DEPARTMENT OF THE ARMY
WOMACK ARMY MEDICAL CENTER
FORT BRAGG, NC 28310

GRADUATE MEDICAL EDUCATION COMMITTEE
STANDARD OPERATING POLICY AND PROCEDURE

MXCX-DME-GME 26 July 2015

SUBJECT: MEDICAL STAFF SUMMARY FOR HEALTH CARE STUDENTS AND RESIDENTS

1. PURPOSE. To provide an executive summary of crucial patient safety and care documentation information for all caregivers at WAMC.

2. POLICY.

a. Students and residents must understand and comply with this information. Students and residents should be familiar with the attached medical staff bylaws and the scope of practice documents for their training programs and their areas to which they will be rotating.

b. All hospital staff, patients, and visitors will be treated with dignity, respect, and courtesy. All competent, adult patients have a moral and legal right to participate in their medical care and to refuse medical treatment, even in life-saving or life-sustaining situations. All patients have the right to appropriate assessment and management of pain.

c. All students and residents will abide by the Health Insurance Portability and Accountability Act (HIPAA) and other privacy training to protect the security of patients, staff, and the institution. Personal protected information will only be accessed on an as needed basis and only with proper authorization.

d. All students and residents at WAMC must be familiar with basic patient safety initiatives that mirror the current National Patient Safety Goals.

(1) Patient Identification: Use at least 2 patient identifiers (full name and date of birth) whenever collecting laboratory samples or administering medications or blood products, and use two identifiers to label sample collection containers in the presence of the patient.

(2) Communication Between Caregivers: The patient name, location, provider name and contact/pager number, date/time of specimen collection and culture location (if appropriate) must be legible entries on all laboratory requests.

- If any provider receives critical lab or radiology test results, the person receiving the test result must verify by "read back" those results.

- The following abbreviations must NEVER be used in ANY form of documentation: U, IU, QD, QOD, SQ, MS04, MgS04.

- When writing numbers with decimal places, always use leading zeros (i.e. 0.4) and NEVER use trailing zeros (i.e. 4.0).

(3) Medication Safety: Be very cautious with sound alike, look alike medications.

(4) Patient Care Transfer: Make a good hand-off when transferring care of a patient. Take time to ask questions. Know key information such as DNR status, labs/rads/consults due, major events that will be occurring soon, likely problems that would be encountered.

(5) Reduction of Infections: Comply with current CDC hand hygiene guidelines. MANDATORY use of approved hand cleansers on all wards between patient contacts, before and after gloving, whenever hands are soiled, and before and after eating.

(6) Reconciliation of Medications through the Continuum of Care: Complete medication lists are expected on history and physical (H&P) documents, transfer summaries, and discharge paperwork. Each medication must list an indication. Patients should go home with a new list if any changes are made.

(7) Prevention of Falls: Identify patients potentially at increased fall risk and communicate that to the entire healthcare team.

e. All students and residents must use OSHA approved safety devices.

f. Under no circumstance will restraint orders be written as "PRN," "continuous" or "as needed." Such orders are never authorized for restraints of any type.

g. Wrong site, wrong procedure, and wrong patient errors can be prevented by using a three-pronged approach—using a pre-procedure verification process, marking the procedure site, and conducting a final pre-procedural "time out."

h. Advanced Directive/DNR (Abatement) Orders must include written documentation of the rationale for the abatement order in the progress notes by the attending staff physician or PGY-2 or higher level GME physician.

(1) GME physicians must document discussion with and agreement by a specific staff physician.

(2) A staff physician must countersign the progress note (with date/time) within 24 hours.

(3) The note must show the patient's decision-making capacity and concurrence of the patient.

(4) Only privileged staff physicians may write an abatement order. Physicians in GME status, at least PGY-2 level or higher, may transcribe a verbal abatement order from a privileged staff physician (e.g. "DNR per Dr John Doe", then stamped/signed/dated/timed by the GME physician).

(5) No other staff (e.g. nurses) may take a verbal abatement order.

(6) Admission notes at the time of initial evaluation must acknowledge and confirm the patient's wishes if it has been annotated that the patient has advanced directives. If the patient does not have advanced directives, a frank discussion of contingency plans in the event of an adverse outcome must be discussed with the patient, family, or surrogate and be documented in the chart.

i. Consents. The provider performing procedures or treatments has the responsibility for informing the patient and for obtaining consent. The consent will include as a minimum:

(1) The alternatives/options to the procedure, procedure risks and benefits.

(2) A statement that all patient questions were answered.

(3) Signatures and date and time prior to performance of the procedure.

j. Consultations.

(1) On call providers must be available by telephone or pager or in person within 10 minutes.

(2) "STAT" or "ASAP" consults must be made by direct provider to provider communication.

(3) When evaluating a patient in the Emergency Department (ED), as soon as it is clear than an admission is appropriate and a suitable ward and admitting service are chosen, admission orders must be written and given to the ED nurses immediately.

(4) The H&P and diagnostic tests that will not change disposition can wait be done while the patient is on the ward.

(5) If the time from consultation to the time orders are written is expected to be > 90 minutes, then back up staff must be called in to facilitate more rapid ED clearance.

k. Documentation.

(1) Notes written by providers in training must include the Post Graduate Year (PGY) status on all documentation.

(2) If hand written documentation must be utilized due to failure mode of electronic record systems, it must be legible with date and time, signature with name stamp or legibly printed name and rank.

(3) H&Ps and progress notes must be in Essentris.

- If PA, PGY-1 physician, PGY-1 oral/maxillofacial surgeon, or student completes the H&P, all sections must be countersigned within 24 hours and before any surgical procedure.

- Trainees will use the long form for all admissions and ensure that a complete evaluation is performed. This includes a detailed HPI, past medical, surgical, social, and family history as well as pertinent occupational or military history, allergies, detailed examination, differential diagnosis, assessment, and plan.

(4) There must be a progress note every day, even on the day of discharge. The discharge note and summary meets this requirement.

- Pain: daily progress notes must include assessment of pain level and plan to mitigate and relieve the pain if present. The follow-up note should document that the treatment used to relieve the pain was successful or that another modality is being used. The discharge planning interdisciplinary plan of care form should be updated regularly.

- The problem-oriented medical record approach utilizing SOAP (Subjective, Objective, Assessment, and Plan) format is the preferred format, although systems review and organization may be used, as well.

- The preceptor or the preceptor's representative will countersign notes made by students. All notes made by any trainee will include documentation of the level of staff involvement for every encounter (i.e. either 'seen with Dr. X' or 'discussed with Dr. X').

(5) Medical orders written for patient care should be signed by the provider issuing the order before the instructions are executed.

- Orders written on inpatients will include the indication for each medication, unless the indication for the medication is noted in the H&P or progress notes. PRN medication orders must have an indication stated.

(6) Discharge summaries must accurately reflect the admission and discharge diagnoses, the summary of hospital care, pertinent diagnostic studies and consultations,

and any information necessary to facilitate effective hand off or transition to the next site of care.

(7) Final diagnoses, complications, and operative procedures are recorded without use of abbreviations or symbols on the inpatient treatment record discharge cover sheet.

John J. Lammie, MD
COL, MC
Director of Medical Education