

Change 129
Manual of the Medical Department
U.S. Navy
NAVMED P-117

16 May 2007

To: Holders of the Manual of the Medical Department

1. **Purpose.** This becomes the new Chapter 13, renamed Garrison Care for Operational Forces. The previous Chapter 13 which was canceled was named Operational Medicine.

2. **Action**

- a. Insert this change under the Chapter 13 tab.
- b. Record this Change 129 in the Record of Page Changes.



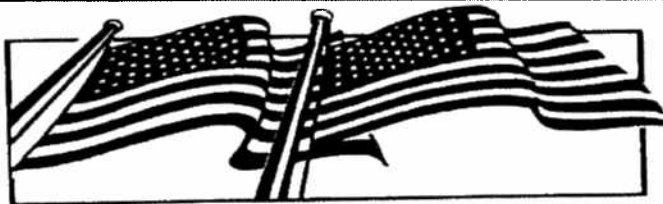
D. C. ARTHUR
Chief, Bureau of
Medicine and Surgery

Chapter 13

**GARRISON CARE FOR
OPERATIONAL FORCES**

Chapter 13

CONTENTS



Sections		Page
Section I.	General	13-3
Section II.	Standards	13-5

Section I GENERAL

Article	Page
13-1 Background	13-3
13-2 Responsibilities	13-3
13-3 Scope	13-4

13-1

Background

(1) Garrison care for the operational forces is a split responsibility of the Chief, Bureau of Medicine and Surgery (BUMED)/Surgeon General and the supported forces. The Chief, BUMED/Surgeon General maintains responsibility for technical oversight to ensure that operational forces receive high quality, effective care commensurate with their great service to their nation.

(2) Field medical care for Marines and Sailors and medical care afloat for Naval Forces is the responsibility of the unit commander who shall apply appropriate quality assurance mechanisms to ensure the highest quality of care.

(3) Naval Forces in garrison and Fleet personnel receiving medical care ashore may receive this care in a variety of environments, ranging from battalion aid stations to naval medical centers.

(4) To ensure quality garrison care, all fixed facilities delivering care shall maintain acceptable environmental and quality standards as specified in Section II of this chapter.

13-2

Responsibilities

(1) The Deputy Chief of Staff for Operations, BUMED-M3 shall:

(a) Serve as the principal policy advisor to the Chief, BUMED/Surgeon General for quality and standards of care to the operational forces.

(b) Develop standards of care for quality, safety, and efficiency that apply to all medical care delivered ashore. These standards shall address leadership and supervision, provision of care, the environment of care, medication management, human resources, management of information, patient rights, infection control, and performance improvement.

(c) Coordinate with The Medical Officer, U.S. Marine Corps and Command Surgeon, United States Fleet Forces Command to ensure effective implementation and oversight of these standards for Navy and Marine Forces.

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

(2) The Deputy Chief of staff for Resources, BUMED-M8 shall:

(a) Provide budget authority, through the Navy Medicine Regions, to the local medical treatment facility commanding officer to support provision of all equipment and consumable supplies required for Fleet and Fleet Marine Force garrison care. This specifically does not include funding for field use or while operational forces are underway.

(b) Provide budget authority, through the Navy Medicine Regions, to the local medical treatment facility commanding officer to support facility requirements for Budget Support Office (BSO)-18 Category 500 buildings where garrison care is provided. This specifically does not include facility funding for garrison care provided in non BSO-18 owned buildings.

(3) The Medical Officer, U.S. Marine Corps, (OPNAV) N093M shall:

(a) Maintain liaison between the Commandant of the Marine Corps and Chief, BUMED on all matters related to the medical support of the Marine Corps.

(b) Promulgate standards of garrison care for Marine Forces. These standards are not intended for field use as the environment and tactical situation shall dictate the level and type of care delivered in the field.

(c) Establish an effective oversight mechanism for care delivered to Marines in battalion, regimental, and group aid stations. This includes Marine Corps Inspector General reviews of the standards.

(4) The Command Surgeon, United States Fleet Forces Command shall:

(a) Maintain liaison between Commander, United States Fleet Forces Command and Chief, BUMED on all matters related to the medical support of fleet forces.

(b) Promulgate minimum standards of care for fleet personnel ashore. These standards are not intended for underway forces as the environment and tactical situation shall dictate the level and type of care delivered.

(c) Establish an effective oversight mechanism for care delivered to fleet forces ashore (e.g., CB battalion aid stations) not provided in BSO-18 fixed facilities.

13-3

Scope

(1) Applies to all health care delivered to Naval Forces ashore in fixed facilities.

(2) Specifically does not apply to health care delivered in field settings ashore or operational platforms afloat.

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

Section II

STANDARDS

Article	Page
13-4 Leadership and Supervision Standards	13-5
13-5 Provision of Care Standards	13-6
13-6 Environment of Care Standards	13-6
13-7 Medication Management Standards	13-7
13-8 Human Resources Standards	13-8
13-9 Management of Information Standards	13-9
13-10 Patient Rights Standards	13-10
13-11 Infection Control Standards	13-11
13-12 Performance Improvement Standards	13-11

13-4

Leadership and Supervision Standards

(1) Leaders provide for adequate facilities, equipment, and resources to directly support space, equipment, and other resource requirements needed to deliver quality health care, treatment, and services.

(2) Leaders continuously monitor the effectiveness of a performance improvement program that includes an integrated approach with other key programs to include patient safety. Priorities for

performance improvement initiatives and patient health outcomes are determined by giving high priority to high-volume, high-risk, or problem-prone processes.

(3) The use of clinical practice guidelines is encouraged to promote evidence-based health care, reduce variation in care, and optimize outcomes.

(4) The initiation of adverse privileging actions, based upon allegation of provider impairment (professional, behavioral, medical) or misconduct, shall be conducted following the BUMEDINST 6320.67A (Adverse Privileging Actions, Peer Review Panel Procedures, and Health Care Provider Reporting).

13-5**Provision of
Care Standards**

(1) When services beyond the capabilities of the aid station are needed for a patient, the subsequent care, treatment, and services are coordinated between the aid station and the accepting health care provider to ensure optimal continuity of care. There is a process to receive or share relevant patient information when patients are referred to other care, treatment, and service providers. Emergent or urgent transfer of seriously ill or injured patients to a higher echelon of care should be accomplished cooperatively with local emergency services. When a patient is routinely referred for consultative evaluation or continued care, appropriate information related to the care, treatment, or services provided by the aid station is communicated to the outside provider(s), to include the following: the reason for referral, the patient's physical and psychosocial status, a summary of care, treatment, and services provided and progress toward goals, and a list of current medications. The patient is educated about the referral process and how to obtain the care.

(2) Responses to life-threatening emergencies are in accordance with policy and procedures. Emergency medications are sealed and stored in containers (e.g., crash carts, tackle boxes, etc.) in such a way that staff can readily determine that the contents are complete and have not expired. Emergency medications and supplies are replaced prior to expiration or as soon as possible after their use.

(3) Policies and procedures are established regarding the use of non-complex diagnostic tests, including identifying staff members who are permitted to perform testing. Policies should ensure that appropriate supervision and training are provided in addition to periodic assessment of current competency. Test procedures comply with the manufacturer's recommendations for each test, to include conducting and documenting quality control checks as appropriate.

13-6**Environment of
Care Standards**

(1) Environmental tours are conducted to identify environmental deficiencies, hazards, and unsafe practices, at least every 6 months. Performance improvement methods are employed at the facility level that address the potential adverse impact of buildings, grounds, equipment, occupants, and internal physical systems on the safety and health of patients, staff, and others coming to the clinic. Environmental improvement efforts should result in a safe environment that maintains the safety and security of patients and their property while ensuring the right of every patient to personal dignity, confidentiality, and privacy.

(2) A policy to prohibit smoking and other uses of tobacco in and around the aid station, in compliance with Federal standards, is implemented and enforced.

(3) There is convenient access to hand-washing stations, to include a hand-washing station in each exam room, to facilitate compliance with the current hand hygiene guidelines of Centers for Disease Control (CDC) and Prevention.

(4) The clinic controls access to and egress from security-sensitive areas, to include medical records and medication storage areas and computer information display terminals, as appropriate.

(5) A written management plan is developed and maintained describing the processes established and implemented for the selecting, labeling, handling, storing, transporting, using, and disposing of infectious and regulated medical wastes, including sharps from receipt or generation through use and/or final disposal.

(6) Participation in an emergency management exercise or actual emergency is encouraged on a periodic basis. The aid station should clearly establish their role in relation to a base-wide or community-wide emergency management program.

(7) Fire Bills are created and fire drills are performed at a frequency no less than recommended by the National Fire Protection Association (NFPA) standards. All fire drills are critiqued to identify deficiencies and opportunities for improvement, and should include an evaluation of the following:

- (a) When and how to sound fire alarms.
- (b) Containment of smoke and fire.
- (c) Transfer of patients to an area of refuge.
- (d) Fire extinguishment.
- (e) Specific fire response duties.
- (f) Building evacuation.

(8) There are processes for regularly inspecting, testing, and maintaining fire protection and fire safety systems, equipment, and components.

(a) All heat detectors, manual fire alarm boxes, and smoke alarms are tested at least annually.

(b) All portable fire extinguishers are clearly identified, inspected by aid station staff at least monthly, and maintained by certified personnel at least annually.

(9) Aid station spaces should be kept clean and well maintained, with means of access and egress unencumbered. Storage areas should be well maintained and free of clutter, with boxes and supplies stowed appropriately, and kept off the floor (to prevent water damage). Passageways should not be used for storage.

(10) Activities are developed and implemented to protect occupants during periods when a building does not meet the applicable provisions for a safe environment. A policy is developed for using interim life-safety measures to ensure the following, as appropriate, when deficiencies and construction hazards are present:

- (a) Free and unobstructed exits.
- (b) Free and unobstructed access to emergency services.
- (c) Ensuring fire alarm, detection, and suppression systems are in good working order.

(d) Ensuring temporary construction partitions are smoke tight and are built of non-combustible or limited-combustible materials.

(e) Providing additional fire-fighting equipment and training staff in its use.

(f) Developing and enforcing storage, house-keeping, and debris removal practices that reduce the buildings flammable and combustible fire load.

(g) Conducting a minimum of two fire drills per quarter.

(h) Increasing surveillance of buildings, grounds, and equipment, with special attention to excavations and construction areas and storage.

(11) There is an appropriate inspection and maintenance process for achieving effective, safe, and reliable operation of all equipment on the inventory.

13-7

Medication Management Standards

(1) Only medication approved in writing by the aid station's respective type command (TYCOM), division, wing, or group surgeon shall be maintained, stocked, dispensed, or administered by the aid station. NAVMED P-117, Manual of the Medical Department (MANMED), Chapter 16, describes the minimum amount of information about the patient that is to be available in the medical record for use by those involved in medication management, to include the following about the patient: age, gender, current medications, diagnoses, and currently occurring conditions, allergies, and where appropriate, height and weight, and pregnancy/lactation status.

(2) Only approved medications are routinely stocked or stored in the aid station. Medications are stored in a manner that ensures product stability and prevents access by unauthorized persons. There is a process to address how unused, expired, or returned medications are managed and all expired, damaged

and/or contaminated medications are segregated until they are removed. When there is a medication recall or discontinuation by the manufacturer or the Food and Drug Administration (FDA) for safety reasons, medications are retrieved and handled per policy and law or regulation.

(3) Emergency medications are available in unit-dose and ready-to-administer forms whenever possible. There is a process to check and inventory emergency medications and supplies to ensure currency and availability of medications and supplies.

(4) Preprinted order sheets (overprints) are approved by a designated aid station medical officer and are reviewed and updated as needed to support clarity, accuracy, and safety.

(5) As part of the peer review process, prescriptions are evaluated for the following:

(a) Appropriateness of the drug, dose, frequency, and route of administration.

(b) Therapeutic duplication.

(c) Allergies or sensitivities.

(d) Real or potential interactions between the prescription and other medications or food.

(6) Dispensing of medications adheres to law, regulation, licensure, and professional standards of practice, including record keeping. Before a medication is administered, there is a verification to ensure the medication is the correct one, that it has not expired, and that the correct dose is being given to the correct patient by the correct route. There are policies and procedures that address prescriber notification along with entry into the performance improvement process in the event of an adverse drug reaction or medication error.

13-8

Human Resources Standards

(1) Services within the aid station are provided based on the availability of an adequate number and mix of staff and licensed practitioners.

(2) Each privileged provider's responsibilities are consistent with their qualifications in compliance with BUMEDINST 6320.66E (Credentials Review and Privileging Program) and OPNAVINST 6400.1 series (Certification, Training, and Use of Independent Duty Corpsmen). All staff that provides patient care are properly credentialed and privileged, possessing a license, certification, or registration, as required by law.

(3) Upon assignment to the aid station, each staff member is oriented to the following:

(a) Aid station policies and procedures, including safety and infection control.

(b) Specific job duties and responsibilities:

(1) Staff members can describe or demonstrate the following:

(a) Risk within the clinic environment.

(b) Actions to eliminate, minimize, or report risks.

(c) Procedures to follow in the event of an incident (e.g., mass casualty, fire).

(2) Participation in ongoing in-services, general military training, or other activities occurs to increase staff knowledge of work-related issues. Ongoing training emphasizes specific job-related aspects of safety and infection prevention and control. Training related to job orientation occurs not only upon initial arrival to the workspace, but whenever job responsibilities or duties change. Ongoing training is documented along with intermittent assessments that validate an individual's competence to

perform job responsibilities. A defined competence assessment process performed by qualified individuals includes:

(a) Assessment of defined and documented competencies during orientation.

(b) Reassessment of competency within a defined time frame is performed.

13-9

Management of Information Standards

(1) There is a written policy addressing the privacy and confidentiality of information that is communicated to staff. Information security, including data integrity, is based on and consistent with law or regulation. Controls to safeguard information and data, including patient records, against loss, destruction, and tampering are developed and implemented. Compliance with the policy of information security, information privacy, and confidentiality is monitored by the aid station.

(2) Processes related to the maintenance of the medical record are in compliance with MANMED, Chapter 16. The aid station has a complete and accurate medical record for patients assessed, cared for, treated, or served and there is a process to track the location of all components of the medical record. Only authorized individuals make entries in the medical record. Entries made by nonindependent practitioners that require countersignature are defined. Standardized formats are used for documenting all care, treatment, and services provided to patients. Medical record entries:

(a) Are dated.

(b) Have the author identified and, when necessary according to law or regulation or organization policy, authenticated, either by written signature, electronic signature, or rubber stamp.

(c) Have sufficient information to:

(1) Identify the patient.

(2) Support the diagnosis/condition.

(3) Justify and document the care, treatment, and services.

(4) Promote continuity of care among providers.

(3) There is a policy that ensures the timely entry of information into the patient's medical record. To support clinical decision-making, information found in the patient record is:

(a) Readily accessible.

(b) Accurate.

(c) Complete.

(d) Organized for retrieval of data.

(e) Timely.

(4) Medical records contain patient-specific information, as appropriate to the care, treatment, and services provided, to include:

(a) Demographic information: patient's name, gender, contact information, date of birth, height and weight.

(b) Documentation and findings of assessments.

(c) Conclusions or impressions drawn from the medical history and physical examination.

(d) Diagnosis, diagnostic impressions, or conditions.

(e) Diagnostic and therapeutic orders, procedures, tests, and results.

(f) Operative and other invasive procedures.

(g) Progress notes, including the date, staff person, and care, treatment, and service provided.

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

- (h) Reassessment and plan of care revisions.
- (i) Consultation reports.
- (j) Allergies to food and medicines.
- (k) Medications ordered or prescribed.
- (l) Referrals or communications made to external or internal care providers.
- (m) Treatment summaries and other pertinent documents to promote continuity of care.
- (n) Records of communication with the patient regarding care, treatment, and services.
- (o) The medical record contains a summary list of significant diagnoses, procedures, drug allergies, and medications. The summary list is quickly and easily available for practitioners to access needed information.

(5) The review of medical records occurs on an ongoing basis and is based on defined indicators that address the presence, timeliness, readability, quality, consistency, clarity, accuracy, completeness, and authentication of data and information contained within the record.

(6) Comparative performance data and information are used within the major subordinate commands for decision-making, when available. The aid station is encouraged to participate in the collection and aggregation of data and information to support care, treatment, and service delivery and operations, including the following:

- (a) Delivery of care, treatment, and services.
- (b) Analysis of trends.
- (c) Performance improvement.
- (d) Infection control.
- (e) Patient safety.

(7) Providers and staff have ready access to current and authoritative knowledge based information resources in print, electronic, Internet, or audio forms, to do the following:

- (a) Acquire and maintain the knowledge and skills needed to maintain and improve competence.
- (b) Assist with clinical/service and management decision-making.
- (c) Provide appropriate information and education to patients and families.
- (d) Support performance improvement and patient safety activities.

13-10

Patient Rights Standards

(1) The patient is engaged in the care provided to them through education, active decision-making, and compliance with treatment plans. To accomplish this, the patient, health care provider, and clinic staff shall employ a Patient Bill of Rights that provides patients with information about their responsibilities when receiving care, treatment and services, to include asking questions, accepting consequences, following rules and regulations, and showing respect and consideration.

(2) Informed consent is documented according to local procedures to ensure patient education about the nature of the proposed procedure, treatment, or service, to include potential risk, benefits and alternatives. Additional documentation can include evidence of patient participation in treatment planning and patient commitment to compliance with the treatment plan. Clinical areas should have designated spaces where privacy can be maintained during patient interactions with corpsmen and providers.

(3) Patients are kept apprised of the effects of care delivered to include information related to results of treatment and services that have been provided even if the resulting outcome was unanticipated and/or adverse in nature.

(4) A process exists for patients to submit compliments, comments, or complaints.

13-11**Infection Control
Standards**

(1) Systems for the investigation of outbreaks of infectious disease are in place. As part of an emergency plan, there is a plan for managing the influx of potentially infectious patients over an extended period.

(2) Strategies for infection control and the prevention of health care associated infections include the following:

(a) Appropriate storage, cleaning, disinfection, sterilization, and/or disposal of supplies and equipment.

(b) Appropriate use of personal protective equipment.

(c) Limiting unprotected exposure to pathogens.

(d) Enhancing hand hygiene.

(e) Minimizing the risk of transmitting infections associated with the use of procedures and medical equipment.

13-12**Performance
Improvement
Standards**

(1) Every health care provider within the aid station actively participates in a performance improvement plan that supports the mission and ensures continuous improvement of care is delivered to the patients entrusted to their care.

(a) Data are collected for priorities identified by the TYCOM, group, division, or wing surgeon to monitor and improve performance.

(b) Collected data are aggregated and analyzed, compared internally over time, and externally with other sources of information when available.

(c) Undesirable patterns or trends in performance are analyzed.

(d) An ongoing, proactive program for identifying and reducing unanticipated adverse events and safety risks to patients is defined and implemented.

Note: The intent of the above standards (articles 13-4 through 13-12) is to assume quality, safety, and efficiency.

THIS PAGE INTENTIONALLY LEFT BLANK