DEPARTMENT OF THE NAVY
NAVAL MEDICAL CENTER
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NAVMEDCENPTSVAINST 6010.23E
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10 MAY 2017

NAVMEDCENPTSVA INSTRUCTION 6010.23E

From: Commanding Officer, Naval Medical Center, Portsmouth

Subj: MEDICAL STAFF POLICY AND PROCEDURES

Ref: (a) through (z), see enclosure (1)

Encl: (1) References
(2) List of Acronyms

1. Purpose. To publish Naval Medical Center (NAVMEDCEN), Portsmouth, Virginia medical staff policies and procedures per references (a) through (z), see enclosure (1). Enclosure (2) is a List of Acronyms used in this instruction.

2. Cancellation. NAVMEDCENPTSVAINST 6010.23D

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

4. Background. References (a) and (b) set forth by the Bureau of Medicine and Surgery (BUMED) and The Joint Commission (TJC) 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, constitutes 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 (c). Reference (c) also outlines the process for granting emergency volunteer privileges in the event of a disaster.

7. Medical Executive Committee (MEC). The Commanding Officer will appoint an MEC, which is empowered to act on behalf of the medical staff.

a. Responsibilities of MEC. Per reference (a), MEC is responsible for making recommendations directly to the privileging authority per references (b) through (d) for approval on these 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 (c) through (f). When privileging action on non-physician practitioners is considered by the MEC, 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 by which medical staff appointments may be terminated, consistent with reference (c).

(5) Reviewing and acting on reports and recommendations from medical staff committees, clinical directorates or departments, process action teams, and other assigned activity groups. If members of the medical staff have a conflict with an MEC policy or decision, they have the right to redress their grievance to the MEC through the regularly scheduled MEC meetings. If redress is still not achieved, then the member may appeal to the Command Executive Board (CEB) via their chain of command.

(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.

(8) Should the need arise for an urgent amendment to this policy, it must be approved by the voting members of the MEC and submitted to the governing body. The urgent amendment may be provisionally approved and provisionally adopted by the governing body without prior notification of the medical staff. If an urgent amendment is provisionally adopted, the MEC would be responsible for immediate notification of the medical staff. The medical staff will have the opportunity for retrospective review of, and comment on, the provisional amendment. If there is no conflict between the organized medical staff and the MEC, the provisional amendment will stand. Significant disagreements from the medical staff will prompt reconsideration by the MEC.

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

b. Membership Eligibility. All members of the medical staff are eligible for appointment or election to the MEC. The President of the Medical Staff will make recommendations to the privileging authority regarding final appointment of nominees to the MEC. 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. These MEC 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 President of the Medical Staff will be the Chair of the MEC. The President will serve for 1 year. The Privileging Authority may opt to extend the President's term to greater than 1 year if a need to do so is dictated by operational, medical, or other constraints.

(b) The Vice President will be elected annually by the medical staff membership and automatically become the President after 1 year (except in circumstances where the President's term is extended by the Privileging Authority, as noted).

(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) Two members from the Directorate for Primary Care (DPC).

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

(j) One member who is an advanced practice nurse or allied health specialist (i.e., a non-physician/ non-dentist licensed independent practitioner) and who is elected to represent non-physician/non-dentist privileged providers.

(2) Non-elected Voting Members. These MEC 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 Performance Improvement (PAPI) and will Chair the Performance Improvement Committee.

(d) Chief Medical Informatics Officer.

(e) Chair of the Professional Practice Evaluation (PPE) Committee.

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

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

(b) Director of Nursing Services (DNS).

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

(d) Chairs of MEC subcommittees (except Credentials, PPE, and Performance Improvement).

(e) Immediate Past President (IPP) of the Medical Staff will act in a non-voting advisory capacity to the President of the Medical Staff and MEC. The position will be assumed upon turnover of the Presidency and last for the duration of the next President's term or until the current President determines the services of the IPP are no longer needed.

(f) QM Department Representative.

(g) Other non-voting members as approved by the President of the Medical Staff, to include an Operational Forces MEC Liaison and representatives from other Medical Treatment Facilities (MTF) in the Tidewater enhanced Multi-service Market.

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 (e) or for other reasons at the discretion of the Commanding Officer. The Commanding Officer has the discretionary authority to terminate membership for any reason including failure to attend at least 75 percent of the MEC meetings averaged over the year.

d. Responsibilities of Voting MEC Members

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

(a) 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 MEC member positions.

(b) Keeping their directors and other senior leadership informed of MEC activities. MEC 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.

(c) 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, MEC, and/or subcommittees for further discussion/action.

(2) Meetings. Each MEC 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 MEC.

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

(b) Absences. MEC members who will be absent from the monthly meetings or other key events will select another medical staff member to represent their position. MEC members who will be absent from the command for more than 3 consecutive months will

notify the President of the Medical Staff. The President of the Medical Staff will formally appoint a qualified medical staff member to temporarily act as an MEC representative during this prolonged period of absence.

e. MEC Meetings

(1) The MEC 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) The MEC 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, the MEC 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). The MEC 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. The MEC will proactively attempt to identify areas for improvement and recommend plans of action to correct deficiencies.

(4) All decisions, policies, and procedures developed by and/or modified by the MEC will be communicated to the medical staff, administrative areas, and as appropriate, annotated in NAVMEDCEN instructions. Each member of the MEC 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

CEB, the President of the Medical Staff will ensure efficient communication to the Commanding Officer and CEB. In addition, MEC will use e-mail to reach the medical staff or the entire staff to identify changes in policy, new instructions, and required training.

f. MEC Sub-committees

(1) Sub-committee List. At a minimum, these committees will assist the MEC 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 (PTC)

(e) Infection Control Committee

(f) Caregiver Wellness Committee

(g) Credentials Committee

(h) Cardiac Arrest Committee

(i) Professional Development Committee

(j) Performance Improvement Committee (Physician Advisors for Performance Improvement (PAPI))

(k) Cancer Committee

(l) Professional Performance Evaluation Committee

(m) Perinatal Advisory Board

(n) Chest Pain Center Accreditation Committee

(o) Critical Care Council

(p) Antibiotic Stewardship Committee

(q) Long-Term Opioid Therapy Safety Program and Committee

(r) Tissue Storage Committee

(s) Procedural Sedation Committee

(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 the MEC on an annual basis. Chairperson nominations for sub-committees, unless otherwise specified, will be made to the MEC. A MEC panel, chaired by the MEC President or Vice President, will be formed to review all nominees. The selected nominee will be presented to the MEC for review. The MEC President will make a final recommendation for each Chairperson to the Privileging Authority for final appointment.

(3) MEC Sub-committee Chairperson Term Length. The Chairperson of each MEC sub-committee will serve a 2-year term, after which nominations will be open for a new Chairperson. The existing Chairperson may be nominated to continue in this role for a maximum of three successive terms. A Chairperson may serve for less than a 2-year term when dictated by availability (e.g., retirement, Permanent Change of Station (PCS)), voluntary relinquishment, or if he/she demonstrates a pattern of repeated failure to meet associated responsibilities (a determination made by the Privileging Authority, under advisement of the MEC President).

(4) Outcome Metrics. Each sub-committee will identify and monitor key performance metrics as appropriate. Metrics may be derived from external sources (e.g., ORYX or Healthcare Effectiveness Data and Information Sets (HEDIS)) or internally derived. Sub-committees will review the metrics on a regular basis, establish goals, and recommend actions when outcomes do not attain these goals.

(5) Sub-committee Reports. Each sub-committee will make a written report to the MEC on at least a quarterly basis, unless otherwise specified by specific committee instructions approved by the MEC. Reports may be in narrative or presentation format, at the discretion of the chairperson or per committee charter. The components of each report will vary based on the issues addressed by the committee. At a minimum, these items must be contained within the reports:

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

(b) Complete report on issues/decisions.

(c) Outcome metric review including pertinent graphs and tables with trend data, when applicable.

g. MEC Special Assistants

(1) Chief Medical Informatics Officer (CMIO). The CMIO will serve to reform NAVMEDCEN by facilitating changes to existing technology and implementing emerging healthcare-related technology. The CMIO is the liaison between the medical staff and Information Management Department (IMD). The CMIO must be familiar with the electronic systems already in place at NAVMEDCEN, including network policies, available infrastructure, electronic medical record health systems, and other software packages available to NAVMEDCEN users. Integrating and improving these systems will be the core responsibility of the CMIO. The CMIO will work closely with the Chief Informatics Officer (CIO) and Chief Nursing Informatics Officer (CNIO) to develop and maintain a successful plan to ensure NAVMEDCEN remains at the forefront of technological innovation as it relates to healthcare management. Training and certification requirements for the CMIO are outlined in BUMEDINST 6000.16.

(2) Professional Education Liaison. This position will be appointed to oversee Grand Rounds and make recommendations regarding other MTF-sponsored medical staff educational activities. The Professional Education Liaison will coordinate with the Chair of the Professional Development Committee and will work closely with other members of this committee to achieve educational goals. In deciding which activities to sponsor, consideration must 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.

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), (c), (d), 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 (e).

10. Medical Staff Organization

a. The organization of the medical staff is described in reference (f). NAVMEDCEN 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 the branch medical and dental clinics, the department head duties listed in this instruction will be the responsibility of the 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. 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), (c), and (d). The Commanding Officer 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. For academic clinical departments (defined as departments with an active GME training program), 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 per GME requirements. Department heads will provide effective leadership and efficient management as described in reference (a) to include:

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

(2) Ensuring 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 the MEC, the departmental-specific criteria for all clinical privileges in the department, including non-core and itemized privileges.

(4) Recommending 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 practitioner's scope of practice as permitted by their license, current level of training, current clinical competence, and ability to perform privileges granted.

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

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

(7) Coordination and integration of departmental services.

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

(9) Recommendations to ensure adequate staffing.

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

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

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

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

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

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

c. Individual Medical Staff Member Responsibilities

(1) It is the expectation that medical staff members attend all Quarterly Medical Staff Meetings (QMSM), as this is the appropriate forum for the discussion of issues (i.e., policies, procedures, and requirements), addressing provider questions or concerns, and information dissemination. Attendance may be satisfied in person at the QMSM, by Video Teleconference (VTC), or through online review of the QMSM. Meeting attendance in person is preferred and is strongly encouraged. Providers who do not attend all QMSM meetings (or complete alternative means of reviewing meeting materials) may be subject to a negative performance evaluation or administrative counseling. The medical staff administrative assistant will post slides and other presentation information from the QMSM on the MEC Web site and videos of the meetings to the Swank account of those members who did not personally attend OMSM. Members will be responsible for all information disseminated at the QMSM, regardless of attendance.

(2) All physicians, dentists, physician assistants, psychologists, certified registered nurse anesthetists, nurse practitioners, podiatrists, and certified nurse midwives new to NAVMEDCEN (without NAVMEDCEN privileges in the preceding 2 years) are required to

attend a Provider Orientation Course within 6 months of command privileging. The requirement for this orientation course, which will be overseen by the Vice President of the MEC, may be waived on a case-by-case basis at the discretion of the MEC President or Vice President.

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

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

(5) Timely completion of medical records in both the inpatient and outpatient settings. Clinical documentation for outpatient encounters is expected to be completed by 72 hours after the encounter. At the discretion of the Privileging Authority (under advisement by the MEC President), medical staff members with consistently delinquent medical records may be subject to an "administrative hold", whereby their clinical responsibilities are curtailed until all delinquent medical records are completed. The duration of this administrative hold will be determined by the Privileging Authority, under advisement of the MEC President and the respective director/department head. More than twenty-five delinquent inpatient records, fifty delinquent outpatient records, or other evidence of inattention to completing medical records on time may be reflected in the provider's Ongoing Professional Practice Evaluation (OPPE). Repeated high delinquency rates may be reflected in the provider's Performance Appraisal Report (PAR) and may be cause for action per the Peer Review process.

(6) Consistently professional behavior in all interactions with peers, medical center staff, and patients per the command's Code of Conduct. Medical staff members who exhibit disruptive behavior will be the subject of administrative action, under the direction of the appropriate director, per reference (x).

(7) Maintenance of current Basic Life Support (BLS) certification.

(8) The provision of care for a provider's own immediate family is strongly discouraged, including the prescription of medications (other than those typically available on an "over-the-counter" basis), ordering of diagnostic testing, or submission of consultations. In addition to creating the potential for a conflict of interest, this scenario is simply not consistent with best practice. In the event that a provider does administer care for a family member, this care must be accompanied by appropriate medical documentation of a provider-patient relationship and the basis for and conduct of the care rendered. Under no circumstances may a provider's care for his or her family involve the prescription of any controlled substances.

(9) Providers may not prescribe medications for themselves, beyond those medications which are otherwise available on an "over-the-counter" basis. Providers found to be non-compliant with this medical staff policy may be referred to their chain of command for appropriate counseling and/or action.

(10) This command is an academic teaching facility and, as such, staff providers are expected to actively participate in the academic programs. Staff providers are expected to be involved in teaching, developing, and presenting didactic lectures, as well as remaining active in scholarly activity. Staff providers are also expected to create an atmosphere conducive to training so that trainees feel comfortable asking for assistance when and if needed.

(11) All staff members must maintain their respective state licensure, and complete continuing education credits at, or above, the minimum set forth by their state license.

11. Formal Licensure Proceedings. Each member of the medical staff is required to notify the Privileging Authority, through the MSSD, of any formal proceedings by a licensing authority or the 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 a MEC 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.

12. Clinical Supervision. Levels of clinical supervision of house staff/trainees by members of the privileged medical staff are predetermined and contained in individual work area training manuals. The manuals are made available to the medical staff in their area of responsibility. In addition, supervision expectations for procedures are identified by the training year level in the "Intern and Resident Supervision Matrix" which is available on the GME SharePoint site.

a. Clinical privileges cannot be denied or limited for members who choose not to participate in the teaching programs.

b. The medical staff assures that each participant in a professional GME 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. The DPE is a member of the MEC to ensure proper communication between the GME programs and medical staff.

c. When providers without NAVMEDCEN privileges are involved in patient care activities related to consideration for GME training, these providers must obtain temporary clinical privileges (typically via an Interdepartmental Credentials Transfer Brief (ICTB)) and an associated Focused Professional Practice Evaluation (FPPE) must be completed.

13. Emergency Services

a. Core Medical Center. In the event of a medical emergency developing in, or presenting to, any ambulatory care clinic within Buildings One, 2, or 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. All other emergency scenarios will be addressed by the appropriate specific medical staff instructions. Medical emergencies occurring at NAVMEDCEN but in locations outside Buildings One, 2, or 3, 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 advanced cardiac life support (ACLS) response/ transport at outlying clinics are to be handled by calling the number designated by the command for 911 responses. All non-emergent transports (up to 120 minutes for transport) will be coordinated by contacting the NAVMEDCEN Clinical Communications Center per reference (i).

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

(1) The Emergency Medicine Department will be responsible for the care of patients until discharged or physically transferred to an inpatient bed.

(2) Except under unusual or extenuating circumstances, consultants must 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 NAVMEDCEN is done in a safe manner.

(1) 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 NAVMEDCEN 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.

(2) Whenever possible, inpatient care must be completed in a multi-disciplinary and collaborative fashion.

(3) The patient's goals of treatment must be addressed and incorporated into the plan of care.

b. Unanticipated Outcomes. NAVMEDCEN 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. Sometimes these outcomes of care are unavoidable, while 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. NAVMEDCEN 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 professionals will comply with the command policy regarding unanticipated outcomes as detailed in reference (j) and, when necessary, consult the Special Assistant for Healthcare Resolutions (pager is listed in the Plan of the Day).

c. Medication Management. Medication management is defined as the process by which an organization plans, selects, procures, stores, orders, prepares, dispenses, administers, monitors, and evaluates all medications used in inpatient and outpatient settings. The term "medication" is interpreted broadly in this context and includes traditional prescription medications, nonprescription drugs, herbals, supplements, blood derivatives, contrast media, parenteral and enteral nutrition, and other diagnostic and treatment agents. The responsibilities of the PTC regarding medication management are detailed in reference (k). The responsibilities of each individual member of the medical staff regarding medication management are:

(1) All medication orders must contain these elements:

(a) The name of the medication.

(b) The required dose.

(c) The route of delivery. The device must be specified if the route of delivery requires a medication-related device (e.g., nebulizer, spacer, or catheter).

(d) The timing and/or interval of dosing.

(e) The duration of therapy, as appropriate.

(2) All orders for weight-based medications must include the calculated dose in appropriate units (i.e., grams, milligrams, micrograms), the desired dose in appropriate units per kilogram (kg), and the patient's weight in kg, so that the Pharmacy Department and the administering nurse can confirm the dose calculation. Medication orders that are based on body surface area must also include the patient's height or calculated body surface area. If a pediatric patient is to receive an adult dose, this must be indicated in the order.

(3) 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.

(4) Indications for the use of "as required (PRN)" medications must be clearly stated on the orders. Inpatient medication orders that specify a range of dosages must include a clear indication for each dosage. All inpatient medication orders must have a specified time interval (e.g., q4 hours, not q4-6 hours).

(5) Orders for multiple PRN drugs with the same indication must be clearly tiered as to the intended order of usage. Each drug must have a distinct and distinguishing indication for its use (e.g., ibuprofen PRN pain level 2-5 and Lortab PRN pain level 6-10).

(6) Orders for medications that are "titrated" must state specific starting dosages, upper and lower limits, and have clear clinical endpoints used for titration.

(7) "Tapering" medication orders must state the dosage and the specific timing and/or clinical criteria of each step. An outpatient prescription for a medication to be used in a complicated taper may simply state a starting dose/interval and "taper as directed by ordering physician." A detailed written plan for the outpatient taper must be provided directly to the patient.

(8) An automatic stop policy that controls the duration of therapy for specific medications has been established by the PTC and approved by the MEC. Medications currently subject to an automatic stop order are meperidine (4 days), ketorolac (5 days), and IV acetaminophen (2 days).

(9) All orders for medications that have been designated by the PTC as "non-formulary" must include appropriate justification for that specific medication's use (i.e., why a formulary medication is not an option).

(10) Medications that have been designated by the PTC as "restricted" may only be ordered by medical staff who can meet the restriction criteria. These criteria may include provider specialty, a specific disease state or medical condition, and stepped therapy (i.e., the requirement of therapeutic failure or intolerance of another formulary option).

(a) When a conflict regarding the use of a restricted medication exists between an attending medical staff provider and the staff member designated to regulate use of a restricted medication ("designee"), a formal consultation to the appropriate specialty regulating this medication's use will be obtained, with the expectation that formal consultant recommendations are documented/available within a period of 1 hour after consultation.

(b) When after a formal specialty-level consultation, a conflict persists between the medical staff provider and the designee regarding the indication for use of a restricted medication, an immediate arbitration meeting will be held to include at a minimum, the patient's attending provider, the designee for the medication in question, their respective clinical directors, and a member of the Pharmacy staff. If the conflict cannot be resolved through this arbitration, the final determination will be made by the director of the designee, with input from the President of the Medical Staff as required.

(11) Orders for medications for which there are established "medical necessity criteria" must include this required documentation. "Medical necessity" forms will are available on the NAVMEDCEN e-forms Web site and the Pharmacy Department Web site.

(12) Orders for compounded medications will be made by following standard recipes that are maintained by the Pharmacy Department. The PTC will provide a list of these compounded medications to the MEC periodically for review. Orders for a compounded medication not on the standard recipe list must specify each ingredient, concentration, and amount. All compounded medications are non-formulary and require appropriate justification.

(13) Antibiotic, antifungal, and antiviral medications have been divided into four categories based on these ordering constraints:

(a) Approved for general use.

(b) Approval by an infectious disease specialist required within 24 hours of initiating therapy. This approval must be appropriately documented in the medical record.

(c) Approval by an infectious disease specialist required prior to initiation of therapy. This approval must be appropriately documented in the medical record.

(d) Use restricted to infectious disease specialists only.

(14) Standing orders are formally established medication orders and specific related instructions for the administration of a medication to a patient in a clearly defined circumstance (e.g., Tylenol given for fever to a patient in a triage area prior to being evaluated by a provider). Standing orders must meet these criteria:

(a) Be written by a physician, dentist, or other licensed independent practitioner.

(b) Contain the standard elements required of all medication orders.

(c) Clearly define the circumstances in which the order may be executed.

(d) Acknowledged in the record of the patient encounter. This acknowledgement is not required for immunizations administered per reference (l).

(e) Approved by the clinical department having oversight for the practitioner and/ or clinical area.

(f) Subject to periodic review in order to determine continued applicability.

(15) A pharmacist must review every medication order or prescription prior to the medication being dispensed except in these circumstances: (1) a physician, dentist, or other licensed independent practitioner controls the ordering, preparation, and administration of the medication, or (2) when a delay would harm the patient in an urgent situation. Practitioner control is defined as:

(a) The practitioner provides a specific order containing the standard elements required of all medication orders and any pertinent administration instructions.

(b) The practitioner assumes responsibility for the process of preparing and administering the medication and for the personnel involved. The practitioner is not required to personally prepare or administer the medication.

(c) The practitioner is immediately available to provide care to the patient during administration of the medication and subsequent monitoring. When necessary and appropriate, this responsibility may be transferred to another qualified practitioner.

(16) All medication containers must be appropriately labeled unless a qualified staff member obtains or prepares the medication, takes it directly to the patient, and administers it without any break in the process. This includes medications or other solutions used in perioperative and other procedural settings. Labeling requirements are:

(a) Medication name and strength/concentration.

(b) Route of administration (if not apparent or if a handoff occurs between staff members during the process of preparing and/or administering the medication).

(c) Amount to be administered (if not apparent from the container or if a handoff occurs between staff members during the process of preparing and/or administering the medication).

(d) Expiration time/date (if not intended for immediate use).

(e) Patient name and location where the medication is to be delivered (if the patient is in a care area remote to where the medication is being prepared).

(17) Medication vials must be accessed in a designated clean medication area and in an aseptic manner. Single dose medication vials are for use in a single patient for a single procedure or injection. They may not be used for more than one patient. Discard any opened single dose vials that are not currently in use. Multiple dose medication vials may be used for more than one patient and/or more than one procedure or injection if prepared away from the immediate patient treatment area. If the multiple dose vial enters the patient treatment area it may only be used for that single patient. Once accessed, the vial must be marked with a "revised" expiration date that is 28 days from the date of first use. If the manufacturer recommends an expiration date for opened vials that is less than 28 days, use the shorter interval. Discard any opened multiple dose vials that are unclearly or incorrectly dated.

(18) Medications must not be removed from secure storage (e.g., Pyxis) or obtained from the Pharmacy until just prior to their intended administration. If administration is delayed after a medication is obtained, the medical staff member in possession of the medication will ensure its secure storage until it is administered. Storage conditions must not compromise drug integrity. Medications not administered within 4 hours of when they were acquired, must be returned to Pyxis if equipped with a return bin, or to the Pharmacy.

(19) Medications will be reconciled (i.e., a complete list of active prescription, herbals, and "over-the-counter" medications will be verified and reviewed) for each admission, transfer to another ward or level of care, and upon discharge. Medication reconciliation will be documented for outpatient encounters as outlined in reference (m).

d. Outpatient Care. Patients receiving outpatient medical or dental care will have their care documented in the appropriate medical record. The clinical documentation will be appropriate for the situation and condition of the patient at the time of evaluation and include communication of necessary information for future care.

(1) To ensure effective communication between patients and their providers, a "Learning Needs Assessment" will be performed once for each patient seen at NAVMEDCEN. The "Learning Needs Assessment" will be reviewed at each clinical encounter and updated with any significant change in the patient's clinical condition affecting the learning needs.

(a) The "Learning Needs Assessment" will consist of documentation of these items:

1. Preferred language for discussing healthcare.

2. Preferred method of learning.

3. Identification of any learning disability, cognitive, hearing, visual, or physical limitations that may affect learning.

4. Cultural or religious beliefs that may affect care.

(b) For pediatric patients and patients with significant disabilities, the "Learning Needs Assessment" will focus on the parent, legal guardian, or caregiver. The learning needs of pediatric patients are important and must be addressed. The patient must be included in the decision making to the extent possible, however, the person with authority to make the final medical decisions is the one for whom the "Learning Needs Assessment" must be documented.

(c) The "Learning Needs Assessment" for NAVMEDCEN patients will be completed utilizing the "Learning Needs Assessment" questionnaire found in the Armed Forces Health Longitudinal Technology Application (AHLTA) or utilizing the Tri-service Workflow templates within AHLTA. Limited exceptions will be made for departments which do not utilize AHLTA, including the Emergency Department and Dental clinics.

1. The Emergency Department will follow the departmental Standard Operating Procedure (SOP) and will document the "Learning Needs Assessment" in T-systems.

2. The Dental clinics will follow the directorate SOP and will document the "Learning Needs Assessment" in the dental record.

(d) The documentation that a review of the "Learning Needs Assessment" has been completed will be as per individual clinic SOPs.

(2) History and Physical Examination Requirements

(a) Patients having procedures in an outpatient setting requiring sedation or anesthesia will have a history and physical examination completed by their referring provider within 30 days prior to the procedure. The history and physical exam will be updated the day of the procedure with any significant changes in the patient's clinical status since the original exam. Any history and physical examination older than 30 days must be repeated and cannot be updated. The history and physical exam will consist of the chief complaint (CC), history of present illness (HPI), review of systems (ROS), medications, allergies, relevant past medical, surgical history, relevant physical exam with minimum of vital sign review, general assessment, cardiovascular, and pulmonary findings, assessment, and plan of care documented. In the pediatric population, an accurate weight is also required. Conduct of sedation is governed by references (n) and (o). Each clinical area is responsible to implement the command policy.

(b) The documentation of the history and physical exam may be formatted in any way consistent with clinical documentation (e.g., CC, HPI, and ROS may be combined into a subjective section of the note, or the assessment and plan of care may be combined). The elements of the history and physical exam must be present and clinically relevant.

(3) Medications will be reconciled (i.e., a complete list of active prescription, herbals, and "over-the-counter" medications will be verified and reviewed) for each outpatient encounter, and prior to sedation, per reference (m).

e. Admission of Patients. All providers may admit patients to the medical center within their scope of practice. Physicians in training may complete the admission process on behalf of a privileged provider, but the designated "admitting physician" must be a privileged member of the active medical staff. Once a patient is admitted, the inpatient chart must always identify the privileged 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 that 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 privileged medical staff member responsible for a patient changes, this must be stated in the SF 508 Doctor's Orders.

f. Patient Transfers. Input from the attending provider is mandatory for inbound inpatient transfers under these circumstances:

(1) Plans not to accept transfer after initial NAVMEDCEN house staff review.

(2) Plans to divert a transfer to a different clinical service after initial NAVMEDCEN house staff review.

(3) Any stated desire by the transferring physician for direct communication with an attending NAVMEDCEN provider. In cases where a referring provider requests communication directly with an attending NAVMEDCEN provider, this communication must be facilitated without any resistance or delay.

g. Inpatient Chart

(1) Provider Identification and Time/Date Requirement. Each provider will time, date, and sign all medical record entries in all areas in the inpatient medical record and outpatient health record where signatures are required. On all paper documents, this signature will include the provider's unique identifying number. This unique identifying number may be the provider's pager number, National Practitioner Identification (NPI), or cell phone number (reference (p)). In all electronic medical records, the provider's specific username and password serve as the unique identifier. Only the provider listed in the signature block may electronically time and date stamp their signature. This time and date stamp is tracked in the electronic medical record for possible auditing purposes.

(2) History and Physical Examinations

(a) All patients being admitted will have a history and physical exam completed within 30 days prior to or within 24 hours after admission. The history and physical exam will be updated the day of the procedure with any significant changes in the patient's clinical status since the original exam. Any history and physical exam older than 30 days must be repeated and cannot be updated. The history and physical exam will consist of CC, HPI, ROS, medications, allergies, relevant past medical, surgical history, relevant physical exam with minimum of vital sign review, general assessment, cardiovascular, and pulmonary findings, assessment, and plan of care documented. History and physical examinations must be completed, timed, dated, signed, and entered into the medical record. Except in an emergency situation, a patient is not to have a procedure performed or enter the operating room without a completed history and physical.

(b) The documentation of the history and physical exam may be formatted in any way consistent with clinical documentation (e.g., CC, HPI, and ROS may be combined into a subjective section of the note, or the assessment and plan of care may be combined). The elements of the history and physical exam must be present and clinically relevant.

(3) General Orders. All orders must be written clearly and signed per policy (reference (p)).

(a) Orders may be written by any provider within the limits of their privileges or GME status at this command. Consultants must discuss any order request with the primary service prior to writing them, unless otherwise arranged.

(b) All orders will be reviewed and modified as appropriate 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 references (m) and (q).

(c) All those writing "STAT" orders must personally communicate this to the nursing staff. All "STAT" electronic medication orders must be accompanied by the ordering provider's pager number or an alternative means for direct contact (e.g., blackberry or cell phone number).

(4) Verbal and Telephone Orders

(a) The professional support staff may receive verbal and telephone orders as outlined:

1. Registered Nurse. Can accept any order.

2. Licensed Practical Nurse. Can accept any order within their scope of practice.

3. Registered Dietician Nutritionist. 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., cardiopulmonary resuscitation (CPR), precipitous delivery, etc.) or situations in which the provider entering 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 documented in the inpatient medical record or the outpatient health record following the standard format.

(c) A telephone order may be issued by privileged providers and house staff. Routine use of telephone orders must be avoided. Support staff receiving a telephone order will document the order in the inpatient medical record or the outpatient health record following the standard format. The transcribed telephone order must be read back to the issuing provider and verbal confirmation received from the ordering 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.

(e) Orders may not be sent or received by text message.

(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 (or addendum and signature to note by a non-privileged provider) at least every 24 hours. If there are multiple progress notes on a given patient within a 24-hour period, a minimum of one note needs to be signed by the privileged attending provider. Progress notes must address the current plan of care, and whenever possible should incorporate the patient's goals for treatment. If an inpatient received a general or regional anesthetic during hospitalization, a statement must be included in the progress note section of the medical record 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 (see references (n) and (o)). 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 Studies. Pathology and cytology specimens require pertinent clinical history. All radiology requests must state a clinical indication for the study. "STAT" radiology requests must be accompanied by a phone call to the radiologist. In addition, when ordering a "STAT" radiology or laboratory test for an inpatient, the ordering provider is responsible for communicating this order verbally to the patient's nurse. A list of the NAVMEDCEN "STAT" laboratory tests is available on the intranet. The ordering

provider is responsible for reviewing all lab and radiology results, and initiating any related follow-up tests or actions (or for ensuring that department processes are in place to ensure follow-up and appropriate action on results). When abnormal finalized test results or information related to pathology studies are communicated directly to a provider, the staff member who initiated the call will document the name of the provider he/she spoke to, and the date and time of the conversation.

(7) Pharmacy Requests. All Pharmacy items must be ordered specifically for each patient, except when replenishing clinic or ward stock medications previously approved by the PTC. Medications classified as non-formulary, restricted, and/or having medical necessity requirements must be ordered per established policy (see paragraphs 14c(9) through 14c(11)). Experimental drugs may be ordered per reference (r) by members of the active medical staff who have been granted investigator status by the command. Requests for the availability of new medications must be made to the PTC per reference (k).

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

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

(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 prior to medical center discharge. Such instructions must be written in a manner that the patient and/or the patient's family or caregiver can understand. These instructions must 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 patient's primary care provider, medical specialists, or other community resources. When appointments have not been made, instructions regarding how to make these appointments must be provided.

(9) Narrative Summaries. A SF 502 Narrative Summary (or designated departmental functional alternative document) is required for inpatient stays of greater than 24 hours. The summary of the hospitalization for patients staying 24 hours or less may be documented as a written Narrative (i.e., Clinical Note in the electronic medical record) or NAVMEDCENPTSVA 6300/22 Transdisciplinary Discharge Form. The summary must be completed prior to discharge. All patient readmissions (even those within 24 hours of discharge) will be associated with a new set of medical documentation forms (including a separate History and Physical Examination) and will be associated with a unique admission record in the electronic medical record. Narrative summaries must be brief, but complete, and must include:

(a) Reason for hospitalization.

(b) Procedures performed.

(c) Pertinent reported or pending lab and radiology test results.

(d) Care, treatment, and services provided.

(e) Patient's condition at discharge.

(f) Information provided to the patient and family.

(g) Plan for any issues needing further follow-up.

h. Consent. Reference (t) is the authoritative document for consent requirements for medical treatment and must be cited in all clinical areas' and nursing care areas' 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 NAVMEDCENPTSVA 6320/105 Consent for Performance of Operations and/or Other Procedures form, by completing the form in its entirety. Additional information may be documented in a SF 509 Progress Notes. Providers

that do not use the consent form to document this discussion are encouraged 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.

(2) For all outpatient clinic procedures requiring use of a consent form, the consent form must be scanned into the outpatient electronic medical record. Consent forms for inpatient procedures will remain part of the official record in paper form.

(3) 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 GME trainee or a member of the medical staff, or in the case of Computerized Tomography (CT) scans or Magnetic Resonance Imaging (MRI), 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.

(4) 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 the 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 all three elements of the Universal Protocol (verification of patient identification, site marking (where applicable), and "time-out") are 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, in completion of the Universal Protocol.

(5) 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 ("brief operative report") 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 (n) and (o).

(6) Except in emergencies, an operative or other procedure will be performed only with the informed consent of the patient or his/her legal representative as stated in reference (t). Although patients may be evaluated by house staff, the final decision to proceed with operative or other procedures must be made by the attending provider. Requirements for attendance by the privileged medical staff member during the procedure are delineated in the applicable Policy and Procedures Manual. The attending provider will be immediately available to begin an operation at the time it is scheduled and participate in elements of the Universal Protocol as needed.

(7) All operations performed will be fully described by the attending or a designated member of the operative team, by dictation or in writing, within 24 hours after the completion of surgery. The attending surgeon must review and sign the final dictated SF 516 Operation Report within 7 days of its transcription. Surgical Case Review is described in reference (t).

i. Consultations

(1) 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 consulter desires the consultant to assume responsibility for a patient's care, this must be indicated in the consult request. The consultant must 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 team must specify whether or not they desire the consultant to write orders on the patient.

(2) 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 consulter, in the same timeframe as the request stipulated, of the inability to answer the consultation request in the time requested. For all consults designated other than "routine," physician-to-physician communication is mandatory.

(3) It is recognized that due to the administrative burden associated with outpatient consult review in high volume clinical departments, this process may be delegated to non-provider clinic staff. However, all outpatient (Composite Health Care System (CHCS)/ AHLTA) consultations that do not result in either clinic acceptance or network deferral, must be screened by a clinic provider, including all consults designated as "no appointment needed" or "information needed." In addition, any outpatient consultation downgraded in acuity (i.e., as soon as possible (ASAP) consult booked as a routine appointment) must be screened by a clinic provider before final appointment designation.

j. 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 procedures 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. These special treatment procedures will be governed by the Psychiatry Department's Policy and Procedures Manual. On the wards, restraint use will be governed by reference (u), and will be applied only upon receipt of a privileged provider's order (a nurse may apply restraint while awaiting a physician's order when deemed necessary to protect the patient or staff members).

(2) These 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.

(3) Administration of sedation will be conducted as described in reference (n).

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

k. Medical Records in General. Reference (q) 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 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 (or the electronic medical records Provider Dashboard tool) as often as necessary to avoid delinquent charts.

(2) Free access to the medical records of patients will be afforded to medical staff members for study and research approved by the Institutional Review Boards (IRB). 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).

l. 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 must seek legal consent for the authorization of an autopsy for all deaths for the purposes of quality assessment, GME, staff education, and enhancing patient care. Staff is encouraged to seek consent for an autopsy for all deaths. Staff is required to seek consent for an autopsy in these circumstances:

(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, the medical staff must seek consent for an autopsy as noted. In the event the staff medical examiner is unavailable, the OAFME or the duty pathologist may be consulted. These circumstances include:

1. Active duty deaths.

2. Deaths occurring within 24 hours of medical center 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. The 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 on 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, the NAVMEDCENPTSVA 5360/3 Death Review Form will be permanently filed in the Risk Management Department.

m. Supervision of Non-physician Healthcare Providers. Supervision of non-physician healthcare providers will be in compliance with references (c), (n), (w), (x), and other NAVMEDCEN policies related to the utilization of these providers.

n. 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) must be included in this process. Peer reviews in the form of FPPEs and OPPEs will occur for all privileged staff members in all departments per NAVMEDCEN's Professional Practice Evaluation Policy.

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

15. Action. The President of the Medical Staff is responsible for ensuring that this instruction 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 the MEC 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. All to whom this instruction applies are responsible for compliance with this instruction and must read and comply with the requirements contained herein.

b. Reasonable efforts have been made to ensure that this instruction is consistent with all current local and higher authority policy. However, readers must 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 instructions will prevail.

16. Records Management. Records created as a result of this instruction, regardless of media and format, must be managed per SECNAV M-5210.1 of January 2012.

17. Review and Effective Date. Per OPNAVINST 5215.17A, the MEC will review this instruction annually on the anniversary of its effective date to ensure applicability, currency, and consistency with Federal, Department of Defense, Secretary of the Navy, and Navy policy and statutory authority using the OPNAV 5215/40 Review of Instruction . This instruction will automatically expire 5 years after effective date unless reissued or canceled prior to 5-year anniversary date, or an extension has been granted.

18. Forms and Reports

a. These forms are available for download via the Naval Forms Online Web site https://navalforms.documentservices.dla.mil/web/public/home:

(1) SF 508 Doctor's Orders listed in subparagraph 14e.

(2) SF 502 Narrative Summary listed in subparagraph 14g(9).

(3) SF 509 Progress Notes listed in subparagraph 14h(1).

(4) SF 516 Operation Report listed in subparagraph 14h(7).

(5) OPNAV 5215/40 Review of Instruction listed in paragraph 17.

b. This forms are available for download via the NAVMEDCEN e-forms Web site https://webapps. mar.med.navy.mil/forms/:

(1) NAVMEDCENPTSVA 5360/3 Death Review Form listed in subparagraph 14l(4).

(2) NAVMEDCENPTSVA 6300/22 Transdisciplinary Discharge Form listed in subparagraph 14g(9).

c. Report Control. The reports required in this instruction are exempt from report control per SECNAV M-5214.1 of December 2005, part IV, paragraph 7.

P. E. KOPACZ
Executive Director

Releasability and distribution:
This instruction is cleared for public release and is available electronically only via the NAVMEDCENPTSVA intranet Web site at: https://nmcp.med.navy.mil/SitePages/Home.aspx

REFERENCES

Ref: (a) BUMEDINST 6010.17B
(b) Comprehensive Accreditation Manual for Hospitals, The Joint Commission
(c) NAVMEDCENPTSVAINST 6010.27
(d) BUMEDINST 6010.30
(e) BUMEDINST 6010.31
(f) NAVMEDCENPTSVAINST 5450.1L
(g) DoD 6025.13R
(h) NAVMEDCENPTSVAINST 6000.17
(i) OPNAVINST 11320.27
(j) NAVMEDCENPTSVAINST 6000.13
(k) NAVMEDCENPTSVAINST 6710.11G
(l) NAVMEDCENPTSVAINST 6230.3B
(m) NAVMEDCENPTSVAINST 6320.77C
(n) NAVMEDCENPTSVAINST 6710.21
(o) NAVMEDCENPTSVAINST 6320.65C
(p) NAVMEDCENPTSVAINST 5212.5C
(q) NAVMEDCENPTSVAINST 5212.4E
(r) NAVMEDCENPTSVAINST 6710.10E
(s) NAVMEDCENPTSVAINST 5420.11A
(t) NAVMEDCENPTSVAINST 6320.28F
(u) NAVMEDCENPTSVAINST 6320.61J
(v) NAVMEDCENPTSVAINST 6470.3C
(w) NAVMEDCENPTSVAINST 6550.5C
(x) NAVMEDCENPTSVAINST 5370.
(y) NAVMEDCENPTSVAINST 6710.8K
(z) NAVMEDCENPTSVAINST 6320.86

LIST OF ACRONYMS

ACLS	Advanced Cardiac Life Support
AHLTA	Armed Forces Health Longitudinal Technology Application
ASAP	As Soon As Possible
BLS	Basic Life Support
BUMED	Bureau of Medicine and Surgery
CC	Chief Complaint
CEB	Command Executive Board
CHCS	Composite Health Care System
CIO	Chief Informatics Officer
CMIO	Chief Medical Informatics Officer
CNIO	Chief Nursing Informatics Officer
CPR	Cardiopulmonary Resuscitation
CT	Computerized Tomography
DCSS	Directorate for Clinical Support Services
DDS	Directorate for Dental Services
DEA	Drug Enforcement Agency
DMH	Directorate for Mental Health
DMS	Directorate for Medical Services
DNS	Director for Nursing Services
DOA	Dead On Arrival
DPC	Directorate for Primary Care
DPE	Director for Professional Education
DPHS	Directorate for Public Health Services
DSS	Directorate for Surgical Services
EBL	Estimated Blood Loss
FPPE	Focused Professional Practice Evaluation
GME	Graduate Medical Education
HEDIS	Healthcare Effectiveness Data and Information Sets
HPI	History of Present Illness
ICTB	Interdepartmental Credentials Transfer Brief
IMD	Information Management Department
IPP	Immediate Past President
IRB	Institutional Review Boards
Kg	kilogram
MEC	Medical Executive Committee
MRI	Magnetic Resonance Imaging
MSSD	Medical Staff Services Department
MTF	Medical Treatment Facilities
NAVMEDCEN	Naval Medical Center
NPI	National Practitioner Identification
OAFME	Office of the Armed Forces Medical Examiner

OIC	Officer in Charge
OPPE	Ongoing Professional Practice Evaluation
PAPI	Physician Advisor for Process Improvement
PAQM	Physician Advisor for Quality Management
PAR	Performance Appraisal Report
PCS	Permanent Change of Station
PPE	Professional Practice Evaluation
PRN	As Required
PTC	Pharmacy and Therapeutics Committee
QM	Quality Management
QMSM	Quarterly Medical Staff Meetings
ROS	Review of Systems
SOP	Standard Operating Procedure
TJC	The Joint Commission
VTC	Video Teleconference