



DEPARTMENT OF THE NAVY
NAVAL MEDICAL CENTER
34800 BOB WILSON DRIVE
SAN DIEGO, CALIFORNIA 92134-5000

IN REPLY REFER TO:

NAVMECEN SANDIEGOINST 6010.12E
00QM

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NAVMECEN SANDIEGO INSTRUCTION 6010.12E

From: Commander

Subj: MEDICAL AND DENTAL STAFF POLICIES AND PROCEDURES

- Ref:
- (a) BUMEDINST 6010.17B
 - (b) Comprehensive Accreditation Manual for Hospitals
 - (c) BUMEDINST 6320.66E CH-2
 - (d) NAVMECEN SANDIEGOINST 6320.14D
 - (e) BUMEDINST 6320.67A, CH-1
 - (f) NAVMECEN SANDIEGOINST 5370.2A
 - (g) OPNAVINST 5350.40
 - (h) DOD Directive 5500.7R of 29 November 2007
 - (i) NAVMECEN SANDIEGOINST 6010.30A
 - (j) NAVMECEN SANDIEGOINST 6010.1H
 - (k) NAVMECEN SANDIEGOINST 6150.11
 - (l) Manual of the Medical Department (NAVMEC P-117)
CHG 115
 - (m) BUMEDINST 6550.7A
 - (n) BUMEDINST 6550.10A
 - (o) BUMEDINST 6550.12
 - (p) NAVMECEN SANDIEGOINST 6010.31
 - (q) NAVMECEN SANDIEGOINST 6320.38D
 - (r) NAVMECEN SANDIEGOINST 5800.2E
 - (s) AMA Code of Medical Ethics
 - (t) NAVMECEN SANDIEGOINST 6320.62G
 - (u) NMCS D GRADUATE MEDICAL EDUCATION COMMITTEE (GMEC)
POLICIES AND PROCEDURES
 - (v) NAVMECEN SANDIEGOINST 6010.20B
 - (w) NAVMECEN SANDIEGOINST 6450.1D CH-1
 - (x) NAVMECEN SANDIEGOINST 6500.9A
 - (y) NAVMECEN SANDIEGOINST 6320.97A
 - (z) Title 10" U.S. Code, section 1102
 - (aa) BUMEDINST 6010.13
 - (bb) NAVMECEN SDIEGOINST 6010.17B
 - (cc) BUMEDINST 6010.23
 - (dd) NAVMECEN SANDIEGOINST 6320.98A
 - (ee) NAVMECEN SANDIEGOINST 6320.25C
 - (ff) NAVMECEN SANDIEGOINST 6320.16F
 - (gg) NAVMECEN SANDIEGOINST 6220.2F

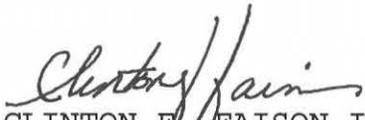
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(hh) NAVMEDCEN SANDIEGOINST 5830.3D

(ii) NAVMEDCEN SANDIEGOINST 5370.7

Encl: (1) Facility Specific Medical and Dental Staff
Policies and Procedures

1. Purpose. To establish medical staff policies and procedures specific to Naval Medical Center, San Diego (NMCS D) per references (a) through (ii).
2. Cancellation. NAVMEDCEN SDIEGOINST 6010.12D.
3. Scope. This instruction applies to the privileged staff at NMCS D and all Naval Branch Health Clinics, the Substance Abuse and Rehabilitation Program (SARP) and the Overcoming Adversity Stress and Injury Support (OASIS) program.
4. Background. References (a) and (b) set forth the requirements of the Bureau of Medicine and Surgery (BUMED) and The Joint Commission on medical staff functions. To the extent possible within available resources, and in keeping with military mission, NMCS D shall meet the standards of the aforementioned references.
5. Policy. All members of the medical and dental staff, and applicants for membership, must agree in writing that reference (a) and the contents of enclosure (1) will govern their activities as medical staff members.
6. Action. The Medical Staff Services Coordinator shall provide a copy of or demonstrate electronic access to this instruction and reference (a) for all medical staff members applying for privileges upon reporting to NMCS D.
7. Effective Date. This instruction shall be implemented 15 days from signature.


CLINTON F. FAISON III

Distribution:
NMCS D Intranet

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FACILITY SPECIFIC MEDICAL AND DENTAL STAFF POLICIES AND
PROCEDURES NAVAL MEDICAL CENTER SAN DIEGO

1. Appointments and Reappointments. Refer to reference (a) enclosure (1), paragraph 3.

2. Privileging

a. Policies and Procedures. See references (a) through (c). This facility provides a full scope of primary care and sub-specialty tertiary care. Each clinical department will maintain policies and procedures, which delineate its scope of services. Reference (c) delineates the Bureau of Medicine and Surgery (BUMED) privileging process. Physicians, oral surgeons, and other specifically named licensed independent practitioner medical staff members of departments with inpatient services will be granted privileges for admission during the initial appointment to the medical staff. In certain circumstances, Emergency Medicine specialists will have the authority to admit per reference (d). Any other member of the medical staff who desires admission privileges may apply for them as supplemental or facility specific privileges. The request will be routed via the Credentials Review Committee (CRC) with recommendations to the privileging authority. Disaster privileges may be granted by the Commander or his/her designee for volunteer Licensed Independent Practitioners (LIPs) after activation of the mass casualty/disaster plan and when the hospital is unable to meet immediate patient needs.

b. Adverse Action

(1) Per references (c) and (e), appropriate action, including adverse privileging action may be taken when review of credentials and recommendations regarding appointment are adverse to the applicant. Only the Commander has the authority to summarily suspend privileges. The following actions or delinquencies will be automatically referred to the Commander for consideration for summary suspension or modification of privileges:

(a) Alcohol or drug related incident or abuse per reference (g).

(b) Ethics violation per reference (h).

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(c) Failure to correct medical record delinquencies despite documented Department Head and Director counseling. Failure would constitute greater than 20 delinquent charts per month for three consecutive months. Director has the authority to alter the maximum number of delinquent charts deemed to be acceptable.

(d) Evidence of substandard, incompetent, unethical or unprofessional medical practice.

(e) Substantial allegations of personal misconduct which affect patient care.

(f) Discovery of a health or physical problem which could significantly impair a provider's ability to care for patients.

(g) Failure to obtain or maintain a valid medical license in a state or territory of the United States unless a waiver is granted by the Director of Navy Medicine (Surgeon General)

(2) Per references (c), (e), and (g) the command will enact the following procedures, as appropriate, when a provider is determined to abuse or be dependent upon alcohol or drugs:

(a) The Command Drug and Alcohol Program Advisor (DAPA) or other cognizant authority will notify the Department Head and Chairperson of CRC in writing when a medical staff member:

- Is enrolled in a substance abuse treatment program.

- Successfully completes treatment and is assigned a formal aftercare program.

- Disenrolls or fails to complete treatment.

- Successfully completes a formal aftercare program.

(b) If a concern about quality of care arises that is thought to be due to substance abuse, the Department Head will refer the provider to the Provider Wellness Committee

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(PWC) and provide a memorandum to the CRC for appropriate action.

(c) The provider's Department Head may create a special Focused Professional Practice Evaluation (FPPE) upon completion of, or failure to complete the substance abuse treatment or aftercare program.

(3) When the Commander suspends clinical privileges he will also withdraw permission for off duty employment. The Commander will notify the provider in writing.

(4) The convening authority on any medical board involving a provider will provide a copy of the medical board for the CRC to consider in the credentials review and privileging process.

3. Organization

a. Commander. Subject to higher authority, the Commander has full administrative authority and military jurisdiction over NMCS D. The Commander is charged to ensure effective, safe, efficient and economical performance of all NMCS D functions. The Commander is the privileging authority, and the final authority for all medical staff matters.

b. Deputy Commander. The Deputy Commander advises and assists the Commander and assumes command during absences. The Deputy Commander supervises the preparation, promulgation and distribution of plans, instructions and other directives to ensure the effective, efficient execution of the decisions and policies of the Commander. The Deputy Commander advises and assists the Commander with execution of medical department policies and provision of effective, efficient delivery of health care. The Deputy Commander participates in strategic planning and administrative decisions regarding organizational policy, plans and procedures essential to healthcare delivery including, but not limited to, budgeting, manpower, provision of clinical services, graduate medical education and compliance with directives of higher authority. The Deputy Commander exercises the privileging authority by direction of the Commander, but cannot further delegate this authority.

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c. Directorates. All NMCS D Departments and Divisions are organized according to professional services under a Directorate. A Director, appointed by the Commander, heads each Directorate and reports to the Deputy Commander. The Director oversees professional and administrative (budgetary, manpower, etc.) activities within the Directorate. Each Director reviews the quality and appropriateness of medical care via Department Head reports and in minutes of staff meetings. These findings are evaluated in light of institutional taskings, resources, policies and procedures. The Director identifies significant occurrences, trends and opportunities for improvement, and refers appropriate issues and recommendations to the cognizant Directorate, Department, the Executive Steering Council, or the Executive Committee of the Medical Staff (ECOMS) as appropriate. Quality Management will be involved in a primary or facilitative role, as necessary.

d. Department Heads. See enclosure (1) of reference (a), paragraph 6b(2), for BUMED delineated department head responsibilities.

(1) Department Heads are appointed by the Commander.

(2) It is the responsibility of the Department Head to:

(a) Be accountable to the Commander via the Deputy Commander and the Director for all professional and administrative activities within the department.

(b) Ensure, monitor, and evaluate the quality and appropriateness of patient care within the department.

(c) Hold medical staff meetings, which address the quality and appropriateness of patient care at least quarterly, and report the findings, actions and recommendations of those meetings to the appropriate Director.

(d) Recommend department-specific privileging criteria to the CRC.

(e) Recommend approval, restriction, limitation or denial of core and supplemental privileges as appropriate for each departmental medical staff member.

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(f) Review performance of the medical staff in the department. This performance review will follow the guidelines in reference (i). They will ensure that all peer review is performed by a privileged provider of similar qualifications and training if a like provider is available at this Medical Center. If the peer review is for purposes of analyzing an event under the risk management program, they will ensure that the provider involved in the event in question is not responsible for that peer review requirement.

(g) Ensure that all department staff complete medical records and medical boards promptly, and that all medical records meet the standards of content and quality of references (b) and (j) through (l).

(h) Ensure that no medical staff assigned to the department renders any patient care before the Commander grants staff appointment and clinical privileges, except in the case of emergencies, per references (c) and (d). Once a provider has been granted privileges, they will be placed on a department submitted CRC approved Focused Professional Practice Evaluation (FPPE) as appropriate, which should be completed within six months of arrival. The FPPE completion letter will be submitted to Medical Staff Services Office.

(i) Document the Ongoing Professional Practice Evaluation (OPPE) in the Clinical Activity Files (CAF) every six months as per reference (i), and submit PARs, as appropriate, to support the processes for reviewing, granting, and renewing clinical privileges. The CAF contains peer review information and is maintained by the Department Head in a secure file.

(j) Department Heads of departments that sponsor Graduate Medical/Dental Education (GME/GDE) programs will serve as the academic chairman for their program that are guided by policies in reference (u). Academic Chairman, in collaboration with their Program Directors, are responsible for maintaining a clinical learning environment that ensures patient safety and is compliant with the Accreditation Council for Graduate Medical Education (ACGME) and/or Commission on Dental Accreditation (CODA) requirements. In addition, the Academic Chairman will work with program directors to designate faculty, and maintain a current faculty roster on the Accreditation Data System (ADS)

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located on the ACGME website. The Academic Chairman, in collaboration with Program Directors, will develop a process and expectations for faculty appointment that will be documented in a faculty contract or other departmental policy and procedure.

(k) Ensure appropriate supervision or delegate this responsibility to the department program director of trainees and non-physician healthcare providers per references (m) through (o) and reference (v) in cases of graduate medical or dental programs.

e. Executive Committee of the Medical Staff (ECOMS). See enclosure (1) of reference (a), paragraph 6a. ECOMS provides oversight for all activities that govern clinical aspects of patient care, and reviews, updates or develops organizational policies associated with the medical staff. It is delegated as the primary authority over professional services and quality management activities provided by LIPs with clinical privileges, and are empowered to act for the medical staff in the interval between medical staff meetings. Should any member of the medical staff disagree with the actions or policy decisions of the ECOMS, he/she may present their concerns to the committee for consideration. Disagreements may also be brought to the attention of the CO via the military chain of command.

(1) Composition of ECOMS. The Commander, as privileging authority, appoints all members of ECOMS. The chairperson and the vice chairperson are elected by the medical staff. Any active member of the medical staff in good standing is eligible to run for these positions. The length of term is two years for all positions. Any member may be reappointed at the Commander's discretion. Committee members are as follows:

(a) Voting members of the ECOMS.

1. Chair of the Medical Staff.

- Physician/dentist member of the medical staff, nominated by a majority of the medical staff, and recommended to the CO for appointment not to exceed two years.

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- Serves as the Chair of the ECOMS.
- Presides over medical staff meetings, decides on questions of order, announces all business, puts all motions to vote and gives the result, presides during nominations and elections, is ex officio of all medical staff committees, and performs other duties as prescribed.
- Communicates with all levels of hospital governance involved in policy decisions affecting medical staff duties and responsibilities, as well as patient care services.

2. Vice-Chair of ECOMS.

- Physician/dentist member of the medical staff, nominated by a majority of the medical staff, and recommended to the CO for appointment not to exceed two years.
- Serves as acting Chair of the ECOMS during absence/TAD/leave of the Chair of the ECOMS.
- Chair, Credentials Review Committee. A physician/dentist member of the medical staff, nominated by the ECOMS to the CO for appointment not to exceed two years.
- Advisor for Quality Management (AQM): The requirements and duties of the AQM are as outlined in Tab (1).
- Director of Branch Clinics Representative: A physician member of the medical staff nominated by the Director of Branch Clinics and recommended to the CO for appointment not to exceed two years.

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- Medical Services Representative: A physician member of the medical staff nominated by the Director of Medical Services and recommended to the CO for appointment not to exceed two years.
- Surgical Services Representative: A physician member of the medical staff nominated by the Director of Surgical Services and recommended to the CO for appointment not to exceed two years.
- Critical Care Council Representative: Medical Director of the adult ICU nominated by the Director of Medical Services and recommended to the CO for appointment not to exceed two years.
- Dental Services Representative: A dentist member of the medical staff nominated by the Director of Dental Services and recommended to the CO for appointment not to exceed two years.
- Clinical Support Services Representative: A physician member of the medical staff nominated by the Director of Clinical Support Services and recommended to the CO for appointment not to exceed two years.
- Mental Health Representative: A physician member of the medical staff nominated by the Director of Clinical Support Services and recommended to the CO for appointment not to exceed two years.
- Licensed Independent Provider Representative: A LIP (Marriage Counselor, Nurse Practitioner, Physician Assistant, Psychologist, Social Worker, Chiropractor, Dietician, Nurse Anesthetist, Nurse Midwife, Occupational Therapist,

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Optometrist, Pharmacist, Physical Therapist, or Podiatrist) nominated by their respective Directorates and recommended to the CO for appointment not to exceed two years.

- Clinical Informatics Advisory Board Representative (CIAB): A member of the CIAB nominated by the Chief Informatics Officer/Chief Medical Informatics Officer and recommended to the CO for appointment not to exceed two years.

(b) Non-voting members of the ECOMS.

1. Executive Committee of the Nursing Staff Representative (or designee).

2. House staff Council Representatives

3. Command Risk Manager

4. Command Joint Commission Fellow/Coordinator

5. Legal Officer

6. Other individuals may be invited to attend committee meetings whenever areas of concern are within their scope of responsibility.

(2) Functions of the ECOMS. ECOMS operates under the guidelines of references (a) and (b) and performs the following responsibilities:

(a) Provides oversight of the CRC, which is charged with management of credentials review and privileging functions.

(b) Directs the CRC in cases of adverse privileging action or other significant issues involving licensed providers.

(c) Ensures adherence to fair hearing procedures.

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(d) In conjunction with special assistant for quality management and the CRC, monitors the professional practice evaluation program and ensures accurate and complete CAFs and PARs.

(e) Facilitates appropriate use of provider profiling data.

(f) Recommends facility and/or departmental privileging criteria.

(g) Provides a forum for review and recommendation regarding quality care concerns identified via peer review of licensed providers.

(h) May recommend medical staff membership termination based on concerns of quality patient care or unprofessional behavior.

(i) May request evaluations of privileged providers when there is doubt about an applicant's ability to perform the requested privileges.

(j) Provides medical staff review of litigation reports and investigations including Root Cause Analysis.

(k) Demonstrates compliance with residency review committee citations. The chair or vice-chair of ECOMS represents the medical staff at the professional graduate education committee (GMEC).

(l) Reviews patient safety data to assess and improve patient care.

(3) Meetings and Minutes.

(a) ECOMS will meet as frequently as necessary, but not less than 11 times per year.

(b) Meetings will include careful review of minutes of all ECOMS subcommittees.

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(c) Voting members will be expected to attend at least 75 percent of the ECOMS meetings over a twelve-month period to maintain membership.

(d) At least 60 percent of the members must be in attendance to constitute a quorum.

(e) A majority vote, with a quorum present, is required for action of the committee; however, every effort shall be made to achieve a consensus.

(f) A designated recorder will take attendance and record minutes.

(g) The ECOMS will use standard templates adopted by the command for minutes and presentations.

(h) The Chair will post the minutes of each meeting on the ECOMS Sharepoint site after final review by the Chair. The Chair will forward the signed minutes to the Quality Management (QM) Department with subsequent routing to the XO and the CO for review and endorsement. After final endorsement, the minutes will be filed with the QM Department and leadership comments will be returned to the committee Chair for action and dissemination to the committee membership.

(i) Leadership comments to the minutes will be discussed at each subsequent meeting.

(4) Responsibilities of the ECOMS. The primary responsibilities of the ECOMS are outlined in references (a) and (c). Its performance improvement mission is accomplished with the assistance of its medical staff committees. Medical staff committees report directly to the ECOMS and the chairpersons will report in person as often as necessary to keep the ECOMS informed of the committee's medical staff monitoring and performance improvement activities.

(a) The following committees are responsible to the ECOMS. Each committee's charter, to include goals, membership, responsibilities, meeting requirements, and reporting requirements are as follows.

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1. Credentials Review Committee (CRC). The CRC charter is outlined in tab (2).

2. Critical Care Council (CCC). The CCC charter is outlined in tab (3).

3. Operative and Invasive Procedure Committee (OIPC). The OIPC charter is outlined in tab (4).

4. Medical Records Review Committee (MRRC). The MRRC charter is outlined in tab (5).

5. Pharmacy and Therapeutics Committee (P&T). The P&T committee charter is outlined in tab (6).

6. Blood Utilization and Review Committee. The BURC charter is outlined in tab (7).

7. Cardiopulmonary Resuscitation Committee. The CPR committee charter is outlined in tab (8).

8. Infection Control Committee. The ICC charter is outlined in tab (9).

9. Oncology Advisory Group (OAG). The OAG charter is outlined in tab (10).

10. Provider Wellness Committee (PWC). The PWC charter is outlined in tab (7).

11. Healthcare Ethics Committee (HEC). The HEC charter is outlined in tab (8).

(a) Medical Staff Committee Membership Eligibility.

1. All members of the medical staff are eligible for appointment to medical staff committees.

2. The Chairperson of each medical staff committee will be recommended by the ECOMS and appointed by the CO for term not to exceed two years.

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3. Committee members are recommended by the chairperson, approved by the ECOMS, and appointed by the CO for a term equal to their duration of their tour at NMCSD.

(c) Committee members will be expected to attend at least 75 percent of the committee meeting over a twelve-month period to maintain membership.

(d) Membership Termination. Removal of any member of a medical staff committee will occur at the recommendation of the ECOMS and at the discretion of the Commander per reference (a).

(5) Meetings of the Medical Staff.

(a) The Chair of ECOMS conducts a biannual meeting of the medical staff

(b) All medical staff members are expected to attend at least 50 percent of scheduled meetings so that updates on medical staff initiatives, reports from ECOMS sub-committees, quality data, and faculty news can be shared.

(c) A majority vote of the medical staff present is required for action; however, every effort shall be made to achieve a consensus. All medical staff in good standing can vote. Medical staff policies and procedures will be adopted and amended by medical staff vote. Only with approval of the Commanding Officer will adoptions or amendments be recognized. This vote may be done electronically to reach the entire medical staff.

(d) The medical staff may invite other non-medical staff individuals to attend and participate in meetings as necessary whenever areas of concern are within their scope of responsibility.

f. Medical Staff Membership

(1) Medical Staff. Enclosure (1) of reference (a), paragraph 2, delineates medical staff membership and also defines clinical support staff as personnel who are required to be licensed but are not members of the medical staff.

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(2) Clinical Affiliate (Consultant). There are circumstances when it is necessary and appropriate to permit practitioners without Department of the Navy (DON) staff appointment to gain clinical privileges to provide direct health care services in DON military treatment facilities (MTFs). At NMCS D, the respective Department Head or Director nominates the desired provider. The provider applies for an initial (provisional) and then active staff appointment after FPPE completion via the CRC. Affiliate providers may provide direct patient care, but always work in affiliation with a privileged staff physician. The privileged staff physician is responsible for the patients involved when the affiliate is not privileged at NMCS D.

(3) Academic Consultant. Academic consultants at NMCS D provide lectures and training but do not participate in direct patient care. Requests for academic consultants are initiated through the Graduate Medical Education office and are approved by the Chairman, Graduate Medical Education Council and by the Commander.

(4) Conditions for relief

(a) General Conditions. The Commander may relieve any member of the medical staff from a position of authority including Directors, Department Heads, and medical staff committee members for any of the following reasons:

1 Personal misconduct, including violation of the Uniform Code of Military Justice (UCMJ), or conviction of a felony or misdemeanor, not to include misdemeanor traffic violations.

2. Medical incapacitation to practice medicine or an illness that impairs judgment as determined by neuropsychiatric testing.

3. Professional misconduct.

4. Adverse action taken by state board of medical licensure, including probation, suspension, reprimand, or revocation of medical license for professional or ethical but not administrative reasons.

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5. Failure to conduct requisite business of the position.

(b) Relief from Medical Staff Committees. Scrutiny alone is not the basis for adverse termination or suspension of any appointment. At the same time, however, a provider under investigation for alleged personal or professional misconduct may not be able to serve the medical staff in his or her fullest capacity or in the best interests of the medical center's beneficiary population during the period of investigation. Under such circumstances, the officer may request a leave of absence from committee activity, or the Commander may award a leave of absence if he considers the officer unable to discharge his duties because of the pending investigation. No leave of absence will exceed either six months or the normal expiration of committee appointment. A committee chair requesting a leave of absence while under investigation relinquishes chairmanship for the tenure of that appointment until reinstated to the committee. The Commander or Deputy Commander will normally grant relief or leave of absence from a medical staff committee for the period of investigation, but reserves the right of summary dismissal for the best interest of the medical center if substantial objective evidence for doing so is presented. If the outcome of the investigation is favorable to the medical staff member, the member may request formal reinstatement to committee membership, or, if the period of tenure has expired, a letter of good standing for medical staff activities.

4. Supervision Issues. Medical staff that are assigned by a Department Head and/or Program Director to serve in a supervisory, and/or faculty position for Graduate Medical Education residents and fellows must abide by all NMCSG Graduate Medical Education Committee and Residency Program policies and procedures concerning the following: resident supervision; transitions of care; duty hours monitoring and compliance; and grievance procedures and due process.

5. Other local Policies and Procedures

a. Naval Medical Center San Diego Instructions.

(1) Reference (ii) indexes all Naval Medical Center San Diego instructions. Medical staff members must be familiar with

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the contents of instructions that are pertinent to medical staff functions. Directors and Department Heads are responsible for the compliance of medical staff with all NMCS D policies and procedures

(2) Any new or revised instruction or policy affecting patient care, clinical practice, or the roles and responsibilities of the medical staff will be reviewed and approved by the ECOMS prior to submission to the CO.

b. Practitioner Behavior Policy.

(1) Unacceptable, disruptive and inappropriate behaviors include overt acts (e.g., verbal outbursts and physical threats) and passive activities (e.g. refusing to perform tasks, refusing to answer questions refusing to return pages/phone calls, using condescending language) that undermine team effectiveness and/or can compromise the safety of patients. This type of behavior will not be tolerated.

(2) Incidents of unprofessional behavior can be reported in a variety of ways. These include the chain of command, customer satisfaction cards, through patient relations representatives or through the AQM, or via the chain of command which enforces the Disruptive Provider Behavior Policy per reference (kk).

(3) All incidents that involve medical staff will be reviewed by the AQM and reported to the ECOMS Chair.

(4) For medical staff, if the incident is felt to meet the criteria for unprofessional behavior, the matter may be referred to the chain of command for disciplinary action under the UCMJ (military) or through the Human Resources Office (civilian). In addition, the incidents will become part of the OPPE.

c. Continuing Medical Education. All medical staff members will participate in continuing education activities that relate, at least in part, to the privileges granted, and remain in compliance with his/her state licensure and board certification requirements. Reference (u) provides additional guidance.

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d. Performance Improvement.

(1) Chart Review. Clinical departments are expected to conduct ongoing and regular chart reviews. A minimum of seven charts per quarter per provider should be reviewed. Charts will be reviewed at a minimum for the following criteria.

- (a) Appropriate history of present illness.
- (b) Appropriate physical examination.
- (c) Appropriate diagnostic studies.
- (d) Assessment of pain with appropriate intervention as indicated.
- (e) Evidence of medication reconciliation.
- (f) Evidence of use of the Universal Protocol, informed consent and a procedure note documented when an invasive procedure is performed.
- (g) Evidence of controversial care.
- (h) As part of the NMCS D process improvement program, the medical staff must continually strive to provide quality patient care and improve performance.
- (i) Ongoing performance improvement is the responsibility of all members of the medical staff.
- (j) Certain functions, such as Blood utilization review, medication usage evaluation, medical records review, operative and other invasive procedures review, risk management and other designated functions, are performed within or by collaborative multidisciplinary committees under the direction of ECOMS per references (bb) and (dd).
- (k) The medical staff will be familiar with the national patient safety goals as delineated in reference (b), and will have an understanding of how to apply these goals to their daily practice.

(2) Morbidity and Mortality Reports. To improve medical

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practices and to learn from difficult medical cases, complications and patient deaths, each clinical department will conduct regular morbidity and mortality reviews (M&M). The format of the M&M is at the discretion of the department head. The notes from the M&M's are part of Navy Medicine's Quality Assurance Program and are protected information under Title 10 United States Code Section 1102. These notes will be submitted to the Risk Manager and the AQM for additional review.

(3) Professional Evaluations. As outlined in Paragraph 3, d, (2), (J) and (k)

e. Off Duty Employment. Reference (f) provides guidance and required forms for off-duty employment.

f. Provider Wellness Program is intended to identify and manage issues of LIP health outside of the adverse privileging process. Reference (dd) applies.

g. Medical Care Responsibilities.

(1) Medical Staff of Record. All patients admitted will have an assigned privileged member of the medical staff. This medical staff of record is responsible for the continuity of care for all patients assigned to his/her care.

(2) Admission Privileges.

(a). Active medical staff physicians with clinical privileges, while not specifically listed in each core privilege list, by virtue of licensure and medical staff status are authorized unrestricted admission privileges to inpatient services. These medical staff members will serve as the attending staff of record for their patients. A physician may admit a patient to a service other than their own provided a physician from the receiving service agrees to accept the patient as the attending medical staff. It is the responsibility of the physician performing the admission to ensure that admission orders are written.

(b). All other non-physician members of the medical staff (LIP) may be granted the supplemental privilege to admit patients. The following are currently granted this privilege:

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oral and maxillofacial surgeons, midwives, adult psychiatric mental health nurse practitioners, pediatric nurse practitioners, and podiatrists.

(c). For departments with training programs, a trainee may act as the representative of the active medical staff supervisor (the active staff member must be identified in the record) and admit or discharge patients per departmental policy. All such patients will remain the responsibility of the active medical staff member.

(d) The Commander and the Deputy Commander may direct admission of any patient to any department.

(e) In cases where there is a dispute regarding emergency admission or the service to which a patient is to be admitted, current policy authorizes the Department Head, emergency department or his senior medical officer of the day to admit a patient from the emergency department and designate the receiving service and cognizant staff physician per reference (d).

(f) The Adult ICU Medical Director will assist in managing Critical Care resources when the ICU census nears or exceeds available bed capacity, or inpatient ICU acuity exceeds available staffing levels.

(g) An admission can be canceled after direct communication between the responsible service staff physician and the admitting physician.

(h) Following admission, there must be a continuous chain of active medical staff responsibility for the patient. All members of the healthcare team should have immediate access to the names of the attending physician (and residents, if applicable) for each patient's care.

(3) Diagnosis. Except in an emergency, no patient shall be admitted as an inpatient until a provisional diagnosis has been documented. In an emergency case, the provisional diagnosis shall be documented as soon after admission as possible.

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6. Inpatient Medical Record. The inpatient medical record must comply with references (b), (j) through (l).

a. Histories and Physical Examinations. Histories and physical examinations must be completed and entered into the medical record within 24 hours of the time of admission or prior to the patient arriving in the operating room, whichever occurs earlier. In an emergency where delay of surgery would constitute a hazard to the patient, the history and physical may be written post-operatively, but documentation of why it was not written pre-operatively must be included. Histories and physical examinations must be entered into the medical record before discharge if the patient's hospital stay is less than 24 hours. Except for oral and maxillofacial surgeons, certified staff nurse midwives, pediatric nurse practitioners, podiatrists (who are privileged to perform histories and physical examinations), and adult psychiatric mental health nurse practitioners, non-physician members of the medical staff who are granted admission privileges must arrange a prompt (within 24 hours) medical evaluation and history and physical examination of their patients by a medical staff physician, oral and maxillofacial surgeon, certified staff nurse midwife, pediatric nurse practitioners, podiatrist or adult psychiatric mental health nurse practitioners. Dentists and other individuals, including trainees, under supervision of an active medical staff member may perform the history and physical examination per departmental and command policy. A staff member must endorse this evaluation in writing within 24 hours of admission. The histories and physicals must include a comprehensive list of all active medications (including over the-counter and herbal supplements).

b. Orders. Members of the medical staff or the trainees they supervise may write orders within the limits of the staff person's clinical privileges. Orders not utilizing computerized physician order entry must be dated, timed and in writing.

(1) Telephone orders will only be taken by licensed registered nurses and must be countersigned by the ordering provider. Telephone orders must be signed within 24 hours for the following conditions: (1) all non-ward patients (e.g., all intensive care units, labor and delivery, post anesthesia care unit, emergency department, operating room); (2) all STAT

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orders; (3) all orders given in the presence of patient deterioration defined as change in mental status, heart rate, respiratory rate, temperature, blood pressure or pain not controlled by non-narcotic pain medications. Telephone orders must be signed within 30 days in the case of' all ward patients ABSENT the above conditions. Telephone orders are distinct from verbal orders.

(2) Verbal orders are defined as orders that are spoken aloud in person, face to face with the nurse, in an emergent/urgent situation or when the staff member is physically unable to write or electronically enter orders (e.g., working in a sterile field). In accordance with hospital policy, verbal orders authorized only in an emergent/urgent situation and must be signed before the cognizant staff member leaves the environment of care in which they were issued.

(3) Pharmacists and respiratory therapists may be authorized to enter an electronic order or write on the order sheet the telephone or verbal orders of privileged providers for pharmaceutical agents, laboratory tests, and respiratory therapy procedures. Such orders must likewise be countersigned in the same manner as above.

(4) For surgical patients, pre-operative orders not directly related to the surgical procedure or anesthesia are discontinued when the anesthesiologist assumes direct care of the patient. Orders for new or continued medication, fluids, laboratory tests, diet, and nursing care must be written as appropriate immediately after surgery.

c. Progress Notes. Progress Notes (SF 509) must be entered per reference (j). Progress notes must permit an analysis of the clinical course of the patient. Each note must be dated, timed and signed by the author. If a progress note is continued on the reverse side of a page or on a new page, it must be re-identified by date, time, and author's signature. All notes written by students or residents must be countersigned by the responsible supervisor. A progress note must be written or signed daily by the inpatient attending. The results of completed diagnostic studies, consultations, the results of therapeutic interventions and significant changes in the patient's condition or treatment plan must be recorded in the

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progress notes in a timely manner. Appropriate staff supervision must be documented. The supervising medical staff physician/oral surgeon/nurse midwife/pediatric nurse practitioner/podiatrist/mental health nurse practitioner must enter a dated/timed admitting progress note within 24 hours of admission and must enter a staff note or counter-signature daily for inpatients.

d. Narrative Summaries. Narrative summaries briefly describe the patient's hospitalization, reflect the patient's presentation, the diagnoses established, significant treatment and procedures performed, significant events that occurred during the hospitalization, the patient's condition upon discharge, the recommendations (diet, activity, limitations, plans), a comprehensive list of all active medications per reference (p), and arrangements that were made for post-discharge care. The format for dictation of narrative summaries is included in reference (q). Narrative summaries for active duty members must be completed before discharge. Only medical staff, residents and interns may complete narrative summaries. Medical staff must countersign a narrative summary completed by an intern or resident.

e. Integrated Disability Evaluation System (IDES) process:

(1) Immediately refer service members into IDES when they have conditions that would make them unfit for service. Only place service members on LIMDU if there is an excellent potential for return to full duties at the end of a 6 or 12 month period.

(2) Prepare a 'draft' Narrative Summary (NARSUM) at the time of and no later than 10 days of IDES referral.

(3) When prompted, finalize and sign the Medical Evaluation Board (MEB) report (NARSUM) within 5 days of notification in the IDES tracker.

f. Identification of Health Care Practitioners. If not utilizing the Electronic Medical Record (EMR) then all chart signatures must be accompanied by the typed, stamped or clearly printed identification of the author. Medical record entries should include the status of the author (intern, resident,

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consultant, attending, etc.), such that, for every entry, the author can be readily identified. For portions of the medical record charted in an EMR, a unique user-code is given to each authorized care practitioner. Use of this code provides a digital signature which is equivalent to a handwritten signature for all legal purposes.

7. Consent. See reference (r).

a. Prior to submitting to medical treatment, the patient has a right to be informed of the nature of the contemplated treatment and procedures, the risks and anticipated benefits, and available alternatives including the probable or expected consequences of a failure to accept treatment. The medical staff is responsible to convey this information to the patient in a way that the patient (and/or family members) can understand. Medical staff may delegate informed consent to a resident whom they have deemed competent to complete this process. Medical Staff or their designee must provide all information that would be significant to a reasonable and prudent patient in making a treatment decision.

b. For all invasive procedures or any treatment or procedure involving significant identifiable risk, informed consent must be documented. Informed consent is documented, at a minimum, in the form of a clinical note (electronic or written). This note should include a brief comment regarding the circumstances of the informed consent conference, to include: date, place, person present, and apparent level of comprehension of the person giving consent. In addition to the clinical note, a properly completed-signed Consent Form (OF-522) must be obtained prior to the administration of any spinal or general anesthesia, major or minor surgical procedure, or other procedure involving a recognized risk of serious harm, as determined by department policy.

c. Reference (t) reviews the determination of capacitance for the process of informed consent. It also states when a minor may give informed consent for medical and surgical treatment. In emergency situations, where consent cannot be immediately obtained, this reference supports our health-care providers obtaining a second opinion, and then doing what is in the best interest of the patient. In these special situations,

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the provider must write a clinical note before or immediately after the procedure indicating why the procedure must be (or was) done without consent. The provider rendering the second (confirmatory) opinion should be named in the note.

d. A witness more than 18 years of age is required to verify that the patient signature on the consent form was performed at the date and time entered. Consent remains valid as long as no material change in circumstances occurs between the date that consent was given and the date of the proposed procedure or treatment. New consent must be obtained if a material change in circumstances has occurred. Patients, including active duty, have the right to refuse treatment but should be fully counseled concerning the consequences of doing so. The patient must be informed of which active medical staff member is responsible for the procedure to be performed and if that individual will be present during the procedure.

8. Consultations. Except in an emergency, consultation with other qualified medical staff members should be considered when the diagnosis is obscure, the best therapeutic is in doubt, or the patient is not responding as expected to treatment.

a. Consultation Report. A satisfactory consultation shall include examination of the patient and review of the patient's record by a consultant qualified in the specialty requested. An evaluation signed by the consultant must be included in the medical record. When operative procedures are involved, the consultation note, except in an emergency, shall be entered into the inpatient medical record prior to the operation.

b. Consultation Timeliness.

(1) When consulted for an outpatient evaluation by a medical staff member, the consultant has the responsibility to respond to the request in a timely manner based on the acuity of the patient's condition. The requesting provider will initiate the consult directly with the consultant in addition to placing an electronic request for any emergent, same-day or 72 hour consults.

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(2) Inpatient, consults must be seen within 24 hours, unless deemed more urgent upon direct discussion between attending provider and consultant.

(3) The on-duty provider must respond to Emergency Department calls within 30 minutes. The consult must then be completed as soon as reasonably possible.

c. Delegation of consultation responsibilities. Medical Staff serving as GME/GDE supervisors may delegate consultation to a resident whom they have deemed competent to complete this process.

9. Self Prescribing/treating. Federal law, state law, and NMCS medical staff by-laws prohibit providers from prescribing any controlled substances (schedules 2, 2N, 3, 3N, 4, 5) to themselves and their family members under any circumstances. As a medical staff, we discourage our peers from prescribing any medications (except for OTC medications, as below) to themselves and their family members. Further, the American Medical Association (AMA) ethics guidelines, reference (s), state that providers should never prescribe medications to themselves and their family, except in emergencies. However, ECOMS recognizes that an emergency or unusual situation may arise and the Pharmacy Department has been authorized to dispense a single course of treatment (of non-controlled substances), not to exceed a 30 day supply, once in a 12-month period, when a provider prescribes to themselves and/or each of their family members. The pharmacy has been instructed by ECOMS not to dispense more than a single course of treatment. The pharmacy will monitor all self-prescribing behavior and report patterns to the provider's Department Head and ECOMS for action. This policy does not include "Over-the-Counter" medications. Additionally, providers are discouraged to enter specialty or sub-specialty consults for themselves, their family members, or friends. It is recommended that all care be sought and provided through routine assessment, diagnostic evaluation, and therapy as indicated.

10. Substance Abuse Services. See enclosure (3) of reference (a), paragraph 1f.

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11. Patient's Rights to Participate In and Direct Healthcare Decisions.

a. Advance Directives. All medical staff members are ethically obligated to provide competent patients and their surrogates the information needed to participate in making sound healthcare decisions. Reference (ee) provides guidance to medical staff members in facilitating this process.

b. Do Not Attempt Resuscitate Orders. Treatment decisions should be made using a shared decision making process to determine appropriate goals of care. For some patients, attempting resuscitation is not appropriate or is not consistent with the goals of care. In such circumstances, providers should write DNAR orders and complete the Resuscitation Care Plan note accordingly. Reference (gg) addresses this issue in detail and provides guidance for handling such cases.

c. Informed Consent. Surgery, anesthesia, and certain other specialized diagnostic and therapeutic procedures shall be performed only with the informed consent of the patient or their legal representative, except in emergencies. The circumstances requiring informed consent, the elements of proper informed consent and documentation requirements are contained within reference (r).

d. Patient Safety. Medical staff members will participate in Naval Medical Center San Diego's multidisciplinary effort to eliminate preventable medical errors and enhance patient safety. In addition, all medical staff will align their efforts in support of NMCSO Quality Healthcare and Patient Safety Initiatives as well as ensure participation of GME/GDE residents in these processes.

e. Medication Safety. Medical staff members will actively participate in Naval Medical Center San Diego's coordinated and multidisciplinary effort to reduce medication errors.

f. Universal Protocol. Medical staff members will actively participate in Naval Medical Center San Diego's coordinated and multidisciplinary effort to eliminate wrong-site, wrong-patient, wrong-procedure surgery. Reference (v) applies.

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12. Improving Communication Between Caregivers

a. Team STEPPS. Medical staff members will actively participate in Naval Medical Center San Diego's coordinated and multidisciplinary effort to improve the effectiveness of communication among caregivers. The Team STEPPS program presented at Command Orientation provides medical staff members with approved and standardized tools that foster improved "hand-off" communications.

b. Transitions of Care. Medical staff members are responsible for transitions of care that ensure patient safety and continuity of care. In cases where GME/GDE residents are participating and/or delegated responsibility for transitions of care, the supervising medical staff is responsible for ensuring an effective transition. GME/GDE medical staff faculty must be familiar with and abide by GMEC and residency program transitions of care policies.

c. Do Not Use Abbreviations. Inconsistencies in medical and dental abbreviations are a potential source of miscommunication among care givers and may result in adverse patient outcomes. The use of symbols and abbreviations in making entries in a patient's medical record is discouraged;

(1) Members of the medical staff will comply with the Navy Medicine "Do Not Use List." Reference (j) applies.

(2) Abbreviations, symbols, acronyms, and/or initials are not acceptable in the final diagnosis, on consent forms, or in any information given to patients/families (e.g., education materials).

(3) The use of prohibited abbreviations will be monitored and reported by the Medical Records Review Committee.

13. Disclosure. Members of the medical staff are expected to achieve complete, prompt, and truthful disclosure of information and counseling to patients, their families and/or legal guardians regarding situations in which a patient safety event occurs. Reference (dd) applies.

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14. Communicable Disease Reporting. Members of the medical staff will notify the Preventative Medicine Department of all reportable communicable diseases per reference (hh).

15. Administrative Responsibilities

a. Release of Medical Information. All medical staff members will respect a patient's right to privacy. Release of protected health information by medical staff members will be in compliance with the privacy rules of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191).

b. Information Systems. All medical staff members will become proficient in the use of the various information systems employed at Naval Medical Center San Diego. Department heads shall ensure that appropriate training is obtained for all medical staff members in their

(1) Outpatient EMR. AHLTA is the outpatient electronic medical record system for Naval Medical Center San Diego. To the maximum extent possible, patient encounters, laboratory/radiology orders, consultation requests, and prescriptions will be entered and documented via Outpatient EMR.

(2) Inpatient EMR. Essentris is the primary inpatient electronic medical record system. To the maximum extent possible, all inpatient admissions and ambulatory procedure visits will be documented via Inpatient EMR.

(3) The Composite Health Care System (CHCS) is the legacy clinical information system for Naval Medical Center San Diego. All medical staff members are expected to maintain proficiency with CHCS until such a time as it is replaced.

(4) PACS System is the web-based radiographic archiving system. Naval Medical Center San Diego uses Carestream in 2013. All providers are expected to be cognizant of the current PACS system and develop proficiency as necessary.

(5) Lighthouse/Enterprise workstation dictaphone. Lighthouse is the web-based dictation service used at Naval Medical Center San Diego. All providers are expected to become proficient in its use.

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(6) The document management system of our EMR is currently HAIMS (Healthcare Artifact and Imaging Management System). Large files of a variety of media are housed in this system including external referrals. All providers are expected to be proficient in its use for retrieval of documents associated with patient care.

(7) ECG Repository system houses ECGs, Treadmill Tests, and in future Holter monitors. The system is currently MUSE. All providers are expected to become proficient in its use as necessary.

(8) ARMD (Anesthesia Reporting Medical Device known as Innovian® Anesthesia) is the current documentation system for anesthesia care. Providers performing anesthesia are expected to document their care in this system. Uploading of this information into the inpatient EMR is expected until such a time that an interface is developed or the system is replaced.

(9) Eyeroute is used to organize ophthalmologic studies. Providers within this department are expected to be familiar with this system or its replacement for retrieving patient specific studies.

(10) MS Outlook E-mail. The Naval Medical Center San Diego computer network, to include MS Outlook, is the primary administrative information system by which official instructions, directives, and general correspondence are conveyed. All medical staff members are expected to become proficient in the use of MS Outlook.

(11) Naval Medical Center San Diego Sharepoint. The Naval Medical Center San Diego Sharepoint site is the primary repository of command administrative and clinical directives, instructions, and resources. All medical staff members are expected to be familiar with its contents.

16. Special Treatment Procedures. See enclosure (3) of reference (a), paragraph 1f.

a. Restraints

(1) Use of restraints in all areas of NMCS D must conform to the requirements of references (b) and (t).

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(2) Per reference (t), a patient in mechanical restraints must be closely supervised to assure that the restraint remains properly applied, that the patient has not harmed himself or herself and that the patient's needs for food, fluid and elimination are met. Close supervision is defined as every 15 minutes. A written record must be kept of these checks and maintained in the individual patient's medical record. Unless authorized by protocol, each episode of restraint must have a written order. PRN or STAT restraint orders are prohibited. Restraint orders can only be ordered by LIPs. Per reference (t), this includes residents but not interns.

b. Electroconvulsive and Other Forms of Convulsive Therapy

(1) Electroconvulsive Therapy (ECT) will be made available by the Mental Health Services Department to those adult patients for whom it is clinically indicated. No other forms of convulsive therapy will be provided.

(2) ECT will not be administered to children or adolescents at NMCS D.

(3) ECT will be provided in accordance with the "Protocol for Electroconvulsive Therapy" maintained in the Directorate of Mental Health.

c. Surgical Procedures. Except in emergencies, a surgical procedure may be performed only with the informed consent of the patient or his/her legal representative. The responsible surgeon must be a member of the medical staff and have privileges to perform the procedure. Major operative procedures must be approved by a medical staff member with privileges to perform the procedure. Departments establish policies concerning required attendance of privileged medical staff surgeons during surgery in accordance with reference (u). Surgeons must be in the operating room and ready to commence an operation at the time surgery is scheduled. There must be a sufficient number of qualified personnel available for each surgical procedure. Prior to any surgery performed at NMCS D which is based on a diagnosis from material obtained at an outside institution, there should be a formal request for review of that material by this institution's pathology department. All specimens removed at surgery, unless specifically exempted by the Operative and

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Invasive Procedures Committee, must be sent to the Laboratory Department. A pathologist performs the appropriate examinations needed to arrive at a pathologic diagnosis. The medical staff operating surgeon or a designated member of the surgical team must dictate or enter an operative report in Essentris EMR, a full description of the operation immediately or as soon as possible after completion of surgery. A member of the surgical team must also enter a brief operation report in the clinical record (electronic or paper) before exiting the operating/procedure room or, if escorting the patient, before leaving that care area. At a minimum, this note must contain the patient's pertinent diagnoses, operation(s) performed, names of the primary surgeon and assistants, type of anesthesia, specimen(s) removed, findings, complications (if any), estimated blood loss and fluid replacement. The responsible surgeon must be designated by name in the operative note even if his participation in the case was in a supervisory role. All staff members performing procedures that qualify as more than minimally invasive shall follow the command's universal protocol, reference (w), regardless of procedural setting.

d. Pathologic Examination. Tissue, orthopedic hardware and/or foreign objects removed during surgery shall be sent to the Naval Medical Center San Diego laboratory. Pathologic examination will be completed by a privileged pathologist. The final report shall state the diagnosis and be signed by the privileged pathologist.

e. Procedural Sedation. Standards, definitions, oversight responsibility, and training requirements relating to the conduct of sedation in an ambulatory setting are delineated in reference (w). Command-wide criteria for patient assessment, equipment, monitoring, training, and patient discharge have been established for each level of sedation. Responsibility for the proper conduct of sedation and the training of personnel is under the purview of the respective Department Heads. Oversight for sedation within NMCS D rests with ECOMS and monitoring by the Chair of the Operative Invasive Procedure Committee and consultation from the Department Head, or appropriate representative, of the Anesthesiology Department.

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17. Important Functions. The Medical Staff provides leadership for the process measurement, assessment, and improvement of the following functions.

a. Operative, Other Invasive and Non-invasive Procedures. The measurement, assessment, and improvement of operative, other invasive and non invasive procedures are performed in a multidisciplinary and collaborative manner via the Invasive Procedure, Tissue and Transfusion Committee.

b. Medication Use. The measurement, assessment, and improvement of medication use are performed in a multidisciplinary and collaborative manner via the Pharmacy and Therapeutics Committee.

c. Blood and Blood Component Use. Refer to Charter of BURC (Tab 7).

d. Medical Record Review. The measurement, assessment, and improvement of medical record documentation are performed in a multidisciplinary and collaborative manner via the Medical Records Review Committee. (Tab 5)

18. General Medical Record Requirements. A medical record must be initiated and maintained for each individual assessed or treated in all areas of NMCS D including inpatient, emergency department and ambulatory care. References (l) and (k) apply.

19. Postmortem Examinations. Members of the medical staff are encouraged to secure autopsies when appropriate. Indications and procedures for obtaining consent to perform an autopsy are outlined in reference (ii).

20. Conduct of Clinical Investigations. Per reference (x) clinical research projects must be performed in compliance with Federal, Department of Defense (DOD), Secretary of the Navy (SECNAV), BUMED- Department of the Navy Human Research Protection Program, and NMCS D instructions. Guidance is provided by the following: Clinical Investigation Department, especially the Scientific Director, Institutional Review Board Administrators, and Statistician; Chairman, Committee for the Protection of Human Subjects; Department Heads, Training Program Directors, and NMCS D Directors. Human subject research

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protocols must comply with current directives, and receive approval from Head, Clinical Investigation Department and Chairman, Institutional Review Board (IRB) and cannot be initiated until final approval signature from Commander, NMCS D. Authors and presenter's of scholarly material must refer to "Request for clearance of authored works prepared for publication or presentation" for proper clearance of their work via the Chain of Command to the NMCS D Director level and then CID with final decision from the Public Affairs Officer.

21. Access, Custody and Handling of Medical and Dental Records

a. All health records (medical and dental), both inpatient and outpatient, are the property of the United States Government. No member of the medical staff or other person(s) to whom this instruction applies has the authority to release a medical record to a patient, his representative, or anyone other than the Medical Records Office or, for dental records, the Head, Dental Department. A medical staff member or other person to whom this instruction applies does not have the authority to retain the medical record of any patient treated at this Medical Center for longer than is necessary to complete record entries or review. Per reference (1), inpatient records must be returned to the Medical Records Division, Patient Administration Department, within five days of record check-out. Outpatient records must be prepared for return to the Outpatient Medical Records Division, Patient Administration Department or, for dental records, to the Dental Department at the time the physician or dentist completes recording his/her entries into the record. No inpatient medical record will be filed until it is complete, except on the recommendation of the Chairman, Medical Records Review Committee, with documentation in the committee minutes. Inpatient medical records are delinquent if they remain incomplete 30 days after the date of discharge. Department Heads are encouraged to implement a progressive plan of discipline to withhold leave, TAD, or off-duty civilian employment in the event of non-compliance to timely charting of inpatient and outpatient records. ECOMS and medical staff agree that timely signage of all medical charting (72 hours for AHLTA notes, 24 hours for inpatient admission, and within 30 days of admission for the entire ESSENTRIS chart, i.e.: daily progress

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notes and discharge summary) is a medical-legal responsibility commensurate with proper delivery of medical care and keeping in good standing.

b. Access to medical (and dental) records of patients will be afforded to medical staff members for bona fide study and research. This access must preserve confidentiality of personal information, must comply with the Privacy Act, and must comply with all directives under Health Insurance Portability and Accountability Act (HIPAA).

c. Records may not be removed or released without permission of the Head, Patient Administration Department per the Manual of the Medical Department and the Manual of the Judge Advocate General. In case of readmission of a patient, all previous records will be available for review by the medical staff.

22. Pain Assessment and Management. Per references (b) and (y) all patients have a right to appropriate assessment and management of pain. Patients are screened upon initial presentation for direct care in primary, specialty or inpatient settings. Pain assessment is completed upon admission to the hospital, after all operative or invasive procedures, periodically and routinely after procedures associated with pain, and after any significant change in the patient's condition. Pain intensity will be documented in the patient's record routinely as the "fifth vital sign."

23. Autopsy. Consent for autopsy is obtained from the primary next of kin and documented using Authorization for Autopsy (SF 523). All autopsies are performed by a pathologist, who is designated by existing instructions, and/or state law. A preliminary, usually handwritten, report is forwarded within 24 hours to Decedent Affairs, where the provider signs the death certificate. This report is entered into the medical record within three days. The completed, transcribed report is placed in the medical record within 60 days. Utilizing the criteria established by the College of American Pathologists, autopsy is recommended when:

a. It may help explain unknown or unanticipated medical complications to the attending physician;

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- b. The cause of death is not known with reasonable certainty based on clinical grounds;
- c. An autopsy may help to allay concerns of the family regarding the death, and to provide reassurance to them regarding the same;
- d. The deceased has participated in an approved clinical investigation study for a therapy or condition reasonably proximate to his/her death;
- e. A natural death that is subject to a forensic medical jurisdiction;
- f. Death results from high-risk infection or contagious disease;
- g. Death occurs in an obstetric patient;
- h. It is believed that an autopsy would disclose a known or suspected illness that may have a bearing on survivors or recipients of transplant organs;
- i. Death is known or suspected to have resulted from an environmental or occupational hazard.
- j. All unexpected perinatal, neonatal and pediatric deaths;
- k. Unexpected or unexplained death occurring during or following any medical, dental or surgical diagnostic procedures and/or therapies; and
- l. Unexpected or unexplained deaths which are apparently natural and not subject to a forensic medical jurisdiction.

24. Death Certificates. Patient Administration and the Command forensic pathologist monitor all death certificates. The responsible active medical staff member or the Graduate Medical Education Senior House Staff Officer (PGY-2 licensed physician or higher) responsible for the patient at the time of death must sign the death certificate.

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25. Process Improvement Functions. Review and Amendment

a. The ECOMS is delegated the responsibility to review this instruction as necessary and revise policies and procedures as indicated. Revisions will be made to reflect current practices with respect to medical staff organization and function as well as comply with all applicable laws and regulations. Recommended changes will be communicated to the medical staff prior to submission to the CO for approval.

b. If the voting members of the medical staff propose to adopt a rule, regulation, or policy, or an amendment thereto, they must first communicate the proposal to the ECOMS.

c. In cases of a documented need for an urgent amendment to policies and procedures necessary to comply with law or regulation, the ECOMS is delegated the responsibility to make necessary provisional amendments with the approval of the CO without prior notification of the medical staff. In such cases the medical staff will be notified immediately by the ECOMS. The medical staff will have the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the medical staff and the ECOMS, the provisional amendment stands. If there is conflict over the provisional amendment, the process for resolving conflict between the medical staff and the ECOMS is implemented.

d. Neither the ECOMS nor the CO may unilaterally modify these policies and procedures. The medical staff will be notified of any significant changes.

e. NMCS medical staff policies and procedures will be reviewed annually on its anniversary date. Revisions of the policies and procedures must reflect current practice and will assure compliance with references (a) through (jj) and with current directives of higher authority.