST AND FINEST"

02 APR 2010

- (t) NAVMEDCENPTSVAINST 6710.11F, Pharmacy and Therapeutics Committee
- (u) NAVMEDCENPTSVAINST 6550.6B, Utilization Guidelines For Nurse Practitioners

1. Purpose. To publish Naval Medical Center (NAVMEDCEN), Portsmouth, Virginia medical staff policies and procedures per references (a) through (u).

2. Cancellation. NAVMEDCENPTSVAINST 5112.2H

3. Scope. Effective on this date, this instruction applies to all members of the medical staff, as delineated in reference (e), assigned to the core medical center and all outlying clinics which comprise the NAVMEDCEN command.

4. Background. References (a) and (b) set forth Bureau of Medicine and Surgery (BUMED) and Joint Commission (JC) requirements on medical staff functions. It is Navy policy that, to the extent practical within available resources and in keeping with the military mission, NAVMEDCEN will meet the standards of references (a) and (b). This instruction defines how this command fulfills those facility-specific requirements and standards.

5. Mission Statement. The mission of the privileged Medical Staff at NAVMEDCEN Portsmouth is to lead the medical team in providing safe, quality patient care by ensuring the academic and professional development of our membership and the continuous evaluation and improvement of our processes; we will actively participate in the education of medical trainees and maintain a constant readiness to deploy in support of the national interests of the United States.

6. Local Medical Staff Membership Policy. All privileged practitioners assigned to, employed by, contracted to, and under partnership agreement with NAVMEDCEN constitute the Medical Staff. This includes physicians, dentists, advanced practice nurses, and allied health specialists. This local medical staff is a subset of the Department of the Navy Medical Staff and must comply with the Naval Medical Bylaws as outlined in reference (a). Membership criteria and the application process for initial appointment and reappointment are delineated in references (a) and (e).

02 APR 2010

7. Executive Committee of the Medical Staff (ECOMS). The Commander will appoint an ECOMS, which is empowered to act on behalf of the Medical Staff.

a. Responsibilities of ECOMS. Per reference (a), ECOMS is responsible for making recommendations directly to the privileging authority per references (b) and (e) for approval on at least the following matters:

(1) Structure of the professional staff.

(2) Reviewing, granting, reducing, revoking, suspending, denying, or terminating a practitioner's appointment to the professional staff and delineated clinical privileges, policies, and procedures, per references (e) and (f). When privileging action on non-physician practitioners is considered by the ECOMS, a peer of that practitioner must be present and involved in the dialogue.

(3) Organization of medical staff Quality Management (QM) activities, including the mechanism used to conduct, evaluate, and revise such activities. A primary goal of QM activities will be to ensure the same quality of care throughout the organization.

(4) Mechanisms for peer review and fair hearing procedures and the mechanism which medical staff may terminate appointment, consistent with reference (e).

(5) Reviewing and acting on reports and recommendations from medical staff committees, clinical directorates, or departments, process action teams, and other assigned activity groups.

(6) Reviewing an annual evaluation of the effectiveness of the medical staff's participation in QM activities that is also included in the annual appraisal of the facility's QM Program, per reference (g).

(7) Adoption or amendment of local policies and procedures of the medical staff subject to the approval of the privileging authority. Such policies and procedures must be developed with due regard for ensuring quality patient care by all individuals with delineated clinical privileges within and across directorates and departments.

02 APR 2010

(8) Disseminating information from medical staff meetings to facility medical staff, clinical support staff, administration, and the privileging authority, per references (f) and (g).

(9) Recommending space, personnel, and other resources, (e.g., categories and numbers of practitioners) needed to support the facility's overall plan for care delivery.

b. Membership Eligibility. All members of the medical staff are eligible for appointment or election to ECOMS. The Medical Staff President will make recommendations to the privileging authority regarding final appointment of nominees to ECOMS. The majority of members must be fully privileged physicians. Failure to fulfill membership duties, or attendance at less than 75 percent of regular meetings, may result in removal from the committee.

(1) Elected Voting Members. The following ECOMS members will be elected in an annual Medical Staff election and appointed by the Privileging Authority. With the exception of the President and Vice-President, all terms will be for 2 years.

(a) The Medical Staff President will be the Chair of ECOMS. The President will serve for 1 year.

(b) The Vice-president will be elected annually by the Medical Staff membership and automatically become the President after 1 year.

(c) Two members from the Directorate for Medical Services (DMS).

(d) Two members from the Directorate for Surgical Services (DSS).

(e) One member from the Directorate for Clinical Support Services (DCSS).

(f) One member from the Directorate for Dental Services (DDS).

(g) One member from the Directorate for Mental Health (DMH).

(h) One member from the Directorate for Primary Care (DPC).

02 APR 2010

(i) One member from the Directorate for Public Health Services (DPHS).

(j) One member elected to represent Licensed Independent Practitioners (LIP) (i.e., other than physicians and dentists).

(2) Non-elected Voting Members. The following ECOMS members will be appointed by the Privileging Authority based on recommendations submitted by the President of the Medical Staff.

(a) Director for Professional Education (DPE).

(b) Chair of the Credentials Committee.

(c) Physician Advisor for Quality Management (PAQM). The PAQM will be the senior Physician Advisor for Process Improvement (PAPI).

(3) Non-voting Members. The following ECOMS members will be appointed by their respective directorates/departments. They will not have a vote on issues brought before ECOMS, but will act as advisors to the voting members.

(a) Commander's Representative.

(b) Two current Graduate Medical Education (GME) trainees selected by the DPE.

(c) Director of Nursing Services (DNS).

(d) Medical Staff Services Department (MSSD) representative.

(e) Chairs of ECOMS subcommittees (except Credentials).

(f) ECOMS Special Assistants.

(g) Other non-voting members as approved by the President of the Medical Staff.

c. Termination of Membership. Membership will be automatically terminated upon revocation, suspension, or limitation of clinical privileges for reasons related to conduct or professional performance listed in reference (c) or for other reasons at the discretion of the Commander. The Commander has

02 APR 2010

the discretionary authority to terminate membership for any reason including failure to attend at least 75 percent of the ECOMS Committee meetings averaged over the year.

d. Responsibilities of Voting ECOMS Members

(1) Constituent Communication. With the exception of the President and Vice-president, ECOMS members are elected or selected to represent certain constituencies within the Medical Staff. ECOMS members will be expected to maintain open communication with those they represent to include:

(a) Welcoming new Medical Staff members within their representative constituency by e-mail or other means. The Medical Staff administrative assistant will be responsible for notifying ECOMS members of newly arrived Medical Staff in their area of purview.

(b) Disseminating information of importance to their Medical Staff constituents on a regular basis by e-mail or other means. The Medical Staff administrative assistant will maintain e-mail groups related to all the voting ECOMS member positions.

(c) Keeping their directors and other senior leadership informed of ECOMS activities. ECOMS members are expected to attend the appropriate directorate-level meetings in order to provide information and receive feedback regarding issues of importance to the Medical Staff.

(d) Always being available to their Medical Staff constituents by e-mail, phone, pager, and other means to receive complaints, ideas, suggestions, or otherwise discuss issues of importance to the Medical Staff. As appropriate, issues will be brought forward to the President of the Medical Staff, ECOMS, and/or ECOMS subcommittees for further discussion/action.

(2) Meetings. Each ECOMS member will make every effort to be fully prepared through careful study of pre-meeting documents, attentive participation during the meeting, and thoughtful voting on issues brought before ECOMS.

(a) Attendance. A member must attend at least 75 percent of the ECOMS Committee meetings averaged over the year to remain eligible for continued membership.

02 APR 2010

(b) Absences. ECOMS members who will be absent from the monthly ECOMS meetings or other key events will select another Medical Staff member to represent their position. ECOMS members who will be absent from the command for more than 3 consecutive months will notify the President of the Medical Staff. The Privileging Authority will formally appoint a qualified Medical Staff member to temporarily act as the ECOMS representative during this prolonged period of absence.

e. ECOMS Meetings

(1) ECOMS will meet face-to-face at least 11 times per year. An additional off-site meeting to discuss strategic issues is recommended annually. Meeting minutes (business, action, and discussion) will be completed for each meeting by the Medical Staff administrative assistant. He/she will also update and maintain a tracking/action list of ongoing projects.

(2) Online/e-mail discussion and voting may be authorized by the President of the Medical Staff when issues require prompt attention and cannot reasonably wait for a scheduled face-to-face meeting.

(3) ECOMS will act as the leadership of the Medical Staff and will take actions, make recommendations, and establish systems which allow the Medical Staff to achieve its mission. Towards that end, ECOMS will:

(a) Review issues concerning patient care and services that involve the medical staff, as described in reference (a).

(b) Monitor the effectiveness of the Medical Staff's performance as a whole and as individual privileged providers, specifically the areas that pertain to reference (a). ECOMS will focus on the manner one exercises granted privileges and compliance with local policies and procedures specifically in the areas related to one's medical and clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communications skills, and professionalism.

(c) Review reports and outcome metrics from the individual sub-committees, departmental peer review activities, and any other relevant data as it pertains to the medical staff and the achievement of its mission. ECOMS will proactively attempt to identify areas for improvement and recommend plans of action to correct deficiencies.

02 APR 2010

(4) All decisions, policies, and procedures developed by and/or modified by ECOMS will be communicated to the medical staff, administrative areas, and as appropriate, annotated in NAVMEDCEN instructions. Each member of ECOMS represents a specific group of the medical staff, and/or an administrative area. Each member will ensure efficient communication with the medical staff in their area of cognizance, via e-mail, work area/directorate meetings, and other means as required. Cognizant individuals will ensure changes are made to NAVMEDCEN instructions as changes in policy are made. As a member of the Executive Steering Committee (ESC), the President of the Medical Staff will ensure efficient communication to the Commander and the ESC. In addition, ECOMS will use e-mail to reach the medical staff or the entire staff to identify changes in policy, new instructions, and required training.

f. ECOMS Sub-committees

(1) Sub-committee List. At a minimum, the following committees will assist ECOMS in its oversight of the Medical Staff:

- (a) Medical Records Review Committee
- (b) Blood Utilization Review Committee
- (c) Operative and Other Procedures Committee
- (d) Pharmacy and Therapeutics Committee
- (e) Infection Control Committee
- (f) Medical Management Committee
- (g) Credentials Committee
- (h) Cardiac Arrest Committee
- (i) Critical Processes Committee
- (j) Critical Care Medicine Committee
- (k) Performance Improvement Committee
- (l) Cancer Committee
- (m) Professional Performance Evaluation Committee

02 APR 2010

(2) Sub-Committee Composition. Medical staff committees, by instruction, will determine the composition of their membership with an emphasis on fair representation of the medical staff given the committees' function. Each medical staff committee instruction will be reviewed by ECOMS on an annual basis. Chairperson nominations for sub-committees, unless otherwise specified, will be made to ECOMS. An ECOMS sub-committee, chaired by the ECOMS Vice-President, will be formed to review all nominees. The final nominations will be made to ECOMS for review. The nominations will be recommended to the Commander for final appointment. The Infection Control Committee Chairperson is exempt from this process. Due to the specific training this chairperson must have, the Commander will appoint the member.

(3) Outcome metrics. Each sub-committee will identify and monitor key performance metrics. Metrics may be derived from external sources (e.g., ORYX or Joint Commission) or internally derived. Sub-committees will review the metrics on a regular basis, establish goals, and recommend action when outcomes do not attain these goals.

(4) Sub-committee Reports. Each subcommittee will make a written report to ECOMS on at least a quarterly basis. Reports may be in narrative or presentation format, at the discretion of the chairperson. The components of each report will vary based on the issues addressed by the committee. At a minimum, the following items should be contained within the reports:

(a) Executive Summary. A brief accounting of key issues decisions of no more than 2 pages. If the complete report is no more than 2 pages, no Executive Summary is required.

(b) Complete Report on issues/decisions.

(c) Outcome metric review including pertinent graphs and tables.

g. ECOMS Special Assistants

(1) Physician Advisor to Process Improvement (PAPI). The PAPI will review and investigate reports of possible care which is outside of Medical Staff standards. The number of

02 APR 2010

PAPIs nominated by ECOMS and selected by the Commander will be based on the workload. The senior PAPI will also serve as the PAQM.

(2) Physician Advisor for Quality Management (PAQM). The PAQM will be the senior PAPI. PAQM responsibilities include:

(a) With the support of Risk Management, the PAQM will review all Quality Care Reports (QCR) and similar reports of possible substandard care to determine if further investigation is warranted.

(b) Supervise the other PAPIs to include making investigation assignments and monitoring for timely completion.

(c) In conjunction with Risk Management and Quality Management Department, the PAQM will establish the necessary databases and other tools to monitor and trend QCRs and other reports regarding the quality of medical care provided at NAVMEDCEN. The PAQM will identify issues which may need focused monitoring/trending.

(d) PAQM will make quarterly reports to ECOMS with special emphasis on concerning trends. Identified trends/issues deemed by ECOMS to require further action will normally be assigned to other ECOMS sub-committees for further staffing and development of an action plan.

(3) Professional Education Liaison. This position will be appointed to oversee Grand Rounds and make recommendations regarding other Military Treatment Facilities (MTF)-sponsored Medical Staff educational activities. In deciding which activities to sponsor, consideration should be given to:

(a) Type and nature of care offered by the facility.

(b) Findings of QM activities.

(c) Results of accreditation and medical inspector general surveys.

(d) Expressed educational needs of individuals with clinical privileges.

02 APR 2010

8. Appointment and Reappointment Policies. Procedures are contained in references (a), (d), and (g). Upon appointment and reappointment, providers must pledge to provide for the continuous care of their patients.

9. Privilege Policies and Procedures. Procedures are contained in references (a), (d), (e), and (g). Adverse privileging action, peer review panel procedures, and healthcare provider reporting are described in references (c) and (e). In those situations where the patient's safety is imminently endangered by an impaired provider, then a director, department/division head, officer in charge (OIC), or Command Duty Officer may initiate the process delineated in reference (c).

10. Medical Staff Organization

a. The organization of the medical staff is described in reference (f). NAVMEDECEN is organized into directorates, departments, and divisions. Clinical departments or divisions will meet regularly (at least quarterly) to conduct departmental/division business pertaining to peer review, process improvement, and to review the findings of QM and peer review activities. At branch medical and dental clinics, the department head duties listed in this instruction will be the responsibility of the Officer in Charge (OIC). If the OIC is not a Medical Staff member, formal arrangements must be made to involve a professional peer as detailed in paragraph 10b below. Regardless of such arrangements, the OIC remains accountable for the establishment of an appropriate medical staff infrastructure which will ensure compliance with all policies related to this instruction and for the accomplishment of all required activities.

b. Responsibilities of the department and division heads are found in references (a), (d), and (e). The Commander appoints department heads. A non-physician staff member may be appointed department head of a clinical department. In that case, peer review monitoring of clinical competency, staff appointment, and privileging issues must include a review by an appropriate professional peer. Department heads must be certified by a specialty nursing, medical, or allied health specialist board, affirmatively establishing their current competence through the privilege delineation process. Department heads provide effective leadership and efficient management as described in reference (a) and include:

02 APR 2010

(1) Oversight of all clinical and administrative activities within the department.

(2) Ensure professional performance is evaluated for all individuals who have delineated clinical privileges within the department, including the administrative oversight of the peer review process.

(3) Recommend to ECOMS the departmental-specific criteria for all clinical privileges in the department, including supplemental and itemized privileges.

(4) Recommend clinical privileges for each member of the department. Exercising clinical privileges is subject to the rules and regulation of that department and to the authority of the department head based on the practitioners scope of practice as permitted by their license, current level of training, current clinical competence, and ability to perform privileges granted.

(5) Oversee continuous measurement, assessment, and improvement of care and services provided.

c. Additional Responsibilities Include

(1) Integration of the department/division into the primary functions of the organization.

(2) Coordination and integration of departmental services.

(3) Development and implementation of policies and procedures that guide and support the provision of services within their clinical areas.

(4) Recommendations to ensure adequate staffing.

(5) Maintenance of quality control and process improvement programs.

(6) Orientation and continuing education of all persons in the department/division.

(7) Recommendations for space and other resources needed by the department/division.

02 APR 2010

(8) Recommendations for off-site sources for needed patient care services not provided by the department/division.

(9) Will ensure that all medical staff providers have the necessary resources to carry out their responsibilities, including a name stamp.

(10) Medical staff monitoring functions is described in references (g) and (h).

d. Individual Medical Staff Member Responsibilities

(1) It is the expectation that Medical Staff members will make every effort to attend all Quarterly Medical Staff (QSM) meetings where issues will be discussed (i.e., policy, procedures, requirements), questions may be asked, and information disseminated. Attendance may be satisfied in person at the QSM, by Video Teleconference (VTC), or through online review of the QSM materials. Providers who attend less than two QSM meetings per year may be subject to Peer Review action. The Medical Staff administrative assistant will post slides and other presentation information from the QSM on the ECOMS website. Members will be responsible for all information disseminated at QSM meetings, regardless of attendance.

(2) Participation and compliance with departmental activities to measure, assess, and improve system performance.

(3) Participation in measurement, assessment, and improvement of care and services provided.

11. Formal Licensure Proceedings. Each member of the medical staff is required to notify the privileging authority, through the Medical Staff Services Department, of any formal proceeding by a licensing authority or Drug Enforcement Agency (DEA), including the filing of an accusation or complaint to suspend, revoke, or place on probation a license, certification, or a DEA certificate, if an ECOMS or governing body of another MTF recommends the members privileges be suspended, revoked, or denied for reasons related to professional competence or conduct, or if the member develops a mental or physical condition or other situation that could significantly compromise his or her ability to perform the functions associated with clinical privileges.

02 APR 2010

12. Clinical Supervision. Levels of clinical supervision of house staff/trainees by members of the privileged medical staff is predetermined and contained in individual work area training manuals. The manuals are made available to the medical staff in their area of responsibility. Clinical privileges cannot be denied or limited for members who choose not to participate in the teaching programs. The medical staff assures that each participant in a professional graduate medical education program is supervised in his/her patient care responsibilities by a medical staff member who has been granted clinical privileges. The responsible GME Program Director makes decisions about each participant's progressive involvement and independence in specific patient care activities. Medical staff policies and procedures also delineate those participants in professional education programs who may write patient care orders, what orders they are allowed to write, and when an order must be countersigned by a supervising privileged medical staff member (see paragraph 14e(3) below). The Director for Professional Education is a member of the Executive Committee of the Medical Staff to ensure proper communication concerning the Graduate Medical Education Program and the medical staff.

13. Emergency Services

a. Core Medical Center. In the event of a medical emergency developing in or presenting to any ambulatory care clinic within the Charette Healthcare Center (Buildings One, 2, and 3), the patient will be evaluated, stabilized, and transported (if appropriate) to the Emergency Department for further evaluation, treatment, and/or admission as deemed necessary by the responsible physician. Medical emergencies occurring at NAVMEDCEN but in locations outside Charette, including the parking garage, will be handled by calling the number designated by the command for emergency response.

b. Outlying Clinics

(1) In the event of a medical emergency developing in or presenting to an outlying clinic, the patient will be evaluated, stabilized, and transported by ambulance to the nearest appropriate hospital Emergency Department. All reasonable efforts will be made to use the Emergency Medicine Department at the core medical center.

(2) Emergencies requiring immediate advance cardiac life support (ACLS) response/transport at outlying clinics are to be handled by calling the number designated by the command for 911

02 APR 2010

response. All non-emergent transports (up to 120 minutes for transport) will be coordinated by contacting the NAVMECEN transfer center per reference (r).

c. Coordination of Specialist and Subspecialist Evaluation in the Emergency Medicine Department

(1) Emergency Medicine Department will be responsible for the care of patients until discharged or admission orders are written.

(2) Except under unusual or extenuating circumstances, consultants should respond to pages within 15 minutes, begin the consultation within 30 minutes if the service maintains an onboard watch (otherwise within 60 minutes), and be prepared to admit or otherwise disposition the patient as promptly as possible.

14. Medical Staff Rules and Regulations

a. Safe Patient Care. Members of the active medical staff are responsible for assuring that all emergency, ambulatory, and inpatient care provided at NAVMECEN is done in a safe manner. Part of the command mission is the conduct of graduate and post-graduate education for designated trainees enrolled in clerkships, internships, and accredited residency and fellowship programs. All NAVMECEN patients, whether emergency, ambulatory, or inpatient, may be managed by authorized graduate medical and dental education trainees under the supervision of active medical or dental staff members. Supervision of trainees by the active medical or dental staff must be documented by appropriate entries in the inpatient chart or outpatient health record.

b. Unanticipated Outcomes. NAVMECEN is committed to providing quality medical care to its patients and the communities it serves. Despite constant and committed efforts to provide and improve care, occasions may arise when unanticipated outcomes occur. While sometimes these outcomes of care are unavoidable, at other times they result from preventable mistakes or errors in the provision of care. Occasionally a deviation in care or a procedure may occur, but it is recognized before it reaches the patient, without resulting in an unanticipated outcome. NAVMECEN analyzes adverse outcomes to prevent the recurrence of such events. We are also committed to respecting the right of patients and their families to be informed about such events. Healthcare

02 APR 2010

professionals will comply with the Command Policy regarding unanticipated outcomes as detailed in a separate instruction on the topic and, when necessary, consult the Healthcare Mediator (pager is listed in the Plan of the Day).

c. Outpatients Requiring Sedation. The conduct of sedation is governed by references (i) and (j). Each clinical area is responsible to implement the command policy.

d. Admission of Patients. All providers may admit patients to the medical center within their scope of practice. Physicians in training may admit for members of the active medical staff, but the "admitting physician" is the member of the active medical staff. Once a patient is admitted, the inpatient chart must always identify the active medical staff member responsible for the patient (i.e., the attending), beginning with the admission order. A note, written or co-signed by the responsible staff physician, which indicates the admission diagnosis, must be entered into the medical chart within 24 hours of admission and/or prior to surgery. In emergency situations, a note written by the resident physician indicating that the patient has been discussed with the staff physician will be entered into the medical record prior to surgery. Whenever the active Medical Staff member responsible for a patient changes, this must be stated in the Doctor's Orders.

e. Inpatient Chart

(1) Provider Identification and Time/Date Requirement. Each provider will time, date, and sign all medical record entries per policy to include the provider's unique identifying number. This unique identifying number may be the provider's last 4 of the social security, pager, National Practitioner Identification (NPI), or cell phone number (reference (s)). It will be used in all areas in the inpatient medical record and outpatient health record, where signatures are required. If the name stamp is not available, legible printing of name and unique ID number is acceptable.

(2) History and Physical Examinations. The patient will receive a medical history and physical no more than 30 days prior to or within 24 hours after inpatient admission. For a medical history and physical examination that was completed within 30 days prior to admission, documentation of any changes in the patient's condition will be completed within 24 hours after admission or prior to surgery, whichever comes first.

02 APR 2010

History and physical examinations must be completed, timed, dated, signed, stamped (or electronically signed), and entered into the medical record. If a patient arrives in the operating room without a documented history and physical examination, the surgery will be delayed until the history and physical is completed or the attending surgeon details how such delay would have constituted a hazard to the patient as soon as the patient's condition stabilizes and documentation can be performed. When podiatrists, certified nurse midwives (CNM), and dentists are privileged to admit patients, provisions must be made for prompt medical evaluation and a history and physical examination by a physician. A history and physical may be performed by the CNM on obstetrics (OB) patients if the finding, conclusions, and assessment of risks are confirmed or endorsed by a qualified physician and member of the medical staff within 24 hours. Qualified Oral and Maxillofacial Surgeons who admit patients may obtain histories and conduct physical examinations on their patients per reference (a).

(3) Orders. Orders may be written by any provider within the limits of their privileges or graduate medical education status at this command. Consultants should discuss any order request with the primary service prior to writing them, unless otherwise arranged. All orders must be written clearly or typed, and must be signed per policy (reference (s)). All orders will be automatically discontinued and rewritten when a patient goes to the delivery room or operating room, is transferred to a different nursing unit, a different level of care, or to a different service, as outlined in reference (q).

(a) All those writing "STAT" orders must personally communicate this to the nursing staff.

(b) FAX orders are encouraged to expedite processing providers' orders. Faxed orders must include the patient's full name and prefix with social security number. When orders are faxed, the original orders must be inserted in the chart within 24 hours. In the interest of patient confidentiality, a cognizant recipient must be ready to accept the faxed orders.

(c) All medication orders will follow the automatic stop policy as approved by ECOMS: therapeutic subcutaneous and oral anticoagulants, 3 days; meperidine, 4 days; ketorolac, 5 days; prophylactic subcutaneous anticoagulants, 7 days. Initial treatment with parenteral antibiotics must be ordered utilizing the Pediatric or Adult Parenteral Antibiotic Order Forms as appropriate and will be automatically discontinued after 7 days

02 APR 2010

unless length of treatment is specified. Preoperative/postoperative antibiotic prophylaxis for adults and children may be written on the standard Doctor's Order Form (SF 508) but will be automatically discontinued after 24 hours. Restricted antibiotics requiring ID approval must be ordered utilizing one of the two Antibiotic Order Forms in all cases. A current list of these antibiotics will be maintained on the Pharmacy Department website. Antibiotic orders in the Neonatal Intensive Care Unit (NICU) will be written on the SF 508. All NICU orders for restricted antibiotics require ID approval. All antibiotics may be reordered or continued on the SF 508.

(d) The medical staff is encouraged to state the indication for use on medication orders, especially if the medication has been designated by the command as a "look-alike, sound-alike" medication. Indications for the use of as required (PRN) medications must be clearly stated on the orders. Medication orders that specify a range of dosages must include a clear indication for each dosage. All medication orders must have a specific time interval (e.g., q4 hours, not q4-6 hours). Multiple PRN drugs ordered for the same indication must clearly define the order of usage and have clear distinguishing indications for which medication to use. Orders for medications that are "titrated" must state specific starting dosages, upper and lower limits, and have clear clinical endpoints used for titration. All "tapering" orders must state the dosage and specific timing and/or clinical criteria of each step. Orders for compounded formula will be made per standard "recipes" maintained by the Pharmacy Department. The Pharmacy Department will provide a command listing of these compounded formulas to ECOMS annually for review. Orders requiring a variation of these standard "recipes" must specify each ingredient and amount.

(e) Medications will be reconciled (i.e., a complete list of active prescription, herbals, and over the counter medications listed and reviewed) for each patient at the time of outpatient care, admission, transfer to another ward or level of care, and upon discharge, and documented as such, as outlined in reference (q).

(f) All orders for weight-based medications, inpatient or outpatient, must include the dose in milligrams per kilogram or body surface area, as appropriate, and the weight in kg, so that the Pharmacy Department can confirm the dose calculation. If a pediatric patient is to receive an adult

02 APR 2010

dose, this must be indicated in the order. Medications taken at home without change upon admission may be listed as "home dose" without a need to delineate the milligrams per kilogram.

(4) Verbal and Telephone Orders

(a) Professional support staff may receive verbal and telephone orders as outlined below:

1. Registered Nurse. Can accept any order.
2. Licensed Practical Nurse. Can accept any order within their scope of practice.
3. Dietician. Can accept orders related to dietary changes and other associated nutritional needs.
4. Respiratory Therapist. Can accept orders related to initiation of and changes to respiratory treatment.
5. Physical Therapist. Can accept orders related to initial, ongoing, and progressive physical therapy needs.
6. Pharmacist. Can accept orders related to medicinal therapy, parenteral nutrition, and pertinent laboratory orders.

(b) A verbal order can be given in emergency situations (e.g., CPR, precipitous delivery, etc.) or situations in which the provider writing out an order would potentially compromise care (e.g., ordering provider is performing a sterile procedure). Support staff receiving verbal orders must repeat them back to the issuing provider and receive confirmation from the provider. All verbal orders will be legibly documented on a Doctor's Order Form (SF 508), through AHLTA (using an SF 600), or in the outpatient medical record following the standard format.

(c) Telephone orders may be issued by privileged providers and house staff. Routine use of telephone orders should be avoided. Support staff receiving a telephone order will legibly transcribe the order on a Doctor's Order Form (SF 508), through AHLTA (using an SF 600), or in the outpatient record following the standard format. The transcribed telephone order must be read back to the issuing provider and receive confirmation from the provider.

(d) The ordering provider or a provider on the treatment team will countersign, date, and time the verbal/telephone order as soon as possible but no later than 24 hours after issuance.

(5) Progress Notes. Any healthcare provider may write progress notes. Progress notes must be recorded whenever there is a significant change in the patient's condition or treatment plan. When there is a significant change in the patient's status, the notes by trainees must state that the attending provider is aware of the patient's present status. Inpatients must have progress notes written at least daily. Progress notes must reflect privileged staff involvement by a note at least every 48 hours. If an inpatient received an anesthetic during hospitalization, a statement must be included in the progress note which addresses the presence or absence of anesthesia-related complications. If discharge is to occur before a post-anesthetic visit can be made by a member of Anesthesia, a progress note may be written by any member of the operating team. It must indicate that the staff attending approves of the discharge decision. For outpatient ambulatory surgery and procedures, transfer or discharge from the Post-anesthesia Recovery Room, from other recovery areas, or from the Ambulatory Surgery Unit, may be via predetermined discharge criteria (references (i) and (j)). A progress note is required at the time a patient dies, is discharged, or is transferred. It must state that the staff attending responsible for the patient is aware of the situation.

(6) Laboratory and Radiology Study Requests. Laboratory and radiology studies must be specifically ordered for each patient. Pathology and cytology specimens require pertinent clinical history. All radiology requests must state a clinical indication for the study. STAT reads for radiology requests must be accompanied by a phone call to the radiologist. A list of the NAVMEDCEN STAT tests is available on the intranet.

(7) Pharmacy Requests. All Pharmacy items must be specifically ordered for each patient. Experimental drugs may be ordered only by members of the active medical staff who have been granted investigator status by the command. New non-formulary Pharmacy requests must be accompanied by justification. Drug utilization is monitored by the Pharmacy and Therapeutics Committee, whose activities are guided by reference (t).

02 APR 2010

(8) Discharge Planning. Discharge planning and documentation are described in reference (1). The responsibility of the medical staff includes, but is not limited to:

(a) Determination of the approximate length of stay and proposed treatment plan.

(b) Identification of patients early in the course of inpatient or outpatient treatment who may require additional psychosocial or physical care, treatment, or services after discharge or transfer.

(c) Ensuring participation of the patient, patient's family, and other providers and staff, as appropriate, in the development of a discharge or transfer plan.

(d) Completion of applicable portions of necessary forms which facilitate transfer, placement, or other discharge requirements.

(e) Development of a written discharge/transfer instruction to be provided to the patient/patient's caregiver. Such instructions should be written in a manner that the patient and/or the patient's family or caregiver can understand. These instructions should include:

1. Information regarding the reasons for discharge/transfer.

2. In the case of a transfer, alternatives to the transfer.

3. Complete list of discharge medications/treatments and other kinds of continuing care, treatment, and services he or she will need after discharge/transfer.

4. Complete list of follow-up/referral appointments made with the patients primary care provider, medical specialists, or other community resources. When appointments have not been made, instructions regarding how to make these appointments should be provided.

(9) Narrative Summaries. A narrative summary is required for inpatient stays of greater than 72 hours and for patients with a complex hospital course. The summary of the hospitalization for patients staying 72 hours or less may be

02 APR 2010

documented either as a written Narrative Summary or using Form 2770. The summary must be completed within 24 hours of discharge. Narrative summaries should be brief, but complete, and should include:

(a) A concise discharge summary that includes the reason for hospitalization.

(b) Procedures performed.

(c) Care, treatment, and services provided.

(d) Patient's condition at discharge.

(e) Information provided to the patient and family.

f. Consent. Reference (k) is the authoritative document for consent requirements for medical treatment and must be cited in all clinical area's and nursing care area's Policy and Procedure Manuals where patient care occurs.

(1) Written informed consent must be obtained prior to any patient undergoing a non-emergent operative and/or other procedure, invasive or non-invasive, if that procedure is considered to carry greater than minimal risk. All planned procedures will be listed on the consent form. Informed consent must include a discussion of the potential risks, potential complications of the procedure, benefits, as well as alternative treatments or diagnostic options. Discussion of these components is a part of the consent process and must be documented. Documentation may be on the Consent Form (OF522), by completing the form in entirety. Additional information may be documented in a medical record progress note. Providers that do not use the consent form to document this discussion are encouraged to have the patient sign the progress note where it is documented, or to clearly indicate in the record that the discussion did occur. Such documentation must include the date and time that the discussion took place, who was involved in the discussion, that the procedure was explained in layman's terminology, who the witness was, the likelihood of transfusion, include risks, benefits, and alternatives, any questions answered pertaining to this discussion, and the patient's understanding of the nature, risks, benefits, and alternatives of the planned procedure.

02 APR 2010

(2) Patients must receive adequate information to participate in care decisions and provide informed consent. If the patient's condition does not allow for such interaction, appropriate documentation to that effect must be placed in the medical record. Informed consent is obtained by a Graduate Medical Education trainee or a member of the medical staff, or in the case of CT scans or MRIs, may also be obtained by the Radiology Technologist performing the procedure. Except in rare circumstances, informed consent is obtained in person. The informed consent process must permit discussion and questions from the patient.

(3) Any member of the organized medical staff involved in performing or supervising any procedures that require written informed consent or any that poses greater than minimal risk, must comply with Universal Protocol. All providers that perform or supervise the performance of such procedures, whether conducted in the outpatient setting, ward, unit, or main operating facility, have the primary responsibility of ensuring that a "time-out" is conducted and properly documented in the medical record, per policy. Providers may only perform or supervise procedures for which they have been granted privileges to perform. All providers are strongly encouraged to involve the entire healthcare team, particularly the nurse involved in the patient's care at the time the procedure is performed.

(4) All procedures that carry greater than minimal risk must have a written or dictated summary of the procedure upon completion, prior to that patient being transferred to the next level of care. If the provider is unable to complete a summary or operative report for the procedure, a progress note is entered into the medical record which includes the primary individual provider performing the procedure and the supervising provider, any assistants, the procedure performed, pertinent findings, Estimated Blood Loss (EBL), any specimens, and post-procedure diagnosis, prior to that patient being transferred to the next level of care. If the provider is to accompany the patient to the next level of care, documentation may be performed at that time. The sedation of patients outside the Main Operating Room is governed by references (i) and (j).

(5) Surgical Procedures. Except in emergencies, a surgical operation will be performed only with the informed consent of the patient or his/her legal representative as stated in reference (k). Although patients may be worked-up by house staff, the final decision to proceed with surgery must be made by the attending surgeon. Requirements for attendance by the

02 APR 2010

privileged medical staff member during the procedure are delineated in the applicable Policy and Procedures Manual. The attending surgeon will be immediately available to begin an operation at the time it is scheduled and participate in elements of the Universal Protocol as needed.

(6) Tissue, foreign objects, and surgical hardware removed from patients will be sent to Laboratory Medicine at the discretion of the clinician and per departmental policy. All operations performed will be fully described by the attending surgeon or a designated member of the operative team, by dictation or in writing, within 24 hours after the completion of surgery. When the dictated operative report is not available upon transfer to the next level of care, an entry in the progress note or a brief operative note must be documented in the medical record. This documentation must include the name of the primary surgeon and assistants, procedures performed, findings, estimated blood loss, specimens removed, and postoperative diagnosis. The attending surgeon must be designated by name in the brief operative note, even if his/her participation in the case was only in a supervisory role. The attending surgeon must review and sign the final dictated Operative Report. Surgical Case Review is described in reference (k).

g. Consultations. Active medical staff members are responsible for assuring that consultations are obtained when indicated. Repetitive failure to obtain consultations may be a cause for appropriate action per the Peer Review process. When an emergency exists such that a delay (to obtain a consultation) would jeopardize the patient's welfare, the physician in charge may proceed with treatment without consultation. In such instances, the physician must enter a note in the medical record detailing the reasons it was necessary to proceed with treatment. When a consultant desires the consultant to assume responsibility for a patient's care, this should be indicated in the request. The consultant should likewise indicate that he/she accepts responsibility for the patient's care. Acceptance of responsibility for inpatients occurs if the consultant transfers the patient to his/her clinical service. The primary care team must specify whether or not they desire the consultant to write orders on the patient. Consultants must answer Consultation Requests in the timeframe stipulated in the consult (routine, 72 hours, today, and emergency). If unable to do so, the consultant must notify the consultant, in the same timeframe as the request stipulated, of the inability to answer the

consultation request in the time requested. When a 72 hour, today, or emergency consult is requested, physician-to-physician communication is mandatory.

h. Special Treatment Procedures

(1) Use of special treatment procedures must be documented in the medical record. Such interventions require a special sensitivity to patient rights and risk management issues. These include restraint and seclusion, electroconvulsive or other forms of convulsive therapy, psychosurgery or other surgical procedure to alter or intervene in an emotional, mental, or behavioral disorder, behavior-management procedures that use aversive conditioning to manage or improve an individual's behavior, and substance abuse services will be governed by Psychiatry's Policy and Procedures Manual. On wards, restraint will be governed by reference (m), but will be applied only on a physician's order (except that a nurse may apply restraint to protect a patient while awaiting a physician's order).

(2) The following special treatment procedures are not allowed at this command:

(a) Surgical procedures done to alter or intervene in an emotional, mental, or behavioral disorder.

(b) Abortions, except as permitted by applicable instructions and law.

(c) Sex change operations except for infants born with ambiguous genitalia.

(3) Conduct of sedation will be conducted as described in reference (i).

(4) Use of fluoroscopy will be conducted per reference (n).

i. Medical Records in General. Reference (o) describes policies which pertain to medical records.

(1) All medical records, both inpatient and outpatient, are the property of the United States Government. Medical records become delinquent if they are incomplete 30 days after the day of the patient's discharge. The definition of a completed medical record, suitable for filing is: the history

02 APR 2010

and physical examination, diagnostic and therapeutic orders, progress notes, operative summary, final diagnosis, pathology report (if applicable), and narrative summary are entered and the chart is signed per policy. Providers must visit medical records as often as necessary to avoid delinquent charts. In general, this would be every 2 weeks. More than 25 delinquent charts at anytime or other evidence of inattention to completing medical records on time should be reflected in the provider's Ongoing Professional Practice Evaluation (OPPE). Repeated high delinquency rates will be reflected in the provider's Performance Appraisal Report (PAR) and may be cause for action per the Peer Review process.

(2) Free access to the medical records of patients will be afforded to medical staff members for Institutional Review Boards (IRB)-approved study and research. When measuring outcomes of patient care or peer review, confidentiality of personal information must be preserved.

(3) Inpatient medical records may not be removed or released without coordination through the Head, Health Information Management Division per the Manual of the Medical Department and Manual of the Judge Advocate General. In cases of readmission, all available records will be made available for use of the medical staff, as requested.

(4) At the outlying clinics, outpatient health records will be controlled as delineated in reference (f).

j. Deaths

(1) Autopsy. All autopsies will be performed by a NAVMEDCEN pathologist or by a physician deemed qualified by existing instructions or laws. The pathologist will notify the medical staff, particularly the attending physician, of the date and time of the performance of the autopsy. A complete report of the autopsy findings must be completed within 30 working days for routine autopsies and 60 days for complicated cases. A preliminary autopsy report must be available within 2 working days. These reports are to be incorporated into the patient's medical record. Every active medical staff member or his/her qualified trainee should seek legal consent for the authorization of an autopsy for all deaths for the purposes of quality assessment, graduate medical education, staff education, and enhancing patient care. Staff is encouraged to seek consent for autopsy for all deaths. Staff is required to seek consent for autopsy in the following circumstances:

02 APR 2010

- (a) Deaths in which an autopsy may explain an unknown or unanticipated medical complication.
- (b) Deaths in which the cause is not known with certainty on clinical grounds.
- (c) Cases in which an autopsy may help allay concerns of the family and/or public regarding death.
- (d) Unexpected or unexplained deaths following a medical, dental, or surgical diagnostic procedure and/or therapy.
- (e) Sudden, unexpected, or unexplained deaths which are apparently natural and not subject to a forensic medical jurisdiction.
- (f) Deaths resulting from high-risk infections and contagious diseases.
- (g) All obstetric deaths.
- (h) All neonatal and pediatric deaths.
- (i) Deaths where an autopsy might disclose a known or suspected illness.
- (j) Deaths known or suspected to have resulted from environmental occupational hazards.

(2) Special Circumstances

- (a) Autopsy requests for stillbirths of fetuses less than 20 weeks and/or 500 grams need to be discussed with the staff medical examiner or duty pathologist.
- (b) The staff medical examiner (or Office of the Armed Forces Medical Examiner (OAFME)) must be contacted regarding deaths in certain circumstances. Should the medical examiner decide to waive jurisdiction in these cases, medical staff should seek consent for autopsy as above. In the event the staff medical examiner is unavailable, OAFME or the duty pathologist may be consulted. These circumstances include the following:

- (1) Active duty deaths.

02 APR 2010

(2) Deaths occurring within 24 hours of hospital admission or deaths following unplanned readmission.

(3) Deaths in which the patient sustained an injury while hospitalized.

(3) Death Certificates. Preparation of death certificates is under the cognizance of the Decedent Affairs Division, Patient Administration Department. The signature on the death certificate will be that of a privileged staff member. If an autopsy is performed, the death certificate will be signed by the pathologist who performed the autopsy.

(4) Death Reviews. Risk Management Department will initiate death reviews within 24 hours (or by the next working day) for all deaths that occur in the core medical center and all patients pronounced dead on arrival (DOA) at the core medical center. Exceptions include those patients who are admitted for palliative terminal care where the cause of death is known. The cognizant clinical department head will ensure the initial review is completed and forwarded to the Risk Management Department. In the event the responsible medical staff member is the department head, an alternate active medical staff member will be assigned and is responsible for the review. After the review is complete, Death Review Forms will be permanently filed in the Risk Management Office.

k. Supervision of Non-physician Healthcare Providers. Supervision of non-physician healthcare providers will be in compliance with references (e), (i), (p), (u), and other NAVMEDCEN policies related to the utilization of these providers.

l. Performance Improvement. The medical staff will participate in performance improvement efforts within their assigned work area as well as for the command. All trainees (residents, interns, and fellows) should be included in this process. Peer review in the form of Focused and Ongoing Professional Practice Evaluation will occur for all privileged staff members in all departments per NAVMEDCEN's Professional Practice Evaluation Policy.

m. Medical or Psychiatric Care. Medical staff requiring medical or psychiatric care, which could give rise to questions of objectivity, should seek care from a clinic other than that which is the member's assigned location.

02 APR 2010

15. Action. The Medical Staff President is responsible in ensuring that this instruction is reviewed annually and that it is available to every member of the organized medical staff. All department and division heads are responsible for ensuring their medical staff is in compliance with this instruction. If the need arises, any problems with non-compliance already addressed at the department level, will be handled at the directorate level. Matters extending beyond the director will be brought to ECOMS and handled in conjunction with the Privileging Authority as needed. Individual program directors are responsible for ensuring that all trainees in their program have reviewed and are in compliance with this instruction. Any issues related to non-compliance of trainees will be addressed via the appropriate chain of command.

a. Each medical staff member is responsible for compliance with this instruction.

b. Executive Committee of the Medical Staff is responsible for the annual review and update of this instruction.

c. All to whom this instruction applies must read and comply with the requirements contained herein.

d. Reasonable efforts have been made to ensure that this instruction is consistent with all current local and higher authority policy. However, readers should carefully review the most current version of the references for clarification of specific details. Should there be a discrepancy or contradiction, the most current version of the referenced instruction will prevail.



W. R. KISER
Commander

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