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CORE COMPETENCIES

- Residents will be regularly evaluated on the following **six** competencies, eventually achieving the expected level of a new practitioner. Adapted from the website of the Accreditation Council for Graduate Medical Education 2010.

- *"Achievement of satisfactory performance levels for all **six** competencies will be necessary for successful completion of the program".*

Core Competencies

- **1. <u>Competency in Patient Care</u>**
  - Will be evaluated using a combination of direct observation of the resident during patient care - both as a primary physician (i.e. at public hospitals) and as an assisting physician (i.e. at private hospitals)
    - the clinical outcomes of the patients under the resident's care
    - the resident's patient presentations to faculty and/or senior residents
    - direct observation during bedside rounds
    - direct observation during morning report presentations.
  - Surgical skill is an important aspect of patient care, and this is already evaluated as part of the regular quarterly evaluations. In addition, evaluations and reports from the responsible faculty members for each rotation will be reviewed and compiled.
  - Residents are expected to increasingly function as independent practitioners, and demonstrate increasing responsibility, skill, and maturity in caring for their patients.

Core Competencies

- **2. <u>Competency in Medical Knowledge</u>**
  - Will be evaluated using a combination of their annual examination scores, direct observation during patient care, and the results of direct questioning during clinical care and teaching experiences (such as case presentations or discussions at teaching conferences).
  - The resident's knowledge base will be directly evaluated during their patient presentations to faculty and to senior residents during routine clinical care as well as during morning report presentations.
  - Evaluation of competency in the cognate sciences (i.e. epidemiological and social-behavioral sciences) will be primarily evaluated during directed discussion in such forums as journal clubs, teaching and research conferences, or in patient-specific discussions as appropriate.

Core Competencies

- **3. <u>Competency in Practice-Based Learning and Improvement</u>**
  - Will be assessed by direct observation of improvement in the resident's clinical care as patient experience, knowledge and feedback grow, and through observation of improvements in surgical technique with repeated performance of procedures.
  - In addition, the use of evidence-based medicine, evaluation of available evidence, and use of best-available evidence is stressed at the morning report meeting and during routine clinical care, and the resident's performance in this area can be directly evaluated in that setting.

Core Competencies

- **4. <u>Competency in Interpersonal and Communication Skills</u>**
  - Will be assessed using direct observation of the resident during communications with other residents, with attending physicians, with physicians from other services, with non-physician clinical staff, with non-physician non-clinical staff, and with patients and their families.
  - These competencies in communication with physicians and non-physicians are already addressed on the existing evaluation form. Reporting back through the resident's mentor or advisor will serve as another mechanism for assessing competency in interpersonal and communication skills.

Core Competencies

- **5. <u>Competency in Professionalism</u>**
  - Will be assessed by direct observation of the resident's responsibility in carrying out their professional duties - including continuity of care, responsiveness to changes in clinical situations, overall responsiveness and availability, and self-sacrifice, and the following of ethical principles in their dealings with patients, their families, and other physicians and health care workers.
  - The resident's sensitivity to different patient populations will be evaluated by direct observation and comparison of the professionalism and responsibility demonstrated when caring for patients of different ethnic and economic backgrounds that are treated in the different hospitals they rotate through.

Core Competencies

- **6. <u>Competency in Systems-Based Practice</u>**
  - Will be assessed by direct observation of the resident's use of the entire health care system in caring for their patients, as well as their teamwork within the system.
  - This will be addressed using both the regular evaluations, as well as through direct observation at the morning report meeting and during clinical care, as well as during discussions at clinical care conferences.

ACGME WORK HOURS REGULATION

Effective July 1, 2011

- Duty hours must be limited to ***80 hours*** per week, ***averaged over a four-week period***, inclusive of all in-house call activities and all moonlighting.
- For further up to date reference, see
  - http://www.acgme.org/acWebsite/home/home.asp

Mandatory Time Free of Duty

- Residents/fellows must be scheduled for a minimum of 1 day free of duty every week. This is ***averaged over a 4-week period***, inclusive of call. At home call cannot be assigned on these “free” days.
- Moonlighting cannot interfere with achieving goals/objectives of the program, and hours count against the 80 hour week.
- PGY-1 residents are NOT allowed to moonlight

Maximum Duty Period Length

- PGY-1 residents must not exceed 16 hours in duration of duty period.
- PGY-2 residents and above may be scheduled up to a maximum of 24 hours of continuous duty in the hospital. Strategic napping after 16 hours of continuous duty and between 2200 and 0800 is strongly suggested.
- Residents must not be assigned additional clinical duties after 24 hours of continuous in-house duty.
- Effective transitions of patient care must occur, and residents may remain on site to do this. This must not exceed an additional 4 hours.

Minimum Time Between Duty

- PGY-1 residents must have 8 hours, and should have 10 hours, free of duty between scheduled duty periods.
- Intermediate level residents, as defined by Review Committee, same as PGY-1 *but* must have 14 hours free after a 24 hour in-house.
- "Chief" residents must be prepared to enter the unsupervised practice of medicine over irregular or extended periods.
- Must still adhere to 80 hour/1 day off in 7 standard, but…
- There may be times when patient care may affect the 8 hours minimum off between duties
- These circumstances must be monitored by the program director.

In-House Night Float

- Residents must not be scheduled for more than 6 consecutive nights of night float.
- The maximum number of consecutive night float weeks, and number of months of night float may be further specified by the Review Committee

Call Frequency

- PGY-2 residents and above must be scheduled for in-house call no more than every 3rd night, averaged over a 4 week period
- At-home call counts towards the 80 hour time limit, but not the every 3rd night limit.
- Must maintain the 1 day in 7 duty free time
- Must not be so taxing as to preclude rest or reasonable personal time.

Work Hours

- If you noted any issues with duty hours, who would you tell about the problem?
  - Program director
  - Residency/fellowship staff
  - GME office
- If feel that you can’t talk to anyone on your service, who would go to with a problem?
  - Any staff mentor, or one you feel close to
  - GME office
  - Chaplain or family support
- Continued……

Work Hours

- If the measures in the previous slide fail to resolve your issue(s), there are a couple of more options:
- First, you may contact NCC Executive Director, CAPT Jerri Curtis, MC, USN directly
- The next alternate mechanism is to contact the NCC Trainee Ombudsman, a neutral third party skilled in assisting trainees with resolving issues or problems and recommending appropriate resources. This individual is not in the military chain of command or associated with any particular training program. To set up an appointment the NCC Trainee Ombudsman can be reached at (301) 319-0709 Monday through Friday, 0700 - 1530.
- The third option is to utilize our new electronic reporting system called the NCC Trainee Helpline which allows reporting via computer or telephone.
- For more details, cut and paste the following link : http://www.usuhs.edu/gme/reportingviolations.html

Resident Supervision

- ACGME rules require **all** housestaff to have staff supervision of some sort while they are on-duty (seeing patients)
- This does not mean the staff is with every resident or intern at all times when they are seeing patients
- Each program/fellowship has business rules outlining how their trainees are to be supervised, depending on their year group and stage of training (see ACGME website for requirements)
- Please make sure you know who your responsible staff is each time you are seeing patients
- If asked “Who is your supervising staff?”, be sure you can answer correctly by name, and where they are located
- It should work both ways, the staff should be in contact with you as well. Let your program director know if there’s an issue

Resident Supervision

- ACGME has proposed an extensive revision of the 2003 standards in resident supervision for 2011
- 2003: “The program must ensure that qualified faculty provide appropriate supervision of residents in patient care activities.”
- 2011 has proposed adding:
  - Residents and attendings should inform patients of their role in the patient’s care
  - Faculty functioning as supervising physicians should delegate portions of that care to resident physicians
  - Senior residents or fellows should serve in a supervisory role of junior residents

Resident Supervision- cont'd

- The privilege of progressive responsibility in patient care delegated to each resident must be assigned by the program director and faculty
- The **resident** is responsible for knowing the limits of his/her scope of authority
- Programs must set guidelines for circumstances and events where residents must communicate with appropriate supervising physicians
- Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of the resident and delegate the appropriate level of patient care authority and responsibility.
- In particular, during the PGY 1 year, residents must have supervision level 1 or 2a (see below)

Resident Supervision- cont'd

- Three Levels of Supervision- In the development and description of systems to oversee resident supervision and graded authority and responsibility, each program must use the following classification of supervision.
  - Direct Supervision —The supervising physician is physically present with the resident and patient (level 1)
  - Indirect Supervision: (level 2)
    - Direct supervision immediately available – The supervising physician is physically within the confines of the site of patient care, and immediately available to provide Direct Supervision (a)
    - Direct supervision available – The supervising physician is not physically present within the confines of the site of patient care, is immediately available via phone, and is available to provide Direct Supervision(b)
  - Oversight-The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered(level 3).

Advancing Education in **MEDICAL PROFESSIONALISM**

An ***Educational Resource***

from the

ACGME
Outcome Project

Professionalism

- Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.
- Residents are expected to:

  -demonstrate respect, compassion, and integrity; a responsiveness to the needs of patients and society that supersedes self -interest; accountability to patients, society, and the profession; and a commitment to excellence and on-going professional development.

  -demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices.

  - demonstrate sensitivity and responsiveness to patients' culture, age, gender, and disabilities (ACGME, 1999)

Professionalism

- Professionalism is based on the principles of primacy of patient welfare, patient autonomy, and social justice. It involves the following professional responsibilities:
  - competence,
  - honesty,
  - patient confidentiality,
  - appropriate relations with patients,
  - improving quality of care,
  - improving access to care,
  - just distribution of finite resources,
  - commitment to scientific knowledge,
- Maintaining trust by managing conflicts of interest, commitment to professional responsibilities
- (ABIMF, ACP-ASIM, & EFIM, 2002).

Professionalism

How does professionalism affect the patient-physician relationship?

- Professionalism is related to patient satisfaction. Patients are more likely to be satisfied with physicians who behave professionally.[1,2]
- Patients are more likely to follow through with treatment recommendations when they trust their physician (trust is a component of professionalism).[1,2]
- Patients say they are more likely to stay with physicians they perceive as behaving professionally and are likely to recommend these physicians to others.[1]
- Most patient complaints about physicians involve physicians' unprofessional behavior.[3]
- Patients are more likely to bring legal action against physicians they perceive as behaving unprofessionally than other physicians.[3]
- Evidence suggests a relationship between physician excellence and professionalism.[4]

Professionalism

Regarding resident professionalism, what should I look for?

Consider important expectations for the medical profession and your specialty. For example, is the resident thorough and careful in completing patient care tasks? Does the resident know the limits of his or her abilities and ask for help when appropriate? Is the resident willing to help or fill-in for others? Is the resident respectful in his or her interactions with colleagues and other health care professionals?

Professionalism

- **References:**

- 1. Hall MA, Zheng B, Dugan E, Camacho F, Kidd KE, Mishra A, et al. Measuring patients; trust in their primary care providers. Med Care Res Review 2002; 59:293-318.
- 2. Hauck FR, Zyzanski SJ, Alemagno SA, Medalie JH. Patient perceptions of humanism in physicians: effects on positive health behaviors. Fam Med 1990;22:447-52.
- 3. Hickson GB, Federspiel CF, Pichert JW, et al. Patient complaints and malpractice risk. JAMA 2002;287:2951
- 4. Baldwin DC, Bunch WH. Moral reasoning, professionalism, and the teaching of ethics to orthopedic surgeons. Clin Orthop 2000;378:97-103.

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Social Media Policy

- The US Government recently allowed users on government computers access to a variety of social networking sites, such as Facebook, Twitter, etc.
- The intent is to recognize the current trends in communication, especially amongst more junior members.
- It is a reflection of the times and how business is conducted in the world today.
- These social media sites may be used for communicating official news or business, but there are rules and requirements.
- The following are some guidelines for postings culled from a variety of medical/DoD policies

Social Media Guidelines

- These are NOT meant to be inclusive, for reference I have included links to the formal messages.
- Remember to always observe OPSEC!
- Remember to always observe HIPAA!
- “Friending” your patients is discouraged.
- Use your personal e-mail for unofficial business.
- Make sure you distinguish personal and official communications on-line, a disclaimer if need be.
- If you are on-line for personal communications, try to use the “first person” when writing or blogging.
- Avoid copyright or trademark infringements as best you can

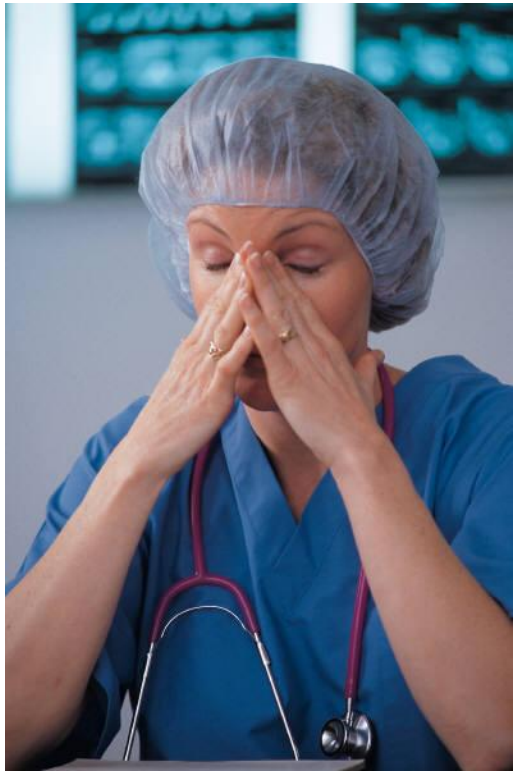
Social Media Guidelines

- Admit your mistakes professionally, and politely correct errors on-line. Don’t get into arguments or prolong disagreements.
- You are still a military officer, remember your professional and military bearing and duties at all times, even if it’s a totally personal on-line communication.
- Protect you and your family! There are many ways to link your postings and you to the military, and you can be sure there are predators or unfriendlies that may find you.
- Remember that many official agencies are screening the internet(FBI,CIA, Homeland Security) for improprieties, and anything on-line may come back to haunt you.

Social Media Guidelines

- The following are some links to the official US Navy and DoD guidance.
- You may find these social sites “turned off” periodically to preserve bandwidth.
- Information Technology departments have the ability to track use of these sites when on the government network.
- DoD Memorandum (Army uses for now too)
  - http://www.defense.gov/NEWS/DTM%2009-026.pdf
- US Navy guidance
  - http://www.governmentcontractslawblog.com/uploads/file/Navy%20Command%20Social%20Media%20Handbook.pdf

SLEEP DEPRIVATION



American Academy of Sleep Medicine

Learning Objectives

1. List factors that put you at risk for sleepiness and fatigue.
2. Describe the impact of sleep loss on residents' personal and professional lives.
3. Recognize signs of sleepiness and fatigue in yourself and others.
4. Challenge common misconceptions among physicians about sleep and sleep loss.
5. Adapt alertness management tools and strategies for yourself and your program.

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The problem of sleepiness and fatigue in residency is underestimated.

- **Physicians know relatively little about sleep needs and sleep physiology.**
- **There is no "drug test" for sleepiness.**
- **Most programs do not recognize and address the problem of resident sleepiness.**
- **The culture of medicine says:**
  - **"Sleep is "optional" (and you're a wimp if you need it)"**
  - **"Less sleep = more dedicated doc"**

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Myth: "It's the really boring noon conferences that put me to sleep."

Fact: Environmental factors (passive learning situation, room temperature, low light level, etc) may unmask but **DO NOT CAUSE SLEEPINESS.**

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Sleep Needed vs Sleep Obtained

- **Myth:** "I'm one of those people who only need 5 hours of sleep, so none of this applies to me."
- **Fact:** Individuals may vary somewhat in their tolerance to the effects of sleep loss, but are not able to accurately judge this themselves.
- **Fact:** Human beings need 8 hours of sleep to perform at an optimal level.
- **Fact:** **Getting less than 8 hours of sleep starts to create a "sleep debt" which must be paid off.**

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The Circadian Clock Impacts You

- It is easier to stay up later than to try to fall asleep earlier.
- It is easier to adapt to shifts in forward (clockwise) direction (day → evening → night).
- Night owls may find it easier to adapt to night shifts.

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- Surgery: 20% more errors and 14% more time required to perform simulated laparoscopy post-call (two studies) Taffinder et al, 1998; Grantcharov et al, 2001
- Internal Medicine: efficiency and accuracy of ECG interpretation impaired in sleep-deprived interns Lingenfelser et al, 1994
- Pediatrics: time required to place an intra-arterial line increased significantly in sleep-deprived Storer et al, 1989

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Sleep Loss and Fatigue: Safety Issues

- 58% of emergency medicine residents reported near-crashes driving.
  - -- 80% post night-shift
  - -- Increased with number of night shifts/month

Steele et al 1999

- 50% greater risk of blood-borne pathogen exposure incidents (needle stick, laceration, etc) in residents between 10pm and 6am. Parks 2000

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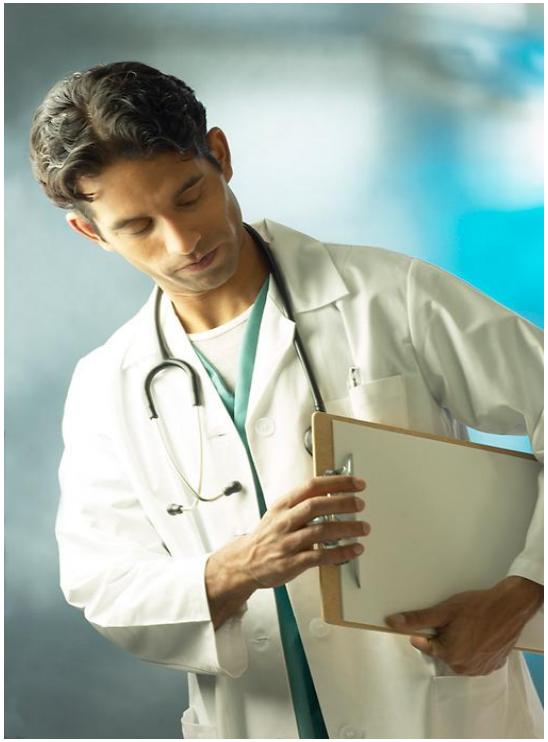

- **Myth:** "If I can just get through the night (on call), I'm fine in the morning."
- **Fact:** A decline in performance starts after about 15-16 hours of continued wakefulness.
- **Fact:** The period of lowest alertness after being up all night is between 6am and 11am (e.g., morning rounds).

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Drive Smart; Drive Safe

- AVOID driving if drowsy.
- If you are really sleepy, get a ride home, take a taxi, or use public transportation.
- Take a 20 minute nap and/or drink a cup of coffee before going home post-call.
- Stop driving if you notice the warning signs of sleepiness.
- Pull off the road at a safe place, take a short nap.

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Adapting To Night Shifts

- **Myth:** "I get used to night shifts right away; no problem."
- **Fact:** It takes at least a week for circadian rhythms and sleep patterns to adjust.
- **Fact:** Adjustment often includes physical and mental symptoms (think jet lag).
- **Fact:** Direction of shift rotation affects adaptation (forward/clockwise easier to adapt).

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In Summary…

- Fatigue is an impairment like alcohol or drugs.
- Drowsiness, sleepiness, and fatigue cannot be eliminated in residency, but can be managed.
- Recognition of sleepiness and fatigue and use of alertness management strategies are simple ways to help combat sleepiness in residency.
- When sleepiness interferes with your performance or health, talk to your supervisors and program director.

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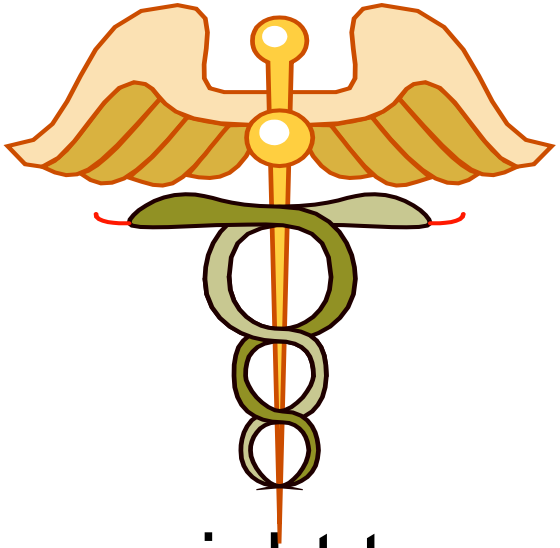

“Patients have a right to expect a healthy, alert, responsible, and responsive physician.”

January 1994 statement by American College of Surgeons

Re-approved and re-issued June 2002

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STRESS AND BURN-OUT

Burnout Self-Check

© Mind Tools Corporation 2003 - this may be used and copied freely only by registered users of the Mind Tools Stress Management Course

Instructions: For each question, put an 'X' in the column that most applies. Put one 'X' only in each row.
When you have answered all questions, you will be scored automatically (see the bottom of the page).

	Question	Not At All	Rarely	Some times	Often	Very Often
1	Do you feel run down and drained of physical or emotional energy?					
2	Do you find that you are prone to negative thinking about your job?					
3	Do you find that you are harder and less sympathetic with people than perhaps they deserve?					
4	Do you find yourself getting easily irritated by small problems, or by your co-workers and team?					
5	Do you feel misunderstood or unappreciated by your co-workers?					
6	Do you feel that you have no-one to talk to?					
7	Do you feel that you are achieving less than you should?					
8	Do you feel under an unpleasant level of pressure to succeed?					
9	Do you feel that you are not getting what you want out of your job?					
10	Do you feel that you are in the wrong organization or the wrong profession?					
11	Are you becoming frustrated with parts of your job?					
12	Do you feel that organizational politics or bureaucracy frustrate your ability to do a good job?					
13	Do you feel that there is more work to do than you practically have the ability to do?					
14	Do you feel that you do not have time to do many of the things that are important to doing a good quality job?					
15	Do you find that you do not have time to plan as much as you would like to?					
		0	0	0	0	0

Scoring:

0 No valid interpretation: You have entered too few or too many Xs!

Working:

Answer	Number	Weight	Weighted Total
Not at all:	0	0	0
Rarely	0	1	0
Sometimes	0	2	0
Often	0	3	0
Very Often	0	4	0
	0		**0**

>=	
-1	No sign of burnout here!
5	Little sign of burnout here, unless some factors are particularly severe
18	Be careful - you may be at risk of burnout, particularly if several scores are high
35	You are at severe risk of burnout - do something about this urgently
45	You are at very severe risk of burnout - do something about this urgently

Stress and Burn-out

- If you score more than 33 on the self-assessment and think you might be getting burned out, what would you do?
- What would you do if you thought one of your colleagues was getting burned out?
- If you didn’t think you could talk to anyone in your chain of command about a problem, what would you do?

Resignation

- What do you do if you feel you made the wrong decision about your program?
  - Talk to your mentor/faculty advisor
  - Talk to another trusted staff member in your program
  - Come talk with the GME staff
- Other resources include
  - Chaplain office or counseling center
  - Mental health referral or Social Work
- You have lots of options to discuss and consider before you make another decision!
- If resigning or changing programs is your final choice, the staff at GME can help you with the process.

WRNMMCB **Patient Safety** Program

- Supports the WRNMMCB mission to provide world class healthcare by creating and sustaining a culture of patient safety
- Activities are guided by the Department of Defense Quality Assurance Instruction and are protected by 10 USC 1102
- Supports patient event and medication error reporting of near misses and actual events
- Reviews and utilizes patient safety event and medication error data to influence processes and systems improvements
- Monitors compliance with the Joint Commission's National Patient Safety Goals
- Performs prospective and retrospective clinical reviews
- Serves as liaison with the Joint Commission and Bureau of Medicine and Surgery on Patient Safety issues
- *NEW* Intranet Patient Safety Reporting (PSR) system access on the Intranet Homepage
- It is NOT punitive or to assign blame! PSR can be anonymous.

PS Office is located in the Tower, Bldg 1, South Wing 2nd Deck Room #2437;

Suzie Farley, Patient Safety Manager, 301-295-6236

Patient Safety and Medication Error Reporting

- **Why report?**
  - Identify real and potential risks
  - Identify the broken processes and/systems
  - Develop & implement strategies to reduce or eliminate risk
  - Integrated throughout all levels of the organization
  - Trending events and respond proactively
  - Standardize processes across command
  - Protect patients from preventable medical errors

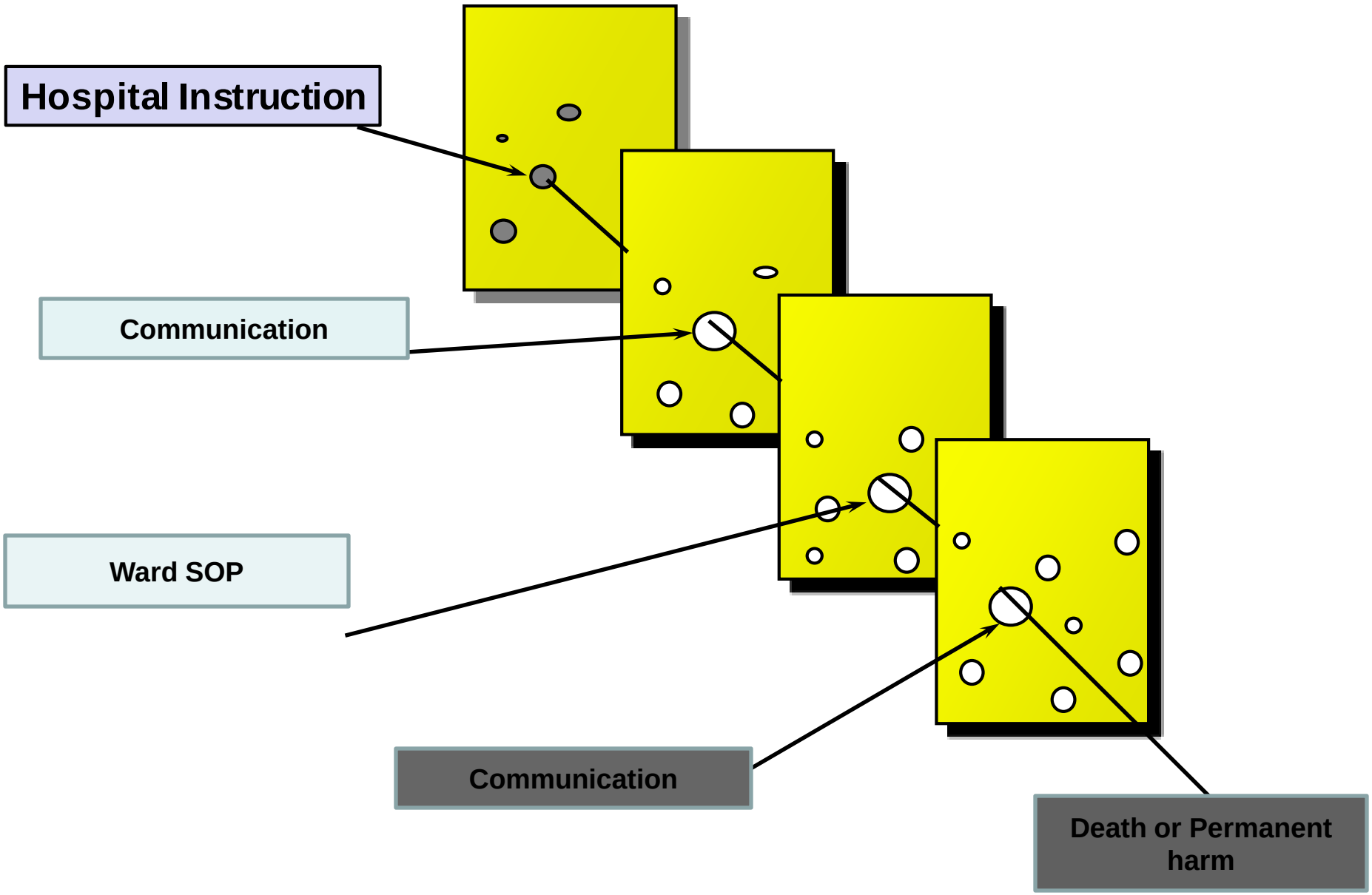
- **What to report?**
  - **Sentinel event reporting is mandatory** for unexpected occurrences involving death or serious physical or psychological injury, or risk thereof
  - Hospital policy event reporting for actual events
  - Near misses an event that could have resulted in harm to the patient, but did not, either by chance or through timely intervention. Near misses are important because for every sentinel event, it is estimated there are 100 near misses

- **How do I Report?**
  - There is a Patient Safety link on the Intranet homepage that will guide you through reporting patient safety issues.

WRNMMC Patient Safety Program

- DoD Patient Safety Reporting (PSR) system
- Patient Safety Committee - Command collateral
- Patient Safety Advisor (PSA) Program – Service level reps
- National Patient Safety Goals – Mandatory TJC Goals
- Patient Safety “Hot Topics” -Interns

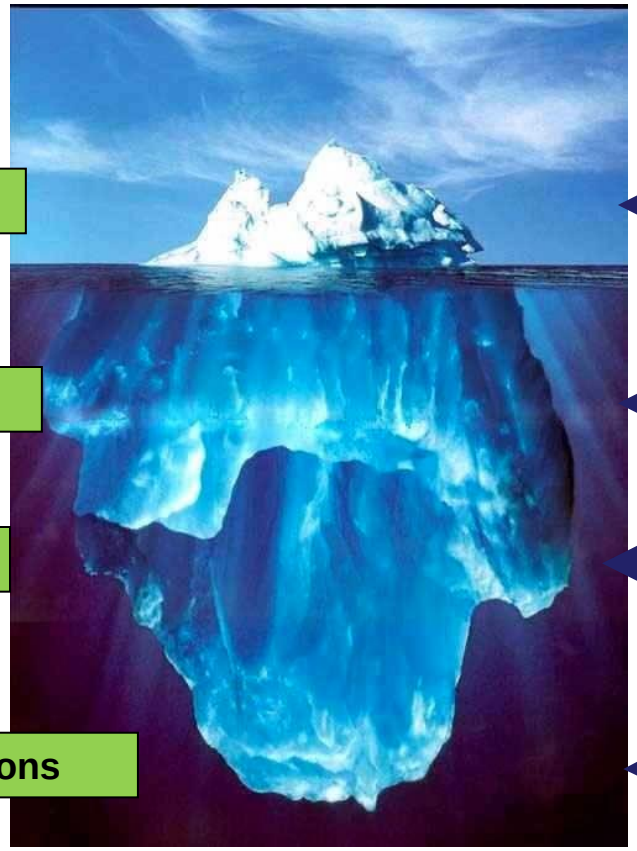
Event



(Reason, 1990)

Melting the Iceberg

Institute of Medicine Report



1 Sentinel event

10 Adverse events

100 Near misses

1000 Unsafe conditions

Root cause analysis

Quality assessments

Opportunity to improve

Proactive risk assessments, National Patient Safety Goals, Universal Protocol for Wrong Site/Person/Procedure

Home - Windows Internet Explorer provided by NNMC Bethesda

https://nnmcintra/Pages/Default.aspx

File Edit View Favorites Tools Help

Home

Page Tools

- NNMC Badge Update
- NNMC Base Map
- NNMC Directives & Instructions
- NSA Directives & Instructions
- Org Charts, Phones
- Our Mission & Vision
- NNMC Staff Search
- Pastoral Services
- Patient and Family Centered Care
- Patient Labeling Program SOP
- Plan Of The Day
- Site Map
- Staff Education & Training

Home Page Links

- Adverse Drug Reaction Application
- AHLTA Toolbox
- Cmd. Awards Program
- Daily Status Report
- DoD Links
- Government Links
- ITD Help Desk
- JTF CAPMED
- Lean Six Sigma Idea Submission
- Medical Readiness
- Medicine Links
- Medical Guidelines
- Navy College (NNMC)
- NCA Extranet
- NNMC Intranet (Previous)
- NNMC Public Web Site
- Non-Formulary Drug Request
- Nursing Directorate
- Tenant CMDS. Links
- What Is My IP?
- Why-Gram???
- NNMC Bed Report

Video Links

NNMC Public Website | Social Networking OPSEC | HIPAA PHI/PII Information | Provider One Call | PSR | STAFF | Duty Pager | BRAC Transition Medical Center Integration | Event Parking Request | Total WorkForce Management Tool

NSA Bethesda | SharePoint Virtual Training | DMHRSi Login | Inter-Departmental Transfer | ITD Helpdesk | Submit TICKET | S.E.A.T. Room Scheduling | HAND HYGIENE | Civilian Action Tracker

Report adverse events here

BRAC

Have questions, suggestions or constructive comments uction
or the Integration process? Call the BRAC/Integration Hotlin BRAC),
or send your questions, suggestions, and/or constructive comments navy.mil.

Command Telephone Directory

To request an update to the command phone directory please call 295-5676

Clinic Hot Line
For staff use only

Influenza (Flu) Vaccine Availability

Command Assessment Team Survey

Job Announcements

Title
NURSE (EDUCATION), YH-0610-02
VACANCY ANNOUNCEMENT: NURSING ASSISTANT (PSYCHIATRIC), YI-0621-01
VACANCY ANNOUNCEMENT: NURSE (CLINICAL/PERIOPERATIVE), YH-0610-02
VACANCY ANNOUNCEMENT: NURSE (EDUCATION), YH-0610-02
VACANCY ANNOUNCEMENT: SUPV IT SPEC (SYSADMIN), GS-2210-14
VACANCY ANNOUNCEMENT: PERSONNEL SECURITY SPEC, GS-0080-09
VACANCY ANNOUNCEMENT: MEDICAL SUPPORT ASSISTANT, GS-0679-05
VACANCY ANNOUNCEMENT: MEDICAL SUPPORT ASSISTANT (OA), GS-0679-05
VACANCY ANNOUNCEMENT: SECURITY ASSISTANT (OA), GS-0086-07
VACANCY ANNOUNCEMENT: FOOD PROGRAM MANAGER (EXECUTIVE CHEF), GS-0301-12
VACANCY ANNOUNCEMENT: ADMINISTRATIVE SUPPORT ASSISTANT (OA), GS-0303-07
VACANCY ANNOUNCEMENT: PROGRAM SUPPORT ASSISTANT, GS-0303-08

Bethesda, MD

4/18/2011 12:34 PM

NNMC Internet Search (Powered by Google)

Internet Search Go

Everyone Links

- Active Directory Profile Updater (Choose Your DOD Cert)
- Armed Services Blood Program
- Awards Program
- BHIE/SHARE
- BUMED Patient Satisfaction Monitor
- Common Access Card Issuance
- Fleet and Family Support (FFSO)
- Guardian Provider Privilege Notification System
- ITD Virtual Helpdesk
- Lean Six Sigma Idea Submission
- Logistics Department
- MDConsult/First Consult
- Mosby Nursing Skills
- Motorcycle Safety Training
- My Pay (DFAS)
- Navy Family Accountability and Assessment System
- Navy Voting Assistance Program
- New S3 Surgery Scheduling System - (Authorized Users Only) - Now use your CAC Login
- NNMC Peer Review Program
- NSIPS for electronic service record
- OptiLink PCSS/StaffRunner
- Pastoral Care Weekly Services
- PRIMS Database
- Quality Council Dashboard
- Send a Skytel Message
- SLDCADA Link

Done | Trusted sites | 100%

Patient Safety Reporting System

Lesson 2 – Navigating the PSR Form

Topic menu

This section asks you to detail *When, Where* and *What* happened.

★ **Event date** (mm/dd/yyyy)	
★ **Event time** (24 hour local time)	
Discovery date (mm/dd/yyyy)	
★ **Service Affiliation** Please select the Service where the event occurred	
★ **Service Region**	
★ **Parent MTF**	
★ **MTF**	
★ **Department/Division/Directorate**	
★ **Clinic/Service**	
★ **Location Type**	
Patient Status	
★ **Event description**	

Navy

National Capital Area

WRNMMC

Directorate

Department

Service

When?
Where?
What?

CC

Mandatory Fields (Slide 4)

Play ▶ ◀ Back Next ▶

avascript:cwsWin.customPlayPause();

Play/Pause

100%

What to report in the PSR system

- Delay in diagnosis
- Medication errors
- Patient ID errors
- Unanticipated surgical intervention required
- Increased length of stay or level of care
- Operative/other procedure related
- Policy not followed
- Documentation errors
- Equipment failures
- Falls
- Lessening of function (sensory, motor, physiologic, intellectual)
- Disfigurement
- Hospital acquired infections
- Unanticipated outcomes
- Near misses
- If in doubt, report

Events to Report

Sentinel events immediate reporting

- Major permanent loss of function (sensory, motor, physiologic, intellectual)
- Unexpected death
- Suicide of patient in a around-the-clock care setting or within 72 hours of discharge
- Unanticipated death of a full term infant
- Abduction of any individual receiving care, treatment or services
- Discharge of an infant to the wrong family
- Rape
- Hemolytic transfusion reaction of major blood group incompatibilities
- Surgery on the wrong patient or wrong body part
- Unintended retention of a foreign object after surgery or other procedure(sponges, catheter tips,etc)
- Prolonged fluoroscopy, >25% above planned doses of radiation therapy or radiation therapy to wrong site
- Severe neonatal hyperbilirubinemia

Hospital policy event reporting

- Medication errors
- Delay in diagnosis
- Patient identification errors
- Unanticipated surgical intervention required
- Increased length of stay or level of care
- Operative/other procedure related
- Policy not followed
- Documentation errors
- Equipment failures
- Falls
- Lessening of function (sensory, motor, physiologic, intellectual)
- Disfigurement
- Hospital acquired infections
- Unanticipated outcomes of care

Sentinel Event (Immediate Reporting)

- Unanticipated death
- Major permanent loss of function (sensory, motor, physiologic, intellectual)
- Surgery/nonsurgical invasive procedure on the wrong patient/site/procedure
- Hemolytic transfusion reaction (ABO, Rh, other blood groups)
- Unanticipated death of a full-term infant
- Infant discharged to the wrong family
- Abduction of any patient receiving care, treatment, and services
- Suicide inpatient or within 72 hours of discharge
- Rape
- Unintended retention of a foreign object in a patient after surgery/ other procedure
- Severe neonatal hyperbilirubinemia (> 30 mg/dl)
- Prolonged fluoroscopy, delivery of radiotherapy to the wrong body part or >25% above the planned dose

Be Involved: Patient Safety is Everyone's Responsibility

Patient Safety Committee

- Command-level collateral
- Responsibilities
  - Identify system/process issues
  - Determination of sentinel events
  - Determine further review
  - Recommends actions for improvement
- Membership
  - Voting members:
    - 7 Quality Assurance Physician Advisors (QAPA)
    - 1 Quality Assurance Nursing Advisor
    - ED, GME, LAB, CMS, QM, Anesthesia

Patient Safety Advisor

- Service level collateral – RNs, SW, Physicians
- Assigned by Service Chief
- Responsibilities: I*C*E
  - **Investigate** PSR events
  - **Communicate** findings with service chief
  - **Educate** Service level staff

Patient Safety “Hot Topics” for Interns

Medication and Lab orders

- If a medication or lab draw is to be done the day the order is written, order must read “start today” or Essentris will defer order until the next day

Critical Results

- Acceptable length of time between the critical result and the reporting of the results is 60 minutes

Anticoagulation Guidelines

- New Instruction FY 13

Reconciliation of Meds

- Obtain a list of patient’s current medication in CHCS, type in 508 Menu
- Reconcile medications with patient, provide the list to the patient and document in EMR

Post Fall Protocol

Initially assess and treat any injury. Reassess at 12 and 24 hours

Medical and Behavioral Restraints

Behavioral Restraint Use

Use restraints if patient's behavior is a threat to self or to others

Sign the restraint order within *1* hour of initiation.

Initial order valid 4 hours for 18 years and older, 2 hours for ages 9-17 and 1 hour if age 8 and below.

Conduct initial in-person evaluation within 1 hour of restraints.

Conduct an in-person re-evaluation every 8 hours ages 18 and older every 4 hours ages 17 and younger if restraint continues beyond initial order.

Medical Restraints Use

Start with the standard Order Set.

Chose a category: Restraint Self Harm or Restraint Line Removal.

Assign the entire restraint order

Use to prevent self harm or patient pulling out lines/devices

LIP must sign initial order within 12 hours after initiation by a nurse

Initial order is valid for 24 hours

LIP must conduct initial in-person evaluation within 12 hours.

LIP must revaluate need for restraints every 24 hours.

The Joint Commission’s (TJC)

National Patient Safety Goals 2012

(NPSG)

Joint Commission National Patient Safety Goals

- Vision: “All people always experience the safest, highest quality, best-value health care across all settings.”
- Goals first established by Joint Commission in 2002
- Extensive revision in 2009
- Modified goal #7 for 2012, effective 1Jan 2013
- The National Patient Safety Goals for each program and more information are available on The Joint Commission Web site:
  - http://www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals/.
- Goals 4,5,6,10,11,12, and maybe 13 don’t apply to hospitals

Goal 1

Improve the accuracy of patient identification

"The Intern used two patient identifiers prior to my colonoscopy"

Patient Full Name

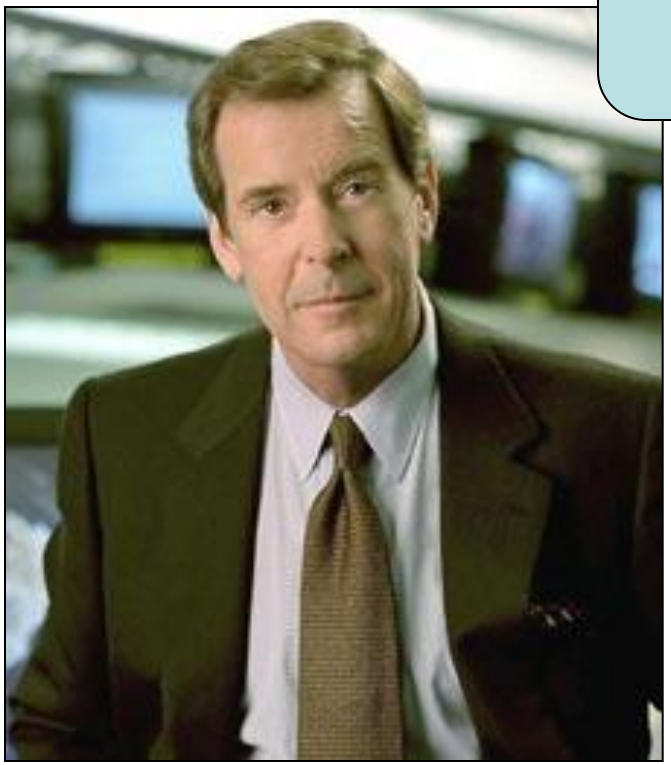
+

Date of Birth

Goal 2

Improve the effectiveness of communication among caregivers.

"The resident, when receiving the critical result documented and read back to the radiologist to ensure accuracy."



"Critical results and values must be reported to the provider within 60 minutes"

Goal 3

Improve the safety of using medications

"Physicians label medications, containers and other solutions on and off the sterile field so mistakes don't happen."

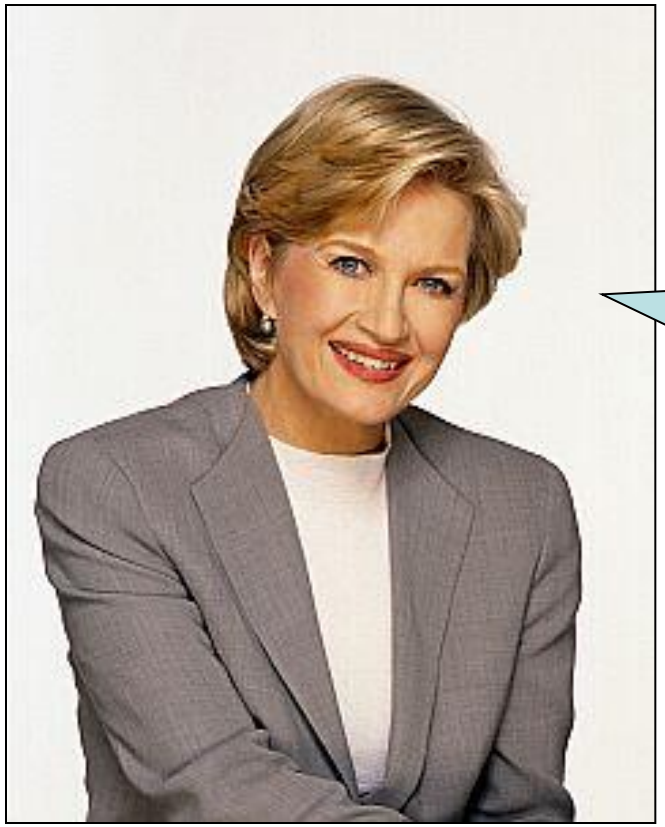
Labels must include

- Medication name
- Quantity
- Strength
- Diluent & Volume

NO unlabeled syringes in pockets

Goal 3

Accurately and completely reconcile medications across the continuum of care



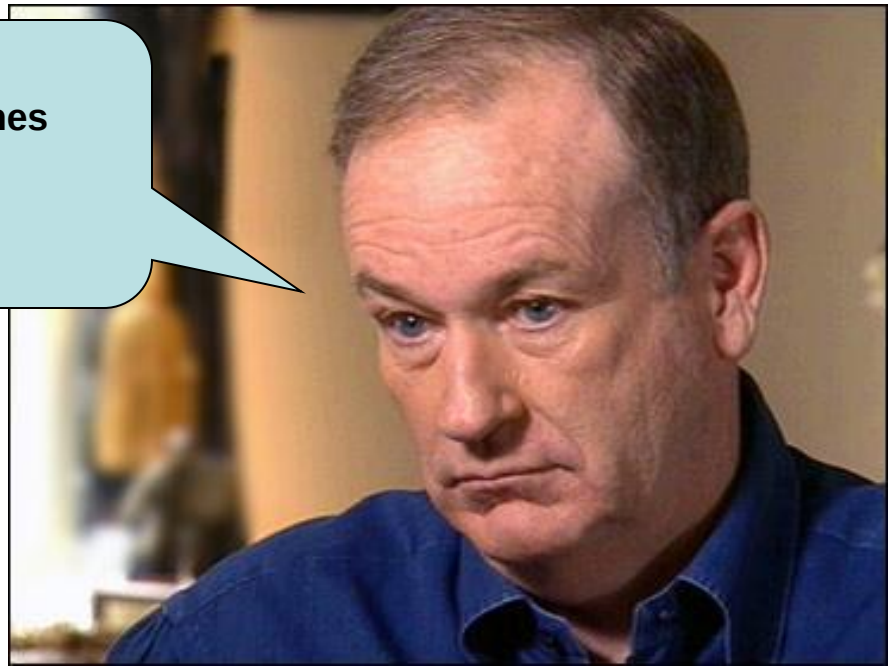
Reconciling medications in hospitals now made easier with the Essentris "Recon of Meds Note"

Goal 3

Improve the safety of using medications

Reduce harm associated with the use of anticoagulant therapy

"Residents who use the anticoagulation guidelines are Patriots not Pinheads"



-Located on Intranet
-Home Page Links
-Medical Guidelines

Goal 7

Reduce the risk of health care-associated infections

"Health care providers can kill patients with their bare hands"

EBP to prevent Health Care Acquired (HCA) Infections:

- ❑ MDRO
- ❑ Central line-associated (CL)
- ❑ Surgical site infections (SSI)
- ❑ Indwelling catheter (CAUTI)

AND # 1

- ❑ Hand hygiene - follow WHO guidelines

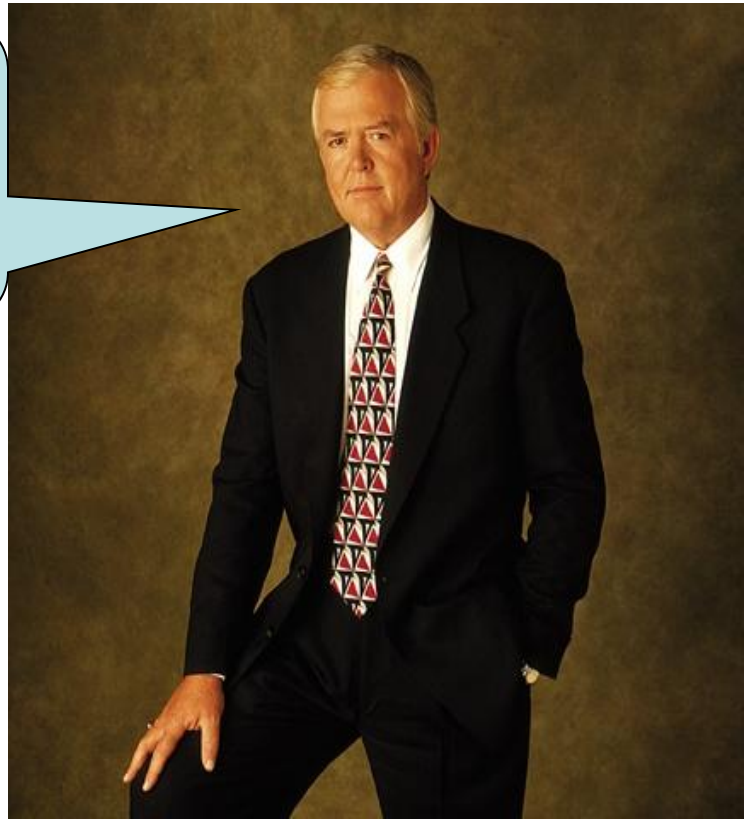
VAP

Goal 15

The organization identifies patients at risk for suicide

"Interns conduct :

- *risk assessments,*
- *address safety needs and*
- *provide SI prevention information*

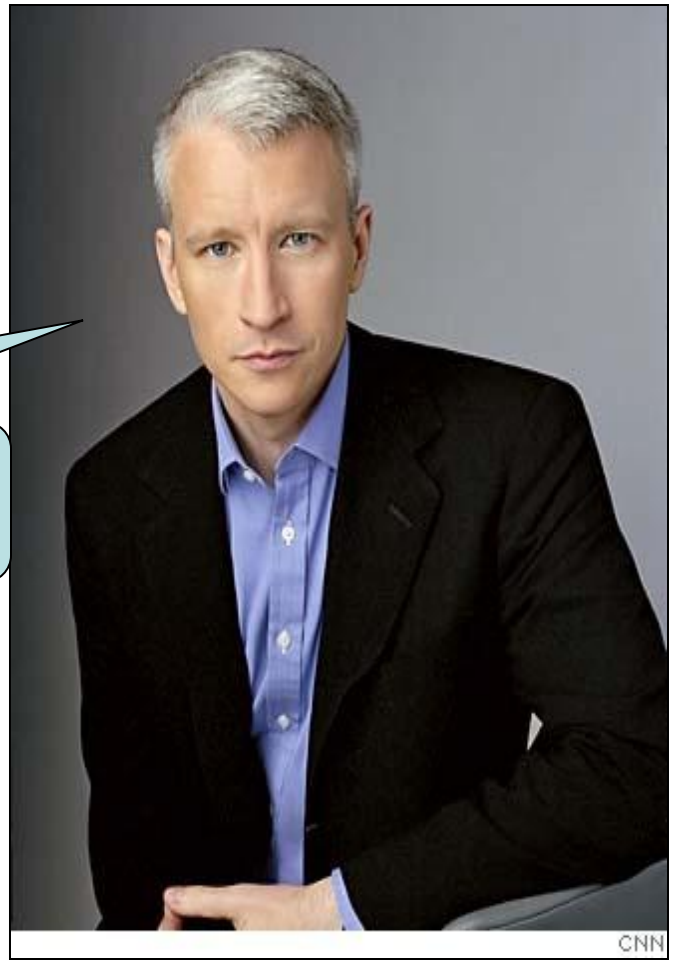


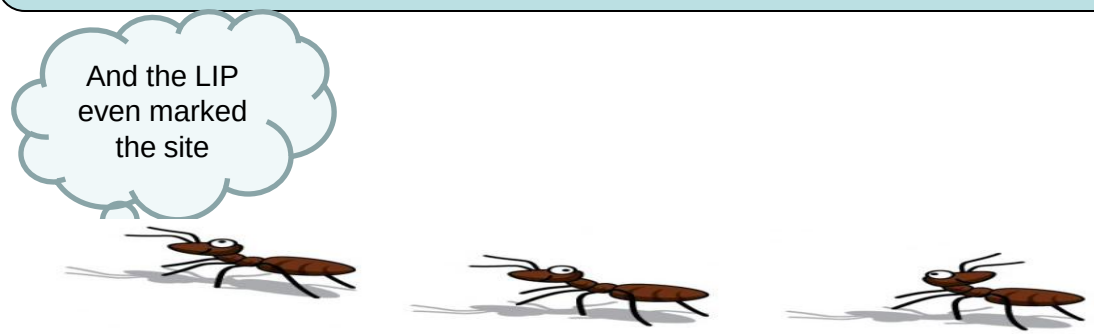
Universal Protocol: Done prior to procedures

‘Time Out’ Prevents

- Wrong Site
- Wrong Procedures
- Wrong Person Surgery

“The team ensured right patient, right procedure and right site.”





SBAR Overview

- What is **SBAR**?
  - SBAR provides a framework for team members to communicate vital information about a patient
- **S**ituation: what is the situation?
- **B**ackground: what is the clinical background?
- **A**ssessment: what is the problem?
- **R**ecommendation: what do I request or recommend be done?
- Also known as **TeamSTEPPS**

How does **SBAR** work?

- We do it all the time without even realizing it. An example of a nurse describing a patient's condition in the ED to a physician:
- **S**: Dr Smith, I have pt JS in ER room 6
- **B**: JS is 56 yo white male w/ CHF, many ER visits, looks pale and diaphoretic. BP 90/50, pulse 110, on O2 and sats 91%
- **A**: He may be having an MI
- **R**: We need you to see him now!

Why is **SBAR** important?

- According to sentinel event data compiled by Joint Commission from 1995-2008, ineffective communication was the cause of TWO-THIRDS of all sentinel events reported!
- Effective communication is the lifeline of the health care team
- A structured tool like SBAR has been shown to reduce the rate of adverse events.
- With more and more staff shift changes, it is vital that we embrace the SBAR format for hand-offs.

Objectives

- Recognize the importance of communication.
- Recognize the connection between communication and medical error.
- Define communication and discuss the standards of effective communication.
- Identify the steps of the SBAR tool and use them for information exchange.

Effective Communication Using SBAR

Agency for Healthcare Research and Quality
Advancing Excellence in Health Care • www.ahrq.gov

PATIENT SAFETY

TRICARE

TeamSTEPPS

Importance of Communication

Ineffective communication is a root cause for **greater than two-thirds** of all sentinel events reported

Source: The Joint Commission's Root Causes and Percentages for Sentinel Events (All Categories) January1995−December 2008

Communication is…

- The process by which information is exchanged between individuals, departments, or organizations
- The lifeline of the Patient Care Team
- Effective when it permeates every aspect of an organization

Standards of Effective Communication

Complete

Clear

Brief

Timely

SBAR provides…

- A framework for team members to effectively communicate information to one another. ***Remember to introduce yourself…***
- **Communicate the following information:**
  - **Situation—what is the situation?**
  - **Background—what is the clinical background?**
  - **Assessment—what is the problem?**
  - **Recommendation—what do I recommend/request be done?**

Scenario

Appropriate for: All Specialties
Setting: Clinic

Dr. Winston has just completed her annual physical exam of Sue Garber. Ms. Rosenthal, the nurse for Hall B, asks, “Isn’t Mrs. Garber a little confused today? I think she’s depressed about her daughter moving away last month. I was wondering if she should be sent to the emergency room for evaluation.” Dr. Winston replies, “Yes, I think she may be confused, but according to her record, her confusion has existed for more than a month. I think she may have something organic going on. We need to rule out a medical cause for her confusion.” “Now that you say it,” Rosenthal observes, “her daughter mentioned that her confusion was not a new phenomenon. Maybe we just need to get an outpatient consult for a formal evaluation. Would you like me to order a consult, Dr. Winston?” “Yes, please order a consult.”

How could Nurse Rosenthal have used SBAR?

Communication Challenges

- Language barrier
- Distractions
- Physical proximity
- Personalities
- Workload
- Varying communication styles
- Conflict
- Lack of information verification
- Shift change

Great Opportunity for Quality and Safety

Teamwork Actions

- Communicate with team members in a brief, clear, and timely format
- Seek information from all available sources
- Practice using the SBAR communication tool daily

TeamSTEPPS

S ITUATION

B ACKGROUND

A SSESSMENT

R EQUEST/ ECOMMENDATION

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PATIENT SAFETY

TRICARE

TeamSTEPPS

SITUATION

What is the situation?

BACKGROUND

What is the clinical background?

ASSESSMENT

What is the problem?

REQUEST/ RECOMMENDATION

What do I recommend / request to be done?

Structured Communication Tool

Universal Protocol for Preventing Wrong Site, Wrong Procedures, Wrong Person Surgery

Applies to ANY surgical or non-surgical invasive procedure wherever performed that involves:

- More than minimal risk (NG tube, peripheral IV, Foley catheter)
- Laterality
- Multiple structures
- Multiple levels
- Requires informed consent!

Three phases of the universal protocol: Correct patient, side/site, and surgery/procedure

- Pre-procedure Verification Process
- Marking of the Operative Site
- "Time Out" immediately prior to start of procedure

Reference: NATNAVMEDCEN Instruction 6320.4B Change Transmittal One Nov 12, 2010

<u>This is an "evolving" process, watch for changes and updates!</u>

If there are any doubts as to whether the Universal Protocol or Time out is needed, initiate the process!

Universal Protocol and Time Out

- What procedures may be included in this process?
  - Any procedure involving a skin incision, puncture(s), or tissue contact w/ laser
  - Any procedure involving general or regional anesthesia, monitored care, or conscious sedation
  - Joint space or body cavity injections of substances
  - Percutaneous aspiration of body fluids or air through skin (LP, bone marrow, chest tube)
  - Any biopsy
  - Cardiac procedures and electrocautery of lesions
  - Any endoscopic procedure
  - Invasive radiological procedures
  - Dermatologic procedures (biopsy, cryotherapy, excisions, etc)
  - Invasive Ophthalmic procedures
  - Central line or PICC line placement
  - Manipulations or reductions
  - Endometrial biopsy, colposcopy w/ biopsy, LEEPs
- This list is not all-inclusive or comprehensive, but a guide! If in doubt, follow the Instruction

ELEMENTS of Performance for the UNIVERSAL PROTOCOL

NNMCMEDCENINSTRUCTION 6320.4B Change One provides detailed instructions for the implementation of the Universal Protocol.

A Walter Reed Bethesda UNIVERSAL PROTOCOL CHECKLIST MUST be used to verify that all components of the three major processes have been accurately and completely accomplished prior to a procedure:

1. Pre-procedure verification
2. Site marking
3. Time out process immediately PRIOR to the procedure by the team member responsible for documenting during the procedure

The use of the Universal Protocol prior to the procedure MUST be documented in the patient chart/record.

SAFE SURGERY REQUIRES THE USE OF THE UNIVERSAL PROTOCOL

Universal Protocol and Time Out: <u>Definitions</u>

- Universal protocol: a detailed procedure for the prevention of wrong site, wrong procedure, or wrong patient surgery.
- “Time Out”: a final verification of the correct patient, site, and procedure.
- Wrong patient surgery: a misidentification of the patient resulting in surgery being performed on the wrong patient.
- Wrong side surgery: a surgical procedure done that involves errors on the wrong extremity or distinct side of the body.
- Wrong site surgery: a broader term that involves all surgical procedures performed on the wrong body part/side or the wrong patient.
- Licensed independent practitioner (LIP): a person permitted by law and privileged to provide care, treatment or services w/o direct supervision. An LIP operates within the scope of their license consistent w/ individually granted clinical privileges. Does NOT include interns or residents, but may involve subspecialty fellows who may be operating under their primary specialty core privileges.

Universal Protocol Process

- Three phases to ensure correct patient, site, and procedure
- LIP performing the procedure is in continuous attendance with patient from time of decision to perform the procedure and obtaining informed consent until the initiation of the procedure may be exempt from first 2 phases
- Third phase time out verification still applies and is documented
- Urgent or emergent life/limb/eyesight procedures may be carried out w/o applying the correct surgical process at the discretion of the surgeon and operating physician if the delay would be deemed a significant risk. Document thought process post-procedure.

Universal Protocol: <u>Phase One</u>

- Pre-Procedure Verification
- Identifies correct person, site, and procedure
- Purpose is to make sure all relevant documents, related information, equipment, studies, and supplies are available and matched to the procedure
- Specimen containers w/ proper labels are available
- This can occur at time of scheduling procedure, preadmission testing, admission, or before the patient enters the procedure room.
- Patient should be involved, awake and aware if possible, prior to sedation or with surrogate available
- If responsibility for patient is transferred to a team member, verification will occur at time of transfer.

Universal Protocol: Phase One- cont'd

- Patient verification: Requires 2 identifiers!
  - Patient or guardian must be asked by staff to verbally state (not confirm) patient's full name (that matches ID wristband if applicable) as 1 identifier
  - Patient's DOB is acceptable as the 2nd identifier
  - Location on body where patient understands procedure will occur
  - Nature of the procedure to be performed
- Document/Equipment verification:
  - Provider verifies that above matches medical or dental record
  - Signed informed consent
  - Patient ID band as applicable and DOB
  - Relevant documentation (ie H&P, pre-anesthesia, etc) correct
  - Correct diagnostic or radiologic test results are properly labeled
  - On-site availability of blood products, implants, devices, as would reasonable be expected are available

Universal Protocol: <u>Phase Two</u>

- Site Marking:
  - LIP ultimately accountable and present for the procedure will mark the procedure site with their initials. This can be delegated to residents or fellows who will be **<u>in</u>** the procedure
- Exemptions: general
  - Single organ cases (C-sections, cardiac surgery)
  - Interventional cases for which the catheter or instrument insertion site is not predetermined (cardiac caths)
  - Infants for whom the mark may cause a permanent tattoo
  - If the site is or will be traumatic- obvious surgical site
  - Durable marker pens used to make mark at or near incision site so as to be visible in the field after pt prepped and draped
  - Try to avoid marking non-operative sites

Universal Protocol: Phase 3

- “Time-out” is the final step
- A standardized “time-out” will take place IMMEDIATELY prior to the start of the procedure in the location where it will take place- pt prepped and draped as applicable
- It is initiated by the team member responsible for documenting during the procedure!
- All other activities at the time are suspended during this process
- All involved parties must agree, absence of a response is not considered agreement
- EMR documentation of the “time-out” is required

“Time-Out”

- If ANY member of the procedural team feels there is an error or a question, or does not feel comfortable with the procedure:
- **STOP!**
- Address the issues, the procedure will not continue until all members are in agreement.
- Please make sure the atmosphere on your team is such that everyone feels comfortable in making this call.

SENTINEL EVENT ALERT, ISSUE 40

BEHAVIORS THAT UNDERMINE A CULTURE OF SAFETY

UNDERSTANDING AND COMPLYING WITH UNIVERSAL PROTOCOL

*Doing the **<u>RIGHT</u>** things to Prevent Wrong Person, Wrong Site/Side, Wrong Surgery/Procedure*

UNIVERSAL PROTOCOL

- Universal Protocol was initiated by Joint Commission in 2004
- Website: http://www.jointcommission.org/assets/1/18/UP_Poster.pdf

- Wrong site, wrong person, wrong procedure continues to be the most frequently reported sentinel event to the Joint Commission

- Current rate of reporting to the Joint Commission is 8-10 new cases per month

- Despite several summits specifically addressing this issue (50 organizations participated in the latest one in 2007), the incidence and frequency is not decreasing

- NNMC Instruction 6320.4B Change One – Verification of the Correct Site and Procedure for Surgical and Invasive Interventions (Universal Protocol) has been revised to reflect all new 2010 Joint Commission requirements for compliance with Universal Protocol

WHAT DEPARTMENTS FALL WITHIN THE SCOPE OF THE UNIVERSAL PROTOCOL?

Clinical Treatment Areas: Endoscopy Suites, Interventional Radiology Suites, Special Procedure Units, Ambulatory Procedure Units

Emergency Department

Main Operating Room

WHAT DEPARTMENTS FALL WITHIN THE SCOPE OF THE UNIVERSAL PROTOCOL?

Intensive Care Unit and Inpatient Wards that perform bedside procedures such as chest tube insertions, PICC lines, and circumcisions

Outpatient Clinics and Branch Health Clinics that perform minor procedures, biopsies, aspirations, etc.

WHAT DEPARTMENTS FALL WITHIN THE SCOPE OF THE UNIVERSAL PROTOCOL?

Laboratory/Pathology Departments if they are doing procedures that require informed consent such as bone marrow biopsies

Dental clinics/Oral Surgery clinics where informed consent is required for the procedure

WHAT PROCEDURES FALL WITHIN THE SCOPE OF THE UNIVERSAL PROTOCOL?

- Any procedure operative or invasive procedure that expose the patient to **more than minimal risk.** WRNMMCB has defined “minimal risk” is anything other than insertion of an peripheral intravenous line, urinary bladder catheter, or nasogastric tube

- Joint Commission defines invasive procedure as “the puncture or incision of the skin, insertion of an instrument, or insertion of foreign material in the body. Invasive procedures may be performed for diagnostic or treatment-related purposes”.

- Examples include PICC line and central line insertions, chest tube insertions, surgical procedures, laser procedures, endoscopic procedures. biopsies, needle aspirations, joint injections, anesthesia blocks, etc.

- The WRNMMCB revised Universal Protocol Instruction has an extensive but not all inclusive list of procedures that are required to follow all applicable elements of Universal Protocol.

THREE PHASES OF UNIVERSAL PROTOCOL

PHASE I:
Pre-Procedure Verification

PHASE II:
Site Marking

PHASE III:
“Time Out” Process

UNIVERSAL PROTOCOL TO REDUCE WRONG PATIENT / SITE PROCEDURES:

Required for all invasive procedures in both the inpatient and outpatient settings except venipuncture.

The responsibility of the provider.

Address the 5 "rights" every time:

Right patient – Full Name and DOB

Right procedure

Right site

Right supplies

Right documentation - state "Time out was performed" in the record.

Be sure to perform individual time-outs for consecutive procedures.

Inpatient procedure notes at WRNMMC require time-out documentation before the note can be closed.

REPORTING OF WRONG SITE, WRONG PERSON, WRONG PROCEDURE EVENT

- All incidences of wrong site, wrong person, wrong procedure events should be **immediately** reported to the WRNMMCB Patient Safety/Risk Manager, Suzie Farley at 295-6236, even if there is no adverse patient outcome

- Wrong site, wrong person, wrong procedure events are reportable to the Joint Commission and BUMED/AMEDD as a Sentinel Event

- A Root Cause Analysis (RCA) team facilitated by the Patient Safety office will be convened to determine causal factors in the incident. The goal is to prevent future repeats, NOT to identify and blame.

- The findings of the RCA team along with a proposed action plan will be provided to the Joint Commission and BUMED/AMEDD within 45 days from discovery of the Sentinel Event

Joint Commission

Frequently Asked Questions!

1. **Q: What is the Hazard Communication Standard?**

   A: It informs workers of the hazards and precautions associated with the hazardous materials present in their workspaces. The standard requires the employer to have a written plan. NNMCINST 5090.6B is our written plan, and also known as the Hazardous Materials Program.

2. **Q: Who does the Hazard Communication Standard apply to?**

   A: Anyone who may potentially be exposed to hazardous materials in the workplace.

3. **Q: What is a hazardous material?**

   A: A material that poses either a physical and/or health hazard.

4. **Q: How is hazardous material (HM) information transmitted?**

   A:
   * Material Safety Data Sheets (MSDS)- Comprehensive data.
   * Container label- identity, responsible party, and health & physical hazards.
   * Authorized Use List (inventory sheets)- lists HMs, and identifies location.
   * Hazmat SOP- explains handling, storage, disposal and use.

   ➔Staff should know where above information is in their department.

5. **Q: What is an MSDS?**

   A: A Material Safety Data Sheet (MSDS) is the chemical manufacturer's most concise information on the properties of a hazardous material.

6. **Q: What is the Authorized Use List?**
   A: It is NNMC's chemical inventory list as provided to county, state, and federal government. Each area that uses, stores, handles, or disposed of chemicals makes up the list.

7. **Q: What is hazmat site-specific training?**
   A: It is divisional training on the specific chemicals used at that work site and declared on the division's AUL. Hazardous Materials training is an annual requirement for all NNMC staff.

8. **Q: What is a hazmat SOP and where is it found?**
   A: Standard Operating Procedure that describes how a chemical is used, under which circumstances, and how it impacts the environment. Found in the Read & Sign Manual and part of HM site-specific training. It must be annually reviewed.

9. **Q: What is a hazardous waste and how is it disposed?**
   A: Any hazardous material that is no longer useful, discarded or an unstable material that is declared a waste. Disposal is coordinated through the Environmental services at 301-295-2527

10. **Q: What is chemical segregation?**
    A: Chemicals are separated according to class (flammables, reducing agents, oxidizers, corrosives [acids and bases]) and like classes are stored together.

11. **Q: Do hazardous chemical wastes require segregation?**
A: Yes! Even though a chemical is a waste destined for disposal, it is still a hazardous chemical belonging to a given class.

12. **Q: Should a division's chemical stock be stored in a flammable liquids storage cabinet?**
A: No! Only flammable or combustible chemicals. These can be liquids or solids. These are a class of chemicals --- flammables.

13. **Q: Since all chemical fall into a class, can hazardous chemicals and hazardous chemical wastes be stored together?**
A: Yes and no. Yes in that hazardous flammable chemicals can be stored in the same flammable liquids storage cabinet, but they must be separated by barrier, such as separation by shelf. Any chemical waste must be labeled as waste. No in that you cannot mix chemical classes.

14. **Q: What does the diamond shaped, tri-colored symbol on store room doors mean?**
A: It is the National Fire Protection Association's (NFPA) standard 704 hazard warning symbol to provide first Responders (Fire personnel) with a numeric rating of the worst case chemical stored within the room. Only one "704 diamond" is posted on the door.

15. **Q: What should you do if the medical air and vacuum system alarm panel alarms?**
A: Note which system is alarming, by the lights on the panel.
* For the vacuum and medical air systems report finding to Facilities Management at 295- 1070 during regular duty hours and 295-0169 after duty hours. Notify your supervisor.
* For Oxygen, Nitrous Oxide, or Nitrogen gas systems notify Central Supply at 295-4539 and notify your supervisor.

16. **Q: What is Code Orange?**
A: Command notice that there is a hazardous materials spill within the facility or on the grounds. When Code Orange is announced, you will hear: “CODE Orange, Building 10, 5 Center". Personnel should be aware of the location and take appropriate actions in the event there is and emergency in which an evacuation is required.

17. **Q: What should <u>you</u> do in the event of a hazardous material spill?**
A:
* **EVACUATE** the area
* **COVER** the spill to keep from spreading…if no risk to you
* **PASS** the word to adjacent areas
* **INFORM** supervisor
* **REPORT** spill to security at **777**

18. **Q: Where are your vertical/horizontal emergency routes?**
A: Horizontal routes are hallways or corridors that lead you from the work space to another area of refuge in a different fire zone. Vertical routes are stairways that take up to or down to another area of refuge into another fire zone. Ensure you know yours.

19. **Q: Where are the fire extinguishers located in your area?**
A: Note the location of the fire extinguishers located in your work area.

20**. Q: What is the location of the nearest manual fire alarm pull station to your work station?**
A: Pull stations are located near any emergency exit. Note the stations in your area.

21. **Q: What is the emergency phone number for the Fire Department?**
A: 777.

RESOURCES

- Joint Commission website has the 2011 Universal Protocol Requirements and Frequently Asked Questions on Universal Protocol

  http://www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals/

- Patient Safety Program intranet site also has the 2011 Universal Protocol Requirements and Frequently Asked Question on Universal Protocol

  https://nnmcintra/SiteDirectory/PSP/default.aspx * you may need to request access from IT to access this website.

- **NATNAVMEDCEN INSTRUCTION 6320.4B - Verification of the Correct Site and Procedure for Surgical and Invasive Interventions (Universal Protocol)**

- Patient Safety Office

  - Suzie Farley = 295-6236
  - Dana Ellis-Barnes = 319-8305
  - Carolyn Craig = 319-4709

WRNMMC Adult Rapid Response System

- **Definitions**
- • **Rapid Response System (RRS):** Broad overarching term that describes a program designed to improve the safety of hospitalized patients whose condition is deteriorating. They are based on prospective identification of high-risk patients, early notification of a team of responders who have been preselected and trained, rapid intervention by the response team, and ongoing evaluation of the system's performance.
-
- • **Rapid Response Team (RRT):** A team of clinicians who bring critical care expertise to the patient bedside to assist in early recognition and treatment of patients with subtle changing conditions to prevent or reverse clinical deterioration. The RRT is separate and distinct from the Code Blue Team. Patients in arrest or extremis are not appropriate candidates for a RRT response and a Code Blue must be initiated.

WRNMMC Adult Rapid Response System

- **Coverage**
- • The RRT is available 24 hours per day 7 days per week.
- • The RRT responds to all adult ***inpatient areas*** excluding the Intensive Care Units, Post Anesthesia Care Unit, and Labor and Delivery. The RRT does respond to Post-partum, Ante-partum, and the APU.
- • The RRT will not be activated for inpatients receiving treatments in outpatient areas (i.e. radiology); instead, a Code Blue should be called.
-
- **Team Composition**
- • Critical Care Registered Nurse
- • Respiratory Therapist
- • Patient's primary medical or surgical team (intern or resident responsible for patient care at the time)
- • The ICU Attending in-house is available for consultation at all times

WRNMMC Adult Rapid Response System

- **Activation**
-
- • The RRT can be activated by any staff member or at the request of patients and families. The activation criteria for RRT are ***mandatory***. A ward inpatient who meets any one of the following criteria **requires** activation of the RRT:
-
- ***Heart rate < 40 or > 130***
- ***Respiratory rate < 8 or > 28***
- ***Systolic blood pressure < 90 or > 220***
- ***Oxygen saturation less than 90% despite supplemental oxygen therapy***
- ***Acute change in mental status***
- ***Staff member concern about the patient's clinical state***
- ***Patient or family member concern (staff will activate the RRT at the family's request)***

WRNMMC Adult Rapid Response System

- • The primary team will be notified simultaneously with activation of the RRT. The primary team will continue to respond to calls from the ward nurse and retains primary responsibility and decision making authority for care of the patient.
-
- • Activation of the RRT is non-punitive. All RRT calls should be viewed as an opportunity for learning and fostering improvement in assessment or critical thinking skills. Regardless of the trigger for the call or the presumed validity, all calls should be viewed as an opportunity to advocate for the patient's safety.
-
- • In situations where a patient consistently meets RRT activation criteria but is otherwise stable (i.e. a patient with a baseline SBP <90), the primary team Attending Physician, or the resident in consultation with the Attending, may write an order suspending that specific criteria. The order must state that specific RRT activation criteria are suspended and new parameters for activation.
- (Example: Suspend activation criteria for SBP < 90. Activate RRT for SBP < 80)

WRNMMC Adult Rapid Response System

- **Duties of the Rapid Response Team**
- • All members of the team respond promptly to the page by arriving at the appropriate location within 5-15 minutes with designated RRT supplies and equipment.
- • Conduct an assessment of the patient.
- • Assist and facilitate the evaluation, early treatment, and, if needed, transfer of the patient.
- • May initiate treatments as authorized by the Adult RRT Standing Orders set prior to arrival of the primary team.
- • The RRT will not assume control or usurp primary team authority, but acts to support the primary team, encourage continuity of care, and promote collaboration and learning.
- • The RRT Nurse Responder will document details of the RRT response including all pertinent clinical information and interventions using the RRT note in Essentris.
- • Follow up each RRT where the patient was not transferred to the ICU within 6 hours to verify stability or improvement in the patient’s condition and document accordingly in Essentris.

WRNMMC Adult Rapid Response System

- **Duties of the Patient's Primary Medical or Surgical Team:**
-
- • The primary team retains responsibility and decision making authority for the care of the patient.
-
- • Conducts a prompt assessment and staffs the case through appropriate channels.
-
- • Notifies the patient's Attending Physician that a RRT was called on their patient.
-
- • Collaborates with the RRT and the primary nurse in providing appropriate care for the patient.
-
- • Contact the Nurse of the Day for bed placement in the case of need for transfer to higher level of care.

WRNMMC Adult Rapid Response System

- **Standing Orders**
- May be initiated at the discretion of RRT members prior to the arrival of the Primary Team.
- • Dextrose 50% - 1 ampule IV for BG < 60
- • Naloxone 0.4mg IV - once for respiratory rate < 8 in setting of narcotic therapy or suspected narcotic overdose
- • 0.9%NaCl solution 500cc IV bolus - may be given once for symptomatic hypotension and SBP < 90
- • Albuterol 2.5mg and Ipratropium 0.5mg by nebulization - once for bronchospasm/respiratory distress
- • Supplemental oxygen administration using delivery device or rate necessary to maintain SpO2 > 90%
- • Establish IV access
- • Blood glucose measurement
- • ABG laboratory testing
- • Portable Chest Radiograph
- • ECG

Restraint Guidance

- Restraints- “ANY method of physically restricting a person’s freedom of movement, physical activity, or normal access to his/her body”
- Non-physical techniques are preferred if possible
- NOT a substitute for supervision or observation
- Restraints can only be ordered by a member of the medical staff, or housestaff acting under their supervision!
- Nursing may initiate restraints if provider not available in person, but medical staff needs to be informed

Restraints cont'd

- Restraint order must include:
  - Type of restraint and justification
  - Time limit for restraint
  - Criteria for discontinuation
- This is a Joint Commission and Patient Safety Requirement!
- If nursing initiates a restraint:
  - Medical provider notified within 12 hours
  - Written order entered within 24 hours of initiation
- For cont'd use, a NEW order must be written every day
- Ref: NNMCINST 6320.14E

Restraint Orders

The How To In Essentris

Order Entry - Essentris

File Edit View Env Admin Status Boards FlowSheets Notes Orders Summary Screens IPLOTS Tools Web Links Help OE Options Order Entry

TRAIN-5 Train, 3W	Age	Sex	Unit Name	BED	Allergies	FMP+SSN	Hosp Reg#	DOB	Admit Date	ATTD PHYSICIAN	Rank
			TRAIN	TRAIN-5	Multiple	99-883-45-6789	999999A		11/07/2009		

Patients Views MD Adm Process A B C D E Essentris

Unsign'd DC'd Pending DC

Standard order sets

Bedside Testing

Name	Freq		Start Time	Stop Time	MD	ANN	ENT	ACK	VERIFY	SIGN	CS	REVIEW
FingerStick Glucose	AC + H	ral feedings or bolus tube feeds	1500 1 Dec 2009				LCA	LCA				

Med Instructio

Name		omment	Start Time	Stop Time	MD	ANN	ENT	ACK	VERIFY	SIGN	CS	REVIEW
For Glucose 40-60, give 1/2			1500 1 Dec 2009				LCA	LCA				
For Glucose <40, give 1 amp			1500 1 Dec 2009				LCA	LCA				

Medications (2 Pendi

Name	Dose	Route	Freq	Comment
INSULIN HUMAN *REG* (N	0 UNIT(S)	SUBCUTANEOUS	AC+HS	Insulin for BG: 61-110=0 Units 111-150=1 Units 151-200=2 Units 201-250=3
PREDNISONE 20MG (DELTA	20 MG	ORAL	DAILY	
PREDNISONE 50MG (DELTASONE) ORAL TAB	50 MG	ORAL	DAILY	

Outputs

Name	Comment	Start Time	Stop Time	MD	ANN	ENT	ACK	SIGN	CS	REVIEW
Wound VAC Drainage	Measure and record Q4H	1000 16 Aug 2010		**CHOOSE CORRECT PROVIDER**		LCA	LCA			

Radiology

Name	Freq	Comment	Start Time	Stop Time	MD	ANN	ENT	ACK	VERIFY	SIGN	CS	REVIEW
CHEST, PA	X1		0900 3 Dec 2009			*	HSM	HSM	HSM	HSM	HSM	

Treatments

Name	Freq	Comment	Start Time	Stop Time	MD
Bari-Rehab Platform (must have bariatric mattress)			1000 16 Aug 2010		**CHOOSE CORRECT
Bensal HP ointment	DAILY		1000 16 Aug 2010		**CHOOSE CORRECT
Collagenase/Santyl	DAILY		1000 16 Aug 2010		**CHOOSE CORRECT
Duoderm/Tegaderm hydrocolloid	EVERY OTHER DAY	or when saturated	1000 16 Aug 2010		**CHOOSE CORRECT
Float heels off bed using pillow or positioner			1000 16 Aug 2010		**CHOOSE CORRECT
Gel pillow at all times			1000 16 Aug 2010		**CHOOSE CORRECT
Iodosorb ointment	DAILY		1000 16 Aug 2010		**CHOOSE CORRECT
Melgisorb	DAILY	or when saturated	1000 16 Aug 2010		**CHOOSE CORRECT

Active Orders | Orders Without ACK | Orders Without SIGN | Orders Without VER | Orders Without REVIEW | Orders With

1.4.0005 msfarley nnmccci6 (10.161.161.113) nnmcd2ua9130wjs TRAIN 09:03 Aug 31, 2010 EDT Clinical link disabled

Standard Orders

Category

Restraint Self Harm
Restraint Line Removal

Select one

restraint

MD Name

OK

Cancel

Order Entry - Essentris

File Edit View Env Admin Status Boards FlowSheets Notes Orders Summary Screens IPLOTS Tools Web Links Help OE Options Order Entry

Patients Views A B C D E Essentris

Unsign'd DC'd Pending DC

Assign All

Restrain Order (0 Pending Orders)

Name	Freq	Comment
Clinical Justification	NO>24hrs	High Potential for removing lines, tubes, equipment, or dressings.
Nurse may release the patient from restraints	NO>24hrs	When Criteria for D/C is met
Criteria for D/C	NO>24hrs	Low Potential for removing lines, tubes, equipment, or dressings.
Periodic Re assessment	NO>24hrs	Per ICU Protocol
Restraint Order renewal	NO>24hrs	If a restraint needs to be continued beyond the expiration of the time limited order, a new orc

Click on this icon and it will "assign all"

IGN Orders Without VER Orders Without REVIEW Orders Without COSIGN Standard Order: Restraint Line Removal

Responsibilities for Restraints

Reason for restraints	Medical-surgical	Behavioral Health	Supporting Documentation
Clinical Justification	Intent of restraint is to restrict a patient's movement but not for violent, aggressive and/or destructive behavior	Patient's behavior is violent, aggressive, and/or destructive; patient is a threat to self or others	Essentris Restraint/Seclusion note; Doctor Restraint order set
Clinical setting to which standards apply	Any clinical setting	Any clinical setting to include in-patient psychiatry, ER, health clinics and/or medical ward	N/A
Time period LIP must sign initial order	Within 12 hours of initiation of restraints	Within 1 (one) hour of initiation of restraints	A signed Doctor's order;
Time frame initial order valid	24 hours for all ages	4 hours if age 18 & above 2 hours if age 9-17 1 hour if age 8 & below	Med/Surg or BH Doctor's order is specific to type of restraint
Time frame LIP must conduct initial in-person evaluation	Within 12 hours of initiation of restraints	Within 1 (one) hour of initiation of restraints	Essentris Restraint/Seclusion note
In-person reevaluation by LIP if restraint continues beyond initial order	Every 24 hours for all ages	Q 8 hours if age 18 & up Q 4 hours if ages 17 & under	Essentris Restraint/Seclusion note
Monitoring by nursing staff	Q 2 (two) hours	Q 15 minutes	Treatment screen for Wards and ICU vital sign screen;

WRNNMCB Wound Care Team

- The Wound Care Team has established a very comprehensive and valuable resource on the Intranet to help you care for patients!
- It includes information on skin/ostomy care, pressure ulcer protocols, WoundVac® info, tools and presentations, and much more.
- Located at: https://nnmcintra/SiteDirectory/nursing/SkinandWound/default.aspx

WRNMMCB LABORATORY INFORMATION

WRNMMCB Laboratory Information

Critical Values Reporting: The hospital has defined a list of test results that are considered “critical” and require immediate interpretation by a physician. If you are called with a critical value, it is your responsibility to “read back” the result to ensure there is no miscommunication. Also, it is your responsibility to interpret the result and ensure the patient gets appropriate treatment/follow up.

STAT REQUESTS: STAT requests are ready in less than one hour. This request should be reserved for emergent patient care needs , so the lab is not overwhelmed by requests and is unable to take care of true emergencies

Duty Pathologist Pager number: #1659743.

Most efforts to improve transfusion safety focus on blood administration . . .. . .but most errors occur due to mislabeling the blood sample! Therefore, samples must be labeled at the bedside – not the nursing station

My patient needs RBCs right now. What should I order?

If a patient needs red cells emergently, and the time required for compatibility testing could result in patient's death or severe morbidity, emergency release units should be ordered. Group O RBCs will be issued immediately. If there is a confirmed blood type, type-specific will be issued. Prior to transfusion, a properly labeled sample of blood must be obtained from the patient and sent to the Transfusion Service. This sample is essential for determination of the patient's ABO and Rho(D) type so that subsequent units may be type-specific, and to determine if significant red cell antibodies are present. If the patient has never been transfused or pregnant, the chances of a significant antibody are virtually zero. If the patient has been previously exposed to blood, the chance of an antibody is increased by about 1-2% for each exposure. An antibody to a minor blood group may cause delayed hemolysis if untested units are issued.
**Labor and Delivery(MICC) has their own "massive transfusion protocol"

To order Emergency Release: Call the Transfusion Service 295-0968, give patient information, state patient needs "Emergency Release" and send a runner to pick up the unit. An Emergency Release Form will be provided by the Transfusion Service for your Signature after the emergency is over.

Resources

- NMMC Instruction 6530.2E: REGULATIONS FOR BLOOD BANKS AND BLOOD TRANSFUSION
- Package Insert [Circular of Information For The Use of Human Blood and Blood Components]
- NMMC Form 6530/100 (Blood Product Requisition Form)
- Transfusion Service number 301-295-0968
  - Medical Director: CDR Katherine Schexneider MC
  - Supervisor: Ms. Gloria Johnson

DEPARTMENT OF PHARMACY

Nana Safo, PharmD, BCPS, MBA
Interim Director, PGY1 Pharmacy Residency Program
National Naval Medical Center

Objectives

- What's going to slow you down?
  - Formulary issues
  - Do not use abbreviations
- What's going to save you time?
  - Standardized drips
  - Order sets
- How we can help
  - Clinical Pharmacy Services

What's going to slow you down?

- When in doubt, CALL first before writing the order @ 295-2121
- Nonformulary items
  - Escitalopram (Lexapro®) – use citalopram
  - Pantoprazole oral (Protonix®) – use esomeprazole (Nexium®)
  - Tamsulosin (Flomax®) – use Alfuzosin
- Do <u>not</u> re-write civilian prescriptions
- Do not use abbreviations

Do Not Use Abbreviations

- Do not use
  - QD
  - QOD
  - IU
  - U
  - µg
  - MgSO4
  - MSO4
  - TIW
  - SS

- Use:
  - Daily
  - Every other day
  - International Unit
  - Unit
  - Mcg
  - Magnesium sulfate
  - Morphine sulfate
  - Three times a week
  - Sliding scale

What’s going to save you time?

- When in doubt, CALL first before writing the order @ 295-2121
- GI Prophylaxis
  - IV – Use Pantoprazole (Protonix®)
  - PO – Use Esomeprazole (Nexium®)
    - Or Omeprazole (Prilosec®)
- DVT Prophylaxis
  - Enoxaparin (Lovenox®) 30mg sq Q12H or 40mg sq daily
  - Heparin 5,000 units sq Q8H
- Order sets (Electrolyte replacement)
  - Magnesium, K+, Phosphorus, Calcium

Drips

- NICU standardized drips
  - Weight-based dosing
- ICU drips
  - Prescribe exact dose of drug to be given (Diltiazem 10mg/hr)
  - Do NOT write 1 amp or 10cc/hr
    - 3 amps sodium bicarbonate **should be written** as 150meq sodium bicarbonate
  - Avoid prescribing non-standard concentrations
- NO default banana bag order
  - Must be specific for the ingredients
  - Thiamine, Folate, B12, Magnesium, K, MVI, etc
    - Typical banana bag order is 100 mg thiamine, 1 mg folate, and 10 ml MVI in 1000 cc normal saline

Clinical Pharmacy Services

- Clinical pharmacists on Internal Medicine, NICU, Oncology, and ICU teams
- Pharmacokinetic monitoring
- Automatic substitutions
  - Cefotetan $\rightarrow$ Cefoxitin
- Automatic stop orders (5 days) – order must be renewed
  - Anticoagulants
  - Narcotics
  - Antibiotics

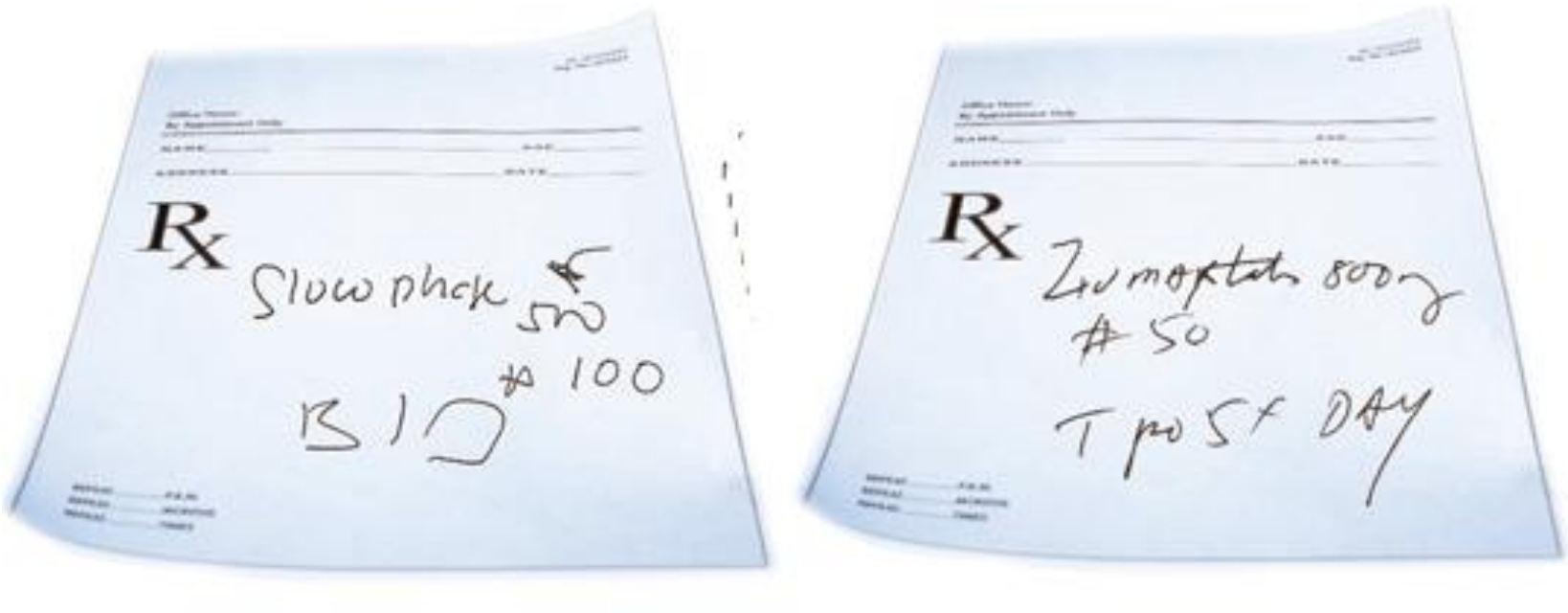
Miscellaneous

- **CPOE** – "**C**omputerized **P**rovider **O**rder **E**ntry"
  - Select medication, route, and frequency
  - PRN medications w/ indications- you must give parameters for PRN
    - "Percocet 1-2 po q6 hours PRN pain level 5-8" and
    - "Motrin 800 mg po q4-6 hours PRN pain level 1-4"
  - Comment for hold parameters, titrating parameters
- National shortages
  - P&T newsletters, via emails from ECOMS chair
- Non-formulary request form
  - NFDR at NNMC (Non-formulary Drug Request)
    - Intranet – under Home page links
  - SPP at WRAMC (Special Product Procurement)
- NO Meperidine (Demerol®) PCA's at NNMC per P&T Committee

CPOE

- Patient safety is the key!!!
- Prevents illegible hand-writing
- Extra steps
- ….But necessary

Can you read these Rx's?



- **Rx 1:** Glucophage 500 mg, #100, 1 tablet bid
- **Rx 2:** Zovirax 800 mg, #50, 1 tablet po 5x day

ANESTHESIA & PAIN MANAGEMENT

Acute Pain Service

- We offer 24-hr availability but…
- KNOW your patient!! *Especially* if you are the "cross-cover" NO EXCUSES!!
- Key information prior to calling for consult
  - Location, type/characteristics, duration of pain?
  - What makes the pain better/worse?
  - What interventions has the primary team tried?
  - Your own personal examination and interview of the patient

Things to Try First

- **NSAIDs**
  - Ibuprofen 400-800 mg PO q8 hours
  - Celebrex 400mg PO x 1, then 200mg PO QD
  - Check renal/GI function
    - Do not use in renal insufficiency or with GI bleed
- **Acetaminophen**
  - Max total adult daily intake 4gms/day
    - Do not use with liver failure, chronic alcoholics
- **Short acting narcotics (PO or IV)**
  - Morphine 1-2mg IV q10 min, Dilaudid 0.2-0.4mg IV q10 min
  - Titrate to respiratory rate > 10
    - Any level M.D./D.O. may administer this medication on the ward, just stay with patient and count their respirations

Things to Try First - PCA

- PCA = patient-controlled analgesia
- More effective than “PRN” orders
- Modes
  - Basal rate, Patient demand, Combine
- Unmonitored patients (ward) should not have basal rate (exceptions made with narcotic-tolerant patients)
- Morphine 1-2mg IV q10 min
- Dilaudid 0.2-0.4mg IV q10 min
- Fentanyl 25 mcg IV q6 min

Chronic Pain Service

- Monday-Friday consultation
- CIS consult note required
- Call 139 from any Nortel phone

- Things to try first
  - NSAIDs, Tylenol, PCA (titrate up dose to effect)
  - Neuropathic pain
    - Neurontin 100mg PO TID
      - Increase by 100mg q3 days up to 600 mg TID
    - Elavil 25mg PO Qhs x 3days, then 50mg Qhs

Chronic Pain - Methadone

- Narcotic with Mu and NMDA receptor activity
- Long-acting (consider it a “basal rate”)

- Start at 5mg PO BID

- Can cause respiratory depression up to 72 hours out from dose
  - Titrate every 3 days! Don’t be aggressive
- Patient may require short-acting med (oxyIR, percocet) for breakthrough pain
- On home narcotics? D/C home narcotic, then give 1mg methadone for every 8 mg of morphine used at home. Need help? Call our service with questions.

Regional Pain Service

- 24-hour availability, covers acute pain consults also
- Service covers patients with epidural, intrathecal, and peripheral nerve catheters
- KNOW your patient! KNOW what type of catheter they have!
  - If you don't know, then *ask*
  - Don't know what those catheters are? Then ask us! We'll be happy to teach you about them
- Page 295-1383, pin **0027** for assistance
- **DVT prophylaxis can *permanently injure* these patients - adhere to guidelines!**

Regional Pain Service

- Acceptable prophylaxis
  - Lovenox 40mg SQ QD
  - Heparin 5000mg SQ BID
- Covers EVERY type of catheter
- **ABSOLUTELY NO OTHER ACCEPTABLE REGIMEN**
- If your team changes the plan, inform the Regional Service **IMMEDIATELY** - epidural, intrathecal, and peri-neural bleeding are surgical emergencies!

Intravenous Access

- There is no IV or Phlebotomy service at NNMC
- We can occasionally assist with intravenous access
- Consult must be called by physician
- Important info to have on hand:
  - Reason for access (antibiotics/meds/CT scan)
  - Type of access (peripheral, central)
  - What sort of attempts have been made to secure access
  - Will the primary team accept a central line if peripheral access cannot be obtained? This is especially important for the cross-cover to know!!
- Patients come to pre-op holding area WITH a healthcare provider (nurse, intern) AT ALL TIMES
  - Exceptions: Obstetrics, ICU, 3West/monitored bed patients

Blood and Blood Products

- Wounded Warriors have high rate of transfusion prior to arriving at WRNNMCB
- Many have antibodies in their blood which predispose patients to delayed hemolytic reactions - can cause liver/renal failure
- Emergency release blood is O-negative, which can trigger this reaction in pts with antibodies
- SO…if you think they aren't going to bleed in the OR (because they are "just" having an I&D) - **you are WRONG**
- **EVERY** OIF needs a type & screen or cross (the screen is for antibodies - if they are positive, then we cross-match them to make sure we have blood in the blood bank that we can actually give without hurting the patient)
- Check this daily - the screens and crossmatches expire automatically. Questions? Call us, or the duty pathologist

Quick Notes

- PCA orders must be re-written upon every patient transfer - including to and from operating room!
  - Hospital, not Anesthesia, policy!
- Remember ALL patients undergoing ANY anesthesia (“sedation”, nerve catheter placement) MUST be NPO after midnight!
- Scheduling
  - Need anesthesia services/support for a procedure? Place your patient/procedure in the Surgical Scheduling System, then page 0029 (floor-runner).
  - Floor-runner will discuss our availability/options with you

Conclusion

- Have a question? Need assistance *FAST?* - call the central Anesthesia pager: **295-1383, pin 0009** (floor-runner pager)
- Cant find anyone? Call Operating Room Front Desk (24-hr/day)
  - Dial **100** from any Nortel phone
- No complaints if you haven’t tried both of those first
- HAVE A GREAT YEAR!!!

RESEARCH/IRB

What is research?

"A systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizeable knowledge"[1]

If in doubt ASK!

[1] Common Rule, 45 CFR 46

Steps in the Approval Process

1. Scientific Review Committee

   Scientific merit

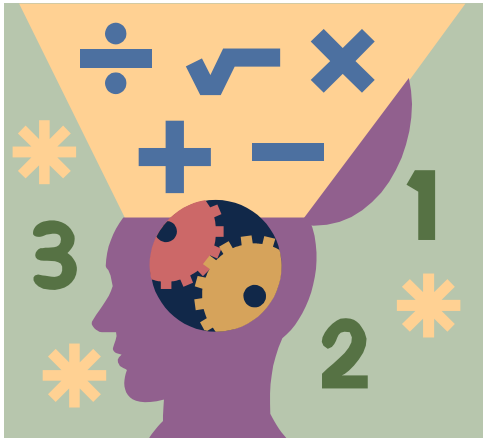
2. Institutional Review Board

   Harm/benefit, informed consent, etc

3. Command approval letter

   Command oversight

Why do we need an SRC?



- Scientific validity is essential to protecting human research subjects
- Research that is poorly designed puts subjects at risk, wastes the subject's, investigator's and the Command's time and resources

Why do we need an IRB?

- **<u>Human subjects protection</u>**
- People are not objective about their own work
- People underestimate the risks of things they are familiar with
- People overestimate the benefit of things they think are important

IRB Considerations

- Minimize risks to subject
  - Sound design, minimal risk procedures
  - Procedures that subject would have anyway
- Risks reasonable compared to benefits
- Selection of subjects is equitable
  - Vulnerable populations/add'l safeguards
- Informed consent process
- Adequate monitoring of data for safety
- Protection of privacy, confidentiality

Why do we need command approval?

- Commander approval
  - Ensures that the SRP and IRB functions are fulfilled
  - Assures that the research is consistent with the Command's mission
- Must obtain approvals ***prior*** to conducting or continuing research
- Must obtain institutional approval ***prior*** to implementing amendments to approved research
- Must notify the IRB in writing of unanticipated problems

All presentations and manuscripts must be cleared by the command

- Publication clearance request form is on the RCRS web site
  - Abstracts for posters or presentations
  - Manuscripts
- RCRS checks that the research being reported was IRB approved
- PAO checks for security and sensitive issues

Research not being done at WRNMMCB but being done by people billeted here

- Commander is responsible for tracking, documenting anytime Command is engaged in or supports research
- “Engaged” or “supports” includes people whose billet is here and whose salary is paid by the hospital.
  - **References: Our FWA, DoD 3216.2, SECNAVINST 3900.39D**

I want to do HSR elsewhere.. what should I do?

- Submit:
  - Completed Research Protocol Cover Sheet
  - Research Proposal as approved by other institution
  - Letter of approval from IRB of other institution
  - Copy of your CITI training certificate
- What will happen then:
  - Will be submitted to IRB/CO
  - If approved, letter will be issued to you
  - CIP number assigned, Joint Research Review Agreement written if necessary

Is retrospective review of patient records really human subject research?

- ***YES !***
- The institution becomes engaged in HSR when:
  - Its employees or agents intervene or interact with living individuals for purposes of federally supported research
  - Its employees or agents obtain, release, or access individually identifiable private information for purposes of federally supported research
- Reference: Federal-wide Assurance of Protection for Human Subjects

Personal Databases and Research

- Personally collected databases for research purposes may not be collected ***unless the research is ALREADY approved***
- Once a provider has ***formed the intent*** to conduct research, no data may be collected without required approval

Responsible Conduct of Research Services

- *Intranet:* RCRS on the site map (below link)
- *Phone:* 301 295-2275
- *Visit us:* Bldg 17 4th Floor- includes bench lab
- 4th Deck Tower (Bldg 1)-moving soon!
- LTC Molly Klote- Research Dept Chief
- "Vacant pending hire" – Administrative Lead
- Research Home Page: http://www.wrnmmc.capmed.mil/ResearchEducation/ResearchPrograms/SitePages/Home.aspx

DISCLOSURE TRAINING

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Walter Reed National Military Medical Center at Bethesda
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Definition

- Disclosure is information-sharing as facts become available. It is not defensive communication. It does not imply that there has been error or negligence. Disclosure is the right thing to do!

AMA Opinion on Code of Ethics

- “It is a fundamental ethical requirement that a physician should at all times deal honestly and openly with patients. Patients have a right…to be free of any mistaken beliefs concerning their conditions. Situations occasionally occur in which a patient suffers significant medical complications that may have resulted from the physician’s mistake or judgment. In these situations, the physician is ethically required to inform the patient of all the facts necessary to ensure understanding of what has occurred… Concern regarding legal liability which might result following truthful disclosure should not affect the physician’s honesty with a patient.”

General Principles

- Open communication demonstrates respect for patients, acknowledges their pain and suffering, reduces feelings of abandonment and keeps patients informed.
- Maintains organizational integrity and transparency
- Enhances patient-provider relationship
- A patient that is told the true is generally less upset than a patient who learns that bad news was withheld.
- Concealing an error or not providing satisfactory responses provokes suspicion or anger/

Successful Disclosure

- Successful disclosure enables the patient and family to understand what happened and the ramifications of the event as well as have sufficient information to make future decisions. Future actions might include seeking compensation. When caregivers humanize the situation, there is a greater likelihood that the demand for compensation is to cover financial damages rather than to be punitive. The true success of disclosure can only be measured in the efficacy of communicating facts and sharing regret for the patient's/family's trauma.

General Principles

- Errors that are disclosed in medical record or to regulatory agencies should be disclosed to the patient.
- Disclose medical errors regardless of whether the error/mistake resulted in harm to the patient.

Hallmarks of Successful Disclosure

- Allows caregivers and systems to promote openness and transparency in patient-centered care philosophy, learn from events, heal psychologically and show health care's humanism to the community at large.
- Allows patients to work out issues of distrust, deal directly with their pain and obtain information to make next-step decisions
- Allows patients and caregivers to recover from devastation of an unanticipated outcome.
- Focuses upon patient/family trust, ethical behavior and caregiver's obligation to patient
- Provides all information needed for future care decisions.

Challenges to Successful Disclosure

KEY ERROR HEALTHCARE PROFESSIONALS MAKE IN A DIFFICULT CONVERSATION IS CONSIDERING IT TO BE A FACTUAL CONVERSATION, FOCUSING ONLY UPON INFORMATION-SHARING

THE REALITY IS THAT DISCLOSURE IS A COMPLEX INTERPERSONAL DISCUSSION, WITH CONSIDERABLE EMPHASIS UPON FEELINGS.

- The more junior the physician, the more difficult to acknowledge mistakes.
- Managing the temptation to defend yourself.
- Being prepared to tolerate silence.
- Knowing how to be comfortable with not knowing all the facts.
- Knowing how to deliver bad news with clarity.
- Knowing how to address rumors, misperceptions and unrealistic expectations.
- Avoiding too much medical jargon.
- Handling patient’s emotions as well as their own.
- Health professionals can assume nothing about how news will be received
- No legal protection for information shared during disclosure.

Preparation for Disclosure Session

- Review facts
  - Review medical record
  - Review what is know about adverse outcomes resulting from treatment
  - Review what is known about causation
- Determine when additional facts should be available
- Identify involved participants

- Joint Commission standard RI 2.90 specifies that disclosure is responsibility of licensed independent practitioner or his/her designee.
- Should include provider involved in unexpected outcome, one who is able to accept responsibility and answer clinical questions
- Keep number of participants to a minimum

Preparation (continued)

- Select timing as soon after the event as practical
- Select appropriate setting
  - Allow for privacy
  - Refrain from sitting behind a desk or around a table (no barriers to communication)
  - Eliminate physical barriers for patients who have physical limitations
  - Pick accessible, private location

- Place beepers or cell phones on vibrate
- Stay seated during the conversation
- Have tissues available

- EXPECT TO FEEL VULNERABLE

Disclosure Conversation

- Initiation:
  - Determine patient/family readiness and ability to participate
  - Assess patient/family level of medical understanding
  - Confirm their understanding of course of treatment to date and expected outcomes

- Present facts:
  - Explain nature of error and harm, causes and consequences, when and where it occurred
  - Describe what happened; transparency is critical
  - Describe what is known about outcome of event; do not avoid negative information
  - Admit what you do not know

Conversation (continued)

- Refrain from yielding to pressure to answer questions you do not know
- Permissible to ask how detailed an explanation patient would like (may retain less information due to emotional context of discussion)
- Acceptable to “fire a warning shot, ”i.e. “I’m afraid the situation is serious” or “This is difficult for me to say.”
- Disclose facts as they become apparent.
- Let patients know if you do not have the answer and when they may expect additional facts.

Conversation (continued)

- Refrain from inconsistency or extended delays with no information, as this yields the perception of a cover-up
- Correct misperceptions and inaccuracies
- Acknowledge that there will be future conversations with frequent updates.
- Describe immediate steps to treat the patient to diminish gravity of harm.
- Describe what organization is doing to find out how event occurred so it may be prevented in future (refrain from using word “investigate” as patients will expect a report; use “review” or “look into” instead)

Discussion

- With regard to medical errors, i.e. failure of a planned action to be completed as intended or use of a wrong plan to achieve an aim, “I am so sad that this has happened. You must be terribly upset, and so am I.”
- After an unanticipated outcome, “This is sad and not what any of us expected. I wish it weren’t this way and I know you do, too.”
- Do not ignore or dismiss strong emotions of patient and family; identify and acknowledge them
- Patients want understanding, respect and an open, honest, genuine and sincere discussion.
- Manage fear
  - Be honest when asked “how bad is it?”
  - Most common reactions to bad news are denial, anger, fear, crying shock, distrust and anxiety.
  - Truth is the most effective antidote to fear

Discussion (continued)

Manage conflicting opinions from different departments

- If there is an difference of opinion as to what occurred, have attending physicians from involved clinic areas disclose jointly
- Acceptable to say that as a healthcare organization, collectively we all accept responsibility when there are unexpected outcomes of care.

Apology

- Benevolent expressions are acceptable rather than liability admissions
- Apology with discussion of outcomes and future treatment plans may be effective in mitigating anger.
- Apology should not be statement of fault
- Absence of apology is inflammatory.

Do Not Disclose…

- Disciplinary actions
- Results of root cause analysis or quality assurance reviews
- Morbidity and mortality conference proceedings
- Peer review materials

- Refrain from admission of personal or institutional liability.
- Do not say: There was negligence.
- Standard of care was not met.
- Military medicine should compensate you.

- Refrain from finger pointing. You may state that we collectively accept responsibility when there is an unexpected outcome of care.
- Refrain from speculation. Share facts as they become available.

SOCIAL WORK DEPARTMENT
MEDICAL SERVICES
DIRECTORATE

Bldg 7, 6th Floor

301-295-1719

0730-1600

Services for Patients

Medical/Surgical Social Workers work in the Social Work Division of the Social Work Department and provide the following services to patients and families whose lives are impacted by medical issues:

- Medical crisis counseling for new diagnoses or exacerbation of illnesses
- Bereavement services for end-of-life issues or other losses
- Psychosocial support
- Discharge planning
- Admission prevention
- Resource Management (information and referral services)

Support for our Medical Teams

Social Workers provide the following services to our medical teams:

- Assistance with patients in crisis
- Assistance with complex or challenging family dynamics
- Assistance with locating community-based resources that can best assist the patient with their ongoing care
- Assistance with navigating multiple medical insurance requirements
- Assistance with patient housing, financial and placement issues
- Assistance with ordering DME and Home Health Care services
- Participation in multi-disciplinary rounds

Which patients require or would benefit from Social Work Intervention?

In accordance with NNMCINST 6320.42(Series), Discharge Planning, the following patients should be referred to the Social Work Department:

- Patients admitted from or being transferred to a nursing home, extended care or assisted living facility.
- Patients who, after discharge from WRNNMCB, will need skilled nursing care, physical therapy, durable medical equipment, oxygen, home intravenous therapy and/or TPN at home.
- Patients who live alone and are not able to care for themselves.
- Patients who are blind, deaf or have significant neurological impairment (stroke, head injury, etc.).
- Patients whose admission is suspected to have been the result of neglect or noncompliance.
- Patients sustaining multiple traumas.
- Patients with terminal or life limiting illness.
- Unmarried pregnant patients.
- Patients with intrauterine fetal demise or known fetal anomalies.
- Patients placing newborns for adoption.

Which patients require or would benefit from Social Work Intervention…continued

- Complex neonates admitted to the Neo-Natal Intensive Care Unit.
- Patients with multiple medical diseases and/or two or more unscheduled admissions within a two (2) month period.
- Patients who request a referral to Social Work.
- Patients who are HIV positive or have AIDS.
- Patients who are scheduled to have or have recently had Total Joint Replacements, Radiation Therapy, Cardio-thoracic Surgery, Chemotherapy or limb amputation.
- Patients who are the primary care giver for a family member/significant other.
- Patients who have been living outside the continental United States (OCONUS).

It is <u>highly recommended</u> that the Social Work Department be consulted for:

- Patients or family members who are having difficulty adjusting to the patient's illness.
- Patients or family members who report marital or family problems which may impair recovery.
- Pediatric patients, with severe or multiple handicaps, and their families.
- Isolated families with limited support systems.
- Patients who are scheduled to have or have recently had Laminectomies, and are also over the age of 50.

HOW TO CONSULT:

To consult Social Work for an **INPATIENT**:

1. ***WRITE*** a Social Work consult in CIS. In the written consult, please include details of the case.

   EXAMPLE: *76 y/o female, newly widowed, s/p CABG, states she has significant family support, please evaluate for home PT vs. skilled nursing facility .*

2. ***CALL*** the Social Work Consult Line at 295-5926. Leave a BRIEF message with the name and PIN of the ordering physician, the name and last 4 of the pt, the pt's current location, and the team or service following the pt.

   EXAMPLE: *This is Dr. Smith with the Red Team Internal Medicine, PIN 1234567, calling with a social work consult for pt George Washington 20/1234, currently on 5C.*

3. ***FAX*** paper orders for the required DME or service to the Social Work Administrative Office at 295-0003 OR give the order(s) to your team/clinic Social Worker

HOW TO CONSULT:

To consult Social Work for an **OUTPATIENT**:

1. WRITE a CON to Social Work (SOC WRK MED BE) in AHLTA. The CONs print in our administrative office. The case will be assigned to the social worker in that clinic.

- ***Be as specific as possible in your CON! Do NOT enter it as a referral, these do not print out for us!***

2. FAX paper orders for the required DME or service to the Social Work Administrative Office at 295-0003 OR give the order(s) to your team/clinic Social Worker

Discharge Planning

- Discharge Planning begins at admission.
- ***PLAN AHEAD*** with your social worker, if in doubt, consult with your social worker about the case in order to determine if social work intervention is necessary and appropriate.
- Safe, thorough, and appropriate discharge planning decreases re-admissions, as well as patient/family complaints

After Hours, Weekends, and Holidays

Routine discharge planning and arrangements for home-based DME or services (i.e. referral to SNF, DME, home health, home IV antibiotics) cannot be initiated over the weekend or on holidays safely and efficiently. These discharge plans require coordination with civilian community-based agencies, many of which do not accept admissions or referrals outside of traditional daytime business hours.

- Delays in discharges and start-of-care dates can be avoided by PLANNING AHEAD and consulting Social Work at the early stages of an inpatient admission or course of outpatient treatment.
- Most of these plans require a minimum of 2-3 BUSINESS DAYS to coordinate, after a consult has been received.
- Delays in obtaining DME or home health care services for OUTPATIENTS can be avoided by FAXING ORDERS at the time the consult to Social Work is entered. The Social Work fax number is 301-295-0003.

Patients with concerns of abuse…

FOR ALL ALLEGATIONS OF SPOUSE ABUSE, CHILD ABUSE AND SEXUAL ASSAULT, PLEASE PAGE THE FAMILY ADVOCACY (FAP) SOCIAL WORKER WHOSE TELEPHONE NUMBER IS ON THE PLAN OF THE DAY.

Points of Contact

Social Workers are assigned to clinics and inpatient units. This allows the clinic staff to develop a professional working relationship with the social worker assigned to their area.

- **Social Work Integrated Dept Head** – LCDR Stephen Bromberek 301-319-8314
- **Social Work Division Officer** – Ms. Kathleen Baxley 301-295-5925 pager # 1068111
- **Social Workers**
  - Mr. Brian Burgener 301-319-8287 pager # 1659632
  - Ms. Terri Craig 301-295-6294 pager # 1140113
  - Ms. Melika Dorroh 301-319-8995 pager # 1071112
  - Ms. Laura Havard 301-295-3582 cell # 301-442-1040
  - Ms. Kate Houtz 301-295-2044 pager # 1084730
  - Mr. Mark Jackson 301-319-8764 pager # 1085242
  - Ms. Anne LaFond 301-295-6360 pager # 1064255
  - Ms. Debbie Mayhew 301-295-2668 pager # 1783045
  - Ms. Deborah Oliver-Davis 301-319-8934 pager # 1659553
  - Ms. Holly Pertmer 301-319-8827 pager # 1614786
  - Mr. Jamie Stockus 301-295-2579 pager # 1100645
  - Mr. Rob Thorner 301-295-2462 pager # 1137417
- **Admin – 301-295-1719**
  - Mr. Jan Roberts 301-319-4611
  - Ms. Maria Elane 301-295-1719

MEDICAL RECORD DOCUMENTATION

Documentation Requirements

- History & Physical – Created in Essentris by Resident &/or Intern w/in 24 hours of admission
- Attending Physician must countersign within 24 hours or write a stand-alone note
- Daily attending progress note OR co-sign housestaff note(s) in Essentris
- For outpatients, AHLTA encounters must be closed out in 72 hours or less. Each clinic has business practices involving staff signatures for notes and timeline
- Recommend housestaff notes include the phrase “seen and discussed with..or discussed with Dr “staff name”

Documentation Requirements

- The history is a record of information provided by the patient or his/her agent. Opinions of the reviewer should not be recorded in the body of the history. The medical history should reflect relevant past history, including developmental, behavioral, family, educational, emotional, social histories when appropriate and a review of systems.

Documentation Requirements

- The history and comprehensive physical examination shall be accomplished, recorded and signed by staff within 24 hours of admission. Providers shall indicate which parts of the physical exam were not performed or not indicated and why. No parts of the H & P forms are to be left blank.

Documentation Requirements

The H & P must include at a minimum:

- Chief Complaint
- Present Illness
- Physical Examination
- Provisional Diagnosis
- *All procedures require an OP note! If done in the OR, a brief OP note needs to be completed <u>before</u> the patient leaves the recovery room, pending dictation.
- Include the dictation number in the brief OP note

Documentation Requirements

- Signature Block: Do not type any name but your own, to do so is forgery, this is meant to be the electronic signature – it is clearly stated on the H & P the name is intended to be the electronic signature

- Progress Notes – Created in Essentris – At a minimum a daily progress note is required or co-signature of housestaff note(s)

Documentation Requirements

Operation Reports – Shall be dictated immediately following surgery including the name of the primary surgeon and assistants. Must include:

- Findings
- Operation performed with a detailed account of technical procedures used
- Tissues altered or removed
- Estimated blood loss
- Dressings and drains as appropriate
- Condition of patient at termination of surgery
- Post-op diagnosis and tubes, dressings and drains as appropriate
- The dictated report shall be signed and authenticated by the primary surgeon
- Comprehensive operative progress note shall be entered immediately after surgery pending the operative report.

Documentation Requirements

Narrative Summary - Created in Essentris by resident &/or intern within 24 hours of discharge, archived at discharge due to residents and/or interns re-opening after the attending had signed Signature Block.

Must include:

- Reason for hospitalization, brief clinical statement of the chief complaint and history of the present illness
- All significant findings
- All procedures performed and treatments given, including the patient's response, complications and consultations
- The condition of the patient at discharge or transfer
- D/C instructions given to the patient or their family (i.e., physical activity permitted, medication, diet and follow-up care
- All diagnoses and complications at the time of discharge or transfer and designation of a primary diagnosis - Discharge Diagnoses must be a Diagnosis and not a procedure – **S/P is not acceptable**

Dictation Requirements

- Operative Reports should be dictated within 24 hours
- Please enter the appropriate work type i.e., 9 for an I/P Op or 13 for an O/P Op this will make life easier for everyone all around
- it helps the transcriptionist identify the template beforehand
- it helps the transcription tech file the Ops in a timely manner
- increases value for coding
- ensures your workload is captured in a timely manner which will make your department head very happy

Dictation Requirements

- Please dictate by identifying yourself as the resident and indicate who the attending surgeon is
- Spell both last names as well as the patient's
- Identify again whether you are dictating an Inpatient or Outpatient Op report – makes life easier
- Dictate according to the written dictation instructions and examples included in the packet
- When checking in you must report to Inpatient Medical Records to register for your provider number to dictate – You cannot dictate w/o a provider number

Chart Completion

- All Essentris documentation should be completed and signed off prior to discharge – this includes consults – the attending physician must sign and date the Consultation Note by typing in their name next to the words Attending Physician and Date.
- Minor procedures performed at bedside – Created in CIS under Procedure Notes or Generic Notes
- You are required to report to the Physician Incomplete Record Room a.k.a. the PIRR located in Bldg 10 just behind the Quarterdeck biweekly to complete any incomplete records
- The record is considered delinquent on the 31st day from discharge per Joint Commission
- Delinquency Rates & Reports are reported to the Department Head Weekly – lists the services delinquency rate as well as those physicians with delinquent records including the number of delinquent records you have assigned to you

MEB/LIMDU or PEB or Fit for Full Duty?

- **Medical Evaluation Board (MEB)-** the medical officer's handwritten or dictated assessment of a patient's condition. Contains **LIMDU**, history, assessment, plan, restrictions, etc.
  - **Limited Duty (LIMDU)-** basically a long light duty chit written up or dictated as part of the MEB
    - Up to six months each cycle
    - Up to 12 months total (for the same medical problem).
    - Requires **Departmental Review by member's service headquarters** if LIMDU exceeds 12 months. Requires a dictation be completed.

- **Physical Evaluation Board (PEB)-** a group of medical and line officers that:
    - Determine a service member's fitness for continued naval service ("fit vs unfit") using a lot of info including the MEB dictation
    - Rate member's whose disabling injury or illness is determined to have been incurred or aggravated while in receipt of basic pay.
    - Ensure member's right to a full and fair hearing.

- **Fit for full duty-** exactly what is says- unrestricted duty – "Ready to Save the World – Anywhere, Anytime…"

When is it time for a PEB?

- **When maximum benefit of medical treatment and rehab attained**
- **When all available SIQ, Light Duty, Convalescent Leave, and LIMDU (Limited Duty) exhausted (12 months)**
- **When Service HQ denied additional LIMDU (Limited Duty)**

Disability

"Any impairment due to disease or injury, that reduces or prevents an individual's actual or presumed ability to engage in gainful employment or normal activity"

SECNAVINST 1850.4E

Diagnosis Vs Disability

The mere presence of a medical condition does NOT necessarily result in UNFIT finding or entitlement to a disability rating.

When Not to Submit a PEB

- **Failure to pass the PFA (Physical Fitness Assessment)(sole reason)**
- **If further surgery or other significant treatment is planned/scheduled**
- **Member requests a PEB to document conditions on retirement**
- **Member's command requests a PEB (sole reason)**

Inability to do PFA or inability to deploy is NOT a sole reason for someone to be found unfit or to submit an MEB/PEB

A GOOD MEB/PEB Dictation

- **Specifies objective findings**
- **Emphasizes impairments and their relation to job interference**

- **"Since the contracture affects the dominant hand, the member cannot adequately extend his elbow to perform maintenance under aircraft"**
- **"The member has difficulty on the rifle range (but not with the pistol) due to the pain of kneeling + lying on his knee at the range"**

MEB/PEB Dictation includes

- **History of present illness**
  - Chronology
  - Mechanism of injury
  - Prior Treatment, Surgery, Limited duty, PEBs and response
  - Outside employment
- **Family/Social History**
  - ETOH/smoking
  - What sports activities can or cannot be done
  - Inquire about social activities (e.g. dancing)

MEB/PEB Dictation includes

- **Exam specific to chief complaint**
- **Baseline General PE**
  - **Vitals, Ht/Wt**
  - **SF 88/93**
- **Dominant Hand**
- **Specify Affected Side**
  - **Compare sides**
- **In referring to prior boards**
  - **Don't copy verbatim**
  - **"Interval history" not acceptable**
- **Lab/X-ray results**

MEB vs PEB

- Two Medical Officers
- NO Line Officers
- Refers to the "patient"
- Diagnosis Oriented
- Reports what the patient tells provider
- Emphasis on what patient tells doctor

- One Medical Officer
- TWO Line Officers
- Refers to the "member"
- Impact Oriented
- Considers what command tells the PEB
- Emphasis on correlation of medical + non-medical Information

Medically Based **Performance Based**

What is FIT?

- **FIT: Member can reasonably perform duties of their office, grade, rank or rating.**

- **PEB balances impact of member's diagnoses, via objective medical and performance evidence, against member's ability to perform duties of office, grade, rank or rating.**

FIT call Characteristics

- **Condition present for several years or more with minimal (or expected) change**
- **Minimal objective findings on physical exam**
- **Commanding Officer states member is performing USN/USMC duties**
- **Member is motivated to stay in service**

When we call a member FIT we are not saying:

- **He/she is fit for FULL duty**
- **That you are wrong (there are frequently items of which you are unaware)**
- **That we do not believe you or the member**
- **That we know more than you do even though you're seeing the person**

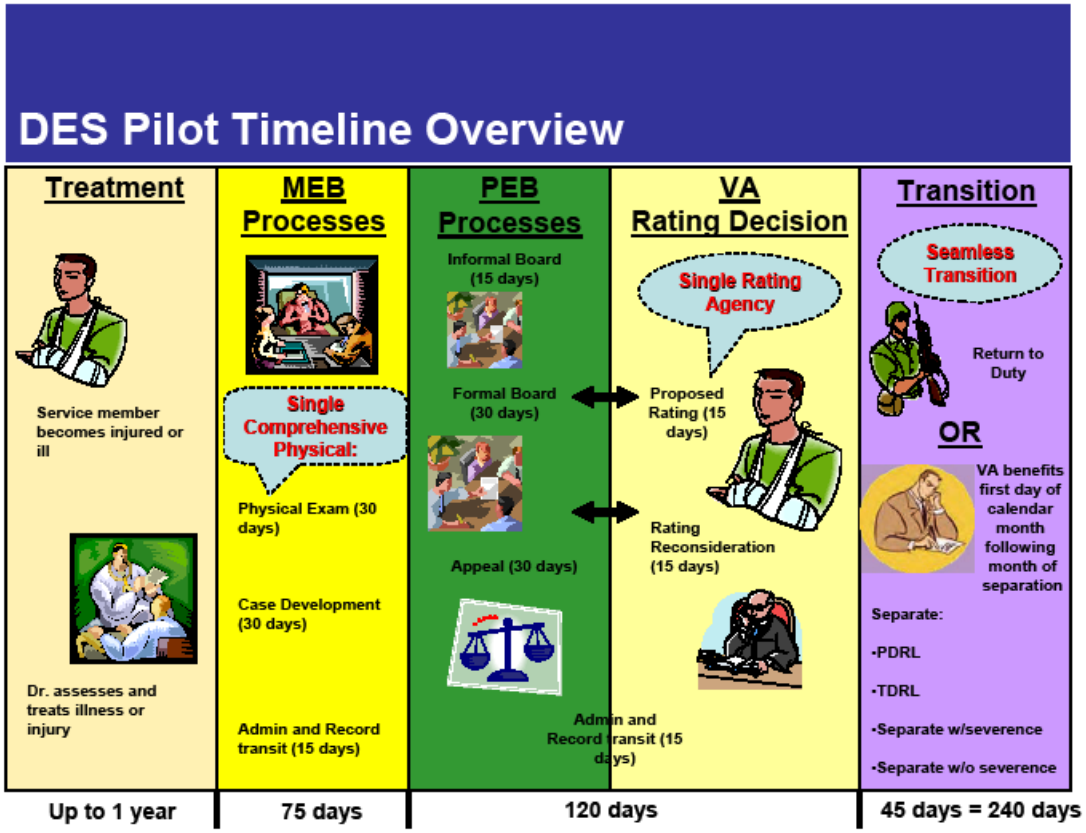
UNFIT Call Characteristics

- **Condition impairs member's ability to perform their duties**
- **Multiple clinic or Emergency Department visits**
- **Objective Findings on physical exam**
- **Commanding Officer's assessment indicates job limitations, absences from work**

DOD/VA Disability Evaluation System Pilot Program

- Began at NNMC on 11/26/07.
- Will continue through 1/09, although may change with merger.
- Use new Pilot Referral Form to initiate Medical Evaluation Board process. (forms located on new Intranet).
- Narrative Summary (Dictation) remains unchanged during the pilot program, however is completed upon member completing examinations at the VA.
- Contact Medical Boards office at 295-5511 with any questions about the pilot program.

DES Pilot TimeLine Overview



WRNMMCB Health Readiness

Background:

Individual Medical Readiness (IMR) is the underlying foundation for Operational Readiness. The primary purpose of the IMR is to keep our Soldiers, Sailors and Marines healthy, medically ready, and functioning optimally for rapid deployment. IMR is a direct reflection of a unit's ability to fulfill its mission.

There are several essential components of the Army and Navy IMR as outlined below:

1. **Periodic Health Assessment (PHA): The Periodic Health Assessment consolidates medical, dental, occupational health/risk screening services, medical readiness requirements, health record review, and preventive health counseling.**

2. **Deployment-limiting Conditions: Deployment-limiting conditions are identified as medical issues, (e.g. pregnancy, Dental Class 3), that would prevent a service member from being deployed, or limit the type and/or location of a deployment.**

3. **Dental Readiness: An annual T2 dental examination will be completed during the service member's birth month. A Class 1 or Class 2 dental designation is required to maintain a deployable status.**

4. **Immunization Status: Immunizations are an effective preventive health intervention for deployed and non-deployed service members. Immunization status will be reviewed annually as part of the birth month Periodic Health Assessment.**

5. **Readiness Laboratory Studies: Specific laboratory studies required for personnel are: DNA, ABO Blood Typing, G6PD, Sickle Cell, Pap for females and HIV (every 2 years).**

6. **Individual Medical Equipment: Individual Medical Equipment is defined as any medical devices, i.e. 2 pair of eyeglasses, gas mask inserts, and medical alert tags as appropriate for personnel subject to deployment.**

Health Readiness

- There are some variations between the services
- Your unit/company will provide you with details regarding your training status and health readiness.
- Ex. AKO for Army will provide you with your status via “traffic lights”. Be aware, more stringent requirements may exist for certain categories than AKO lists.
- **CURRENT** up to date status is required BEFORE you are able to take leave or go TAD/TDY!
- Any questions, see your Division Training Officer or training NCO/SEL for your status or requirements

WRNMMCB Health Readiness

NAVY Reporting:

IMR for of each service member will be assessed by using the following parameters:

- **Full Medical Readiness (FMR) – 100% Current in all 6 IMR components including dental class 1 or 2.**
- **Partial Medical Readiness (PMR) – Lacking any of the 6 components without fault to the Service Member.**
- **Not Medically Ready (NMR) – Has a deployment-limiting condition or dental class three.**
- **Medical Readiness Indeterminate (MRI) – Inability to determine health status because medical record data is missing.**

Periodic Health Assessment (PHA)

Delinquent = PHA is greater than 30 days overdue

Incomplete = Member has not completed the PHA during their Birth Month

NOMEDREC = No medical record to determine PHA status

Pending = Member has started IMR the process

NOT Dental Ready = Dental Class 3 or 4, not deployable

Physical Fitness Assessment (PFA)

The Physical Fitness Assessment (PFA). The PFA is part of a total health, physical fitness, and readiness program. All military personnel shall strive to optimize fitness and
readiness by exceeding minimum standards and achieving continual improvement.
The two-fold purpose of the PFA:
a. Provide members with goals to promote basic physical fitness, health, and readiness.
b. Provide COs a means of assessing the general fitness of command members.

Component:

- PRT - Physical Readiness Test
- Body fat measurement if out of weight standards

Physical Fitness Assessment (PFA)

The PRT/APFT is a series of physical activities designed to evaluate factors that enable members to perform physically. Factors evaluated are

(1) Flexibility via sit-reach (Navy).
(2) Muscular strength and endurance via:
    (a) Curl-ups.
    (b) Push-ups.
(3) Aerobic capacity via*:
    (a) 1.5-mile run(2.0 mile Army)
    (b) 500-yard or 450-meter swim(Navy)
(4) Alternate events include walk/bike or elliptical

*** BEGINNING WITH THE SPRING 2007 PHYSICAL FITNESS ASSESSMENT (PFA) CYCLE, USE OF THE ELLIPTICAL TRAINER IS APPROVED AS AN ALTERNATE TEST OPTION FOR THE Navy only 1.5 MILE RUN.**

Physical Fitness Test

- **All** personnel are required to meet standards set forth in the Navy instruction or Army regulation. Members who are unable to meet PFA standards will be subject to administrative action. COs shall recognize members who make significant improvements in physical fitness or consistently score excellent or better through comments on fitness reports, evaluations, OER's, and other incentive awards.
- Navy reference: http://www.navy-prt.com/
- Army reference: http://www.army-fitness.com/

Random Urinalysis

Every active duty member is subject to random urinalysis according to the regulations or instruction for their respective service. It will be administered according to policy and procedure set up by their service branch. This is a mandatory requirement, and members will be notified the day of random testing.

<u>Disciplinary Action</u>. Violation of the prohibitions set forth in this instruction subjects military members to disciplinary action under the Uniform Code of Military Justice. The full range of administrative and disciplinary actions is available to address violations. These include informal counseling, comments in fitness reports and evaluations, administrative separation, and punitive measures under the Uniform Code of Military Justice.

Random Urinalysis

Zero Tolerance Policy. The Army, Navy, and this command's policy on drug abuse is "zero tolerance." Members of this command determined to be using drugs, in violation of applicable provisions of the Uniform Code of Military Justice, Federal, State or Local statutes, shall be disciplined as appropriate and processed for administrative separation as required. Members diagnosed as drug dependent shall be offered treatment prior to separation.

Disciplinary Action. Violation of the prohibitions set forth in this instruction subjects military members to disciplinary action under the Uniform Code of Military Justice. The full range of administrative and disciplinary actions is available to address violations. These include informal counseling, comments in fitness reports and evaluations, administrative separation, and punitive measures under the Uniform Code of Military Justice.

Random Urinalysis (Cont.)

Responsibilities. All military personnel assigned to WRNNMCB are responsible for adherence to the policy of "Zero Tolerance" with respect to drug abuse. Failure to properly report known or suspected drug and alcohol abuse could result in disciplinary action.

The following are the only acceptable reasons for personnel to miss a scheduled drug screening, and must be immediately reported to Drug Screening Division:

1. Written TDY/TAD Orders.
2. Leave.
3. Normal or scheduled liberty arranged prior to testing notification.
4. Training away from the command approved by the Directorate (off-site rotations but not NIH or USUHS!)
5. Hospitalization/SIQ.

INTERN LICENSURE

Tom P. Charlson
Medical Staff Services

Overview

- POLICY
- RESTRICTED STATES
- LICENSURE GOAL DATES

Policy

- DOD DIRECTIVE 6025.13
- BUMED INST 6320.66E
- BUMED INST 6320.67A
- JCAHO ACCREDITATION MANUAL
- BUMED INST 6010.17A
- SECNAVINST 6401.2A
- DOD DIRECTIVE 6040.37

Policy

- Licensure, certification, or registration is a qualification for employment and commission as an uniformed health care provider in the MHS and is required the entire period of employment and commission regardless of assignment, billet type or duties and responsibilities.

- DON policy states all health care practitioners responsible for making independent decisions to diagnose, initiate, alter or terminate a regimen of medical or dental care within the scope of their licensure or certification are subject to credentials review and must be granted a professional staff appointment with clinical privileges by a designated privileging authority before providing care independently.

- Practitioners must possess a current, valid, **unrestricted** license or certificate, a license or certificate of exemption, or be specifically authorized to practice independently without a license or certificate or exemption of same, as prescribed in BUMED INST 6010.17A, to be eligible for a professional staff appointment with clinical privileges.

Restricted States

- Per current DoD Guidance on Physician Licensure, no physician may elect to apply for a license from one of the states listed below:
- Florida
- Kansas
- Massachusetts
- Oregon
- Pennsylvania
- Colorado
- This is based on the above states having requirements for unrestricted licenses, usually due to a clause requiring providers to pay into a malpractice or birth injury fund. You may choose to get a license in theses states, but you will be responsible for paying those annual fees for those funds, or meeting the state's requirements. The military exemption clause will not be allowed.

Restricted States

- Be advised, many other states have requirements for GME after medical school before you can apply for a license. It changes annually, so be sure to verify with your desired state's licensing board before submitting your application.
- http://www.fsmb.org/usmle_eliinitial.html
- More and more states are requiring 2 or even 3 years GME before you can apply for a license.
- The military requires you to obtain a license after your internship year, by the end of your second year of training, so plan ahead.
- See your individual program director if you have questions, or contact the Medical Staff office or GME offices.

Goal Dates

- ALL INTERNS SHOULD HAVE SCHEDULED USMLE PART III OR COMLEX BY DECEMBER 31 20XX OF INTERN YEAR
- JANUARY 15, 20XX – LETTER FROM COMMANDER REQUIRING LICENSURE

MARCH 31, 20XX– ALL INTERNS MUST HAVE TAKEN AND PASSED THE USMLE PART III OR COMLEX.

- MAY 15, 20XX– ACKNOWLEDGEMENT LETTER RETURNED TO PROFESSIONAL AFFAIRS
- MAY 15, 20XX – COPY OF LICENSUE APPLICATION TO INCLUDE
  - CHECK AND CERTIFIED MAIL RECEIPT
- NON-COMPLETION = YOU WILL NOT PCS FROM WRNNMCB

Hazing Policy

Hazing is defined as any conduct whereby a military member, or members, regardless of service or rank, without proper authority causes another military member or members, regardless of service or rank, to suffer or be exposed to any activity which is cruel, abusive, humiliating, oppressive, demeaning, or harmful. Soliciting or coercing another to perpetrate any such activity is also considered hazing.

The details for what is hazing and actions to be taken can be found in SECNAV INSTRUCTION 1610.2A

Hazing cont’d

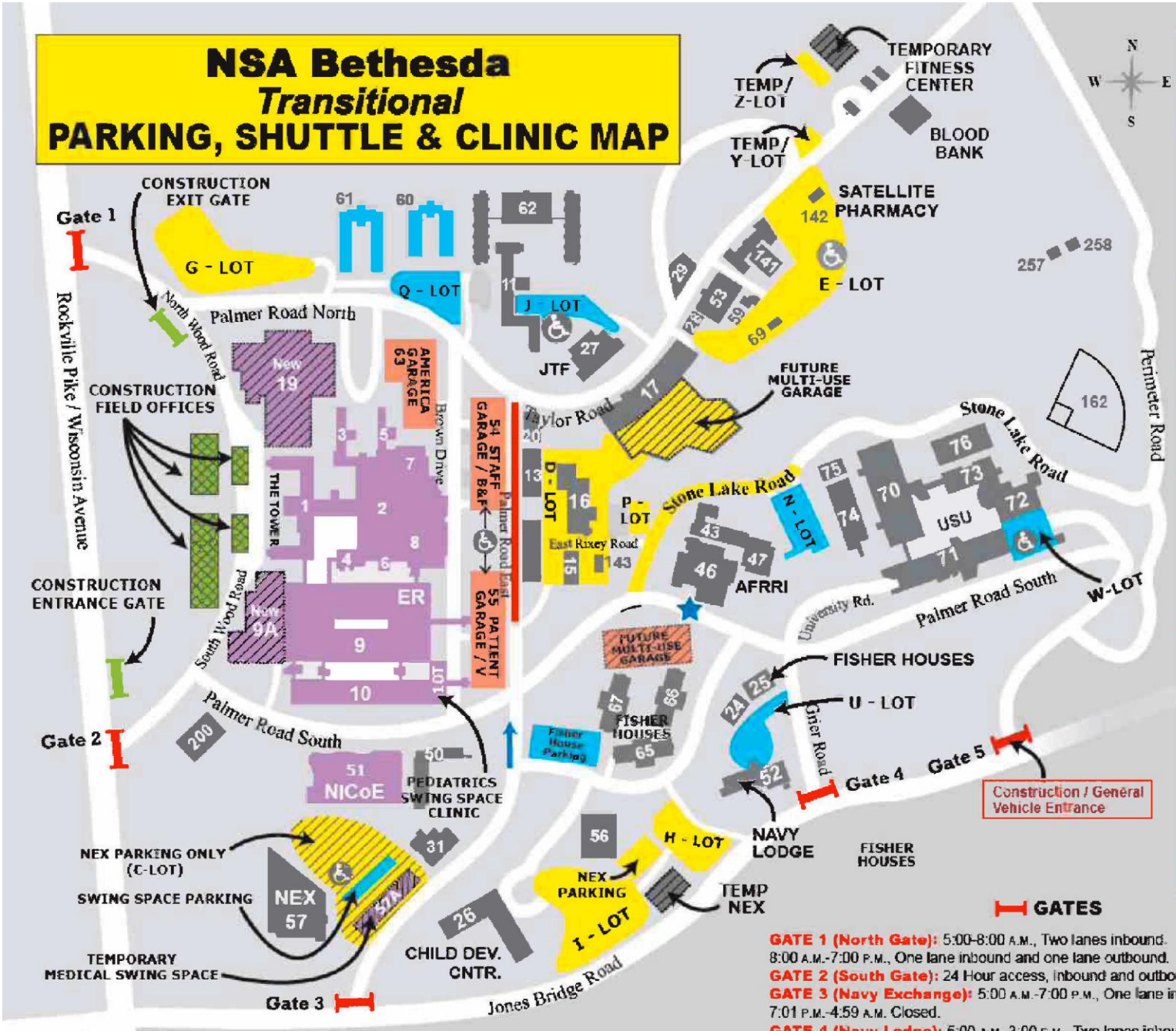
- Hazing need not involve physical contact among or between military members; it can be verbal or psychological in nature. Actual or implied consent to acts of hazing does not eliminate the culpability of the perpetrator. The last line is particularly important. Hazing occurs whether there is a true victim, or a willing participant. The only difference is if the willing participant has foreknowledge of the event, which happened in this case, then they are in violation of the instruction as well. I need to emphasize that all sailors, both officer and enlisted, are expected to know the rules and regulations that govern the Navy. Good order and discipline is the foundation of our service, and our reputation. Knowing and following the rules is the responsibility of all who wear our uniform. Five good sailors received punishment because they "didn't know the rule". Hopefully, everyone will learn from this incident. I do not expect it to happen again.

Code White Drill-Active Shooter

- **What is <u>Code White</u>?**
- **Code White** is used to notify staff, patients, and visitors of an Active Shooter. When Code White is announced all personnel will Shelter-in-Place (stay where you are!).
- **What is an** Active Shooter**?**
- An **Active Shooter** is an individual actively engaged in killing or attempting to kill people in a confined and populated area.
- **What is meant by** Shelter-in-Place**?**
- Seek immediate cover or concealment. If possible, lock and/or barricade all doors and remain hidden until the all clear is given or until secured by law enforcement personnel. Silence or turn off all electronic devices to minimize light and sounds. Close blinds and avoid windows.

- **What can I expect to occur during a Code White Drill?**
- Any Code White Drill will begin with a Public Address System announcement of “Exercise, Exercise, Exercise; This drill pertains only to the “whatever” Building; Code White, Active Shooter, Shelter-in-Place; The “whatever” Building is secured to all other traffic at this time; Exercise, Exercise, Exercise.” A postmaster will also be released.
- Any exercise will take place only in the announced building. All other buildings will continue normal business operation. Staff, patients, and visitors will be able to enter and exit the hospital and base freely during this exercise.
- Every effort is being made to ensure there is no interruption in patient care.
- All staff in the whatever building is being tested that are not actively engaged in patient treatment will shelter in place. Staff will direct patients and visitors to shelter-in-place.

NSA Bethesda
Transitional
PARKING, SHUTTLE & CLINIC MAP



PARKING LOTS:

- General Parking
- Restricted Permit Parking Only

CLINICS:

- Clinics
- Temporary and Future Clinics

SHUTTLE HOURS:

- Green Line Shuttle and Red Line Shuttle
  - 5:30 – 9:00 A.M.
  - 2:45 – 6:30 P.M.
- Blue Line Shuttle
  - 5:30 A.M. – 6:30 P.M.
  - *Shuttle makes additional stops at Navy Lodge* 9:00 A.M. – 2:45 P.M.
- Metro Line Shuttle
  - 5:30 A.M. – 6:30 P.M.

BUILDING 10

- *Start of Shuttle Routes*
- *NNMC–WRAMC Shuttle pick-up and drop-off point (Departs every half-hour from 5:30 A.M.; final departure at 6:30 P.M.)*

All times shown are for Monday-Friday

GATES

GATE 1 (North Gate): 5:00-8:00 A.M., Two lanes inbound. 8:00 A.M.-7:00 P.M., One lane inbound and one lane outbound. 7:01 P.M.-4:59 A.M. Closed.
GATE 2 (South Gate): 24 Hour access, inbound and outbound.
GATE 3 (Navy Exchange): 5:00 A.M.-7:00 P.M., One lane inbound and one lane outbound. 7:01 P.M.-4:59 A.M. Closed.
GATE 4 (Navy Lodge): 5:00 A.M.-3:00 P.M., Two lanes inbound. 3:01-6:00 P.M., Two lanes outbound. 6:01 P.M.-4:59 A.M. Closed.
GATE 5 (USU): 5:00-8:30 A.M., One lane inbound. 8:30-4:59 A.M. Closed.

rev. 12/2010

O-1	O-2	O-3	O-4	O-5	O-6	O-7	O-8	O-9	O-10	SPECIAL
ARMY										
Second Lieutenant (2LT)	First Lieutenant (1LT)	Captain (CPT)	Major (MAJ)	Lieutenant Colonel (LTC)	Colonel (COL)	Brigadier General (BG)	Major General (MG)	Lieutenant General (LTG)	General (GEN)	General of the Army (GA)
MARINES										
Second Lieutenant (2ndLt)	First Lieutenant (1stLt)	Captain (Capt)	Major (Maj)	Lieutenant Colonel (LtCol)	Colonel (Col)	Brigadier General (BGen)	Major General (MajGen)	Lieutenant General (LtGen)	General (Gen)	
NAVY										
Ensign (ENS)	Lieutenant Junior Grade (LTJG)	Lieutenant (LT)	Lieutenant Commander (LCDR)	Commander (CDR)	Captain (CAPT)	Rear Admiral Lower Half (RADM)(L)	Rear Admiral Upper Half (RADM)(U)	Vice Admiral (VADM)	Admiral (ADM)	Fleet Admiral (FADM)
AIR FORCE										
Second Lieutenant (2d Lt)	First Lieutenant (1st Lt)	Captain (Capt)	Major (Maj)	Lieutenant Colonel (Lt Col)	Colonel (Col)	Brigadier General (Brig Gen)	Major General (Maj Gen)	Lieutenant General (Lt Gen)	General (Gen)	
COAST GUARD										
Ensign (ENS)	Lieutenant Junior Grade (LTJG)	Lieutenant (LT)	Lieutenant Commander (LCDR)	Commander (CDR)	Captain (CAPT)	Rear Admiral Lower Half (RADM)(L)	Rear Admiral Upper Half (RADM)(U)	Vice Admiral (VADM)	Admiral (ADM)	

Rank Insignia of the U.S. Armed Forces

ENLISTED

	E-1	E-2	E-3	E-4	E-5	E-6	E-7	E-8		E-9		SENIOR ENLISTED ADVISORS
Army	no insignia Private E-1 (PV1)	Private E-2 (PV2)	Private First Class (PFC)	Corporal (CPL) Specialist (SPC)	Sergeant (SGT)	Staff Sergeant (SSG)	Sergeant First Class (SFC)	Master Sergeant (MSG)	First Sergeant (1SG)	Sergeant Major (SGM)	Command Sergeant Major (CSM)	Sergeant Major of the Army (SMA)
Marines	no insignia Private (Pvt)	Private First (PFC)	Lance Corporal (LCpl)	Corporal (Cpl)	Sergeant (Sgt)	Staff Sergeant (SSgt)	Gunnery Sergeant (GySgt)	Master Sergeant (MSgt)	First Sergeant (1stSgt)	Master Gunnery Sergeant (MGySgt)	Sergeant Major (SgtMaj)	Sergeant Major of the Marine Corps (SgtMajMC)
Air Force	no insignia Airman Basic (AB)	Airman (Amn)	Airman First Class (A1C)	Senior Airman (SrA)	Staff Sergeant (SSgt)	Technical Sergeant (TSgt)	Master Sergeant (MSgt)	First Sergeant (E-7)	Senior Master Sergeant (SMSgt)	First Sergeant (E-8)	Chief Master Sergeant (CMSgt)	First Sergeant (E-9)	Command Chief Master Sergeant (CCM)	Chief Master Sergeant of the Air Force (CMSAF)
Navy	no insignia Seaman Recruit (SR)	Seaman Apprentice (SA)	Seaman (SN)	Petty Officer Third Class (PO3)	Petty Officer Second Class (PO2)	Petty Officer First Class (PO1)	Chief Petty Officer (CPO)	Senior Chief Petty Officer (SCPO)		Master Chief Petty Officer (MCPO)	Force or Fleet Command Master Chief Petty Officer (FORMC) (FLTMC)	Master Chief Petty Officer of the Navy (MCPON)
Coast Guard	Seaman Recruit (SR)	Seaman Apprentice (SA)	Seaman (SN)	Petty Officer Third Class (PO3)	Petty Officer Second Class (PO2)	Petty Officer First Class (PO1)	Chief Petty Officer (CPO)	Senior Chief Petty Officer (SCPO)		Master Chief Petty Officer (MCPO)	Command Master Chief (CMC)	Master Chief Petty Officer of the Coast Guard (MCPO-CG)

U.S.ARMY

www.army.mil/symbols

Finding Your PC’s IP address

- You may find at some point that you need to locate your computer’s IP address, to get software updates, submit a trouble ticket for IT, or whatever reason.
- Log on to the WRNMMCB Intranet, which should happen automatically when you double-click on the Internet Explorer Icon.
- Scroll down to the bottom of the page, the IP link is on the lower left. See next page…

Home - Windows Internet Explorer provided by NNMC Bethesda

https://nnmcintra/Pages/Default.aspx

File Edit View Favorites Tools Help

Page Tools

- Adverse Drug Reaction Application
- AHLTA Toolbox
- Cmd. Awards Program
- Daily Status Report
- DoD Links
- Government Links
- ITD Help Desk
- JTF CAPMED
- Lean Six Sigma Idea Submission
- Medical Readiness
- Medicine Links
- Medical Guidelines
- Navy College (NNMC)
- NCA Extranet
- NNMC Intranet (Previous)
- NNMC Public Web Site
- Non-Formulary Drug Request
- Nursing Directorate
- Tenant CMDS. Links
- What Is My IP?
- Why-Gram???
- NNMC Bed Report

Video Links

- CDC Hand Hygiene
- Code Response
- R.A.C.E.

Documents

- CMAX

Lists

Sites

Surveys

SharePoint Training

NNMC SharePoint Virtual Training Center

Fall Festival 2010

uB Healthy Staff Initiative

VACANCY ANNOUNCEMENT: PHYSICAL THERAPIST, GS-0633-11

VACANCY ANNOUNCEMENT: MEDICAL TECHNOLOGIST, GS-0644-11

VACANCY ANNOUNCEMENT: PRACTICAL NURSE SPEC (APU), GS-0620-07

VACANCY ANNOUNCEMENT: SOCIAL WORKER, GS-0185-12 ! NEW

VACANCY ANNOUNCEMENT: COUNSELING PSYCHOLOGIST (SUBSTANCE ABUSE) (0180), SOCIAL WORKER (SUBSTANCE ABUSE) (0185), GS-12 ! NEW

Add new announcement

NNMC News

Title
ARE YOU GETTING OUT OF THE MILITARY IN THE NEXT 12-18 MONTHS? ! NEW
SAPR Victim Advocate Training
IMMIGRATION & CUSTOMS ENFORCEMENT (ICE) NETWORKING EVENT
FINANCIAL PLANNING FOR MILITARY TRANSITION CLASS
HOUSING OFFICE CLOSURE
BAE SYSTEMS NETWORKING OPPORTUNITY PRESENTATION
ADECCO STAFFING EMPLOYMENT REGISTRATION
Database Literature Search Class
Wounded Warrior Ou[redacted]cupuncture COMING VERY SOON!
FRE[redacted] Reviews and Mock Interviews!!!
[redacted]Workshop
** IMPORTANT ** DIRECTION FOR USE OF BC 1000 BACKCHECK VALVE
High-Level Disinfection/Sterilization Overview

Add new announcement

- Galley Menus
- Guardian Provider Privilege N
- ITD Virtual Helpdesk
- Lean Six Sigma Idea Submissi
- Logistics Department
- Maryland Workforce Exchang
- MDConsult/First Consult
- Mosby Nursing Skills
- Motorcycle Safety Training
- My Pay (DFAS)
- Navy Family Accountability ar
- Navy Voting Assistance Progr
- New S3 Surgery Scheduling S Only) - Now use your CAC Lo
- NNMC Peer Review Program
- NSIPS for electronic service re
- OptiLink PCSS/StaffRunner
- Pastoral Care Weekly Service
- PRIMS Database
- Quality Council Dashboard
- Send a Skytel Message
- SLDCADA Link

Trusted sites 100%

start Inbox - Microsof... Home - Windows... how to copy scre... How do you cop... Microsoft Power... 12:53 PM