DEPARTMENT OF THE ARMY
WOMACK ARMY MEDICAL CENTER
FORT BRAGG, NORTH CAROLINA 28310

REPLY TO ATTENTION OF:

MCXC-CO

1 July 11

MEDICAL STAFF SUMMARY FOR HEALTH CARE TRAINEES

Listed below is an executive summary of some crucial information for all caregivers at WAMC. Before you perform any patient care, you must be familiar with this information. In addition, you must also be very knowledgeable about the attached complete medical staff bylaws, the scope of practice documents in the areas where you will be working, as well as the scope of practice expectations from you own training program.

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

Safety. All WAMC staff must be familiar with basic patient safety initiatives. These mirror the current National Patient Safety Goals.

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

2. *Communication Between Caregivers*: The patient name, location, provider name and contact/pager number, date/time of specimen collection and culture location (if appropriate) must be legible entries on all laboratory requests. If any provider receives critical lab or radiology test results, the person receiving the test result must verify by "read back" those results. The following abbreviations must NEVER be used in ANY form of documentation: **U, IU, QD, QOD, SQ, MS04, MgS04. Also when writing numbers with decimal places, you MUST use leading zeros (ie 0.4) and must NEVER use trailing zeros (ie 4.0).**

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

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

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

6. *Reconcile Medications through the Continuum of Care*: Complete medication lists are expected on both the H&P and transfers, as well as the discharge paperwork. Each medication must list an indication. Patients should go home with a new list if any changes are made.

7. *Prevent Falls*: Identify patients potentially at increased fall risk and communicate that to the entire healthcare team.

In addition:
1. All care providers must use OSHA approved safety devices.
2. Under **NO CIRCUMSTANCE** will restraint orders be written as "PRN," "continuous" or "as needed." Such orders are **NEVER** authorized for restraints of any type.
3. Wrong site, wrong procedure, and wrong patient errors can be prevented by using a three-pronged approach—using a pre-procedure verification process, marking the procedure site, and conducting a final pre-procedural "time out."

Advanced Directive/DNR (Abatement) Orders. At the time an abatement order is written, documentation of the rationale for the abatement order will be made in the progress notes by the attending staff physician or PGY-2 or higher level GME physician. GME physicians must document discussion with and agreement by a specific staff physician. A staff physician must countersign the progress note (with date/time) within 24 hours. The note must show the patient's decision-making capacity and concurrence of the patient. Only privileged staff physicians may write an abatement order. Physicians in GME status, at least PGY-2 level or higher, may transcribe a verbal abatement order from a privileged staff physician (e.g. "DNR per Dr John Doe", then stamped/signed/dated/timed by the GME physician). No other staff (e.g. nurses) may take a verbal abatement order.

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

Consents. The provider performing procedures or treatments has the responsibility for informing the patient and for obtaining consent. The consent will include as a minimum the alternatives/options to the procedure, procedure risks and benefits. A statement will be included that all patient questions were answered. Consent forms must be completed, signed, dated, and timed prior to performance of the procedure.

Consultations. When providers are "on call" they are to be available by telephone or pager. They are to respond telephonically or in person within 10 minutes. "STAT" or "ASAP" consults must be made by direct provider to provider communication. Patient flow and overall patient times in the ED are directly dependent on the ability to disposition patients in a timely fashion. The goal, though not always attainable, is treatment and disposition within 2 hours, which includes the time a consultant takes to visit the patient. When seeing a patient in the emergency room, as soon as it is clear than an admission is appropriate and a suitable ward and admitting service are chosen, admission orders must be written and given to the ED nurses immediately. The H&P and diagnostic tests that will not change disposition can wait be done while the patient is on the ward. If the time from consultation to the time orders are written is expected to be > 90 minutes, then back up staff must be called in to facilitate more rapid ED clearance.

Documentation. H&Ps and progress notes must be legible. The provider must as a minimum date, sign, and use a name stamp or legibly print his/her name beneath the signature. Daily progress notes must include assessment of pain level and plan to mitigate and relieve the pain if present. The follow-up note should document that the treatment used to relieve the pain was successful or that another modality is being used. There must be a progress note every day, even on the day of discharge. Narrative summaries must be done on patients whose stay exceeds 48 hours and dictation should be performed on the day of discharge. Notes written by providers in training must include the Post Graduate Year (PGY) status on all documentation. The interdisciplinary plan of care form must be completed on the front of every patient chart.
Medical orders written for patient care will be dated, timed, and signed by the provider issuing the order before the instructions are executed. The provider will either use a name stamp or will legibly print his/her name beneath the signature. Orders written on inpatients will include the indication for each medication, unless the indication for the medication is noted in the H&P or progress notes. PRN medication orders must have an indication stated.
Final diagnoses, complications, and operative procedures are recorded without use of abbreviations or symbols on the inpatient treatment record discharge cover sheet. If a PA, PGY-1 physician, PGY-1 oral/maxillofacial surgeon, or student completes the H&P, all sections must be countersigned within 24 hours and before any surgical procedure. The problem-oriented medical record approach utilizing SOAP (Subjective, Objective, Assessment, and Plan) format is the preferred documentation style. The preceptor or the preceptor's representative will countersign notes made by students. All notes made by any trainee will include documentation of the level of staff involvement for every encounter (ie either 'seen with Dr. X' or 'discussed with Dr. X').
WAMC is committed to high quality H&Ps. Trainees should use the long form for all admissions and ensure that a complete evaluation is performed. This includes a detailed HPI, past medical, surgical, social, and family history as well as pertinent occupational or military history, allergies, detailed examination, differential diagnosis, assessment, and plan.

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